S. HRG. 105–986

MEDICARE+CHOICE IMPLEMENTATION

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

JULY 30, 1998

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

56–273—CC WASHINGTON : 1998

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-058666-6

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MEDICARE+CHOICE IMPLEMENTATION

THURSDAY, JULY 30, 1998

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

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

Also present: Senators Grassley, Mack, Moynihan, Baucus, Rockefeller, and Breaux.

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

The CHAIRMAN. The committee will please be in order.

It was exactly 1 year ago yesterday that Congress passed the conference report creating the Medicare+Choice program. After three full years of deliberation, we arrived at a bipartisan consensus. We granted Medicare beneficiaries more benefit design options for their health care coverage and we established requirements for comparative health plan information to help them make informed decisions, and we strengthened consumer protections.

We also began a several-year transition period over which we are making payments to private Medicare+Choice health plans more equitable across the country.

We expect this to encourage more organizations to contract with the government to offer Medicare+Choice plans, steadily improving options available to beneficiaries around the country.

These steps were taken because we believe that allowing seniors to pick the type of health plan that best suits their needs and preferences will create competition that will result in improved benefits and quality, while also constraining cost.

As Federal employees, we participate in a similar program that provides a wide degree of choice among high-quality health plans.

Today, we are here to examine the progress the administration has made in the last year in carrying out implementation of the Medicare+Choice program. We will examine the administration's readiness to roll out this new program. In addition, we will take testimony from individuals and firms involved in the Medicare+Choice undertaking.

In the near future, it is my hope that we will hear from the American Association of Retired Persons, who was invited to join our panels but was unable to participate today. It is critically im-

portant that we receive testimony from the beneficiaries who are at the very center of this effort, and from their representative organizations.

In taking today's testimony, I will be doing two things. First, I will be assessing where we are now in the Medicare program. Are we, in fact, on course to fulfill the promise of the Medicare+Choice program for beneficiaries?

I intend to examine how the Federal Health Care Financing Administration is planning to inform beneficiaries of the change in Medicare and, most specifically, of the plans that are available to them in their own communities.

HCFA has deviated significantly in recent days from its own plan to distribute informative material to all beneficiaries nationwide. The good news, is that HCFA prepared an information book to send out. The bad news, is beneficiaries in 45 States will not get it.

So, separately, we will take testimony concerning the quality assurance required imposed by HCFA on Medicare+Choice plans, and review whether HCFA adheres to comparable standards in the fee-for-service plans that it administers directly. Our goal is to make sure that all the Medicare plans, whether publicly or privately administered, meet the highest standards of performance and outcome.

Without objection, I will include my full statement as if read and, with that, call upon my good friend and colleague, Senator Moynihan.

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

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

Senator MOYNIHAN. Mr. Chairman, I would so the same. I would echo each of your remarks. I would add only that I hope we might hear a little something from Mr. Hash about the year 2000 problem with the HCFA computers.

You have 183 systems in place, and getting on top of and ahead of that problem is a very real one, and the time is going by very quickly. You are going to want to be ready by the end of this year. I see you nodding. I will look forward to hearing what you have to say.

Welcome to you all.

The CHAIRMAN. Senator Baucus?

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

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

This hearing is very important to our State of Montana. Obviously to other States as well, but particularly to our State, because we are a State that is changing very fast and HMOs are now forming in many parts of our State, Billings, Mazula, Great Falls, and some others, and even in small towns where HMOs are developing, like Haver, for example, which is smaller than some other towns.

But I might say that, with all its growth in managed care in the private market, plans are not expanding in Medicare. The reason is quite simple, and that is the Medicare reimbursement in man-

aged care is just too low. I might say, in our entire State, which spans the distance from Chicago to New York, or from Chicago to Washington, DC, we do not have much choice, other than fee-for-service. We only have one managed care plan in the State which provides Medicare coverage, and that is called the Yellowstone Community Health Plan that is in Billings, Montana. But only one entire State is able to make a go of it with such low reimbursement rates.

So, at this hearing I hope to explore what we can do. That is, I would like HCFA's response to questions about a blended rate, for example, of rural versus national; what HCFA plans to do about funding the blended rate, at least that was enacted last year, because I believe that all parts of the country, including rural parts of the country, should have the benefit of choice between the managed care or fee for service or other services like for provider-sponsored organizations, et cetera.

We have on our third panel, Mr. Chairman, Mr. Jim Paquette, who is from Billings, who is the manager or the Billings organization, and he is very knowledgeable in this and he can help inform our committee of some of the particulars of the problems that he faces, and hopefully can help us find a solution. Thank you.

The CHAIRMAN. Thank you, Senator Baucus. I would now like to welcome our first witness, Mr. Michael Hash, the Deputy Administrator of the Health Care Financing Administration.

Mr. Hash, it is a pleasure to welcome you. Please proceed with your opening statement.

STATEMENT OF HON. MICHAEL HASH, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Mr. HASH. Thank you, Senator Roth. Mr. Chairman, Senator Moynihan, Senator Baucus, it is a pleasure for us to be here and to participate in these hearings about the implementation of the very significant statutory provisions on Medicare+Choice that were included in the Balanced Budget Act of last year. We are anxious to talk to you about our progress in implementing these critical changes to the Medicare program.

The Medicare+Choice program, as you know only too well, provides important new opportunities for our beneficiaries. They will have more options in terms of private plans than ever before; they can receive their care through plans that are organized and run by providers or from traditional insurers; they can choose plans that cover benefits that Medicare does not cover, including things like prescription drugs and other services that are not in the traditional Medicare benefit package.

They can be offered the entire range of health delivery options that are existing in the private sector today and choose a plan that best meets their needs and their values.

This is an historic step forward for the Medicare program. We take our responsibility to help both the health plans and our beneficiaries understand these new opportunities very seriously.

We have accomplished a great deal, I think, in our efforts to implement the Medicare+Choice program, including as of today, pub-

lication of all Balanced Budget Act mandated Medicare+Choice regulations.

We are implementing, are you referred to, Mr. Chairman, an eight-point program, which I have a chart here that summarizes the key elements of our Medicare education campaign, which is designed to help beneficiaries make informed choices that best meet their needs.

We are also reaching out to the potential audience of health care plans around the country throughout outreach meetings that we have been conducting all summer. So far, we have actually touched some 1,200 representatives of health plans and organizations that are interested in becoming Medicare+Choice plans.

A key Medicare+Choice feature is, as you know, measuring and improving the quality of care and service to beneficiaries. We need to make sure that we provide clear information so that our beneficiaries can compare the quality and performance among the options that are available to them. We will require coordinated care plans, managed care plans, with networks to show that, in fact, they are improving quality over time.

We are not, however, in this effort of quality accountability trying to adopt a one-size-fits-all approach. We intend to work closely with our health plan applicants so that we provide appropriate flexibility to plans that have less rigorous networks, such as preferred provider organizations, so that they can be ensured to meet appropriate and feasible quality improvement requirements.

We are also providing, we believe, appropriate flexibility to provider-sponsored organizations, which are a key option that the Congress authorized in the Balanced Budget Act last summer.

Our regulations setting forth the requirements for provider-sponsored organizations are the product of a very successful negotiated rule making process and I think they, in the end, recognize, appropriately, the unique characteristics of provider organizations that wish to become health plans.

The law does require providers affiliated with these organizations to provide a substantial portion of the covered benefits directly through their affiliated providers. This ensures that the many types of providers participating in such organizations work together to coordinate care and to share the financial risks attendant with capitated payments.

Educating our beneficiaries, as I mentioned a moment ago, so that they can make informed choices is one of our most important tasks. We have revised our plans, as you noted, Mr. Chairman, for our special information campaign that is scheduled for November of 1998, this fall, based on advice both from the Institute of Medicine, from focus groups that we have conducted throughout the country, and from our own internal analysis.

This plan that we are following today will allow us to refine our efforts before the first coordinated enrollment period that is called for under the statute occurs in November of 1999.

We have launched an eight-point program that includes, again, as is indicated on the chart here, beneficiary mailings, toll-free telephone information services, Internet activities, a national train the trainer program, a national publicity campaign, State-, local- and community-based publicity and outreach campaigns, enhanced

beneficiary direct counseling from State insurance assistance programs, and, importantly, in all of this, in order to put an effective system in place, a comprehensive evaluation and assessment of the effectiveness of our education program.

We will first test this entire system, not just the printed materials but the telephone, the counseling services, and the outreach activities, in five States this fall.

This includes mailing to the beneficiaries in those five States handbooks that are tailored to reflect the market plans that are available, with side-by-side comparisons of costs and benefits for the plans that are available.

We also will have our toll-free number available in those five States this fall, with personnel who will be trained to answer beneficiary questions about their choices.

We plan to phase in our call center access to another 25 percent of our beneficiaries over the next 9 months in phases of 3 months each, with full nationwide service of the toll-free number by August of next year.

Now, outside the five pilot States that we are testing this fall, we will also send this fall to every Medicare beneficiary outside of those five States a bulletin which is outlining their Medicare+Choice options in a generic form, other useful information about the Medicare program, and telling them how they can obtain, this fall, comparative information about the health care options that are available in their area.

This phased approach of putting into place a comprehensive system for educating our Medicare beneficiaries allows us to make, I think, wise use of our scarce resources.

As you know, there was $200 million authorized in the BBA to support this first year of activities for Medicare education, but in the end, the appropriations process produced $95 million for this purpose, roughly a little over $2 for each Medicare beneficiary.

Next year, if we receive a similar appropriation, $95 million in fees to support this activity, it will mean that beneficiaries will not have all of the tools that they will need to make informed choices about the options that are available to them.

The Medicare+Choice program is the most significant change in Medicare's 33-year history. We have already published all of the regulations required under the Balanced Budget Act, we are helping health plans to understand how they can participate in this program, and we are undertaking what we believe is a prudent strategy to help beneficiaries understand their options.

Again, let me stress that adequate funding for education is essential if the Medicare+Choice program is to succeed.

Mr. Chairman, we very much appreciate your calling this hearing and inviting us to participate. At this point, I would be happy to respond to any questions that you or other members of the committee may have. Thank you.

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

The CHAIRMAN. Well, Mr. Hash, I have to say that I am extremely disappointed at the lack of action this year. Let me point out that the BBA specifically provided that, during November 1998, "The Secretary shall provide for an educational and publicity campaign to inform Medicare+Choice-eligible individuals about the

availability of Medicare+Choice plans offered in different areas, and the election process provided under this section."

Now, as I said earlier, the good news is that you developed a pamphlet that does exactly that. But this is a pamphlet that has been worked upon and was to be delivered to everybody that was eligible throughout the country. It contains the information as to what is available within regions, as required.

At the last moment, instead of supplying it nationwide, HCFA has decided to send it to only five States. Now, that does not meet the criteria. The agency was given $95 million—that is a lot of money—to help educate. Now, as you said, the whole purpose of education is to put the senior citizens in a position where they can make intelligent decisions.

Now, instead of doing that, we are sending out, I think it is an eight-page pamphlet that raises more questions than it answers. It does not attempt to break down by region what is available.

So I have to tell you, I am very unhappy about this. If it is good enough to send to the five States, why it is not good enough to send to the others? Why was this decision made at the last moment? Can you name the five States, please?

Mr. HASH. Yes, Mr. Chairman. They are Ohio, Arizona, Washington, Oregon, and Florida.

The CHAIRMAN. Why those five States?

Mr. HASH. Those five States were chosen because they represent a range of penetration of managed care plans in Medicare as of today. That is to say, they include States with very high penetration, medium amounts of availability of managed care plans, and States with very little in the way of managed care options for Medicare beneficiaries.

They were chosen, obviously, as a sample that would be reflective of the different circumstances we would encounter in terms of educating our beneficiaries so that we could test our full system, which is not just a handbook, but also involves other materials, the telephone, the counseling services, our network of partners of over 80 organizations who are helping us, in effect, provide one-on-one counseling for beneficiaries.

In response to your comments about the requirements in the BBA with regard to the November special information campaign which is required, we believe that in the program as I outlined it—and I would be glad to talk about it further—that we are fully meeting the requirements of the statute with regard to November 1998. The actual requirement for the mailing of a handbook in the statute is in advance of the first coordinated enrollment period, which is November 1999.

We were going to send the handbook to all beneficiaries, as you noted, Mr. Chairman. But, after we evaluated from our focus groups, from our consultations with expert advisers, from our own analysis, we felt like more full evaluation of not just the handbook, but the entire support system, needed to take place before we actually committed in advance of the coordinated enrollment period that takes place in November of 1999.

The CHAIRMAN. Well, I have to say, I just do not find that response satisfactory. What, in effect, we are doing is delaying, for all practical purposes, the new program for another year. It is not

going to be practical for most people to make an informed decision. I have to tell you, I am very, very disappointed.

Now, we gave you a $95 million use-fee appropriation. Frankly, it is hard to see much benefit. Now you are coming back and you want $150 million next year. Why should we ask providers to pay this large sum of money, when the 1998 appropriation accomplished very little?

Mr. HASH. Well, Mr. Chairman, I guess I would have to disagree with you that it has accomplished very little. We think we are putting into place the infrastructure that is necessary to provide the support our beneficiaries need for our choices.

With respect to this fall's special information campaign, it is important to recognize, as I know you know, Mr. Chairman, that in that handbook that you referred to that we prepared, that that handbook went to press in June, and therefore it would not contain, and does not contain, any information about any new health plans that may be available by November of this year.

So even if we had sent the handbook to all 39 million beneficiaries, all that it would contain in the way of specific plan information would be with respect to the existing HMOs that hold risk contracts with the Medicare program as of June of this year.

The CHAIRMAN. Well, as I said, I am unhappy because I think this delays the program.

Let me turn to another matter. We are all, of course, much concerned about the quality of Medicare medical care. It is important to the committee, I know it is important to the agency. But there are complaints that HCFA—and you did touch upon this in your opening statement—has developed a very, very complex data collection program for Medicare+Choice plans, and that this quality program is so stringent, that it will be very difficult for preferred provider organizations, in particular, to meet these requirements.

Now, you, in your opening statement, said you are going to be flexible and make adjustments. What do you mean by being flexible and making adjustments? Just let me read you what the Blue Cross Blue Shield Association states.

They say, "Preferred provider organizations are designed to provide a wide choice of providers and, therefore, PPOs do not have the contractual or administrative capabilities to collect the extensive data or to perform health outcome improvement mechanisms that QISMC requires.

If forced to comply with a standard of quality that was formulated for HMOs, then PPOs would need to change their structure so fundamentally that they would no longer be PPOs."

How are you going to meet that challenge?

Mr. HASH. I am glad you asked about that, Mr. Chairman, because we join you in our commitment to making sure that any health plan with which we do business meets appropriate quality standards and protections for our beneficiaries.

To that end, the Congress wisely included in the BBA very specific requirements for any coordinated care plan, that is an HMO, that is a PPO, that is a provider-sponsored organization, any organization that includes a network of providers comes under the requirements that are set forth actually in the BBA itself in the Medicare+Choice program.

There are three elements to those requirements in the law. One, is to report information relative to individuals who are enrolled in these managed care plans, and the instrument for doing that is something called the HEDIS data collection survey which was developed in the private sector by the National Committee on Quality Assurance and which has been adapted for use in the Medicare program to collect information about the services and the status of individuals who are participating in health plans.

So, with regard to the reporting of information under the quality requirements, we think all health plans will be able to report the kind of information that HEDIS is requiring. We want to work with plans, if there are special circumstances where there may be obstacles to that reporting.

The CHAIRMAN. You sound to me like you are saying there is no flexibility.

Mr. HASH. No, on the contrary, Senator. I am saying, if there are any special circumstances——

The CHAIRMAN. You are saying special circumstances.

Mr. HASH. That would prohibit a plan from being able——

The CHAIRMAN. Let me ask you. Do you think there are special circumstances with respect to PPOs?

Mr. HASH. We have been having discussions with the Blue Cross and Blue Shield——

The CHAIRMAN. That was not my question. I said, do you think there are.

Mr. HASH. We are working with them to further identify what they think are the special circumstances and to see how we can accommodate them in our reporting.

The CHAIRMAN. I want you to report back to me how you address this problem.

Mr. HASH. Yes, sir.

The CHAIRMAN. Let me ask you this question. Do these same requirements apply to the government-run program?

Mr. HASH. When we report the HEDIS information that we are collecting from health plans, we will be reporting that data for the traditional Medicare program as well.

The CHAIRMAN. Let me ask you this, then I am going to turn to my colleague. Have any PPOs submitted applications?

Mr. HASH. Senator, I do not know the answer to that question. I will get back to you on that. I do not believe——

The CHAIRMAN. Is that not a matter of concern, you do not know?

Mr. HASH. Well, I have the data, I just do not have it in front of me right now. I would be happy to furnish it for you.

Senator MOYNIHAN. Mr. Hash, surely there is someone behind you who has it.

Mr. HASH. As you know, the regulation which sets forth the terms and conditions for the organizations to meet was published on June 27, and it has just been about a month. We have been having our outreach meetings that I referred to.

The CHAIRMAN. Have you any applications?

Mr. HASH. We have some, I just cannot identify the exact number. But it is relatively small at this point, across the board. We obviously have over 350 existing organizations that we believe will be continuing in the Medicare+Choice program.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Thank you, Mr. Chairman. Mr. Hash, we want to assure you, you are appearing before a friendly committee. We are on your side.

Mr. HASH. I appreciate that, Senator.

Senator MOYNIHAN. Just to make a general point, or observation, if anything. When this committee was holding a year-long set of hearings on the administration's health care legislation in 1994, there came a moment that had a quality of epiphany about it. As a matter of fact, it was a Jesuit who offered it, a professor of ethics at Fordham named Feahy, who said, what you are observing is the commodification of medicine. Where previously it was a guild arrangement, separate, self-regulating, self-defining, it is now entering a market system.

There is a history in this. For half a century, we argued to Congress whether or not labor was a commodity, and indeed, we passed the law in 1914 that said it was not. I do not know that that law made any difference or not, the Clayton Antitrust Act.

When Feahy made that remark about commodification, a gentlemen, who is a doctor, who is head of the UCLA Hospital in Los Angeles said, can I give you an example? In Southern California, we now have a spot market for bone marrow transplants. There is a spot market for pig iron, soybeans, and bone marrow transplants.

That means that Medicare and HCFA, which begin as government-run activities prior to any real beginnings of this market system, has to adapt to a market system and it surely must be one of the more complicated things to do. We are asking you what was, in effect, a government monopoly to come to terms with an emerging market for which there are as yet very few rules.

The Congress, predictably, has begun picking up regulations for this new market, and we will call them by various names. We call it the Interstate Commerce Commission, and we think of railroads. Would you want to comment on that? Do you know what I am talking about? Am I talking about anything that makes sense?

Mr. HASH. Yes, Senator, you are. As someone who has been an observer of this program for many years as you have, you recognize that in the beginning of Medicare the goal was to create a health insurance program that roughly mirrored the choices and opportunities for health coverage that working people had. That was the goal in 1965.

Senator MOYNIHAN. Yes, it was. I was here.

Mr. HASH. That is what the Medicare design, I believe, today reflects. The traditional program looks like traditional coverage in the mid-1960's. Obviously, there have been changes along the way.

Now we see, in the last number of years, very profound changes in the way in which health care is organized and delivered. In fact, what has been historically a much——

Senator MOYNIHAN. Can I interrupt just to say that one of the sources of these changes has been an enormous increase in the amount of health care that is possible. Medical science has changed some.

Mr. HASH. Definitely.

Senator MOYNIHAN. Yes.

Mr. HASH. What we are trying to do, and I think what the Congress intended to do with this legislation, was to, in effect, update the Medicare program to make sure that the choices, opportunities, and protections that people in the working age bracket have in terms of their health coverage would also be available to people once they reach the Medicare age.

So I think what you see here, what the Congress did, what you did, what we have been trying to do, is to make sure that the choices and opportunities that are available to Medicare beneficiaries mirror those that are available to working people.

Senator MOYNIHAN. In this respect, you are trying to repeat the 1965 objective, which was to make it so that elderly, retired persons would have health care that is normally available to working age people.

Mr. HASH. That is correct, Senator.

Senator MOYNIHAN. And that health care system has now profoundly changed, and you are trying to do the same thing. It cannot be easy, but I appreciate your recognizing it. Could you send us a note on how you are doing on the Y2K?

Mr. HASH. I would be happy to.

Let me just say for the record, if I may, Senator, that there is no higher priority at our agency or at HHS with respect to being millennium compliant with both the systems that we rely on internally, as well as the very large number of systems that our contractors use to process claims and pay bills.

Senator MOYNIHAN. I do not envy you, but I thank you.

The CHAIRMAN. Senator Baucus has agreed to proceed with one question.

Senator BAUCUS. Mr. Chairman, I just wondered if you might move that easel way back over to the side. There are a couple of folks from Montana behind it and cannot see everyone here upon the dais. Can you move that over, please?

The CHAIRMAN. They cannot see us?

Senator BAUCUS. They cannot see you, Mr. Chairman.

Senator GRASSLEY. I thank my colleagues for letting me go out of order, because I have a situation I have to get to in about 5 minutes.

So, Mr. Hash, one question orally, and then two I would ask for recommendations. Also, to follow up on the question that Senator Roth asked you about not getting this out to all these States, I would only say that, for both your benefit and Senator Roth's, that there is a timetable that has come out and it might help a little bit. But we have got to make sure that we hit that timetable, because I agree with everything Senator Roth said. But if the time table is followed, that will make up for some of the shortcomings.

Mr. HASH. Thank you, Senator. I appreciate that.

Senator GRASSLEY. The question is in regard to the report that was out on Monday from the Inspector of HHS on the adjusted community rate process. For those who are not familiar with it, this is a process by which HMOs estimate the amount that they need to cover their costs of providing the Medicare benefit package to each enrollee.

According to that report, HMOs have overestimated their administrative costs and were overpaid by the Medicare trust fund to the tune of almost $2 billion in 1996.

I understand that HCFA does not agree with the Inspector General's recommendations that legislation be introduced to recover excessive amounts paid for administration. So my question is, should these monies not be returned to the trust fund?

Mr. HASH. Senator, my understanding is that our position is that we have made—and I know we had made—changes in the ACR process in the requirements and the methodology that must be followed which were included in our June regulation affecting the Medicare+Choice program, and we believe that the kinds of difficulties and shortcomings that are identified in that IG report have been fully addressed and will be a part of the requirements for submitting this information in the future.

Senator GRASSLEY. But what about the $2 billion already lost, can we not get that back for the trust fund?

Mr. HASH. I would be happy to take a look at that, Senator. I do not know how feasible that is. I would be happy to look into that for you and get back to you.

Senator GRASSLEY. Thank you very much. Thank you to all my colleagues for giving me the time.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Hash, our concern in Montana is the formulas which provide managed care payments for Medicare are just way too low. The payments are just way too low. You know as well as I, for example, in Dade County the payments are very high, like $700 something per person, per month. Whereas, I think in Nebraska, it is like $200 something a month. In Montana, we get the floor, which is $367, as all of the lower States get.

But the problem is, this was locked in, as you know, based upon historical costs. Some States in rural parts of the country, because of under-utilization and lots of other factors, are now locked into a much lower rate, whereas other parts of the country where there is maybe lower utilization and certain other factors, are getting rewarded for inefficiency. In a certain sense, we are penalized for our efficiency.

As you well know, in the Balanced Budget Act, the law provided for phasing in the blended rate, beginning November 1998. As I understand it, that is not going to happen because the dollars are not there.

As I understand it, the dollars are not there because, under the Balanced Budget Act, the dollars first go to the floor payments; then next the 2 percent update, and then whatever is left goes to the plan. Apparently, there is nothing left for the plan. That might have something to do with excessive charges or costs in the first two categories; I do not know.

But the fact is, rural States are getting penalized. They are getting hurt as a consequence of this. My question to you is, when is the blend going to start to kick in?

Mr. HASH. I think my information, Senator, is it will not happen in 1999, but we believe there is some possibility——

Senator BAUCUS. It, first, will not happen in 1998, even though the law requires it.

Mr. HASH. That is correct. You stated that correctly. Because of adjustments that had to be made and the budget neutrality requirements for 1999, there will not be any effect of the blend once again.

We hope that, beginning for calendar year 2000, that that will be changing and that some opportunity to provide the blended rate to those counties that are qualified for it will begin occurring.

Senator BAUCUS. You say you hope. What is the basis that you are hopeful to achieve reality?

Mr. HASH. Senator, the reason there is sort of a tentative nature in my answer, is because the budget neutrality requirements and the other adjustments are based upon estimates.

In the past and in the future, if those estimates which affect the rates turn out in reality after the fact to have been in error, either too low or too high in comparison with real experience, then there has to be an adjustment for the future year in order to make up for that.

I think the precision of the estimates is improving, and the likelihood is that we will be able to accommodate maybe not the full amount of the blend payments in 2000, but certainly start down that road, as the Congress fully intended, and as we would like to see as well.

Senator BAUCUS. Well, why not change the order of payment?

Mr. HASH. Under the statute, Senator, we do not have any discretion.

Senator BAUCUS. No, no. But why not this public policy matter? What would your reaction be if Congress were to change the order of payment?

Mr. HASH. Well, I think we would be willing to work with the Congress and look for a solution that could be broadly supported.

Senator BAUCUS. Is there any public policy reason why it has to be first floor, second, 2 percent, whatever is left, blend?

Mr. HASH. I believe that was a decision that——

Senator BAUCUS. No, no. I know that is the decision, that is what Congress enacted. That is not my question. My question is, as a policy matter, do you think it has to be that way, or should be that way?

Mr. HASH. I do not think it has to be that way as a matter of policy, no, Senator. We would be glad to talk with you about ways in which the statute might be modified.

Senator BAUCUS. For example, the 2 percent and the blend shared, or a different order, or something like that.

Mr. HASH. I think that would be among the options. Yes, sir.

Senator BAUCUS. Thank you very much.

Senator CHAFEE. I have a couple of questions. How many people do you have enrolled, do you know? What percentage of the population? Of course, you are only working in those five States. Within those five States, what percentage of the Medicare population is enrolled in these plans, do you know?

Mr. HASH. I would need to get that for you. I know there are 5.5 million beneficiaries total in those States. The total number who are participating in managed care plans, I can get for you.

Senator CHAFEE. It may be anecdotal, but do you have any evidence back that this is a success, or it is not a success, or people like it? There are certain advantages, obviously. What is the biggest advantage, they are able to get pharmaceutical products, prescription drugs?

Mr. HASH. In many cases, Senator, up until now where we have been exclusively dealing with HMOs, the growth in enrollment has been very significant. It has been over 20, 25 percent a year in recent times.

So it is clear that the organizations that are offering private plans to our beneficiaries are being well received because they are enrolling in very rapidly increasing numbers.

Benefits had something to do with it. Lower cost sharing had something to do with it. No extra premiums has something to do with it. So there are a combination of incentives that make these options, that have made them up until now, quite attractive.

Senator CHAFEE. What do you mean, up until now?

Mr. HASH. Well, I mean, as far as we know, up until today.

Senator CHAFEE. All right. Fine. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Chafee.

Senator Rockefeller?

Senator ROCKEFELLER. Good morning.

Mr. HASH. Good morning.

Senator ROCKEFELLER. My question is just going to be off the subject altogether. You are doing your best to try and inform people and that is daunting, because I have had eight or nine hearings in my own State just on Medicare, and for the most part seniors are almost entirely unaware, almost 100 percent unaware, of any possibilities for being in PPOs, PSOs, whatever, and what that might mean, what they are, even to a great extent what Medicare itself is, when pressed.

Therefore, we are discussing, how are we going to inform them? All of this, of course, depends upon the fact that, if we get all these things up and going—and in West Virginia, they are not. HMOs are still very, very rare. There are really only two big ones, and one of the biggest in the south is losing money like crazy. They may go out of business as an HMO.

But if you look to the future and you say that we are now spending $207 billion on Medicare and the projections are that, in 10 years—actually, now, 9 and one-quarter years—that we will be spending $448 billion on Medicare, without changing a single thing in Medicare, without enacting anything else, without doing prescription drugs, without doing anything, just put it on cruise control right up to $448 billion.

Do you have in your own mind, number one, a confidence that we are making any pretense of honesty when we are talking about the keeping of health services, talking about making sure that quality is exactly the way it ought to be? By the year 1998, where are you going to get $250 billion?

The Republicans on the House side say you cannot raise new taxes, and that may very well happen on this side, too. Maybe it will happen on our side, too. Who knows? You cannot do very much with seniors. You raise the age, you means test it, and you have got a grand total of $4 billion a year. If you raise the age to 70,

you have got to fill that in with something to give health insurance to people.

So, essentially, it is a very bleak outlook, Medicare, I think. A very bleak outlook, without sort of major restructuring or reform. And I do not really know what I mean by that, but I am now willing to include, and I think Senator Moynihan and Senator Kerrey have talked about this, Medicare, Social Security, Medicaid all being wrapped into one enormous thing. And I do not know if that would make any difference, because Social Security is also going to have enormous problems.

But during the course of your day, do you worry about things like that as you are sort of figuring out, how are we going to get information and toll numbers out to those people out there so they can make proper choices? That, in fact, continues. There may be no choice for them to make at all.

Mr. HASH. Well, Senator, we do worry about it. I think it was wise, as the Congress, in the BBA, established the bipartisan Commission on the Future of Medicare, and wise that you and your colleagues who have pointed to that——

Senator ROCKEFELLER. We have a great Chairman. We have a great Chairman, right here.

Mr. HASH. And wise that you were pointed to that body yourself.

Senator ROCKEFELLER. That is also true. [Laughter.]

Mr. HASH. I know the way you just articulated the challenges facing Medicare, and other programs that are financed in the way they are, are very daunting challenges, indeed.

I think only working through vehicles like the bipartisan commission, the administration, and the Congress working together to address these longer term problems can we ensure and sustain the Medicare program for the next generation of beneficiaries.

But I do not think there is any question in our commitment or resolve to ensure that the Medicare program not only survives, but over time, actually better meets the needs of the elderly and the disabled. That is a big part of the agenda, I know, of your commission, as well as the financial underpinnings of the program, so that it is financed in a secure and a fair manner.

Senator ROCKEFELLER. Sometimes I think in these meetings that we are almost misleading. And I do not, because I have charts that leave people fairly realistic, and sometimes depressed, as they depart the meeting. We are misleading in this list over here in not talking about that crisis. When you say, 207 to 448, most people think, oh, that must be 2030 or 2025. No, that is probably $750 to $1 trillion gap. But just in the next nine and one-third years, $250 billion.

I sometimes wonder whether, when doing all this, because they are virtually and totally and entirely unbelieving of the figures, they see them, they accept them, they trust me—at least in my State—to tell them what I believe to be the truth, but I think they do not carry it out with them on the basis of their feeling that, well, in Social Security and Medicare the government will always fix it up and, therefore, there is no real responsibility.

I asked at the last one, would you be willing to pay more yourselves if the burden were shared by others on a proportional basis,

and all that kind of thing. They said, absolutely. I have no real idea that they necessarily mean that.

In other words, I think that this Medicare debate is going on almost entirely without the participation of the people, even as you are reaching out to them in a few States. I just want to put my statement in the record, Mr. Chairman, my opening statement which I did not give.

The CHAIRMAN. Without objection.

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

Senator ROCKEFELLER. But I just want to muse out loud about that.

Mr. HASH. I appreciate that, Senator. I do want to say, we are touching and reaching out to Medicare beneficiaries this fall in every State. All 39 million will receive information about the Medicare+Choice plan.

I would assume, and hope, that we could find better ways to engage the public's attention to the work that you and Senator Breaux are involved in, and others, about the future challenges that face Medicare. Our information campaign right now is trying to make sure that beneficiaries do understand, in the short run, these important choices.

Senator ROCKEFELLER. And I will stretch the Chairman's patience by just saying this, that——

Senator CHAFEE. It is not just the Chairman's patience.

Senator ROCKEFELLER. I will stretch the Chairman, Mr. Moynihan, Mr. Breaux's and Mr. Chafee's patience by saying one more thing. That is, without seniors understanding the full consequences of what is upcoming, it is possible that the Congress will not have the political will to do what needs to be done, which is the reason why I think there ought to be one more section on that chart.

Mr. HASH. I understand.

The CHAIRMAN. Senator Breaux, please.

Senator BREAUX. I am glad you reminded, Mr. Hash, Senator Rockefeller that it is his duty to reform this in the Medicare Commission. It is quite a challenge.

I think one of the problems we have is the fear of the unknown. If there is any program in the Federal Government that people are not able to understand quite easily, it is the Medicare program. I think it is probably true for members of Congress who actually have written the program, as well as for the people who are enrolled in it.

I have told the story a thousand times about the lady back home who told me, when we were working on health care, who said, well, whatever you all do up there, make sure that the Federal Government does not take over my Medicare. [Laughter.]

I mean, she loved it, but she did not want the Federal Government to have anything to do with it, because she thought it was a great program. I just told her, do not worry about that; we are not going to let that happen. [Laughter.] I did not have enough time to go into all of the details.

But, I mean, I think we are making some progress on the thing. Quite frankly, the smaller newsletter or bulletin which is going to go to, I guess, 45 of the States——

Mr. HASH. Correct.

Senator BREAUX. And not the ones who get the entire booklet, will all get this.

Mr. HASH. That is correct, Senator.

Senator BREAUX. I think, basically, it tries to summarize in the simplest of terms, but with adequate information, what the differences are. People are scared of change, but we are in a transition period with the delivery of health care in this country.

There is going to be a lot of people very upset, but I think it is going to be temporary. I think when they understand that there are more opportunities for how they get the health care, they are going to be more happy, not less, with the choices that are going to be there.

But it is very important, and here is my question. I have told this to Secretary Shalala and Nancy-Ann Min DeParle, we have to compare apples to apples and oranges, not apples to bananas, to lemons, and then never get an equal comparison.

The private sector can do this. I think it is going to be incumbent upon HCFA to make sure that the plans are speaking the same language. I want you to address how we are going to do that, so that when a Medicare recipient, and maybe their children, sit down and say, all right, mama, what plan is the best for you, they do not have five different proposals that really are not in synch with what they are offering.

So how can we guarantee to the person who gets this, and gets these plans that the private sector is going to be sending the material out, you are not, and how can we guarantee that they speak in a language that allows that person to compare apples to apples, and oranges to oranges?

Mr. HASH. Senator, I am glad you asked this question, because you and I have talked about this before and I have a much more specific answer than the one I gave to you back in May when we talked about this.

That is, beginning next year, we are requiring the plans that are contracting with us to display their benefit information, much as in the FEHPB framework that you showed us at the hearing several weeks ago, to display the benefit information about their plan in a standard, uniform format and, to the extent possible, uniform terminology.

That will be available and will be required to be a part of the materials that are submitted to beneficiaries in advance of the first coordinated enrollment period, which is November 1999.

Senator BREAUX. We need to make sure, I think, that this committee sees how that is developing. The most important thing I think we can do, Mr. Chairman, is to make sure that the plans that are going to be sending this information to all these beneficiaries have it in a form that they can understand it.

The Federal Employees Health Benefit Plan that we are all on, and everybody behind us is on, does that. They have Plan A, B, C, D, and it says how many days are you covered, and each plan says how many; what drugs are covered, each plan has to say; what drugs are not covered, each plan has to say. They speak the same language.

But, I mean, some of the plans who are outside the Federal plan, they speak in all kinds of different phraseologies and they are not comparing the same thing, so you cannot make a reasonable choice. That is critically important.

The final point I want to ask has nothing to do with this, but I may not get another chance to ask you, Mr. Hash, in person and I want to take the opportunity, Michael, to do it now. That is, the problem of home health care. And what we thought we did, and what I am afraid we did, are two entirely different things.

It seems to me that what Congress did, was to establish a system in order to gain control over the explosion of home health care costs, which were 100 percent reimbursable, and have established a system whereby we are rewarding the high-cost operators and penalizing the more efficient, low-cost operators, where the end result is that we are going to be losing thousands of these facilities.

The end result could very well be that we have an inadequate number in this country to do home health care and that is going to dump them into the nursing home system at a much higher cost to the Medicare program.

A whole bunch of us on this committee—I mean, we have 11 members of the Finance Committee, very bipartisan, big States, little States, medium-sized States, which have all joined in introducing legislation. Senator Grassley, Senator Rockefeller, Senator Baucus, Senator Mack, are all on a bill, and others, to try and do this fix in a budget-neutral way.

There is also an effort, which is about a $15 billion over five year effort, to put a moratorium on the new regulations. But I honestly think we have got a very serious problem. Can you elaborate on what you think could be done? Is it a problem? I mean, I think it is a very serious one.

Mr. HASH. Just briefly, Senator, and I would be happy to follow up on this with you. It is clear that the requirements in this area in the BBA are very specific, as you know. Our regulations that are out on this actually follow the statute very closely. We virtually exercise no discretion whatsoever.

Having said that, as you point out, there are great disparities, historically, between the resources for home care in one part of the country versus another part of the country. Because this system, in effect, is overlaid on these disparities, the kind of results that you just described occur.

The issue, of course, is working within the confines of budget neutrality to try to adjust things like the blend and the rates will, in fact, presumably, also change the impact and the distribution of who bears the cuts.

What we are looking for, and we have been working, I know, with your staff and with the staff of many of the members on this side and in the House as well, to explore what our options are to make some changes in the context of budget neutrality, in the context of the short-term limitations we face in systems changes related to Y2K that Senator Moynihan brought up earlier, and in also looking for a proposal that enjoys broad support in the Congress. We are committed to working with folks to explore those options, and we would like to be helpful.

Senator BREAUX. Just a final, one-sentence comment. I mean, the prospective payment proposal for home health care will not go into effect, because of the problems now, until April of the year 2000.

I will guarantee you that, unless we do something, we are going to create a nightmare out there which ultimately could increase the cost of Medicare because of people being dumped into nursing homes, which we are paying for. If there ever was a law with unintended consequences, this is clearly it. This is a big, big, big mistake. Thank you.

The CHAIRMAN. Well, thank you very much for being here this morning. I think you have obtained, probably, a pretty good idea of what importance we attach to educating the Medicare beneficiaries. So, we will want to continue to work with you on this matter and make certain that we move as rapidly as possible.

Mr. HASH. Mr. Chairman, if I may, I just want to thank you, personally, and the rest of the members of the committee, because throughout this process on Medicare+Choice you have been very supportive, and we appreciate the efforts on behalf of the beneficiaries. So, thank you very much.

The CHAIRMAN. Thank you, Mr. Hash.

Senator CHAFEE. Mr. Chairman, could I just say one thing to Mr. Hash, and I think I speak for the Chairman in this. If you run into problems that we can be helpful with, we want this thing to succeed. It may need statutory changes, for all we know, from when we set this thing up a while ago. There may be flaws to it. But I think you should feel we are not antagonists, we are here to make this thing fly.

The CHAIRMAN. We want to see it work.

Mr. HASH. I appreciate that. We have actually had lots of help from your staff, all of you. Your staffs have participated in reviewing our documents, in reviewing our plans, and giving us very constructive improvements. So, you have already made an important contribution.

The CHAIRMAN. Just let me say that one of the best run programs in the Federal Government, I think, is the Federal Employees Health Benefit Plan. We want to see the same success in Medicare.

Mr. HASH. Thank you. So do we, Senator.

The CHAIRMAN. Thank you very much.

Now, I would like to introduce our second panel of witnesses. We will hear from Ms. Janet Newport, who is vice president of Legal and Regulatory Affairs of Pacificare Health Systems, testifying on behalf of the American Association of Health Plans. Next, we will hear from Ms. Sally Gronda, who is executive director of Tampa Bay Regional Council Area Agency on Aging. Finally, we will hear from Dr. Daniel Lestage, who is vice president of Blue Cross Blue Shield of Florida.

Ms. Newport, would you please begin?

STATEMENT OF JANET NEWPORT, VICE PRESIDENT OF LEGAL AND REGULATORY AFFAIRS, PACIFICARE HEALTH SYSTEMS, SANTA ANA, CALIFORNIA ON BEHALF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS

Ms. NEWPORT. Yes. Thank you, Mr. Chairman. Mr. Chairman and members of the committee, thank you very much for the opportunity to comment on issues related to the implementation of the Medicare+Choice program.

I am Janet Newport, vice president of Regulatory Affairs for Pacificare Health Systems based in Santa Ana, California.

Pacificare owns and operates Secure Horizons, the Nation's largest Medicare risk program. Pacificare enrollees include nearly one million Medicare members in 10 States, including Texas, Oklahoma, and Nevada.

I am testifying today on behalf of the American Association of Health Plans, which represents more than 1,000 HMOs, PPOs, and similar network health plans.

Establishment of the Medicare+Choice program presents many opportunities. Integrating private health market choices into Medicare is a huge step forward, however, it also presents many challenges.

In my statement today, I will focus on three critical implementation issues: the risk adjustment of payment, the Medicare beneficiary education program, and the service area definition.

The implementation of the risk adjustor poses critical issues for the industry. AAHP believes that implementation of a payment risk adjuster should be done on a budget-neutral basis.

According to Price Waterhouse, the BBA Medicare+Choice reimbursement changes will reduce payments to 89 percent of fee for service by the year 2003. This does not account for reductions by the risk adjustor.

HCFA's current plan is to use only individual inpatient claims to develop an adjustment for each enrolled beneficiary. This approach is extremely complex and requires systems infrastructure capable of managing data and calculating payments for individual enrolles in every plan.

Further, this approach will reward plans with higher and more costly inpatient utilization, while ignoring the significant resources used to provide chronic care on an outpatient basis. Risk adjustment in this manner essentially de-evolves managed care back to a retrospective, cost-based reimbursement system.

I would also like to note that, despite difficulties in meeting the year 2000 challenge, HCFA continues to insist on implementing this heavy systems infrastructure approach to risk adjustment on schedule.

The industry also has concerns about the Medicare beneficiary education program. While we support efforts to enhance informed beneficiary choice, we have significant concerns about the funding, cost, and design of the program developed by HCFA.

HCFA's decision to phase in its program provides a greater opportunity to test materials and ensure that the program design meets beneficiary needs. While we support the more thoughtful approach HCFA is undertaking, it raises questions about HCFA's use of the full 1998 assessment. Congress should ensure that HCFA is

held accountable for the fiscal year 1998 assessments collected from health plans given the reduced program.

Finally, we continue to be concerned about the design of the program and whether the information provided will be meaningful. Will the information raise more questions among beneficiaries than it answers?

As the largest Medicare risk plan, Pacificare has 14 years of experience in communicating with seniors so that they understand their rights, responsibilities, and choices under the Medicare program.

Given the scope of the education campaign and the critical need to get it right, we believe HCFA would benefit by consulting more with the private sector health plans.

Service area designation is the third area of key concern to the industry. Prior to enactment of the BBA, Medicare HMOs had been allowed to vary premiums and supplemental benefits within a contracted service area on a county-by-county basis. This allowed customization of products to meet the needs of beneficiaries and employer-covered retiree plans.

The BBA and Medicare+Choice regulations restrict this, requiring plans to offer uniform benefits and uniform premiums across a plan's total service area. This is a significant problem in markets with different payment levels across counties.

For 1998, HCFA developed a transition policy to mitigate these effects. However, the policy contained in the Medicare+Choice regulations is more restrictive than the transition policy.

Medicare+Choice plans serving multiple counties with higher and lower payment rates could be forced to withdraw from the lower payment areas. Many of these lower payment areas are rural counties, and the new policy will dramatically reduce incentives for health plans to remain in, or even enter, these counties.

We believe that a less restrictive approach would retain plans in more rural areas and allow plans to meet the needs and challenges of employers who provide health care coverage to retirees.

Before closing, I would like to note for you that the Medicare+Choice regulations raises a number of additional issues. Among these are the adjusted community rate process, the provider relations provisions, and the quality improvement system for managed care.

My written testimony elaborates on these areas and I would be happy to answer any of your questions. Thank you, Mr. Chairman and members of the committee.

The CHAIRMAN. Thank you, Ms. Newport.

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

The CHAIRMAN. Now we will call on Ms. Gronda.

STATEMENT OF SALLY GRONDA, EXECUTIVE DIRECTOR, TAMPA BAY REGIONAL COUNCIL AREA AGENCY ON AGING, ST. PETERSBURG, FL

Ms. GRONDA. Thank you, Mr. Chairman and members of the committee. Good morning. My name is Sally Gronda, as the Chairman has already indicated. I am the executive director of the

Tampa Bay Regional Planning Council Area Agency on Aging in St. Petersburg, Florida.

Our Area Agency on Aging represents approximately 400,000 seniors and has the largest concentration of those people 85 years of age and older. My testimony today will focus on the Medicare+Choice information campaign.

I am speaking on behalf of the National Association of Area Agencies on Aging, which represents 655 Area Agencies on Aging, and 229 Title VI Native American grantees.

Our agencies have over two decades of expertise coordinating services for millions of seniors and chronically ill persons. NAAAA administers the elder care locator funded by the Administration on Aging, a toll-free help line.

Trained information specialists provide information to older persons and their care givers about local area agencies on aging and their services. It serves as initial contact for all senior information in our local communities.

For millions of Americans, including many seniors, the rapid changes in health care are confusing. More than three-fifths know little or nothing about Medicare HMOs. Of paramount importance is that beneficiaries understand they do not have to make a choice if they are satisfied with their current Medicare arrangement. This should be a statement that is included on all marketing materials.

Though the Balanced Budget Act of 1997 requires a national information campaign and a toll-free telephone line, these representatives will not counsel beneficiaries on their health care options. This is a critical statement I just made. According to HCFA, callers will be referred to local agencies for further assistance.

Florida is one of five States, as you heard earlier, where the handbook and the Medicare+Choice toll-free line will be tested. This means my agency will receive a magnitude of referrals.

It is important that information be available in local communities through organizations that are accessible and trusted by seniors. Even if beneficiaries have access to plan information through printed materials and/or the Internet, many will have other, more personal, concerns.

NAAAA is particularly concerned about the vulnerable and hard-to-reach populations. The Health Insurance Counseling and Assistant Program, known as ICA, offers hands-on advice and services to seniors about health insurance coverage.

The $10 million currently in HCFA's budget for counseling and assistance amounts to about 38 cents per beneficiaries and barely scrapes the surface of current counseling needs. Funding for the ICA program in Florida is called SHINE and comes through HCFA through the State Department of Elder Affairs down to the 11 Area Agencies on Aging.

I might add that, also, $5 million has recently been released from HCFA, which results in about $400,000 to the States of Florida. This will amount to about 57 cents per beneficiary, which is woefully inadequate.

Each Area Agency on Aging in Florida receives between $6,000 and $13,000 to operate both the ICA program and Operation Restore Trust. These dollars do not even pay for the staff that is needed to handle complex and difficult cases and is essential to

train our local volunteers. HCFA funding is insignificant and must be augmented by Older American funds and we are doing this repeatedly in Florida.

Calls that come into my senior help line requesting assistance with health insurance decisions are referred to one of our 38 volunteers. During our first 6 months of 1998, we have already seen the number of health insurance calls rise from 20 to 30 percent. Health insurance ranks every year as the number one need from our senior help line.

I have two real people, two real cases, in the St. Petersburg area. I am going to keep looking at the lights; I am trying to hurry. The first case is Mary. Mary is an 85-year-old widow who came in for insurance counseling. She had a shoe box of insurance bills and Medicare statements, doctor bills. How can Mary's questions be answered on the telephone? How can that happen? Oh, there goes the light.

The CHAIRMAN. Go ahead.

Ms. GRONDA. All right. The second case, and I am moving quickly, is that of Charlie. Charlie is a quadriplegic man in our area. He called our senior help line, had three boxes filled with all kinds of ambulance bills, doctor's bills, bank statements, et cetera.

It took two of our volunteer counselors over four months to resolve Charlie's situation. But this situation is compounded by the fact that Charlie needed a whole lot of extra services. This is just one example of how the Area Agency on Aging current infrastructure worked to meet the multiple needs of this one disabled man.

In conclusion, I will wrap up quickly. HCFA conservatively estimates that it will refer about 3.2 million persons for local assistance—can I continue?

The CHAIRMAN. Yes.

Ms. GRONDA. Thank you, Mr. Chairman.

According to these estimates, 224,000 people will need assistance in Florida. Attached to my statement is a chart showing all the States in the country and the amount of people in your State that are going to need assistance. It only makes sense to enhance the existing infrastructure that is available nationwide, where well-established organizations have proven records. We are already doing the job and have expertise in this area.

I am here today to tell you our local agencies will not be able to absorb additional demand for assistance without additional resources. In NAAAA urges a total investment of $64 million for face-to-face counseling to help ensure that seniors get their questioned answered.

A "dear colleague" letter requesting these funds is currently being circulated by Senators Grassley, Breaux, and Mikulski. Please join their efforts in this. It is vital that Congress does the right thing and adequately fund this.

I am confident this committee will do the right thing, and I thank you for inviting me here today and permitting me to share my views and my very strong convictions on this issue. Thank you.

The CHAIRMAN. Thank you, Ms. Gronda.

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

The CHAIRMAN. It is a pleasure to welcome you, Dr. Lestage.

Ms. GRONDA. This is my first time at Congress. I have testified many times before the Florida legislature, but I will have to say, this is quite a difference and I am very impressed.

The CHAIRMAN. Well, come back again.

Dr. Lestage, please.

STATEMENT OF DANIEL LESTAGE, M.D., VICE PRESIDENT, PROFESSIONAL AND ORGANIZATIONAL RELATIONS, BLUE CROSS BLUE SHIELD OF FLORIDA, JACKSONVILLE, FL

Dr. LESTAGE. Thank you. Mr. Chairman and members of the committee, I am Dr. Dan Lestage, vice president of Blue Cross and Blue Shield of Florida. Thank you very much for the opportunity to testify today on behalf of the Blue Cross Blue Shield Association on the quality provisions in the new Medicare+Choice regulations.

I would like to make two key points about the effects of these regulations. First, HCFA's quality standards will prevent broad access preferred provider organizations from entering the Medicare market.

This means, for example, that the type of PPO option available to Federal employees in the Federal Employee Health Benefits program will not be available to Medicare beneficiaries.

Second, HCFA's quality standards could raise costs to the extent that many HMOs will have to exit the program or reduce benefits to beneficiaries. Certainly, these outcomes would mean fewer choices for Medicare beneficiaries.

It is important that we understand that HCFA's mega-reg is closely tied to a set of performance standards known as the Quality Improvement System for Managed Care, or QISMC.

These standards were being designed for tightly managed HMOs long before the Balanced Budget Act was enacted. HCFA's standards will require a significant increase in the level of clinical intervention and medical management by health plans.

HCFA wants all health plans to measure a core set of clinical performance indicators, essentially, physician clinical practices, and meet minimum levels of performance. Failure to meet any minimum performance levels could lead to non-renewal of contracts. Plans would also be required to demonstrate annual, measurable improvements in physician practices.

HCFA's requirements far surpass standards for HMOs in the private sector. Private accreditation does not include standards for requiring measurement of improvements in health status of enrollees.

The architecture of PPOs, by design, cannot support this standard of measurement of medical practice patterns or clinical management of physicians. Private accrediting organizations and private employers hold PPOs to a different standard than HMOs.

For example, the California Public Employees' Retirement System warns against comparing PPO measures and HMO measures because of "inherent differences between PPOs and HMOs, such as benefit design, not being required to have a primary care physician, and the freedom to access services outside the network."

Indeed, PPOs are structured to meet a different demand in the marketplace than HMOs. They offer broad choice of physicians, ability to use physicians outside the network, and lower adminis-

trative costs. They do not have programs that routinely intervene in how physicians practice. They are, to put it simply, very popular products, both with physicians and with patients.

To meet HCFA's expectations for improvements in the health status of plan enrollees, PPOs would have to: first, assign beneficiaries to primary or principal care providers; second, begin collecting detailed patient medical record information; third, restrict out-of-network coverage or pose some measure of accountability, perhaps on the beneficiary; fourth, impose practice protocols and new payment incentives for physicians; and, lastly, reduce the size of their networks.

In short, PPOs would have to redesign into a product much more closely resembling tightly-managed HMOs, hence, less choice for Medicare beneficiaries.

In contrast with PPOs, many HMOs are involved in the type of medical management activity contemplated by HCFA. However, the HCFA standards far surpass any accreditation standards in the private sector. The standards are so labor and data intensive that they would create serious cost problems for all HMOs.

Small HMOs, for example, those in rural areas, would face special problems. This is because the same infrastructure is necessary to conduct a performance improvement project, regardless of the size of the enrolled population. As a result, some HMOs would be deterred from entry or would leave the Medicare+Choice program.

Similarly, newly emerging entities, as referenced this morning, may not be viable. The added cost burden of quality standards could have another negative effect: reduced benefits for beneficiaries.

Many HMOs now offer such extra benefits as coverage of prescription drugs, physical exams, vision and dental benefits. If HMOs are required to spend precious resources on programs of unproven value, fewer dollars will be available to fund benefits that we know beneficiaries do value. We may also see no-premium and low-premium Medicare+Choice products disappear from the marketplace.

Less choice, reduced benefits, higher out-of-pocket costs. We hope these are not outcomes of the mega-reg. The references in the mega-reg not withstanding, we are encouraged that the preamble to the regulation states that HCFA does not intend to adopt a one-size-fits-all approach.

We also appreciate HCFA's willingness to discuss these issues with us and look forward to continuing our dialogue with HCFA to ensure the viability of PPOs in the Medicare+Choice program. We hope that HCFA will reduce the regulatory burden on all Medicare+Choice plans to ensure a wide range of innovative health plan choices for all of our Medicare beneficiaries.

Thank you, Mr. Chairman, and members of the committee.

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

The CHAIRMAN. Thank you, Dr. Lestage. Let me ask you this. You were here when Mr. Hash was before us and heard my questions about the impact of the regulations. Is your concern allayed at all by what he had to say this morning?

Dr. LESTAGE. Senator, if I could answer that by saying HCFA has offered a continuing dialogue at this point. But I guess I learned many years ago that what you see is what you get, and so far all we have seen is the QISMC standards and the Medicare mega-regs. So, unless those are adjusted, I would have very serious concerns.

The CHAIRMAN. Well, I have to say, I somewhat share that concern. I had the feeling that he was talking about very special circumstances as to where the exception would be made rather than recognizing that PPOs are a very different program and deserve different attention.

Is it not paradoxical that, if you are going to make it apply to PPOs, it does not apply to fee-for-service? In other words, the government is imposing certain requirements on the private sector, but not on itself. Is that correct?

Dr. LESTAGE. Well, as currently written, that, in my view, would be correct, Senator. It would appear that there is not an appropriate, I suppose, recognition of the fact that PPOs, by and large, are modified fee-for-service programs.

The CHAIRMAN. So they should be treated somewhat similarly?

Dr. LESTAGE. Yes, sir, that would be my view.

The CHAIRMAN. You mentioned increased costs that would result with respect to HMOs. Are you able to estimate what percentage that would be, have any studies been made?

Dr. LESTAGE. I am not aware of specific studies, but I would give you an example of my own plan. In meeting this year's HEDIS measurement requirements for our HMO for data collection and verification alone, including contractors to help us with the nurse review of records, that has cost us right at $1 million.

This does not touch on the analysis of that data, the potential planning for special quality intervention projects, and the ultimate interventions that those may bring and the measurement thereof. So, just as an example, the measurement along for a tightly managed HMO plan is a huge expense for us.

The CHAIRMAN. Let me turn to you, Ms. Gronda. I was interested in your testimony about building upon existing beneficiary counseling services rather than creating a new level of bureaucracy. It seems to make a lot of sense.

Can you tell me, have you discussed this with HCFA, and if you have, what was their response?

Ms. GRONDA. No, I have not discussed it with HCFA. May I make a comment?

The CHAIRMAN. Please.

Ms. GRONDA. It only makes sense to utilize the network of Area Agencies on Aging and their senior help lines across the country. As you heard before, there are over 655, and we are already involved in health insurance counseling.

So that infrastructure is there, with minimal resources. Rather than reinventing the wheel, we could go ahead and expand this. We are local, we are available to seniors. Janice Jackson, behind me, has just passed a note. Yes, NAAAA has, to answer your question.

The CHAIRMAN. What was that?

Ms. GRONDA. Has had conversation with HCFA about this.

The CHAIRMAN. Could you tell us what the reaction was?

Ms. GRONDA. They were interested, but felt the 1–800 national number would be adequate to meet the need, which I disagree with.

The CHAIRMAN. Thank you. All three of your organizations have had a lot of experience working with Medicare beneficiaries. We think that the program has a lot to offer, but we are concerned about the education problem. Do you have any suggestions about how we can do a good job of educating the beneficiaries, Ms. Newport?

Ms. NEWPORT. Well, I think that I would agree with my colleague on the panel here that one-on-one interaction with the beneficiaries is the most pointed, and interactive in terms of their personal needs.

As a matter of fact, the organizations she represents do an excellent job in dealing with beneficiaries, as do many consumer groups which my organization works with quite closely in our markets.

I think that we have a lot of experience. Our written materials are already are approved by HCFA before we send them out. The types of materials go from everything from notices of appeal rights, to detailed information on what benefits are covered.

I think there is a multiplicity of answers, resources, and solutions that should be coordinated so that you can have the most effective communication with anyone, no matter whether they are over 65 or in the under-65 programs. There is no simple, glib answer.

But I am concerned about things like toll-free hotlines not necessarily having people staffed who understand what is going on locally. To paraphrase, all health care is local, and I think that is one thing we need to encourage both plans and private and public agencies that deal with this community of individuals to use all those resources.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Thank you. I would say, Ms. Newport, that all health care is local unless you are an Arab sheik and you can fly to Houston on every possible occasion. The world is full of people moving all around the world for health care.

Could I just continue this idiosyncratic, if you like, suggestion that we are dealing here with this phenomenon of the commodification of medicine. I do not know that the government quite understands that it is moving into a regulatory mode of the kind that we developed in the late 19th century, in the first instance, for railroads, actually.

But I would say to my distinguished colleague from West Virginia, who observed that an HMO in his State may be going out of business. Dr. Lestage referred to organizations that may disappear from the marketplace. The Chairman spoke of the government imposing rules on the private sector. Ms. Newport referred to our market.

I do not want to press anybody, but I am saying, unless we get a conceptual grasp on this phenomenon, we are going to make an awful mess of it. I have a feeling the PPOs are kind of a guild reaction to the appearance of marketplace organizations, maintaining the autonomy of physicians that previously existed.

Let me ask Dr. Lestage. In Florida, what decade would you say that the random patient with the random ailment encountering the random doctor was better off for the treatment received?

Dr. LESTAGE. I am sorry, Senator. I am not quite sure I understood. In what decade?

Senator MOYNIHAN. Decade. Yes.

Dr. LESTAGE. Was patient care better? Is that what you are asking, sir?

Senator MOYNIHAN. Yes. Did medicine begin to seriously change the outcomes of disease? The fourth decade of this century.

Dr. LESTAGE. Certainly, with sulpha drugs and penicillin.

Senator MOYNIHAN. Yes. You can reach out and touch it. I mean, it took the whole of the 19th century to get medicine to stop harming patients. And it did. It was a very difficult thing to do, but by 1900 or so, doctors did not do any harm. Then for a half century, they comforted patients. By the middle of the century, they began curing them. That is a wholly new phenomenon. That meant that there is so much more medicine than there was.

There is a French economist named Sae who wrote in the first decade of the 19th century, sort of a follower of Adam Smith, who propounded something called Sae's Law, which declares that supply creates demand. A little counter-intuitive, but when you think about it, as the supply of medicine grew, the demand grew.

I think the numbers on—my friend, Senator Rockefeller, would know more than I—but in the 1920's, 1930's, the typical, average medical cost per person was about $400 per year. That was about all the medicine there was. Now it is much higher because there is much more medicine. So the government is beginning to regulate, and it can do it well or do it badly.

Do you recognize what I am talking about?

Dr. LESTAGE. Yes, sir.

Senator MOYNIHAN. I mean, do you disagree? If so, please say so.

Dr. LESTAGE. I cannot say that I disagree with you at all. I guess the way I would express my reaction, is that I think government has a very clear role in setting certain broad regulations or parameters, and then ensure that whatever the marketplace or whoever the regulation applies to is, indeed, complied with.

I think the idea that multiple regulation upon regulation and duplicate assessment by various bodies contributes very little to the quality of the system.

Senator MOYNIHAN. Well, that is all I hope for. I appreciate your comment.

Dr. LESTAGE. Yes, sir.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Mr. Chairman, I would just ask one quick question because I know we have others coming.

Doctor, on page 5 of your testimony you say it is difficult to compare PPOs and HMOs because they are very different products. I think we will agree with that.

But is not the point of having PPOs provide the HEDIS data is not to compare them with HMOs, but to compare one PPO with another PPO; is that not the purpose?

Dr. LESTAGE. Well, that is not the way, first of all, that the QISMC and mega-reg standards read, as I understand them, Sen-

ator. But, even given that, one would try to collect HEDIS data to compare PPOs. I think there are very few of the HEDIS measures that could be considered reliable across all plans without doing an enormous amount of work on validation and verification at, frankly, the medical record level. To measure the number of occurrences in one plan as opposed to another would tell me very little. I would have to know an awful lot more about the population that the measured targets, be it mammograms in women of certain ages, be it Pap smears, what have you, if I had only the number of one plan as opposed to another, it would mean nothing to me as a purchaser, I do not think. I think it could be very misleading.

So I would suggest that, beyond HEDIS, a PPO would have to do very much what an HMO does, take that data as a guide, go into intensive validation and verification, analyze the data, and then, if possible, if one could identify the particular physician responsible for the care and coordination of that patient which generally does not exist in a PPO, then one would have to take some intervention measures and then, on a process of continuous improvement, measure those. That is what HMOs do, and I think it really amounts to applying the same measure to PPOs as one might try to apply to an HMO.

Senator CHAFEE. Well, I do not want to beat this to death, but it is my understanding that GAO has issued a report recently that disputes Blue Cross Blue Shield's position that this information is so hard to produce, that is, comparing PPOs to PPOs.

In any event, they do do the comparison in the Federal Employees Health Benefit Plan. I share the Chairman's praise for the Federal Employees Health Benefit Plan. They seem to be able to work out these comparisons.

Dr. LESTAGE. I beg your pardon, really, Senator. In my reading of that report, it is clear to me that the Federal Employees Health Benefit Plan has yet to take any of those measures or to figure out which of those measures are particularly appropriate, or even achievable.

Blue Cross Blue Shield of Florida is the second largest FEP provider in the Blue Cross system, which I know you are aware, has over 40 percent of the Federal employees enrolled. We, as yet, have not found agreeable measures, or even measures that have been agreed upon by OPM, to try to apply to our programs.

Senator CHAFEE. All right. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Senator Rockefeller.

Senator ROCKEFELLER. Ms. Newport, I want to quote from your annual report of 1997. It says, "We are confident that our history of continuous, consistent growth in size as well as profitability, achieved with values including accountability and quality as our guide, will stand us in good stead to meet the considerable challenges that await us.

Our goals for 1997 are quite simple: improved health care for our members, increased profitability, and growing success for our provider partners," which I assume means profitability, "as we blaze a new trail for our company."

Now, I am going to sort of try to gather myself emotionally from this stirring statement. I am sort of following in the Moynihan line, but he is far more adept than I am.

When you say in your testimony that you object to paying this horrendous burden that must be upon you for the information campaign that HCFA is putting out to try to make Medicare beneficiaries a little bit more aware of what is going on, and then you say how unfair it is that you had, last year, you had only 14 percent of the program, but shouldered 100 percent of the cost of the information campaign.

Then you say, and this practically tears me apart, "The burden of this fee directly affects the premiums and benefits that health plans can offer to their Medicare members."

Now, can I just ask, for example, what percentage of your revenues come from Medicare?

Ms. NEWPORT. I believe, and I would be happy to make sure that the record is correct, 80 percent.

Senator ROCKEFELLER. And if this information campaign works or does not work, or something in between, you stand to make a lot of new members, do you not? You stand to gain a lot of new members.

Ms. NEWPORT. It depends.

Senator ROCKEFELLER. No. We have all agreed that 700,000 new people sign up every month; 70,000 more are going into HMOs every month. It does not depend, it is going to happen, right?

Ms. NEWPORT. Not necessarily in all of our markets, Senator.

Senator ROCKEFELLER. So you would say that you will not get new members?

Ms. NEWPORT. No. We are getting new members. But our growth rate in some markets is slower than others, and in some markets we are actually withdrawing from the market.

Senator ROCKEFELLER. Slower, but you are getting new members.

Ms. NEWPORT. In some markets, yes, we are. In some markets, we are losing membership.

Senator ROCKEFELLER. I see. Can you give me a sense of what percentage of your costs are spent on administration as opposed to the 1 percent that is spent on Medicare?

Ms. NEWPORT. Our administrative costs—and we can detail exactly what they include—is approximately 15 percent. So our medical costs average around 85 percent.

Senator ROCKEFELLER. So that is kind of astounding, is it not, that they are delivering 99 percent health care, you are delivering 85 percent health care.

Ms. NEWPORT. I am sorry. Who is they, sir?

Senator ROCKEFELLER. I will not go into the question about executive compensation, because that is prosaic and rude.

Now, I would think that, despite your enormous objection to having to virtually question your profitability by sharing in the cost of this HCFA information program to seniors so they can better understand what they do not now understand, and they certainly do not understand about HMOs, that as you gain more members, which you will, and as your association gains many more members, which they surely will, that is, therefore, going to leave those who

do not join your HMOs, the sicker, the poorer, the people who have chronic care, those who you turn down, and we will have a much sicker Medicare pool remaining.

I would like to know what your public policy view is about that, your responsibilities about that.

Ms. NEWPORT. Well, you have asked a question that has a long and detailed answer, and I will try to make it as quick as possible.

We do believe that everyone has the right to fully-informed enrollment in whatever option they choose. In terms of the education campaign, which I think is the cost of that and our concerns about that, which is, I think, at the heart of your question, is that we feel that it is questionable not just for my company, but for the Medicare+Choice beneficiaries to have the total amount of monies available for their health care to be eroded to pay for an education campaign that benefits everyone, whether they are in fee-for-service or areas where there are no options.

Senator ROCKEFELLER. You are not answering my question.

Ms. NEWPORT. Well, I apologize. I will attempt to.

Senator ROCKEFELLER. I was asking what your views are about the remainder that do not join. I mean, 60 percent, 70 percent of Americans are now in HMOs, and Medicare is going to follow in some form, more slowly, obviously, which is going to make those remaining in fee-for-service the sickest and the poorest. Your views about that?

Ms. NEWPORT. I disagree. I think as, let us call it, Medicare+Choice enrollment increases across the country, which we support, I think that you will naturally get the natural selection or average selection of people that run the gamut of being relatively healthy to being very ill. We have found over time that this concept is called regression to the mean.

I think that, as your participation in any companies or any options, whether they are PPO, private fee-for-service, MSA, that as your enrollment grows—and we found this in our plan; our average age is about 72—as you know, as you get older you do get sicker.

I think that the options are attempting every day to make sure that we are doing and following the rules in terms of our outreach to members and our growth to make sure that we are doing it fairly, equitably, and people have a fully informed enrollment.

Senator ROCKEFELLER. Mr. Chairman, I will cease my questioning, but I would just point out that there is virtually no data whatsoever that suggests that HMOs are attracting the sickest, the most elderly, and the most chronically ill and those with bad histories in health care. The suggestion from our witness that they are trying to do their very best to dig into that group is one that would need a lot of convincing for me.

I thank the Chair.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. I thank the panel. Let me ask a couple of questions. I am trying to figure out what is fair as far as assessment on who pays for the publication of the information in both the bulletin and the pamphlet as well.

Do you have a ball park idea of how much Pacificare would pay for marketing of your own managed care plans to the people that you all have out there, a ball park figure?

Ms. NEWPORT. Our user fee payment——

Senator BREAUX. No, no. I am not talking about a user fee. I am talking about your regular marketing of your managed care to the seven million people you all represent.

Ms. NEWPORT. I understand that, sir. I was just going to use that as a benchmark for comparison. The fact is, our marketing budget is less than the user fee that we pay. So we are talking——

Senator BREAUX. Pacificare's marketing for your advertising and spelling out your whole thing for your clients.

Ms. NEWPORT. For commercial and Medicare program is exceeded by the fee that we pay.

Senator BREAUX. By the user fee.

Ms. NEWPORT. Yes.

Senator BREAUX. Now, what are the numbers on those figures?

Ms. NEWPORT. Well, my plan will pay $17 million this year.

Senator BREAUX. You would pay $17 million to pay for the distribution of these booklets. What does Pacificare pay for marketing of your health plans outside of this area?

Ms. NEWPORT. I believe it is approximately $15 million, but I would be happy to make sure that we get you an accurate figure.

Senator BREAUX. That is kind of interesting. I mean, the assessment is more than they spend on marketing and advertising for the whole company.

Ms. NEWPORT. Senator, if I could add——

Senator BREAUX. Is that right?

Ms. NEWPORT. Yes.

Senator BREAUX. Am I saying that correctly?

Ms. NEWPORT. Yes. Senator, if I could add, we recognize the need to pay for this education program.

Senator BREAUX. I understand that.

Ms. NEWPORT. That is not the issue.

Senator BREAUX. Let me get to the questions here, because I am really trying to find a solution to your problem.

Ms. NEWPORT. It is the value of the expenditure.

Senator BREAUX. The way it is set up, as I understand from HCFA, is that the idea was to say to companies that are doing Medicare+Choice that you will be assessed on helping to get the information out in a fashion that is presentable, accurate, fair, and not just fluff.

I am not against fluff. I mean, marketing and advertising is separate from this. This is a government document and we want to present it in an apples to apples comparison form. I think it is legitimate to ask companies that are going to be selling these products to help present, distribute, and pay for the information that is going out.

So we said that you will be assessed based on the percentage of Medicare managed care plans that you are selling. Is it a suggestion that those who do not even sell Medicare managed care, that they are not going to be paying anything because they do not sell any of that?

I take it that you are saying that it is unfair for those who are selling it to pay for 100 percent of the costs. Who else pays for the difference, those that do not even sell it, who never benefit from it? Is that fair?

Ms. NEWPORT. Well, I think the information is going to all 36 million Medicare-entitled beneficiaries, people who are eligible for Medicare. The information is going to areas where there are no Medicare+Choice options now and they may not be for the foreseeable future. It is targeted to say Medicare+Choice is available. I think that what we're saying is——

Senator BREAUX. You are saying, you are paying for areas that you do not do business in, that nobody else does business in under these types of proposals.

Ms. NEWPORT. I think if you look at it, about 15 States pay 89 percent of the cost for the rest of the country. There is a lot of data to support that. I think that all we are saying——

Senator BREAUX. Do you have a recommendation that would be fair?

Ms. NEWPORT. Well, I think Congress should determine that. You could take it out of the trust fund. There are lots of different options that could create balance. I mean, this is a legitimate cost. It is a legitimate function. I think what we are saying, is that all beneficiaries benefit, so there should be balance in how it is paid.

Senator BREAUX. Well, I am really sort of shocked that—are we not? Yes, we are shocked. [Laughter.] I mean, I find it unusual that the assessment is more than they spend for marketing of all their plans to all their paying customers.

That is a pretty good assessment. I actually thought that the amount of money you spent on marketing your Pacificare plans was going to be a bazillion dollars, and that the assessment was like 1 percent of that.

Ms. NEWPORT. Well, we are in California.

Senator BREAUX. All right. I understand.

If you all in your industry, because I think you are speaking on behalf of all of the industry, could come up with some suggestions as to what you think would be fair and give that to myself or to the Chairman or the committee, I think that would be helpful. Give us some guidance on what you would recommend.

Dr. Lestage? I am sorry.

Dr. LESTAGE. Lestage.

Senator BREAUX. Lestage. Sounds French.

Dr. LESTAGE. South Louisiana, sir.

Senator BREAUX Monsieur Lestage. Let me ask you this. The data that is being required from the PPO type of plans, the reason is to compare and see. I guess your point is, it is difficult to get it if you do not have a primary care physician who is the gatekeeper of the plan. It is hard to collect that information. Is that the gist of the concern?

Dr. LESTAGE. Yes, sir. That is certainly part of the problem, and a major part. In a PPO, the idea of choice is that the consumer, the patient, can seek out and select the physician of choice, and that may be several physicians in any given period of time that is measured. It would be very difficult to be able to use any use data to track it back to any particular physician to try to deal with any particular improvement. It just is a difficulty there.

Senator BREAUX. Doctor, if you are paying the bills, is it just a question of a little bit more difficult to collect it? I mean, under a

PPO, I presume, Blue Cross Blue Shield would be paying for each physician who delivers services to that beneficiary.

Under an HMO, there would be one primary care doctor that you could go to and get the information on the treatment and quality of care. But with a PPO, you would just have to get it from several different doctors instead of just one gatekeeper, so it is a little bit more difficult. Is that not the only problem?

Dr. LESTAGE. Well, there is also the problem of outside the network care. But, in addition to that, as I had mentioned earlier in response to Senator Chafee's question, the numbers that we collect are just that, numbers.

I do not really know how useful those are without some clear understanding of what you just measured. If you are measuring only the occurrences, that does not tell me a rate, it does not tell me anything particularly meaningful without doing a much more intensive evaluation of what those numbers mean.

Senator BREAUX. So, in other words, what HCFA was requesting of you for PPO evaluation is basically price and frequency of visit, but not outcome measures very much.

Dr. LESTAGE. Well, they are asking for that as well. Our point has been, to do that, then we are going to have to perform the same measures that we do, indeed, apply to our HMO products. As currently structured, they really cannot be done in a network PPO arrangement.

Senator BREAUX. All right. That is a problem.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, I think this brings us to the conclusion of this panel today. I want to thank all three of you for being here. Your testimony is very helpful.

Senator MOYNIHAN. Thank you, indeed.

The CHAIRMAN. We would now like to welcome and introduce our third and final panel. Mr. Steven Smith, president and CEO of St. Joseph Health System, Albuquerque, New Mexico; Mr. James Paquette, president and CEO of Sisters of Charity of Leavenworth, testifying on behalf of the American Hospital Association; and finally, Dr. Thomas Reardon, president-elect of the American Medical Association.

Mr. Smith, we will start with you, please.

STATEMENT OF STEVEN J. SMITH, PRESIDENT AND CEO, ST. JOSEPH HEALTH SYSTEM, ALBUQUERQUE, NM

Mr. SMITH. Thank you, Mr. Chairman and members of the Senate Finance Committee. I appreciate you inviting me here today. I am representing myself, but also my organization as a provider. That was the whole nature of the provider-sponsored organization.

St. Joseph Health Care was the first hospital in Albuquerque, and it was the territory of New Mexico at that time. The Sisters of Charity came to New Mexico in 1902 and developed the first hospital.

Today, we have four hospitals in the Albuquerque area, a nursing home, and also we were the first provider in Mexico to participate in the Federal-waived program, the PACE program, a program for all-inclusive care to the elderly.

That is a very, very important program because what it does, is it allow us to provide adult day care to nursing home eligible patients to help them stay out of the nursing home rather than be in the nursing home.

This program is very important to us. As I said, we are a provider. We do not have an insurance license at this point. In fact, the reason I believe I was invited today to the Senate Finance Committee is because I discovered, as we had our head down and we were applying for a HCFA PSO license, we are the first in the Nation to be Federally waived.

What that means is, because we were not licensed in the State of New Mexico, with a collaboration with the State Department of Insurance, they waived the State requirements and allowed us to directly apply to HCFA to become a provider-sponsored organization.

Let me tell you the three reasons why we are applying for this and why we believe that the law that was passed is an opportunity for us, as providers, physicians, and hospitals to participate directly contracting with HCFA.

The first reason, is that Medicare is an extremely important part of St. Joseph Health Care. Fifty-five percent of the patients that we see in our hospitals, nursing homes, and the like are Medicare. So, it is an extremely important part. As I said, we participate in the PACE program.

Now, we have in the past, and will continue, to contract with other insurance companies and other HMOs that provide Medicare, but this gives us an opportunity now to participate in what I call population health. And I believe that is the purpose of this, is that Medicare, through their managed care plans, it is a way to look at the cost of the entire amount of money that is being spent in an area and it gives us an opportunity be involved in looking at all the expenditures of doctors and hospitals in the way that health care expenditures are going to be spent.

Senator MOYNIHAN. Mr. Chairman, if I could just ask, you are principally involved in Albuquerque.

Mr. SMITH. Yes, sir.

Senator MOYNIHAN. And are there other hospitals there now?

Mr. SMITH. Yes. There are four hospitals in Albuquerque: University Hospital, and then there is a hospital affiliated with——

Senator MOYNIHAN. University of New Mexico?

Mr. SMITH. University of New Mexico, yes, sir.

Senator MOYNIHAN. Yes.

Mr. SMITH. And then there are three other hospitals, like ourselves, that are basically private. In our case, we are a religiously-sponsored not-for-profit organization.

Senator MOYNIHAN. Yes.

Mr. SMITH. And we are part of a large organization called Catholic Health Initiatives, which is the largest faith-based health care system in the United States.

Senator MOYNIHAN. Right. Thank you very much.

Mr. SMITH. But, as I said, the second reason why we are participating is, in our market—and you may be seeing this in other markets in your States—there are fewer and fewer insurance companies.

The mergers that are occurring on a national basis are creating fewer choices in the marketplace for our seniors, so with that happening in Albuquerque, we felt it important for us to step up and be able to participate and provide another choice to the seniors.

The third reason we are participating, is because of the whole nature of the provider-sponsored organization. It is doctors and hospitals joining together to be able to look at the entire package of expenditures of funds and be able to put them toward what we feel is the best care for the patient.

We are making an investment in information services so we can provide information to the physicians about how the outcomes of their care is affecting the health of the population, because that is our mission, is to improve the health care status of the population.

We firmly believe that good physicians, given good information, make good decisions. At this point in the fee-for-service mechanism, sometimes there is a disjointedness in the way that an expenditure is made to benefit individual patients. So, we are very excited about participating with the physicians.

Now, just a couple of concerns. We know that we are a rural State, and three of the four counties that we are serving surrounding Albuquerque were raised to the floor. So, we appreciate Congress even doing that, of being able to raise three of the four counties that we are going to serve in our service area up to the floor. But it is still a low effective rate.

However, as a Medicare provider, in a sense, that is what it has cost Medicare over the years through the fee-for-service, so we are proud that we are very effective and respect the resources that Medicare spends on fee-for-service. We believe, by having the full amount come to us from HCFA and sharing that information with the physicians who are risk in the network, that we will be able to be efficient and effective.

The other concern we have, and we believe that within the House, and now within the Senate, they are working to correct this, is that, as a Catholic organization, a faith-based organization, there has been some concern up until this point that we would not be able to participate as a PSO because there is a small segment of the Medicare population under 65, and, as you know, in certain women's health services, we have a prohibition on providing that. However, we believe that, with the recent information, the Senate and the House are working on it to make sure that there is a conscience clause within the PSO.

We believe that those services for Medicare, for the Medicare beneficiaries, should be provided. As a religious-based organization, we would make known to our enrollees how they could receive those services. As long as HCFA was able to carve out the cost of those services and have that go to another organization, then we would be all right with that. We believe that that is in place and working.

Just to finish up, we are proceeding rapidly toward the submission of our application. Actually, tomorrow, we are going to be submitting our application. It is 12 inches thick. It is four, three-inch binders.

However, we feel that we should be held to the same standards as other entities applying for HCFA because HCFA is the largest

purchaser of health care in the United States and has a public duty, from Congress, down to HCFA, then to providers, that we do a good job.

We are anxious to get started and provide that service, so we are submitting the application. We hope it will be reviewed, approved in November, and be able to start marketing to seniors within our market by January 1, 1999.

We have a spirit of innovation and a legacy of care in the last hundred years. I hope, as the steward for the legacy that the sisters gave me, that we are doing this on behalf of the community, and that we will be here another hundred years. We are going to be there to provide care to the seniors in our marketplace.

Thank you.

The CHAIRMAN. Thank you, Mr. Smith. I congratulate you for being well on your way to making history.

A quick question. How much did it cost you to prepare that 12-inch application?

Mr. SMITH. Well, the odometer is still turning over. I estimate it will be in the neighborhood of $300,000 to $400,000, with consultants who are helping us. But we recognize that these standards were put in place in order for HCFA to protect the Medicare enrollees, to be able to directly contract with us.

So it is a very daunting amount of paperwork, but, again, we went into this with our eyes open, understanding the risk of now taking insurance risk. So our board decided that it was a risk to take in order for us to be able to participate in population health.

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

The CHAIRMAN. Mr. Paquette?

STATEMENT OF JAMES T. PAQUETTE, PRESIDENT AND CEO, SISTERS OF CHARITY OF LEAVENWORTH, BILLINGS, MONTANA, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. PAQUETTE. Thank you very much. Mr. Chairman, I am Jim Paquette, the CEO of the Sisters of Charity of Leavenworth Health Services Corporation, in charge of their Montana region.

The Yellowstone Community Health Plan, which Senator Baucus alluded to earlier, is a Medicare+Choice demonstration project. So, unlike Mr. Smith, we have been into this now for about 13 months. That plan is a wholly-owned subsidiary of one of our institutions, St. Vincent Hospital in Billings.

Today I have another hat on. I am representing the American Hospital Association which, as you know, represents some 5,000 hospitals and health systems across the country. Twenty percent of our members have health maintenance organization licenses, and some 30 percent others include preferred provider organizations among their services.

Almost all of our HA members enter into managed care contracts with some kind of HMO and PPOs, so clearly we have a strong interest in the success of the Medicare+Choice project.

First, Mr. Chairman, the Medicare+Choice program involves a great deal of interaction between Federal and State regulations. Congress provided an opportunity for PSOs faced with unreasonable State barriers to obtain a 3-year waiver, after which they

must get a State license. As a condition of that waiver, eligible PSOs must contractually agree to comply with State consumer protection and quality requirements.

While HCFA may contract with States to monitor this compliance, we believe that the enforcement is subject only to Federal sanctions and due process procedures.

In dealing with the rural issue, a major purpose of Medicare+Choice was to promote the availability of managed care options in rural areas, such as we have in Montana.

The rules that we have established require that benefits, premiums, and cost sharing must be identical throughout the entire service area. However, Medicare managed care rates, as you know, vary from one county to another. Mr. Smith brought this up as well.

Most service areas, and ours is no exception, includes more than one county, so it is difficult for a plan to provide the same benefit throughout a service area without receiving the same payment for each plan in that area.

Now, HCFA maintains that the rule addresses this by allowing a Medicare+Choice organization to have multiple plans. The problem is, having multiple plans is practical to solve the problem. HCFA must change the rule to make benefits standard throughout the plan service area, otherwise organizations such as ours in rural areas have little incentive to establish those rural plans.

We have had some discussions this morning about the quality assurance program. I would just say that HCFA's rule requires that the Medicare+Choice plans have an ongoing quality assurance program, and they define the elements of that program. The QISMC standards that we have talked about this morning in the rule represent appropriate goals for the future, there is no question about that.

Currently, however, few measurements of outcomes exist and it is unclear how much control health plans have over the health status of their enrollees. Therefore, we feel that the implementation of QISMC is premature.

HCFA also requires plans to implement a comprehensive compliance plan. We agree with HCFA's intent. However, we question their decision to mandate such a plan on two counts. First, HCFA requires the implementation of a compliance plan in the absence of clear guidelines designed specifically for health plans.

Second, we believe, and the OIG agrees, that voluntarily adopted compliance plans ensure the commitment of an organization to incorporating compliance into its culture. The voluntary nature of compliance also allows organizations to tailor a compliance plan to their individual needs. We would urge HCFA to revisit this issue.

Finally, hospitals and health systems are increasingly concerned about the failure of managed care plans to reimburse them in a timely manner. A Florida Hospital Association survey of 20 hospitals recently found that 191,000 managed care claims were more than 30 days old, half of those were more than 150 days old. Keep in mind, we have to pay our payroll, et cetera, every two weeks, so that creates a problem for us.

We commend HCFA for including in its rule a recognition of this problem. For contract providers the rule includes a new requirement that the parties define prompt payment in their contract.

However, we suggest that HCFA incorporate the same standard for contract providers as it currently does for non-contract providers, which is basically a 30/60 standard. This would ensure that a basic standard that unchallenged claims must be paid within 30 days; others paid within 60 days is included in the rule.

In conclusion, Mr. Chairman and members of the committee, Medicare has been an outstanding success for all of us for the last three decades, bringing health care security to America's elderly. If we work together to do the job right, this Medicare+Choice project can help us keep that Medicare promise into the 21st century.

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

The CHAIRMAN. Thank you.

Now, Dr. Reardon.

STATEMENT OF THOMAS R. REARDON, M.D., AMERICAN MEDICAL ASSOCIATION, WASHINGTON, DC

Dr. REARDON. Thank you, Mr. Chairman. Mr. Chairman and members of the committee, Senator Moynihan, my name is Thomas R. Reardon, M.D. I am a family physician from Portland, Oregon and serve as the president-elect of the American Medical Association.

Senator MOYNIHAN. Congratulations.

Dr. REARDON. The AMA appreciates your invitation to testify today on the implementation of the Medicare+Choice PSO regulations called for under the Balanced Budget Act of 1997.

Last year, the BBA created the Medicare+Choice program where Medicare beneficiaries can choose to receive health care services through a variety of new private plans.

The AMA was, and continues to be, a strong advocate of patient choice and supported the passage of these provisions to provide Medicare beneficiaries with a wide range of health plans, including PSOs.

PSOs are defined as health care delivery networks that are owned and operated by physicians and other health care providers. These Medicare+Choice PSOs can accept risk in the form of a set monthly payment per beneficiary to deliver health care services.

The benefit to patients of receiving care through a PSO is based on the premise that medical decisions are best left in the hands of physicians, in consultation with their patients.

As the sole individuals educated and trained to practice medicine, physicians are best able to determine what health services are medically necessary. This unique ability enables physicians to realize the full potential of managed care by focusing on the quality of care and not just the cost of care.

Under the BBA, Medicare+Choice PSOs may contract with HCFA to provide health care service to Medicare patients without first having to obtain an insurance license from a State.

PSOs may choose an alternative standard or the strict financial standards required of traditional insurance products regulated by

the States. Thus, how the Federal standards compare with State standards will be an important development of PSOs.

A negotiated rule making committee, on which the AMA sat, developed a set of financial requirements for Federal PSOs. While they represent a good first step, we believe that these requirements may not fully facilitate the formation of Medicare+Choice PSOs on a significant scale.

According to these new regulations, at the time of start-up PSOs must have: (1) a minimum net worth of $1.5 million, half of which must be in cash; (2) maintain a minimum net worth of $1 million; (3) maintain an additional $100,000 administrative deposit; and (4) prefund the first 6 months of projected losses.

In addition, the regulations strictly limit the amount of intangible assets, such as the value of a physician network, that can be counted toward the minimum net worth requirement.

Although the Federal PSO financial requirements appear to be somewhat less rigorous than the relevant HMO or PSO standards in some States, they are equally, if not more, rigorous than the standards in most States.

We believe that PSOs should be subject to solvency standards, but these standards should be less burdensome than other types of health plans because physicians and other health care providers have the unique ability to continue delivery of care, even if the risk assumed is underestimated.

The strict regulatory requirements, especially those related to PSOs's financial solvency, make it unlikely that any but the largest and most sophisticated PSOs will have the ability to start up and successfully run a Medicare+Choice PSO.

As a result, many PSOs that were interested in participating in the Medicare program prior to the issuance of the strict regulations are now sitting on the sidelines, adopting a wait-and-see approach.

The AMA believes that PSOs are important to the future of health care in our country, including the Medicare program. Their development is essential to reach the next level of cost savings, while enhancing quality of care and patient protections.

Also, by engaging physicians and other health care providers as managers and owners of health care delivery systems, we will maximize cost savings and quality improvement.

To conclude, the AMA believes that PSOs are important to the future of health care in our country. The Medicare+Choice program PSO provisions in the BBA, along with the respective regulations promulgated by HCFA, will no doubt foster the formation of PSOs.

But widespread formation of PSOs may not be forthcoming until a regulatory structure is adopted that takes into consideration the unique features of PSOs and accounts for the different degrees of risk PSOs assume under varying arrangements.

We remain ready to work with Congress to this end, and we thank you for the opportunity to be here today.

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

The CHAIRMAN. Thank you, Dr. Reardon.

Mr. Smith, let me ask you, from your experience, what words of encouragement or warning would you have for other hospitals and physician groups considering the same venture?

Mr. SMITH. Sure. We prayed over this quite a bit before we entered into it. We have had experience in accepting——

Senator MOYNIHAN. The Sisters of Charity really did influence you both.

Mr. SMITH. Yes. [Laughter.] We have experienced, in accepting risk from an insurance company—in other words, they give us a set fee per member, per month for the services we provide, both hospitals and in partnership with the physicians.

So, I think that is the first experience that a hospital and physician group should have in order to know that you are on a fixed budget. No matter what the medical needs are of that population, you are going to have to live within that budget.

You do not take that money and take a ski trip, you husband that money very securely because, although you start receiving fixed fees for a population up front, you are going to have to use that as you go along to take care of that population when there are illnesses. So, I would say that is the first level of experience.

To take the next level of risk, which is the insurance risk, is what we did our analysis on. We decided in our market that, because we had had this previous experience and the experience with the PACE program where we receive a fixed fee from the State which is less than they pay for nursing home care to keep nursing home eligible patients healthy, that we were ready then to take the next layer.

So my advice to all of my colleagues, is to make sure you have a strong relationship with your medical staff, that you are collaborative, that you are willing to look at the data and come up with the best practices, and then be conservative, husband your resources so that you can have the money to spend when you have that sick patient that is going to need those extensive services.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Well, I think we have had very important testimony here. I think we had better, first, make clear, as you would, Mr. Chairman, that we would hope to hear from each of you about specifics in regard to HCFA. We may need some legislation here.

I very much like the idea of population health. Is there literature on that? I am sure there is.

Mr. SMITH. Yes.

Senator MOYNIHAN. Could you send a fellow a brief bibliography?

Mr. SMITH. Yes, sir. I will do that. I was interested in your previous comments, and Dr. Reardon, I am sure, has a view of this, that the major strides that were made in health care were public health strides.

Senator MOYNIHAN. Yes.

Mr. SMITH. Malaria, safe water. Then the tremendous strides made in this century have been on individual care, medical as well as surgical. Now I believe we have come back full circle. It is the old French saying, the more things change, the more they stay the same.

Today, we have to recognize that we have to husband the resources of the money spent for the health care of the entire population, so now we are going back and saying, how can we best use those resources.

So, we are in a very important stage in health care, acknowledging the tremendous strides being made on an individual basis, but now reorganizing that we have to spend the money to benefit the entire population.

It does us no good to extend the life of an individual and then have them live 20 years with dementia. So, we have to incorporate quality of life and quantity of life.

Senator MOYNIHAN. Yes. That is a nice way to conceptualize it. The great achievements of the 19th century were in public health. I mean, clean water did more than anything could do. Then we got into the care of specific illnesses and specific patients, and we now might want to have to move back to a more general view of the collective population. That is rewarding.

Could I say to Dr. Reardon, PSOs are clearly, in some sense, the response of doctors saying, where did these insurance companies come from? We used to run these hospitals. There is no reason in the world we should not have doctors competing, which is what, in effect, you are doing. Are you having trouble with HCFA?

Dr. REARDON. Senator, I would not say we ere having trouble. I think the issue is the amount of money that is required and covering the costs. In other words, they are asking for, and there is a term I am looking for, the financial standards, the financial requirements.

Senator MOYNIHAN. Yes.

Dr. REARDON. It is difficult for physician organizations to raise that sort of capital to do it on their own, rather than for physicians to be able to do this. There is an important provision in here, however, that they can affiliate with other providers. In other words, a physician organization could start be affiliated with a hospital, so long as the provider was 70 percent of the basic services.

Senator MOYNIHAN. Oh, yes.

Dr. REARDON. But our concern is, perhaps some of the restrictions—and they do not take into consideration the value of the services provided by the physician networks, or intangible values, that we can continue to provide services. It is not like an insurance plan that has to go out and contract the physician to provide the services, we provide the services ourselves.

Senator MOYNIHAN. No, no. I think that if we are going to have markets, they ought to be competitive. I think that is a very rewarding thing. In fact, the hospital associations welcome the PSOs, I gather.

Mr. PAQUETTE. Yes, we are, Senator. We encourage this legislation and have been very supportive of it.

Senator MOYNIHAN. Good. Mr. Chairman, this is remarkable testimony. These gentlemen have come—well, I do not want to say from the other side of the world, because I know I know they would not appreciate that at all. [Laughter.] But they have come a long way.

The CHAIRMAN. That is a New York point of view. [Laughter.]

Senator MOYNIHAN. And I thank them very much.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Anything west of the Hudson is a long way away. [Laughter.] Thank you, Mr. Chairman.

Jim, I think it would be instructive if you could tell us what health care services to seniors that you might not be able to provide that some other managed care institutions with much higher AAPCC would be able to provide because they are just receiving a lot more dollars.

Mr. PAQUETTE. We have had a great deal of conversation with this whole AAPC rate with Senator Baucus and his staff, and certainly the AHA. As the Senator indicated at the onset, our counties are all floor counties, similar to what you referred to, Mr. Smith.

Let me just put it this way. As we go into our plan, our payment actually works out, because of gender and age adjustments, to be about $326 per member, per month. Now, we charge our seniors $40 a month premium. It is a relatively rich benefit to what they might normally receive under the regular Medicare program, assuming they do not have a supplement, of course, because they do have some pharmacy benefit.

But, in terms of vision benefits and the richness of the pharmacy benefits, it does not compare to what they are able to offer in States like Florida, Arizona, and some of the other States.

I think the one thing that I would point out is, where this is most poignant, is when we have seniors moving into our area, where maybe the migration is mostly from a place like Arizona up to Montana, and we deal with seniors who are very surprised that moving from the managed care plan that they have had before and they move up to Montana and find out they have to pay $40 for the same plan that they had in Arizona with fewer benefits.

This whole conversation we had this morning with the HCFA administrator, talking about the progression into this blended rate, is a critical issue in terms of providing the same level of benefits across the country.

Senator BAUCUS. I appreciate that. Do you have any thoughts on the progression, how that should be handled?

Mr. PAQUETTE. Well, I am actually old enough to remember when this whole problem got started, because I was an auditor in those days. That was back in 1966. But I remember, we have gone through migrations when we implemented the DRG program and we were implementing capital into that program.

In every case, as I recall, Senator, there was a specific progression of time, and whether it was 10 years, 8 years, or 5 years, that we progressed to some sort of a blended national rate.

The problem that I see here, and I realize this is a legislative issue and may require some legislation, but in my opinion it is going to be very difficult for providers and PSOs in rural States, like New Mexico and Montana, to really take this thing on until they see that blended rate actually occurring.

I would not be hopeful, for example, in the State of Montana that there would be another option for seniors. We bought into this. We understood it actuarily when we got into it.

Mr. Smith, our sisters prayed over this when we got into it, and after 13 months they are praying even harder. [Laughter.] But the fact of the matter is, we are going to get this equation to balance by improving our utilization, that is the responsibility we have on the provider side, but getting to some fair payment level so that we can provide a uniform benefit level is going to be critical.

I realize, based on the line of questioning this morning, that that might require some legislative action, but I think that is going to be critical.

Senator BAUCUS. We obviously want to be fair to all parts of the country, but you get to some of these States that have a pretty high rate. I mean, believe me, we want to be fair. Are some of those States' rates, do you think, too high, or do they have to be that high, just as we try to find the right balance across the country?

Mr. PAQUETTE. Well, Senator, if we look at this thing actuarily, and as I understand the mechanics of this, when those payment rates were established they were established at 95 percent of the cost of providing that service.

I think there are all kinds of data that the AHA has come up with, and other organizations. Look at the Dartmouth analysis of the cost of health care, the incidence of heart surgery, et cetera, across this country in various parts.

There is no question that the cost of health care in some parts of the country is higher than others. It has a lot to do with utilization, it has a lot to do with the practice of medicine. I think we are evolving. Hopefully we are evolving as providers to understand that data better, to come up with best practices.

But I, frankly, have a hard time understanding the difference between the cost of $700 in a place like Florida versus $360 in the State of Montana.

Senator BAUCUS. One brief question.

The CHAIRMAN. I think Dr. Reardon wanted to make a comment.

Senator BAUCUS. Yes. Excuse me. Sorry.

Dr. REARDON. No. I am sorry, I wanted to make a comment later, Mr. Chairman.

The CHAIRMAN. All right. Yes.

Senator BAUCUS. Just one quick question. So, legislatively, how might we address that? I mean, you heard that probably the blended rate is not going to kick in for some time unless there is some legislative change. We have got this progression. Should the progression be modified, changed, or something?

Mr. PAQUETTE. Without understanding the mechanics of the legislation itself totally, I think the blending, and understanding budget neutrality and all the other challenges we face, that blending needs to be on a track with some specific time period so that providers have a sense for what they are getting into.

Until we do that, I really believe most people, especially in our rural States, Senator Baucus, are going to sit on the sidelines and watch this happen.

Senator BAUCUS. Does that mean, all things being equal, that other seniors who are fee for service basically are not getting the same benefits that are given to a managed care patient?

Mr. PAQUETTE. Well, my personal belief on that, Senator, is that we have seniors who can afford it. What I am concerned about, are the seniors who cannot afford supplemental coverage in our marketplace. They are still getting excellent care in all of these States, but they are taking the Medicare payments under the traditional program and the rest of it is being written off to charity.

Our concern, and where we think Medicare+Choice has been of great benefit in our market, is with those people who do not have

an employer who provides a supplemental policy, or they cannot afford it. This has provided them an opportunity, for basically $40 a month, to not have to worry about that.

It puts them in an environment where we can manage their care and take responsibility for it. So my concern, frankly, is for the elderly in this country who are not fortunate enough to be able to afford a supplemental policy.

Senator BAUCUS. Thank you, Mr. Chairman, for your indulgence.

The CHAIRMAN. I will now call on Dr. Reardon.

Dr. REARDON. Thank you, Mr. Chairman. I should remind the committee that I also come from a small rural State, Oregon, so I share the concern with the two previous speakers.

But I wanted to come back to the concept of population-based medicine which came up and the fact that public health and medicine worked very closely historically prior to the 20th century. In the early part of the 20th century they sort of separated as medicine began to cure, with the advent of antibiotics, which Senator Moynihan pointed out.

While we understand population-based medicine and support that concept, and I think we are moving there with managed care, the issue I want to bring forward is that medical decision making is still generally one-on-one between the physician and the patient in the exam room. When any of us go to our physicians, we want and expect that physician to do everything possible that is reasonable, appropriate, and necessary to take care of us.

So, as we move towards this concept of population-based medicine, and perhaps finite resources, there are going to be some problems. It comes down to the physician making that decision with the individual patient, ultimately.

Senator MOYNIHAN. Could I say in that regard, Mr. Chairman, this September I am going to be giving the opening lecture at Yale on the 100th anniversary of heroin. We are having a two-day conference on that. Medicines do not always work out as anticipated, as you will recall. There you have a population health problem that derives from a medical advance. The Bayer people patented heroin the year before they trademarked aspirin. It made people feel heroish.

The CHAIRMAN. Well, gentlemen, you have been an excellent panel. We appreciate your being here. We particularly appreciate your coming from the other side of the world. [Laughter.]

Senator MOYNIHAN. Send our regard to the sisters.

Mr. PAQUETTE. We will. Thank you.

The CHAIRMAN. The committee is in recess.

[Whereupon, at 12:34 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF SALLY GRONDA

Good Morning Mr. Chairman and members of the Committee, my name is Sally Gronda. I am the Executive Director of the Tampa Bay Regional Planning Council Area Agency on Aging in St. Petersburg, Florida. Our Area Agency covers Pasco and Pinellas counties and represents the needs of approximately 400,000 seniors. Furthermore, our area has the largest concentration of those people 85 years of age and older in Florida. My testimony today will focus on the Medicare+Choice information campaign. I am speaking on behalf of the National Association of Area Agencies on Aging (N4A) which represents 655 Area Agencies on Aging (AAAs) and 229 Title VI Native American aging grantees nationwide. The mission of all of our agencies is to enable older adults to remain living independently in their own homes and communities for as long as possible.

My agency, along with the Area Agencies on Aging and Title VI grantees have over two decades of expertise coordinating services for millions of seniors and chronically ill persons. As information brokers, we respond to thousands of requests per year from older persons and their families and direct them to local service choices. A large number of the requests our agencies handle concern health care choices. A recent N4A Health Insurance Counseling Survey shows a majority of AAAs are involved in educational activities surrounding health care choices, which includes information regarding Medicare, Medigap, managed care and a wide array of other health and long term care services. Furthermore, a 1996 N4A survey commissioned by the AARP, revealed that one-fourth of all N4A respondents (26%) received referrals directly from managed care organizations on behalf of enrollees regarding home and community-based service choices. The White House turns to AAAs as a reliable source of information and services for older persons, having referred more than 1,600 older persons and their families to 322 AAAs in 1997 alone.

N4A administers the Eldercare Locator funded by the Administration on Aging, a toll-free helpline that operates between 9:00 a.m. and 8:00 p.m. (Eastern Standard Time). Trained information specialists provide information connecting older persons and their caregivers to local AAAs and home and community-based services. Since its inception in mid-1991, the Eldercare Locator has assisted more than 325,000 callers. Many older persons and their caregivers are already familiar with the Eldercare Locator as a reliable source of information and it serves as their initial contact for senior information. As the Health Care Financing Administration (HCFA) implements a toll-free number for its information about Medicare+Choice, N4A welcomes the opportunity to share the experience gleaned from our years of administering the Eldercare Locator.

Our history of serving older and vulnerable adults had led us to conclude that no one, single educational approach will reach all older and disabled persons served by the Medicare program. We believe the success and effectiveness of the Medicare+Choice information campaign hinges upon its ability to offer a wide range of information options tailored to the needs of diverse groups of beneficiaries.

The Balanced Budget Act (BBA) offers Medicare beneficiaries a host of new choices and information about plan options. Well-informed beneficiaries may be able to make health care decisions based upon information received in the mail. Some beneficiaries will review this material and have questions that can be easily answered by picking up the phone before they make their choices. Younger retirees with computer experience may get their information directly through the Internet, but according to HCFA, only seven percent of beneficiaries have access to the Internet.

Yet, for millions of Americans, including many seniors, the rapid changes in health care are confusing. According to the 1997 Medicare Current Beneficiary Survey and the 1995 OIG study " Medicare Beneficiary Interest in HMO's," thirty-two percent say they know little or nothing about Medicare; more than two-fifths know little or nothing about Medigap; more than three-fifths know little or nothing about Medicare HMO's; and almost two-thirds did not know whether they have an HMO available to them in their area. Even more confusion and anxiety will abound once seniors receive their mailing from HCFA this October informing them about their new options under Medicare+Choice. The marketing materials seniors will begin to receive directly from health plans will only enhance this confusion and anxiety. It often falls to our agencies to sort through with beneficiaries potentially misleading marketing materials. Of paramount importance is that beneficiaries understand they don't have to make a choice if they are satisfied with their current Medicare arrangement. This should be a statement that is included on all marketing materials. In addition, HCFA could minimize confusion by requiring standardized language, as is the requirement with Medigap plans.

Though the Balanced Budget Act (BBA) of 1997 requires a national information campaign and a toll-free telephone line, these will not be fully implemented until October 1999, and may not provide all of the answers seniors need. The 1-800# will be an automated response system with access to a customer service representative if the caller desires. However, these representatives will not counsel beneficiaries on their health care options. According to HCFA, callers will be referred to local agencies for further assistance.

Florida is one of five states where beneficiaries will receive the "Medicare and You" 1999 Handbook and where the Medicare+Choice toll-free line will be operational this fall. HCFA is estimating an average of seven minutes per call to their toll-free line. Many beneficiaries will want to seek person- to- person counseling to discuss their health insurance options. For some beneficiaries, personalized assistance, including face-to-face contact with a non-biased and objective facilitator will be essential. This means that my agency and AAAs in the other five pilot states will receive a multitude of referrals.

It is important that Medicare+Choice information be available in local communities through organizations that are accessible and trusted by seniors. Even if beneficiaries have access to comparative plan information through printed materials and/or the Internet, many will have other more personal concerns. There will be a need for education/counseling about the benefits and risks of fee-for-service versus the various types of managed care plans related to a beneficiary's specific need for both acute and chronic care. Many beneficiaries will need assistance in determining which considerations are most important to them, such as following a doctor into a health plan, transportation to providers, accessibility of specialists, or prescription drug coverage and which plans have the best "track record" in these areas. This type of counseling requires individualized attention and cannot be "pre-packaged."

The N4A is particularly concerned about vulnerable and "hard-to-reach" populations, such as those with: 1) language and cultural barriers; 2) mobility limitations and other disabilities; 3) cognitive impairments; 4) surrogate decisionmakers; and 5) persons who are geographically isolated. These beneficiaries are particularly subject to discriminatory marketing practices that exclude them from having access to the broadest range of health insurance choices. In many cases, active outreach at the local community level will be needed if these beneficiaries are to be identified and reached.

THE KEY ROLE OF THE HEALTH INSURANCE COUNSELING AND ASSISTANCE PROGRAM

The Health Insurance Counseling and Assistance Program (ICA) is comprised of professional staff and over 14,000 dedicated and highly trained volunteers nationwide who offer unbiased one-on-one counseling to help Medicare beneficiaries understand their health insurance benefits and options. The ICA program offers "hands on" advice and service to seniors about health insurance coverage, protects seniors from fraud and empowers seniors to make informed choices about health insurance options. This program is now established in all 50 states, Puerto Rico and Guam.

The $10 million currently in HCFA's budget for counseling and assistance amounts to about 38 cents per beneficiary and barely scrapes the surface of current counseling needs. Other programs that might support these efforts have been level-funded or cut over the past decade. Funding for the ICA program in Florida comes from HCFA through the state Department of Elder Affairs (DOEA) to the eleven (11) Area Agencies on Aging. It is an extremely successful and popular program called Serving the Health Insurance Needs of the Elderly (SHINE). There are currently 600 skilled and highly trained volunteers that provide health insurance coun-

seling and assistance to seniors and disabled adults. Seniors and family caregivers can access the SHINE program through the local AAAs' Senior Helplines or the DOEA's Elder Helpline.

Each Area Agency receives between $6,000 to $13,000 to operate both the Insurance Counseling and Assistance (ICA) and Operation Restore Trust (ORT) programs. These dollars do not even pay for the staff that is needed to handle complex and difficult cases and is essential to train and supervise our cadre of volunteers, and to assure that accurate and quality information is provided. There are costs to running an effective and responsive volunteer program, which will increase as more beneficiaries need assistance. Funding for paid staff, as well as the Senior Helpline comes from the Older Americans Act. HCFA funding is insignificant and must be augmented by Older Americans Act funds. Still, this only begins to meet the need for health insurance information in my local community.

Calls that come into my Area Agency on Aging Senior Helpline requesting assistance with health insurance decisions are referred to one of thirty-eight SHINE volunteers. Since the inception of our Helpline, health insurance counseling has consistently ranked as the #1 need every year. In the 12-month period of calendar year 1997, we received 12,280 calls of which 2,467 or 20 percent were for health insurance counseling. During the first six months of calendar year 1998, we have already received 1,640 referral calls for health insurance counseling or 30 percent of total calls. As you can see, the demand is increasing and will surpass last year's statistics. This increase does not include the effect of Medicare+Choice calls nor does it reflect the impact created by plan withdrawals which, according to press accounts, are on the rise. These withdrawals severely affect Area Agencies since many plans list us as the information source for seniors needing to make immediate and urgent plan choices. Furthermore, we know from past experience that any kind of press about Medicare also causes our phones to "ring off the hook."

HEALTH INSURANCE COUNSELING CASE EXAMPLES

Mary is an 85-year-old widow who came in for insurance counseling at our agency. She had a box of insurance bills, Medicare statements, and doctor bills. She had no idea of what to do, because her husband handled everything in the past. She didn't understand how Medicare works and how to get prescription medicines. All she saw was a balance due at the bottom of her statement and she was very confused. She really didn't know what to pay. A counselor spent about an hour reviewing all of her bills and explained to her what type of plan she had. The woman found she really didn't owe anything. Her supplemental covered the balance. She was elated. She hadn't paid money that she didn't owe. This is a typical case that the SHINE program handles on a daily basis.

I would now like to share with you the story of "Charlie," which demonstrates how Medicare issues often do not occur in isolation from other beneficiary concerns. Charlie is a quadriplegic man. He contacted our Area Agency on Aging Senior Helpline and was referred to SHINE for health insurance counseling and assistance. The counselors (a husband and wife team) made a home visit to assist Charlie. He had recently been robbed and attacked. His wife and family left him. He had three extremely large boxes of mail that had never been opened which included hospital bills, doctor bills, ambulance bills, bank statements, check book balances, and collection agency notices. The two SHINE volunteers spent four days sorting all the items in the boxes. They reported that they had to literally remove the boxes outside in order to destroy the roaches and bugs before they could begin their work in the home. It took a total of four months for the volunteers and Area Agency on Aging staff to resolve Charlie's situation. He owed about fifteen thousand dollars in unpaid bills. SHINE satisfactorily resolved all issues with the collection agency and was able to convince the hospital, doctors, ambulance carriers, and other health care providers to accept his Medicare as payment-in-full. The Area Agency on Aging was also coordinating with SHINE to provide other services for this gentleman. This reflects just one example of how the Area Agency on Aging's current infrastructure worked together to provide multiple services and assistance to one disabled man.

CONCLUSION

HCFA conservatively estimates that 5.2 million persons will call the new 1-800 Medicare Helpline and that it will refer about 3.2 million persons for local assistance under Medicare+Choice. According to these estimates, 224,028 people will need assistance in Florida alone. (See attached chart for the impact of Medicare+Choice in other states.) However, our local counselors estimate these numbers will be significantly higher. It is clear that additional resources will be needed to assist our

oldest, frailest and most vulnerable citizens and protect them from marketing abuses.

It only makes sense to enhance the existing infrastructure that is available nationwide in all local communities where well established and sound organizations have proven records of client satisfaction and program success. Why reinvent the wheel and add another layer of 1-800 numbers that are estimated to cost over $100 million during the next two years when, with minimal resources, Congress can expand on the current Area Agencies on Aging and Health Insurance Counseling and Assistance (ICA) programs? We are already doing the job and have expertise in this area. Many seniors are still going to call our Agency on Aging Helplines anyway.

There seems to be an expectation that our local agencies will be able to absorb additional calls and requests for personalized assistance without significant additional resources. I am here today to tell you that this simply is not going to be possible. Seniors and family members expecting assistance will roach busy signals and wait for assistance. I understand that HCFA has just recently released $5 million in additional funding for the ICA program. Still, this additional funding amounts to only 57 cents per beneficiary. After consulting with the Florida Department of Elderly Affairs, it was determined that Florida's share would be about $400,000. This is woefully inadequate to meet current beneficiaries' needs without experiencing the explosion of the Medicare+Choice information campaign.

N4A strongly urges that at least $20 million be specifically appropriated for support of ICA programs. There is clearly a great need to strongly support this program as Medicare undergoes these historic changes. In addition, we request that the Committee recommend an additional $44 million, over and above an eight percent increase for the Older Americans Act, for health insurance counseling in Title III-F of the Older Americans Act to provide these services at the local Area Agency on Aging level. This would provide a total investment of $64 million for face-to-face counseling to help ensure that seniors can get their questions answered. A "Dear Colleague" requesting these funds is currently being circulated by Senators Grassley, Breaux and Mikulski. This additional funding for health insurance assistance would be a big step in the right direction toward assisting seniors with making the right health insurance choices for their individual needs.

It is vital that Congress does the right thing and adequately funds programs that meet the needs of our seniors. I have confidence that this Committee will do the right thing. Thank you for inviting me today to share our views and convictions.

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Projected number of Medicare Beneficiaries needing local face-to-face assistance with Medicare + Choice

STATE	# MEDICARE BENEFICIARIES	# LIKELY TO NEED ASSISTANCE
Alabama	655,000	55,020
Alaska	35,000	2,940
Arizona	613,000	51,492
Arkansas	431,000	36,204
California	3,701,000	310,884
Colorado	431,000	36,204
Connecticut	511,000	42,924
Delaware	103,000	8,652
Dist. of Columbia	79,000	6,636
Florida	2,667,000	224,028
Georgia	851,000	71,484
Hawaii	152,000	12,768
Idaho	153,000	12,852
Illinois	1,645,000	138,180
Indiana	838,000	70,392
Iowa	482,000	40,488
Kansas	390,000	32,760
Kentucky	600,000	50,400
Louisiana	591,000	49,644
Maine	206,000	17,304
Maryland	613,000	51,492
Massachusetts	949,000	79,716
Michigan	1,373,000	115,332
Minnesota	642,000	53,928
Mississippi	406,000	34,104
Missouri	848,000	71,232
Montana	132,000	11,088
Nebraska	253,000	21,252
Nevada	198,000	16,662
New Hampshire	159,000	13,356
New Jersey	1,189,000	99,876
New Mexico	216,000	18,144
New York	2,685,000	225,540
North Carolina	1,050,000	88,200
North Dakota	105,000	8,820
Ohio	1,696,000	142,464
Oklahoma	496,000	41,664
Oregon	476,000	39,984
Pennsylvania	2,104,000	176,736
Rhode Island	171,000	14,364

South Carolina	520,000	43,680
South Dakota	118,000	9,912
Tennessee	787,000	66,108
Texas	2,124,000	178,416
Utah	191,000	16,044
Vermont	85,000	7,140
Virginia	835,000	70,140
Washington	701,000	58,884
West Virginia	335,000	28,140
Wisconsin	775,000	65,100
Wyoming	62,000	5,208

(Medicare Beneficiary Figures based on statistics in AARP "Reforming the Health Care System: 1996 State Profiles"/N4A Estimates of Beneficiaries Needing Assistance based on National Estimates from HCFA for a Medicare+Choice Toll-free Helpline)

PREPARED STATEMENT OF MICHAEL HASH

Chairman Roth, Senator Moynihan, Committee members, thank you for inviting us here today to talk about our efforts to implement the Medicare + Choice program and educate beneficiaries about the many new options that will be available to them. This marks the greatest change in Medicare in the program's 33 year history, and we are eager to proceed in a thoughtful and responsible manner.

We have made substantial progress in implementing the Medicare + Choice program and the many other changes enacted through the Balanced Budget Act of 1997. We have completed 189 of this historic law's more than 300 individual provisions affecting our programs. Since our new administrator was confirmed last November, we have published 64 regulations, including major Balanced Budget Act provisions such as the Medicare + Choice regulation. We have approved Children's Health Insurance Plans to cover a projected two million additional children for nearly half the states. We have issued 65 program guidance letters to state Medicaid and child health officials, 49 of which are related to the Balanced Budget Act.

In addition to our Balanced Budget Act efforts, we have been working closely with state insurance regulators in monitoring enforcement of important Health Insurance Portability and Accountability Act provisions. We delivered 10 official Reports to Congress. We have made major strides in improving program integrity. And we made essential progress in aggressively addressing the Year 2000 issue for Medicare and Medicaid information systems.

The Medicare + Choice program provides important new opportunities for beneficiaries. They will have more options than ever before. They can receive care through plans run by providers rather than insurers. They can choose plans that cover prescriptions and other services not included in traditional Medicare. They can be offered the entire range of options in the private sector today, and choose a plan that matches their own personal values. This is an historic step forward for the Medicare program. We take our responsibility to help both plans and beneficiaries understand these new opportunities very seriously.

We have accomplished a great deal to implement the Medicare + Choice program, including publication of all Balanced Budget Act-mandated Medicare + Choice regulations.

- In September 1997 we issued 1998 plan payment rates based on the new methodology in the Balanced Budget Act which breaks the previous link to local fee-for-service spending, and establishes a minimum payment amount. This new methodology applies to existing Medicare HMOs as well as to the new types of Medicare + Choice plans. In March we issued the 1999 plan payment rates.
- In April we published a regulation establishing the definition of a Provider Sponsored Organization.
- In May we published a regulation identifying the solvency standards for Provider Sponsored Organizations, which had been developed through a careful and

well balanced negotiated rule making process with broad representation from interested parties.

- In May we published details of how Provider Sponsored Organizations can obtain a federal waiver from state licensure requirements to participate as a Medicare + Choice plan.
- In May we held the first meeting of the Medicare Competitive Pricing Advisory Commission, chaired by General Motors Health Care Initiative Executive Director James Cubbin. This Commission will recommend key design features of a Medicare managed care competitive pricing initiative.
- In June we published the remaining Medicare + Choice regulations which detail requirements for plans and incorporate important new protections for beneficiaries and providers. New types of plans, including Provider Sponsored Organizations (PSOs), Preferred Provider Organizations (PPOs), and Private Fee-For-Service plans (PFFS). Plans can now submit applications to participate in the Medicare + Choice program.
- In July we began a "train-the-trainers" program for 700 individuals across the country in our education partner organizations. The goal is for them to teach others in their organizations and communities how to help beneficiaries understand their new options.
- We have launched a consumer-friendly Internet site, Medicare.gov, where beneficiaries can find direct comparisons of the benefits and costs of plans available in their community.
- And we are implementing an eight-point National Medicare Education Program to help beneficiaries understand the important changes and their new options in Medicare.

We have several additional steps scheduled, as well.

- This November we will conduct the first open enrollment period for Medical Savings Account plans.
- Also this November, we will begin mailing information, running a toll-free call center, and providing other educational services to beneficiaries to help them understand the changes in the program.
- In January we will convert all existing Medicare risk contract managed care plans to Medicare + Choice plans.
- By March 1999 we expect to report to Congress our plans for "risk adjusting" plan payment rates. Risk adjustment will help account for the health status of individual beneficiaries and curb any incentive to avoid enrolling those with chronic or high-cost care needs.
- We will work with beneficiaries and health plans to standardize the format and language used in plan summaries of benefits.
- In November 1999 we will conduct the first annual coordinated open enrollment period into all Medicare + Choice plans.

OUTREACH TO PLANS

There is substantial interest among health plans in participating in the Medicare + Choice program. We have scheduled a series of outreach sessions for existing plans and those interested in offering Medicare + Choice plans.

- An outreach session held July 13–14 in Baltimore had approximately 350 attendees.
- An outreach session held July 21–22 in Chicago had more than 400 attendees.
- An outreach session held July 28–29 in Los Angeles had more than 400 attendees.
- A special outreach session held July 15 for those interested in offering Medical Savings Account plans was attended by representatives from 11 organizations.
- Another special outreach session on Medicare + Choice quality improvement requirements is scheduled for August 3–4 in Baltimore with 400 attendees expected. Also, on July 17, we issued the first federal waiver for a Provider Sponsored Organization so that it can apply to participate in Medicare + Choice without a state license.

RIGHTS AND PROTECTIONS

The Medicare + Choice regulation incorporates important rights and protections for beneficiaries, as well as providers. They address the most common consumer complaints about health plans.

- Appeal rights: Time frames are significantly tightened for decisions on appeals of decisions to deny care. Plans must issue initial decisions within 14 days, down from a previous maximum of 60 days. If a beneficiary appeals the initial decision, the plan must issue a ruling within 30 days, also down from 60 days.

Plans must rule within 72 hours on denial-of-care decisions, including terminations of care, that could jeopardize the life, health or ability of the enrollee to regain maximum function. For all service-related decisions, extensions of up to 14 days may be permitted if the enrollee asks or the organization justifies a need and explains how the delay is in the enrollee's interest. The rules also sets the same 72 hour and 30 day limits on Medicare's independent appeal body, where appeals are automatically forwarded when a plan denies a beneficiary request.

- Protections from Gag Rules: Plans are prohibited from limiting what providers can tell patients about treatment options.
- Protections in the Emergency Room: Plans can charge no more than $50 copayments for emergency room visits. They must cover emergency room visits for situations that a "prudent layperson" would consider an emergency. And they must pay for any services needed to stabilize a patient until discharge, a plan physician arrives, or an emergency room physician agrees with a plan physician on transfer of the patient to another facility. They must return emergency room calls seeking care authorizations for post-stabilization care within one hour.
- Protections for Women: Women are guaranteed access without primary care referrals to women's health specialists in plan networks for women's routine and preventive care, such as Pap smears and breast exams.
- Protections for Preexisting Conditions: Plans may not discourage enrollment or deny, limit or condition the coverage because of medical history, genetic information, mental or physical illness, disability, or prior use of services.
- Protections for Serious, Complex Conditions: Patients with complex or serious medical problems are guaranteed direct access to specialists without a new primary care referral for each consultation in a given treatment plan.
- Protections for Cultural Differences and the Disabled: Plans must accommodate those with disabilities, diverse cultural backgrounds, and limited English or reading skills.
- Protections for Privacy: Plans must protect patient confidentiality, disclose records to patients, and may not sell enrollee names or addresses for any purpose.
- Protections from Fraud: Plan executives are required to certify that data they submit about enrollees and their health care usage are accurate. This helps ensure that adjustments in payment to plans based on enrollee health are accurate.
- Protections for Providers: Plans must explain decisions to cancel or refuse to sign contracts with physicians, and let physicians appeal decisions to remove them from networks. Plans also are prohibited from discriminating against any class of providers.
- Rights to Financial Information: Plans must provide beneficiaries, on request, data on their financial condition and on how they pay physicians.

MEDICARE + CHOICE BENEFICIARY EDUCATION

Among the most important facets in implementing the Medicare + Choice program is helping beneficiaries understand their options so they can make informed decisions. The Institute of Medicine held a conference of experts to examine this task and make recommendations on how we should proceed. I have attached to my testimony a letter from them outlining their recommendations. The IOM strongly recommended that we stagger mailings to allow for market testing, and that we emphasize to beneficiaries that they do not have to make any change.

Our own work with some 30 beneficiary focus group sessions, conducted by an outside contractor, Barents Group/Westat/Project HOPE/Sutton Social Marketing, also counsels against immediate nationwide mailing of detailed information to all beneficiaries. Based on this advice and experience, we have revised plans for the special information campaign called for in the Balanced Budget Act [1851(e)(3)(D)] for November 1998. This will allow us to refine our efforts before November 1999, when the first full-scale education campaign and mailing mandated by the Balanced Budget Act [1851(d)(2)] will occur.

We have an eight-point plan beginning this summer that includes:

1) beneficiary mailings;
2) toll-free telephone services;
3) internet activities;
4) a national train-the-trainer program;
5) a national publicity campaign;
6) state and community-based publicity and outreach campaigns;

7) enhanced beneficiary counseling from State Health Insurance Assistance Programs; and

8) targeted and comprehensive assessment of our education efforts.

We will first test the whole system, including the comprehensive handbooks and the toll free call center, in five states—Arizona, Florida, Ohio, Oregon and Washington.

The handbooks will include detailed information on Medicare+Choice options, and be tailored to each market with side-by-side comparisons of costs and benefits for local plans. The call center will have personnel to answer questions about specific options. We plan to phase in call center access to another 25 percent of beneficiaries every three months, with full nationwide service by August 1999.

Outside the five pilot states we will send beneficiaries a bulletin outlining Medicare+Choice options and other useful information. It will stress that beneficiaries do not have to make any change. It will discuss assistance for low-income beneficiaries, new preventive benefits, and other changes. And it will tell how to obtain comparison data on plans in local markets.

The American Association of Retired Persons endorses this strategy. A July 2, 1998 letter, attached to my testimony, calls the decision "the right course of action under the circumstances."

EDUCATION CAMPAIGN COSTS

Our phased education campaign allows us to make wise use of scarce resources. As you know, $200 million was authorized for the first year of this education campaign, but only $95 million was appropriated by Congress. We are supplementing those funds with $19.2 million in funds from HCFA's program management and peer review organization budgets.

For FY 1998, the first year of the education campaign, we expect to spend:

- $30.2 million on printing and mailing materials to beneficiaries and outreach partners. We will spend $9.3 million of this to produce and mail the comprehensive booklet with localized plan comparison charts in the five test states, $13 million to mail the Medicare bulletin to beneficiaries in other states, $4 million to provide an initial enrollment package to new beneficiaries, and $3.9 million on materials for training outreach partners.
- $50.2 million on the toll-free call center. The call center operation will cost $38.2 million. Mailing printed comparison information on Medicare+Choice options in local markets to those who request them as the call center is phased into other states will cost $12 million.
- $22.3 million on program development. Evaluation of the education program will cost $2 million, fielding the Consumer Assessment of Health Plans survey will total $6.8 million, grants to State Health Insurance Assistance Programs will total $5 million, training outreach partners will cost $2.75 million. The rest will cover such activities as project integration and management and business requirements analysis.
- $9.9 million on community-based outreach activities, including health fairs.
- $1.5 million on the Internet site.

For the second year, FY 1999, an effective education campaign will cost $173 million. We propose to finance it by a combination of the full $150 million in user fees authorized in the Balanced Budget Act, plus $23 million from other agency accounts. We project spending:

- $50 million for printing and mailing the handbook and other materials;
- $68 million for the toll-free Call Center;
- $39 million for program evaluation, development and technology investments;
- $2 million for the Internet site,
- $14 million for health fairs and other community-based outreach.

Appropriation of only $95 million in user fees in FY 1999 would result in an inadequate education campaign. That would thwart Congressional intent to bring market forces to bear since we would not be able to provide Medicare beneficiaries with all the tools they need to make truly informed choices. We would have to scale back a number of activities including: toll free call center service, funding to State Health Insurance Assistance Programs, local community outreach, and beneficiary satisfaction surveys. We would also have to postpone investments in technology needed to make it easier for beneficiaries to access comparative plan information. The costs of beneficiary education are ongoing. The authorization provided in the Balanced Budget Act, however, declines from $150 million to $100 million in user fees for fiscal years 2000 and beyond. Due to the uncertainty about the demands for Medicare+Choice information, we may need to revise these funding levels to ensure that all activities are funded.

ENSURING QUALITY

Among the most important provisions in the Medicare+Choice program are those that address the quality of care and services. These help make sure beneficiaries have meaningful information so they can compare plans. They also help ensure that coordinated care plans improve quality, and that Medicare will use its market leverage to promote quality and be a prudent purchaser.

All plans must report objective, standardized measurements of how well they provide care and services. They will use HEDIS, the Health Plan Employer Data and Information Set. HEDIS is the industry standard for measuring health plan performance, and it has been tailored specifically for the Medicare program. Medicare+Choice plans must have HEDIS data audited before submission to ensure accuracy. We also will use CAHPS, the Consumer Assessment of Health Plans Survey, to objectively measure beneficiary satisfaction with plan care and service. The results of both HEDIS and CAHPS will be translated into plain English and arranged in charts so beneficiaries can make direct, apples-to-apples comparisons among their plan options.

Plans with provider networks must conduct performance improvement projects and over time achieve demonstrable and sustained improvement. Eventually these plans, except for network-based Medical Savings Account plans, will have to meet minimum performance standards. Establishing minimum performance standards is important because data now starting to come in from the objective HEDIS performance measures show wide variation in how well plans provide care. For example, according to HEDIS data from existing Medicare managed care plans, 90 percent of women in some plans get yearly mammograms, while in one plan only 15 percent get this essential screening service.

Plans that do not have defined provider networks, such as non-network MSA plans and private fee-for-service plans, must report the same standardized performance measures as all other plans. These non-network plans also must evaluate the continuity and coordination of care that enrollees receive. However, they do not have to meet the quality improvement requirements because they lack the ability to influence provider behavior. Appropriate flexibility will be provided so plans with networks that are less rigid than networks in traditional HMOs, such as preferred provider organizations (PPOs), can meet quality improvement requirements. The regulation preamble makes clear that we are not adopting a "one size fits all" approach for all types of Medicare+Choice plans. Our quality improvement systems will be sensitive to different plan structures and their different abilities to affect provider behavior. However, while there is flexibility in quality improvement standards, all plans must report standardized data. Collecting information from PPOs is feasible, according to a General Accounting Office investigation. In a July 16, 1998 letter to Senate Finance Committee member John Chafee and others, the GAO reports that "several large purchasers already collect quality-related information from PPOs."

PROVIDER SPONSORED ORGANIZATIONS

Appropriate flexibility is also provided for Provider Sponsored Organizations (PSOs). The Medicare+Choice regulations establish standards that, while similar to the time-tested HMO standards, reflect the unique characteristics of these provider-based plans. The PSO solvency standards are the result of a negotiated rulemaking process that included a broad range of interested parties. The standards are designed to assure that these plans are financially sound.

The PSO regulations require that affiliated providers own and maintain control of at least 51 percent of the PSO. These plans must demonstrate that each affiliated provider shares in the financial risk. The statute requires that affiliated providers furnish a "substantial proportion" of the services delivered to Medicare enrollees. The regulations establish that the "substantial proportion" of services that providers must furnish directly, rather than through contracts with unaffiliated providers, is 70 percent for most PSOs, and 60 percent for rural PSOs. This ensures that many types of providers work together to coordinate care and share risk.

PSOs that meet these standards may obtain waivers to participate in Medicare without state licenses, so long as they meet all other Medicare+Choice standards, including state standards on quality and consumer protection. Federal waivers are non-renewable, state-specific, limited to 36 months and cannot be granted after Nov. 1, 2002. We have already approved one such PSO waiver, for the St. Joseph Healthcare PSO in Albuquerque, New Mexico.

CONCLUSION

The Medicare+Choice program is the most significant change to Medicare in the program's 33 year history. We have already published all of the regulations required under the Balanced Budget Act. We are helping health plans understand how to participate. And we are undertaking a prudent strategy to help beneficiaries understand their new options. Adequate funding for education is essential if the Medicare+Choice program is to succeed. We appreciate this committee's support as we proceed, and I am happy to answer any questions you might have.

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Letter Report to the Administrator of the Health Care Financing Administration on Developing an Information Infrastructure for the Medicare+Choice Program

Committee on Choice and Managed Care
Office of Health Policy Programs and Fellowships
Institute of Medicine
June 22, 1998

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration
200 Independence Avenue, SW
Room 314G
Washington, DC 20201

Dear Ms. Min DeParle:

In March 1998, the Institute of Medicine (IOM) Committee on Choice and Managed Care (see the attached list of members), held a one-and-one-half-day workshop on "Developing an Information Infrastructure for Medicare Beneficiaries." This workshop followed in the footsteps of the Committee's 1996 report, *Improving the Medicare Market: Adding Choice and Protections.* One of the 1996 report's seven major recommendations was the following:

> The Committee recommends that special and major efforts be directed to building the needed consumer-oriented information infrastructure for Medicare beneficiaries. This resource should be developed at the national, state, and local levels, with an emphasis on coordination and partnerships. Information and customer service techniques and protocols developed in the private sector should be used to guide this effort, and the best technologies currently available or projected to be available in the near term should be used. (p. 89)

The March workshop focused on the information and dissemination requirements established in the Balanced Budget Act of 1997 (BBA), as they pertain to instituting an open-season enrollment process by the year 2002 for Medicare beneficiaries and implementing the Medicare+Choice (Part C) program. As part of the BBA mandate, HCFA is required to mail an announcement of the new Medicare+Choice options to all 39 million Medicare recipients by November 1998. Approximately 50 people from the public and private sectors were invited to the workshop. They were selected for their special expertise on information needs and information technologies as they relate to exercising health plan choice in a competitive, managed care environment, especially among senior citizens.

We want to share some of the committee's findings and recommendations based on the presentations and discussions at the workshop, and on the committee's 1996 report. The committee supports the major provisions of the BBA pertaining to increasing Medicare beneficiaries' health plan choices and providing beneficiaries with better information about the options available to them. However, the committee would like to underscore the following findings and concerns:

- The introduction of Medicare+Choice brings with it new rules and procedures that will be totally unfamiliar to most beneficiaries. In addition, the scope and speed of the proposed changes are likely to cause confusion and anxiety among many elderly beneficiaries.

Medicare beneficiaries have had much less exposure to managed care than have people who are insured through their employers. While managed care enrollment for the over-65 population is increasing rapidly, according to May 1998 HCFA data only about 16 percent of people eligible for Medicare are enrolled in a managed care plan, compared to over 70 percent in the under-65 insured population. In addition, unlike most employed people—particularly those working in larger firms—whose employers help screen and evaluate their health plan options, most Medicare beneficiaries must rely on their own knowledge and judgment to select a plan wisely. In its 1996 report, the committee noted that the elderly need more time and require more outside help to make health care decisions. In addition, findings of a study presented at the workshop indicate that the information processing tasks that would be required of Medicare beneficiaries under the BBA are highly cognitive and would be difficult for *any* population to address successfully (Hibbard et al., 1997).

- The new system scheduled to be introduced by November 1998 will give many elderly people a broader array of health plan options from which to choose. However, although HCFA will present comparative information about the plans in a standardized format, most of the marketing materials available

from individual plans themselves will not be standardized or presented in a way that would be conducive to helping elderly people make informed decisions they could feel comfortable with.

The 1996 IOM study and experts at the workshop addressed the value of standardized packaging, pricing, and marketing of benefit options to allow beneficiaries to more easily compare the benefits offered by different plans. Representatives from the plans, however, told the committee that the current trend in private-sector marketing is to move toward "mass customization," whereby materials are tailored to an individual's demographic characteristics, socioeconomic status, neighborhood, ethnic group, language, and religious belief. To help decrease confusion and to make it easier for beneficiaries to make informed choices, the committee refers to the findings of its 1996 report to underscore the advisability of the government developing a common terminology that would be used by all plans to describe their benefits, as well as common formats for presenting the information; both efforts should draw on the best practices used by employers and by private and public organizations.

- Many beneficiaries do not understand how basic Medicare and Medigap coverage works. Far fewer elderly persons have even a rudimentary understanding of how managed care works or of how to choose among managed care plans, traditional Medicare, and Medigap.

Research over the past 12 years has documented how poorly Medicare beneficiaries understand the differences between traditional and managed care Medicare (Cunningham and Williams, 1997; Davidson, 1988; Hibbard et al., 1997; McCall et al., 1986; and Sofaer, 1993). Beneficiaries now face the daunting challenge of having to choose between two systems they do not understand, and, for many elderly persons, having to compare and to select from among many more plan options than employed populations face. In an examination of current survey research, the committee heard evidence at the workshop that 30 percent of beneficiaries in high-penetration managed care markets "know nothing" about managed care organizations, even though half of this group is currently enrolled in a managed care plan (Hibbard and Jewett, 1998).

- Despite HCFA's best efforts, a fall health plan marketing campaign is likely to produce, at the very least, a high level of confusion and anxiety among Medicare recipients—perhaps a backlash—and a host of questions about the impending changes.

Several presenters at the workshop commented that the increased range of health plan choices available to Medicare recipients under Medicare+Choice will likely spawn a great deal of anxiety and confusion among those unaccustomed to having to make such choices. The 1996 IOM report and testimony given at the March workshop spoke to the benefits of allowing

sufficient time for beneficiaries to learn about and understand the new system. The potentially daunting scope and speed of the transition to what, for most beneficiaries, remain uncharted waters underscores the need for building trust and familiarity in this arena. Trust and confidence can be greatly enhanced through the development and dissemination of reliable, objective, and understandable information. Efforts to build trust and a level of comfort with Medicare Part C are particularly important given the ongoing negative public perception and attitude about managed care in general.

- Compounding the likelihood of raised anxiety and confusion among the elderly will be a concurrent flood of mailings marketing existing plans as well as a number of new Medicare products. Despite current rules designed to monitor and control marketing materials sent to Medicare beneficiaries, such mailings can too easily include misleading or incomplete information. Most materials sent to the elderly lack a clear, understandable explanation of what it means to be part of a managed care plan and what coverage or cost trade-offs need to be considered by beneficiaries in order to make a good health plan choice. Such information must be part of the marketing materials to minimize dissatisfaction among beneficiaries that could subsequently lead to excessive, costly rates of plan disenrollment.

Many health plans understand the importance of spending time with Medicare beneficiaries up front to provide them with reliable information about the plan and how it differs from traditional Medicare. The committee, however, heard ample evidence that plans tend to interpret and relay information differently from each other. Experts who work with beneficiaries provided extensive evidence at the workshop that all too frequently, the information that plans provide is incomplete and confusing. A recent report published by the Kaiser Family Foundation also points to evidence that HMOs, particularly those using aggressive sales tactics, rarely include explanations of how they differ from traditional Medicare or detailed explanations of their benefits and coverage limits (Frederick Schneiders Research, 1998).

- Whereas HCFA is making Herculean efforts to prepare for Medicare+Choice, the information infrastructure and resources available for this daunting task appear inadequate, particularly in terms of the capacity to answer both the volume and content of the inquiries that will surely result from HCFA's mailing and from the marketing materials sent out by the health plans themselves. A major upsurge in the number of constituent calls to members of Congress should be anticipated as one consequence of the sweeping nature of implementing Medicare+Choice as it is now scheduled.

At its March workshop, the committee invited a representative of General Electric to discuss that company's Answer Center as a model for handling large volumes of toll-free telephone calls. The GE representative noted

that out of a 6-million person customer base, the Answer Center receives 8 million calls annually. He also informed the committee that GE places a high value on recruiting and training its Answer Center employees and prefers to employ college graduates rather than less well-educated clerks. The committee also received testimony from the California Public Employees' Retirement System (CalPERS), which reported that during its annual 1-month open-enrollment period, about 15 percent of their over 1 million members call its customer service center (Stanley, 1997). The timing of HCFA's fall mass mailing, as outlined in the BBA, will roughly coincide with the congressional elections. Presenters and congressional health staff members at the workshop both indicated that any likely surge in telephone calls would thus take place during a time when many members of Congress are in their home districts campaigning for reelection.

- If the current timetable and choice process hold, many elderly people are likely to make ill-considered choices that will ultimately undermine Congress' efforts to restructure Medicare..

Congress is moving the major federal entitlement programs that deal with health (Medicare and Medicaid) into managed care with the purported goal of saving money. This committee has previously found that "[b]eneficiaries who make misinformed choices can be hurt financially or clinically, or both" (Institute of Medicine, 1996, p. 85). Speakers at the workshop cautioned that any political rhetoric emanating from the beneficiaries' confusion may complicate Congress' long-term efforts in the managed care arena.

- Medicare+Choice is quite different from the Federal Employee Health Benefits Program, a program that many people are holding up as a model. The Medicare market consists of 39 million people, more than 3 times the size of FEHBP's membership. Further, FEHBP has involved the option to chose among plans for 35 years. Federal workers are very familiar with the options open to them, and many of them have a detailed understanding of how the various plans work. The opposite is true for Medicare beneficiaries. Furthermore, most federal workers have ready access to professional counselors in their benefits offices or to peers who can readily assist them with their questions

There are other clear distinctions between FEHBP and the Medicare program as well. Federal retirees have about 25–30 years' experience with an open-season enrollment environment. Even though the retirees may not have changed their health plan often over the past 25 or 30 years, they have had the opportunity to do so, and they have had direct interactions with health plans during this period. In addition, because they have been in this system for a number of years, the retirees already possess a great deal of knowledge about deductibles, copays, and so on. This level of familiarity and experience among beneficiaries indicate that HCFA's task will be much more complex than

FEHBP's. Jim Morrison, past director of FEHBP, indicated at the March workshop that federal employees in FEHBP trust that the Office of Personnel Management has adequately screened the health plans, thus limiting the likelihood of their making a poor health plan choice. Medicare+Choice introduces several new types of plans, such as preferred provider organizations (PPO's) and provider sponsored organizations (PSO's), that do not have a performance history that HCFA or beneficiaries can evaluate.

In light of the preceding findings and concerns, and keeping in mind this committee's prior work in the areas of beneficiary information and the development of a sound information infrastructure, the committee makes the following recommendations:

- **HCFA should stagger its mailings over a period of several months, both to reduce and spread out the certain upsurge in the volume of inquiries and to allow some level of market-testing of the material.**

- **HCFA should urgently request more time from Congress for additional educational efforts among beneficiaries and infrastructure development at the front end of the process.**

- **HCFA should delay the initial mailing until market-testing demonstrates that the differences among the various health plan choices and benefit packages will be presented in a standardized, easily understandable way.**

- **HCFA should focus on conveying a few key messages and the answers to a few select questions on topics about which the elderly most need assurance. For example: (1) Will I be able to continue seeing my current physician? (2) Will I be able to see a specialist if I think I need one? (3) Will the plan save me money, and if so, how? (4) How will my pharmacy costs be covered? (5) Can I leave the plan if I am unhappy? And (6) If I have a complaint, how will it be addressed?**

- **All the major groups that the elderly reach out to for help (e.g., HCFA, Congress, and local Health Insurance Counseling and Assistance Programs [HICAPs] among others) need to be enlisted in the effort and well prepared to respond to both the volume and content of the inquiries that will certainly result.**

- **Given that the vast majority of people eligible for Medicare have not had to change plans, and bearing in mind the anger and opposition that resulted from an earlier attempt to substantially change the program (i.e., the 1988 Medicare Catastrophic Coverage Act), beneficiaries should be reassured that: (1) They are not in any danger of losing traditional Medicare coverage if they prefer to keep it, and (2) they can delay making any choice at all indefinitely, in which case they would continue to be covered by traditional Medicare.**

We appreciate your consideration of our views. We will make this letter public on June 22, 1998. If you have any questions about the issues raised in this letter please contact Marion Ein Lewin, Study Director at (202) 334-1506.

Sincerely,
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CHOICE AND MANAGED CARE:
Furthering the Knowledge Base to Ensure Public Accountability and Information for Informed Purchasing By and on Behalf of Medicare Beneficiaries

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AARP

July 2, 1998

Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
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Dear Ms. Min DeParle:

Last year, as part of the landmark Balanced Budget Act (BBA), the Congress and the President ushered in a major set of changes in the health care choices Medicare offers beneficiaries. In supporting expansion of Medicare choices, AARP emphasized the importance of solid, consumer-friendly information. HCFA recently announced that it would postpone national distribution of the revised Medicare handbook which was to have included information on the traditional Medicare program, the Medicare+Choice program and specific comparative information about Medicare+Choice plans.

We understand that your decision to postpone distribution and the related decision to phase in the 1-800 telephone lines over the next year is for the purpose of further testing and refining the contents of the handbook and the operation of the telephone assistance line. For the reasons outlined in this letter, we believe HCFA's decision is the right course of action under the circumstances.

In Medicare+Choice, Congress established a worthy but ambitious goal: to allow Medicare beneficiaries to choose from among the broad range of health care options that are generally available in the commercial marketplace, and to provide beneficiaries with information that will enable them to make informed decisions. The goal is all the more ambitious because Medicare was given limited resources (roughly $2.50 per beneficiary) and a very short time to launch an educational initiative far more challenging than any similar effort in the private sector.

Educating beneficiaries so that they understand the complex range of choices facing them is an enormous task. Recent research in five cities conducted for AARP by Dr. Judith Hibbard of the University of Oregon found that many beneficiaries are not yet prepared to make knowledgeable choices even between the traditional Medicare fee-for-service program and the *current* HMO option. Preparing beneficiaries for the still more

PREPARED STATEMENT OF HON. ORRIN G. HATCH

Thank you Mr. Chairman.

I'd like to welcome the witnesses to the committee for this very important hearing on the implementation of the Medicare Plus Choice program.

I would briefly like to make just a few comments.

First, I am concerned about the monthly Medicare reimbursement payments—the so-called Average Adjusted Per Capita Costs, or AAPCC.

As members of this committee recall, in last year's Balanced Budget Act, we worked to increase payment levels in rural counties in order to provide needed financial incentives for managed care organizations to establish plans in these areas.

These changes were made as part of the Medicare Choice package to address the wide disparity in managed care reimbursements between high-payment counties in many of the urban areas of the country, and low-payment counties in many of the rural areas of the country.

Unfortunately, the opposite effect seems to be occurring. We are now seeing Medicare HMOs withdrawing from markets in California, Ohio, South Carolina, and from the entire state of Utah.

Just last month, the Intermountain Health Care and the PacifiCare organizations announced they are terminating their HMO plans in Utah at the end of this year.

As a result, 20,000 Utah Medicare beneficiaries who are currently enrolled in these plans will have no choice but to return to the traditional fee-for-service arrangement. For Medicare beneficiaries in Utah, Medicare Choice will not be an option.

And, unlike some of the horror stories we have heard about managed care recently, I have heard from numerous individuals who tell me they are pleased with their Medicare HMO plans. Low reimbursement levels remain a problem for rural America.

So I am hopeful this hearing will give us some insight into ways to address the problem—either administratively or legislatively.

Finally, Mr. Chairman, I could not let this opportunity pass without briefly mentioning an issue that is particularly troublesome to me and I know to many of my colleagues in the Senate.

The implementation of the home health provisions in the BBA is creating extreme problems for home health agencies and for the people who depend on these services.

Quite frankly, I am not happy with the Health Care Financing Administration's handling of this issue.

First there was the issue with surety bonds; then the issue with the blood draw benefit; and now we continue to have problems with the Interim Payment System or IPS.

I have cosponsored bipartisan legislation with Senator Grassley and Senator Baucus and others on this committee to address what has clearly become a tragic problem for thousands of people in my state and around the country.

Just in the last six months, approximately a dozen home health agencies in Utah have gone out of business because of the new reimbursement formula under the IPS.

These agencies served primarily rural areas. And, as a consequence, many of these people in these remote communities have no alternative source of health care, except maybe for admission to a nursing home.

The status quo is simply unacceptable.

We have to do something and it must be done this year.

Representatives from HHS have met with my staff and other staff on this committee regarding the implementation of the home health provisions. And,

I appreciate their effort to work with us in resolving some of these problems.

And clearly, Congress must share the blame for the IPS because we put it in the BBA.

Nevertheless, we now know it has had unintended consequences which are hurting the very people we are trying to help.

We need to find a workable solution to this very complex and difficult problem. I want to thank my colleagues on the committee especially Senator Grassley and Senator Baucus for their leadership on this issue.

Once again, Mr. Chairman, I am hopeful we can work out this problem in the coming months and I thank you for holding this hearing today.

PREPARED STATEMENT OF DANIEL LESTAGE, M.D.

Mr. Chairman and members of the subcommittee, I am Dr. Daniel Lestage, Vice President of Professional and Organizational Relations for Blue Cross and Blue Shield (BCBS) of Florida. I am testifying on behalf of the Blue Cross and Blue Shield Association, the organization representing 54 independent Blue Cross and Blue Shield Plans throughout the nation.

The BCBS system is a major presence in the Medicare program. Collectively, BCBS Plans provide Medicare HMO coverage to more than three-quarters of a million Medicare beneficiaries, which makes the Blue system the second largest Medicare HMO provider in the country. BCBS of Florida itself is a major Medicare risk contractor with an enrollment of approximately 105,000 Medicare beneficiaries.

I appreciate the opportunity to testify before the subcommittee today on the quality provisions in the new Medicare + Choice regulations. I would like to make two key points about the effects of these regulations:

- First, unless the regulations are carefully modulated for different types of health care products, they will limit beneficiaries' options to tightly managed HMOs and deny access to popular PPO products;
- Second, the regulations could add so significantly to HMO costs that HMOs would have to reduce benefits to beneficiaries (e.g., prescription drugs). In fact, some HMOs might not even be able to participate in Medicare + Choice.

Before I address these points, let me summarize the main provisions of the regulation, and its relationship to HCFA's Quality Improvement System for Managed Care (QISMC).

THE QISMC AND THE MEGA-REG

During the past two years, HCFA has been working to develop a new set of quality standards for Medicare and Medicaid managed care organizations—the Quality Improvement System for Managed Care or QISMC. The QISMC is the basis for the quality assurance standards in the recently released Interim Final Regulations on Medicare + Choice (the so-called "mega-reg"). HCFA incorporated many QISMC standards directly into the rule, and HCFA indicates it will use QISMC as part of the contracting process to determine whether a managed care organization can meet the quality assurance requirements.

On the basis of the QISMC, HCFA crafted the mega-reg around two key components. First, Medicare + Choice plans must measure performance for both clinical and nonclinical areas using standard measures required by HCFA, and they must meet minimum performance levels in these areas. Initially these performance levels may be locally or regionally based, but HCFA wants to move toward minimum uniform national performance standards. HCFA will develop a core set of measures for all plans. The preamble states that for contract year 1999, performance measures will include most HEDIS 3.0 measures and data from the Consumer Assessment of Health Plans Survey.

By the end of the contract year, a Medicare + Choice plan must meet any identified minimum performance levels. If HCFA determines that the plan has not met minimum performance levels, it may decline to renew the contract. In fact, if the plan failed to meet minimum performance levels in, say, the year 2000, but HCFA did not determine this until the next contract year had already begun in 2001, then HCFA could decline to renew the contract for 2002.

Second, Medicare + Choice organizations must conduct "performance improvement projects" that achieve "demonstrable improvement" in the health or functional status of their enrollees across various clinical (e.g., prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care) and nonclinical (e.g., appeals, grievances, and other complaints, access to and availability of services) focus areas. As part of the contract, HCFA will set plan-specific obligations for the number and distribution of projects and the length of the performance improvement cycle (i.e., the number of years over which the project must continue to achieve improvement). Also, consistent with the QISMC, HCFA states in the mega-reg that it is considering requiring a 10 percent reduction in negative outcomes in each performance improvement project. Depending on how HCFA makes these final determinations, Medicare + Choice organizations could have to spread their resources over as many as 20 to 30 different projects to comply with HCFA's requirements. And, in addition to these projects, HCFA notes that plans "are likely to carry out projects in other areas in order to meet their contractual performance improvement obligations."

Although the QISMC forms the basis for the mega-reg, the QISMC is not yet final. Last May, HCFA solicited public comments on an earlier draft of QISMC, and HCFA is now working to prepare a final version of the QISMC, perhaps by the end

of August. We would be pleased if the revised QISMC solves the problems we have. The rest of my testimony discusses these problems.

I. MEDICARE+CHOICE REGULATIONS COULD LIMIT BENEFICIARIES CHOICES

In creating Medicare+Choice under the Balanced Budget Act of 1997 (BBA), the Congress sought to expand significantly the types of private health plan options that are available to Medicare beneficiaries. Medicare+Choice is to reflect the health benefit design, delivery, and cost containment innovations that have occurred in the private sector and that, to a great extent, have been captured by the Federal Employee Health Benefit Program (FEHBP). Thus, Medicare beneficiaries should have access not only to HMOs, as under the old Medicare risk program, but also other options such as PSOs, POS products, private fee-for-service plans, MSAs, and Preferred Provider Organizations (PPOs).

However, we are concerned that Medicare beneficiaries may not actually have access to one of the most popular commercial and FEHBP choices: PPOs that have very large networks and that promote free choice of providers. The reason: HCFA's new standards for quality assurance and performance improvement, while intended for all managed care products, are primarily applicable to a specific type of product—tightly managed HMOs. Ironically, far from increasing choice to reflect options in the private sector, the Medicare+Choice regulations might end up restricting choice for Medicare beneficiaries.

THE QISMC IS DESIGNED FOR HMOS

It is significant that HCFA's work on QISMC began before the Congress passed the new Medicare Part C. Thus, as HCFA itself has stated, "QISMC deliberations focused chiefly on assuring quality in the types of entities that most frequently contract with HCFA and States under current law —that is, TEFRA risk HMOs under Medicare."

Because the QISMC is designed for tightly managed HMOs, we believe that significant revision is needed to accommodate broad access PPOs. Recently, several other BCBS Plan medical directors and I met with senior HCFA officials to explain our concerns. Although HCFA is firmly wedded to the QISMC framework, HCFA did agree to consider areas of flexibility and invited BCBS to continue a dialogue. This dialogue is critical because if the QISMC does not have sufficient flexibility, broad access PPOs will likely not be in the Medicare+Choice program.

HCFA'S QUALITY ASSURANCE STANDARDS CREATE SERIOUS PROBLEMS FOR PPOS

The two key components of the mega-reg—a core set of clinicial/non-clinical performance measures and demonstrable performance improvement—will pose serious problems for broad access PPOs. Industry standards in today's market (i.e., National Committee for Quality Assurance or NCQA and American Accreditation HealthCare Commission/Utilization Review Accreditation Commission, or AAHC/URAC) simply do not use such components for PPOs.

PPOs are Held to Different Standards in the Private Sector.

In fact, private accrediting organizations and private employers hold PPOs to different standards from HMOs. For example, HEDIS (the Health Plan Employer Data and Information Set) is controlled by NCQA, a private sector organization that accredits HMOs. NCQA exclusively accredits HMO-style health plan. HEDIS has become the standard benchmark for clinical quality indicators in HMOs. In contrast, the leading private sector organization for accrediting PPOs, the AAHC/URAC, does not collect HEDIS measures or HEDIS-type measures from PPOs. PPOs do not have to produce a core set of performance measures to become accredited.

Can PPOs produce any HEDIS data? Under some circumstances, some PPOs might be able to produce some HEDIS data, but even then the quality of the measures is not the same as in HMOs. For example, the California Public Employees' Retirement System (CalPERS)—which covers about one million people—requires that its participating HMOs and PPOs each provide information on several HEDIS measures. However, the CalPERS Health Plan Decision Guide does not compare PPO results with HMO results. The guide explains:

> "Inherent differences between PPOs and HMOs such as benefit design, not being required to have a primary care physician, and the freedom to access services outside the network, limit the data available and limit their comparability."

Indeed, these inherent differences in design between PPOs and HMOs lie at the heart of our concerns over HCFA's quality standards.

HMOs are Structured to be Accountable for Enrollees' Health Status.

The key feature of an HMO is clinical accountability for a defined population. This means that HMOs are structured to support measurement of health indicators and improvement in enrollees' health status. HMOs can achieve these goals by assuring a central point of accountability for every individual's health care (i.e., the enrollee's primary care physician), controlling the physicians that their enrollees use (i.e., managed access to physicians in the network), and assuring (by contract) that physicians will participate in the HMOs medical management and information collection program.

HMOs achieve the improvement in health outcomes by measuring individual physician performance, assuring that physicians are following professionally accepted practice protocols, and using payment arrangements and incentives that foster improvement in patient outcomes (i.e., capitated and payment incentives). Also, HMOs are dependent on information abstracted from patient medical records; health plan nurses work with physicians to collect the information.

PPOs are structured to meet a different demand of our subscribers and employers.

PPOs' key feature is broad choice of physicians at a reduced cost to enrollees and employees (i.e., negotiated payment rates and protections against balanced billing). Enrollees have an incentive to use providers—hospitals and physicians—under contract (the negotiated rates are based on the promise of volume for providers). However, enrollees can go outside the network and pay a higher level of cost sharing.

Unlike HMOs, PPOs do not expect an enrollee to select a single primary care physician to be accountable for managing all their health care needs. An enrollee can see any physician or specialist in the network or an enrollee can seek care outside the network and the health plan will make some level of payment.

There is not the level of clinical oversight of physician care in a PPO that is present in an HMO. Physicians are generally paid on a fee-for-service basis and their contract is generally limited to a requirement to accept the health plan payment as payment in full (i.e., not bill the enrollee for any extra cost).

Importantly, PPO utilization review and quality programs are based on information generated from claims (bills for care provided). This claims data can indicate that a service was rendered, but does not indicated the outcome of the service. PPOs do not perform the routine collection of patient medical record information that is critical to HMOs in assessing medical outcomes.

It is important to note that employers and enrollees are asking for both types of products. They are very different products: HMOs offer a tightly controlled care management style with a relatively restricted network of physicians; PPOs offer broad choice, the benefit of negotiated payment rates, and the option to use any physician, anywhere at the individual's choice.

PPOs are very popular products. One in three working Americans is currently enrolled in a (PPO), attracted in part by the broad choice of physicians a network product with broad choice of physicians and open access to non-network providers. Some of the larger BCBS Plans, for example, have PPO networks that comprise 10,000, 20,000, or even 30,000 or more physicians within a state. And the BCBS Plans serving the Federal Employees Health Benefits Program together have 400,000 physicians in the PPO.

Problems with "One Size Fits All Standards"

Broad access PPOs are simply not set up to monitor, measure, and assure improvement in enrollees health status and physician outcomes. This level of clinical management requires (1) constraining the physicians enrollees can use (i.e., network physicians); (2) assuring that enrollees have a single point (physician) of accountability for their care; (3) having in place physician payments arrangements that support the desired impacts in clinical status of enrollees, (4) assuring access to all medical records information on patients; and (5) a very major investment in systems to track and analyze the collected information.

These characteristics do not appear in broad access PPOs. PPOs are structured to allow enrollees to use the provider of their choice. This freedom to choose and change providers permits enrollees to use providers that satisfy their needs and expectations. Because PPOs are designed to promote free choice of providers, they have limited ability to intervene in provider treatment decisions. PPOs generally allow participating providers to practice independently and do not have mechanisms for oversight of providers (other than basic credentialing requirements such as licensure or certifying hospital privileges). PPOs usually do not maintain mechanisms (e.g., medical management programs, primary care physician programs, or referral requirements) to manage and oversee the provision of care. Nor do PPOs have the

ability to exert significant leverage over provider performance, since PPOs usually do not put providers at financial risk.

Finally, performance measures nearly always depend on supplementation of administrative information with medical records data. On-site medical chart review is simply not feasible for large network, broad access PPOs.

THE EFFECTS OF QISMC ON PRODUCT DESIGN

PPOs could comply with "one-size-fits-all" QISMC standards only by eliminating the very features that make them popular products in the private sector. PPOs would have to:

- restrict beneficiaries' open access to non-network providers in order to track and improve outcomes.
- introduce mechanisms for coordinating and managing care (e.g., an assigned primary care provider).
- recontract with providers so as to enter into a much more information-intensive and management-based relationship.
- reduce significantly the number of physicians and other health care professionals in their networks.

In essence, PPOs would have to redesign fundamentally to become tightly-managed health plans.

II. MEDICARE + CHOICE REGULATIONS COULD SUBSTANTIALLY RAISE COSTS FOR HMOS

If QISMC poses insurmountable problems for PPOs, it also raises very serious challenges for HMOs. As I indicated earlier, QISMC goes beyond the current private sector "gold standard," NCQA accreditation. Requiring HMOs to meet such a rigorous standard—which will entail new investments in information systems and in staff—will certainly raise costs for HMOs. The key question is whether these costs add value. If not, then every dollar spent on a quality initiative of dubious value is one less dollar available for added benefits to enrollees.

That costs could be considerable is indicated by Medicare's own Peer Review Organization (PRO) program. Like the QISMC standards, PRO review emphasizes continuous quality improvement, though most PRO review is focused on inpatient hospital care. Medicare spends about $300 million a year for the PROs. I would note that the capitation payments Medicare + Choice plans receive from HCFA do not reflect the costs of this program.

QISMC STANDARDS ARE EXTREMELY LABOR AND DATA INTENSIVE

The QISMC quality assurance and performance improvement standards are extremely labor and data intensive—in fact, they would seem to require two to three years worth of trended data on a large sample of enrollees. This could create serious cost problems for plans with relatively small enrollments. A survey conducted in 1997 by the Blue Cross and Blue Shield Association's Accreditation Resources Department found that the same infrastructure is necessary to conduct performance improvement projects regardless of the size of the enrolled population. Thus, plans with very small enrollments had huge per-member costs. Moreover, Blue Cross and Blue Shield experience in Medicare and Medicaid managed care indicates that programs often lack a large enough enrollment to support a population-based study of care for specific chronic conditions.

The QISMC sets a rather arbitrary (and certainly costly) number of focus areas for improvement: they increase from zero in year one to seven clinical and six nonclinical in four years, for a total of thirteen areas. Even HCFA's consultant, the National Academy for State Health Policy (NASHP), stated that the proposed standards were unattainable given the amount of information required and the timeline available to demonstrate improvement. It would be more prudent for a health plan to concentrate its resources in a few areas than to spread them over thirteen. Plans should be expected to address the top concerns of their populations based on their data rather than an arbitrary number of concerns.

Also, I would point out that to realize the required levels of demonstrable and sustained improvement, plans would need to conduct two to three times the number of studies mandated. Because every project will not necessarily yield measurable improvement, plans would have to conduct more than the minimum number of projects. Moreover, because it takes at least two years to collect baseline data, perform an intervention, and evaluate results, plans would have to conduct old projects and develop new projects simultaneously. Thus, HCFA's QISMC standards could force plans to undertake 20 to 30 projects a year.

We appreciate HCFA's encouragement, as stated in the mega-reg's preamble, "to undertake complex projects or innovative projects that have a high risk of failure

but that offer potential for making a significant difference in the health or functional status of enrollees." Nonetheless, exhortations cannot substitute for business realities, because the regulations give health plans no credit for effort. As one senior HCFA official put it, "Trying hard will get you only so far." Especially given that health status measures may improve very slowly, even after extensive interventions, HCFA's requirements are far too demanding.

PROBLEMS WITH "DEMONSTRABLE IMPROVEMENTS"

As a requirement for "demonstrable improvement", HCFA is considering a 10 percent reduction in adverse outcomes. This rigid approach raises at least two concerns. First, it may be more important to change the rate of variation in a population (e.g., reduce both overuse and underuse of a treatment) than to change the average of a rate. Thus, HCFA's "10 percent" standard might preclude meaningful quality improvement activities. Second, the arbitrariness of the "10 percent" standard itself may unnecessarily raise costs. Although it is true that (as HCFA indicated) "the use of a constant percentage reflects the likelihood that change is harder to achieve when an organization's baseline performance is already superior," it is also true (as HCFA indicates) that, "as a practical matter, the last 1 percent improvement may be the most difficult to achieve."

Finally, because of the sheer complexity of health care, it would be extremely difficult to pin down "cause and effect" relationships in any quality improvement project. If it turns out that an outcome is determined less by a plan intervention and more by factors that are beyond a plan's control, then should a plan be required to spend taxpayer dollars on that project?

CONCLUSION

As stated in the beginning of the testimony, the QISMC standards are not yet final, although they are in the final stages of development. BCBSA appreciates the opportunity to work with HCFA to ensure that beneficiaries have as many Medicare + Choice options available as possible, including the broad access PPOs that are so popular in the commercial sector and in the FEHBP. It is very encouraging that HCFA expressed awareness of our concerns by stating in the mega-reg's preamble:

> "We do not intend to adopt a one size fits all' approach that assumes that reporting under all types of M + C plans will be possible in the same manner for all measures. We will balance our efforts to increase uniformity to facilitate consumer comparison of plans with sensitivity to the different organizational structures of plans and their different abilities to affect provider behavior."

Nonetheless, the standards that are actually embodied in the regulation, and the underlying QISMC document, still have a ways to go before they will encourage a wide range of Medicare + Choice plan choices. And they still have a ways to go to allay HMO anxieties over the value of added costs.

Therefore, BCBSA hopes that HCFA will permit a variety of approaches to quality assurance and performance improvement so as to encourage innovation and flexibility. As the former President of the Institute of Medicine has noted, "A healthy patient or a satisfied patient is not a standardized product. Therefore, the processes for making a patient well and satisfied must be varied and flexible, and so must be performance standards."[1] We look forward to a continued dialogue with HCFA to ensure the viability of PPOs in the Medicare + Choice program.

We also hope that as HCFA revises the QISMC, it carefully weighs the value of any new quality standards against the added costs. Spending precious resources on activities of dubious value to beneficiaries will only take dollars away from things that do matter to beneficiaries, such as added health care benefits.

Thank you for the opportunity to speak with you on these important issues.

PREPARED STATEMENT OF HON. CONNIE MACK

Thank you, Mr. Chairman:

Medicare is very important for the health and medical care of many Floridians. It directly impacts those over age 65, but also involves the lives of their families as well. Florida has the highest proportion of senior citizens, 18.5%, more than any other state in the Union. Therefore, any proposed change in Medicare generates a great deal of interest in our state. Florida has a population of nearly 15 million people. There are almost three million Floridians over age 65 eligible for Medicare.

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[1] Samuel Their and Annetine Gelijns, "Improving Health, The Reason Performance Measurement Matters," Health Affairs, v. 17 n.4, July/August 1998.

Health maintenance organizations enroll 25% of those eligible for Medicare in Florida or almost three quarters of a million seniors. Florida has large rural areas with relatively few providers of care, cities with an abundance of health facilities and some nationally recognized academic medical centers. A large number of our seniors are already enrolled in Medicare HMOs. Whenever a change in Medicare is implemented, there is little doubt that there will be an impact on the way care is delivered and how it is received in Florida.

In the past, health care was largely provided by doctors and in hospitals. Now, delivering health care involves a variety of managed care organizations including, but not limited to, health maintenance organizations, preferred providers and insurers. Years ago, people customarily received care in their doctors office or at the hospital. Now, providers give care in their own offices, patients homes, ambulatory settings and hospitals. Today, obtaining medical care is a more complicated undertaking. I would like to receive information from the witnesses so that I am in a position to know and assure Medicare beneficiaries in my state that they will be able to obtain needed and appropriate care despite the complexities of modern medicine and the changes in the organizational arrangements around Medicare.

Medicare+Choice should offer Medicare beneficiaries more choices. For this to be implemented, information about plans must be effectively communicated. Medicare+Choice was established to be able to offer comprehensive services which are required to be monitored for quality.

At the same time, the costs for these services can be better controlled than in traditional Medicare. Medicare+Choice should accomplish at least four things. First, expand the variety of capitated health plans available. Thus far, there is little evidence that this is happening. Existing Medicare HMOs are converting to Medicare+Choice plans in order to remain in business and very few new types of plans have come forth to be included. I am looking forward to seeing the growth in the availability of MSAs to seniors under Medicare+Choice. Second, these plans must cover existing benefits and not cost more than if the services were received in traditional fee-for-service Medicare.

Third, payment rates to the Choice plans are calculated and increased on a new formula basis. I am concerned that the new increased capitation for some areas of the country may be higher than what Medicare presently costs, but still will not be sufficient to attract new Medicare+Choice plans into these areas. And, while increased choice for seniors is a major goal of this program, it should not be accomplished by escalating Medicare costs in situations where geography and population density are predominant. Fourth, there are new procedures to be followed for the enrollment of seniors in these plans.

I have major concerns about these since they involve the dissemination of not easily explained information in writing and over the telephone. There is a real possibility that Congressional offices may be flooded with telephone calls about specific Medicare+Choice plans and procedures. I want to know what steps are being taken to establish mechanisms that will adequately inform and accommodate the needs of Medicare beneficiaries relative to the introduction of Medicare+Choice.

I look forward to learning how HCFA and the individual Medicare+Choice plans have coordinated to inform beneficiaries about Medicare+Choice plans. I want to know additionally how this will be conducted in Florida. It is essential that plans for communicating with Medicare beneficiaries are in place and that information will be distributed sufficiently ahead of time so that beneficiaries can investigate the types of systems for obtaining care that will be available in their geographic areas. This will require close cooperation between Medicare+Choice plans and HCFA.

Medicare+Choice should be just that, a new set of options from which Medicare beneficiaries can choose. We all share the responsibility to see that this occurs. I look forward to receiving answers to these questions.

PREPARED STATEMENT OF HON. FRANK H. MURKOWSKI

Mr. Chairman, thank you for conducting this hearing on the new Medicare options created in the Balanced Budget Act.

Unfortunately, much of what will be discussed today will have no impact on the elderly of Alaska. Why? Because choices in health care are not the over-riding concern for Alaska Medicare patients—access to health care is the biggest problem for Alaska's elderly.

Nearly every week I hear from an elderly Alaskan who writes me saying that his doctor can no longer take her as a patient. I want to read excerpts from letters I received from two of those patients:

1. "Dear Senator Murkowski,

I received a letter from my doctor saying that she can no longer accept me as a patient. This came as quite a shock, as I still have two years left on care following surgery for cancer. It is frightening at my age (75) to have to start looking for a new doctor . . . After checking around, I find that more and more doctors are contemplating doing exactly what my doctor has done. Please help.

Sincerely,

MRS. DANA NIEMANN (PALMER)".

* * * * *

2. "My Dear Senator Murkowski,

Medicare forced my longtime family doctor to sever our relationship because many Alaskan doctors are being forced to turn away elderly patients due to inadequate Medicare reimbursements and threats of fines for inadvertent billing mistakes. No, we do not have a private contract. If she should continue to see me, she'll not be able to see any Medicare patients for two years. (Note: You are a co-sponsor of legislation that would change that.)

So as of now I am very angry, have no personal doctor and do not plan to go till I absolutely must. I have been going to my doctor for 10 years. I feel Medicare is discriminating unfairly in thwarting the until now productive relationship between my doctor and myself. It sounds like you and your staff are serious in wanting to make the system more practical and simple. Thank you for any assistance you can give me.

Very truly yours,

MRS. WANDA M. GRIFFIN (ANCHORAGE)".

Why are Alaska physicians no longer accepting Medicare patients? Well, there's three reasons:

1. *Physician reimbursement in Alaska is insufficient.* (Medicare reimbursement to physicians has never taken into consideration certain costs associated with providing health care in Alaska—such as transportation costs of shipping and air travel);
2. *The new Medicare regulations are too complex;* and
3. *Investigative tactics into alleged fraud and abuse* by both the Dept. of Justice and the Health Care Finance Administration are viewed by doctors as unwarranted and abusive.

Here's a letter from an Alaskan doctor in Palmer that's representative of many Alaskan physicians:

"Dear Mrs. Buchert (of Palmer, Alaska)

This letter is written to regretfully inform you that as of February 1, 1998, I can no longer see you in my practice. For many years Medicare has been underfunded by the Federal Government and reimbursement has been well below my overhead costs.

I enjoy taking care of mature women and have been willing to pay for the privilege, but recent changes have made this untenable. Medicare has just issued a 50-page booklet with new rules and regulations about what I, as a physician, need to document in order to be reimbursed. While I already do most of what they require, I find the burden of these new government regulations and interference with patient care unacceptable in a situation where I am essentially paying for the privilege of providing health care for mature women.

Medicare has also been much more active in prosecuting "fraud," particularly in inadvertent billing mistakes. Future predictions include more audits at individual practitioner's offices. I no longer feel I can take the risk of any minor billing error targeting me for a potential fraud audit.

Federal law precludes me from accepting you as a private patient if you have Medicare, or are Medicare eligible, so it is unfortunate there is no way I can see you in the future. This deeply saddens me, and believe me, your attendance in the office will be missed by both me and my staff. I only wish there were some way around this.

I offer the suggestion that you write to our congressman and senators, particularly if you have difficulty finding healthcare in the future. I know that many physicians in this area are no longer accepting new Medicare patients and I pray that you will find someone else.

After years of providing healthcare in this Valley, I am deeply distressed that it has actually come to this. Best wishes for the future.

Sincerely,

DR. SUSAN L———".

* * * * *

I have held several workshops in Alaska to help the situation. Representative from both the Health Care Finance Administration and the Dept. of Justice explained their fraud and abuse procedures and the strides attempted in the coding guidelines—however, the problem persists. To exacerbate the problem, Alaska has the fastest growing elderly population in the country.

Mr. Chairmen, the purpose of the hearing today is to ensure patient choice in health care for the elderly. However, I'm still trying to ensure patient access to health care in Alaska.

Therefore, I am asking for the help of Mr. Hash, Deputy Director of the Health Care Finance Administration. I ask Mr. Hash to commit to an "outreach program" to Alaska to help resolve this problem.

My workshops have taught me that better communication, better access and better cooperation is needed by the Health Care Finance Administration to the state of Alaska. Mr. Hash, can you commit your cooperation on this issue vital to Alaska?

PREPARED STATEMENT OF JANET G. NEWPORT

I. INTRODUCTION

Mr. Chairman and members of the Committee, thank you very much for the opportunity to comment on issues related to implementation of the Medicare+Choice program. I am Janet Newport, Vice President of Regulatory Affairs[1] for PacifiCare Health Systems, based in Santa Ana, California. PacifiCare provides health care coverage for more than 3.7 million enrollees in ten states—Arizona, California, Colorado, Kentucky, Nevada, Ohio, Oklahoma, Oregon, Texas and Washington—and the territory of Guam. Through Secure Horizons, our Medicare plan, we enroll nearly one million Medicare beneficiaries, the largest enrollment nationwide.

I am testifying today on behalf of the American Association of Health Plans (AAHP), which represents more than 1,000 HMOs, PPOs, and similar network health plans. Together, AAHP member plans provide care for more than 140 million Americans nationwide. AAHP appreciates this opportunity to comment on HCFA's implementation of the Medicare+Choice provisions of the Balanced Budget Act of 1997.

With last year's passage of the Balanced Budget Act (BBA), Congress created the new Medicare+Choice program, designed to expand choice and competition for beneficiaries across the country. AAHP and its member plans have long supported these efforts to modernize Medicare and give beneficiaries more choice. Today, more than 16 percent—or 6.1 million beneficiaries—are enrolled in health plans, up from 6.2 percent five years ago.[2] Approximately 90,000 Medicare beneficiaries are joining health plans each month, selecting among the more than 330 health plans available nationwide.

Among the significant Medicare changes included in the BBA were revisions to the methodology for health plan payments establishing a minimum payment floor, phased-in blend of national and local capitation rates, and annual two percent payment update. Taken together, these revisions to the payment methodology were designed to reduce the variation between traditionally higher and lower payment areas and, as a result, enhance choice and competition in Medicare. The revisions to the payment methodology also included provisions limiting the annual rate of growth in payments to health plans, which allowed for $24 billion in savings from health plans.

AAHP and its member health plans supported the passage of the payment reforms in the BBA, and were pleased to contribute our fair share toward the savings necessary to stabilize the Medicare Trust Fund. Our support was given based on the payment provisions outlined above and the stability we sought to achieve for the Medicare+Choice program. We are concerned, however, that certain aspects of the BBA are not being implemented as intended by Congress and in a manner which best serves the beneficiary population.

This statement addresses a range of specific issues related to implementation of the Medicare+Choice program, including risk adjustment and payment, the bene-

ficiary information campaign, service area designation, and other concerns raised by the Medicare+Choice regulation recently promulgated by HCFA.

II. RISK ADJUSTMENT AND PAYMENT

The BBA requires HCFA to develop a risk adjustment method, based on beneficiaries' health status, for implementation beginning in the year 2000. In addition, the BBA authorizes HCFA to collect, beginning in January 1998, retroactive hospital encounter data from health plans dating back to July 1997. AAHP has consistently supported the goal of ensuring that Medicare payments to health plans are accurate and that they fairly reflect the health care service needs of the Medicare beneficiaries who enroll. We believe that risk adjusting Medicare+Choice payments should be implemented in a manner that will improve payment accuracy and result in the least disruption possible to beneficiaries and plans participating in the program.

The initial use of a risk adjuster based solely on hospital utilization data creates incentives for increased inpatient utilization. Many health plans have developed programs to reduce unnecessary hospitalizations for chronically ill members who would have otherwise been treated in inpatient settings. HCFA needs to address this important issue prior to implementation of its proposed risk adjustment methodology.

The aggressive timeframe stipulated by the BBA for implementation of a risk adjuster has challenged both health plans and HCFA. We are working with HCFA to address a wide range of complex, technical issues related to implementation of risk adjusted payments. Our member plans have undertaken major systems modifications to prepare for submission of hospital encounter data which contain all of the elements HCFA requires and can be submitted electronically in the required format. The collection of retroactive data, from July 1, 1997 through December 31, 1997, has been particularly problematic, because plans and inpatient providers had no opportunity to put necessary systems in place prior to the period for which data must be reported.

In addition, HCFA has made clear that it is struggling to meet the challenges of "Year 2000" compliance and, as a result, has postponed certain statutory reimbursement changes enacted by the BBA. The risk adjustment methodology proposed by HCFA will require similarly complex systems infrastructure and administrative resources. Congress and HCFA should evaluate HCFA's systems capabilities to determine whether a delay in the implementation of the risk adjustment methodology is appropriate.

AAHP believes that the risk adjustment methodology developed by HCFA should be implemented without a further aggregate reduction of payment to the Medicare+Choice part of the program as a result of risk adjustment. As discussed below, growth in Medicare+Choice payment rates will not keep pace with growth in FFS payments over the next five years. Using a risk adjustor to further reduce payments would make plans hesitant to enter certain market areas and leave beneficiaries with fewer Medicare+Choice options, reduced benefits, and higher premiums.

A recent study by Price Waterhouse illustrates that the BBA payment reforms alone dramatically reduce growth in capitation rates to health plans compared to pre-BBA payment levels. The study found that prior to the BBA, the average payment would have risen from $553 in 1998 to $746 in 2003 and would have remained at 95 percent of the fee-for-service program. After the BBA, the average payment rate is reduced to $530 in 1998 and $658 in 2003. The study found that enactment of the BBA reduced average payments relative to the fee-for-service program to 94 percent in 1998 and 89 percent in 2003. The combined effects of the substantial reduction in payment growth contained in the BBA and HCFA's proposed risk adjustment methodology will be to further reduce Medicare+Choice payments relative to FFS.

HCFA has stated that its proposed risk adjustment methodology could reduce health plan payments by as much as eight percent, on average. Contrary to ensuring predictability in the new Medicare+Choice program, the impact of this risk adjustment will erode payment growth and undermine the intent of the BBA by restricting both new market entrants and potential expansions, and leaving beneficiaries with fewer options, reduced benefits and higher out-of-pocket costs.

Given the administrative complexity and potential impact of HCFA's proposed risk adjustment methodology, Congress and HCFA should consider whether delaying its implementation would better serve beneficiaries. We also urge the agency to assess the overall performance of the Medicare+Choice program under the new payment methodology. The changes made by the BBA are complex and the impact on

plans is significant. For the future success of the program, HCFA needs to evaluate the impact of this new methodology on beneficiaries, health plans and other Medicare+Choice options.

III. BENEFICIARY INFORMATION CAMPAIGN

The BBA instructs the Secretary to educate Medicare beneficiaries about their choices using a variety of approaches, including a handbook, toll-free number, an internet website, and community outreach. To finance these activities, the BBA authorizes HCFA to charge each Medicare+Choice organization and Medicare risk contractor a fee equal to the organization's pro rata share of HCFA's estimated costs of enrollment and information dissemination activities. While AAHP supports efforts to enhance informed beneficiary choice, we have significant concerns about the funding, costs and design of the program developed by HCFA.

First, while it is reasonable for health plans and their enrollees to contribute to funding HCFA's enrollment and information dissemination initiatives, their contribution should be in proportion to their participation in the Medicare program. Last year, Medicare risk HMOs and their enrollees represented 14.3 percent of the program but shouldered 100% of the cost of the information campaign.[3] The burden of this fee directly affects the premiums and benefits that health plans can offer to their Medicare members.

While AAHP supports disseminating information to all beneficiaries to enhance informed choice, we believe that an equitable funding mechanism is critical to the success of this effort. The goal of expanded choice is not served if the costs of underwriting the information campaign reduce the level of benefits that Congress sought to make available to more beneficiaries.

We are also concerned about the costs of the education campaign that HCFA intends to implement. Congress appropriated $95 million for these activities in 1998 and suggested that HCFA focus first on developing and publishing the comparative information booklet; this year, the agency is seeking $150 million for FY99. However, in June 1998, HCFA announced that it would scale back plans to distribute Medicare handbooks to 38 million beneficiaries and instead pilot test the handbook in five states, reaching only 5.5 million beneficiaries. In addition, HCFA is phasing in over 12 months implementation of the toll-free call center. Yet HCFA has collected close to its full 1998 assessment of $95 million from health plans.

The 1998 assessment of $95 million was intended to educate all beneficiaries about their options under the Medicare+Choice program, not just a subset of these beneficiaries. While we support a scaled-back, more thoughtful process for the education campaign, a significantly scaled-back program raises questions about HCFA's use of the full 1998 assessment. Congress should ensure that HCFA is held accountable for the FY98 assessment collected from health plans, especially since the reduced activities should be reflected in reduced FY98 expenditures. To date, HCFA has not provided detailed information on the budget, resource allocation, or expenditures for the beneficiary education campaign for FY98. Furthermore, the very limited budget information that the agency has made available indicates that costs for the beneficiary education campaign are significantly higher than those borne by other federal agencies or the private sector for similar activities (see attached chart).

Finally, we continue to be concerned about the general design of HCFA's program and whether the information provided will be meaningful—or more confusing—to beneficiaries. For example, it is unclear whether the information to be contained in the national bulletin will provide needed information or simply raise more questions among beneficiaries; whether retiree group members will understand that their employer's plan is different from a regular Medicare+Choice plan; or whether beneficiaries will understand that they do not need to make any changes. For most beneficiaries, the transition to the Medicare+Choice program will have little impact until and unless new health plan options begin to be available in their market areas. Given this, sending materials discussing new programs that remain unavailable to beneficiaries may be more confusing than informative.

We urge HCFA to revisit their plans for a beneficiary education campaign and ensure that it provides beneficiaries with information that will educate, not confuse. AAHP and its member plans will continue to work with HCFA, beneficiary groups and others to develop an education campaign that provides accurate, timely and meaningful information to beneficiaries without compromising the services to which they have become accustomed. The central goal of this initiative, to provide more and better information to beneficiaries about all of the options available to them, is critical to permitting beneficiaries to take advantage of the expanded range of choices envisioned under the new Medicare+Choice program.

IV. SERVICE AREA DESIGNATION

Prior to enactment of the BBA, Medicare HMOs have been allowed to vary premiums and supplemental benefits within a contracted service area on a county-by-county basis, and to customize products—or offer "flexible benefits"—to meet beneficiary and employer needs and the dynamics of individual markets. The BBA and the Medicare+Choice regulations are both more restrictive than this policy, and require that Medicare+Choice plans offer uniform benefits and uniform premiums across a plan's total service area without regard to different county payment levels. For 1998, HCFA developed a transition policy for existing contractors which allows Medicare+Choice organizations to segment service areas and offer multiple plans in an effort to mitigate the effect of moving away from the flexible benefits policy.

The policy contained in the Medicare+Choice regulation, however, appears to be more restrictive than even the transitional policy allowed by HCFA during 1998. As a result, Medicare+Choice organizations serving multiple counties—with higher and lower payment rates—could be forced to either withdraw from the lower payment areas or reduce supplemental benefits in the higher payment areas. Many of these lower payment areas are rural counties and HCFA's new policy disallowing flexible benefits will reduce dramatically incentives for health plans to enter or remain in rural markets.

Prior Medicare policy permitted HMOs similarly to customize benefit packages for employer groups who pay for retiree health coverage, enabling them to offer a consistent level of benefits to retired workers living in different counties throughout the contracted service area. This flexible approach allowed employers to comply with union agreements, coordinate with active employee health coverage, and purchase coverage carve-outs to facilitate a common administrative system. We encourage Congress to revise the statute so as to revert to the prior policy allowing flexible benefits within plan service areas. Maintaining this policy will best serve beneficiaries and the intent of the BBA in expanding choices and competition.

In addition to the provision governing the extent to which premiums and benefits may vary within the service areas associated with Medicare+Choice plans, the BBA contains a provision that continues the current requirement for development of an adjusted community rate (ACR). The ACR determines the Medicare+Choice plan's allowable premiums and beneficiary cost sharing for each service area. HCFA has chosen to develop new reporting requirements that will be substantially different than current requirements and will necessitate significant systems modifications for existing contractors. The Agency plans to make these changes effective for ACR proposals due May 1, 1999, but does not expect to have final details available about the new requirements until late in calendar year 1998.

Given the numerous other changes that are required by the BBA and the short time that will be available for contractors to prepare to meet the new requirements, AAHP believes that HCFA should consider delaying implementation of these requirements. In addition to providing sufficient time for systems changes, a delay will permit needed pilot testing of the new reporting documents and refinement of the reporting documents and requirements to address issues that are identified through the testing.

V. PROVIDER RELATIONS

The Medicare+Choice regulation significantly expands the scope of the BBA provisions related to provider relations. While the BBA requires Medicare+Choice organizations to develop numerous new physician participation procedures, including a process for allowing physicians to appeal adverse participation decisions, the Medicare+Choice regulation dramatically expands the scope of these requirements to encompass all health care professionals. AAHP has serious concerns regarding these requirements which now encompass not only physicians, but also dentists, podiatrists, optometrists, nurse practitioners, chiropractors, licensed social workers, and all other health care professionals either participating or desiring to participate in a network. HCFA's statutory authority to expand these provisions is unclear. Moreover, appeals rights are not commonly available to other professionals as a right accompanying their employment. These provisions will impose administrative burdens on health plans and contracting provider groups. It remains to be seen whether the provisions are workable as expanded by the Medicare+Choice regulations.

VI. QUALITY IMPROVEMENT SYSTEM FOR MANAGED CARE

The Quality Improvement System for Managed Care (QISMC) is designed to establish a consistent set of quality oversight standards for health plans for use by

HCFA and state Medicaid agencies under the Medicare and Medicaid programs, respectively. AAHP has long advocated coordination of quality standards for health plans in order to maximize the value of plan resources dedicated to quality improvement. While we believe that QISMC holds the promise of contributing to this important goal, we have a number of serious concerns regarding QISMC and its implementation. We urge HCFA to engage in an intensive dialogue with health plans contracting under the Medicare and Medicaid programs to permit full consideration of their outstanding concerns about the QISMC standards and guidelines.

One of our primary concerns is that QISMC lacks clear coordination with existing public and private sector accreditation and reporting standards. Health plans currently meet voluntary private accreditation standards, such as those developed by the National Committee for Quality Assurance, in order to satisfy requirements of private sector purchasers and some states. Rather than coordinate with these existing standards, QISMC appears to establish a new system of outcomes-based requirements and "demonstrable improvement." In addition, QISMC fails to establish realistic goals for QISMC-related health plan activities and performance that take into consideration available resources and health plan responsibilities for the delivery of quality care to beneficiaries.

VII. PREEMPTION

The BBA supersedes state law to the extent that state laws and regulations applying to Medicare+Choice organizations are inconsistent with federal Medicare+Choice rules and standards. Specifically, inconsistent state laws are preempted for three areas of Medicare+Choice requirements: plan benefits, participation of providers and suppliers, and coverage determinations, including those related to appeal and grievance processes. This provision is beneficial to the Medicare+Choice program because it makes clear that consistency in health plan standards is important for the Medicare+Choice program and its beneficiaries. In the Medicare+Choice regulation, HCFA states that it has chosen to interpret narrowly the preemption provisions of the BBA. AAHP is concerned that this narrow interpretation of the preemption provisions may undermine Congress' intent in developing these provisions. In addition, it remains unclear from the Medicare+Choice regulation how HCFA will monitor and implement the preemption provision of the BBA.

* * * * *

Health plans have valuable experience to share with Congress and HCFA on implementation of many of the provisions in the Balanced Budget Act of 1997. AAHP appreciates this opportunity to comment on the BBA and its implementation to date. We look forward to continuing to work with members of the Committee, other members of Congress, and HCFA to ensure the successful implementation of the Medicare+Choice program.

ENDNOTES

[1] Ms. Newport also serves as a commissioner on the Medicare Payment Advisory Commission.
[2] Includes enrollees in risk, cost, and HCPP contractors.
[3] Includes enrollees in risk contracts only.

NATIONAL MEDICARE EDUCATION CAMPAIGN

	HCFA FY99 REQUEST	PACTICARE ESTIMATES FOR 50-STATE CAMPAIGN	MBS, INC. ESTIMATES FOR 5-STATE CAMPAIGN
Medicare + Choice Information	**$45,380,550**	**$15,750,000**	**$6,564,957**
• Handbook	• $32,380,550	• $15,750,000	• $4,358,277
• Four-Page Newsletter to All Beneficiaries	• $13,000,000	• -0-	• $2,206,680
1-800-Medicare Toll Free Number	**$80,151,000**	**$31,500,000**	**$3,300,000**
Community Support/Info Infrastructure	**$32,542,200**	**$100,000**	**$9,856,680**
• Internet Site	• $538,700	• $100,000	• $100,000
• Health Insurance Advisory Program	• ?	• -0-	• -0-
• Satisfaction Surveys	• ?	• -0-	• -0-
• Publicity Campaign/Health Fairs	• $7,550,000	• -0-	• $7,550,000
• Evaluation of Consumer Info Activities	• ?	• -0-	• -0-
Contingency Fund	**$14,997,937**	**-0-**	**-0-**
TOTAL	**$173,071,687***	**$47,350,000**	**$17,514,957**

* HCFA is requesting the full authorized amount for user fee assessments ($150,000,000) and intends to make up the difference from program management and peer review accounts.

PREPARED STATEMENT OF JIM PAQUETTE

Mr. Chairman, I am Jim Paquette, CEO of the Sisters of Charity of Leavenworth, Montana Region. I have responsibility for the system's three hospitals in Billings, Butte, and Mile City. Yellowstone Community Health Plan, a Medicare Choices demonstration, is a wholly owned subsidiary of one of these institutions, St. Vincent's Hospital in Billings. The plan has 11,000 enrollees from four counties, 1,800 of whom are Medicare beneficiaries. Yellowstone Health Plan has been serving Medicare beneficiaries for 13 months.

I am pleased to appear today as a member of the American Hospital Association (AHA). The AHA represents nearly 5,000 hospitals and health systems, networks, and other providers of care. We appreciate this opportunity to present our views on

an issue that is critical to the future of many of our members and their communities: the Health Care Financing Administration's (HCFA) rules for Medicare+Choice (M+C) plans, including provider-sponsored organizations (PSO) and other plans offered by providers.

Hospitals and health systems have a variety of interests in this matter. We have been strong advocates of PSOs because we believe they expand the choices available to Medicare beneficiaries. In addition, 20 percent of our members offer a health maintenance organization (HMO), and 30 percent offer preferred provider organizations (PPO). In each case, almost double that number enter into managed care contracts with HMOs and PPOs. Clearly, hospitals and health systems across the country have a major stake in the success of the M+C program.

Before discussing HCFA's rule on M+C, I would like to applaud the agency for its leadership and support of the PSO solvency negotiated rulemaking committee. This committee brought together all parties with a stake in the PSO program. They worked very hard and very long, and, as a result, the parties not only made their own concerns known, they also got a better understanding of the concerns of others. At the same time, working relationships were developed that promise to be valuable as we all work together to refine and improve PSOs down the road.

THE MEDICARE+CHOICE PROGRAM

When the M+C program was included in the Balanced Budget Act (BBA) last year, Congress made history by expanding the health care coverage choices available to millions of Medicare beneficiaries. And by including PSOs, health care providers were given the opportunity to become one of those options through the type of organization for which they are well-suited: a coordinated network that delivers Medicare benefits in exchange for a single monthly payment for each enrollee. PSOs can make a major contribution to the evolution in how managed care is practiced in this country and, at the same time, offer tremendous value for Medicare and its beneficiaries as the Baby Boom generation begins to retire.

As it turns this historic legislation into reality, HCFA is in the midst of a monumental task: implementing critical provisions of the BBA, which means overhauling its system of Medicare alternatives at the same time that it overhauls the original Medicare program. In doing so, HCFA staff has been handed an extremely difficult job, along with very tight deadlines. Our overall concern with the rule on M+C is that beneficiaries, health plans and providers should not pay the price for HCFA's agenda being too full. Most of the issues that I will outline can be improved dramatically through clarification and elaboration of the implementing instructions.

COORDINATION OF FEDERAL AND STATE REGULATION

Because the M+C program is designed to offer private health plan options to Medicare beneficiaries, it naturally involves a great deal of interaction between federal and state regulatory requirements. In the BBA, Congress identified those areas where federal rules would apply and preempt state rules (such as benefit design and coverage determinations). In the recently published M+C rules, HCFA chose to narrowly construe these preemptions. For example, the type and depth of services covered is governed solely by federal rules, but cost-sharing limitations are not. It remains to be seen whether such narrow constructions cause more uncertainty in or impediments to offering a M+C plan. Clearly, the interaction between federal and state requirements needs to be thoroughly thought out. It is what Congress intended, and it is what M+C plans need in order to know which rules apply in any given area. These preemption requirements affect all M+C plans.

In the case of PSOs, there is an additional interaction between state and federal rules. This will be critical to how and whether health care providers are able to develop effective PSOs. Congress provided an opportunity for PSOs faced with unreasonable state barriers to obtain a three-year waiver, at the end of which they would be expected to be state licensed. For PSOs that are eligible for a federal waiver of the state licensure requirement, the statute requires that the PSO contractually agree to comply with state consumer protection and quality requirements as a condition of the waiver. The statute also provides the Secretary of Health and Human Services (HHS) with a great deal of discretion as to whether to enter into agreements with the state to monitor and enforce such requirements. There are two key limitations in the statute. First, if the secretary chooses to contract with states, she may not require any variation in the method used by the state for judging compliance with its standards. Second, any state monitoring or evaluation of compliance is prohibited from lengthening the process for reviewing and approving waivers.

For the most part, the interim rule incorporates the statutory requirements, except in two important respects. First, the rule does not include any reference to the

two limitations described above. Second, it appears that the agency may be interpreting the BBA incorrectly and, in doing so, is granting states authority that they are not granted under the BBA. More specifically, the agency's preamble discussion of the interim rule refers to "the state's right" to require PSOs to "comply with consumer protection and quality standards . . . "

During congressional debate on the issue there was an explicit decision to incorporate compliance with certain state requirements as a matter of contract between the HHS secretary and the PSO. This decision was based in large part on the need to keep the application of sanctions at the federal level, including the same notice, corrective action, and due process attached to any other issue of noncompliance with a Medicare contract. While HCFA might use contracts with states to monitor and evaluate compliance, only HCFA can take enforcement actions based on available federal sanctions, following federal due process procedures. Under the BBA, states were not given any independent rights or jurisdiction to take action against a federally-waivered PSO, based on their own state sanctions.

We have recommended that HCFA undertake an approach under which the agency would:

- Clarify that the basic requirement of a PSO is the contractual assurance of compliance with specified state consumer protection and quality standards, establishing the legal basis for federal sanctions if that compliance is not maintained once the PSO begins serving Medicare beneficiaries. This approach would be consistent with the BBA.
- Enter into contracts with all states to provide a state-specific document identifying state requirements; provide for the state to receive beneficiary complaints related to the applicable state standards, the investigation of the complaint, and the transmittal of the resulting analysis; and provide for state monitoring of consumer protections or quality requirements that states identify as significantly greater than or different from federal standards, as long as they are not inconsistent with federal requirements.

RURAL ACCESS TO MEDICARE+CHOICE PLANS

A major purpose of the M+C program is to promote the availability of managed care options in rural areas generally shunned by insurers as not profitable. There are two implementation issues related to the ability to create M+C options in rural areas: the combined effect of the service area, access, and benefit requirements; and the need for adjustments to the solvency requirements for rural PSOs.

Service area, access, and benefit requirements. A M+C plan's service area must generally follow natural health care delivery patterns and networks, and the benefits, premiums, and cost-sharing must be identical throughout the entire service area. Given that Medicare capitation rates vary (often significantly) from one county to another and most service areas include more than one county, there is a readily apparent problem: It is difficult for a plan to provide the same benefit throughout a service area without receiving the same payment for each plan member in that area. It is even more difficult if M+C standards require the creation of services in areas where they did not previously exist.

Plans have three approaches to resolving this problem under the new rules: reduce benefits in higher-rate areas to cross-subsidize lower-rate areas; pull out of lower-rate areas; or seek HCFA approval of multiple M+C plans offered by the same M+C organization.

The first of these approaches is not viable from a competitive perspective. Plans will have to offer benefit packages that are competitive in the highest-rate county within their service area. Reducing benefits would reduce their competitiveness. With respect to the second approach, we are already hearing reports from around the country that major HMOs are either pulling out of Medicare altogether or are pulling out of rural portions of their service area. This reduces options for beneficiaries. The third approach is newly available, and is subject to a great deal of HCFA discretion. It remains to be seen whether HCFA will allow payment levels to be a factor in defining service areas, or in setting benefit, premium, and cost-sharing levels. It also remains to be seen whether developing multiple plans by a single M+C organization ultimately results in unworkably high administrative costs.

While we believe that these requirements were appropriately intended to avoid discrimination against certain Medicare beneficiaries, our fear is that their effect may be much broader—hurting access to health plan alternatives in rural areas.

Adjustments to rural plan solvency requirements. Toward the end of the negotiated rulemaking process, there were several discussions about how the various deposit, net worth, reserve and liquidity requirements would affect the development of rural PSOs. In examining this issue, AHA started from the premise that any rec-

ommended adjustments for rural PSOs should be focused on where the solvency rules require more than is necessary for a smaller, rural PSO. The AHA does not want to suggest any adjustments that would jeopardize the financial stability of a rural PSO, which could have a ripple effect on access to care in that area. We have, however, recommended to HCFA several ways that the requirements could be modified without creating financial jeopardy.

- Reduce the $100,000 insolvency deposit for small and rural plans whose enrollment is at or below 2,000. This deposit takes cash out of the hands of the PSO and segregates it in a special account, to be held for HCFA's use to cover the administrative costs of moving beneficiaries out of an insolvent plan. The amount of the deposit is the same for all plans, regardless of size. A deposit of $100,000 seems excessive to cover administrative expenses for moving 2,000 or fewer enrollees from a failed plan to another plan, or to the traditional fee-for-service program.
- Allow the use of irrevocable letters of credit for the insolvency deposit. Funds devoted to this type of deposit are unavailable for use in meeting ongoing operating requirements. The cost of purchasing an irrevocable letter of credit is significantly less than providing the entire amount in cash, but would provide the Medicare program with the same protection.
- Maintain the minimum cash portion of a rural PSO's net worth requirement at 50 percent for as long as the required net worth of the PSO is set at a flat dollar amount. This would mean continuing the initial 50 percent relationship between cash and net worth requirements (i.e., $750,000 of $1.5 million) whether the rural PSO's required net worth was $1.5 million, an amount less than $1.5 million (to as low as $1.0 million) because the rural PSO demonstrates that it has an administrative infrastructure already available to it, or the flat $1.0 million ongoing minimum. This would change when the PSO's enrollment growth triggered use of a percentage test for setting its required net worth.
- Ensure that, where rural providers join into a regional PSO, they are considered as a whole, not as their individual community parts, for purposes of applying the solvency requirements. Banding rural providers and health systems into regional PSOs is likely to provide greater financial stability and staying power.

Encouraging rural PSOs to form, especially on a regional basis, is one of the best ways to promote greater access to plan options in rural areas without jeopardizing beneficiaries or their local delivery systems.

QUALITY ASSURANCE REQUIREMENTS

Mr. Chairman, hospitals and health systems have taken the lead in quality assurance for decades. The AHA currently is engaged in a wide variety of activities designed to help hospitals ensure that the people they serve get the highest quality care possible. Our Quality Leadership Team has implemented several initiatives that look into such issues as care at the end of life, understanding the patient experience, public perception of the health system, technologies for shared decision making, and many more. In addition, we publish the Dartmouth Atlas of Health Care in the U.S., which provides detailed information about the use of health care resources from one community to another, and we continue to focus on the patient perspective through our "Eye on Patients" focus group project. Given our members' diverse yet central role in quality assurance activities, this segment of HCFA's rule is especially critical. The correct construction of the quality requirement for M+C plans can further the efforts of hospitals and health systems to improve and measure quality. An incorrect construction can impede those efforts.

HCFA's rule requires M+C organizations to have an ongoing quality assurance program and defines the elements of that program. HCFA has used this opportunity to put in place its new quality initiative, known as Quality Improvement System for Managed Care (QISMC). QISMC is a dramatic new approach to quality assurance—one we believe exceeds the intent of the drafters of the BBA.

The AHA believes that these standards represent appropriate goals for the future. Currently, however, few measurements of outcomes exist, and it remains unclear how much control health plans have over the health status of their enrollees. Therefore, implementation of QISMC is too dramatic a change to initiate without further public discussion and evaluation. HCFA has said it intends to require plans to undertake fewer projects under QISMC than it previously had envisioned, and we appreciate that response to our earlier concerns. However, we still believe that codifying this approach in the M+C regulations is premature.

We should be clear that these new requirements will affect not only PSOs, but all M+C contractors. In addition, our hospital members who contract with M+C organizations will be affected, because they often provide the data that plans rely on

for these kinds of quality projects. Hospitals will not only be required to perform their own quality projects through the Medicare conditions of participation for hospitals, but also to respond to numerous requests from M+C plans with whom they contract. In this era of limited resources, dramatic new approaches to quality measurement need to be embarked upon carefully.

MANDATORY COMPLIANCE PLAN

The HCFA rule requires M+C plans to implement a formal, comprehensive compliance plan to ensure that the organization takes all steps possible to comply with all applicable federal and state laws and regulations, including Medicare's rules and regulations on payment. We agree with the intent of this provision—helping the government cut down on waste and fraud in the health care system. Hospitals and health systems have a zero tolerance policy toward those who would intentionally cheat the taxpayer.

However, we question HCFA's decision to mandate such a plan, on two counts. First, HCFA has mandated the implementation of a compliance plan in the absence of clear guidelines designed for health plans. Second, we believe—and the Health and Human Services Office of the Inspector General (OIG) agrees—that voluntarily adopted compliance plans ensure the commitment of an organization to incorporating compliance into its culture. The voluntary nature of compliance also allows organizations to tailor a compliance plan to their individual needs.

The OIG is issuing a series of voluntary model compliance plan guidelines for the health care field. So far guidelines have been issued for clinical labs and hospitals. We worked closely with the OIG on its Model Compliance Program Guidance for Hospitals. The model will help hospitals establish better internal safeguards and processes to successfully comply with Medicare, Medicaid and other government health programs. Guidelines for home health are expected soon.

Despite the fact that OIG has not yet issued model compliance program guidelines for managed care plans, HCFA appears to have taken the basic elements that OIG issued for hospitals and made them mandatory for M+C plans, without adding specific guidance for health plan application. We question HCFA's decision to mandate compliance in the absence of health plan guidelines from OIG.

And this mandatory requirement is not consistent with statements from HHS. HHS lauded the merits of voluntary guidelines in the introduction to its hospital guidelines. HHS said, "The adoption and implementation of voluntary compliance programs significantly advance the prevention of fraud, abuse and waste in these health care plans while at the same time furthering the fundamental mission of all hospitals, which is to provide quality care to patients."

PROMPT PAY

There is a growing concern among hospitals and health systems about the failure of managed care plans to reimburse them in a timely manner. As a result, there has been a fair amount of activity at the state level, where managed care plans are regulated, to address issues related to prompt payment by plans. For example, the Florida Hospital Association earlier this year surveyed 20 hospitals. As of March 31, those hospitals reported that $166 million in claims for managed care patients were more than 30 days old. That figure represents 191,000 outstanding claims, half of which were more than 150 days past due.

Because Medicare is a federal program funded with federal dollars, we believe it is appropriate for the M+C program to establish standards for provider payment.

On this issue there are two categories of health care providers. The first is the provider who is under contract with a health plan: a contract provider. The second is the provider who is not under contract with a plan, but provides services to a plan's members for example, in the emergency room: a non-contract provider.

The proposed prompt payment rule for M+C is taken largely from the previous Medicare risk-contractor rules, which require health plans to pay non-contract providers within 30 days for claims that are uncontested by the plan, and within 60 days for all others.

We congratulate HCFA for including in its new rule a recognition of this problem. For contract providers, HCFA's rule includes a new requirement that the parties to define prompt payment in their contract. Because HCFA requires all health plans to have provider contracts in place by January 1, 1999, that meet the new rule's requirements, and because all the details of these requirements are not yet available from HCFA, some plans and providers may not have sufficient time to negotiate mutually acceptable prompt payment time limits. Therefore, we suggest that HCFA incorporate the same 30/60-day standard for contract providers as it does for non-contract providers, unless a different standard is negotiated between the two

parties. This would ensure that a basic standard is included if the BBA deadlines lead to boilerplate contracts with no time for negotiation.

CONCLUSION

Mr. Chairman, AHA and its members are focusing significant resources on moving health care delivery to a more efficient and effective integrated model. We believe provider-based health plans are the right vehicle to accomplish this goal. Powerful market, regulatory, and demographic forces buttress our view. But, we need to be regulated in a manner that allows our members to do the job right—to reach their full potential for beneficiaries, providers, and the government as well. This can be accomplished if providers, health plans, and the government work together to clarify the coordination of state and federal regulation, to protect rural access, and to ensure that our members are able to provide quality care, to comply with all applicable rules and regulations, and receive prompt payment.

Medicare has been an outstanding success in bringing health care security to the elderly. In a nation where eroding access to health care coverage in the working population is already contributing to a steady rise in the number of uninsured, we cannot afford a future in which we lack the resources to keep the Medicare promise. We look forward to working with you and with HCFA to ensure that PSOs can become significant contributors to a fiscally healthy Medicare program.

PREPARED STATEMENT OF THOMAS R. REARDON, M.D.

Mr. Chairman and Members of the Committee, my name is Thomas R. Reardon, MD. I am a family practice physician from Portland, Oregon, and the President-elect of the American Medical Association (AMA). The AMA appreciates your invitation to testify before you today on the implementation of the Medicare+Choice provider sponsored organizations (PSOs) regulations called for under the Balanced Budget Act of 1997 (P.L. 105-33).

PSO DEFINED

Last year, the Balanced Budget Act of 1997 created a new Medicare Part C, or the "Medicare+Choice" program. Under this new program, Medicare beneficiaries can choose to receive health care services through a variety of new private health plans, including PSOs. PSOs are health care delivery networks that are owned and operated by providers. Under the Medicare+Choice program, PSOs will accept risk in the form of a set monthly payment per beneficiary to deliver health care services to those Medicare beneficiaries electing to receive care through the PSO.

POTENTIAL BENEFITS OF PSO'S

The concept of the PSO revolves around the premise that medical decisionmaking is best left in the hands of physicians. As the sole individuals trained to practice medicine, physicians are best able to determine what health services are necessary. This unique ability makes physicians particularly well-positioned in terms of realizing the full potential of managed care.

Since their arrival in the health care market, managed care organizations have enjoyed a certain amount of success in keeping health care costs under control. The techniques that have allowed them to do so typically involve placing limits on patients' access to tests, treatments, and procedures. They also involve removing from their panels physicians who spend greater resources on patients, even where a particular physician's patients are sicker and in need of more care than those of other physicians. Although these techniques can be very effective in containing costs, they involve decisions that often are made by non-medical employees of organizations that are often distant and removed from the original site of care.

PSOs, by contrast, delegate the authority to determine how to treat patients in a cost-effective manner to the level of the treating physician. When physicians are given this responsibility, they can cooperate with other physicians to develop ways to really manage care, not just the cost of providing care. PSOs also allow physicians to analyze the care that is delivered on a local, as opposed to a geographically removed, level. In fact, a recent study looking at physician organizations that accepted risk in California demonstrated that these organizations had some of the most successful cost performances.

PSOs provide physicians with the power to deliver quality, cost-efficient care for several reasons. First of all, the opportunity to accept risk directly from payers equips physicians with the incentive to communicate and coordinate their efforts to provide services as efficiently as possible. Second, innovations in medical manage-

ment techniques and computer technology have given them the tools to realize efficiencies and improve the quality of care. Continuous quality improvement (CQI) is a technique that involves gathering data about the performance of tasks and analyzing that data to determine how quality and cost performance can be improved. This process has been applied to medical management in recent years through the use of claims data and other relevant data elements physicians are able to capture in the course of delivering care to patients. Technological improvements include developments in computer hardware and software that enable physicians to have interactive use of significant databases about their performance at the desktop. The availability of such medical management and technological improvements opens up the door for physicians to practice more efficiently while, at the same time, maintaining their role as medical decisionmaker.

STARTING UP A PSO

Although PSOs can offer significant benefits to the public, starting up a PSO can be a confusing and difficult process for providers. This stems primarily from the fact that PSOs exist in many forms, from independent practice associations that contract with managed care organizations on a discounted fee-for-service basis, to integrated health care delivery systems that accept global capitation directly from employers. Some PSOs in the market bear risk by accepting capitated payments from payers, and some bear risk by instituting methods to share this risk with payers. Furthermore, some contract on a risk-bearing basis with managed care organizations, while others contract on a risk-bearing basis directly with self-insured employers.

Depending upon the nature of a particular PSO, it may or may not need to obtain a license. The purpose of securing a license is to ensure that the PSO meets certain requirements in order to satisfy the relevant licensing body, most often a state's insurance department, that the PSO will operate in a manner that protects the enrollees' interests. Typically, a license is required where the PSO is determined to be in the business of insurance, defined as a scheme to spread and share the risk that a person may suffer a specified loss. It is distinct from business risk, which is the risk that a business will lose money on the sale of its products, or service risk, which is a risk assumed as incidental to the sale of a product. Insurance companies and managed care organizations, understandably averse to competition from PSOs, steadfastly contend that where PSOs bear any amount of risk, they are indistinguishable from HMOs, or other health insurers, and therefore must obtain a license. This view, however, fails to take into account the ability of PSOs, unlike non-physician directed managed care companies, to draw upon the personal services of their owners.

The issue of whether states can require PSOs to obtain an insurance or HMO license is further complicated by the preemption of state insurance laws by the Employee Retirement Income Security Act of 1974 (ERISA). Since its inception, ERISA has been interpreted very broadly to preempt state laws affecting health benefit plans. Such broad interpretation also would seem to preempt state laws regulating PSOs that furnish health services to employees. Moreover, although ERISA's savings clause preserves a state's authority to regulate PSOs that function as insurers, its "deemer" clause reinstates ERISA preemption for employers who self-insure their own employee benefits. The confusion over whether ERISA preempts state regulation of PSOs that contract with self-insured employers was reflected by a recent survey of states questioned on the issue, in which:

- Twenty-five states replied that only licensed PSOs can directly assume risk, even if the party to the risk-bearing contract is an employer exempted from state regulation under ERISA;
- Two states replied that the ERISA exemption clearly supercedes the states involvement;
- Two states said that the ERISA exemption applies if the PSO contracts with only one employer at full financial risk, but if the PSO contracts with multiple employers at full-financial risk, then it is an HMO or insurer and must be licensed; and
- Twenty-three states do not have a defined policy on the issue, but before PSOs enter risk-bearing contracts, the state department of insurance must be notified.

Although there is little clarity on the subject, it appears that the states are consistent with respect to requiring PSOs to obtain a license where PSOs assume full risk for an entire benefit package. This is what traditional insurers and HMOs do when they accept premiums from employers, and states have settled authority to regulate solvency and quality issues with respect to those entities. Therefore, PSOs that are interested in bearing full risk for an entire benefit package with employers

must seek licensure from the appropriate state authority—much like federally qualified PSOs will do through the Medicare+Choice program.

Because the regulatory climate for PSOs is so murky, to be prudent, PSOs that accept any degree of risk directly from employers must seek licensure or face the consequences of operating as an insurance company without an appropriate license. This includes PSOs that function as something short of an HMO, such as a PSO that shares risk with an employer to provide a limited benefit package. However, obtaining an insurance or HMO license is no easy feat, especially for physicians and other non-institutional providers. This is due, in large part, to the extremely strict and rigid financial standards found within state insurance and HMO licensing schemes. Physicians, unlike large managed care organizations, and, to a lesser extent, hospitals, do not have at their disposal vast amounts of capital required to satisfy the regulatory standards demanded by state insurance departments. These standards, therefore, can be prohibitive to physicians who might otherwise have the skills and knowledge necessary to operate a successful PSO. In fact, despite the widespread interest the AMA has received in PSOs from physicians, there has been little activity in terms of PSOs obtaining licenses to bear risk in the states.

MEDICARE+CHOICE PSO'S

The Balanced Budget Act of 1997 creates another avenue for PSOs to bear risk for the provision of health care services. Specifically, this new law allows PSOs to contract with the Medicare program to provide health care services to Medicare beneficiaries without first having to obtain an insurance license from the state. PSOs, therefore, can choose an alternative standard to the strict financial requirements often found in the states, provided they meet those found in the federal regulations. How the federal standards compare with state standards, therefore, will be important for the development of PSOs.

A negotiated rulemaking committee developed a set of financial requirements for federal PSOs that is unlikely to facilitate the formation of Medicare+Choice PSOs on a significant scale. According to these new regulations, at the time of start-up, PSOs are required to come up with a minimum net worth of $1.5 million, half of which must be in cash. A minimum net worth of $1 million must be maintained thereafter. PSOs must also maintain an additional $100,000 administrative deposit, which does not count toward the minimum cash requirement. In addition, the regulations strictly limit the amount of intangible assets, such as value of a physician network, that can be counted toward the minimum net worth requirement. Finally, the regulations require PSOs to prefund the first six months of projected losses.

Although the federal PSO financial requirements appear to be somewhat less rigorous than the relevant HMO or PSO standards in some states, they are equally, if not more rigorous, than the standards in a great number of states. In any event, the federal standards do not represent a recognition that PSOs should be subjected to less burdensome solvency standards than other kinds of health plans because providers have the ability to deliver more care in the event that they underestimate the amount of care that will have to be provided to a beneficiary population.

The strict regulatory requirements, especially those related to a PSO's financial solvency, make it unlikely that any but the largest and most sophisticated PSOs will have the ability to start up and successfully run a Medicare+Choice PSO. As a result, many PSOs that were interested in participating in the program prior to the issuance of the strict regulations are now sitting on the sidelines, adopting a "wait-and-see" approach.

AN ALTERNATIVE SOLUTION

Under the current state and federal regulatory schemes, starting up and operating a risk-bearing PSO is not a viable solution for most physicians interested in contracting directly with payers, including the Medicare+Choice program. These regulations fail to recognize that not all PSOs are set up to achieve the same goals. Although a strict regulatory scheme might be warranted for PSOs that function just like HMOs in terms of both degree of risk assumed and size of the health benefit package delivered, the same regulatory scheme is not necessary for PSOs that are set up to share risk with employers, or to provide them with a limited set of services.

However, whether a PSO functions as an HMO or simply shares risk with an employer to provide a limited benefits package, it can offer the public much in the way of improved quality and cost-efficiency. Therefore, the AMA believes that a regulatory structure should be developed that facilitates PSO development, while also offering adequate protection to potential enrollees. Such a structure should focus on the amount of risk assumed by a PSO contracting directly with employers and the

size of the benefit package it is responsible for delivering. We envision that this type of analysis would yield a system under which certain PSOs would not be required to seek a license for the limited functions they assume. Such a structure would be an optimal solution that would adequately protect the public, while at the same time encouraging the development of PSOs that can benefit the marketplace.

CONCLUSION

The AMA believes that PSOs are important to the future of health care in our country, including the Medicare program. Their development is essential to reach the next level of cost savings while enhancing quality of care and patient protections. Also, by engaging physicians and other health care providers as managers and owners of health care delivery systems, cost savings and quality improvement will be maximized. While the Medicare+Choice PSO provisions in the Balanced Budget Act of 1997, along with the respective regulations promulgated by the Health Care Financing Administration, will no doubt foster the formation of PSOs, widespread acceptance of PSOs may not be forthcoming until a regulatory structure is adopted that takes into consideration the unique features of PSOs that need to account for the different degrees of risk PSOs assume under varying arrangements.

The regulations for implementation of this new program were issued just last month and, while interim final, are still out for public comment. With the complexity and costs involved with starting a Medicare+Choice PSO under the interim final rules, we expect few PSOs to form until the rules of the program become better understood. With further refinement of the rules, we expect physician groups and other providers to move forward with their plans to form Medicare+Choice PSOs and develop products to meet the needs of their patients and communities.

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV

Mr. Chairman, I want to thank you for holding this hearing today on the implementation of the Medicare+Choice program. This is a very important topic and one which I hope we will continue to follow up on in the coming months.

Implementation of the Medicare+Choice program is extraordinarily complex, cutting across virtually every aspect of the Medicare program. We need to make sure not just that the necessary statutory changes are made, but that they are done right. We also need to see that the changes are made in a way that continues to provide the broadest possible choices for our seniors while also protecting their access to high quality care.

Beginning in 1999, Medicare will let seniors choose from among a broad range of health plans—undoubtedly these choices represent the most significant change in Medicare since the program's creation. No longer will beneficiaries have to choose between just two options: fee-for-service or HMOs. The new Medicare+Choice program will allow beneficiaries to choose from a number of different plans including: HMOs, preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), high deductible indemnity plans associated with medical savings accounts (MSAs), and private fee-for-service plans. I hope that some of the Medicare reforms enacted will eventually give West Virginia seniors an opportunity to enjoy some of the benefits of managed care—if they choose to.

However, since most Medicare beneficiaries are only accustomed to traditional fee-for-service health coverage and the only type of managed care plan currently available in Medicare is an HMO, explaining the complexities of these new choices will be a daunting task.

Realizing that seniors may be confused by the changes we've made, Congress instructed HCFA to educate seniors on the new program. It is important our efforts to educate beneficiaries are done right so that we don't undermine their confidence in the Medicare program. I am encouraged by the work that has been done so far, and I want to congratulate HCFA for their efforts in this area to create the best possible environment for new options to be understood and well received by beneficiaries. There is no doubt that informed beneficiaries make better choices about their own health care.

We know that we have an incredible opportunity ahead of us. But we also know that we have to carefully watch this program so that it develops into a meaningful new option for beneficiaries. We must be diligent in our oversight if we are to make sure the Choice program is well integrated into our existing Medicare structure and that access to needed care is not sacrificed. We have accomplished much by passing this program but we still have more work to do.

Mr. Chairman, again I thank you for calling this hearing. I look forward to learning more about the Medicare+Choice program and the ways we can assure it continues to deliver the quality care that our Medicare beneficiaries depend on.

PREPARED STATEMENT OF STEVEN J. SMITH

Mr. Chairman, members of the Senate Finance Committee, thank you for inviting me here today. My name is Steven J. Smith, I am President and Chief Executive Officer of St. Joseph Healthcare System in Albuquerque, New Mexico. I appreciate the opportunity to share with you our experience with Medicare+Choice legislation.

Almost a century ago, St. Joseph Healthcare's founders, the Sisters of Charity, must have had some sense of trepidation as they traveled into the territory of New Mexico. They had come to meet healthcare needs in frontier Albuquerque, building its first hospital.

Today, we are building one of the first Provider Sponsored Organizations (PSO) on a new frontier, and we are just as excited about breaking new ground.

The Sisters didn't have the benefit of special legislation to help them make the decision to build a hospital. They knew in their hearts this is what the community needed. We know that, today, a provider sponsored health plan is what our community needs, and the Medicare+Choice legislation facilitates PSO development.

Shortly after the Balanced Budget Act of 1997 was signed into law, our sponsoring organization, Catholic Health Initiatives (CHI), the nation's largest non-profit faith-based healthcare organization, began to explore the possibilities and opportunities offered by PSOs. CHI reviewed all of the markets throughout the 22 states in which it provides healthcare services. Albuquerque was one of the markets where further investigation into the development of a PSO made sense.

In May 1998, St. Joseph Healthcare completed the analysis necessary to recommend to the St. Joseph Healthcare Board of Directors and CHI that we proceed with the development of a PSO. The Board and CHI granted approval to proceed in taking on the substantial risk of developing a PSO.

There are three overarching reasons St. Joseph Healthcare is pursuing licensure as a PSO. First, taking care of the Medicare population is an essential part of our healthcare mission. We were the first healthcare organization in New Mexico to work with the state to gain a HCFA waiver to open a Program of All Inclusive Care for the Elderly (PACE) project. In this program, St. Joseph accepts a fixed fee from the State to keep seniors who are medically eligible for nursing home stays, out of a nursing home. St. Joseph Healthcare has, and will continue to, contract with insurance companies under capitated payments as a Medicare provider. In the PSO, we are now looking to take on the additional layer of insurance risk as a direct contractor with HCFA.

Secondly, as in many markets, Albuquerque is witnessing a rapid consolidation in the number of health insurance companies in the marketplace. Seniors have fewer options for healthcare. The PSO will give greater opportunity for Medicare enrollees to choose St. Joseph Healthcare, the last remaining religiously sponsored healthcare system in the state.

Thirdly, forming a Medicare PSO allows St. Joseph Healthcare to extend its long standing partnership philosophy with physicians. Physicians and hospitals, as partners, will develop the treatment protocols to provide the best care for this "at risk" population. St. Joseph Healthcare is also making a significant investment in Medical Information Systems to provide the PSO caregivers with medical information to optimally manage the healthcare needs of the PSO membership. Physicians will participate in the governance, operation and ownership of our PSO. Our goal is to have our PSO make a contribution in renewing the focus on the patient-doctor relationship. As a faith-based healthcare system with a long tradition of providing compassionate health services to our community, we would like to think we can put the "care" back into managed care. The current pressures on Congress to pass the Patients Rights Bill are clear evidence that managed care is really widely believed to be managed costs instead.

Developing and implementing a PSO does not come without risk. The annual capitation rate offered by the Health Care Financing Administration (HCFA) is set at an extremely low level in our market. Three out of the four counties in our proposed service area are at the annual capitation rate reimbursement floor. This is a continuing challenge for us, to craft medical management that will work within the annual capitation rate in our market, and in so doing, provide the highest quality of care for our seniors and Medicare-eligibles.

As a Catholic sponsored healthcare organization, we are challenged by our ability to participate as a PSO under current legislation. There needs to be clarification to

the Public Health Service Act to eliminate discrimination by the federal government against health care entities (including PSOs) because of their refusal to perform, refer for, or make arrangements for abortions. Developing a financing structure to allow for a carveout of these services would support our participation as a PSO.

Our development of a PSO has been facilitated by our state officials and HCFA. The New Mexico Department of Insurance has been very cooperative in supporting our request for a Federal waiver of State licensure. In the past week, HCFA has informed us that it has waived the State licensure requirement, and given us the ability to submit our PSO application. We have become the first PSO applicant in the nation to obtain such a waiver.

We are submitting our PSO application to HCFA August 1, 1998. It is our desire, through this aggressive timeline, to have a new PSO product in our market for a January 1, 1999 effective date. Throughout the application process HCFA personnel have been extremely helpful. As this is a new process for both St. Joseph Healthcare and HCFA there have been many questions. HCFA has been very accessible and willing to work collaboratively as we chart new ground.

Our PSO will be an extension of the mission and vision of our founding Sisters. We care for our patients, in body, mind and spirit. The structure of the PSO, with its strong physician component, will allow us to continue this tradition of compassionate care.

Sister Hyacinth didn't have to file a twelve inch thick application to open her new hospital in 1902, but hers was also a difficult challenge with an uncertain future. Ours is not without risk, but we are strengthened by our "spirit of innovation, a legacy of care."

We are pleased and proud to move forward with the new opportunities Congress has creates.

COMMUNICATIONS

STATEMENT OF THE NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS (NAHU)

[SUBMITTED BY DIANE MAHONEY]

My name is Diane Mahoney. I am an insurance agent specializing in senior products with Velco Insurance Agency in Randallstown, MD. These comments are presented on behalf of the National Association of Health Underwriters (NAHU), where I am the Senior Products Chair for the NAHU Legislative Council. NAHU's more than 15,000 members are insurance professionals involved in the sale and service of health insurance and related products, serving the insurance needs of more than 100 million Americans.

Last month the Administrator of the Health Care Financing Administration (HCFA) requested a delay in the implementation of the per episode home health prospective payment system and the outpatient prospective payment system provisions of the Balanced Budget Act. Furthermore, the agency is seeking a delay in the fiscal year 2000 updates for the hospital prospective payment and the physician fee schedule.

These serious steps preceded yet another HCFA announcement earlier this month, to curtail plans to distribute vital information regarding the Medicare+Choice options to all 38 million Medicare beneficiaries, another important component of the Balanced Budget Act. HCFA is now planning a sharply limited distribution to the 5.5 million beneficiaries living in Ohio, Florida, Arizona, Oregon and Washington.

Mr. Chairman, we hope you and your colleagues will critically review HCFA's plans because, we believe, the agency has failed to take advantage of a resource available to inform older Americans of their options: the health insurance professional. Over the kitchen and family room tables of millions of Americans through the last several decades, the health insurance professional has been that trusted advisor who has "walked" wage earners and owners through health plan options and benefits, and not moved to the next topic until they understood what is important for them. Despite the complexity of the Medicare+Choice options, we are convinced that only an educational process that includes the personal, eye-to-eye dynamics of the client-agent relationship will succeed.

Instead, HCFA is relying on an impersonal strategy of using printed materials, the Internet, a toll-free telephone number, and community-based resources to help seniors make their choices. We share the concerns of you and your colleagues that these tools will prove inadequate to address the many questions older Americans will pose.

We believe the long-delayed handbook and other printed materials will be too thick and complex for beneficiaries to compare Medicare+Choice options and apply them to their specific needs. For example, HMOs, PPOs and PSOs might look the same but they are quite different, and MSAs are a new concept. For specific questions, beneficiaries will be directed to an 800-number, manned by individuals responsible for talking with hundreds of seniors daily. Anyone familiar with the delays in reaching someone on a toll-free number can easily imagine the frustration seniors will face as they look for help with their Medicare choices.

People staffing these numbers, whose training has not been detailed and who apparently lack any public accountability, will have a limited time for each caller. This problem will be more acute for the senior who has several "what if" questions, the type likely to be raised. With others awaiting their turn, the 800-staffer will be anxious to get the caller off the phone. Seniors will have detailed questions these harried individuals will not have the time to answer. Rushed and confused, the senior will be inclined to select that which is familiar (and expensive), traditional fee-for-service Medicare.

We do not believe the impersonal Internet, with its required hardware, software, expertise, and small print, is widely enough available, sufficiently interactive and user-friendly to provide older Americans with the information they need to make these important health plan decisions. Furthermore, the monthly Internet access fees may be unaffordable for seniors on a fixed income.

For their part, community organizations may have the zeal and commitment to be of dedicated service, but they lack the knowledge, skills and accountability to advise seniors on this serious issue, and may actually do great harm in what they recommend.

In sum, NAHU believes there are two fatal flaws in the HCFA strategy. First, there is a complete lack of accountability to older Americans, the agency, Congress and the tax-paying public for the information and advice provided. Certainly the decisions seniors must make on their own behalf demand that responsibility be fixed for the success and effectiveness of this information campaign.

The second flaw, if addressed, will remove the first. Nowhere in the HCFA strategy is there a role for the health insurance professional. By virtue of their expertise, personal interaction with consumers, required state licensure, and public accountability, agents represent an untapped resource for older Americans. Because an agent would take the time to explain managed care and other options in detail, seniors would become more familiar with choices other than traditional fee-for-service Medicare. As a result, both seniors and the Medicare program would be able to enjoy the significant pricing advantages available only through many managed care plans.

Agents bring a valuable service to seniors by providing them with the wise counsel long enjoyed by millions of younger Americans. During their working years, many seniors had a trusted insurance agent they relied on to explain health plan provisions, help with the paperwork, contact providers, and represent their interests. Through their own personal experience, they know that an agent would be willing to take the time to explain in detail, and in person, how each Medicare + Choice option would work.

For example, an agent can help a senior on a limited budget identify an HMO plan offering a drug benefit, or describe the ease of a PPO plan to someone unlikely to adjust well to seeing a primary care physician when specialty care referral is needed. Once choices have been made, the insurance professional can serve as an intermediary helping with claims, benefits and billing.

Insurance agents must be licensed and satisfy continuing education requirements, which are important protections for the public, but lacking for those anonymous individuals and impersonal tools HCFA would employ for older Americans. In fact, agents are used extensively by the insurance industry to market insurance and related products, both to the benefit of the carrier AND the consumer and, we believe, would be of great value to the older American.

Since independent health insurance professionals are contractors and not employees, insurance carriers do not have such associated costs as benefits and reimbursement expenses to provide. They simply have the cost of the agent's commission. It is important to remember that the agent's commission does not add any cost to the Medicare program, for ALL health plans, public and private, have a marketing component built into their administrative fees.

In light of the budgetary restraints now claimed by HCFA for communicating Medicare + Choice information to limited numbers of seniors, ignoring such a cost effective and value added educational tool seems fiscally imprudent at best. Since most plans already use agents to market health insurance to those under 65, many insurance carriers will now use them for their Medicare products. Because of a directive HCFA issued in 1992 strongly discouraging the use of independent insurance agents for Medicare HMOs, however, many carriers have relied upon their own employees to explain the benefits of their HMO plans.

A recission of the 1992 directive would encourage carriers to increase the number of independent agents marketing their HMO plans. More importantly, it would provide seniors the benefit of viewing and comparing all plan choices with someone having no personal incentive to recommend one plan over another. We believe this independence is critical for both beneficiaries and HCFA. In a highly competitive market, the insurance professional working for the consumer, not the plan, will represent what is best for the client. Since the beneficiary can end the relationship at any time, it is in the agent's interest (and thus HCFA's and the client's), to help the senior decide on the most appropriate Medicare plan, and then provide meaningful service.

Once a beneficiary has selected the appropriate Medicare + Choice option, it would be the agent who would serve as the intermediary between the beneficiary and the plan, assisting with questions or problems involving claims, plan benefits, and bill-

ing. This personalized local consumer service is strikingly different from HCFA's faceless, unaccountable strategy.

To encourage integrity in advising seniors, NAHU proposes the adoption marketing practice guidelines. First, these guidelines should be modeled after the marketing rules of Medicare Supplement plans. Well understood by insurance carriers and agents, these rules have worked well in this arena and would be readily adaptable to Medicare + Choice.

Second, marketers of Medicare + Choice plans must be licensed in the state where they do busiress. Currently insurance professionals must be licensed where they practice, and they must complete continuing education requirements annually in order to retain that license: In addition to a loss of license, some states provide criminal and monetary penalties if an agent is found guilty. Licensure assures public accountability while preventing the dishonest individual, who is only interested in an immediate gain, from having an incentive to market Medicare products.

Third, those who would market Medicare + Choice plans, independent agents and carrier representatives alike, must complete a training program. Regardless of their employment, all agents should be well versed in the choices available to seniors. Fourth, agent commissions for the sale of Medicare + Choice products should be level and paid monthly. At the same time, there should be no finder's fees or higher first year commissions. We join HCFA and private sector witnesses who have expressed concern about "churning" (moving beneficiaries from one plan to another) in order for agents to realize new commissions. The payment of level commissions, extending over the life of the health plan contract, would eliminate any incentive for this practice.

Fifth, contracts between carriers and agents should contain a clause stating that commissions on existing cases would continue in the event of termination of the contract, provided the agent remains licensed. Carriers entering a new geographic area sometimes contract with many agents in order to gain market share quickly. Over time, they may decide to continue contracts with only a handful of their "top producers." By continuing to pay commissions to those who are not "top producers" for plans written before contract termination, the incentive is eliminated to move beneficiaries from one plan to another. This recommendation also addresses concerns about churning.

Mr. Chairman, we urge that HCFA take advantage of the expertise, motivation, service, and advocacy that is provided by the professional insurance agent to help older Americans to select health plans under the Medicare + Choice options. Licensed agents provide accountability and the greatest assurance against fraud and abuse. Why, Mr. Chairman and members of the subcommittee, should 38 million Americans be denied the right to consult with insurance professionals for their health coverage merely because they have turned 65?

NAHU appreciates the opportunity to provide our views to the members of the subcommittee on this important issue. We look forward to working with you and HCFA to maximize the choices available to older Americans under the Balanced Budget Act.