

MEDICARE+CHOICE PROGRAM

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
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MEDICARE+CHOICE PROGRAM

THURSDAY, MARCH 18, 1999

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 11:08 a.m. in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE

CONTACT: (202) 225-3943

March 11, 1999

No. HL-3

Thomas Announces Hearing on the Medicare+Choice Program

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on the Medicare+Choice program. The hearing will take place on Thursday, March 18, 1999, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 11:00 a.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include representatives of the Administration and a panel of experts. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The Balanced Budget Act of 1997 (P.L. 105-33) created the Medicare+Choice program to provide seniors with a greater variety of health plan choices. Today, six million seniors, or 16 percent of Medicare beneficiaries, are enjoying the benefits of Medicare+Choice. However, the transition from Medicare's risk contracting program to the new program has not been without difficulties. Several issues need examination, including the proposed new risk adjustment method, dissemination of health plan information to seniors, and new plan requirements for quality measurement.

In announcing the hearing, Chairman Thomas stated: "Medicare+Choice, with its many options, is the foundation on which we can build a stronger, better Medicare program for our seniors. Continual and careful fine-tuning may be required to ensure that the Medicare+Choice program operates smoothly and efficiently. This hearing will offer the Committee an opportunity to examine several important Medicare+Choice issues."

FOCUS OF THE HEARING:

The hearing will focus on three key aspects of the Medicare+Choice program: making appropriate payments to health plans, providing information for seniors' health plan choices, and measuring health plan performance and quality.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect 5.1 format, with their name, address, and hearing date noted on a label, by the close of business, Thursday, April 1, 1999, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may de-

liver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect 5.1 format, typed in single space and may not exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at "[HTTP://WWW.HOUSE.GOV/WAYS_MEANS/](http://WWW.HOUSE.GOV/WAYS_MEANS/)".

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman THOMAS. This hearing is convened today to examine the state of the Medicare+Choice Program. The Medicare+Choice Program was created as part of the Balanced Budget Act of 1997 and to many is thought to mean managed care within the Medicare Program.

To some extent this is true, but congressional intent was for Medicare+Choice to encompass much more than just managed care and Medicare. To many, Medicare+Choice was meant in its simplest terms to be the last best chance to see if a Federal bureaucracy could duplicate many of the innovations that are occurring in the private market and to bring more choices to our elderly and disabled Americans.

This summer will mark the 2-year anniversary of the passage of the Balanced Budget Act of 1997 that created the Medicare+Choice Program. Today, we will examine three major components of the program: payment, information, and quality.

As you know, prior to 1997, Medicare's county level rates varied from \$221 per month in Banner County, Nebraska, to \$767 per month in Richmond County, New York, an annual difference of over \$6,500. The rates also varied from year to year, making it difficult for companies to make long-term plans.

The Medicare+Choice payment system, although still artificial, was designed to create the disparities between counties, while providing some certainty that counties at the lowest end would receive an adequate rate and that counties at the high end would receive something, a 2-percent increase.

The Medicare+Choice payment annual updates were tied to the growth in Medicare fee-for-service spending, something that both this administration wanted and the health plans felt was important during drafting of the bill. Because of that tie to the fee-for-service spending, in 1998, the first year, and again last year, the growth in Medicare fee-for-service spending was lower than expected, and, therefore, there were no so-called blend counties, a merging of the national and the local rate.

For the year 2000, the picture is beginning to change. Sixty-three percent of the counties, based upon the data that has been presented to us, will receive a blended rate, and many counties will see significant increases in their rate. Six percent of the counties will see increases of 10 percent or more.

In addition to the county level payments, the Balanced Budget Act instructed the Secretary of Health and Human Services to develop a risk adjustor that reflects variations in health status. A good risk adjustor would reward the plans that take on the toughest cases, those seniors and disabled Americans with multiple medical conditions. Today, we will take a closer look at the Administration's proposed risk adjustor.

Knowledge is key to choice, so the Medicare+Choice Program includes a beneficiary information campaign, including booklets, an Internet site, a toll-free telephone number, 1-800-MEDICARE, and that 1-800-MEDICARE number just became available nationwide. Last year, seniors in five States received comprehensive booklets. In other States, they have received pamphlets.

While Administration officials predicted that our seniors would be incapable of comprehending the information and that Members' offices would be inundated with calls, this did not happen.

What I find amazing is that in the data that is being used to get a feel for whether or not the seniors understand, use, and believe this information is valuable to them, 67 percent of the seniors did not know basic information, for example, that they would be able to disenroll from an HMO if they enrolled in it in a given year.

Now, HMO risk models have been available since 1985, so I think that is clear evidence that HCFA, the Health Care Financing Administration, has done an absolutely abysmal job of informing seniors of their choices long before we reached the Medicare+Choice period, and so I am very concerned about the way in which seniors are being provided information so that they can make a choice. The track record is not bright.

Finally, we will examine the Administration's approach to measuring the quality of care delivered to our seniors. It is important that we maintain high-quality care in the program while creating

a system that does not produce a centralized, one-size-fits-all regulatory burden, which makes dealing with Federal health programs less and less attractive and, therefore, producing a self-fulfilling structure.

I look forward to the testimony of our witnesses. First, we will hear from three individuals at the Health Care Financing Administration who have been given direct responsibility for overseeing key Medicare+Choice issue areas, payment information and quality, and then we will hear from two outside experts and two health plans.

[The opening statement follows:]

Opening Statement of Hon. Bill Thomas, a Representative in Congress from the State of California

This hearing is convened today to examine the state of the "Medicare+Choice" program. The Medicare+Choice program was created as part of the Balanced Budget Act of 1997 and, to many, is thought to mean managed care within the Medicare program. To some extent, this is true. But Congressional intent was for "Medicare+Choice" to encompass much more than just managed care in Medicare. Medicare+Choice was meant—in its simplest terms—to be the last best chance to see if a Federal bureaucracy could duplicate many of the innovations that are occurring in the private market and bring more choices to our elderly and disabled Americans.

This summer will mark the two year anniversary of the passage of the Balanced Budget Act of 1997 that created the Medicare+Choice program. Today we will examine three major components of the program—payment, information, and quality.

As you know, in 1997, Medicare's county level rates varied from \$221 per month in Banner County, Nebraska to \$767 per month in Richmond County, New York—an annual difference of \$6,552. The rates also varied from year to year, making it difficult for companies to make long-term plans. The Medicare+Choice payment system was designed to decrease the disparity between counties, while providing some certainty that counties at the lowest end would receive an adequate rate and that counties at the highest end would receive a 2 percent increase in their rate. The Medicare+Choice payment annual updates were tied to the growth in Medicare fee-for-service spending—something that both the Administration and health plans felt was important during drafting of the bill.

In 1998, and again in 1999, the growth in Medicare fee-for-service spending was lower than expected. This resulted in no "blend counties" for the first two years. For the year 2000, the picture is much different. Sixty-three percent of the counties will receive a blended rate and many counties will see significant increases in their rate. Six percent of counties will see increases of 10 percent or more.

In addition to the county level payments, the Balanced Budget Act instructed the Secretary to develop a risk adjuster that reflects variations in health status. A good risk adjuster would reward the plans that take on the toughest cases—those seniors and disabled Americans with multiple medical conditions. Today, we will take a closer look at the Administration's proposed risk adjuster.

Knowledge is the key to choice, so the Medicare +Choice program includes a beneficiary information campaign including booklets, an internet site and a toll-free phone number, 1-800-M-E-D-I-C-A-R-E. Just this week, 1-800-M-E-D-I-C-A-R-E became available nationwide. Last year, seniors in 5 states received comprehensive booklets. In the other states they received pamphlets. While Administration officials predicted that our seniors would be incapable of comprehending the information and that members' offices would be inundated with calls, this did not happen. HMOs have been available to Medicare participants since 1985, but HCFA's efforts to educate seniors about basic information have largely failed. Seventy-six percent of seniors did not know basic information about their ability to enroll and disenroll in private plans.

Finally, we will examine the Administration's approach to measuring the quality of care delivered to our seniors. It is important that we maintain high quality care in the program without creating a centralized, one-size-fits-all regulatory burden which makes dealing with federal health programs less and less attractive.

I look forward to hearing the testimony of our witnesses. First, we will hear from three individuals at the Health Care Financing Administration (HCFA) with direct responsibility for overseeing key Medicare+choice issue areas—payment, information, and quality. We will then hear from outside experts and two health plans.

Chairman THOMAS. With that, I would ask the gentleman from California, my friend Mr. Stark, the Ranking Member, if he has any comments.

Mr. STARK. I would like to thank you for having this hearing, Mr. Chairman.

I share your concern that the Medicare+Choice Program should work effectively for the beneficiaries. I will soon introduce legislation to suggest ways in which we could increase beneficiary protections and perhaps do some of the things the industry wants.

I hope we can agree that the filing date for plans should be moved from May to July to give the plans the necessary time to plan their following year's rates more accurately.

In the future, I also hope we can hear from the plan enrollees. Their satisfaction seems to me to be the key component as to whether or not this program will survive or expand. We are going to hear plenty today about the financial concerns of the HMOs and why they are not making any money, so I think we should hear from enrollees.

Also, I understand we are going to focus on risk adjustment and quality improvement initiatives. I think it is important that the HCFA continue on their quality initiatives for managed care plans. I would urge HCFA to resist any calls from the industry for more delay in that regard.

On the education front, I share with you the concern that was raised here in a bipartisan sense, but I do not think we can have HCFA improve that effort if we do not help them get their full \$115 million appropriation.

Congress keeps pushing HCFA. I just came from a discussion of why HCFA is not adequately surveying nursing homes. The programs are good. I am concerned we have heaped a lot on their plate, but we are not giving them a chance to digest it. I think they need help.

I am going to urge my colleagues against delaying the phase-in of the risk adjustor. It seems to me that such delay only rewards those plans that are doing the wrong thing. Delaying the risk adjustor rewards the plans who avoid the sick or cherry pick to get healthy risks, and it punishes those plans that have the sicker than average patients. That is exactly the opposite of what I think good health policy should be.

We called for the risk adjustor in the Balanced Budget Act amendment. We required HCFA to develop a risk adjustment system. HCFA did not dream this up. It was at our direction in the Balanced Budget Act that they begin with a collection of hospital-based data. We also asked them to have a risk adjustment system implemented no later than the end of this year.

Now, we should not be surprised if they have to start that with a system that uses the data that we first ordered them to collect and analyze. While it may not be the best system, it is one that we created, not HCFA.

The other point I would like to suggest as an argument for not phasing in risk adjustment is that we are already overpaying the managed care industry. We have \$31 billion in overpayments due

to a mistake, \$31 billion over 10 years, \$8.7 billion over the next 5 years, because we removed HCFA's ability to recover overpayments when health care inflation is lower than anticipated.

If we do not change that, we are just throwing away somewhere from 8 to 30 billion dollars' worth of the taxpayers' money. There are other areas in which we overpay: fraud and abuse. We should not pay for that. Overpayment due to Medicare's administrative costs, overpayment due to lack of risk adjustment. These are funds we are tossing at the managed care industry, and yet we are going to hear that they cannot survive.

I think we ought to look more closely at the ability of the managed care industry to do a job that we anticipate, and I look forward to their pleadings today.

Thank you.

[The opening statement and attachments follow:]

**Opening Statement of Hon. Fortney Pete Stark, a Representative in
Congress from the State of California**

I want to commend Chairman Thomas for holding this hearing. I share his concern that the Medicare+Choice program work effectively for beneficiaries. In fact, I have introduced legislation, HR 491, The Medicare+Choice Improvement Act, to make a number of changes to the program that would increase beneficiary protections as well as address some of the industry's concerns. I think many of the provisions of this bill are also incorporated in the Administration's recommendations for improvements to the Medicare+Choice program. One issue upon which I hope we can all agree is that the filing date for plans to submit their benefit and price information should be moved from May 1 to July 1 in order to give plans the time necessary to plan the following year's rates more accurately.

In a future hearing, I hope we will hear from plan enrollees. Medicare beneficiaries' satisfaction with the Medicare+Choice program is a key component of whether the program will expand. We will hear plenty regarding the health plans' financial concerns today; we need to also hear from enrollees.

It is my understanding that today's hearing will focus on risk adjustment, HCFA's quality improvement initiatives for Medicare+Choice plans, and the beneficiary education campaign.

Let me emphasize that I think it is very important that HCFA move forward with quality initiatives for managed care plans. We are turning over a growing portion of the Medicare program to these private companies and it is incumbent upon us to ensure that we are getting a quality product for our dollar. To that end, I urge HCFA to continue moving ahead and to resist calls from the industry for more delay.

I would also like to submit for the Record a fact sheet that describes the development of HCFA's Quality Information System for Managed Care (QISMC). As this fact sheet shows, the industry has been fully involved in the development of QISMC from day one and HCFA has been very responsive to their concerns throughout the process.

On the beneficiary education front, I cannot over-emphasize the importance of making sure that Medicare beneficiaries understand their options and the consequences of those options when they consider signing up for a Medicare+Choice plan. Last year, I sent a newsletter to seniors in my district that explained the new Medicare+Choice program. This year, I've included a notice in my most recent newsletter that California now has access to the 1-800-MEDICARE number where beneficiaries can get answers to their questions about Medicare+Choice. I urge my colleagues to do the same. We must also work to ensure that HCFA receives their full appropriations request of \$150 million for running an effective beneficiary education campaign.

One of the pleas we will hear from the health plans later today is that we delay the implementation of risk adjustment. On behalf of the HMOs that have done the right thing and enrolled a fair and representative proportion of the Medicare population—both the sick and the well—I urge that Congress not consider legislation delaying the phase-in of the risk adjuster. Any delay will reward those plans who have avoided the sick and chronically ill, and punish those who have sicker than average patients—and that is exactly the opposite of good health policy.

HCFA has already announced that they will phase-in the risk adjustment over five years—a compromise that is supported by the Medicare Payment Advisory Commission (which includes Ms. Newport, one of today’s witnesses) whom we appointed to provide us with expert advice on Medicare. Let’s heed their advice. Even this compromise hurts the best HMOs and gives the industry a \$4.7 billion bonus over the next five years. Further delay is simply not warranted.

There is another fact surrounding risk adjustment that seems to continually get lost in the debate. HCFA did not dream up this idea as a way to reduce Medicare HMO payments. In fact, the Balanced Budget Act required HCFA to develop such a risk adjustment system. When you read the BBA language, it is no surprise at all that HCFA started out with a hospital-based risk adjuster. Let me quote: “The Secretary shall require Medicare+Choice organizations...to submit data regarding in-patient hospital services for periods beginning on or before July 1, 1997 and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.” It was precisely at the direction of the BBA that HCFA began with the collection of hospital-based data. Since BBA also required a risk adjustment system to be implemented “no later than January 1, 2000,” none of us should be surprised that they had to start with a system that uses the data they have first been able to collect and analyze.

I also take issue with the arguments from the managed care industry that Medicare is not paying them enough today to remain in the program. I would like to enter into the Record a summary of the ways we have been overpaying Medicare HMOs. I would also like to enter a letter from the HCFA Administrator that describes a little known “glitch” in the Balanced Budget Act that overpays HMOs \$8 billion over five years, and \$31 billion over ten years. This overpayment occurs because we took away the authority of HCFA to adjust for overpayments in 1997. We paid plans a higher amount than was justified in light of the lower medical inflation which actually occurred. By allowing these overpayments, we build into the budget base billions of dollars in extra payments. As the Administrator’s letter makes clear, *the other budget savings in the BBA do not even correct for this mistake—let alone reduce the earlier, underlying overpayment to the Plans.*

I couldn’t let this opportunity pass by to also highlight that what we will hear from the health plans on the last panel of this hearing proves why the Premium Support plan being pushed by a majority of the Bipartisan Commission on the Future of Medicare will not work.

AETNA is testifying today that:

“If the current reimbursement structure is not adjusted, more Medicare+Choice organizations are likely to withdraw from areas served and beneficiaries enrolled in the remaining plans will likely experience premium increases or reduced benefits.”

Similarly, PacifiCare’s testimony states:

“These problems [relating to risk adjustment] will make it difficult for Medicare+Choice plans to operate in certain markets and to maintain a level of benefits and services to which beneficiaries have become accustomed.”

In other words, pay us more or we can’t offer extra benefits—in fact, we may not even stay in the program.

As I’ve already described, we currently pay Medicare HMOs more than we should. We pay the plans more for the people they enroll than we would have paid if those people had stayed in Medicare fee-for-service. To rephrase that, the taxpayers would actually save money if we abolished the Medicare+Choice program today.

Unfortunately, the beneficiaries in these plans who have been getting extra benefits at little or no cost are the first ones who will lose under the Premium Support model. That is why we need to improve the core Medicare program so that everyone has a drug benefit and catastrophic protection—and so that people do not need to join an HMO to get extra benefits.

But, if plans say they cannot offer extra benefits at a time when we are overpaying them, they certainly won’t be able to do so if Medicare were to actually start saving money by paying them more accurately for the people they enroll.

And, if the plans cannot offer extra premiums, who in the world would want to join a system that rationed their choices and services?

Premium support won’t work to save Medicare—it is just a way to raise premiums on seniors and the disabled to force them into bare-bones, no-frills HMOs that will offer no extra benefits.

I hope all of the members will consider the testimony of these witnesses before they endorse the Premium Support scheme.

CURRENT MEDICARE OVERPAYMENTS TO MANAGED CARE PLANS
(prepared by Rep. Pete Stark's staff)

SOURCE OF OVERPAYMENT	COST TO MEDICARE	SOURCE OF ANALYSIS
Overpayments due to BBA change that removed HCFA's ability to recover overpayments when health care inflation is lower than expected.	\$800 million in 1997 \$8.7 billion over 5 years \$31 billion over 10 years	Congressional Budget Office
Overpayments due to lack of risk adjustment.	5-6% overpayment to HMOs per beneficiary who is enrolled	Physician Payment Review Commission (now MedPAC) 1996 Annual Report
Overpayments due to inflation of Medicare's share of plan administrative costs.	More than \$1 billion annually	HHS Office of Inspector General July 1998
Overpayments due to inclusion of fraud, waste and abuse dollars from FFS payments. Managed care plans should better "manage" and therefore avoid such fraud, waste and abuse.	7% annual overpayment Annual savings with a corrected 1997 base year would be: \$5 billion in 2002 \$10 billion in 2007	HHS Office of Inspector General Sept. 11, 1998

FEB - 1 1999

The Honorable Pete Stark
House of Representatives
Washington, D.C. 20510-6200

Dear Mr. Stark:

Thank you for your letter regarding the American Association of Health Plans (AAHP) concerns about the Medicare+Choice (M+C) program and their Adjusted Community Rate (ACR) proposals. I regret the delay in this response.

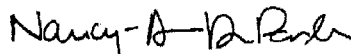
The AAHP asked the Health Care Financing Administration (HCFA) to allow plans to revise their ACR proposals. I informed AAHP by letter on October 1, 1998, that, given the late date for the request, we would not allow such broad revisions to the approved ACR proposals because many beneficiaries would receive fewer benefits, while paying more for their health care. We concluded it would not be in the best interest of beneficiaries, nor administratively feasible for HCFA, to reopen the premium and benefit calculations for virtually all Medicare managed care plans.

HCFA's only divergence from this position occurred in early November 1998, when we allowed health maintenance organizations in Massachusetts a brief, time-limited opportunity to resubmit the prescription drug portion of the previously approved 1999 ACR. This proposal applied to coverage and premiums related only to prescription drugs. Plans were not allowed to change their service areas or any of the other benefits for enrollees. HCFA wanted to do everything possible to work with the Massachusetts' plans in order to minimize any confusion resulting from a conflict between Federal and state laws. We believe this opportunity to address the prescription drug benefit is the best solution.

It is true, as indicated in your letter, that the 1997 rates which are the mandated base for the Balanced Budget Act of 1997 (BBA) payment methodology, are overstated by 3 percent. The BBA mandated reductions to the updates for M+C rates through 2002, and some have argued that these reductions were meant to adjust rates for favorable selection. However, the savings from the reductions, once they are fully implemented, do not even equal the increased costs due to the overstatement. While the BBA provided authority for making adjustments to updates for over and under estimates, no authority was provided to adjust the base rates.

I hope this information is helpful.

Sincerely,



Nancy-Ann Min DeParle
Administrator

Quality Standards for Medicare+Choice Fact Sheet

1. Pre-BBA 97 quality assurance (QA) requirements for managed care organizations in Section 1876 of the Social Security Act

- Two requirements indirectly related to quality:
 - 50/50 rule (no more than 50 percent of enrollees could be Medicare/Medicaid) assumed plans would ensure quality in order to attract non Medicare/Medicaid enrollees.
 - 30-day disenrollment option allowed Medicare enrollees to “vote with their feet” on the plan’s quality.
- Formal internal QA system required in regulations which HCFA monitored. In recent years HCFA has required plans to report objective standardized measurements on quality of care using the Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans Study (CAHPS).

2. Development of Quality Standards for Managed Care

- Purpose—Recognizing an opportunity to improve existing QA policy with its emphasis on structure and process and the need to move managed care plans toward actively improving the quality of care, HCFA in 1996 contracted with the National Academy for State Health Policy to develop, in consultation with consumer groups, the managed care industry, state Medicaid agencies and HCFA, new standards which emphasized measurable outcomes of the quality of care. The purpose was to encourage managed care plans to protect and improve the health and satisfaction of Medicare and Medicaid enrollees.
- Collaboration/consultation—The contract process included extensive consultation, review and opportunity for input by all the parties cited above. Periodic formal meetings of a technical expert panel composed of plans, purchasers, consumers, and regulators were held and opportunity given for representatives to poll their constituencies. After an initial draft was developed it was released for comment in December, 1997. During 1998 HCFA sponsored public meetings and training programs around the country, during which participants had the opportunity to voice their comments and concerns. The current document outlining HCFA’s quality standards is the result of collaboration among Federal, State, insurance industry, and private organization representatives.
- BBA 97—The BBA added section 1852 (e) to the Act which greatly expanded upon the previous Section 1876 QA requirement and espoused the same philosophy of performance improvement as in the quality standards HCFA had been developing. Therefore, it was logical and required few changes to use what had been developed as a model for the regulations necessary to implement the BBA Medicare provisions. In Medicaid, states can also use these standards as a tool to ensure that Medicaid plans meet comparable QA obligations.
- Modifications—HCFA has demonstrated continuous flexibility, consistent with that permitted by the law, from the initiation of the project with the NASHP contract. For example, revisions from early drafts include: a reduction in the number of annual clinical performance improvement projects from as many as nine in an early draft to two in the current version; waiver of participation in a national mandatory project; a more generous phase-in period for implementation; and giving plans discretion as to the circumstances under which they will conduct site visits for provider credentialing.
- Preferred Provider Organizations (PPOs)—HCFA recognizes that these quality standards may be somewhat more challenging for PPOs because of the difficulty influencing individual provider practice. However, HCFA also believes it is important that beneficiaries have access to outcome information from these quality standards in order to make informed decisions regarding their choice of plans. Through the American Association of Health Plans’ participation in the drafting process, PPOs had the opportunity to participate in the development of the quality standards. HCFA expects to be flexible in working with all plans in helping them become compliant with the quality standards. For example, in the February 17, 1999 regulation (see below) HCFA expanded the structural requirements dealing with coordination of care to be more accommodating to a broader range of types of plans, especially those which do not require enrollees to be assigned to primary care providers.
- Consistency with NCQA and Other Accrediting Body Standards—NCQA and other accrediting body standards were reviewed and incorporated by the technical expert panel in developing the quality standards. In addition, HCFA evaluated the

interim standards against the current NCQA standards and generally found them and their burden of improvement comparable.

3. HCFA Quality Standards; Four Domains

- Domain One: Quality Assessment and Performance Improvement (QAPI)—Plans are required to conduct performance improvement projects, report on standard measures and achieve minimum performance levels. The standard measures include HEDIS and CAHPS, indicators well known to industry.

- Domain Two: Enrollee Rights—Standards for enrollee privacy, dignity, access to services and information, participation, and grievances/resolution of issues.

- Domain Three: Health Services Management—Standards for availability and accessibility of services, continuity and coordination of care, service authorization, practice guidelines, new technology, provider qualifications, medical records, transfer of clinical information.

- Domain Four: Delegation [of functions/responsibilities]—Plans still responsible for oversight of delegated activities, and are not permitted to delegate their responsibilities to providers.

4. Medicare+Choice Regulations

- The interim final with comments regulations implementing the BBA's Medicare+Choice provisions, including QA, were published in the Federal Register on June 26, 1998.

- On February 17, 1999 HCFA published a final rule dealing with selected issues in the June 1998 rule. Among these were the coordination of care requirements, which impact on the quality standards and which were modified.

5. Interim Quality Standards/Guidelines

HCFA published the interim quality standards in an operational policy letter (OPL No., 72) which furnished operational advice on complying with the standards.

6. Implementation

Recognizing it takes time for plans to adapt to the quality improvement requirement, HCFA made several changes to help plans comply. These include the following:

- First year: Continue reporting on HEDIS and CAHPS but no minimum performance levels required. Plans must initiate two performance improvement projects, one national (diabetes) and one of the plan's choice. (This is comparable to the standards of private sector accrediting organizations.)
- The plans have three years to achieve demonstrable improvement.

7. Enforcement

Since this is a transition year for HCFA and Medicare+ Choice organizations (M+COs) as well, the agency feels the best strategy is one which "phases-in" not only implementation of the QAPI projects but enforcement as well. Therefore, in its desire to provide on-going consultation and technical assistance to M+COs, HCFA will move first to corrective action plans rather than nonrenewals or contract terminations. HCFA will look to the Quality Assurance Action Plans submitted this February by over 300 M+C organizations to provide a snap-shot of the organizations' educational needs and projected compliance activities for 1999.

8. Deeming

The Act now permits the Secretary to allow a Medicare+Choice organization to be deemed to meet certain HCFA requirements if it is fully accredited by a private, national accreditation organization approved by HCFA. These requirements are the quality assessment and performance improvement requirements (see 42 CFR 422.152), and the confidentiality and accuracy of enrollee records requirements (see 42 CFR 422.118). HCFA will approve an accreditation organization if it applies and enforces standards that are at least as stringent as HCFA's own and it complies with HCFA's application procedures.

The procedures HCFA will use to oversee deeming of Medicare+Choice organizations are being modeled on those used in fee-for-service. HCFA is actively working with national accreditation organizations (AOs) in developing the deeming application process.

Chairman THOMAS. I thank the gentleman.

If any Members have written statements, they will be made a part of the record.

[The opening statement of Mr. Ramstad follows:]

**Opening Statement of Hon. Jim Ramstad, a Representative in Congress
from the State of Minnesota**

Mr. Chairman, thank you for calling this important hearing on the Medicare+Choice Program.

I have always strongly supported increased health care options for all Americans, including seniors enrolled in Medicare. For this reason, I have closely followed the progress of the Medicare+Choice program.

Like many of my constituents, I understand the possibilities of the Medicare+Choice option in comparison to the traditional fee-for-service Medicare. Some of my constituents have expressed preference for the Medicare+Choice option because of its comprehensive, integrated approach to providing health services. They like that Medicare+Choice includes more preventive health benefits and, for many seniors across the nation, has also included such things as prescription drug and dental coverage.

I am also learning that Medicare+Choice, with its increased ability to evolve more quickly, reviews new, innovative technologies in a more timely fashion to ensure seniors have access to the most up-to-date and best health care devices and procedures available. And, unlike the traditional fee-for-service, the quality of care provided under Medicare+Choice, as well as the general administration of program services by the plan, is closely monitored.

My constituents continue to be concerned about payment levels within the program and I will be closely monitoring the introduction of the new risk adjustment method. While I agree with the concept of the risk adjuster, there may be some sensitive issues that need serious attention as we transition into the payment adjustment system.

Thank you again, Mr. Chairman, for calling this important hearing. I look forward to hearing from today's witnesses on how we can further improve the Medicare+Choice option for current and potential enrollees.

Chairman THOMAS. I want to welcome the HCFA team, Dr. Berenson, Dr. Cronin and Dr. Kang. Any written testimony you have will be made a part of the record, and you can address us as you see fit in the time that you have.

Let us start with Dr. Berenson in the middle. We will move to Dr. Cronin and then—

Dr. BERENSON. I am actually going to give a statement for the three of us, and then we will be available for questions at that point.

Chairman THOMAS. Fine.

STATEMENT OF ROBERT BERENSON, M.D., DIRECTOR, CENTER FOR HEALTH PLANS & PROVIDERS, HEALTH CARE FINANCING ADMINISTRATION; CAROL CRONIN, PH.D., DIRECTOR, CENTER FOR BENEFICIARY SERVICES; AND JEFF KANG, M.D., DIRECTOR, OFFICE OF CLINICAL STANDARDS & QUALITY

Dr. BERENSON. Thank you, Mr. Chairman. Chairman Thomas, Congressman Stark, and distinguished Subcommittee Members, thank you for inviting me and my colleagues today to discuss progress in implementing the Medicare+Choice Program.

Successful implementation of Medicare+Choice is a high priority for us. We believe very strongly that managed care and other private plans are important voluntary options next to original Medicare, and we believe that Medicare beneficiaries need to be

equipped with information to make more informed decisions about their health care.

We are meeting regularly with beneficiary advocates, industry representatives and others to discuss ways to improve the Medicare+Choice Program, and we are already making adjustments based on that consultation.

Last month we published initial refinements to the Medicare+Choice regulations which improve beneficiary protections and access to information while reducing the administrative workload of the plan. We tested a national education campaign and are using what we have learned to refine it for the full-scale open enrollment period this fall.

We have participated in more than 1,000 events around the country to help beneficiaries understand health plan changes, and we are also establishing a Federal advisory committee to help us better inform our beneficiaries.

We have converted the vast majority of former Medicare HMOs to the Medicare+Choice Program. We published all BBA mandated Medicare+Choice regulations, we have worked diligently to improve communication with plans, and have recently designated a senior official at HCFA to assure that the various HCFA components coordinate their activities that affect plan operations.

We are on track to begin risk adjustment payment to plans on schedule, and we are proceeding carefully to meet the statutory mandate while minimizing the impact on beneficiaries and plans in the early years. We are also proceeding with quality improvement requirements in a prudent manner that will meet the statutory mandate while giving plans reasonable time and flexibility to comply.

One of the most important things we are doing now is a test of competitive pricing for managed care, which will begin soon in Phoenix and in Kansas City. This test will provide central, objective data that is needed to evaluate Medicare reform proposals that assume savings from price-based competition among plans.

We look forward to working with you as we proceed to make adjustments that may be necessary to ensure success of the Medicare+Choice Program.

We thank you again for holding this hearing, and we would be happy to answer your questions.

I think we have decided, to avoid confusion, that the questioning can be posed to me, and then I will figure out with my colleagues who is the best qualified to respond.

[The prepared statement follows:]

Statement of Robert Berenson, M.D., Director, Center for Health Plans & Providers, Health Care Financing Administration; Carol Cronin, PH.D., Director, Center for Beneficiary Services; and Jeff Kang, M.D., Director, Office of Clinical Standards & Quality

Chairman Thomas, Congressman Stark, distinguished committee members, thank you for inviting us to discuss progress in implementing the Medicare+Choice program. Medicare+Choice allows private plans to offer beneficiaries a wide range of options, similar to what is available in the private sector today. It requires a massive new beneficiary education campaign to inform beneficiaries about these options. It includes important new protections for patients and providers, as well as statutory requirements for quality assessment and improvement. And it initiates a 5-year transition to a fairer and more accurate payment system.

Successful implementation of Medicare+Choice is a high priority for us, and we have accomplished a great deal. We believe very strongly that managed care and other private insurance plans are important voluntary options, next to original Medicare, and that Medicare beneficiaries need to be equipped with information to make more informed decisions about their health care. Medicare managed care enrollment has nearly tripled under the Clinton Administration, from 2.3 million when the President took office to now 6.8 million. We are meeting regularly with beneficiary advocates and industry representatives, and others to discuss ways to improve the Medicare+Choice program. We are already making refinements based on these comments and discussions.

We have converted the vast majority of former Medicare HMOs to the Medicare+Choice program and published all Balanced Budget Act-mandated Medicare+Choice regulations. Last month, we published initial refinements to these regulations which improve beneficiary protections and access to information while reducing plans' administrative workload to make it easier for plans to offer more options to beneficiaries. And we have met statutory deadlines for reporting to Congress and to plans on how we will risk adjust payment to plans.

We launched a national education campaign and participated in more than 1,000 events around the country to help beneficiaries understand health plan changes. And we are establishing a federal advisory committee to help us better inform beneficiaries.

BENEFICIARY EDUCATION

Helping beneficiaries understand the Medicare+Choice program is perhaps our most important challenge. As mentioned above, we launched the National Medicare Education Program to make sure beneficiaries receive accurate and unbiased information about their benefits, rights, and options. The campaign includes:

- mailing a *Medicare & You* handbook to explain new benefits and health plan options;
- a toll-free "1-800-MEDICAR(E)" call center with live operators to answer questions and provide additional print information on request;
- a consumer-friendly Internet site, www.medicare.gov, which includes comparisons of benefits, costs, quality, and satisfaction ratings for plans available in each zip code;
- work with more than 120 national aging, consumer, provider, employer, union, and other organizations who help disseminate Medicare+Choice information to their constituencies;
- enhanced beneficiary counseling from State Health Insurance Assistance Programs;
- a national publicity campaign;
- more than a thousand individual state and local outreach events around the country in senior centers and town halls, on radio call-in shows and other venues, and in alternative languages, including sign language, Spanish, and Chinese; and,
- a comprehensive assessment of these efforts.

We tested the whole system in five states—Arizona, Florida, Ohio, Oregon and Washington in 1998. Unfortunately, the decisions by some plans to withdraw from the program or reduce their service area significantly complicated our task. We learned a great deal in this "dry run." We are also conducting case studies to evaluate the education campaign in five communities in the five pilot States and one community outside the pilot States. And we have conducted focus groups.

We have learned a great deal from our assessment efforts already. For example, we learned that a majority of beneficiaries found the information in the *Medicare & You* handbook to be informative and useful. Fully 93 percent want to be mailed *Medicare & You*. However, even with the handbook, they are often confused about differences in plan options and do not always understand the basic Medicare program. We also have learned that, even though there are many places to receive Medicare+Choice information, beneficiaries often do not know where to go for specific types of information, and they tend to seek it only as they need it.

These preliminary results are already suggesting ways to improve our education efforts. We have identified ways to make "Medicare & You" easier to use. We learned that the number of calls to our toll-free number was lower than we expected, and that the amount of time for each call was about the 7 minutes we had predicted. And we identified additional links we can add to our Web site to help users find key information faster. Last month, almost 300,000 viewers used the Web site to review Medicare+Choice plan comparisons, Nursing Home Compare, and view or download HCFA publications. These and other findings will help us to refine

efforts for a full-scale, national campaign before the November 1999 open enrollment period.

Also, as mentioned above, we are establishing the Citizens Advisory Panel on Medicare Education, in accordance with the Federal Advisory Committee Act, as a formal mechanism to obtain public input for our education efforts on an ongoing basis. The panel will meet quarterly to help:

- enhance our effectiveness in informing beneficiaries, including the appropriate use of public-private partnerships;
- expand outreach to vulnerable and underserved communities, including racial and ethnic minorities; and
- assemble an information base of "best practices" for helping beneficiaries evaluate plan options and strengthening a community infrastructure for information, counseling, and assistance.

Panel members will include representatives from the general public, older Americans, specific disease and disability group advocates, minority communities, health communicators, health economics researchers, health plans and insurers, providers, and other groups. We are already receiving nominations for the Panel, and expect to announce members and meeting schedules soon.

We are also working with beneficiary advocates and health plans to standardize plan marketing materials that summarize benefits so beneficiaries can make apples-to-apples comparisons. Our goal is to complete this work before the first annual coordinated open enrollment period in November 1999.

REACHING OUT TO PLANS

We have taken several steps to reach out to health plans to encourage participation in the Medicare+Choice program. We have converted the vast majority of Medicare HMOs—more than 300—to the new Medicare+Choice program, and added 12 new plans and expanded service areas for another 11 plans since last November.

We are currently reviewing another 24 new plan applications and 18 service area expansion applications. The newly approved plans include provider sponsored organizations, which are HMOs run by hospitals and physicians rather than insurers. One of these plans is the first to enter Medicare with a federal waiver from State licensure, which is allowed for the first time ever under the Medicare+Choice program.

Last summer, we held outreach sessions attended by more than 1,500 plan representatives, and we continue to strengthen lines of communication with plans. HCFA Administrator Nancy-Ann DeParle has named a senior HCFA official, Tom Gustafson, whom plans can call directly if they have trouble resolving issues through normal HCFA channels.

Last month, we published initial refinements to the Medicare+Choice regulation that improve beneficiary protections and access to information, while making it easier for health plans to offer more options to beneficiaries. The new rule:

- clarifies that beneficiaries enrolled in an M+C plan that withdraws or is terminated from Medicare are entitled to enroll in other remaining locally available M+C plans;
- specifies that any changes in plan rules must be made by October 15 to ensure beneficiaries have all the information they need to make an informed choice during the November annual open enrollment period;
- waives the requirement for an initial health assessment within 90 days of enrollment for commercial health plan enrollees who remain in the same managed care organization's Medicare+Choice plan when they become eligible for Medicare at age 65, and for enrollees who switch plans but remain under the care of the same primary care provider;
- allows plans to choose the form of the initial health assessment;
- stipulates that the coordination of care function can be performed by a range of qualified health care professionals, and is not limited to primary care providers;
- limits the applicability of provider participation requirements to physicians rather than all health care professionals; and,
- aligns requirements for terminating specialists with the process for other providers.

We intend to publish a comprehensive final rule with further refinements this fall.

To further facilitate plans' ability to offer choices to Medicare beneficiaries, the President's budget includes a proposal to give plans 2 more months to file the information used to approve benefit and premium structures. This "Adjusted Community Rate" data would not be due until July 1, rather than May 1. The move from May 1 to July 1 should help plans base their cost and premium packages on more current

trends and costs in the marketplace. July 1 is the latest we can accept, process, and approve premium and benefit package data, have the data validated by plans, and still mail beneficiaries information about available plans in time for the November 1999 Medicare+Choice open enrollment period. Given legislative schedules and the need to act immediately, we have informed plans that the required filing date this year will be July 1. We look forward to working with you to enact the legislation necessary to support this change that is so important to the success of the Medicare+Choice program.

We have also informed plans that they can continue to segment their service areas, according to the transition rules that were applicable for the 1999 adjusted community rate filings. We are considering whether to make this policy permanent in our final Medicare+Choice regulation.

PAYMENT REFORM

The Balanced Budget Act of 1997 requires Medicare to "risk adjust" Medicare+Choice payments starting January 1, 2000. That means we must base payment to plans on the health status of individual plan enrollees. Data on individual beneficiary use of health care services in a given year will be used to adjust payment for each beneficiary enrolled in a Medicare+Choice plan the following year. Health status adjustments are based on the average total cost of care for individuals who had the same diagnoses in the previous year. Risk adjustment represents a vast improvement over the current payment methodology. It helps assure that payments are more appropriate, and curtails the disincentive to enroll sicker beneficiaries.

Risk adjustment will help beneficiaries feel more confident in their Medicare+Choice options. It assures beneficiaries that Medicare pays plans the right amount to provide all necessary care because payments take each enrollee's health status into account. That will help people with serious illnesses, such as cancer or cardiovascular disease, who can benefit most from the coordination of care health plans can provide.

Risk adjustment will help taxpayers by addressing the main reason Medicare has lost rather than saved money on managed care. Many studies show health plans enroll beneficiaries who, on average, are much healthier and less costly than those who remain in original Medicare. That discrepancy has cost taxpayers \$2 billion a year.

Risk adjustment will also help level the playing field among Medicare+Choice plans. It tempers the risk of significant financial loss when plans enroll beneficiaries who have expensive care needs. And it focuses competition more on managing care than on avoiding risk. It also will help plans by alleviating concerns among beneficiaries that plans have financial incentives to deny care.

The law requires us to proceed with risk adjustment starting January 1, 2000, and does not specifically call for a transition. However, we believe we must implement these changes in an incremental and prudent fashion, as was done with other new major payment systems. We are, therefore, using flexibility afforded to us in the law to phase in risk adjustment over five years to prevent disruptions to beneficiaries or the Medicare+Choice program.

Initially, we will use data on inpatient hospital stays and move in an orderly fashion, as envisioned in the Balanced Budget Act, to use of data from other health care settings. In the first year, only 10 percent of payment to plans for each beneficiary will be calculated based on the new risk adjustment method. By 2004, we and health plans will be ready to use data from all sites of care, not just inpatient hospital information, for risk adjustment. Then, and only then, will payment to plans be 100 percent based on risk adjustment.

It is essential to stress that risk adjustment will not and cannot be budget neutral if we intend to protect the Medicare Trust Fund and be fair to taxpayers. The whole reason for proceeding with risk adjustment is that Medicare has not been paying plans properly. There is considerable evidence that we overpay plans because payments are not adjusted for health status, and managed care enrollees tend to be healthier than beneficiaries who remain in fee-for-service Medicare.

Congress also recognized that plans have been paid too little for enrollees with costly conditions, and too much for those with minimal care needs. The simple demographic adjustments made now for age, gender, county of residence, Medicaid and institutional status, do not begin to accurately account for the wide variation in patient care costs. Risk adjustment will.

If risk adjustment was budget neutral, Medicare and the taxpayers who fund it would continue to lose billions of dollars each year on Medicare+Choice. Budget neutral risk adjustment would cost taxpayers an estimated \$200 million in the first

year of the phase-in, and \$11.2 billion over five years if health plans maintained their current, more healthy mix of beneficiaries.

The impact on plan revenues during the transition will depend on the extent that less healthy beneficiaries enroll in Medicare+Choice plans, resulting in higher payments than health plans receive today. Total payment may be higher for some plans than it would be under the current system if they enroll a mix of beneficiaries that is more representative of the entire Medicare population.

Overall, we project plan payment to change on average by less than 1 percent the first year. Phasing in risk adjustment substantially buffers the impact. The federal government is foregoing an estimated \$1.4 billion in savings in the first year, and as much as \$4.5 billion over the full five years because of the phase in. Impact will be further buffered by an annual payment update for 2000 of 5 percent. And, importantly, we estimate that payment rates in 63 percent of counties in 2000 will be based on the higher, blended rates called for in the BBA, thereby further helping plans adjust to risk adjustment.

COMPETITIVE PRICING DEMONSTRATION

We will soon begin a test of competitive pricing for managed care, as called for in the BBA. This test is an important step in our efforts to learn how to improve and protect Medicare. It will provide objective data that is needed to evaluate Medicare reform proposals that assume savings from rate-based competition among plans.

In this demonstration project, managed care plans will compete to offer benefits at the most reasonable cost. A bidding process, similar to what most employers and unions use to decide how much to pay plans, will be used to set Medicare+Choice rates.

To ensure broad community involvement in this project, a Medicare Competitive Pricing Advisory Commission, chaired by General Motors Health Care Initiative Executive Director James Cubbin, has made recommendations regarding key design features. It also has selected the markets of Phoenix, Arizona and Kansas City, Kansas and Missouri, as initial demonstration sites. We are establishing local advisory committees in these communities, and they will hold public meetings to ensure that local beneficiaries and other stakeholders have a voice in how the test program will operate. In particular, the local committees will set the local minimum benefit package on which plans will bid. We will also explore ways to reward plans that provide higher quality care.

ENSURING QUALITY

The BBA includes important quality provisions for Medicare+Choice. It raises the bar by requiring most plans to not only monitor quality but also to improve quality. The new requirements will be phased in over the next several years. This way beneficiaries can compare plans based on quality, and we can utilize Medicare's substantial market leverage to be a prudent purchaser and promote competition based on quality. We are working to incorporate quality assessment and improvement into original fee-for-service Medicare, as well, so beneficiaries will be able to make truly informed choices about all their options. And we have committed to making measurable quality improvements throughout the Medicare program as part of our Government Performance and Review Act objectives for fiscal 2000.

All Medicare+Choice plans must report objective, standardized measurements of how well they provide care and services. They have been using HEDIS, the Health Plan Employer Data and Information Set, for reporting purposes since 1997. HEDIS is the industry standard for measuring health plan performance, and it has been tailored specifically for the Medicare program. As a result of our audit of data from the initial round of HEDIS reporting, we learned that some plans needed to improve data systems, and we are seeing improvement. We will continue to require HEDIS data to be audited before submission to ensure accuracy.

We also are using CAHPS, the Consumer Assessment of Health Plans Study, to objectively measure beneficiary satisfaction with plan care and service. We are in the second year of requiring Medicare HMOs to conduct CAHPS surveys, and got a strong 74 percent beneficiary response rate. Reported results include overall ratings of each health plan's service, overall ratings of each health plan's care, ratings of how well doctors communicate with patients, and ratings of experience in getting referrals to specialists.

This fall, we will conduct a CAHPS survey specifically of beneficiaries who disenroll from plans, asking about the beneficiary's experience and why they left their plan. This will give beneficiaries the perspectives of both those who left and those who stayed. Also, importantly, next year we will conduct a Medicare fee-for-

service survey with results available in 2001. This will enable us to provide beneficiaries with comparable data on all options.

The results of both HEDIS and CAHPS are being formatted so beneficiaries can make direct, apples-to-apples comparisons among their plan options, and are posted on our Website at Medicare.gov. Beneficiaries may also request HEDIS and CAHPS information through our 1-800-MEDICAR(E) call center. To the extent possible, we intend to also include this information in the 2000 edition of *Medicare & You*.

Plans must conduct performance improvement projects and achieve demonstrable and sustained improvement. Eventually, plans will have to meet minimum performance standards. The date for meeting these standards may be delayed until 2001 in order to make sure plans have adequate time to comply. These standards are important because there is wide variation in how well plans provide care. For example, our HEDIS data show that 90 percent of women in some Medicare+Choice plans get yearly mammograms, while less than 50 percent get this essential service in other plans. Also, the National Committee on Quality Assurance *State of Managed Care Quality* reports that, despite the promise and capacity of managed care to improve quality, the industry's overall performance on HEDIS measures was "essentially unchanged" from 1996 to 1997.

We recognize that it takes time for plans to adapt to the quality improvement requirements, and that a learning curve is involved. Therefore, we made several changes from our draft proposal to help plans comply.

We are requiring plans to conduct two performance improvement projects per year. This workload is comparable to standards imposed by private sector accrediting organizations. Plans can choose projects they believe will target their enrollees' specific concerns.

We are permitting waivers of mandatory participation in a national project each year, and allowing plans to substitute any related ongoing projects of their own. For 1999, the national HCFA-sponsored project focuses on diabetes, but plans with existing diabetes projects can instead continue these projects without obtaining preapproval from HCFA.

We are phasing in quality improvement requirements by giving plans three years before they must achieve demonstrable improvement. In the first contract year, plans need only select a topic, establish performance indicators, and collect baseline data.

We are clarifying the schedule for compliance with minimum performance level requirements. We intend to establish these levels in 1999, first measure compliance in 2000, and require plans to have achieved demonstrable improvement in 2001.

We are giving plans discretion as to where they conduct site visits for provider credentialing, rather than mandating site visits to each provider location. Plans also have discretion in developing criteria for site visits, and they may delegate these functions.

Phasing in enforcement is normal and prudent when implementing new programs or rules. The Medicare+Choice quality improvement requirements remain similar to those in the private sector. We are simply making sure plans have sufficient time to come into compliance.

Appropriate flexibility will be provided so plans with networks that are less structured than traditional HMOs, such as PPOs, can meet these requirements. Our quality improvement systems will be sensitive to different plan structures and their different abilities to affect provider behavior.

We are extremely impressed with the quality improvement project outlines submitted by plans. Most are very thorough and thoughtful. Many include detailed benchmarks and timetables. They make abundantly clear that plans are very capable of achieving what Congress envisioned in the BBA. We will continue to work closely and extensively with plans to help them understand and meet all Medicare+Choice quality requirements. But, if plans do what they have indicated in these outlines, we are confident that they will succeed and, as a result, provide beneficiaries with better care and taxpayers with better value for their money.

Once we have published the final Medicare+Choice rule, we will begin to allow private accrediting organizations to "deem" that plans meet requirements for quality, confidentiality, and records accuracy, as allowed under the BBA. We will continue to review compliance with other requirements.

MARKET VOLATILITY

As you know, some Medicare HMOs did not convert to the Medicare+Choice program, and others reduced their service areas last year. While we are concerned about the business decision that some Medicare HMOs made to reduce participation in the program, and especially the impact on beneficiaries who were left with no

other managed care options, it is important to put those business decisions in context. Some of the plans that withdrew had market positions or internal management issues that made it hard for them to compete. And they faced rising prescription drug prices and other commercial pressures. Many of the disrupted beneficiaries had several other plans to choose from, and all but 50,000 had at least one other plan option.

It is our understanding that the Federal Employees Health Benefits Program experienced a similar rate of plan pullouts. We have observed instances where plans that withdrew Medicare service from specific counties also withdrew from FEHBP in many of those same counties. As mentioned above, the vast majority of Medicare HMOs converted to the Medicare+Choice program. We have approved 23 new plan and service area expansions since November, and are now reviewing applications from another 42 plans that want to get into or expand their role in Medicare+Choice. This suggests that plan withdrawal decisions have more to do with internal plan and larger marketplace issues than with Medicare rates or regulations. In fact, a certain amount of market volatility must be expected when relying on the private sector to serve beneficiaries.

To buffer against such market volatility, the President's budget includes proposals to protect beneficiaries from disruption by plan withdrawals. We have provided for earlier notification of plan withdrawals in our recent refinement to Medicare+Choice regulations. We look forward to working with you on legislation the President has proposed to broaden access to supplemental Medigap policies if beneficiaries lose their plan option, and to allow enrollees with end stage renal disease to move to another plan.

CONCLUSION

We are making substantial progress in implementing the Medicare+Choice program. We are incorporating lessons learned from our initial beneficiary education campaign to refine future efforts. And we are establishing an advisory committee to further help improve these essential efforts. We are working with plans to encourage participation. And we are refining regulations so plans will be able to offer beneficiaries more choices. We are proceeding with payment system improvements in a prudent manner that will meet the statutory mandate while minimizing any impact on beneficiaries and plans. We are also proceeding with quality improvement requirements in a prudent manner that will meet the statutory mandate while giving plans reasonable time and flexibility to comply.

We look forward to working with you to enact necessary beneficiary protections and make other adjustments that may be necessary to ensure success of the Medicare+Choice program. We thank you again for holding this hearing, and we are happy to answer your questions.

Chairman THOMAS. Thank you, Dr. Berenson. I guess that is a familiar way of doing things in the hierarchical bureaucratic structure. Normally, when we have folks in front of us, they get to have their say and then respond, but you run your shop the way you want to.

Talking about running your shop, you used to do something in your former life, did you not, that was actually out in the private sector?

Dr. BERENSON. Yes. I have done a couple of things. I practiced medicine, internal medicine, actually about eight blocks from here on Capitol Hill in a private internal medicine practice, and for 10 years I was the medical director and member of the board of a local PPO from about 1988 until about 2 years ago that currently serves about 140,000 members in the Washington area, so I have experience, as do my colleagues.

Chairman THOMAS. When you ran that plan, did you receive risk-adjusted payments?

Dr. BERENSON. No. We were a PPO. We did not take risk ourselves. We were a PPO network, and so the various insurance com-

panies contracted for our services. They negotiated the deals with the purchasers.

Chairman THOMAS. One of the concerns I have is the way in which information is collected and disseminated. Obviously, I was concerned about that in my opening remarks in terms of the knowledge to allow people to make a choice and that we have committed ourselves to as complete an analysis as we are able in terms of a comparative knowledge structure for our seniors.

I understand you folks have a Web site. Is that correct?

Dr. BERENSON. I am going to let Carol answer these questions.

Ms. CRONIN. Yes. Yes, we have a Web site, Medicare.gov.

Chairman THOMAS. You mean www.Medicare.gov—

Ms. CRONIN. Correct.

Chairman THOMAS [continuing]. Is how I get there.

You provide information by zip code of the plans that are available to seniors. You also provide information regarding four measures that are intended to measure quality, right? They are mammography rates, beta blockers after a heart attack, eye exams for plan members with diabetes, and the percentage of members seen by a provider in the last year.

What percent of women enrolled in fee-for-service in 1998 had a mammogram?

Ms. CRONIN. Jeff knows the answer to that question.

Dr. KANG. Nationally, in 1997, it was about 55 percent.

Chairman THOMAS. In the fee-for-service?

Dr. KANG. In the fee-for-service.

Chairman THOMAS. Is that on the Web site?

Dr. KANG. No, but we are working toward putting that on the Web site.

Chairman THOMAS. What is on the Web site—

Dr. KANG. Right now—

Chairman THOMAS [continuing]. In regard to women having mammograms? Anything?

Ms. CRONIN. It is comparative information by health plan compared to a State average.

Chairman THOMAS. Can they compare the fee-for-service plan with the other plans?

Ms. CRONIN. No, it does not at this time.

Chairman THOMAS. What percentage of fee-for-service enrollees in 1998 who had a heart attack were prescribed beta blockers?

Dr. KANG. In 1997 it was about 60 percent nationwide.

Chairman THOMAS. And what is it in the fee-for-service program?

Dr. KANG. I am sorry. That is 60 percent fee-for-service.

Chairman THOMAS. Fee-for-service. Is that on the Web site?

Dr. KANG. It is not.

Chairman THOMAS. What percent of fee-for-service enrollees with diabetes in 1998 had an eye exam?

Dr. KANG. I know I have that number back in my office. I did not bring that.

Chairman THOMAS. Well, the followup question would be is it on the Web site?

Dr. KANG. No, it is not.

Chairman THOMAS. See, you are talking about setting up an informational structure so seniors can make a choice, and 76 percent

of the seniors today in a program that was available since 1985 do not know they can disenroll from an HMO.

We are taking this money and saying that we are going to provide information on a comparative basis so people can make a choice, and when 85 percent or more of the people are in the fee-for-service program, you do not set up a structure which allows them to make a choice which includes the fee-for-service program.

How useful is that Web site to the average beneficiary who happens to be in the fee-for-service program to compare what they are doing versus what the plans are offering?

Dr. KANG. If I may? From a measurement perspective, we agree wholeheartedly that we need to compare fee-for-service and managed care. That is part of their choice.

The issue is comparison. It turns out that the measurement collection we are doing in fee-for-service is not strictly an apples-to-apples comparison to Medicare managed care. The dilemma here is that HEDIS was developed for Medicare managed care. It was not developed for Medicare fee-for-service.

There are technical issues and accuracy issues we have to solve here, and the dilemma we are in is a balancing act of putting up inaccurate information, or not 100 percent comparable information, versus the issue that the beneficiaries need to know. This is a process—

Chairman THOMAS. Let me get this straight. You are not saying, and I do not think you are saying, that you do not care about the quality of service that 85 percent of the seniors get in the fee-for-service program. It is just that you do not have any ability to measure it?

Dr. KANG. I just gave you the numbers. We have the ability to measure it.

Chairman THOMAS. Then why do we not put them in a place where they can be conveniently referenced vis-a-vis the other kinds of programs?

Dr. KANG. It is not an apples-to-apples comparison, so the question is: Are they making a true comparison between managed care and fee-for-service.

Chairman THOMAS. What is the true comparison that we are concerned about?

Dr. KANG. I will give you an example. In fee-for-service, the beta blocker measure is the number of beneficiaries who received beta blockers following a hospital discharge.

In managed care, it is the number of beneficiaries who received beta blockers following a hospital discharge plus what they are getting in the outpatient setting, so there is a different methodology for—

Chairman THOMAS. As a doctor, which is the preferred procedure using beta blockers?

Dr. KANG. The latter measure is the preferred. We would like to see beta blockers in both settings, in the hospital and the physician's office. The problem here, though, is that we do not have the statutory authority in fee-for-service to get this information from group practices or physicians' offices. We have—

Chairman THOMAS. So the problem is not being able to get the information in a useable form, but since managed care and the way

in which it deals with medicine wanting to understand how these things work collects the data?

Dr. KANG. The fee-for-service program has certain statutory and regulatory barriers, as well as operational barriers that prevent us from getting the information in the same way that Medicare managed care can.

Chairman THOMAS. I am not going to continue this line of questioning, but, frankly, I think this is one of the fundamental problems we have.

We are talking about creating, for example, risk adjustors and others in the managed care area in which we will remove money from this area if certain criteria are not met, but we do nothing over on the fee-for-service side. In fact, it is an entitlement program open to whatever money is available.

If the pot shrinks, there is a greater chance it will fail, which is a self-fulfilling structure, yet we provide information to seniors only on an internal comparative basis between managed care plans because the answer is statutorily we are not able to get this information from the fee-for-service.

I have to tell you that I never heard anyone from the administration during the entire time we talked about, worked on, and negotiated the Balanced Budget Act amendments in Medicare who came to me and said that seniors are not getting the kind of information they need. Would you please make these statutory changes so that we can collect the data and allow seniors to make a realistic choice between all of the offerings in Medicare? I never heard that once.

Dr. KANG. This was actually an Administration proposal several—

Chairman THOMAS. I never, ever had it laid in front of me in a way that you folks wanted it as compared to all the other things you wanted, including a 15-percent reduction on home health care costs and a number of items that you made very clear you wanted.

Now, our goal is to try to create a system to provide as much information as possible to seniors to make comparisons, but it does not make a lot of sense to me, and we will be talking about this in other contexts, to run a system which removes money from one side and which makes a comparative structure available on one side and requires one side to fund it.

That does not sound to me like a system that is intended to be integrated, to providing knowledge so the choice is an across-the-board choice available in Medicare. We have to work on that together.

Ms. CRONIN. Congressman Thomas, I want to point out before we leave this topic that the other piece of the information that we provide to beneficiaries on medicare.gov is satisfaction information.

At this point, you would be correct in noting that there is also no satisfaction information on the original Medicare Program. Our intent, however, is to field test a consumer satisfaction survey of Medicare beneficiaries in the original Medicare Program and report that information on the original plan, so that is going to occur on the satisfaction side.

Chairman THOMAS. I have said this several times and no one has reacted, so I will invite reaction.

In your own documents, you indicated that 76 percent of Medicare beneficiaries do not know they can disenroll from an HMO once they enroll, even though it has been available as a choice to them since 1985. Does that disturb you—

Ms. CRONIN. Absolutely.

Chairman THOMAS [continuing]. In terms of that knowledge?

Ms. CRONIN. Absolutely.

Chairman THOMAS. Since 1985 prior to Medicare+Choice, did HCFA ever include in any of the materials that it mailed out to the beneficiaries information about risk programs, their ability to enroll and not enroll?

Ms. CRONIN. It was probably there, but it was not mailed to every individual. It was probably in small print in the back of a book. We are starting from a low baseline, there is no question, in terms of our educational efforts.

Chairman THOMAS. But you were mailing stuff to beneficiaries for more than a decade.

Ms. CRONIN. Well, that actually is not true. We were not mailing. We were not mailing out anything to beneficiaries. Beneficiaries had to take the initiative to get anything from us.

I think now we are providing information to them so that they can have it as a reference document when they need it. We did not do this before.

Chairman THOMAS. The argument has been that you are having trouble because we are not giving you as much money as you asked for.

Interestingly enough, the signup for the Medicare+Choice Program has not been as high as we anticipated, so if in fact they are the ones that are going to pay the bill, you may not have as much money as necessary.

The point I have repeated over and over again was there prior to Medicare+Choice, so I am hopeful you folks are looking at finding the resources to inform and to educate seniors, especially the 85 percent who are not in the Medicare+Choice Program, because it obviously is not the case, is it, that you want to educate all beneficiaries about all of Medicare using those people who pay under the Medicare+Choice?

Are you in fact providing information to seniors beyond the Medicare+Choice Program with the Medicare+Choice providers' money?

Ms. CRONIN. We are providing information to all beneficiaries. That includes information about the Medicare+Choice Program.

Some of the funding, the overall funding we are using to do that, is from other HCFA budget categories because we understand there is a maintenance of effort required in terms of our education efforts.

Chairman THOMAS. If the maintenance of effort is that 76 percent of the people do not know they can disenroll from an HMO, the hurdle for the maintenance of effort is pretty low.

The gentleman from California.

Mr. STARK. We are going to hear later that we receive great information as Federal employees, which I presume you all get, as I do.

Why do you not tell me, and somebody is going to ask it, why do we not just do what we do with FEHBP, the Federal Employee Health Benefit Program, and send out a book that is in simple English and is easy to understand?

That is not my assessment of what you get from the Federal Employee Health Benefit Plan. I think you have to look at it carefully, and I think there is quite a bit of small print. But, could you assess for me, any of you, the major differences between what FEHBP does and Medicare does? If all it takes is to copy FEHBP and it will quiet the critics, why do we not do that?

Ms. CRONIN. We are. You know, we have been. In the context of developing our overall national Medicare education program and the different components, we looked at a wide range of approaches, including OPM, the Office of Personnel Management.

I would say we are incorporating many aspects of their approach. In fact, we anticipate that if in fact the ACR is moved back in the year, that will make our document possibly look even more like what OPM does now, which is to provide a rather limited amount of information in the document that you receive and with satisfaction information.

What we would do is also provide performance measurement information as well and then—

Mr. STARK. Now, the Federal Employee Health Benefit Plan provides no satisfaction information, if I am not mistaken.

Ms. CRONIN. The FEHBP does.

Mr. STARK. No, none. I do not think so.

Ms. CRONIN. I believe it does.

Mr. STARK. Where? It does? What kind of satisfaction information?

Ms. CRONIN. Yes. I think it is an overall rating of satisfaction of the health—

Mr. STARK. By whom?

Ms. CRONIN [continuing]. Of the health plans. The overall rating of health plan satisfaction is in FEHBP in that book that you get.

Mr. STARK. Where does that information come from?

Ms. CRONIN. They do a survey. FEHBP does an annual survey of all the enrollees in managed care plans, and that is—

Mr. STARK. And then they—

Ms. CRONIN. Report on it.

Mr. STARK [continuing]. Put that in their list?

Ms. CRONIN. Correct.

Mr. STARK. I am surprised to learn that. I was unaware of that. Is it a number? Do you get 90 or 30 or 60?

Ms. CRONIN. No. I think they have a broken bar, so you get the number of beneficiaries that are—I am sorry. The number of FEHBP enrollees that are very satisfied, and then it is broken down in a bar.

We in fact are working closely on a Federal interagency workgroup. The HCFA and the Office of Personnel Management are the lead on the consumer health information group. What we are trying to do is to develop a common government lexicon around the whole concept of how you give information to the public, or to our public.

Mr. STARK. Now, that same FEHBP bulletin would go out to Medicare beneficiaries who are retired Federal employees, right?

Ms. CRONIN. Our information would, yes.

Mr. STARK. Yes. Now, is there any difference there? Do you notice any difference in the information they receive or questions they ask?

Is there any thought on the bulletin for the average Federal employee beneficiaries who are for employees in their forties, while the average Medicare beneficiaries are really in their seventies? It is conceivable that there might be more confusion among the older beneficiaries. But, FEHBP makes no differentiation for them in this as far as you know?

Ms. CRONIN. I do not know that. We are very conscious that anything we do with our beneficiaries, and you were very quick to alert us in case we forgot, has to be in plain English.

I think that is the biggest thing we are going to work on in terms of our handbook this year. We tried to take out as much jargon as possible. We are going to do an even better job this year.

Mr. STARK. Go ahead, Dr. Kang.

Dr. KANG. I was going to say that FEHBP does not make a distinction between the age groups.

The only other thing I should mention is they are moving to our survey that we are using rather than the other way around. They like the survey that we are using, the CAHPS, Consumer Assessment of Health Plans Study, satisfaction survey.

Mr. STARK. Federal Employee Benefits is using your survey?

Dr. KANG. They are moving toward using our survey.

Mr. STARK. Would the job not be a whole lot easier if we had standard benefits? The Medigap comparisons are much easier, are they not, than the Medicare+Choice plans? If we require uniform benefits, would it not be easier to compare?

Dr. Berenson.

Dr. BERENSON. It is a tradeoff. Certainly, it would be easier to compare. At the same time, plans are able, with our capitation payments, to offer additional benefits to beneficiaries, and we do not want to limit that ability. A lot of beneficiaries take advantage of those additional benefits as well.

Ms. CRONIN. I might also note that one of the things we are also doing that does not move completely in your direction, but we are standardizing the way in which the marketing materials will be portrayed to beneficiaries so that when they get a summary of benefits from one managed care plan, the information they see will be in the same order using the same types of words as they would receive from another plan.

Mr. STARK. I think that is what I was referring to. There are differences in the plans under Medigap. In a sense, you can offer additional frosting on the cake if you choose to do so, but there must be certain underlying benefits that are common to all plans.

Thank you very much.

Chairman THOMAS. I am sure Dr. Cronin did not intend when she said in plain English, because that was a generic statement, that there would also be one necessary in plain Spanish or in plain whatever other language is necessary. She did not mean just plain English.

Does the gentleman from Minnesota wish to inquire?

Mr. RAMSTAD. Thank you, Mr. Chairman. Thank you for being here today, all three of you.

I am concerned that HCFA's proposed risk adjustment methodology will impose very problematic financial penalties on health plans that appropriately provide quality health care in outpatient settings.

For example, it seems to me from what I am hearing and reading that including congestive heart failure in the payment model penalizes plans with cardiac disease management programs. That does not make any sense. Is my concern real?

Dr. BERENSON. Well, that is in fact the one diagnosis where I personally had a long talk with the staff to figure out the right solution to that. We very much do not wish to penalize plans that do creative things in disease management.

Because of that, we eliminated about 30 percent of inpatient diagnoses that are not typically hospital diagnoses where plans can adequately manage and correctly manage the condition on an outpatient basis. We have modeled it in a number of ways to try to minimize that incentive.

For congestive heart failure, there may be some decrease in payment to the plans that do a terrific job, but it is basically the example that we keep hearing about. There is just so much congestive heart failure that we could not eliminate it from the model.

The other point I would make, we now have the opportunity for a plan to start marketing to fee-for-service beneficiaries—that the plan has a state-of-the-art disease management programs in congestive heart failure. They should be attracting beneficiaries because of that.

We have not heard that kind of marketing in the past because plans had no rewards for, in fact, recruiting beneficiaries who had health needs. It is not a perfect system. It is a system we could start with. We do not think there are serious flaws in it.

Mr. RAMSTAD. I am also concerned about how the proposed risk adjustment would impact a program that I have heard about from a lot of my constituents that is very important to them. This program is called Ever Care.

Are you familiar with it? I think Dr. Kang is familiar with it.

Dr. BERENSON. Yes. Jeff knows it quite well, he has worked with them.

Basically, for some of the demonstrations like Ever Care and the social HMOs, the PACE Program, which focus specifically on nursing home beneficiaries and others in long-term care facilities, we are not imposing the risk adjustor that we are putting on Medicare+Choice plans as we work out alternatives for those specific kinds of demonstrations. We are working with Ever Care to try to figure out an appropriate risk adjustor.

Mr. RAMSTAD. I appreciate that collaborative effort on your part. I know you are aware that all the empirical data suggests that hospital admissions under Ever Care within that program have decreased 40 percent, a very, very impressive program.

I also appreciated that 1-year exemption from the risk adjustment payment methodology. I understand you are considering the

development of a hybrid payment methodology for programs like Ever Care. Is that accurate?

Dr. BERENSON. Yes. We are looking to see whether we can use approaches that do not rely solely on encounter data, like functional status of nursing home residents, that might be appropriate.

We can advance the comprehensive risk adjuster which involves encounters from sites of service other than inpatient hospitals, so we are looking at the range of alternatives that we have.

Mr. RAMSTAD. One final question, and it is broader in scope. Could you just briefly explain the systems that HCFA has in place to monitor and analyze the effects of the new risk adjustment system?

In other words, will HCFA be able to detect whether plans that are providing good care and preventing avoidable admissions are getting underpaid under the new system?

Dr. BERENSON. Yes. Clearly our goal is to move as quickly as we can from an inpatient-only model to an all sites of service model. As we do that, and we anticipate it will take us about 4 years to get there, we will make corrections.

Again, you have pointed to congestive heart failure. That may be something we need to make a correction on, if necessary. We are looking at the inevitable concern about the incentives for upcoding or miscoding that could take place to take advantage of the system and will have an oversight program to make sure that that does not happen.

This is one of the most important initiatives we have at HCFA, and we are devoting the resources we need to do it right and to respond to the concerns that plans have about it.

Mr. RAMSTAD. Thank you, Doctor.

Mr. Chairman.

Chairman THOMAS. Thank you.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON of Connecticut. Thank you.

Dr. Berenson, in a recent study supported by the Physician Payment Review Commission they concluded that the data you were requiring the PPOs to collect was not operationally feasible. I am quoting. "Not operationally feasible for product structure to promote unrestricted choice of providers." Would you agree with that?

Dr. BERENSON. Could you repeat the quote again?

Mrs. JOHNSON of Connecticut. The Physician Payment Review Commission believes the information you are requiring PPOs to develop under the new regulations is "not operationally feasible for product structure to promote unrestricted choice of providers."

Dr. BERENSON. I see. I think that is referring to the fact that as a coordinated care plan, PPOs, along with HMOs and PSOs, under our regulations would be required to submit data to us so we can do the same kinds of comparisons that we are doing with the other plans and also that they would conduct quality improvement projects.

I will take the first part of it. I come from a PPO environment. That is where I spent 10 years. What characterizes PPOs is that they collect encounter data, both from their contracted network as well as noncontracted providers, and they in fact have the ability, in our opinion, to generate what most of the HEDIS, Health Plan

Employer Data and Information Set, data and other measures are based on, which is encounter data.

There are some unique problems that PPOs have in conducting quality improvement projects, and I am going to let Jeff respond to that because we have tried to accommodate that concern.

Dr. KANG. We have, on the quality improvement side, created more flexibility around the quality improvement projects they can do. Also, through our peer review program or our quality improvement—

Mrs. JOHNSON of Connecticut. Excuse me just for a moment. You have—

Dr. KANG [continuing]. Created greater flexibility.

Mrs. JOHNSON of Connecticut. In other words, you stepped back from your original regulatory requirements?

Dr. KANG. That is correct, especially in some of the structural quality requirements, to recognize looser networks.

The other is that with regard to the quality improvement projects, we are offering the assistance of the peer review organizations to actually help them in their quality improvement projects.

We are actually paying for that. I do need to say that, in fee-for-service, we are measuring performance, and we are actually holding ourselves, through the GPRA measures, accountable for quality improvement in fee-for-service.

Mrs. JOHNSON of Connecticut. Are you collecting the same information in your fee-for-service section that you want your PPOs to collect?

Dr. KANG. The answer, again because of the legal, operational, and technical reasons, is no.

Mrs. JOHNSON of Connecticut. Right. You are not collecting the same information from fee-for-service physicians that you want PPOs to collect from fee-for-service physicians in their network. Bottom line, you will make it impossible to be a PPO Medicare plan.

I really am disappointed, Dr. Berenson, with all your experience and that what Congress was trying to do is to say give seniors the same options that the Federal employees have, and now you are imposing requirements on PPO networks whose sole goal it is to give seniors much more choice of physician—

Dr. BERENSON. No.

Ms. JOHNSON [continuing]. Requirements you do not impose on your own fee-for-service physicians. That is what comes through.

Dr. BERENSON. But let me repeat that PPOs, under the Balanced Budget Act, are defined as a coordinated care plan, and we do hold all coordinated care plans to certain reporting requirements. The data that they report is essentially based on the encounters they receive from physicians and other providers that they are able to turn around into the information we need.

We have met with representatives of the industry to try to get into this in more detail, and I really do not think that on the data requirements side that they are in fact, if anything, an HMO that has a capitated contract with a group of providers has more difficulty providing some of the information we need because they capitate 90 percent of the payment, and that physician group has

not been obligated to provide it, so in fact we have unique situations.

Mrs. JOHNSON of Connecticut. Dr. Berenson, I have a few more questions, so we really have to move on.

Dr. BERENSON. OK.

Mrs. JOHNSON of Connecticut. I do not believe the Federal Employee Health Benefits Program is derelict in being concerned about quality. They use NCQA, National Committee on Quality Assurance, standards. They require their plans to be NCQA approved.

Why did you not use that mechanism for this kind of a structure rather than impose regulatory requirements that will mean these kinds of plans cannot participate in Medicare managed care? Why are you not turning to the private sector entities that assure quality for the majority of Americans across the country?

Dr. BERENSON. I have two responses. One is that under the BBA authority, we do get to deem private accrediting agencies such as NCQA.

Mrs. JOHNSON of Connecticut. Are you prohibited from using NCQA?

Dr. BERENSON. No, and we plan to. We have a deeming authority that we will be using, and we will be deeming NCQA, presumably—

Mrs. JOHNSON of Connecticut. Excuse me one moment. Why did you—

Dr. BERENSON. Let me make another point that most PPOs are not accredited by the private accrediting agencies.

Mrs. JOHNSON of Connecticut. But it would have been so simple to require accreditation. Why did you not do that at the beginning instead of setting up a bureaucratic system that is heavy, costly, burdensome?

Why do you think some of those plans pulled out after they had submitted their data and set rate in May, but in July you came out with a step?

One of the things I was pleased about was that you had experience in the industry. Frankly, it does not take a rocket scientist to know that if now instead of using NCQA data you have to start collecting all of this stuff yourself, this is big money. Furthermore, it changes your relationship with your network docs.

Basically, what you did not only made it impossible for plans to stay in and so they pulled out, disrupting the lives of our seniors, but you also are moving in a way that means we will never get to a Medicare set of alternatives that are similar to the alternatives our employees have throughout the country with the exception that they offer by law the Medicare bundle of services.

Unfortunately, my time has run out, but I know we will have a second chance to get back at this, and I wanted to get clear that I am profoundly concerned.

Your answer to Mr. Ramstad that maybe you were not able to completely recognize the benefits of disease management, that there may still be some deficit there, that is the future of medicine. If we are going to underreimburse for management, we are going to destroy quality for seniors, so I am concerned about what you are telling us.

Thank you.

Chairman THOMAS. On the gentlewoman's remaining time, I only want to underscore, Dr. Kang, I am very pleased you are collecting the information that you are collecting in the fee-for-service area.

My assumption is that that is a means to an end and not an end in itself, and that it will be available to seniors to make choices. That was the point I made. The fact you are collecting it is only halfway there.

Does the gentleman from Washington wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

You are being put through a stress test today as we bounce from subject to subject. I am going to bounce back to another one.

CBO recently revised its Medicare baseline estimates and now says that in 1999, the increase will only be 1.1 percent, yet the plans got a 2-percent increase in 1999, and 5 percent is anticipated for 2000, but the managed care industry is telling us they cannot make it on that amount of money.

Now, are they saying that they cannot compete with the FFS, fee-for-service, system even with increases above inflation? Is that what we are to draw from their statements?

I would like to have your comments about that because the GAO study says that managed care is actually dealing with fewer sick people than fee-for-service. I have a difficult time figuring how HMOs get bigger increases than inflation and are dealing with the least sick of the population, and yet they continue to say they cannot make it.

Dr. BERENSON. Again, the point you make about favorable selection HMOs is the rationale for why we have proceeded cautiously with a risk adjustment system that is based on inpatient diagnoses, which are predictors of the health needs of beneficiaries for subsequent health care costs.

We have done an impact analysis that suggests that if we had fully implemented the risk adjustment system, there would be a reduction in payment to the plans in aggregate of about 7 percent. That would be if their case mix had stayed the same.

Again, we hope the incentives of risk adjustment will result in plans attempting to attract patients who have the kinds of problems that Congresswoman Johnson is endorsing, disease management programs that they can then promote to fee-for-service beneficiaries and get rewarded under that payment system.

To go back to the basic thrust of your question, because of favorable selection we felt we wanted to and needed to proceed as the BBA called us to do with risk adjustment phased in over 5 years.

The final point I would make is that the 1.1-percent increase was based on projections for this year. The actuary assumes that next year's spending will be significantly higher, and that is how the blend in fact is going to get funded.

Many counties, including in your own State in Washington, will be getting increases on the order of 10 or 12 percent. The goal of the BBA is to begin to have a differential between what we are paying in the fee-for-service side, in higher payment areas, and begin to provide some support for more efficient areas that have been underpaid under fee-for-service, so I think now some of the promise of the BBA redistribution will begin to take place.

Mr. MCDERMOTT. Some of the problems?

Dr. BERENSON. Some of the promise.

Mr. MCDERMOTT. I am sorry.

Dr. BERENSON. Some of the promise of the BBA formula.

Mr. MCDERMOTT. OK. I have a second question.

One of the major insurers last year offered a \$300 fee to licensed brokers for every managed care senior citizen that could be brought into their HMO. Does that suggest there is more than enough money out there for operating a managed care system if HMOs have \$300 to give to licensed brokers?

Dr. BERENSON. I am not sure. Clearly, many insurance companies use brokers in their normal marketing activities. We are actually looking right now at the issue of plans using brokers to recruit.

I think it is fair to say that for a number of reasons, until the very recent past plans had been overpaid, but after 2 years of only getting 2 percent increases and many plans still only get 2 percent, I think the situation is changing at this time.

There is no question that in some parts of the country plans are doing quite well. However, in other parts, they felt the need to pull out of the Medicare Program, and that was a problem for all of us.

Mr. MCDERMOTT. Which really brings me to my last question, and that is the question of what do you anticipate is going to happen here come July 1, if we move the date back down to July 1 before people have to put their nickel on the bar and decide whether they are going to go with the program next year?

Are we going to get more managed care operations pulling out of Medicare, or do you expect them to all stay the same?

Dr. BERENSON. It is hard to predict. Clearly, there will be some. Some of it will be better this year for the simple fact that for this coming year, the plans will have to tell us if they are in for the following year, or whether they are withdrawing at the same time. It will not happen just before like on November 2 of last year when the beneficiaries had no notice.

We think that last year was a difficult transition year. The plans had to provide their ACR, adjusted community rate, proposals to us even before they had a chance to see what our regulations were. They now have an opportunity to know what the program requirements are. They can perhaps make somewhat more conservative assumptions on their ACR proposals.

We are hopeful that most of the plans will stay in. We are still getting a number of new applications. Since November, we have approved 10 new Medicare+Choice HMOs, and we have improved service area expansions for another dozen, so there is still a lot of interest.

Right now the enrollment in HMOs has gone back up to where it was before the pullouts occurred back in December. There is still interest in this program, and we are hopeful there will not be the kind of pullouts that there were last year.

Mr. MCDERMOTT. Primarily in urban areas you have had the increase in enrollment, or is it across the country?

Dr. BERENSON. I do not know that we have done that breakdown. Most of the HMOs are in urban areas and metropolitan areas. That is where they are, so I assume the increases are in those areas.

Mr. MCDERMOTT. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Certainly.

Does the gentlewoman from Florida wish to inquire?

Ms. THURMAN. Thank you, Mr. Chairman.

I want to read, first of all, a statement that I guess Ms. DeParle made in front of the Senate Finance Committee where she said we should not call the Medicare+Choice Program a failure simply because managed care plans are pulling out, but then she went on to say that, "Some plans withdraw not because of low payment, but because they had problems pulling together networks or faced rising prescription drug prices or other commercial pressures."

I do not understand that. Those are money issues. Prescription drugs is a money issue. Networking to try to pull people into a network is probably because of money issues.

Then I go, and I am thinking OK, we are estimating an average per person fee-for-service spending when you do the formula, but yet fee-for-service is not paying for prescription drugs and some of these other areas. How do we then make the determination if you are trying to compare these folks? How do you make that determination as to what that cost would be?

Then I look at what the cost is, or we have something from CRS that gives us what the percentage of change was. Dade County, who got \$748 in 1997 and \$794 in 2000; Citrus County, which is one of the counties that I represent, got what was \$446 and went to \$489. Our managed care just pulled out. Dade County is thriving. Somewhere along the line something is not jiving here for me.

Dr. BERENSON. Well, you have raised a number of points. I will just take two of them.

One is that the Balanced Budget Act attempted to partly deal with those discrepancies between Dade County and Citrus County. Unfortunately, because the fee-for-service increases were so low for 2 years in a row and the projections of those were so low, there was no ability to, what we are calling in shorthand, fund the blend, the combination of taking the national rate and the local county rate and over a period of 5 years getting to a 50-50 blend between the two. Now that will happen and so those discrepancies will start decreasing as that happens.

Ms. THURMAN. But how do you just take it from a fee-for-service when fee-for-service is not giving the same benefits to a beneficiary? I do not—

Dr. BERENSON. Yes. Well, I guess all I would say is that is how it is statutorily defined at this point. It used to be that the payment to the HMOs was based on every year's update in fee-for-service payment, causing some swings in payments, though it was directly tied to each year's fee-for-service payment.

The BBA went part of the way to a new system by establishing a baseline in 1997, but then having the increase be based not on the continuing fee-for-service expenses within the county, but based on the BBA formula. So, the BBA did break the link to fee-for-service partly.

Ms. THURMAN. Am I missing something? Help me here. We have still not taken into account the additional services. I am not saying that—

Dr. BERENSON. Yes.

Ms. THURMAN [continuing]. We are not wrong. I am not blaming anybody.

Dr. BERENSON. No. We are not taking in—

Ms. THURMAN. I am saying is there a better way than in a way of a monetary issue here back to these counties based on the other—

Dr. BERENSON. Yes.

Ms. THURMAN [continuing]. Benefits that an HMO gives? If there is, I would really like to hear that.

Dr. BERENSON. I think the only way would be to learn from the competitive pricing demonstrations that we are authorized now to conduct, and the Subcommittee selected Phoenix and Kansas City. In those communities, the HMOs, instead of being paid based on the administrative pricing formula, will actually bid on a benefit package that will be the community standard benefit package, including prescription drugs.

They will actually bid to provide those services, and the beneficiaries will then have incentives to pick the low bidders essentially, so in essence we are testing a new approach which is closer to how the private markets work, but except for that, we have no ability to factor in the cost of prescription drugs, as the major example, in the updates that go to the plans, and the plans do have difficulty controlling cost on prescription drugs.

Ms. THURMAN. Quite frankly, I think that is a part of the problem for some of the pullout, which is what really has me a little concerned because, as I said, in Dade County they get \$700 and some based on the fee-for-service, but not necessarily the drug issue, which is creating some of the problems for these HMOs and pulling out.

Dr. BERENSON. I think this year the HMOs are in a better position to more accurately do their actuarial projections of how much it will cost them, and there may be some increase in cost to the beneficiaries, but it should still be far lower than what they face in Medigap insurance, or the alternatives with the fee-for-service and supplemental insurance.

Ms. THURMAN. However, in some places they are paying no premium at all.

Dr. BERENSON. I understand that.

Ms. THURMAN. In others they are paying high.

Dr. BERENSON. Right. You are right.

Ms. THURMAN. I am sorry, Mr. Chairman.

Chairman THOMAS. Thank you, gentlewoman.

I want to thank the gentleman from Louisiana, Mr. McCrery, for yielding to me.

I wanted to ask a couple of process questions in terms of your ability to collect data under this risk assessment model. Obviously, the question of the collection of data is a critical one in a number of different regards.

How did you go about establishing the relative risk weights when you have the 15 diagnostic groups that you are creating in the proposed risk adjustment? Did you basically go back and look at what the average cost of different inpatient episodes were and kind of lump them together around structures and you came up with the

15, or did you come up with the structure and take the data and fit it into the category? How did you come up with it?

Dr. BERENSON. No, the other way. The initial group was to take all the ICD-9 diagnoses and come up with groups that were clinically coherent, similar kinds of diagnoses. The key part of this was to identify in a subsequent year the total spending—not just hospital spending—associated with an individual with a particular hospitalization and to determine what those costs were.

Basically, there was clustering, expense clustering, so it was a combination of diagnoses and then expenses for statistical techniques that I do not understand.

They ended up with 15 groups. In the first version of this there were 10 groups, and it got expanded to 15. So, now we have, in the 15 groups, diagnoses that are somewhat different, but what they have in common is the anticipated subsequent year spending for all points of service cluster around the same number.

Chairman THOMAS. OK. Take that data then and feed it back down to the individual level. How do you propose to assign that group to an individual? Do you go back and just take a look at what their history was in the previous year, their inpatient stays, and then—

Dr. BERENSON. Yes, basically.

Chairman THOMAS [continuing]. Assign them to whichever category fits?

Dr. BERENSON. Every Medicare beneficiary, whether in fee-for-service or in managed care, is assigned to the highest hospitalization that that person had during the year, the highest ranked hospitalization. That becomes the diagnostic roof that they are assigned to.

If somebody was hospitalized for congestive heart failure and metastatic cancer, metastatic cancer of the prostate, let us say, that is a higher ranked diagnosis and so the additional payment would be associated with that diagnosis.

Chairman THOMAS. How successful would you be in creating this risk adjustment model, if each individual Medicare beneficiary had the right to withhold that information and you would have to go to them and get them to sign a document that said you had the ability to use that information?

Dr. BERENSON. We would be severely disabled in being able to do the risk adjustor if we—

Chairman THOMAS. Is severely disabled a sufficient description?

Dr. BERENSON. We would not be able to do this model. We would be dead.

Chairman THOMAS. You would be dead. You could not do the essential work that we need to do.

Dr. Kang, in terms of your trying to verify the QISMC quality data that has to be reported, how are you going to validate that in terms of whether the plan actually achieves the performance standards? How are you going to crosswalk that information?

Dr. KANG. I am not sure I understand the question. How when we go to look at—

Chairman THOMAS. Well, they are going to report the quality data to you.

Dr. KANG. Right.

Chairman THOMAS. How do you verify it? How do you know whether or not the plan to actually achieve the performance standards—

Dr. KANG. OK. We do have monitors and enforcers who actually look at and go onsite.

Chairman THOMAS. What percentage?

Dr. KANG. I think we are onsite at all plans every 2 years.

Chairman THOMAS. A 100-percent examination?

Dr. KANG. We are looking at not only just the Medicare+Choice quality standards, but also compliance, in general, with other standards and data validity, and so forth.

Dr. BERENSON. I think we need to say that the self-reported HEDIS data was not valid, and we have now taken as a policy that we only want beneficiaries to have access to data that is in fact valid. We have now as one of the pros, I believe, of the contract to actually validate the HEDIS data.

Chairman THOMAS. I think that was the genesis of my question.

Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Thank you, Mr. Chairman.

Dr. Berenson, I am trying to ascertain the success to date of the Medicare+Choice Program. We are told that 16 percent of the Medicare population is currently enrolled in HMOs. I frankly was surprised it is that high.

I do not know what type of gauge you can give me, but let us try. From January 1 to date, what type of growth are we seeing in the Medicare+Choice Program? Are you seeing a sufficient number of plans out in the various States offering managed care plans to seniors? Where are we going with this whole program?

Dr. BERENSON. I guess I would answer in two parts. One, the number of enrollees that are signing up. Because last year over 400,000 beneficiaries lost their plan, certainly some went back to original Medicare. Our current estimate is that approximately 60 percent as of February signed up with a new plan and 40 percent went back into original Medicare, so—

Mr. KLECZKA. Of those who lost their coverage?

Dr. BERENSON. Of those who lost their coverage. Now, 50,000 of that 400,000 plus had no choice and had to go back into original Medicare, so even a higher percentage of those that had a choice actually went back into a managed care plan.

We actually had a drop off of enrollment in December because of the withdrawals, but with the new enrollments in February and March, we are now at the same level we were before the withdrawals. The increase is on the order of about 50,000 or 60,000 new enrollees a month again.

When I first came into HCFA 1 year ago, the increase was even higher with about 80,000 to 100,000 beneficiaries a month moving into HMOs, so I anticipate continued movement into what were the traditional kinds of HMOs that we have been contracting with.

The other part of Medicare+Choice is to try to bring in new kinds of plans like PPOs, PSOs, MSAs. In those areas, we have been less successful, and I think this year will be the year that we see whether or not there will be some of those kinds of organizations coming in.

I think for a PPO, which traditionally has not managed risk, when they looked and saw that many HMOs had pulled out because of their cost pressures, I think they were somewhat reluctant to come in quickly until they really had a medical management program in place to know that they could manage this. So, I do not know how quickly we will be successful in getting some of those new kinds of entities, but we are trying very hard to work with them.

Mr. KLECZKA. Are you signing up those plans now? Do you see many coming forward to offer health care benefits?

Dr. BERENSON. Again, most of the new applicants, and, as I said, when we had all those withdrawals back in the fall, we actually had 46 plans seeking applications from us. The large majority of those were traditional HMOs.

We have approved one PSO waiver and approved an application, and that is St. Joseph's in Albuquerque, New Mexico, that is now in the program. We have approved another PSO waiver, and they are now applying. There were four other PSO applicants who we sent back to the State because they had not gone through the required approach to get State licensure.

We have approved one PPO. We have one private fee-for-service insurance company that has talked to us extensively and we are anticipating an application, but we have not seen it yet.

Mr. KLECZKA. Are there any MSA plans signed up at this point?

Dr. BERENSON. None.

Mr. KLECZKA. OK.

Chairman THOMAS. Would the gentleman yield briefly?

Mr. KLECZKA. I surely would.

Chairman THOMAS. One of the concerns would be, and it is a concern, that when you create something as different as this, that you in fact have it structured correctly so that it is competitive with the other products in the marketplace. I believe the Chairman of this Subcommittee has a bill in because we believe it is not properly structured.

When there is a demonstration plan, the chance of a demonstration plan getting up and running when there is a clear termination also makes it fairly difficult, but I think the gentleman's question is a good one, and I was interested in it.

Mr. KLECZKA. One of the biggest problems with Medicare+Choice that I see in my district is a reluctance on the part of Medicare beneficiaries to change from their current plan over to a managed care operator because of what they read in the paper about the problems of managed care.

We have a patient's bill of rights pending. There are stories where doctors cannot refer to specialists or they are prohibited by their plan from telling the patients all the medical options. Seniors read these stories and they say well, I will be darned if I am going to change and go into a system that is having some serious problems today.

Again, I am surprised you have 16 percent. Until some of those problems are rectified with the managed care system on the whole, I do not think you are going to have a migration of seniors running to managed care plans for their health care needs.

If you would like to respond, go ahead.

Ms. CRONIN. I just want to indicate that everything you have said is true. It is also interesting that the first round of beneficiary satisfaction surveys that we did of beneficiaries that are in Medicare managed care plans shows very high satisfaction. That is what is on our Web site that was referred to earlier. Very high satisfaction.

That is not to say that there is not some dissatisfaction. We are going to be looking this year specifically at enrollees who disenrolled to see what their views on the plans are, but beneficiaries who are in managed care plans now, according to our data, with very high response rates indicate that they are very satisfied with that option.

Mr. KLECZKA. Do most of those plans offer some type of drug coverage?

Ms. CRONIN. We do not link the survey to that, but my guess would be yes.

Dr. BERENSON. Most of the Medicare+Choice HMOs offer prescription drugs. That is one of the major benefits that beneficiaries are looking for.

Mr. KLECZKA. OK. Thanks.

Chairman THOMAS. Just a quick followup on that in terms of the fear and the concern that folks have about changing.

I still find relatively interesting the statement that you made in response to the 400,000 who because of market decisions by their plan had to go somewhere else. If 50,000 of those 400,000 had no other plan, that was the only plan available, they obviously had to go back to fee-for-service, so you had 350,000 who had a choice. I am trying to do the math on that. I need a calculator.

Somewhere around 75 percent chose what would have been their second choice since the one that was their first choice, the one they were in, was no longer available. They still preferred to choose their second choice in a managed care option rather than go back into fee-for-service. There is a way of looking at that data that indicates something.

Dr. BERENSON. Some satisfaction with that option and having it.

The other thing to say is that the majority of the pullouts were in counties where there were four or more other plans.

Chairman THOMAS. Right.

Dr. BERENSON. Some beneficiaries moved across plans without having, in some cases, to take advantage of a drug benefit that may be up against the cap or something like that.

Chairman THOMAS. One additional question, and I do want to go to the gentleman from Georgia, but I think the gentlewoman from Florida wants to ask questions.

Did you do any analysis of those plans where there were other competing plans, and to what extent were the plans that had zero premium plans versus those plans who charge a small copay?

I just think psychologically that if you put yourself in the marketplace with a zero dollar premium and you are up against somebody who already had bitten the bullet and put \$5 in, if they change the plan and add another \$5 it is not nearly as cataclysmic as going from nothing to something when you thought you were going to get nothing.

I think it is the marketing position that may have caused some of those concerns. Is that a reasonable statement?

Dr. BERENSON. I think that is right. I guess I cannot answer your question directly. We do know that 14 percent of beneficiaries who were in the floor counties were affected by withdrawals and only 3 percent of the beneficiaries in the higher payment areas. Those were probably the zero premium plans and so not too many zero premium plans actually did pull out, but I do not have the specific numbers for you.

Chairman THOMAS. If the gentleman from Georgia would allow me to let the gentlewoman from Florida follow up on that same line?

Ms. THURMAN. You said, and I need to have this clarified, that where the plans withdrew were from counties that had competition?

Dr. BERENSON. Yes.

Ms. THURMAN. Is that—

Chairman THOMAS. What that tells us is that, and, again, out of the 400,000 only 50,000 were from counties that had no other option on a managed plan.

To me, it was more the market placement or the competitive capability of one plan versus another where they simply could not make their nut in the way they designed their plan and entered that market, and they decided to make a decision using the confusion of what was going on rather than owning up to the fact that they failed in their market analysis and did not do a good job of marketing their product.

The plans found another excuse, and that is, "These people are making it more difficult for me." That is probably one of the factors, and, therefore, they pulled out. It is key to me that the plans that pulled out were primarily in areas where there were other plans available.

Dr. BERENSON. Eighty percent of the plans either had 1,000 or fewer enrollees or had lower than 25 percent market share, meaning there are some fixed costs of doing business with Medicare, and they had not had major market impact.

In fact, some of the companies that did pull out have never viewed Medicare as a core business, as some other ones for whom Medicare really is, so they saw fit to pull out. That is why it is hard to know what is going to happen this year.

Ms. THURMAN. But I think there is an important statement in what you just said. For those that had 1,000 or less, wherein some of the rural areas that were affected really was done with no competition in those areas, but because they had a low enrollment, because there were fewer people to be enrolled, I do not know that we can blanketly say it was just those people in areas where there was competition. I think we also have to look at the amount of people that were eligible.

Chairman THOMAS. Clearly, those 50,000 are the ones that to me are more interested in analyzing in terms of those that were pulled out. Where are the counties? Are they in proximity?

Are they rural counties in proximity to an urban area where a plan took a flyer trying to stretch out to see if they could in fact work it, and there was such a differential in the AAPCC between

that county and the county that they had been operating in there was a threat that the service plan had to be the same? That was the confusion?

If I were outstretched there in a very cheap county coming from a higher paying county and I was going to have to deal with that whole structure that had not been clarified at that time, I think if you go through and look at them it is possible to come up with a very plausible reason for each of them pulling out, either never getting off the ground, not worth the hassle, took a flyer, did not work, ready to back out.

That is why I think Dr. Berenson's statement might be accurate that the first time around really is not as meaningful as we might like to think it is. It is the second and third time around that is going to give us a better picture.

Dr. BERENSON. This was a new program. The previous 2 years there were a total of five withdrawals in the 2 years put together, so there was something special that happened last year with the new program.

We actually expected only a 2-percent increase for the next few years as well. I think it came as a positive surprise to many of the plans in areas. In fact, there will be a 5- or 10- or even 15-percent increase for many of those counties. If that had been known last year, the behavior might have been different.

There was, again, a technical reason, I think. Last year there was no penalty for pulling out. This year there will be a 5-year penalty and a plan is out of the program, so I think some pulled out and know that they can come back in, although I think they have created some ill will for the beneficiaries when they do come back in.

Chairman THOMAS. The gentleman from Georgia.

Mr. LEWIS. Thank you very much, Mr. Chairman.

Last year, the Inspector General of HHS reported that Medicare+Choice paid some \$1 billion annually in inappropriate payments based on their own inflated reporting to Medicare of their administrative costs.

The Inspector General recommended that you take administrative action to stop these losses, and MedPAC recommended that you require separate reporting of administrative costs and profit projection by Medicare+Choice plans.

Do you agree that you need to take action, and what action do you plan to take to stop these losses?

Dr. BERENSON. In fact, we were underway with a new approach to the requirements, the accounting requirements that the health plans provide to us when the Inspector General was doing the analysis.

In fact, in the old methodology, you did not have to account specifically for the administrative costs attributable to the Medicare Program, and you could project your profit margin from commercial business simply on a straight proportionate basis.

We are changing that now. I think we did make overpayments to plans at least how they allocated their payments, and we will be changing that. Instructions have gone out, are going out to the plans. We have held training sessions with the plans about the new accounting approaches, and this overpayment will not be going on

in the future, so that report did identify a significant issue that we are in the process of addressing.

Mr. LEWIS. Thank you. I believe there is a proper place for a trade association in America in so many different ways. Is it proper for the Federal Government to turn over enforcement of the standards to them?

Should any private organization to receive financial support from industry like a trade organization be a credit for deeming purposes? Is that not a conflict of interest?

Dr. KANG. This actually speaks to the issue of accreditation and certification. This is the dilemma of deeming, that there is a potential conflict of interest.

The history, if you look across the entire Medicare Program, with accreditation and certification, has been a checkered history. There have been places where it works. There have been other places where perhaps because of this conflict of interest, we have substandard providers still being accredited who would not otherwise be notified.

We are very interested in achieving the efficiencies that we can get through deeming. The difficulty here is we still need to have our own—

Mr. LEWIS. Are there substandard providers still being certified today as we speak?

Dr. KANG. Well, see, this explains exactly why the Federal Government needs to have its own standards and actually monitor and enforce against those standards for proper stewardship of the program. The notion that we could just deem away and then just ignore it is very problematic.

The answer to your question is, we do not know. It explains, though, why we need to have our own standards and to do “look behind surveys” to make sure that there is appropriate application of the Federal standards.

Dr. BERENSON. But let me just say, we have made it clear in our regulations, in the interim final regulations, that we would not deem an organization that is not independent of the kinds of entities that they are being asked to accredit.

We will apply that and make sure that only organizations that are truly independent will be approved by HCFA to be able to provide that kind of deeming certification for us.

Mr. LEWIS. Thank you. Would you like to respond? Thank you very much.

Madam Chair.

Ms. JOHNSON [presiding]. Thank you.

Mr. LEWIS. I yield back my time.

Mrs. JOHNSON of Connecticut. Mr. Thomas has asked me to proceed in his absence. I am sorry I missed the answers to the questions in the last few minutes, but I just want to ask you a couple other things.

Through HEDIS, can you collect outpatient payment data separate from inpatient payment data?

Dr. KANG. The answer is no.

Mrs. JOHNSON of Connecticut. In designing the system, why did you do that?

Dr. KANG. Actually, the system was designed by the National Committee for Quality Assurance, not by us, so I think——

Mrs. JOHNSON of Connecticut. But you were quite involved?

Dr. KANG. We were.

Mrs. JOHNSON of Connecticut. Did people not foresee the need for that?

Dr. KANG. Actually, the way HEDIS collects its data is on a sample, so it is not all the encounters. That was largely to try to decrease the burden on plans. At that point, there was no thought of risk adjustment and the need to collect 100 percent encounter data. HEDIS really is designed as a sample, not a 100-percent data collection.

Dr. BERENSON. If I could insert, actually in one of my other hats I participate in the CPT coding area that the AMA manages, and they actually are planning for the new update in coding to have in their coding a series of HEDIS relevant information where a physician can, in fact, code that they have conducted a certain kind of examination, say a preventive screening for rectal cancer. That would become something that would be routinely reported so that special record reviews, which is what has to happen now, would not have to happen, would become routinely reported, so people are aware of that deficiency.

Mrs. JOHNSON of Connecticut. I do think it is a very serious matter to go on the Internet with information about mammogram participation and fee-for-service and be silent on managed care plans, performance in that area.

Even if it is not apples for apples, I think constituents have a right to know that while it is more inclusive, for instance, the beta blocker information, nonetheless this is the degree to which the plans provided beta blockers both in and out.

We are only telling you in fee-for-service the inpatient setting, and we do not know about the others, but I do think it would be a terribly misleading project to go out there on the Internet and begin reporting fee-for-service information without reporting managed care information.

I think it is going to be clear that they will never be exactly comparable. Managed care, if it succeeds, is going to be much more disease management preventive oriented, and you are not going to be able necessarily to identify dollars. It is not going to show up on your screens in the same way, so you are going to have to report their kind of data for them and not be so hung up on apples and apples and those issues.

I would hope that from the very beginning, like this week, when you put that other data out there, you put out what you know about those kinds of incidents in the managed care plans.

I also wanted to move on to make a second comment. You did not talk much, at least while I was here, about the risk adjustor issue. I have really grave concerns with moving ahead and implementing a risk adjustor based on inpatient care when the whole purpose, the whole purpose of managed care, is to keep people out of the hospital, so the costs associated with that operation are not recorded and are not part of, and the whole management of disease is not recognized in that risk adjustor.

Dr. BERENSON. Yes. Let me try again. First of all, the only data available now is inpatient data, and the BBA anticipated that that is what we would be using. What we have worked very hard to do was eliminate many diagnoses which are typically handled on an outpatient basis where good managed care, good regular medical care, does not generally require a hospitalization.

What we are left with are about 70 percent of the diagnoses, which the overwhelming majority of them, most every physician would agree, need to be treated on an inpatient basis.

We are talking about myocardial infarctions. We are talking about strokes, metastatic cancers and just a whole series of diagnoses that are in fact inpatient diagnoses that predict where those individuals have higher health care costs in subsequent years.

We are left with one or two diagnoses where managed care, by doing disease management, can keep people out of the hospital some of the time, but even there patients with congestive heart failure will be hospitalized despite the best efforts of the managed care organization, so we really do not have a system with perverse incentives. We have one or two diagnoses where the plans are not adequately rewarded, but the system works pretty well.

The second point I want to make is we have something of a catch-22 problem. I think you are going to hear in subsequent testimony that the plans, at least some of them, feel that they cannot move quickly to provide us outpatient data from physicians' offices, outpatient departments, because of administrative burdens, so they are basically saying they want to move as quickly as possible to an outpatient, to an all sites of service system, but they cannot provide the data because of the administrative burden.

Mrs. JOHNSON of Connecticut. But do you—

Dr. BERENSON. So we want to move as quickly as the plans, and we can do that to—

Mrs. JOHNSON of Connecticut. [continuing]. Do you have the simpler data as to what percentage of the outpatient cases fall in these diagnostic categories that you are looking at inpatient? Do you know that general information?

Dr. BERENSON. We do not have at this moment any routinely reported data on, for example, the treatment of congestive heart failure in the doctor's office. We do not have that at this moment.

Mrs. JOHNSON of Connecticut. What about in outpatient and outpatient facilities like the outpatient portion of the hospital? Do you not have that information?

Dr. BERENSON. We do not get that from the managed care organizations, and that is exactly what we want to work with them to be able to get. Where we—

Mrs. JOHNSON of Connecticut. But do the hospitals not have this? Do they not know what percentage of their outpatient care is devoted to these 10 diagnoses?

If they could provide you with that information, then you could make sort of a statistical adjustment knowing that a certain percentage of those heart patients treated in outpatient who did not quite need to go into the hospital would have long-term higher cost. It would be a rough measure, but it is important to have some measure.

Dr. BERENSON. We need to assign that information to the individual to be able to assign the risk adjusted score for the individual, and that is the information we do not have. It does not help us to just have the hospital's information. It has to be attributable to an individual, and that is what we want to work on getting as quickly as we can.

Mrs. JOHNSON of Connecticut. Yes. I can see that, but if you find out the first generic information, you will have a sense of whether 50 percent of their cases are in this category or 80 percent or 10 percent. If it is 10 percent, it is probably not consequential. If it is 50 or 60 or 70 percent, then you probably are going to have an unintended consequence of your risk adjuster.

Just having that generic information I think would be valuable and important for us to be able to evaluate—

Dr. BERENSON. Yes.

Mrs. JOHNSON of Connecticut [continuing]. Whether the risk adjusters were having unintended consequences.

Dr. BERENSON. Again, we used a contractor which had a clinical panel that went diagnosis by diagnosis and made clinical judgments supported by data as to which diagnoses should be pulled out because they typically are performed on an outpatient basis and which diagnoses should be left in because they are typically provided on an inpatient basis, and that is the system we have left.

Again, the one specific diagnosis that creates a problem is congestive heart failure where the ICD-9 coding includes very sick patients in intensive care units on ventilators and fairly mild congestive heart failure that can be adequately treated with a good disease management program.

We will be happy and have already started talking with representatives of plans to figure out if we can deal with that specific diagnosis in a different way, but we did go through the whole process of eliminating many diagnoses that are typically not inpatient diagnoses. We eliminated diagnoses like appendectomies that are not predictive of subsequent costs.

This has been a many year project, and it actually holds up. I think you are going to hear later from the actuaries association, who I think have some suggestions about phasing in some of the fine points, but basically think that our approach was pretty responsible and pretty well done.

Mrs. JOHNSON of Connecticut. Well, I am extremely concerned in an environment in which we have made arbitrary cuts in reimbursements rates for purposes unrelated to cost of health care, for us to then do something, no matter how rational, that will further reduce reimbursement, so there is a generic concern here that has to be overlaid against the concern with what will be the consequence of the risk adjuster.

Let me just conclude by saying that I am also very concerned about the impact of the nursing home reimbursement rates on particularly small, rural facilities. I think when Congress passed the initiative to bundle payments, we intended to bundle ancillary payments, and it really came out ending up including ambulance payments in that reimbursement.

For small nursing homes out in the country, this is a catastrophic problem. I have facilities with a \$200 a day reimburse-

ment rate and a \$700 or \$800 ambulance drive because they are so far from the hospitals. This is unfair, completely unfair, and I want to be working with your shop if you are interested to eliminate that.

The inclusion of the cost of prosthetic devices is just simply grossly unfair. They have no control over that, and some of those devices are extremely expensive. I think that we did not intend to include those when we included ancillary services, and I think we clearly have a responsibility to better delineate the bundle of services on which we are going to place that reimbursement.

I would ask if there is someone in your shop that I could work with on that, Dr. Berenson?

Dr. BERENSON. The administrator has asked me to work on it and in fact has suggested, and I have agreed, that I should come to your district and meet with some of the nursing home administrators to understand firsthand what the concerns are.

The whole issue around nontherapy ancillaries under skilled nursing has arisen. We are looking at it, and I am personally going to be looking at that issue.

Mrs. JOHNSON of Connecticut. Thank you. All right. Thank you very much.

Mr. McDermott, would you like a second round?

Mr. MCDERMOTT. Thank you, Madam Chair.

I have a question about this whole business that Ms. Johnson was asking you about, maybe an extension of that really. Some of the managed care people have said that you should not move ahead with risk adjustment because who do not have the outpatient data, and inpatient data will skew it. Then they go on. The continuum of that logic is that this will cause managed care to gain the system and somehow wind up with more costs inside.

Now, my question really is do you believe that the incentives for added hospitalization are greater than the financial disincentives? It seems to me the Medicare risk-adjusted payments would not be greater than the added costs of greater hospitalization for the managed care operation.

Dr. BERENSON. Right. I think you are basically right. For a managed care organization to decide to hospitalize rather than the alternative, they would have to take into account the following factors. Number one is the direct costs of the hospitalization.

Number two is that the period of time is a different period of time, and that beneficiary might not be with the plan 18 or 24 months later when they would receive the additional payment. I think the most important part is to have a coherent medical management program that works consistently where you communicate a set of standards to the physicians you are contracting with. You cannot suddenly start picking off this diagnosis, or "Let us hospitalize this patient this time, but only once a year, not twice a year, and only for 2 days, not 3 or 4 days."

It brings a sophistication and a sort of overt, explicit attitude of trying to take advantage of the system that I do not think most plans would engage in, and I do not think that most of the providers who the plans work with would support it.

In fact, it will still be in the interest of a managed care organization to run the same kind of medical management program to find alternatives to hospitalization that they do today, in our opinion.

Mr. MCDERMOTT. You are essentially saying that it is a bogus argument for why we should not begin risk adjustment?

Dr. BERENSON. I basically think it would be better if we could start with a comprehensive risk adjustor from all sites, but I am not persuaded that an inpatient model for 4 years, until we are able to move, creates such perverse incentives that we should not go forward.

At the margin, for a disease or two, it creates something of a perverse incentive, but the basic incentives under this system are very consistent with how managed care functions. I would emphasize the point I said earlier. This provides an incentive for health plans who have a disease management program to make that known to fee-for-service beneficiaries.

If they have a good disease management program for congestive heart failure, they should let people know that, and then they might attract some beneficiaries that they can take care of quite well and get the additional payment because those beneficiaries were most likely hospitalized in fee-for-service.

Mr. MCDERMOTT. The Association of Actuaries is going to come in and testify that as you obtain this encounter data from the plans, there is a need for what they call substantial testing, including cost benefit analysis, to determine the impact on plans.

Do you have plans, and one of the problems in sequencing witnesses is I would like them to have said this so then I could ask you, but I will have to say it for them. Do you have plans to do that kind of testing? Is there anything in the works by which you are going to try and do the kind of things they are talking about?

Dr. BERENSON. We have been working with the plans for a couple years. There are some glitches that need to be worked out in terms of making sure the data flow gets to the fiscal intermediaries and ultimately gets to our system, but our view is that we have adjusted the rare glitches by having the first year transition be a 90-10 blend. Only 10 percent of the payment to the plans will be based on the new risk adjustment system.

The only way to really make this work is to make it live. When it really affects payment is when the plans will take it seriously, when we will take it seriously, when the intermediaries will do what they are supposed to do. We very much want the incentives of this plan to start working now.

We want the plans to no longer find that it is not in their interest to have sicker Medicare beneficiaries, so by making it live, but at the same time only having a small portion of the payment be based on it, we think that is the right way to go.

As I said earlier, we will make some corrections. There is a controversy we have about 1-day stays as to whether to include them or not include them. We have taken the position that it is too easy for a plan to redesignate what was outpatient surgery or observation care as a 1-day stay in the hospital for the additional payment, so we have eliminated that. The plans feel that that is not right.

We will learn from that, and we will make some adjustments if that is necessary.

Mr. McDERMOTT. I want to say I support the idea. It is like skiing. You finally have to lean forward and start down the hill. You can talk about it and make all the adjustments in your bindings and all the rest, but until you actually put yourself at risk, I think that is really what has to happen to make this work.

Thank you.

Mrs. JOHNSON of Connecticut. Mr. McCrery.

Mr. MCCRERY. No questions.

Mrs. JOHNSON of Connecticut. Mr. Stark, do you have further questions?

Mr. STARK. Thank you, Madam Chair.

The plans, the managed care plans, are due to get a 5-percent inflation increase based on projected Medicare spending, as I understand it. CBO has just released its Medicare baseline, and it is projecting Medicare inflation of only a little over 1.1 percent.

The plans, many of them, are reporting to the stockholders that their costs for the government plans have been flat. Does that indicate to you that based on what they are spending and what has happened to inflation, there is any great urgency to increase the rates that we are paying to the plans?

Dr. BERENSON. Well, I guess I would disagree a little bit with what the plans' experience seems to be. At least what they are telling us is that their own medical trend of inflation is more like a 6- to 8-percent increase.

Mr. STARK. Hey, read their stockholder reports. That is not what they are telling the stockholders.

Dr. BERENSON. In fact, there is actually an important point to make here.

Mr. STARK. Well, look.

Dr. BERENSON. Let me just—

Mr. STARK. Whoa, whoa, whoa.

Dr. BERENSON. OK.

Mr. STARK. We are going to hear from these dudes later, but you might as well hear now. This is their consolidated medical care ratio. That is it, is it not?

The consolidated medical care ratio increased 1.2 percent as a result of higher commercial costs. The government medical care ratio for the year 1997 numbers remained flat, and somewhere in this report that say it is going to remain flat in 2000. That is PacifiCare. We are going to hear from them later.

Do you guys know what a 10-K is? Read them. That is where they tell you the truth.

Dr. BERENSON. Again, I guess the basic response I would make is that that is the reason we want to conduct these demonstrations in Phoenix and Kansas City, so that we can have more of a market test and not just be locked into this formula.

Mr. STARK. Let me try this for 1 minute.

Dr. BERENSON. OK.

Mr. STARK. Do you have information on what the plans spend per patient?

Dr. BERENSON. Yes, we do.

Mr. STARK. You know what we spend fee-for-service per patient, right, in—

Dr. BERENSON. Yes.

Mr. STARK [continuing]. Medicare? Do you know what they spend per patient in managed care plans? Yes or no? Do you know? Do you have that data?

Dr. BERENSON. I do not have that data handy.

Mr. STARK. No. You do not collect it, do you?

Dr. BERENSON. I do not think we know that.

Mr. STARK. All right. So you are shooting in the dark there.

Let me ask you this. What would you say to the nearest percent or so is your medical care ratio? What is your loss ratio? I always assume it is up in the nineties. Is that—

Dr. BERENSON. Well, it is about 99 percent. We spend about 1 percent on administration.

Mr. STARK. All right. That includes the money you pay out to the Blues and the others who are the intermediaries. It does not include my salary and Mrs. Johnson's salary, your board of directors, but it includes virtually your entire cost, right?

Dr. BERENSON. That is right.

Mr. STARK. OK. So what you are telling me then is if a plan that we are contracting out with—like these Medicare+Choice plans—have medical care ratios in the neighborhood of 85 or 90 percent.

By definition, they are that many points less efficient than what we call original or fee-for-service Medicare. Is that not correct?

Dr. BERENSON. Well, they do more things, but in terms of medical loss ratio they keep more of the administrative—

Mr. STARK. Yes, but they are supposed to do those additional things out of the spread, not out of what they spend in the medical care. I am just making a suggestion that the data would certainly not indicate, or at least maybe you could tell me why it would indicate, that it takes more money then. What does that do?

Dr. BERENSON. They are providing additional benefits. That is what they are doing with the extra money.

Mr. STARK. But they are telling us they cannot do that anymore.

Dr. BERENSON. That is what they are telling us, and that is the question.

Mr. STARK. And yet they have a broader spread and their costs are not going up, but their income is going up.

Do you ever question the things these guys tell you, Doctor? You do not take that as the straight skinny, do you?

Dr. BERENSON. There are times I do, and there are times I do not. I think there is in fact—

Mr. STARK. That is the wrong time, Doc. That is when you cost us money.

I wanted Dr. Kang to answer just one quick question. The managed care industry is also saying that we are being much tougher on Medicare+Choice plans than on fee-for-service plans in regard to quality standards.

The General Electric director of health care, Dr. Galvin, was quoted last week as saying that managed care has been a terrible failure at managing care with patients or providers. As the managed care revolution took hold, it got worse, said Dr. Galvin, and he believes we have to have data that are important to patients if they are going to make a choice.

Do you want to comment about how nasty you are being to the managed care plans, as opposed to fee-for-service plans, in regard to their quality standards?

Dr. KANG. I think we are being equally demanding of both programs. We do require quality improvement projects for both programs, and on the fee-for-service side we are measuring our performance. That is why I could give Chairman Thomas our measures. There is an issue of comparison, but certainly within fee-for-service we are measuring and demanding improved performance.

These are in our GPRA measures. Just to give you an example, Medicare heart attacks for Medicare fee-for-service, we are looking for a 4-percent reduction in the annual mortality rate over the next 3 years. That would meet the same quality improvement standards in Medicare fee-for-service that we are asking for in Medicare managed care.

For mammography rates, we are looking for an 11-percent improvement in the mammography rates in Medicare fee-for-service over the same 3-year period; for flu shots, a 5-percent improvement over the same, so we believe that we need to have performance measurement and accountability in both systems, Medicare managed care and fee-for-service, and we are measuring it in our GPRA measures. We are holding ourselves accountable, or you are, Congress, in Medicare fee-for-service.

The issue we were wrestling with earlier is the technical issue of comparison between the two, and we need to solve that problem. As a matter of principle, we do think we should get to a comparison between the two, but certainly that does not preclude us within the program from measuring and asking for measurable improvement. That is exactly what we are doing in Medicare fee-for-service.

Dr. BERENSON. I would like to just add to that. There is one difference between fee-for-service and managed care, which is in managed care you get a capitated payment, and there is a potential of underservice in a capitated payment. The public wants protection.

Mr. STARK. You are kidding?

Dr. BERENSON. Well, you got it. Therefore, we have an affirmative obligation to really oversee, as purchasers do, as other large purchasers do, that in fact the beneficiaries are getting the services that we are obligated to provide and that they deserve to get.

Mr. STARK. But you just told me you do not know.

Dr. BERENSON. I do not know.

Mr. STARK. Should we not get that data, Doc? Should we not know what they are spending? How the heck can we compare?

My guess is you talk about managed care plans having better benefits, but not ones people use. So they could give my 3-year-old son birth control benefits. Big deal.

Dr. BERENSON. Well, let me just say in terms of not knowing, we are doing two things, and this was a BBA provision.

We are going to start auditing each plan every third year, a third of the plans, to see that their ACR submissions in fact comport with reality. We also are validating their own data, and we go on-site to see what is going on, so in fact—

Mr. STARK. Just get the numbers.

Mrs. JOHNSON of Connecticut. Mr. Stark, I think this line of questioning certainly reveals the dramatic difference in philosophy between the two sides.

I do not want you to develop a separate bureaucracy that collects data that the private sector for Federal employees and people of all ages do not collect because they rely on our quality oversight organizations that we have developed.

I think you are perfectly right to say we are not going to validate someone to do quality oversight if they have an economic connection with the plan, but I do not want to see the kind of bureaucracy develop that Pete would like to see because I do not believe we can from Washington guarantee action by action quality.

I do want to put on the record a couple of questions, if I may, before we move on because this is important to our technical understanding of what is going on.

Dr. Berenson, how did HCFA go about establishing the relative risk weights assigned to the 15 diagnosis groups used in the proposed risk adjuster? Did you essentially look back at the average costs of different inpatient episodes and combine those episodes with similar costs into the groups you proposed?

Dr. BERENSON. We combined costs from all sites of service that an individual who was hospitalized in 1 year experienced in a subsequent year, so we combined costs from all sites, so the inpatient model predicts not just inpatient cost, but total cost that somebody who was hospitalized in 1 year will experience in a subsequent year.

Mrs. JOHNSON of Connecticut. When you go to actually assign the relative weights to each enrollee that signs up for a given plan, you would essentially go back and look at that person's inpatient stays in the previous year?

Dr. BERENSON. Yes. We define a period of time, and we take the highest ranked inpatient stay for that year to determine what additional scores are associated with that beneficiary for the subsequent year.

Mrs. JOHNSON of Connecticut. For that beneficiary? It is beneficiary specific?

Dr. BERENSON. It is beneficiary specific.

Mrs. JOHNSON of Connecticut. Dr. Kang, how will HCFA verify the QISM quality data that has to be reported, and how will you validate whether or not the plans actually achieve the performance standards that will be required?

Dr. KANG. The HEDIS measures are audited by an independent auditor, and on the quality improvement projects we are developing monitoring protocols to go out and review those.

Now again, to the extent that NCQA is doing the same on those same projects or any other accrediting organization, we are very interested in developing the deeming relationship to allow an NCQA accreditation. If they are equal or higher than our standards, we would allow that.

We are working along those lines to get those efficiencies. I do not have any problems with that.

Mrs. JOHNSON of Connecticut. How has HCFA implemented quality improvement projects in the fee-for-service Medicare population in the past? For example, how about the cooperative cardiovascular

project that set out to improve the use of beta blockers? How did HCFA implement that project?

Dr. KANG. That actually was through the peer review organization program or the quality improvement organizations.

For the projects and the improvement that we are trying to achieve, get in Medicare fee-for-services, I just referred to, with Congressman Stark, the vehicle for that in Medicare fee-for-service in all 50 States will be the PRO Program in the next 3 years.

We are funding them to do that and to achieve the measurement and quality improvement that we are looking for in Medicare fee-for-service.

Mrs. JOHNSON of Connecticut. If, for instance, the 4-percent reduction in cardiac problems is not achieved, who will be penalized?

Dr. KANG. Well, actually this is in the Government Performance Review Act. Congress actually then looks at our performance in managing the agency.

Mrs. JOHNSON of Connecticut. You will implement this through the PRO Program, but you will take responsibility.

Dr. KANG. And I assume—

Mrs. JOHNSON of Connecticut. It is a very different mechanism than a managed care plan trying to implement quality improvements.

Ms. Thurman.

Ms. THURMAN. Thank you, Madam Chairman.

Just reading in your booklet, Medicare payment, or I guess it is actually from MedPAC, it says under this scheme the Health Care Financing or HCFA updated payments for each county based on the estimated growth in Medicare fee-for-service spending per beneficiary in that county, so it updated payments on an estimated growth.

Do you ever go back and look at the information that these payments were first based on? Are we in some way back to the problem with what we are spending out there. Are we building in over utilization issues? Are we building it into this base because we really do not go back and look at the initial criteria in that area; we just keep adding on?

Dr. BERENSON. We have not known very well what explains the difference between Dade County and a county in Nebraska where the difference in payment is three times.

We actually, now, for the first time, with the risk adjustor, can take into account that portion of the difference that actually has to do with individuals' health needs and at least isolate that from the rest of it, which has to do with practice styles that occur.

Some of the difference is explained by health needs, but that is a relatively small part of it. A lot of the other difference is not well explained. Dr. Wennberg has a whole atlas documenting variations across the country that we do not have good explanations for, so we do not know how to account for those differences very easily in spending.

Again, I think one of the positive things about the BBA was to try to narrow those differences, but it was done in an arbitrary kind of a way.

Ms. THURMAN. Have we gotten there yet?

Dr. BERENSON. We certainly have not gotten there yet.

Ms. THURMAN. OK.

Dr. BERENSON. In the first 2 years we were going in the wrong direction. Now, at least, we are making some progress in going in the right direction, and I think we do need to look at that.

Now that we actually have information about relative morbidity of the populations in the various counties, we might be able to think more creatively about how those payments should in fact take place.

Ms. THURMAN. OK. I thank you.

Chairman THOMAS [presiding]. Thank you very much. We appreciate your testimony.

Dr. BERENSON. Thank you.

Chairman THOMAS. We look forward to your work product.

We would now ask the second panel. Sorry for the delay.

Walton Francis, who is a consultant, an expert on consumer information and the FEHBP, Federal Employees Health Benefit Program, which had been mentioned previously; William F. Bluhm, who is chair of the Risk Adjustor Work Group, American Academy of Actuaries; Janet G. Newport, vice president, Regulatory Affairs, PacifiCare Health Systems; Dr. Sandra Harmon-Weiss, vice president and head of government programs, Aetna.

I would indicate to each of you that any written testimony you may have will be made a part of the record, and you can inform the Subcommittee in any way you see fit beginning, we might as well, on my left, your right, with Mr. Francis and move across the board.

STATEMENT OF WALTON FRANCIS, CONSULTANT, EXPERT ON CONSUMER INFORMATION AND THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, FAIRFAX, VIRGINIA

Mr. FRANCIS. Thank you very much, Mr. Chairman, members of the panel. I am honored to be here today. I would like to summarize, with your permission, my testimony very briefly, hitting a few high points.

I have been disappointed over the years at HCFA's utter lack of willingness to undertake any beneficiary education measures as they relate to participation of HMOs. One of the things I try to do when I evaluate something is do a little hands on experimentation. One year I found a HCFA pamphlet that said if you want information, call the regional office. I called several regional offices pretending to be a beneficiary asking for lists of participating HMOs and their telephone numbers. I was unable to obtain such a list anywhere, and I was shocked.

I will fast forward past all this ancient history, but I think it is important to the present situation in which we find ourselves. Having said that, I want to emphasize I think the people who were here today before you are excellent, I know them all by reputation. Tom Gustafson was mentioned. He is an extraordinarily dedicated and able civil servant, and he is working on the Medicare+Choice Program directly for Nancy-Ann Min DeParle. HCFA's problem is not that it does not have good people who are well intentioned. I do not know what the problem is, but let me come back on that.

In any event, up until very recently, HCFA provided zero in the way of helping people make these choices, and this despite the fact

that there was this history of chicanery and marketing abuses and so on, particularly in the Miami area.

These things matter. People, beneficiaries, did not get the information they needed and were entitled to despite the fact that as many as 1 million people were enrolled in HMOs a decade ago. The participation of HMOs in this program on a major scale goes back 15 years.

Starting in the midnineties, about 4 or 5 years ago, HCFA began to get a lot more serious about this. I was in the department at the time, and I participated in a very marginal way in some of its early work developing a Web site and reviewed its plans to do the CAHP survey, and so on.

HCFA clearly was getting the message that something needed to be done. Then, in preparing for this hearing, I decided to look at what was really happening today, and for the first time in a year or so actually looked at what HCFA was providing. Frankly, I was appalled, and I feel terrible to come here before you today and tell you that I think they are nowhere near a minimally acceptable level of performance.

As I detail in my written testimony, I spent a fair amount of time on the HCFA Web site, and could not find certain things that exist, and that they should by law be posting on that Web site.

This morning, still not believing the situation and knowing that someone from PacifiCare was going to be here today, I decided to go research the PacifiCare health plan on the HCFA Web site. I downloaded everything on the Web site that it has on the PacifiCare plan. It is 62 written pages long. It took me 10 minutes and 72 mouse clicks just to find the pages to tell the computer to download and print; I mean, 10 minutes of clicking my mouse and watching pages load.

It took another 20 minutes to print it all out. It was actually 24 separate print jobs. About two-thirds of the way through my computer died because it could not handle that many print jobs at once.

I got this stuff, and I found in all these pages—and you have heard testimony today that HCFA has on its Web site this information—nothing on plan quality and consumer satisfaction. I do not understand that. I have looked at a dozen or so plans. I have found zero information on those subjects. I get a page that says we do not have that information for every plan, and then the page is blank. It does not list it for any plan.

It is possible the problem is that I am using a minority web browser, OK, but part of good Web site design is to make sure your Web site works on all the web browsers that are used, not just the latest version of Microsoft Internet Explorer.

I honestly do not understand why I cannot find all the Web site information HCFA officials have told you that is there. I will not go through the rest of it, but I would call this a Web site from hell. It is unusable.

Let me then talk about what I found when I actually looked at the information. I thought—what might a person who was thinking about enrolling in a specific HMO want to know? I picked a few examples. They might want to know how many outpatient mental health visits they could get. They might want to know whether

they could get smoking cessation drugs. They might want to know whether they could get Viagra. I think those are the sort of reasonable questions you might ask. None of that information, nor information on a whole lot more, is in those 62 pages.

Now, I do not want to hold up OPM as the paragon of virtues. Believe me, it is, in my view, only about a B in providing information on the web, but it is not bad. That is a pretty solid grade.

I have in my hand the PacifiCare brochure that OPM publishes on paper, OK, and it is 24 pages long. I did not bother, but I could have downloaded this exact, identical brochure formatted identically in something called the PDF format from OPM's Web site in about three mouse clicks.

If I turn to the page on prescription drugs, I would find out if PacifiCare covered smoking cessation or Viagra. They do, by the way. They only pay 50 percent for Viagra, but at least they cover something. HCFA has serious, serious problems in comparison to OPM.

I had also got a friend to give me, because I was so concerned about this, the written document that went out from HCFA in five States. I have it in my hand, "Medicare and You." I got the one for Oregon.

Now, let us leave aside the problem that all the plans in this document may not still be in the program. That is a tough problem to deal with in an environment when you have to print stuff early, but let me comment. If this document as such were on their Web site, they could have corrected it the day after those plans withdrew. They could have notified counselors and beneficiaries that if you want the latest version, go to our Web site and download it.

Leave that aside. This document is 39 pages long. It includes on Medicare+Choice plans about 4 pages of information, which I think properly presented would have taken up less than a page. It has an immense amount of verbiage. People could differ on how helpful it is. I do not think it is all that helpful.

If you want to look up information on health plans, that is what you want to do. You do not necessarily need a lot of advice about how to fill out a worksheet, which you may or may not want to have.

Let me conclude with a couple of points about all this. First, I think despite my "is the cup half empty or half full and I think it is less than half full" conclusion, the problems I am describing are not as serious as they may sound. They are fixable, correctable problems with hard work and dedication and paying serious attention to what people are doing.

It is not rocket science to fix up a Web site, and there are just any number of things HCFA could get on with. I do not know why they have not put up disenrollment data, for example. The law requires it. GAO told them to do it in the strongest possible terms 3 years ago in a wonderful GAO report. They have the data. I have seen printouts of it. I do not understand why it is not there.

There was some mention earlier of consumer satisfaction information. I do not know precisely where HCFA is in processing the CAHPS data, but OPM has been publishing data on these very same plans for years. Here is a copy of it. By the way, there was a question earlier. They do publish in their comparison guide for

the whole country detailed satisfaction data that is pertinent to the same HMOs. PacifiCare, for example, is in there.

There are things HCFA could do right now or in the very near future to fix it up, and I do not think it takes rocket science, and I do not think it takes encounter groups and all this complicated stuff, advisory panels.

Part of the problem HCFA has that I alluded to earlier is as a bureaucracy it often is in a paroxysm of review and recreation and rereviews, and it changes and it fiddles. They find it very hard to get certain things done. You must "do it" sometimes when it needs to be done.

The other general point I would make is I think the Congress shares some complicity in the problem here. The Congress had an oversight role all those same years that HCFA was not producing information.

The Congress, in the Balanced Budget Act, understanding there were some problems, was very specific in what it was requiring HCFA to do, but I think some of those requirements in their details actually interfere with getting this job done effectively.

I would hope and urge that you, in talking with HCFA and seeing what you can work out in legislation this year, would seek to adjust a few deadlines and other things that might make it a little easier for them to do the kind of job that I know they are in fact capable of doing.

Thank you, sir.

[The prepared statement and attachments follow:]

Statement of Walton Francis, Consultant, Expert on Consumer Information and the Federal Employees Health Benefits Program, Fairfax, Virginia

Mr. Chairman and Members of the Committee:

I am honored to be invited to testify on progress in implementing the Medicare+Choice program. My experience in providing health insurance information to consumers, in Federal program evaluation, in regulatory reform, and in disseminating consumer information on the World Wide Web, have led me to monitor the progress in providing plan information in the Medicare program with keen interest.

Twenty years ago I conceived the idea of providing Federal employees and annuitants with information on the costs, benefits, and customer service of 50 or so health insurance plans then participating in the Federal Employees Health Benefits Program (FEHBP). As a private author, I worked with the Washington Center for the Study of Services (sometimes called CHECKBOOK, after its main publications), a non-profit organization dedicated to providing objective consumer information, on developing the most useful possible publication for participants in the FEHBP. To date, we have sold more than one half million copies of *CHECKBOOK's Guide to Health Insurance for Federal Employees* and have saved both the Federal government and program participants billions of dollars by encouraging the choice of more cost-effective plans. We now cover some 300 plans across the entire nation, with comparative information on cost, coverage, and quality. I not only write on this topic, but also directly advise thousand of employees and annuitants on choosing health plans, over radio call-in shows, seminars, and one-on-one counseling.

Quite apart from our own publication, we stimulated the Office of Personnel Management (OPM) to improve its own program of consumer information in substantial ways. CHECKBOOK designed, and persuaded OPM to adopt, the survey of customer service that was added in the mid-1990s. While others pontificated about the need for quality measures, CHECKBOOK and OPM delivered the first real world example of multi-plan comparative quality measures, presented to consumers in plain English and easy formats. (See both *CHECKBOOK's Guide* and *OPM's own Guide*.)

For many years I served as the chief regulatory review official in the Department of Health and Human Services. In that capacity, I sought to enforce the several laws and executive orders requiring that proposed regulations minimize unnecessary burden on the public. On many occasions I persuaded the Department to require con-

sumer information in lieu of “one size fits all” regulation when dealing with issues of service quality.

Most recently, I served as co-chair of the Department of Health and Human Services’ internet “reinvention laboratory” during the formative years of the World Wide Web. Our job was to stimulate the provision of customer friendly information on the Internet. My colleagues and I created major information services, including the award-winning HealthFinder Web site for consumer information on health care. We also placed abstracts or full text of most HHS evaluations, testimony, press releases, and other policy information on the Web. To date, despite the passage of the so-called “Electronic Freedom of Information Act” amendments, no other Federal agency provides nearly as much public information on its policies as HHS.

It is from these perspectives that I provide my views on recent progress of the Health Care Financing Administration (HCFA) in implementing the Medicare+Choice program. I focus particularly on dissemination of health plan information to seniors. Obviously, however, that there are much larger issues at stake. If, as Senator Breaux and others have proposed, Medicare can be transformed to a system looking much more like the FEHBP, then the financial viability of the program can be extended and its inadequate benefits can be improved. In this regard, it is notable that in the last decade Medicare costs per capita have risen at a rate of 7.2 percent annually, compared to 5.8 percent in the FEHBP. Over time, a difference like this leads to immense savings. During this same period, the FEHBP financed rapidly rising medical needs of increasingly aged enrollees, and provided substantial benefit increases, or its savings would have been even larger.

In what follows, I describe Medicare+Choice in terms of HMOs. I appreciate that the statute allows for other types of plans, but so far as I know no other plans have yet been able or willing to participate. This is obviously a function in some combination of (a) unwieldy and in some respects impossible regulations (partially corrected in a recent update), (b) the government’s checkered history as a business partner, and (c) the economics of current payment rates. Regardless, it seems unlikely under plausible reforms that many plans that are not heavily managed care—HMOs or PPOs or a close variant—will make major inroads in the Medicare market.

Before I appraise progress to date, I think it important to put this subject in some context. There are all too many “experts” who look at the problem of choosing health plans and conclude that seniors will be hopelessly confused, at best. After all, decision research tells us that even the smartest of us cannot mentally process more than a half-dozen variables at a time. About one-fourth of seniors do not even have a high school diploma, and a tenth or more are functionally illiterate. Ten percent have Alzheimer’s disease. How then, can these elderly cope with the problems of shopping for food, clothing, automobiles, or any other complicated activity of a modern life? For that matter, how can any of us cope, with functional illiteracy and confusion common in every age group?

One way to think about this problem is to consider the automobile. There are literally hundreds of different models available and, with options, many thousands of possible purchases. Few of us are automotive engineers or race car drivers, yet who else is qualified to evaluate those complex engines or evaluate brakes and emergency handling? The market creates lemons, such as the infamous Edsel and Jugo. Seductive advertisements permeate the airways. Not one government agency provides objective and unbiased advice on which cars function best (with the minor exception of mileage statistics on purchase stickers). A wrong decision can cost \$20 or \$30 thousand, or even one’s life. Yet, somehow, things go well. Better cars get more market share. Losing manufacturers reinvent themselves. Companies that make lemons go out of business. Over time, valuable improvements are added and the hours of work needed to purchase an auto decrease.

Health insurance is a simple product compared to an automobile. What can we learn from the auto purchasing experience when we consider Medicare+Choice? First, only a small fraction of consumers have to be highly informed to “drive the market.” We all benefit from the people who do their homework and advise the rest of us. Second, there are innumerable sources of information, starting with friends and neighbors who have real life experience with different products, and including private sector publications such as *Car and Driver* and *Consumer Reports*. Third, there are many intermediaries who help us digest that information, including TV shows, newspapers, and counselors of one kind or another. Fourth, most of us learn to tune out the irrelevancies and focus on the essentials, particularly those of most concern to us.

In the real world in which we live, even such an intractable seeming problem as deciding which car will serve us best seems to solve itself almost invisibly. How, then, will we choose health insurance plans?

Clearly, the government has a role. The Balanced Budget Act of 1997 laid out important fiduciary responsibilities for providing information to seniors. The startling thing is that the statute had to be so specific. Yet, the historical record demonstrates that in the Medicare context—in sharp contrast to the FEHBP—the government has been worse than negligent. In fact, for a decade or more the government actively resisted every effort to improve information available to seniors on Medicare HMO choices.

Perhaps the best evidence on this matter can be found in a superb 1996 GAO report entitled *HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance*. In that report, the GAO not only identified vital information that HCFA was not making available to seniors at all—notably disenrollment data that show how seniors “vote with their feet” against inferior plans—but also demonstrated that it was almost impossible for a senior to get simple information on local HMO options. In 1996, more than a decade after HMO choices became available under Medicare, it was as a practical matter impossible for a senior to obtain a copy of a set of brochures describing the benefits of each plan available locally.

In contrast, consider that OPM has long made available to 3 million employees and 1½ million seniors participating in the FEHBP:

- an annual comparison guide providing summary premium and benefit information on each plan available in the area, including in recent years information on quality;
- a brochure for each plan written in plain English and in a standard format facilitating comparison of key benefit features;
- an 800 number for confused elderly to use during Open Season;
- a simple postcard system so that a senior can get any brochure mailed to him from a central facility; and
- in recent years, a World Wide Web site that takes customers both to simple plan comparisons and to brochures that they can download on the spot, in multiple formats.

OPM has developed methods of creating and disseminating information that do not cost it scarce Salaries and Expenses appropriations or require hiring a lot of staff. For example, to publish brochures it simply makes the plans responsible, as a condition of getting contracts. And to minimize paper and mailing costs, it relies heavily on its Web site.

The main fault of OPM is that even today it collects but does not publish disenrollment information. In measuring health plan quality, “quit” rates are a gold standard. The number of plan participants getting immunizations or mammograms is all very well, but the real nitty gritty is information on how many people are served so poorly—for any reason—that they quit a plan compared to other plans with similar premiums and benefits. If one plan loses 5 percent of its customers in a year and another plan loses 20 percent, a prudent consumer knows which to choose.

It is unclear why HCFA did not copy the economical and effective OPM system, lock, stock and barrel, 10 years or more ago. I was once told by a HCFA official that the reason why no usable information was provided was because the plans didn’t want to make comparisons easy, and HCFA felt obliged to defer to the plans’ wishes. This theory is so scandalous that it is hard to believe. I am more inclined to believe in tight budgets and weak imagination. Another theory is that a well-run Choice program would drive traditional Medicare (a grossly inferior insurance product) into the ground and that agency staff are unwilling to foster fair competition. Regardless, the record on Medicare HMO information is atrocious.

Even today, after an explicit Congressional mandate and a major infusion of funds, HCFA’s information products are notably inferior to those of OPM or of other Web sites providing comparative information. Before this hearing I spent some time testing the www.medicare.gov Web site to get information on participating plans in Virginia. I found the site intolerably slow and confusing. Even an expert would have a hard time using it to compare plans. In fact, as a practical matter it is almost impossible to get the most obvious comparisons. Literally hundreds of mouse clicks, and tens of pages of printout, would be needed to compare the five Medicare participating HMOs in Virginia on cost, coverage, and quality.

It does not focus on key information by deleting unnecessary verbiage. For example, the standard table entry says “You pay nothing for your hospital stay” or “You pay \$250 per admission to a plan hospital” next to a hospital cost heading, instead of simply saying “Nothing” or “\$250” (with a redesigned heading couched in terms of cost per admission). Crafting tables so that the entries are single words or numbers is one of the first principles of user friendly and user comprehensible design. In *CHECKBOOK’s Guide*, we try to make every single table entry—and there are thousands—a number or simple word such as “Yes” or “No.”

The Medicare+Choice Web site does not facilitate comparisons and correctly warns that its design will not let users compare more than two plans at once. It suggests that users who want more information change fonts in their browsers to prevent results from becoming unreadable. When comparing plans, it first presents traditional Medicare compared to Medicare with Medigap rather than taking users to a Choice option or giving them control. It doesn't have the most obviously needed features, such as simple tables listing all plans in an area and showing, for each, premium, copayments, and drug coverage. It doesn't let seniors get around its clumsy presentation by downloading information in PDF or text formats or comma delimited text files. Instead, files must be "unzipped" and can be used only by consumers with data base software in the Windows format—so much for Macintosh users, America Online users, and millions of others without sophisticated knowledge going far beyond the operation of a browser through mouse clicks. In seeming violation of two civil rights statutes, section 504 of the Rehabilitation Act and the Americans with Disabilities Act, it fails to provide health plan information in formats and presentation modes accessible to the blind.

Interestingly, Congressional agencies such as GAO and GPO have made presentation choices—such as presenting most documents in both text and PDF formats—that avoid many of these problems. And many of the documents presented on the Internet for easy access by citizens, such as copies of HCFA regulations, are far longer and more complex than anything needed to compare health plans.

When I was at HHS, mid-level HCFA staff made the bizarre decision to ban all "links" from the HCFA Web site to commercial, for-profit Web sites. No other Federal agency has made such a limiting decision. Presumably for this reason, users at the Medicare site are unable to click directly to the home pages of participating health plans. Again, this sharply contrasts with OPM's encouragement of visits to the Web sites of health plans. Medicare seniors get the URL address but must type it in or copy it rather than connect directly. This kind of inconvenience is totally unnecessary and discourages access to some of the most important plan information, such as the location of facilities and names of providers.

Despite a voluminous presentation of information—one which drowns vital details amid unnecessary text—HCFA leaves out important information completely. For example, many plans provide out of area services to snowbirds and others who travel. HCFA does not indicate which plans have reciprocity and similar arrangements, but simply says "call plan for details." Nowhere does the material clearly point out how much money can be saved by joining an HMO rather than purchasing a Medigap plan. (Most seniors are smart enough to figure out the big dollar savings, but some could use a little help.)

As another example, HCFA stopped publishing several years ago its annual data on hospital mortality, by procedure, for almost every hospital in the country. For a senior citizen looking for a good hospital to perform a coronary bypass, or looking for a health plan that signs up several good hospitals, this information should be on the Web, linked plan by plan. (However, CHECKBOOK continues to publish this important information on paper and may come out with an electronic version). Compare the value of outcome information on life and death to the process-oriented HEDIS measures.

Incidentally, www.medicare.gov promises to provide information on "helping you stay healthy" (HEDIS measures like percent getting eye exams and mammography), "about your providers" (how many are board certified), and "beneficiary satisfaction" (survey information). So far as I could determine, none of this information is available on the Web site for any plans—certainly none that I checked in several states. With all due respect, most of this information is available today and has been available for several years. To be sure, the new Consumer Assessment of Health Plans survey results will take some time to process, but in the meantime OPM has excellent survey data on most of the same plans that contract with HCFA. Why not use the OPM data until the newer data are available? Similarly, HEDIS information is available for many plans, though not all. In this regard, why not at least tell users which plans are NCQA certified (another OPM practice eschewed by HCFA)?

In a reflection of either my expert inability to find the obvious, or of HCFA's inability to do the obvious, I tried but failed to find a copy of the published Medicare+Choice handbook on the HCFA Web site while preparing for this hearing. I had reviewed the handbook in draft but wanted to refresh my memory of its contents. Apparently, not living in Arizona or one of the other demonstration states, I cannot be trusted with the published version. And even if I lived in Arizona, I would apparently be forced to find a paper copy rather than view or download the information from the Web.

Users are even warned that the information on the Web site may be obsolete and told to ask the plans for accurate information. As OPM long ago discovered, plan

functionaries are almost incapable of providing reliable, up-to-date information in response to a telephone call. Instead, the plain-English brochure is made a binding element of the contract that the plan may not abrogate or change in any way. Brochure information (whether on paper or on the OPM Web site) is MORE accurate than anything a plan employee might tell an enrollee. And it is standardized to facilitate comparisons. To the best of my knowledge, Medicare participating plans have never been required to provide standardized written information.

Any one or even a few of these gaps and gaffs could be excused and may well be justified. But taken as a whole, the entire panoply of overload and omission suggests that radical improvement is needed.

Having said all these depressing things about the quality of available information on Medicare+Choice, let me add that the agency has come a long way in the last two years. It would take only modest reforms—not much more than common sense contracting, data assembling, editing, editorial, and presentation decisions—to transform its Choice-related information products from scanty and barely usable to models of ease and clarity. In fact, many other HCFA information products, such as advice on choosing a nursing home, are exemplary in their usefulness and clarity. As one of many fine practices, HCFA publishes most of its key material in Spanish as well as English.

I also have no doubt that significant improvements are planned for this year. After all, the Balanced Budget Act requires certain information that is now missing, such as quality, disenrollment, and satisfaction survey results. HCFA undoubtedly plans to provide this information in the reasonably near future. The agency can do better and it will do better.

However, more is needed. My suggestion, both directly to HCFA and to the Committee, is that independent evaluations of current and planned information for plan comparison be performed right away, with corrective actions completed this year. These evaluations should not be theoretical or researchy. Instead, they should be aimed at practical improvements that would facilitate use of the most important information both by seniors and by those who advise them. For example, could extraneous details be excised so that comparative tables could be presented covering all available plans in an area? Can the number of levels “clicked down” and back-clicked be reduced from hundreds to a handful so that the information on all plans in an area can be found quickly and easily? Can all plans be required to produce plain English brochures in a standard format, with copies made available in several file formats on the Medicare Web site? Can HCFA get the plan comparison handbook up and available, in several formats, and can the handbook be redesigned to improve readability and reduce verbiage (to say nothing of mailing costs)? Can outcome information, such as disenrollment data and hospital mortality, be added quickly and easily to the Web site, at least on a “look up” basis?

I don't share the view that radically different informational efforts are needed for seniors because of their cognitive deficits. Seniors can do “just fine, thank you” with carefully presented and summarized information. Unfortunately, the existing information would confuse anyone. With readily achievable improvements, I have no doubt that seniors can be greatly aided in making sensible plan choices. And, as can reasonably be expected from the experience of the FEHBP, those choices will save both seniors and taxpayers a lot of money.

To illustrate a few of these concerns, I have attached two tables, one replicating the www.medicare.gov presentation of information (which takes two printed pages and covers only two plans), and one illustrating how the same information can be provided in a far simpler format covering four plans. The www.medicare.gov version is accurate in every respect, including blank spaces and wording of answers.

Web search result at www.medicare.gov

What's Most Important to You?	Company Name A, Segment 1	Company Name B, Segment 1
Plan type	HMO—M+C Plan (Definition)	HMO—M+C Plan Definition
Basic Plan Information:		
Product Name	Senior Advantage	Bonus Plus
Federal Approval Status.	
Phone number	1-800xxx-xxxx	1-800xxx-xxxx
Websit Address	www.nameA.org	www.nameb.com
Tax Status	Nonprofit	For Profit
Additional Packages	
Important Note	
Cost:		
Premium	You pay nothing if you have Medicare Parts A and B.	You pay nothing if you have Medicare Parts A and B
Physician Visits	You pay \$5 per visit with your personal physician.	You pay \$5 per visit with your personal physician
Inpatient Hospital	You pay nothing for your hospital stay.	You pay nothing for your hospital stay
Doctor and Hospital Choice:		
Doctor Choice	You must go to plan specialists, and hospitals. You need a referral to see specialists.	You must go to plan doctors, specialists and hospitals. You need a referral to see specialists
Prescription Drugs	Prescription drugs are covered with limits. You pay \$5 per generic prescription. You pay \$20 per brand name prescription. Your generic and brand name prescriptions are covered up to \$1,000 per year. You must use plan-approved prescription drugs.	Prescription drugs are covered with limits You pay \$7 per generic prescription You pay \$15 per brand name prescription Your generic and brand name prescriptions are covered up to \$600 per year You must use plan-approved prescription drugs
Extra Benefits:		
Physical Exams	You are covered for an unlimited number of physical exams per year.	You are covered for 1 number of physical exam(s) per year
Vision Services	You have some coverage for glasses, contacts and routine eye exams—contact plan for details.	You have some coverage for routine eye exams—contact plan for details
Dental	You are covered for 2 preventive dental exam(s) every 1 year(s). You pay \$30 per preventive dental exam. You are covered for some other dental care beyond the basic Medicare benefit—contact plan for details.	In general, you are not covered for dental services

Illustrative revision to display double the information more clearly and concisely

Plan Name	Original Medicare	Senior Advantage	Bonus Plus	Grey Bonus
Company/Product Line	HCFA	Company A	Company B	Company C
Plan Type	fee for service	HMO	HMO	HMO
Phone Number	800-xxx-xxxx	800-xxx-xxxx	800-xxx-xxxx	800-xxx-xxxx
Website?	[symbol click]	[symbol click]	[symbol click]	[symbol click]
Additional packages?	No	No	No	No
Important note?	No	No	No	No
Extra premium cost?	None	None	None	None
Deductible for doctor visits?	\$100	None	None	None
Cost per doctor visit?	20 percent	\$5	\$5	\$10
Cost per hospital stay	\$768	None	None	None
Limited to plan doctors and hospitals?	No	Yes	Yes	Yes
Referral needed to see specialist?	No	Yes	Yes	Yes
Prescription drugs covered?	No	Yes	Yes	Yes
—cost of generic drug	NA	\$5	\$7	\$10
—cost of brand name drug	NA	\$20	\$15	\$20
—maximum plan will cover per year	None	\$1,000	\$600	\$1,500
Pays for physical exam? ...	No	Yes—unlimited.	Yes—1 per year.	Yes—1 per year
Pays for routine eye exam?	No	Yes	Some	Yes
Pays for glasses & contacts?	No	Some	No	No
Covers dental exams?	No	2 at \$30 each	No	No
Any other dental coverage?	No	Some	No	No

Chairman THOMAS. Thank you very much, Mr. Francis, and we are in fact engaged in discussing how we can work out either administratively or legislatively some of that stuff. We appreciate your testimony.

Mr. Bluhm.

STATEMENT OF WILLIAM F. BLUHM, MAAA, FSA, FCA, CHAIR, RISK ADJUSTOR WORK GROUP, AMERICAN ACADEMY OF ACTUARIES

Mr. BLUHM. Good afternoon, Chairman Thomas, other distinguished Members. My name is Bill Bluhm. I am a principal with Milliman & Robertson in Minneapolis. I am here today in my capacity as the chair of the American Academy of Actuaries Risk Adjustors Work Group.

That volunteer work group was formed in response to a request from HCFA to do a review of the new risk adjustment methodology from an actuarial point of view. We did that review. Our analysis

was presented to them in a report which became an appendix of their report to Congress.

The new system is obviously a significant change for health plans, contracting providers, and Medicare beneficiaries. We think there is a substantial risk to the system, it is fairly obvious, if this does not work as it is intended, including withdrawals from the market, financial problems, and potential for reductions in benefits.

Our conclusion at the end of analysis was that new methodology does meet the actuarial requirements of the Balanced Budget Act, provided it is implemented carefully. The work group also believes the methodology is actuarially sound as we defined it in the report.

On balance and with the phase-in approach, and I underline that, that HCFA has recommended, the new method appears to be a reasonable first step in what should be a long-term evolutionary process.

Based on our review, we did note in our report some concerns about the implementation of the new system and its impact on the market. There were five significant ones.

The first was lack of adequate testing by HCFA, at least at the time we did the review, of the potential impact of the methodology on health plans and beneficiaries. A lot of this concern was alleviated by the adoption of the phase-in approach.

Second, the administrative feasibility of implementing the new system because of timing problems and data collection issues.

Third, the processing by HCFA and health plans of new, huge amounts of data, and a lot of seriously complex calculations makes things a little bit uncertain as we are moving forward.

Fourth, HCFA used only fee-for-service data, which was apparently the only data available at the time, but which has some potential problems with it that we hope will be fixed over time.

Fifth, decisions made by HCFA to exclude or limit certain diagnostic categories such as 1-day hospital stays, which might penalize some health plans that effectively manage care.

We see that HCFA has done a lot of work in a short time period in developing this methodology, but additional work does need to be done. Our group recommends that HCFA further modify this model on an ongoing basis with knowledge that they gain in the first year. Our report also includes a number of recommended changes to the methodology that we urge be considered following implementation.

I also need to note that we did not analyze fully the final version of this, because the data was not all available at the time we did our analysis, and the methodology was still being fine tuned at the time. We did not perform any audit or analysis of the data or the calculations by HCFA. We relied on those, and because of all this, our report is a qualified opinion of the soundness.

I would be glad to answer any questions you have.

[The prepared statement and attachment follow:]

Statement of William F. Bluhm, MAAA, FSA, FCA, Chair, Risk Adjustor Work Group, American Academy of Actuaries

Good morning Chairman Thomas and members of the committee. My name is Bill Bluhm and I am a principal with the actuarial consulting firm of Milliman & Robertson in Minneapolis. I am appearing today in my capacity as the Chair of the Risk Adjustors Work Group of the American Academy of Actuaries. Our work group was formed at the request of the Health Care Financing Administration (HCFA) to com-

plete an actuarial review of the health status risk adjustment methodology the agency will use starting on January 1, 2000 to pay Medicare+Choice health plans.

As you are aware, the use of a health status risk adjustment formula is required by the Balanced Budget Act of 1997 (BBA). That law directed HCFA to report to Congress on the proposed risk adjustment method and, further, provides for, "*an evaluation of such method by an outside, independent actuary of the actuarial soundness of the proposal.*" (BBA, Section 1853). Last fall, the Health Care Financing Administration asked the American Academy of Actuaries to perform this evaluation. As the Academy's Vice President of Health at that time, I appointed a volunteer work group consisting of health actuaries who are either consultants to or staff members with health plans and health insurers to review HCFA's proposal. A list of the members of the work group is attached to my testimony. Our analysis was included as part of the agency's report to Congress which was issued earlier this month. The Academy's work was provided pro bono, although HCFA did reimburse the members for travel expenses associated with the meetings of the work group.

HCFA'S PROPOSAL

Currently, HCFA's payment rates for Medicare+Choice plans are adjusted to reflect the risk characteristics of the plans' participants as defined by the demographic factors of age, gender and the beneficiary's status (institutionalized or noninstitutionalized; Medicaid recipient or non-Medicaid; employed or not; disabled or not). Beginning in the year 2000, HCFA is required by the BBA to supplement these demographic adjustments with a health status risk adjustor.

HCFA plans to assign a risk score to each Medicare beneficiary based on diagnosis information for that individual, taken from previous hospital inpatient stays. The risk scores were developed using a list of "principal inpatient diagnostic cost groups" (PIP-DCGs), which were developed for this purpose. The previous medical costs for inpatient hospital stays incurred by the individual are used to determine their expected future medical risk and, therefore, how much the Medicare+Choice health plan in which they are enrolled should be paid. New enrollees in Medicare will be assigned an estimated risk score based on HCFA's analysis of existing Medicare fee-for-service (FFS) data.

CONCLUSIONS

The new risk adjustment system represents a significant change for health plans, contracting providers, and health plan members. While the Academy work group believes the conceptual basis of the risk adjustment method proposed by HCFA is "actuarially sound," as we have defined it for this purpose, we have serious concerns about the method's implementation, operation, and impact. These issues include:

- Exclusions of certain risk categories from the risk adjustment methodology, such as one-day hospital stays, which may penalize health plans that effectively manage the delivery of health care.
- Lack of adequate testing of the potential impact of the new methodology on health plans and Medicare+Choice beneficiaries, although the phase-in will significantly soften the impact of changes in reimbursement levels from what it might otherwise be.
- Administrative feasibility of the implementation of the new system because of timing and data collection issues.
- The processing of extraordinary amounts of newly collected data and completing a series of complex calculations introduces an element of uncertainty that cannot be anticipated until health plans and HCFA have full opportunity to understand the implications.
- Use of only fee-for-service data as the basis for the development of risk adjustment weights.

There is a substantial risk for the Medicare system if the risk adjustment methodology does not work as intended. The negative consequences could include withdrawal of Medicare+Choice health plans from the market, financial problems or insolvency for health plans and the potential for a reduction in benefits provided to beneficiaries. Because of these concerns, the work group believes HCFA's decision to implement the new methodology under a phased-in approach is a sound one and will limit changes from the current payment system while HCFA and the health plans assess the impact of the new methodology.

While HCFA has done much work in a short time period to develop the new methodology and design implementation strategies, additional work remains to fully define HCFA's risk adjustment method and test application of the method to make sure it achieves the intended results. The work group recommends that HCFA fur-

ther modify the risk adjustment model with the knowledge gained during the first year of operation.

DEFINITION OF ACTUARIAL SOUNDNESS

The Academy was asked by HCFA to evaluate the actuarial soundness of its proposal. For this purpose, there is no widely recognized definition of "actuarial soundness." The work group therefore analyzed HCFA's proposal in terms of: (1) established actuarial criteria for risk adjustment, (2) Actuarial Standards of Practice, and (3) the general principles and practices of actuarial science. Actuarial Standards of Practice are guidelines developed by the Actuarial Standards Board to help actuaries in their work. Specific actuarial goals and criteria for risk adjustment are described in the Academy's May 1993 monograph titled, "Health Risk Assessment and Health Risk Adjustment: Crucial Elements in Effective Health Care Reform." The criteria used to evaluate risk adjustment systems are:

Accuracy: Because payments to health plans will be determined based on the risk adjustment mechanism, accuracy and avoidance of statistical bias is critical.

Practicality and Reasonable Cost: The risk adjustment mechanism should not be so complex that implementation is extremely cumbersome, thereby adding significant cost to the system.

Timeliness and Predictability: Carriers setting premium rates should be able to predict the impact of risk adjustment on their premiums with a fair degree of accuracy and in a timely manner, in order to avoid solvency concerns and disruption to members.

Resistance to Manipulation: The risk adjustment mechanism should aim to make it impossible for specific carriers to benefit financially by "gaming" the mechanism.

The Academy's review took into account all aspects of the proposed methodologies that impact on its "actuarial soundness," including, but not limited to the proposed formulas, the availability, quality, and relevance of the data required, and the ability to be implemented as intended.

In addition, the Academy has evaluated the appropriateness of the proposed methods in relation to available alternatives (including non-administrative data models such as surveys, enhanced age/gender/status, and the status quo) and in light of the modifications being made to the underlying base rates by county over the same time period.

LIMITATIONS OF THE WORK GROUP'S ANALYSIS

It is important to note that the work group's analysis and conclusions relied on the information supplied by HCFA. During the review process, HCFA provided the work group with preliminary results of the potential payment impact of the risk adjustment methodology on Medicare+Choice plans. However, the work group was not able to verify the accuracy of the data collected by HCFA or the calculations used by HCFA to determine the impact on health plans.

In addition, HCFA did not provide the work group with an assessment of the impact of the risk adjustment methodology on beneficiaries, and the scope of our opinion is similarly limited.

HCFA's risk adjusted payment system is still a "work in progress," and it should be understood that our opinion on the actuarial soundness of HCFA's proposals are based on the system as they were described to us at the time we performed our review.

The work group was not able to undertake a detailed analysis of the mathematical formulas used to develop the risk adjustment methodology, but rather focused its review on the conceptual and theoretical basis of the system. Because HCFA is still working on the proposed methodology and there are a number of unresolved implementation issues, our report is a qualified review of the actuarial soundness of the proposal.

ANALYSIS AND RECOMMENDATIONS

The new methodology for making health status risk adjustments to Medicare payments appears to meet the requirements of the Balanced Budget Act of 1997, provided the system is implemented carefully. On balance, and with a phase-in, the proposed risk adjustment method appears to be a reasonable first step in what should be a long-term evolutionary process. HCFA is to be commended for the progress to date and for recognizing the limitations of the proposal arising from the available data, timing requirements and areas for future improvements.

In general, the work group believes the PIP-DCG risk assessment methodology developed by HCFA meets the goals of risk assessment I outlined earlier in my tes-

timony. However, there are a number of concerns about the health risk assessment formula that the work group raised in its report:

Using Only Inpatient Data: A significant component of the PIP-DCG model is the restriction of the risk adjustment method to conditions identified by inpatient hospital claims. This feature has both advantages and disadvantages. As one positive factor, this requirement matches well with the information currently available to the Medicare program. Currently, hospital claim information is more accessible and easier to audit than ambulatory care data, and requires less additional work by health plans to report to HCFA.

However, there are several drawbacks to a system that uses only inpatient data. A major feature of managed care has been the measurable shifting of inpatient care to outpatient sites and the substitution of less invasive therapies to treat a given condition. When the risk assessment system is restricted to inpatient claims, the members subject to effective managed care can appear healthier than average, because of limits on what is measured.

If outpatient (ambulatory) data is added to the inpatient claims information, a better picture of the potential "risk" of each individual Medicare beneficiary is obtained. We have therefore recommended that outpatient data be included in HCFA's methodology as soon as it is feasible to do so.

Exclusion of One-Day Hospital Stays: The risk adjustment methodology does not "give credit" for one-day hospitalizations, under the assumption that including them may result in "gaming" of the system by health plans. If included, plans could "game" the system by ordering unnecessary one-day stays for minor medical conditions, in order to include beneficiaries in the health status risk adjustment process, and thereby increase payments the next year.

The underlying concept of excluding one-day admissions does have merit. It can reduce gaming of the system by requiring each hospitalization to be of a certain severity (measured by a length of two days or more) and plans would not have an incentive to hospitalize a patient overnight just to receive "credit."

However, the exclusion of one-day stays may unduly penalize plans which efficiently manage the delivery of health care. This is because effective care management tend to reduce stays to one day which might otherwise be two or more day stays. Since those stays would then be excluded from the risk adjustment process, this would penalizing plans for their efficiency.

According to the report from Health Economics Research (HER), which assisted HCFA in designing the PIP-DCGs, excluding one-day stays reduces the predictive power of the health status risk adjustment methodology. Also, it might be noted that excluding one-day hospitalizations shifts the issue of "gaming" from whether to hospitalize someone at all to a question of whether to keep the patient for a second hospital day.

The work group suspects that the disadvantages of excluding one-day hospitalizations may outweigh any possible gain. It would be appropriate to analyze the risk adjustment methodology based on whether it is easier to "game" admissions or to "game" length of stay and any resulting adverse incentives for health plans.

HCFA may want to consider either using one-day stays as part of the risk adjustment formula or giving a partial credit or other adjustments for those hospitalizations in structuring payments to health plans.

Principal Diagnosis: The PIP-DCG model measures conditions by capturing the principal diagnosis recorded on each inpatient claim. The use of the principal diagnosis for the PIP-DCG model is based on existing coding practices for inpatient claims used by hospitals. Since only the principal diagnosis is generally used, it is possible that not all appropriate information is collected or used. A qualifying condition could be listed as the secondary (or other) diagnosis, which could be a contributing factor leading to the need for hospitalization.

Alternately, there is a common belief that many secondary conditions currently reported are not as reliable and should not be included in the measurement system. Since the initial stages of the risk assessment system will be using data that was recorded without the presence of direct coding incentives, it may be reasonable to use only principal diagnosis information. However, as the PIP-DCG system is implemented, the restriction to using only principal diagnostic groups should be reevaluated.

Number and Development of the PIP-DCG Groups: Health Economics Research developed the diagnostic groups using a HCFA survey of Medicare FFS data which sampled 5% of Medicare beneficiaries. The claims information for this sample fell in the two-year interval from January 1, 1995 through December 31, 1996. Beneficiaries who were not alive and enrolled in Medicare for the entire time period were excluded, as were individuals who would not have been eligible for the Medicare+Choice program for various reasons. Because of these limits, the actual

sample represents roughly a 3.5% sample. We have included some technical recommendations in our report, which can be included as HCFA revises the methodology.

Excluding Discretionary Conditions: The base cost group (those individuals who are not assigned health status risk scores) also includes Medicare beneficiaries with diagnoses that were determined by HER to be discretionary, vague, or only occasionally resulted in inpatient admissions. The exclusion of those "discretionary" conditions has the beneficial effect of reducing potential bias in the formula against Medicare+Choice health plans with well managed care delivery systems by not giving credit for discretionary admissions and by removing the incentives to hospitalize a patient for minor illness.

However, we suggest that the diagnoses included in the base cost group should be reviewed in the future as coding practices change under the PIP-DCG system. If hospitals become more aggressive in their coding in the future, the percentage of claims falling into a PIP-DCG may change and weights would need to be recalibrated, particularly if the PIP-DCG method is used beyond the currently planned three-year period.

Chemotherapy: HCFA has indicated that beneficiaries who are undergoing chemotherapy will be placed in a diagnosis category based on the patient's secondary diagnosis (most likely cancer). Since the medical conditions underlying the need for chemotherapy represent high-cost, ongoing conditions that are predictive of future medical expenses, it is appropriate that they be included in the risk assessment model. The work group believes including chemotherapy as part of the diagnosis groups will increase the ability of the methodology to predict future health care costs.

Exclusion of Indirect Medical Education Costs: The model developed by HER excludes indirect medical education (IME) costs from the Medicare FFS data used to calculate the relative weights used in this system. The IME costs are approximately two-thirds of the total graduate medical education costs currently paid through Medicare (the FFS data does include direct medical education expenses). While it is technically incorrect to include any graduate medical education costs (since medical education costs will be paid outside of the capitation rate in the future), any distortion is likely to be small. However, it is possible there will be some internal inconsistencies in the model since high-cost conditions captured in the PIP-DCGs may more likely be treated in a tertiary care or teaching hospital.

Factors for Newly Enrolled Medicare Members: HCFA decided to develop a special set of risk scores for those individuals who are eligible for Medicare for the first time and do not have any previous encounter data in the Medicare system. HCFA used FFS data to construct average expenditures for categories of newly eligible members (beneficiaries who become eligible for Medicare because of age or disability, or members who were previously eligible for coverage but deferred entry into the Medicare system). Newly eligible members will be assigned an estimated risk score based on HCFA's estimate of their predicted medical expenditures. The validity of these risk scores is unclear. The work group suggested that HCFA review its risk scores for the newly eligible once current data is available.

Additional Testing: Health Economics Research performed a number of tests on the PIP-DCG risk adjuster methodology to determine how accurately it predicts total expected medical costs. The recommendations made by HER regarding several key components of the model such as the use of inpatient data only, exclusion of one-day stays and the number of PIP-DCG groups to be used, appear to be reasonable based on the FFS data which was reviewed. While the HER report discusses potential bias against managed care organizations that deliver care more efficiently than fee for service providers, HER did not have managed care data to determine what, if any, bias exists.

HCFA has completed some preliminary testing of the potential impact of the new risk adjustment methodology on Medicare+Choice plans, including managed care organizations. In order to understand the impact of the new system on the marketplace, the work group suggests that HCFA update these tests as additional data is available, and as health plans gain more experience with the operation of the risk adjustment mechanism.

Cost-Benefit Analysis: The proposed system is relatively new and it is likely that there will be difficulties in implementation. It would be very helpful to establish more accurate estimates of the cost of implementing the PIP-DCG methodology and any modifications (such as using ambulatory data) and to determine the benefits to be derived from these systems before final decisions as to implementation are made. We suggest that consideration be given to producing a cost-benefit analysis of the PIP-DCG methodology and any subsequent modifications. The analysis should specifically include the costs incurred by health plans due to changes to the system.

Actuarial Oversight: HCFA apparently plans to conduct additional analysis of the impact of the PIP-DCG methodology on managed care plans. It is unclear what form that impact analysis will take. In addition, there is a need for continuing monitoring and testing of the system and future modifications. The work group suggests that additional actuarial review be included as the system and subsequent changes are implemented.

American Academy of Actuaries Risk Adjustors Work Group

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Chairman THOMAS. Thank you very much, Mr. Bluhm.
Ms. Newport.

**STATEMENT OF JANET G. NEWPORT, VICE PRESIDENT,
REGULATORY AFFAIRS, PACIFICARE HEALTH SYSTEMS,
SANTA ANA, CALIFORNIA; ON BEHALF OF AMERICAN
ASSOCIATION OF HEALTH PLANS**

Ms. NEWPORT. Good afternoon. Mr. Chairman, Members of the Subcommittee, I wish to thank you for the opportunity to testify on behalf of the American Association of Health Plans. I am Janet Newport, vice president of Regulatory Affairs for PacifiCare Health

Systems, which is the Nation's largest Medicare managed care program with almost 1 million members.

Millions of Medicare beneficiaries are counting on Congress, HCFA, and the plans to guarantee the future success of the Medicare+Choice Program. Medicare beneficiaries may not know much about risk adjustment or other complex policy issues. However, they know they like the Medicare+Choice plans, and they like the high quality of services, additional benefits, and low out-of-pocket costs offered by these plans.

The BBA intended to create more private health plan choices for Medicare beneficiaries. AAHP strongly supported this objective. Regrettably, the approach to implementing Medicare+Choice threatens to eliminate or reduce choices to the Medicare population.

Because the Medicare+Choice Program will serve as the foundation for future Medicare reform, we believe the success of this program is essential. Many Medicare beneficiaries are seriously concerned as they learn about the unfairness of the approach to paying for their care. Two points illustrate this unfairness.

First, over the next 5 years, Medicare+Choice payments, when measured against fee-for-service payments, will decline with each passing year. Many Medicare+Choice members live in counties where by 2004 the annual Medicare+Choice payment per person will be \$1,000 less than payment for Medicare fee-for-service beneficiaries. In many instances, the gap will be much wider.

Second, as our chart shows, HCFA's risk adjustor, combined with the indirect effect of the administration's proposed Medicare fee-for-service cuts, will cut \$1,676 from government payments for each Medicare+Choice member over the next 5 years. In contrast, Medicare fee-for-service cuts proposed in the administration's budget would equal about \$248 per person.

If the disparity between Medicare+Choice and Medicare fee-for-service payments is allowed to continue, beneficiaries will pay a price. Enrollees will lose critical benefits like pharmaceutical and end up paying higher out-of-pocket costs. Higher premiums will be particularly hard on low-income beneficiaries who rely on our plans.

Physicians and hospitals are also affected by inadequate payments to Medicare+Choice plans. Our Medicare provider networks have become fragile in some areas as payment dollars have been stretched to the limit. The risk adjustment methodology HCFA has chosen will make this problem worse. Every dollar HCFA has chosen to cut is actually a dollar that cannot be used to attract and retain the high-quality providers members expect and deserve.

We have serious concerns relating to HCFA's risk adjustor. This methodology would impose significant cuts at the expense of Medicare+Choice enrollees, an additional \$11.2 billion over the next 5 years. These administratively imposed cuts reflect a 50-percent increase over the \$22 billion in cuts enacted by the BBA.

Had HCFA followed through with full and immediate implementation of this methodology, the cuts shouldered by Medicare+Choice enrollees would have accounted for one-third of the total Medicare cuts achieved by the BBA, even though these enrollees accounted for only 14 percent of all the beneficiaries. Clearly, it was not Congress' intent to cut that much out of Medicare+Choice.

HCFA's risk adjustor reflects a strong bias against managed care. It penalizes the basic principle of managed care; keeping people healthy and avoiding unnecessary hospital admissions.

For example, consider diabetes, a highly manageable disease. We actively manage our diabetes patients to keep them out of the hospital. The same patient in fee-for-service may experience multiple hospitalizations. Our beneficiary with the same chronic condition is considered healthy.

The American Academy of Actuaries has cautioned that reliance on inpatient or hospitalization data and the exclusion of 1-day hospital stays will result in a distorted picture of beneficiaries' health, causing certain Medicare+Choice enrollees to appear healthier than they actually are. We have serious concerns about the administrative feasibility of implementing a new risk adjustment system by January 1, 2000.

With respect to QISMC, Quality Improvement System for Managed Care, we are concerned that the program as currently structured does not recognize the importance of coordinating HCFA's quality oversight standards with existing private and public accrediting programs. The process should be established for using private sector standards to deem Medicare+Choice plans to be in compliance with HCFA's requirements.

Finally, we believe it is unfair to require Medicare+Choice enrollees, who account for about 15 percent of Medicare, to shoulder 100 percent of the cost of the Medicare beneficiary information campaign. Mismanagement of this campaign has been a significant problem. Last year, in every PacifiCare market, there were errors in HCFA's brochure.

Thank you.

[The prepared statement follows:]

Statement of Janet G. Newport, Vice President, Regulatory Affairs, PacifiCare Health Systems, Santa Ana, California; on Behalf of American Association of Health Plans

I. INTRODUCTION

Mr. Chairman and members of the Subcommittee, 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 Affairs¹ 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 the Health Care Financing Administration's (HCFA) implementation of the Medicare+Choice provisions of the Balanced Budget Act of 1997 (BBA).

When passed by Congress, the goal of the BBA was to expand on the successful Medicare HMO program and to provide for additional private sector options for beneficiaries while allowing the program to expand into other parts of 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 million beneficiaries are enrolled in health plans, up from 6.2 percent five years ago.²

¹Ms. Newport also serves as a commissioner on the Medicare Payment Advisory Commission.

²Includes enrollees in risk, cost, and HCPP contractors.

The transition from Medicare's risk contracting program to the Medicare+Choice program has not been without difficulties. As the Medicare+Choice program has been implemented, the result has been unintended negative consequences for beneficiaries and the health plans that serve them. Last year, health plans holding nearly 100 Medicare contracts reluctantly reduced their service areas or withdrew from the Medicare program largely because of the combination of reduced payments and the significant administrative burden of the many new regulatory requirements under the Medicare+Choice program. These decisions resulted in disruptions in care and a loss of benefits and increased out-of-pocket costs for more than 440,000 Medicare beneficiaries. Of these beneficiaries, 50,000 were left with no choice but to return to the traditional fee-for-service program. HCFA's decision to proceed with phased-in deep cuts under its new risk adjustment methodology will further contribute to the program's instability and penalize beneficiaries who have chosen to join Medicare+Choice plans.

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. However, it is critical to place the program on a stable and predictable footing so that beneficiaries enrolled in the Medicare+Choice program can continue to receive the high quality services, benefits, and lower cost sharing that they have come to rely on. This statement examines three areas of Medicare+Choice implementation: 1) the proposed new risk adjustment method; 2) dissemination of health plan information to seniors; and 3) new plan requirements for quality measurement.

II. RISK ADJUSTMENT

The risk adjuster proposed by HCFA threatens the stability of the Medicare+Choice program in two ways: 1) by exacerbating the cumulative impact of payment reductions to Medicare+Choice plans; and 2) by creating unworkable and burdensome administrative processes that increase plan costs and raise the likelihood of inaccurate payment. Taken together, these problems will widen the growing disparity between payment to Medicare+Choice plans and reimbursement under fee-for-service. In addition, these problems will make it difficult for Medicare+Choice plans to operate in certain markets and to maintain the level of benefits and services to which beneficiaries have become accustomed. It is unrealistic for HCFA or Congress to assume that a disparity of this magnitude will have no adverse impact on providers, delivery of services, or health care options for seniors.

On January 15th, HCFA announced its new methodology for adjusting Medicare+Choice payment rates to reflect the health status of individual Medicare beneficiaries. AAHP has serious concerns about the impact of HCFA's new risk adjustment methodology on Medicare beneficiaries, as well as on Medicare+Choice participating organizations and their providers. Under HCFA's new methodology, between 2000 and 2003, Medicare+Choice payments will be based on a blend of rates adjusted for demographic characteristics only and rates adjusted for health status as well as demographic factors. During this period, the portion of the payment rate that reflects health status adjustment will be calculated under a model that uses only inpatient hospital data. The phase-in will be completed in 2004 when Medicare+Choice payments will be risk-adjusted using full encounter data—not just inpatient hospital data.

According to HCFA, fully implementing the PIP-DCG risk adjustment methodology in 2000—without using any transition period—would have resulted in \$15.7 billion in cuts over a five-year period. These reductions would have accounted for 71 percent of the \$22 billion savings that Congress anticipated from the Medicare+Choice program enacted in 1997. With the transition period proposed by HCFA, aggregate payments to Medicare+Choice organizations will be cut \$11.2 billion over a five-year period. This is an administratively imposed 50 percent increase in the \$22 billion savings Congress anticipated from the BBA payment methodology. Congress did not anticipate this level of savings from the risk adjuster when the BBA was enacted. In fact, the Congressional Budget Office did not score the risk adjustment provision in the BBA. As discussed in our recommendations below, AAHP strongly believes the new risk adjustment methodology should be budget neutral to ensure that it does not reduce aggregate funding of the Medicare+Choice program. HCFA projects that, when fully implemented, its proposed risk adjuster will cut payments, on average, by a further 7.0 percent. HCFA's own data show that

only 5 to 6 plans³ will receive increased payments as a result of the new risk adjustment methodology.

The BBA required that HCFA have its risk adjustment method evaluated by an outside, independent actuary. In response to this mandate, the American Academy of Actuaries Risk Adjustor Work Group conducted an analysis of HCFA's new health status risk adjustment methodology.⁴ The Academy issued only a "qualified review" of HCFA's methodology, which is significant because it means that the Academy was unable to analyze HCFA's methodology fully due to incomplete available data and information (p.4). In other words, the Academy was unable to replicate HCFA's approach and expressed "serious concerns" about the method's "implementation, operation and impact" (p.3). AAHP believes, and the Academy's report confirms, that the design of HCFA's risk adjustment methodology results in a bias against managed care due to the system's exclusion of one-day hospital stays and its reliance on inpatient-only hospital utilization data. Additionally, according to the Academy report, health plans could be underpaid if claims are "denied due to edits, or get caught in a data processing bottleneck" (p.27).

At PacifiCare, we have experienced problems with HCFA's ability to process our claims in an accurate and timely manner. While PacifiCare, like all plans, has faced challenges, particularly since the system relies on the reporting of retroactive data, HCFA's internal systems issues have been a more significant factor in slowing the establishment of the database necessary for risk adjustment. In addition, HCFA has admitted to errors in their estimates of our plans' average risk adjustment factors and has urged us to rely on our own estimates to determine next year's benefits. In order to prepare our adjusted community rate proposals, through which we determine the benefits we will offer and the premiums we will charge to beneficiaries, we must have accurate estimates of our plans' average risk adjustment factors from HCFA. Without such information, our own estimates may not be accurate and have the potential to translate into decreased benefits for the many beneficiaries that PacifiCare serves. Furthermore, as a requirement of the BBA, we must attest to the accuracy of our adjusted community rate proposal. This will be difficult to do without the assurance from HCFA that the data provided to us and which serves as the foundation for the ACR are accurate.

The initial use of a risk adjuster based solely on hospital inpatient data penalizes health plans that use disease management or other care management programs designed to reduce hospitalizations for chronically ill and other patients who would have otherwise been treated in inpatient settings. These programs are designed to provide superior quality care while preventing costly hospitalizations by treating patients in alternative settings. The Academy of Actuaries identifies "several drawbacks" to a risk adjustment system that uses only inpatient data, noting that "health plans which use outpatient alternatives to hospitalization would be financially penalized" (p.10, p.19). The Academy also notes "many observers recognize that using only inpatient data in the PIP-DCG risk adjustment model may result in a bias toward the FFS system" (p.30). Since the PIP-DCG method is restricted to inpatient claims, beneficiaries enrolled in health plans may appear healthier than they actually are because of the limits of what HCFA's new risk adjustment method can measure.

HCFA's decision not to count diagnoses related to one-day hospital stays in the risk adjustment formula reduces payment for health plan members. We believe that Medicare+Choice organizations have a higher proportion of one-day hospital stays than occurs in the fee-for-service Medicare program and that more of these stays involve diagnoses for which hospitalization is the common course of treatment. In its report, the Academy of Actuaries warns "this limitation could penalize efficient plans enough to make them leave the Medicare market" (p.19). The Academy also notes that excluding one-day stays reduces the predictive power of risk adjustment. The Academy concludes, "the disadvantages of excluding one-day hospitalizations may outweigh any possible gains" (p.13).

The Academy's report questions the administrative feasibility of implementing the new risk adjustment system given the timing and data collection challenges involved, some of which we have identified above. The Academy notes that other programs have had difficulty implementing the PIP-DCG method due to data collection problems and administrative challenges. Many of these programs conducted extensive simulations prior to implementation of risk adjustment including the Health In-

³ Out of 195 plans that submitted substantially complete data for the base period July 1, 1997 to June 30, 1998.

⁴ American Academy of Actuaries Risk Adjustor Work Group, *Actuarial Review of the Health Status Risk Adjustor Methodology*, January 14, 1999.

insurance Plan of California (HIPC), which conducted a one year test prior to the start of the program.

AAHP recommends the following with regard to implementation of the new risk adjustment methodology:

- The new risk adjustment methodology should be budget neutral to ensure that it does not reduce aggregate funding of the Medicare+Choice program.
- Payments to Medicare+Choice organizations should not be based on a new risk adjustment mechanism until, at the earliest, January 1, 2001.
- In the meantime, HCFA should redesign the new risk adjustment method to eliminate serious inaccuracies with the data and the methodology itself.
- HCFA should also move forward with the calculations and data collection initiatives that are necessary to support implementation of the model and allow simulations of its impact.

This additional time will provide an opportunity for Medicare+Choice organizations and HCFA to gauge more reliably the potential impact of the PIP-DCG model on health plan payments and the benefits and premiums offered to Medicare beneficiaries. Postponing implementation of the PIP-DCG model will also provide an opportunity to resolve numerous significant outstanding issues with the model and complete the data submission and processing that are necessary to support it.

III. BENEFICIARY INFORMATION AND EDUCATION

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 Web site, 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.

We urge HCFA to revisit its plans for the 1999 beneficiary education campaign and ensure that it provides beneficiaries with information that will educate, not confuse. HCFA's 1998 beneficiary information and education campaign experienced numerous problems that confused beneficiaries and hindered access to the new Medicare+Choice program.

- In Omaha, Nebraska, Baltimore, Maryland and West Virginia, the Spanish language brochures were sent to areas with no Spanish-speaking population.
- In Eastern Washington and parts of Florida, the brochures were mailed with a statement that the information presented is incorrect and that the beneficiaries should call a toll-free number if they have any questions.
- The toll-free call centers were expected to receive 15,000 calls per week per center. However, during the month of November 1998, the total number of calls received by all centers was only 9,400. Most of the calls regarded HCFA's mistake in sending Spanish language brochures, and requests for additional brochures.

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 percent of the cost of the information campaign.⁵ Requiring health plans and their members to bear 100 percent of the burden of this fee directly affects the premiums and benefits that plans can offer to their 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 also are concerned about the costs of the education campaign that HCFA intends to implement. Congress appropriated \$95 million for these activities in FY 1998, less than one half of the \$200 million allowed by the BBA. In FY 1999, HCFA requested the full \$150 million allowed by the BBA, and Congress again approved only \$95 million. The President's proposed FY2000 budget requests that Congress appropriate \$150 million, \$50 million more than the amount allowed by the BBA. In addition, the President's budget calls for a series of new user fees to generate an additional \$194.5 million. Of these proposed new user fees, which also would apply to fee-for-service providers, \$36.7 million would be levied on Medicare+Choice plans to support HCFA's application and renewal processing activities. At a time of

⁵ Includes enrollees in risk contracts only.

growing instability in the Medicare+Choice program, we are concerned that these user fees set a dangerous precedent and translate into reduced choices for beneficiaries.

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. QUALITY IMPROVEMENT SYSTEM FOR MANAGED CARE

One area of significant concern to our member plans is HCFA's Quality Improvement System for Managed Care (QISMC). 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 implementation. We urge HCFA to engage in 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. Furthermore, we are also concerned that the Medicare program is not providing equal attention to the overall quality of care furnished under the fee-for-service program.

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 an entirely new system of requirements. This adds to administrative cost while actually detracting from health care quality improvement. Additional concerns expressed by AAHP members include:

- QISMC fails to establish realistic goals for health plan activities and performance that take into consideration available resources and health plan responsibilities for the delivery of quality care to beneficiaries. The significant additional resources that would be required to meet the new QISMC standards and the prescriptive nature of the QISMC standards would seriously hinder health plan pursuit of quality improvement projects focused on the needs of their enrolled Medicare and Medicaid beneficiaries.

- Far more consideration should be given to standards that would be applicable to all types of Medicare+Choice plans. While QISMC requirements are modeled after a health plan using the primary care gatekeeper model, organizations participating in the Medicare+Choice program will have many different structures.

- In establishing goals for health plan performance, QISMC lacks recognition of differing characteristics of Medicare and Medicaid beneficiaries and the programs and policies under which they receive health care.

- We have urged HCFA to engage in an intensive dialogue with health plans contracting under the Medicare and Medicaid programs to permit full consideration of their serious outstanding concerns about the draft QISMC standards and guidelines. We are eager to work collaboratively with HCFA to develop an approach to future health plan quality oversight activities under Medicare and Medicaid that is responsive to the interests of beneficiaries, health plans, and federal and state responsibilities under the Medicare and Medicaid programs.

As the Committee considers reforms to the Medicare+Choice program, we encourage you to examine the experience of our member plans in implementing quality initiatives such as QISMC. As numerous studies demonstrate, health plans provide high quality care. In recent years, private sector quality initiatives have provided the leadership in this area. We are concerned that government programs are not adequately recognizing these initiatives and coordinating better with them.

V. CONCLUSION

Health plans have valuable experience to share with Congress and HCFA on implementation of many of the provisions of the Balanced Budget Act of 1997. AAHP appreciates this opportunity to comment on the Medicare+Choice program and its implementation to date. We urge you to undertake mid-course corrections to implementation of the Medicare+Choice program to ensure the program's future stability.

We look forward to continuing to work with members of the Subcommittee, other members of Congress, and HCFA to ensure the successful implementation of the Medicare+Choice program.

Chairman THOMAS. Thank you very much, Ms. Newport.
Dr. Harmon-Weiss.

STATEMENT OF SANDRA HARMON-WEISS, M.D., VICE PRESIDENT AND HEAD, GOVERNMENT PROGRAMS, AETNA U.S. HEALTHCARE, BLUE BELL, PENNSYLVANIA; ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA

Dr. HARMON-WEISS. Mr. Chairman, Members of the Subcommittee, I am Dr. Sandra Harmon-Weiss, vice president and head of government programs for Aetna U.S. Healthcare.

My company is one of the Nation's leading health benefits companies and has 5,000,000 members covered in their managed care plans nationwide. Aetna U.S. Healthcare has 18 Medicare+Choice plans, which provide coverage for quality comprehensive care for more than 530,000 Medicare beneficiaries in 16 States.

I am testifying today on behalf of the Health Insurance Association of America, HIAA, a prominent trade association of 265 member health care companies and insurers, including companies that currently serve Medicare+Choice beneficiaries, companies who are considering offering new Medicare+Choice options, and companies that offer Medicare supplemental insurance.

I am pleased to have the opportunity to discuss the implementation of the Medicare+Choice Program with you and to share a few of our principal concerns. HIAA believes the central purpose of the Medicare+Choice is to restructure the Medicare managed care program in order to deliver high quality, cost-effective health care services to Medicare beneficiaries through a broad array of private health plans. We support this goal.

In the next few minutes, I would like to focus on several fundamental concerns, namely the adequacy of payment rates to health plans and the proposed risk adjustment methodology.

The limits on the annual increases in capitation rates to plans pose a threat for the continued success of the Medicare+Choice Program. The program rules must allow payment rates that recognize and adjust for the actual cost of providing health care and complying with the increased administrative burdens stemming from BBA.

The payment methodology option of a blended capitation rate, a minimum county rate or a 2-percent increase in the AAPCC rates do not meet the current threshold of medical expenses in 1999, which are expected to increase in the range of 7 to 10 percent for a comprehensive benefit package.

The practical result, based upon the Medicare+Choice enrollment, is that organizations serving a majority of Medicare beneficiaries receive rate increases at a minimum of 2 percent or only slightly more. The impact is illustrated on these charts.

HIAA suggests that the annual increase in Medicare+Choice payment rates be sufficient to cover medical inflation experienced in local markets for basic Medicare benefits.

The new risk adjustment methodology will substantially reduce payments to Medicare+Choice organizations. HCFA recently released data on the estimated impact of the risk adjustor on health plans as proposed for year 2000 that is with only a 10-percent risk-adjusted rate and a 90-percent demographic rate. The net impact is an estimated reduction in payment of approximately 1 percent for health plans in the year 2000.

The risk adjustor is based upon inpatient hospital encounter data projected on a model based on fee-for-service experience in 1995. The model is not reflective of the current managed care experience in providing access to the most appropriate care in the most appropriate setting.

HIAA urges Congress to delay the risk adjustor beyond January 1, 2000, to allow additional study, to allow collection of a broader data set, including outpatient encounters, to more fully adjust for health status of beneficiaries. At a minimum, HIAA encourages Congress to direct HCFA to conduct a demonstration project to validate the proposed methodology.

HIAA believes that quality standards are important for any market-based approach to Medicare. It is necessary to measure the quality of services provided to Medicare beneficiaries in both managed care and fee-for-service.

QISMC introduces an ambitious and comprehensive approach to quality improvement for Medicare and Medicaid. HCFA has worked collaboratively with the health care industry to initiate quality improvement studies in a well-defined manner, linked with the efforts of the peer review organizations. The quality improvement efforts are focused on chronic disease and, with additional guidance which is needed from HCFA, should yield useful information on the management of conditions common to Medicare beneficiaries, thus improving health status overall.

QISMC includes a provision that Medicare+Choice organizations may be deemed to meet quality assessment and performance improvement requirements if judged to do so by an independent external review organization approved by HCFA. This approach has much merit for consistency in quality improvement standards.

HIAA encourages HCFA to move forward promptly with the implementation of this deemed status process. Many Medicare+Choice organizations like Aetna U.S. Healthcare meet the rigorous quality improvement requirements set forth by NCQA for full accreditation and welcome consistency of standards and encourage the deeming effort that the QISMC offers.

A consumer-oriented infrastructure for Medicare beneficiaries is imperative to the success of the Medicare+Choice Program. Funding of the information campaign solely by Medicare+Choice organizations needs further consideration.

In closing, let me stress that we believe the Congress, HCFA, and HIAA member companies share a common goal, the successful implementation of Medicare+Choice. Aetna U.S. Healthcare's goal is to provide access to comprehensive quality care for Medicare beneficiaries at an affordable premium. We feel the prospect for success will be greatly improved if there are adjustments to the payment structure—

Chairman THOMAS. Doctor, we have a vote going on, and we are losing time.

Dr. HARMON-WEISS. OK.

Chairman THOMAS. You have a chart up there.

Dr. HARMON-WEISS. Yes.

Chairman THOMAS. Can you wrap it up, please?

Dr. HARMON-WEISS. Yes, I can.

I appreciate being able to appear before you with these remarks, and certainly now that the Medicare Commission has defined for all of us the challenges that lie ahead for Medicare and failed to recommend to Congress a plan to restructure and privatize Medicare, I want to take this opportunity to offer our assistance in seeking long-term solutions.

I will be happy to answer any questions the panel might have. [The prepared statement follows:]

Statement of Sandra Harmon-Weiss, M.D., Vice President and Head, Government Programs, Aetna U.S. Healthcare, Blue Bell, Pennsylvania; on Behalf of Health Insurance Association of America

Mr. Chairman and members of the Committee, I am Dr. Sandra Harmon-Weiss, Vice President and Head of Government Programs of Aetna U.S. Healthcare. I am testifying today on behalf of the Health Insurance Association of America ("HIAA"). As the preeminent health insurance trade association, HIAA is the principal voice of the broadest spectrum of the health insurance industry. HIAA represents over 265 members that include commercial insurers, health maintenance, preferred provider and managed care organizations and businesses that provide products and services to the health insurance industry. Together, HIAA members provide health, long-term care, supplemental, and disability income insurance coverage to more than 110 million Americans. Association members include companies currently serving as Medicare+Choice managed care contractors, companies who are considering offering new Medicare+Choice options, and companies that have recently withdrawn from the Medicare+Choice program, giving us a unique perspective on the issues under review by this Committee. Aetna U.S. Healthcare offers 18 Medicare+Choice plans (under 15 Medicare+Choice contracts) which serve 530,000 Medicare beneficiaries in 16 states.

I am pleased to have this opportunity to discuss the implementation of the Medicare+Choice program with you and to share a few of our principle concerns. HIAA and Aetna U.S. Healthcare believe that the Medicare+Choice program represents an essential component in the government's effort to ensure the financial survival of the Medicare program and to meet the health care needs of the baby boom generation as we move into the 21st Century. HIAA applauds the Health Subcommittee of the Ways and Means Committee for its role in shaping these bold Medicare reforms through the Balanced Budget Act of 1997. Recent developments, however, suggest that the Committee's work is not yet done. To ensure the promise of the reform, and to facilitate beneficiary choice under the Medicare program, additional legislative and policy modifications must be made.

CONCERNS ABOUT LOW ANTICIPATED MEDICARE+CHOICE ORGANIZATION PAYMENT RATE INCREASES.

Limits on Annual Increases in Capitation Rates and Concerns Regarding the New Proposed Risk Adjustment Methodology Threaten the Continued Attractiveness of the Medicare+Choice Program to Beneficiaries and Providers.

a. Most Plans Will Experience Cost Increases From Medical Inflation That Exceed Payment Increases During the Coming Year. Perhaps the greatest threat to the success of the Medicare+Choice program is the collective impact of changes in Medicare's payment methodology enacted by the BBA. In order to achieve a successful partnership between the federal government and Medicare+Choice organizations, program rules must: (1) allow payment rates that recognize and adjust for the actual costs of covering quality health care services and complying with the increased administrative burdens imposed by the BBA, and permit necessary investment in clinical and operational improvements, and (2) incorporate financial incentives to reward those Medicare+Choice organizations that achieve the government's economic, quality and operational objectives.

As set forth in Section 1853(c) of the BBA, Medicare+Choice organizations will be paid the greater of:

(a) a blended capitation rate, which is the sum of a percentage of the area-specific capitation rate and a percentage of the national Medicare+Choice capitation rate (the percentage balance will change over time until it reaches a 50/50 blend in 2002); or

(b) a minimum amount, which is \$401.61 per enrollee per month in 2000; or

(c) a minimum percentage increase equal to an increase of 2 percent of the 1997 Adjusted Average Per Capita Cost rate for the particular county for 1998, with increases of 2 percent in each subsequent year.

Due to a budget neutrality requirement, the blended capitation rate was not available in 1998 or 1999. The Health Care Financing Administration (HCFA) has announced, however, that the blend will apply to 63 percent of counties in the year 2000. While the majority of counties will receive blended payments, it is HIAA's understanding that approximately 27 percent of counties will continue to receive the floor amount and 10 percent of counties will receive the minimum two percent increase.

The practical result, based on actual Medicare+Choice enrollment, is that Medicare+Choice organizations serving a majority of Medicare beneficiaries enrolled in such organizations will receive rate increases of the minimum 2 percent or only slightly more. For most—if not all—of these organizations, this increase would not be sufficient to cover the increased cost of covering mandated services, given projected medical inflation.¹ This, combined with the fact that many Medicare+Choice organizations experienced significant losses in 1998 (and anticipate additional losses in 1999), forecasts trouble for the program.

Indeed, inadequate reimbursement rates for 1999 largely were responsible for the retrenchment of Medicare+Choice plans last fall. At that time, some of the most respected Medicare+Choice organizations in the country withdrew from states and counties with low capitation rates. Other withdrawals occurred in low enrollment areas even though capitation rates were above average. As reported, 45 health plans decided to withdraw from the Medicare+Choice program and 55 plans decided to cut back their coverage area. In all, about 400,000 Medicare beneficiaries were effected. To put this in perspective, HCFA averaged two Medicare risk contract cancellations per year from 1993 through 1997.

The use of the blended rate for some Medicare+Choice plans for the first time in 2000 is clearly a step in the right direction in terms of ensuring fair and adequate reimbursement. However, HIAA strongly believes that additional adjustments are necessary to attract and maintain the number and diversity of Medicare+Choice organizations necessary to establish a sound and attractive market-based alternative to the traditional fee-for-service program.

Accordingly, HIAA urges Congress to reconsider the artificial and arbitrary limits on capitation rate increases set forth in the BBA.² Specifically, HIAA suggests that annual increases in Medicare+Choice payment rates be sufficient to fully cover medical inflation experienced in the local markets. Because local employer health plans and other commercial customers have a tremendous incentive to keep costs down, they will positively affect the inflation rate in each market. If the current reimbursement structure is not adjusted, more Medicare+Choice organizations are likely to withdraw from areas served and beneficiaries enrolled in the remaining plans will likely experience premium increases or reduced benefits. Finally, as Medicare+Choice plans leave the market, the original Medicare program (with its higher per capita costs) will have more beneficiaries and put additional strain on both the Part A Trust Fund and the budget.

b. The New Risk Adjustment Methodology Will Substantially Reduce Payments to Medicare+Choice Organizations. Change in the Medicare+Choice payment calculations is all the more necessary because the risk adjustment process which HCFA is implementing will substantially reduce aggregate payments to Medicare+Choice

¹ The budget for fiscal year 2000 includes funding for original fee-for-service Medicare that reflects anticipated increases in medical costs over a five year period of 27% and an increase in the Federal Employee Health Benefit Program of about 50%. Estimates of the likely growth for Medicare+Choice plan payments in high paying counties for the same period is less than 10%.

² In addition to the 5-percent reduction in payment from fee-for-service costs which existed prior to the BBA, the increase in payment to Medicare+Choice organizations under both the blended rate and the floor will not fully reflect anticipated medical inflation. A reduction of 0.8 percent was made in 1998 and reductions of 0.5 percent are to be included in 1999 through 2002. The cumulative effect of these reductions will be that even the blended rate adjustment will be inadequate. This, coupled with the insufficient increases in the minimum rate, will undermine Congressional intent to encourage growth of Medicare+Choice options for seniors in low cost areas.

plans while adding additional administrative requirements and expenses. According to preliminary HCFA estimates, total Medicare+Choice plan revenues for the year 2000 are projected to be \$200 million less than they would have been under the Adjusted Average Per Capita Cost ("AAPCC") payment method and \$6.3 billion less in 2004. As a result, some plans will see even their minimum two percent increase eroded in 2000 as the risk adjustment methodology is phased in. Thus, what began as a well-intended effort to compensate plans for the health care costs of their particular members will, in reality, result in an overall reduction in funds to Medicare+Choice organizations.

This development runs counter to HIAA's understanding of Congressional intent, i.e., that the savings resulting from the percentage reduction in plan payments for years 1998 through 2002 was intended to be *in lieu of* any net program savings from risk adjustment. (Indeed, the Congressional Budget Office did not score any projected savings in connection with the risk adjustment program under BBA 97). The new methodology, and huge projected revenue reductions, underscores HIAA's concerns regarding the inadequacy of plan payments under Medicare+Choice. To the extent that the proposed HCFA risk adjustment methodology translates into a significant overall decrease in payments for the Medicare+Choice program, it will undoubtedly be an additional deterrent to program participation. Accordingly, HIAA urges Congress to require HCFA to modify the risk adjustment methodology so that aggregate payments to Medicare+Choice plans for 2000 and beyond are based on aggregate BBA adjustments, making the risk adjustment process budget neutral.

c. The User-Fee "Tax" on Medicare+Choice Organizations for Beneficiary Education is Inequitable and Reduces Even Further Payments to Medicare+Choice Organizations. HIAA strongly supports educating and informing Medicare beneficiaries about all coverage options, including the Medicare+Choice program, and supplying beneficiaries with straightforward, unbiased information to help them choose appropriate coverage. That said, we are concerned that the BBA, to support beneficiary education activities for *all* 37 million beneficiaries, places a "user fee tax" on Medicare+Choice organizations only.³ The educational campaign is a benefit to all Medicare beneficiaries. Indeed, initial information suggests that the toll-free number HCFA established last year with funds from the \$95 million dollar "tax" assessed upon Medicare+Choice organizations primarily fielded calls from beneficiaries seeking information about the *fee-for-service* program. Considerations of equity dictate that the educational program—which informs beneficiaries about basic program benefits and requirements—be funded from the Medicare trust fund, or another broad-based source of revenue, as are other such essential program functions.

This user fee tax equals .355% of the total monthly payments to each Medicare+Choice plan in 1999. The detrimental impact of the user fee tax would be magnified under the Administration's recent Budget proposal, which would boost the authorization by 50% (to \$150 million in Fiscal Year 2000), and which would add another type of user fee (estimated at \$37 million in Fiscal Year 2000) to cover the cost of reviewing initial M+C organization applications and renewing annual contracts.

We note that this tax further exacerbates the problems outlined above concerning inadequate reimbursement. Indeed, when the user fee tax is combined with the large revenue reductions due to adjustment, some existing Medicare+Choice plans will see little or no increase in their payment rates from 1999 to 2000 even though HCFA is using a phase-in of an interim risk-adjustment methodology.

In your district, Chairman Thomas, there were 33,527 beneficiaries enrolled in Medicare risk plans in 1997 (or 29.1% percent of Medicare beneficiaries). We project⁴ that by 2003, Medicare+Choice plans will receive only 53.3% percent of the projected per capita increase in Medicare fee-for-service costs. We also project an increase in the 65+ population from 103,296 in 1998 to 117,030 in 2003. If Medicare+Choice options are withdrawn or have less perceived value by then, a reduction of Medicare+Choice enrollment to 75 percent of existing numbers would reduce the savings from BBA for 2003 by \$14.6 million⁵ from your district alone.

In your district, Representative Stark, there were 137,276 beneficiaries enrolled in Medicare risk plans in 1997 (or 41.9% percent of Medicare beneficiaries). We

³ Medicare+Choice organizations essentially pay a "head tax" (i.e., an amount based on the number of Medicare+Choice enrollees in their plan) to support the public information program.

⁴ Our projections of the change from 1997 to 2003 utilize September 1998 enrollment figures, a 1998 Price Waterhouse report on Medicare Capitated Payments, and reflect HCFA's assumption for the average cost to Medicare+Choice organizations of risk adjustment.

⁵ Lost savings, based on the difference in projected per capita payments to HCFA vs. Medicare+Choice, multiplied by the potential Medicare+Choice enrollment less 75 percent of current enrollment.

project that by 2003 Medicare+Choice plans will receive only 46.2% percent of the projected per capita increase in Medicare fee-for-service costs. We also project an increase in the 65+ population from 312,704 in 1998 to 351,438 in 2003. If Medicare+Choice options are withdrawn or have less perceived value by then, a reduction of Medicare+Choice enrollment to 75 percent of existing numbers would reduce the savings from BBA for 2003 by \$72.8 million from your district alone.

Overall, over the period 1997 to 2003, the per capita increase in payments to Medicare+Choice plans will average only 49.5% of the expected per capita increase in costs for the fee-for-service portion of Medicare. In some areas of the country, Medicare+Choice plans may get less than \$50 more per month over this entire period to deal with medical inflation.

2. The May 1 Deadline for Filing ACRs Has Created Serious Problems in the Administration of the Medicare+Choice Program and Should Be Changed to November 1. The BBA moved up the deadline by which Medicare+Choice plans must submit their adjusted community rate (ACR) proposals from November 1 to May 1. The problem with this early date is two-fold. First, by submitting proposals seven months in advance of the actual effective date (*i.e.*, January 1), plans place themselves at substantial risk that health care costs will rise in unexpected ways in the latter half of the year and thus not be captured in the proposals. This is what occurred last year, contributing to the decision by many Medicare+Choice organizations to not renew their Medicare+Choice contracts for 1999, or to reduce their service areas. Also, proposals submitted by May 1st are based on relatively limited claims experience with the Medicare beneficiary population enrolled in the more rapidly growing plans and are thus less likely to be accurate predictors of costs than proposals based on a longer period of time.

In regulations published earlier this month, HCFA "recognize[d] the difficulties inherent to estimating the cost of a benefit package for 2000 based on at most 4 months of experience under the 1999 benefit package," but indicated that it had no discretion in this matter due to the statutory mandate. The President's fiscal year 2000 budget includes a proposal that would extend the deadline for ACR submissions until July 1. HCFA strongly supports this proposal. In fact, in several recent public statements, HCFA has indicated that M+C plans should proceed assuming a July 1 due date. However, HCFA has NOT provided official notice to M+C organizations. Consequently, even today my company (Aetna U.S. Healthcare) and others are struggling to compile ACRs for the official May 1 due date. Given the importance of this issue to Medicare+Choice organizations, and the concerns involved, HIAA urges the Committee to take steps to put in place a permanent workable deadline for ACR submissions and suggests an ACR date of November 1, or as close to that date as operationally possible.

3. Congress Should Return to the Previous Policy Allowing Flexible Benefits and Premiums Within a Service Area. Historically, Medicare risk contractors were able to offer different benefit or charge structures within a given contracted service area. For example, modified benefit packages were often developed and offered in a subset of the contracted service area. While Medicare beneficiaries residing in the segmented service area were offered a uniform array of benefits at a uniform price, uniformity was not required across the entire service area. This flexibility was important because it allowed contractors to adjust their benefit package and premium structure to take into account differences in capitated payment rates received, which varied by county.

In the BBA, Congress mandated a new policy requiring that organizations offer uniform benefits and premiums throughout a service area, despite varying payment levels. Under the Medicare+Choice regulations, an organization may offer multiple plans and propose different service areas for each plan. (Were this not the case, organizations would be discouraged from expanding to outlying rural counties that typically offer lower reimbursement rates.) This regulatory policy allows Medicare+Choice organizations to achieve results similar to the original flexible benefit policy, but only at *significant* additional expense. Instead of one ACR being filed for a broad service area with benefits modified to reflect anticipated revenues, as used to be the case, multiple ACRs must be generated for separate Medicare+Choice plans by each organization, and reviewed and approved by HCFA. The Congressional mandate thus imposes significant administrative costs on the organizations and the agency, with absolutely no benefit to beneficiaries. Therefore, HIAA urges Congress to repeal the uniform benefits and premium provisions of the BBA.

IN MANY PLACES THE REGULATIONS ARE OVERLY RIGID AND DEMANDING SO THEY BECOME AN IMPEDIMENT TO ALL MEDICARE+CHOICE ORGANIZATIONS, AND ESPECIALLY FOR SMALL AND/OR RURAL MEDICARE+CHOICE PLANS

1. The Quality Assurance Approach is Misguided.

HIAA believes that some form of quality standards are important to any market-based approach to Medicare. Without quality standards, or some other performance measurement, the added costs of maintaining quality will be difficult to present fairly although over time, it will be obvious. That being said, HIAA has serious concerns about the breadth and depth of the onerous quality assessment, performance improvement and performance measurement standards developed by HCFA.

More Guidance from HCFA is Needed To Implement the Quality Improvement Program. QISMC establishes ambitious new quality improvement standards for Medicare+Choice organizations. While HCFA has scaled back their initial, overly ambitious implementation plan in response to M+C organization concerns, more guidance is needed from HCFA in several areas. For example, local Peer Review Organizations (PROs) are intended to collaborate with M+C organizations on quality improvement projects, yet the specific role of the PRO is not clear. In many cases, PRO staff will need additional training to fulfill their role.

The Extensive Data Collection Proposed Is Not Necessary. The extensive data collection and reporting efforts required under the regulations will add significant administrative costs to Medicare+Choice organization operations. We question whether these costs are justified or desirable, and whether the quality assurance goals might not be met just as well through alternative approaches. HIAA strongly believes that consumers, not government officials, should dictate through their plan choices the extent and nature of quality improvement, balanced against costs. Under this approach, organizations that are responsive to consumer preferences would be rewarded with greater market share. Fewer government resources would be required for oversight.

HCFA could, however, play a central role in ensuring that minimum standards are met and encouraging quality initiatives through flexible, incentive-based standards established by contracts. HCFA is to be congratulated for posting beneficiary satisfaction survey results and other such information on the Medicare internet site (www.medicare.gov). In HIAA's view, this would be far superior to the current practice of setting detailed regulatory mandates which run the risk of leading to micro-managing and encouraging uniformity at the price of creative experimentation.

In trying to determine the cost of the extensive data collection effort proposed, HIAA notes that many health care organizations, particularly those with loosely managed network-style delivery arrangements (such as PPOs) do not currently have the capability to capture or report performance data at the level being proposed. The BBA's limitations on increases in capitation rates means that outside sources will be required to fund system upgrades. Even if financially possible, the time required for procurement, installation, training, and validation are not consistent with HCFA's scheduled implementation and reporting requirements for Medicare+Choice plans. As a result, these quality assessment requirements will be a significant deterrent to expanding senior's choices as potential new plans decide not to participate in the Medicare+Choice program. At the very least, HIAA believes that organizations making a good faith effort to meet the regulatory requirements should be provided a transition period where penalties would not be imposed. This is particularly important given plan efforts to address Year 2000 computer issues.

The "Deemed Status" Program Should Be Implemented Immediately. Most Medicare+Choice organizations already adhere to rigorous quality assurance review by nationally accredited health care organizations such as the National Committee on Quality Assurance (NCQA), the Utilization Review Accreditation Committee (URAC), and the Joint Commission on Accreditation of Health Organizations (JCAHO). HCFA has provided by regulation that Medicare+Choice organizations may be "deemed" to meet quality assessment and performance improvement requirements if judged to do so by a national accreditation organization approved by HCFA and applying HCFA's standards for assessing compliance. This approach has much merit. It would allow plans to work with reviewers who already are familiar with their operations, creating obvious efficiencies and potential cost-savings. HCFA has failed, however, to establish procedures to implement the "deemed status" process. To date, HCFA has not designated any national accreditation organization for this purpose, nor has it issued policy guidance on how this process will work. HIAA urges Congress to direct HCFA to promptly institute a procedure for awarding deemed status since this process has the potential to reduce some of the substantial costs associated with HCFA's extensive quality assurance measures.

2. The Proposed Risk Adjustment Policy is Ill-Conceived.

On March 1, 1999, HCFA reported to Congress on its methodology for implementing the risk adjustment mandate set forth in the BBA. While HIAA believes that improved risk adjustment is an appropriate and essential long-term goal for the program, we have serious concerns regarding the current HCFA proposal, which calls for the initial use of only inpatient hospital data. During the Administration's proposed 5-year phase-in period, plans would receive capitated payments based on a blend of payment amounts under the current demographic system and the interim (PIP-DCG) risk adjustment methodology. For the year 2000, for instance, the HCFA plan calls for a separate capitated payment rate for each enrollee based 90 percent on the demographic method and 10 percent on the risk adjustment methodology.

By 2004, payment rates would be based on comprehensive risk adjustment using full (i.e., inpatient and other) encounter data and the demographic method would not be used. HCFA estimates a much greater negative impact on M+C plan revenues, on average, with the switch to full encounter data risk adjusters. HIAA's concerns with this proposal are both practical and programmatic.

First, the practical. The time frame for implementation outlined by HCFA is simply far too short. Given the significant technological considerations involved, it is unreasonable for the agency to require that all Medicare+Choice organizations be able to provide physician, outpatient hospital, skilled nursing facility and home health data beginning as early as October 1, 1999. (HCFA has not yet identified a specific date by which this information must be provided, creating additional uncertainty.) The collection, verification, transmission and analysis of "representative" encounter data is a complicated endeavor. Capturing these data in a valid, accurate and transferable manner will be a major challenge for most plans. Indeed, some HIAA member companies that currently contract with HCFA do not have the technical capability to capture and transmit encounter data other than inpatient encounters. Nor do our members with PPO and similar network-style delivery systems have the capability to do so. They are simply not organized in a manner that will allow them to collect this level of data.

Even if the capital needed for technological up-grading can be arranged, HCFA's proposed time frame is insufficient to allow Medicare+Choice organizations to procure and install the required systems. Procuring systems that can accomplish these tasks requires very careful planning and assessment, review of the capabilities of competing technologies and vendors. Time is needed to install the systems, modify provider contracts if necessary to ensure adequate reporting to the Medicare+Choice plan, train the staff (both at the Medicare+Choice organization and provider locations) and verify and validate the data. All of these steps must be carefully executed or the system will fail. These obstacles to compliance cannot simply be wished away. Moreover, the imposition of these costs on all Medicare+Choice plans will make the development of rural plans even more difficult because they will continue to have fewer beneficiaries enrolled compared to plans in other areas.

The process by which information is communicated to, and received by, HCFA is likely to present significant technological problems as well, if past experience is any guide. HIAA members have experienced, and continue to experience, problems in ensuring that accurate inpatient hospital data is transmitted via Medicare fiscal intermediaries to HCFA.

Difficulties can also be expected as HCFA attempts to manipulate significant amounts of data for the first time using the proposed PIP-DCG risk adjustment model. The methodology developed by HCFA is complicated and requires numerous steps. The process is yet untested. HCFA faces a monumental task in getting the PIP-DCG system to work. Moreover, as HCFA acknowledges, "the PIP-DCG model is [simply] an interim step towards implementation of a comprehensive risk adjustment model (i.e., one which uses diagnoses from all sites of service.)" HIAA strongly believes that the ambitious time frame proposed by the agency rests on a flawed premise: namely, that all of the anticipated technological and methodological problems can be resolved in the five-year window.

HIAA's doubts in this regard are heightened by the fact that planned implementation coincides, at least initially, with agency efforts to ensure Year 2000 readiness, both internally and in connection with Medicare+Choice organizations and other contractors. If HCFA transitions to risk adjustment before the necessary fixes are made and before reliable data are gathered and properly analyzed, the consequences could be catastrophic for individuals enrolled in Medicare+Choice plans, as well as the Medicare managed care program generally.

As if all this were not reason enough to delay implementation, HIAA has significant programmatic concerns regarding the proposed risk adjustment model. First, HIAA is concerned that variations resulting from excessive payments under the

original Medicare fee-for-service program have been incorporated into the risk adjustment calculation. Additional, unnecessary hospitalizations that have occurred within the original Medicare Part A fee-for-service program, despite HCFA's attempt to fight this, are still significant. As a result, Medicare+Choice organizations will receive lower payments through the proposed risk adjustment methodology. HCFA should not penalize the managed care portion of Medicare for the program's failure to limit false or fraudulent claims and medically unnecessary hospitalizations. One approach to avoid this, would be to limit the use of risk adjustment so that the total amount paid to all Medicare+Choice plans is not reduced but instead redistributed among Medicare+Choice plans only.

Second, recognizing the fact that most federal agencies rely on sampling, HCFA's expectation of reported data on all individuals seems excessive. Given that even the more comprehensive risk adjuster will not be able to fully reflect all differences, HIAA believes that Congress should require HCFA to reexamine the use of plan-based sampling to reduce the administrative burden on the plans, reduce the potential for errors in the start-up phases, and increase the privacy of each individual's sensitive medical information.

Third, HIAA strongly believes that it is poor public policy to base risk adjustment—even temporarily—on inpatient hospital data only. Such an approach, even with the adjustments that HCFA has made to its initial risk adjustment proposal, would reward Medicare+Choice plans that, through inferior utilization management or poorer quality, experience excessive hospital use, and penalize plans that have effectively reduced inpatient hospitalizations and focused on providing more care on an outpatient basis and improving quality through preventive care. The incentives created by a risk adjustment methodology based exclusively on inpatient hospital data would inevitably result in increased inappropriate hospital use, increased avoidable costs, and a setback in the effort to realize greater efficiency and quality in the health care system. Beneficiaries enrolled in plans with a relatively high proportion of members who receive care for expensive chronic illnesses outside the hospital setting would be particularly harmed.

For all these reasons, HIAA urges HCFA to delay the implementation date of risk adjustment beyond January 1, 2000. Since HCFA believes it does not have the authority to do this, Congress should revise the implementation date. While the effort to collect encounter data should proceed in a careful and deliberate manner, changes in payment methodology based on risk adjustment should not be implemented until complete and reliable encounter data are available. To ensure the validity of the data and a viable risk adjustment process, Congress should direct HCFA to (1) conduct a demonstration project aimed at validating the proposed methodology and (2) identify less costly and less data intensive ways of performing risk adjustment. Alternatively, the impact of the risk adjuster should be capped at a level, perhaps 1%, that would reduce the potential for perverse effects, and Medicare+Choice plan withdrawals or benefit reductions.

SUMMARY AND CONCLUSION

If the Medicare program is to be sustained for the next generation of beneficiaries and beyond, it is crucial that the federal government employ every strategy appropriate to enhance quality health care options for beneficiaries and encourage the development of lower cost options rather than relying on punitive regulations which will reduce choice and funnel more people into the highest cost option—fee-for-service Medicare. The Medicare+Choice program already is at an early crossroad where improvements can allow it to flourish but neglect of necessary change will doom it to failure. It would be more wise, in the long run, for the government to employ market-oriented strategies to ensure that there are Medicare+Choice options available to beneficiaries and to create incentives for private health insurers and providers to deliver value in the context of the Medicare program. Because it is a critical building block in this market-based strategy, Medicare+Choice must be successful.

In summary, HIAA believes that the prospects for success will be greatly improved if the following steps are taken with respect to the Medicare+Choice program:

- Adjust the payment structure so that increases cover medical inflation;
- Issue revised regulations to reduce costly administrative burdens on all M+C plans;
- Change the due date of ACRs to November 1 to eliminate unnecessary risk;
- Delay and revise the proposed risk adjustment model to reduce the cost of reporting and system development; and

- Modify the role of risk adjustment so that overall revenues to the Medicare+Choice program are not reduced, but simply reallocated among M+C plans based on the health status of enrollees.

A final word of caution: Congress must act quickly to direct HCFA to change course in the manner outlined and to find ways to reduce the regulatory burden of participating in the Medicare+Choice program if it wants the program to succeed. The time frames for critical decisions relating, for instance, to system investments are very short, particularly given HCFA's anticipated risk adjustment schedule. Thus, if Congress is to make adjustments to the program, it should act now.

Thank you, Mr. Chairman. I would be happy to answer any questions you may have at this time.

Chairman THOMAS. Thank you very much, because we are going to need a lot of help to see if this particular structure works. In fact, a number of us believe we need to look at a different structure.

I would like to ask a series of questions. Not very many; three, I think. Anybody can respond if they want to to several others, but this is directed to Mr. Francis.

I have looked at your book. I have heard it advertised, and I am glad I got it without paying for it because—although it is some money, I do not think it is a gift; I think I took it—it is very useful, and I have heard it talked about.

How many people did you have to employ to put this book together?

Mr. FRANCIS. Well, sir, I am about 90 percent of the effort personally, and I spent about 1 month of the year full time on it, some time elsewhere in the year. Checkbook puts a few people on it just, you know, things like page grouping and so on, but it is about half an FTE in Federal jargon.

Chairman THOMAS. About half an FTE and about 1 month's worth of work?

Mr. FRANCIS. Right.

Chairman THOMAS. What could you do with \$95 million? You do not need to answer that, but, boy, I would like to see you turned loose on that.

Mr. Bluhm, in your testimony regarding the proposed risk adjuster you mentioned that you have serious concerns about the method of implementation, operation, and impact.

When we tried to move the information structure to all 50 States, HCFA threw up its hands and said we just really cannot do it. Maybe we ought to do it in five and talk about a phased rollout.

What is your reaction? Should we go nationwide with this, or should we talk about maybe a phased rollin?

Mr. BLUHM. I guess there is too much of a practical nature in that question that I do not have enough data to answer it.

Chairman THOMAS. Would you get back to me in writing, because I would very much like to have that, as soon as you can?

Obviously, we are trying to risk adjust here. What is the difference between where we are and what we get with the information that we are collecting? Is it a 1-percent difference; a 5-percent difference; a 10-percent difference?

Mr. BLUHM. Between the new method and the old method?

Chairman THOMAS. Yes, in terms of the variation of individual health costs. How much can we measure? What is this bringing us in correcting the problem?

Mr. BLUHM. My understanding, we saw a list from HCFA that they had done of calculations. That was one of the things we were not able to verify, but it appeared to have some variance that on average the impact, if it were fully implemented, would be about a 7-percent reduction in payments in aggregate.

The variation, that being an average, went to 10, sometimes even 15 percent, but the larger the variation might have been happening on smaller plans, so the dollar impact might not have been that big.

Chairman THOMAS. Last question from me, and then I will turn it over to the gentleman from Washington.

You can do this in writing, Dr. Harmon-Weiss, if you want to. I am in possession of a letter from the Health Insurance Association of America in terms of its positions on the BBA, and one of them is that the annual increases in Medicare+Choice payments fully cover medical inflation experienced in local markets.

If you use as a multiplier 100 percent of the cost against the managed care cost, which is an adjusted cost, does it make sense to use the multiplier of 100 percent of the medical inflation?

Dr. HARMON-WEISS. There is medical inflation for the basic benefit package, and then there is medical inflation for the enriched benefit package that—

Chairman THOMAS. The point here is that HIAA is calling for payments that fully cover medical inflation. Where do we get the savings if you are managing the cost, if we give you the full update?

Dr. HARMON-WEISS. There are savings built into the system currently, and what we would request is that we be able to increase our rates to meet that target of medical inflation on a regular basis.

[The following was subsequently received:]

HEALTH INSURANCE ASSOCIATION OF AMERICA
555 13TH STREET, NW., SUITE 600 East
WASHINGTON, DC 20004-1109
April 13, 1999

The Honorable Bill Thomas, Chairman
Subcommittee on Health, Committee on Ways and Means
1136 Longworth House Office Building
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Thomas:

On behalf of the Health Insurance Association of America (HIAA), I wanted to follow up to your inquiry presented at the Subcommittee's March 18, 1999 hearing on the Medicare+Choice Program. You requested a written response to a question involving a statement issued by HIAA in a letter to Members of the Committee. At the hearing, you described the statement as seeking larger increases than what BBA assumes, and asked if such increases would mean that the savings assumed in BBA would not be realized.

To reiterate a central point of our testimony, HIAA is very concerned about the significant disparity in payments between Medicare+Choice and fee-for-service Medicare which will occur under the BBA Medicare+Choice payment formula. HIAA actuaries estimate that by 2003, per capita payments for beneficiaries in Medicare+Choice plans, on average, will be down to 83% of the original Medicare payment (\$616 vs. \$742). The payment disparity will be *much greater* in high cost

counties, where Medicare+Choice payments, on average, will be only 74% of original Medicare payments (\$768 vs. \$1,032). Charts illustrating these HIAA estimates are attached.

The budget savings in the Balanced Budget Act of 1997 (BBA) assumed that a significant increase in Medicare+Choice enrollment would occur. While the per capita cost of the Medicare fee-for-service program would not be affected by such growth in private plan enrollment, savings would be achieved as Medicare+Choice enrollment rose because per capita payments to Medicare+Choice plans are expected to be lower than per capita payments in the original fee-for-service program.

BBA made certain assumptions about the level of growth in private plan enrollment. Future budget projections will need to reflect differences from the BBA assumptions for the following:

- the actual rise in medical costs per capita vs. those projected in 1997;
- actual numbers in Medicare+Choice and fee-for-service vs. those projected in 1997;
- tax and budget effects of new benefits, or loss of benefits, in either Medicare+Choice or fee-for-service portions of Medicare.

HIAA's concern is that without sufficient growth in revenue, the projected levels of Medicare+Choice enrollment are unlikely to be met. This could result from some combination of beneficiary decisions not to enroll and Medicare+Choice organization decisions not to offer Medicare+Choice plans.

Without sufficient growth in revenue, Medicare+Choice plans will be forced to reduce benefits and/or increase premiums, and will eventually leave the market. In the near term, revenue constraints may squeeze out the additional benefits that most Medicare+Choice plans have been able to offer. Without the attraction of additional benefits, enrollment in Medicare+Choice plans could slow.

If federal revenues do not grow sufficiently to cover the increases in the costs of the basic Medicare benefits in some local markets, the Medicare+Choice organizations, having eliminated added benefits, could be forced to discontinue offering benefits entirely. Some Medicare+Choice organizations, as a number did in 1998, may not wait until revenues are actually insufficient. With fewer Medicare+Choice plan options available in the market, it is even more likely that the BBA projected levels of Medicare+Choice enrollment will not be met.

When Medicare+Choice plan options are reduced (or even eliminated) in particular markets, fewer beneficiaries will be in private plans and more beneficiaries will return to or stay in fee-for-service. For those, the per capita cost will not be the per capita amount that was projected to be paid under a Medicare+Choice plan. Instead, the cost will very quickly rise to the level of the average per capita in fee-for-service, where there is an incentive for over-utilization of services. This will add to federal expenditures and make meeting the BBA projections impossible without cuts in other areas.

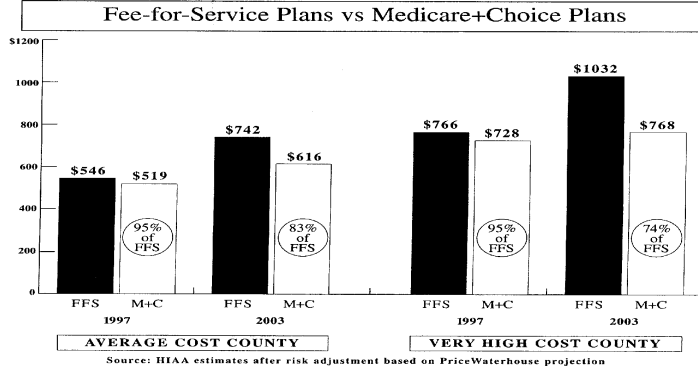
Thus, while increasing Medicare+Choice payments will not necessarily increase savings to the Medicare program, the savings assumed under the BBA will not be achieved without sufficient Medicare+Choice options, and the availability of those options depends on Medicare+Choice organizations' expectation of adequate payment levels.

I hope this clearly outlines our concerns and the rationale for our position that the revenues to Medicare+Choice organizations must increase to cover increases in medical trend of required benefits. If you have any questions, please do not hesitate to contact me.

Sincerely,

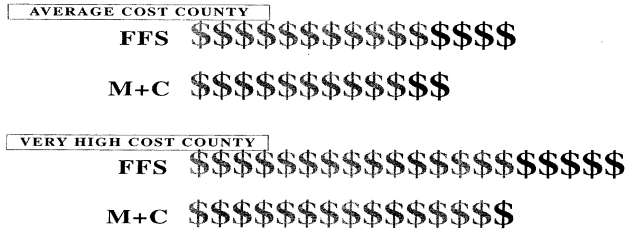
CHARLES N. KAHN III
President

Projected Payments per Medicare Enrollee



Projected Payments per Medicare Enrollee

\$ = Fifty Dollars



■ 1997 HCFA Payments ■ Additional 2003 HCFA Payments

Source: HIAA estimates after risk adjustment based on PriceWaterhouse projection



HIAA Recommendations:

- Delay risk adjustment
- Modify Medicare+Choice payments to cover medical inflation
- Reduce prescriptive regulations that increase costs and limit choice



Chairman THOMAS. OK. The gentleman from Washington.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

A couple of quick questions. Does the managed care industry support the managed—

Chairman THOMAS. I will tell the gentleman we have 7 minutes, so he has 3 or 4. If we can walk fast, he can have 5.

Mr. MCDERMOTT. Yes, thank you. Do you support the managed competition demonstrations going on in Phoenix and Kansas City?

Ms. NEWPORT. We would support the fundamental concept of testing competition. Our problem with the demonstration as we currently understand it is that it will not include fee-for-service, which we do not think is a true test of the competitive market.

Mr. MCDERMOTT. So you do not like the way they are doing it?

Ms. NEWPORT. I think you have very profound concerns, and they are doing it essentially giving us 3 months—we are in Phoenix—to put together a very significant proposal, which takes major reworking.

Mr. MCDERMOTT. Let me ask a second question. Some people think that the so-called premium support program that was talked about in the Commission would save \$65 billion by the year 2009.

Do you agree that plans would accept less under a premium support model than they already get under the Medicare+Choice Program, and do you support the premium support plan that was put out here?

Ms. NEWPORT. I would prefer, if you do not mind, I am a Medicare expert, and I followed in the press the deliberations on this bipartisan commission. If we could submit for the record something from AAHP in terms of that specific question, I would be happy to do that.

I think there were so many moving parts it is very difficult to decide what the impact would be or not.

Mr. MCDERMOTT. You do not think that you would accept less than you are already getting in Medicare+Choice though, do you?

Ms. NEWPORT. Well, I think if there were propounded decreases and the efficiencies were eroded or the protection of fee-for-service was such that we could not compete, that would obviously be a problem, but the details of the program I would not profess to make a position statement here today.

Mr. McDERMOTT. I think we would all like a letter from you telling us where you stand on the premium support program, the organization.

Ms. NEWPORT. And I think the AAHP would be happy to provide you with the statements they have made to date to your specific question.

[The following was subsequently received:]

AMERICAN ASSOCIATION OF HEALTH PLANS
1129 TWENTIETH STREET, NW, SUITE 600
WASHINGTON, DC 20036
April 9, 1999

The Honorable Jim McDermott
*1035 Longworth Building
United States House of Representatives
Washington, DC 20515*

Dear Representative McDermott:

Thanks for taking the time on a particularly busy day to meet with us to discuss Medicare. I hope as discussions begin in your committee that we might have the opportunity to share the results of our research with you and offer any appropriate technical assistance.

At the March 18 hearing by the House Ways and Means Subcommittee on Health regarding implementation of the Medicare+Choice program, you invited AAHP to share its views on the premium support model proposed by Senator Breaux during the Bipartisan Commission's deliberations. In our view, the premium contribution approach to restructuring Medicare could fundamentally change the way Medicare finances coverage to beneficiaries, offering seniors a wide variety of choices with the anticipation also of curbing long-term spending growth. While the broad outlines of an approach were laid out by the Commission, many details of the premium support model remain unresolved. Changing the Medicare program along these lines raises a number of important design issues that should be explored thoroughly before moving forward.

To that end, our members view the following principles as a starting point for discussions within Congress of a premium support approach for the Medicare program.

- Establish a Core Set of Benefits and Allow for Competition Around Additional Services. The program should require a core set of benefits, while allowing plans flexibility in offering other benefits. To help beneficiaries compare different plan offerings, benefit descriptions could be standardized.

- Government Contribution Must Be Actuarially Sound. Determining the amount of the government contribution will be a critical decision in the design of a premium support program. The level of the government's contribution should be a fixed proportion of an amount necessary to adequately meet the needs and costs of the benefits package for Medicare beneficiaries.

- Include the Fee-For-Service Program. All Medicare options, including the Medicare fee-for-service program (FFS), should be included in any premium support program.

- Let the Beneficiary Choose. The federal government's premium contribution should not vary according to the type of program or delivery system selected.

- Ensure Parity between the Fee-For-Service Program and other Models. A premium support program should ensure parity between health plan options and the fee-for-service option. There are a number of ways to ensure such parity, including a requirement that the FFS program meet the same standards, where applicable, as health plans.

- Pilot Testing and Phase-In. A premium support approach—including the traditional program—should be pilot tested on a limited basis. Subsequently, the program should be phased-in to allow time to make necessary adjustments.

AAHP and its member plans have long supported efforts to modernize Medicare and give beneficiaries more choice. Today, more than 16 percent—or 6 million bene-

ficiaries—are enrolled in health plans, up from 6.2 percent five years ago. As we testified on March 18, it is critical that Congress and the Administration act this year to address the growing disparity between Medicare fee-for-service and Medicare+Choice payments, HCFA's controversial new risk adjustment proposal, the user fee, and other issues that will have significant effects on beneficiaries who have chosen Medicare+Choice. Many of these beneficiaries cannot afford to return to the traditional program where they will pay more out of pocket and receive fewer benefits.

We look forward to continuing to work with you and other Members of Congress in addressing the challenges in the Medicare program and ensuring its viability for future generations.

Sincerely,

KAREN IGNAGNI
President and Chief Executive Officer

Mr. McDERMOTT. Mr. Chairman, I think that is probably all. We have to go vote.

Chairman THOMAS. I want to thank the panel very much. We will be back to you as we look at some of the particulars. We appreciate your willingness to help and your offer to help.

The Subcommittee stands adjourned.

[Whereupon, at 1:26 p.m., the hearing was adjourned.]

[A submission for the record follows:]

Statement of American Medical Association

The American Medical Association (AMA) appreciates the opportunity to submit this written testimony for consideration by the Ways and Means Subcommittee on Health and requests that it be included in the printed record. Our statement will focus on the Medicare+Choice program that was created under the Balanced Budget Act of 1997 (BBA) (P.L. 105-33).

The AMA represents 300,000 physicians, many of whom provide patient care under the Medicare+Choice program. The primary mission and responsibility of the AMA and the medical profession is to promote the art and science of medicine and the betterment of public health. When Congress began to seriously debate expanding Medicare choices in 1995, the AMA vigorously supported legislation that would provide Medicare patients with a wider range of health plan choices as alternatives to Medicare fee-for-service and Section 1876 plans. When the President ultimately signed the BBA into law, the AMA was pleased with the significant number of choices that could become available to Medicare patients, including Medicare+Choice coordinated care plans with a point of service (POS) option, provider sponsored organizations (PSOs), preferred provider organizations (PPOs), medical savings accounts (MSAs), and private fee-for-service (PFFS) plans.

The AMA was deeply dismayed, however, that so few PSOs, PPOs, and no MSAs or PFFSs, submitted applications to HCFA for participation in the Medicare+Choice program in 1999. We expressed this sentiment to the Health Care Financing Administration (HCFA) last September in our comments regarding HCFA's interim final rule on the Medicare+Choice program. Since our comments were submitted, matters have deteriorated for Medicare patients. At the end of last year, about 50 managed care plans that either were already participating in Medicare or had applied to become Medicare+Choice plans withdrew from the program. Another 50 plans reduced their service area. This forced nearly 450,000 Medicare patients to find new coverage, of which about 50,000 Medicare patients did not have the option of joining another Medicare+Choice plan.

While we believe that it is HCFA's duty to assure that the regulatory structure properly facilitates the development of Medicare+Choice organizations that offer quality plans to Medicare patients, we believe that Congress must provide the appropriate legislative framework to ensure that the objectives of the Medicare+Choice program are achieved. As HCFA stated in the interim final rule's preamble, the Medicare+Choice program is one of the most significant changes in the Medicare program since its inception. We agree. And Medicare patients should not be the victims of this change. Thus, we strongly encourage Congress and HCFA to consult continually with physicians, other health care professionals, and providers for input on modifying the statutory and regulatory structure of Medicare+Choice to improve

the quality of care, access, and patient protections within the Medicare+Choice program.

MEDIGAP REFORM

The AMA believes that permitting newly-eligible Medicare patients to elect and subsequently discontinue enrollment in a Medicare+Choice plan and move back into Medicare fee-for-service is a useful temporary device to protect those unfamiliar with all the features of the managed care option. In our view, however, this protection should be afforded to beneficiaries who become eligible due to a disability as well as those who gain eligibility by turning 65. We recognize that the statute specifically extended this option only to those entering the program at age 65, but we believe that Congress should now extend this patient protection to all Medicare patients.

MEDICARE+CHOICE REGULATIONS

On February 17, 1999, HCFA issued a final rule that made some changes to the Medicare+Choice regulations published in the June 26, 1998, interim final rule. In the AMA's view, this final rule significantly reduces a number of essential patient and physician protections to placate the managed care industry. For example, the final rule makes several concessions on treatment plans for Medicare patients with complex conditions so that patients' rights to see needed specialists is no longer guaranteed. Also, under the guise of protecting proprietary information, HCFA appears to be condoning a practice by Medicare+Choice plans of withholding basic information on how payments for their services are determined.

In an ideal world, physicians and patients could simply not participate in plans that refuse to provide adequate care and information. However, in reality this simply is not an option, especially as markets are increasingly dominated by a few very large plans. Also, under the current antitrust laws, physicians do not have equal bargaining power. Consequently, neither physicians nor patients can walk away from poorly-performing plans.

The AMA does not believe that vital issues such as whether patients have adequate access to specialists and whether plans have to tell physicians how they will determine payment should be decided in contract negotiations where physicians have no ability under current law to collectively bargain. *For this reason, we are opposed to legislative or regulatory initiatives that further compromise patient and physician protections under Medicare+Choice. At the same time, legislative and regulatory modifications intended to discourage managed care plans from leaving Medicare should not come at the expense of patients and physicians protections.*

PAYMENT RATES

The AMA concurs with much of the Medicare Payment Advisory Commission's (MedPAC) recent report to Congress. We have previously argued that Congress should modify the Sustainable Growth Rate expenditure target established in the BBA, and we are pleased that MedPAC echoed many of our suggestions in this area.

The Medicare+Choice plans that withdrew from Medicare last year had been guaranteed a 2% a year increase in payments while physicians are subject to an SGR formula that is expected to lead to negative updates in their fees. In fact, under recent simulations by MedPAC, the conversion factor that determines physician payment rates would drop from \$34.73 this year to \$34.50 in 2009—or by about 20% after adjusting for inflation. These new payment cuts would come on top of years of meager increases in Medicare payments. From 1992 to 1998, for example, increases in the physician conversion factor averaged just 0.8% a year or 1.6% less than inflation in physicians' costs.

Many physicians have had to adjust their practice style to cope with these constraints. However, most physicians are maintaining their commitment to their patients and continue to treat the elderly and disabled whom they see as individual patients, not just faceless enrollees tied to a particular payment amount. For Congress to now address the managed care industry's financial concerns while leaving physicians headed toward a downward payment slope would reward the plans for abandoning Medicare patients while ignoring physicians who have stood by their elderly and disabled patients even when times got tough. The AMA believes this sends the wrong message to Medicare patients and the physicians who provide their care. Thus, *we urge Congress to follow the advice of the MedPAC which is recommending no change in Medicare+Choice rates and an increase in the SGR for physician services.*

MEDICARE+CHOICE PLAN ACCOUNTABILITY

Contrary to claims made by some in the managed care industry, Medicare+Choice plans are not being held to a higher accountability standard than applies in the fee-for-service program. In fact, the AMA believes that in areas such as payment policy and time-frames, Medicare+Choice standards are not as high as those for fee-for-service. Here are a few examples:

- While the carriers that process Medicare fee-for-service claims are required to pay 95% of claims within 30 days, there are no deadlines at all for payments to physicians who contract with Medicare+Choice plans that use fee-for-service reimbursement.
- Claims edits in Medicare fee-for-service are subject to review by HCFA and the physician community, but Medicare+Choice plans are allowed to use "black box" edits that disregard standard coding convention, effectively denying payment for certain services.
- Medicare fee-for-service payment rates are distributed to physicians and locked in for a year, but Medicare+Choice plans are allowed to deny physicians a list of their reimbursement rates and can alter the rates in mid-year.
- HCFA pays Medicare+Choice plans as soon as a Medicare+Choice patient enrolls in a plan, but Medicare+Choice plans are allowed to withhold payments to subcontracting physicians until the patient actually receives care.

There is no reasonable justification for holding Medicare+Choice plans to a lower standard of accountability than applies in the fee-for-service program. *Thus, the AMA believes that Medicare+Choice plans using fee-for-service reimbursement should be subject to Medicare's fee-for-service payment deadlines and policies. In addition, Medicare+Choice plans that make capitation payments to subcontracting physicians should be required to begin payment as soon as a beneficiary enrolls, and not delay payment until the beneficiary actually receives care from the subcontracting physician.*

QUALITY ASSURANCE

As the nation's oldest and largest professional association of physicians, the AMA has a firm commitment to quality standards, quality measurement, and quality improvement. That commitment is grounded in our belief in professionalism and professional responsibility. Our commitment to quality improvement has been well demonstrated in the formation of the American Medical Accreditation Program (AMAP), which will provide health plans with a single source for credible information about physician quality. Along with AMAP, the AMA is working to:

- *Set standards* for the education, training, behavior, and delivery of care by our profession;
- *Measure and evaluate* the qualifications and performance of physicians using those standards; and
- *Educate and assist* physicians to meet those professional standards.

We agree that the government should demand assurances of quality in Medicare+Choice and we are pleased that HCFA intends to automatically deem as qualified any plans that are accredited by national bodies such as the Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance. However, physicians share in the Medicare+Choice plans' skepticism about the overly-ambitious quality improvement system HCFA has designed for Medicare+Choice plans.

Under the Medicare program, these private accreditation bodies would have to follow unrealistic standards dictated by HCFA in order for their accreditation to be deemed sufficient. The AMA is concerned that HCFA's proposed standards go beyond the state-of-the-art and would impose a significant new paperwork burden on Medicare+Choice plans and physicians without a corresponding improvement in the quality of care.

In fact, the burden of this system may fall even more heavily on physicians than the Medicare+Choice plans. For example, although plans will initially be limited to two projects (one of which addresses diabetes), physicians will be required to collect data for a variety of different projects run by all the plans in which they participate. In addition, HCFA officials intend to extend quality improvement measures developed for Medicare+Choice into fee-for-service. Thus, physicians will be required to provide data on fee-for-service as well as Medicare+Choice patients.

Although Medicare officials have already scaled back their Quality Improvement System for Managed Care (QISMC), *the AMA is not convinced that QISMC is ready for full implementation and we favor legislation that would require additional modifications or move back the implementation date.*

CONCLUSION

Like Congress, the AMA is worried about the impact of managed care plan withdrawals on Medicare patients. We would not like to see a repeat of the massive exodus that occurred last fall. We note, however, that managed care plans are guaranteed a 2% increase in payments every year while fee-for-service physicians face potential cuts in their payments. We also agree with MedPAC that Congress should adopt a wait-and-see approach before taking any drastic steps to encourage the managed care industry to continue to serve Medicare patients.

While we endorse the expansion of private options to the traditional Medicare program, we believe that success will depend upon the development of a fair and equitable payment method that does not encourage biased selection. The AMA supports MedPAC's recommendation that a new risk-adjuster begin on schedule in January of 2000. We also concur with HCFA's and MedPAC's call for a five-year phase-in of the new adjuster.

The AMA believes that the best value in medical care can be achieved by ensuring that the medical profession has a central role in the design and implementation of the Medicare+Choice program. Also, patients must receive timely and accurate information on the both the Medicare fee-for-service and Medicare+Choice programs. We stand ready to work with Congress and HCFA to ensure that Medicare patients continue to have access to the highest quality medical services.

