

SAVING MEDICARE

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

September 22, 1995

Serial 104-55

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SAVING MEDICARE

FRIDAY, SEPTEMBER 22, 1995

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

The Committee met, pursuant to call, at 10:07 a.m., in room 1100, Longworth House Office Building, Hon. Bill Archer (Chairman of the Committee) presiding.

[The advisories announcing the hearing follow:]

(1)

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
September 14, 1995
FC-9

CONTACT: (202) 225-1721

Archer Announces Hearing on Saving Medicare

Congressman Bill Archer (R-TX), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing on "Saving Medicare." The hearing will take place Thursday, September 21, 1995, at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building. The Committee will receive testimony from invited witnesses only.

BACKGROUND:

According to the Board of Trustees of the Federal Hospital Insurance Trust Fund, which includes three Clinton Administration cabinet secretaries, Medicare Part A next year begins spending out more than it takes in for the first time in the program's 30-year history. By the year 2002, the Trust Fund will be bankrupt.

If the program is insolvent, the Treasury cannot issue checks to pay hospital bills. If nothing is done, the health care of millions of current beneficiaries and millions more nearing retirement who have paid into the system all their working lives will be threatened. Bankrupting Medicare is unacceptable public policy.

"As we move forward with our plan to save Medicare from bankruptcy," Archer said, "I look forward to the nineteenth hearing that this Committee will have held over the past seven months on the issue of saving Medicare. It is vital that we proceed with preserving, protecting, and saving this important program."

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 at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Tuesday, September 26, 1995, to Phillip D. Moseley, 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 distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Committee office, room 1102 Longworth House Office Building, at least one hour before the hearing begins.

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 typed in single space on legal-size paper and may not exceed a total of 10 pages.
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. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplementary sheet must accompany each statement listing the name, full address, a telephone number where the witness or the legislator is available, and a brief summary of the comments and recommendations in the full statement. This supplementary sheet will not be included in the printed record.

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

NOTICE -- CHANGE IN SCHEDULE

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
September 20, 1995
No. FC-9-Revised

CONTACT: (202) 225-1721

Schedule Change for Full Committee Hearing on Saving Medicare

Congressman Bill Archer (R-TX), Chairman of the Committee on Ways and Means, today announced that the full Committee hearing on "Saving Medicare," originally scheduled on Thursday, September 21, 1995, has been **rescheduled for Friday, September 22, 1995, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.**

All other details for the hearing remain the same. (See full Committee advisory No. FC-9, dated September 14, 1995.)

Chairman ARCHER. We will begin just as soon as our guests and staff take seats.

Prior to the discussion and the hearing today, let me recite the Rules of the Committee and the House so there will be no misunderstanding for the rest of the hearing session. Under the Rules of the House and the Rules of the Committee, no demonstrations are permitted at hearings. The Chair will evenhandedly invoke the rule.

We are commencing this hearing today in an orderly fashion and it will continue to proceed through the day in an orderly fashion according to the Rules of the House and the Rules of the Committee.

In April this year, the board of trustees for Medicare reported that the trust fund that supports our Nation's Medicare Program would go broke in the year 2002. The underlying actuarial projection on which that report was based said that it could happen before 2002. The trustees, three of whom are Clinton administration Cabinet secretaries, reported that for the first time in the history of Medicare, the part A trust fund would spend more than it takes in beginning in 1996.

The report concluded that in just 7 years, the fund would be completely bankrupt. The fund has no ability to borrow under the law, and these hearings mark another important milestone in the efforts of this Congress to do two things: First, to keep our word because we said that we would save Medicare from bankruptcy, and we have offered a plan that does, indeed, save it. The plan is, yes, bold, innovative and, most importantly, it protects Medicare for today's retirees and it preserves it for the next generation of seniors.

Second, conventional wisdom said it was political suicide to touch Medicare. It has been called the third rail of American politics, touch it and you will die, but leadership requires us to challenge conventional wisdom, to rise above politics and to do what is right.

A long-term problem for the Congress should not be simply one that lasts between now and the next election and proposing we sweep it under the rug until after the next election. That will not be the hallmark of this Congress. At all of our townhall meetings, senior citizens have told us that they agree Medicare needs to be reformed if it is to survive. For too long, politicians in Washington hid from the real problems that our Nation faces. Our failure to face the bankruptcy problems presented by explosive entitlement spending has threatened the very solvency of these programs that we deeply cherish, not to mention the solvency of our Nation itself. So it is with Medicare.

The Medicare Trust Fund has been faced with insolvency before. Due to its unsustainable spending growth, it has teetered on the brink of bankruptcy. The solutions offered by the previous Congress were to raise taxes and to mandate fixes that save politicians through their next elections but they did little to save Medicare. Previous Congresses used up all the quick fixes.

Because of changing demographics, the crisis is out of hand. To protect and preserve Medicare, major reform is necessary. Republicans believe that the American people asked us to become the majority party to stop the quick fixes and they directed us to address the fundamental problems. That is why the solutions we offer will

save the trust fund for up to 12 years beyond the year 2002 and get us to the eve of the baby boomer retirement period.

Today's hearing is on saving Medicare. The Republicans have offered a plan and I have been informed that Ways and Means Democrats will also offer an alternative plan. The Republican plan has been developed as a result of 17 previous hearings on Medicare, 16 in Subcommittee, and one in the Full Committee. During this time, we took more than 2,500 pages of testimony from over 230 diverse witnesses chosen by both parties. This is the stack of testimony that has been heard by this Committee throughout all of those hearings. We have before us today a number of distinguished guests who will testify on saving Medicare, and I say, Sam, as we did throughout the previous 17 hearings, we have accommodated your requests and all the witnesses you requested today will appear before us.

But before we begin, I have one final message. These issues are truly difficult. They are important and they often become emotional. I would like to remind you, no one party or person holds a monopoly for compassion or dedication to the elderly. When it comes to saving Medicare from bankruptcy, it is easier to demagog and scare people than it is to move forward with meaningful solutions.

I know that both the majority and the minority care deeply about compassion and the elderly. In fact, our compassion has grown so large that it has driven Medicare to the brink of bankruptcy. We are on the verge of compassioning Medicare to death.

It is interesting to note that the growth of Medicare this year is anticipated to be more than three times the rate of inflation. We must find a plan that continues the growth of Medicare above the rate of inflation but not over three times the rate of inflation each year for the next 7 years, and our plan provides for an increase in Medicare spending, while saving, that is almost twice the rate of inflation over the next 7 years.

When the issues are important, they are not easy. That is why in this new day and age of the American government, it is important to keep our word and face our problems head on. The Republican plan to save Medicare empowers seniors with the ability to choose the health plan they like best and it breaks the government's monopoly over health care for seniors. It is exciting, bold, and it preserves, protects, and strengthens Medicare.

I look forward to hearing about the Democrat plan, and I now yield to the Ranking Democrat on the Committee, Mr. Gibbons, for an opening statement.

Let me say, Sam, before you begin your statement that every Member will be, without objection, permitted to enter a statement in writing in the record.

[The opening statements of Mr. Coyne and Mr. Neal follow:]



OPENING STATEMENT
CONGRESSMAN WILLIAM J. COYNE
SEPTEMBER 21, 1995

Yesterday, I received an outline of the Republican Medicare Preservation Act. While this document contains some details, it does not clearly describe how Republicans will reduce Medicare payments by \$270 billion over seven years. It is difficult to draw thoughtful conclusions or develop informed opinions from the information provided in this document.

I strongly oppose cutting Medicare by \$270 billion over seven years. I understand that we need to address the long-term solvency of the Medicare Part A hospital trust fund. However, it appears that this Republican solution does not deal properly with balancing Medicare Part A. Rather, this plan seems to jeopardize the security that Medicare has provided to beneficiaries for the past thirty years. I am particularly concerned because I represent one of the largest elderly populations in any Congressional district in the country.

It is not clear to me that beneficiaries will be protected from absorbing a good portion of the \$270 billion in Medicare cuts. For example, if the Part B premium is held at 31% of the program's expenditures, beneficiaries will see their monthly Social Security check reduced by \$93.00 per month -- that's \$30.00 more a month than current law.

It also appears that beneficiaries will continue to pay more than 50% of the accepted Medicare rate for outpatient copayments. Present law is flawed and needs to be corrected -- particularly because patients are increasingly receiving care in this setting. If this plan was truly about Medicare reform, there would be a provision that would guarantee that patients pay a 20% copayment for services received in the outpatient setting.

Also, I am concerned about the impact that this proposal will have on providers -- and specifically, teaching hospitals. Teaching hospitals have the responsibilities of clinical education, biomedical research and highly specialized patient care. Additionally, they provide quality health care to distressed inner city populations. Should their payments be radically modified, workers will lose jobs, quality of patient care will be threatened, clinical research will be compromised, and Medicare beneficiaries could possibly face a disruption in the services they receive.

Mr. Chairman, from what I can glean from this document, it seems that no one benefits from the Medicare Preservation Act. I ask that we construct a bipartisan reform plan for Medicare that protects and improves patient care, limits seniors' out-of-pocket costs, and addresses the long term solvency of the Medicare Part A trust fund.

RICHARD E. NEAL
SECOND DISTRICT, MASSACHUSETTS
WHIP AT-LARGE



COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON TRADE
SUBCOMMITTEE ON SOCIAL SECURITY

Congress of the United States
House of Representatives
Washington, DC 20515

September 22, 1995

Ways and Means Medicare Hearing
Congressman Richard E. Neal
Opening Statement

Good morning. This is an momentous day for all of us who serve on this prestigious committee. As we hear today's witnesses testify about their opinions of the Republican's Medicare plan, we should keep in mind the significance of the decisions we make in this room and how our deliberations here in Washington, D.C. affect the very security, health, and quality of life for America's families - especially our nation's senior citizens.

Since its creation thirty years ago, the Medicare program has become an integral part of the lives of America's senior citizens. Senior citizens need Medicare. It is not a luxury - an expendable social policy as many Republicans might lead you to believe. Instead, Medicare is the very reason why today's seniors are living longer than they did thirty years ago, why seniors can now afford to keep their family homes as they grow older, and why today's seniors are protected from falling into severe poverty in their most vulnerable years.

But Medicare is important in many other ways as well. My state of Massachusetts is home to many of the finest health care institutions and teaching hospitals in the world. Massachusetts' hospitals and academic health centers produce physicians and health care providers who continue on in their careers to serve the health care needs of the nation, and in many cases, the world. The Medicare program has been an integral ingredient in funding this quality and expensive education.

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I realize the complexities surrounding graduate medical education and the Medicare program, but I warn this committee today that the impact of any changes that we make affecting the education of our future physicians and health care providers won't be felt for many years to come. The Republican plan addresses the unique needs of teaching hospitals by creating a GME Trust Fund, but mind you, this plan we have before us today includes no specifics or funding levels for this fund. We need to give very careful consideration to the issue of medical education. The quality and future of health care delivery in America is at stake.

Jobs are also at stake. A recent study, which analyzed the impact of the Republicans Medicare and Medicaid cuts on employment in Massachusetts, found that more than 71,000 health sector jobs in Massachusetts alone are at risk if these cuts are allowed to pass. The layoffs and unemployment numbers associated with these cuts are huge, and would have a disproportionate effect on women and minorities. Slashing the Medicare program by \$270 billion is an employment issue. The jobs that will be lost because of these cuts are good, well-paying jobs. And don't let the Republicans fool you. Once these jobs are gone, they are never going to come back.

\$270 billion in cuts to the Medicare program is excessive. The summary of the Republican plan that we received yesterday glosses over the fact that this is by far the largest cut to Medicare since the program's creation. If the Republicans are confident that these Medicare cuts are as worthy as they say, then unveil the real details of the plan, let's debate these details, and let's have more than one day of hearings in this committee.

Creating good public policy takes time and careful consideration, and good public policy should be this committee's goal. Medicare serves more than 37 million seniors. Our focus in this committee should be to restore Medicare's solvency, and to ensure the program's integrity for the future. Our debate should be thoughtful and thorough. Today's hearing should be the beginning of a series of hearings so that we can truly comprehend the impact of the decisions we make. We owe this courtesy and our consideration to America's seniors.

I look forward to hearing the testimony of this morning's witnesses. Thank you Mr. Chairman.

Chairman ARCHER. Mr. Gibbons.

Mr. GIBBONS. This pile of material that you see next to me presented here is absolutely useless. Let me repeat that. This pile of material that you see here is absolutely useless. No demonstrations, please.

Chairman ARCHER. We ask our guests, under the Rules of the Committee, the Rules of the House, not to have any audible or visible demonstrations. It is our desire to permit everyone in the public that wants to attend these meetings to sit in these meetings, but we must invoke the Rules of the Committee and the Rules of the House.

The gentleman may proceed.

Mr. GIBBONS. I will tell you why—it is absolutely useless. There is no bill before us. All the words that are stacked up here were uttered before there was any legislative piece or plan put together. They were commenting about dreams. They were commenting about aspirations. They were commenting about goals, but we are here talking about facts. So I would ask the staff to please remove these words.

Well, if the staff won't remove them, I guess I will have to remove them.

I appreciate the chance to speak, Mr. Thomas, and I am glad that our Republican colleagues have regained their sense of fair play which was so absent last Wednesday when I tried to speak. I have been in Congress a long time, Mr. Chairman, and I can only shake my head in dismay that you have allowed a process like this one to be employed in a matter that involves the life, and yes, perhaps even the death of so many of our seniors and disabled people.

Here we are just 5 days away from the time that we will start marking up a piece of legislation, one that we haven't seen and perhaps will not see until we get to mark it up, and let me tell all of you who are not familiar with what you will probably see, it will be at least that thick, perhaps thicker, and it will be full of all kinds of law. We are not talking about thoughts and desires. We are talking about law. That is what the Ways and Means Committee does, we make law.

We have no cost estimate as of this date, and perhaps we won't have an estimate until too late, as to what all of this will do in terms of money: Money from the pockets of the elderly, money from the pockets of the taxpayer, or revenue to this government. We do know that the goal is to take \$270 billion out of Medicare and devote most of that to a tax cut for the very wealthy. That much we know. That much is incontrovertible.

Yesterday in this room, and what a desecration to this room that has seen so many historic events, we saw another press release paraded out as a piece of legislation. All of us in this room know you can't mark up a press release for a piece of legislation. You have got to have a bill. How can anyone be expected to analyze or to score a press release in place of legislation? It is just impossible.

Are you, Mr. Chairman, or any of you, prepared to tell me that these witnesses that we will be listening to today can talk about the plan or talk about the legislative language that you will hopefully be laying on the table finally 5 days from now? No. The witnesses that we are going to have today, with no disrespect to them

individually, will just be able to comment very generally about their hopes and aspirations, but that is not what we are here for. We are here to talk about making law, not just commenting on some vague press release document that was presented in this room yesterday.

Critical material, critical details, as deviling as they are, are important to what we have to do, and we have none. We simply have a press release document. Can you or anybody tell me or tell this Committee what the so-called "fail-safe provision" will do to doctors, to patients, to hospitals if all of your grand dreams, radical dreams go astray? Can you assure us that your limit on payments, which are far below anything that anybody has ever dreamed of, will not encourage doctors to turn Medicare patients away from their offices, or the hospitals to put up signs, "No more Medicare patients"? Of course, we will hear a great deal about goals and about lofty ideals, but we won't hear anything about what this Committee must eventually do, adopt or reject a piece of legislation.

I don't believe that Medicare needs saving, but I believe it needs saving from the Republicans. When we created this program, and I was here in Congress at that time, we set it up to be a pay-as-you-go program. We thought it would be wise to keep 1 year ahead of the bills that came in. Somewhere, without congressional direction or congressional authorization, you have changed this program to one that must be 10 years of reserves to pay bills. There were good reasons why we didn't set this program up to be in that kind of shape and we have never changed the design of this program.

The rhetoric on all of this amazes me. Almost one-half of the cuts which you have proposed in the Medicare Program come from part B, and you know as well as I know that none of these part B run programs go to fund any of the Medicare Trust Fund that you claim is in such dire straits. All of these funds will go into the general revenue fund to help pay for that rather enormous, and I think obscene, tax cut that you voted out earlier this year.

If you are so worried about the Medicare Trust Funds, why don't you take some \$90 billion from that tax cut and put it back into the Medicare Trust Fund that you pretend to worry so much about? That will solve the so-called "insolvency" of the fund, the fund that was never designed to have more than 1 year's reserve in it, for 10 or 12 years in advance. That is the right approach if we have any crisis, and I think the crisis has been largely PR generated.

I will conclude, Mr. Chairman, with deep regret. This is a historic Committee, this is a historic responsibility, this is a historic program. The debate that we are entering into, we need a piece of legislation in front of us from which we can work, not just more PR documents. Ultimately, the American people will understand. Mr. Gingrich has been very successful in keeping from the American people those important parts of this program, and still it will be too late for the American people to understand what is about to happen to them.

Mr. Chairman, I would like to yield to Mr. McDermott who—Mr. McDermott.

Chairman ARCHER. Mr. Gibbons, the minority has been permitted, as the majority, to have one opening statement. If Mr.

McDermott wishes to enter a statement in writing in the record, he may do so. Without objection, that privilege is given to every Member of the Committee.

Mr. RANGEL. Parliamentary inquiry, Mr. Chairman.

Chairman ARCHER. Mr. Rangel.

Mr. RANGEL. Mr. Chairman, exactly what bill are we marking up? Could you give me the number of that particular piece of legislation?

Chairman ARCHER. The gentleman's inquiry is—as to what bill we are marking up, and the response is, we are not marking up any bill. We are having hearings on how we should save Medicare, and the witnesses are going to be asked and invited to, in the first panel, take the witness table.

Mr. RANGEL. Correction, Mr. Chairman. Parliamentary inquiry as to the bill for which this hearing is being held, the number of the bill—

Chairman ARCHER. This hearing is being held on the subject of saving Medicare, as is generally true of most hearings before this Committee where a specific bill in statutory language is not before the Committee. The Chair does not wish to belabor for a long period of time procedural comments. The facts are, however, that this Committee over the years has operated over and over and over again with hearings where statutory language of a bill is not before the Committee.

In addition, to set the facts straight, when, in the last Congress, this Committee considered a very voluminous comprehensive proposal by the Clinton administration on health care, it was not in statutory language, even when presented to the Committee at the time of markup. So there is a great smokescreen that is being put before the public today to cover up the fact that this is simply an effort to delay the Congress from acting on saving Medicare.

Mr. STARK. If the Chairman would yield, I take exception to him. It was in parliamentary language before the Subcommittee markup.

Mr. RANGEL. Parliamentary inquiry, Mr. Chairman.

Chairman ARCHER. It was not—it is a fact that what the Committee considered last year in Full Committee was not in statutory language, but we are not going to continue debate on that.

Mr. STARK. That is not true.

Mr. RANGEL. Further parliamentary inquiry, Mr. Chairman.

Chairman ARCHER. The gentleman will state his parliamentary inquiry.

Mr. RANGEL. Mr. Chairman, will there be any witnesses from the administration to testify on this document that is before us today?

Chairman ARCHER. The Chair will say to the gentleman that every witness that was suggested by the minority has been accommodated and will be before the Committee today.

Mr. RANGEL. My last parliamentary inquiry, Mr. Chairman, is, do we have any reports from the Congressional Budget Office as to the cost of whatever is in this press release?

Chairman ARCHER. Is the gentleman suggesting that before we have a hearing, we must have a CBO analysis of the cost of printing a notice of the meeting?

Mr. RANGEL. Mr. Chairman, I am not.

Chairman ARCHER. That is highly, that is highly out of order.

Mr. RANGEL. I am fully aware, Mr. Chairman, that the Chair can proceed with any legislation you have votes for. I was merely asking whether or not there was any budget analysis before the Committee that we could use as we listen to the witnesses discuss your release.

Chairman ARCHER. The witnesses are not just going to discuss what you call a release, which is a notice of a meeting which is customary for the Committee. What they are going to talk about are methods to save Medicare, and the Democratic witnesses I am sure will put forward their suggestions as to how we should save Medicare, the ones that have been invited, at the suggestion of the minority, and that is the purpose of these hearings.

Mr. RANGEL. Thank you, Mr. Chairman.

Mr. MATSUI. May I ask a parliamentary inquiry, Mr. Chairman. My understanding was that originally we were going to have a hearing before the markup on a specific piece of legislation, or at least an outline of a piece of legislation. When the bill is finally completed, will we have the opportunity for a hearing in view of the fact that this is a general discussion on how to save Medicare?

Chairman ARCHER. We will continue to run this Committee in the way that it has been run in the past, according to the customary standards, I will say to the gentleman. Now, if the minority wishes to be dilatory and attempt to delay these hearings—

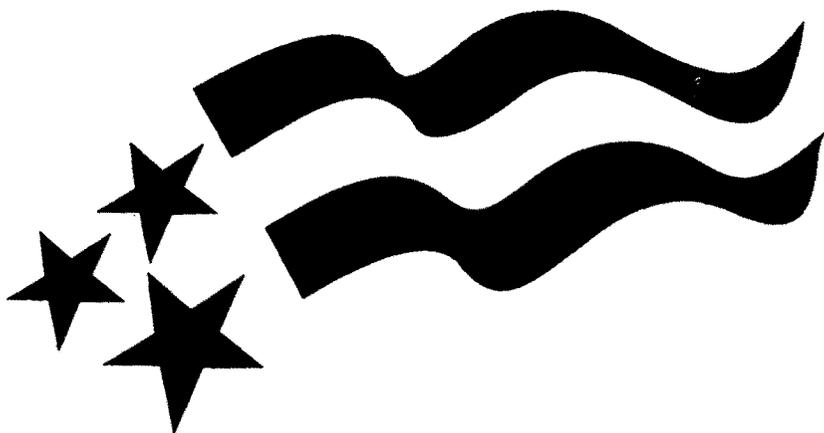
Mr. MATSUI. Not at all, Mr. Chairman.

Chairman ARCHER [continuing]. Then of course you can continue to ask parliamentary inquiry questions, you can continue to ask all the questions that you wish, but I think it is in the interest of this country that we proceed with the business of the country, as the notice for this meeting said when it was sent out.

The first witness before the Committee today is Mr. King.

Mr. King, if you will identify yourself for the record, we will be pleased to have your testimony. We would ask you, if you would, to limit your verbal comments to 5 minutes, but you may insert your complete written testimony for the record.

[A summary of the 1995 annual reports from the Social Security and Medicare Board of Trustees follows:]



Status of the Social Security and Medicare Programs

A SUMMARY OF THE
1995 ANNUAL REPORTS

Washington, D.C.
April 1995

**Social Security and Medicare
Boards of Trustees**

A MESSAGE TO THE PUBLIC:

The Boards of Trustees are pleased to present this Summary of the 1995 Annual Reports of the Social Security and Medicare trust funds. The reports include extensive information about these important social programs and, we believe, fully and fairly present their current and projected financial condition.

In particular, we encourage current and future beneficiaries to consider what the reports mean for them as individual citizens. Based on the Trustees' best estimates, the reports show:

- * *The Federal Old-Age and Survivors Insurance (OASI) Trust Fund, which pays retirement benefits, will be able to pay benefits for about 36 years. The Board believes that the long-range deficit of the OASI Trust Fund should be addressed. The Advisory Council on Social Security is currently studying the financing of the program and is expected to recommend later this year ways to achieve long-range actuarial balance in the OASI fund.*
- * *The Federal Disability Insurance (DI) Trust Fund, which pays disability benefits, is projected to be exhausted in 2016. The Board believes that the long-range deficit of the DI Trust Fund should be addressed. The Advisory Council on Social Security currently also is studying the financing of the DI program and is expected to recommend later this year ways to achieve long-range actuarial balance in the DI fund.*
- * *The Federal Hospital Insurance (HI) Trust Fund, which pays inpatient hospital expenses, will be able to pay benefits for only about 7 years and is severely out of financial balance in the long range. The Trustees urge the Congress to take additional actions designed to control HI program costs and to address the projected financial imbalance in both the short range and the long range through specific program legislation as part of broad-based health care reform. The Trustees believe that prompt, effective, and decisive action is necessary.*



- * *The Federal Supplementary Medical Insurance (SMI) Trust Fund, which pays doctor bills and other outpatient expenses, is financed on a year-by-year basis and, on this limited basis, is adequately financed. The Trustees urge the Congress to take additional actions designed to more effectively control SMI costs through specific program legislation as part of broad-based health care reform. The Trustees believe that prompt, effective, and decisive action is necessary.*

Public discussion regarding the financing of the Social Security and Medicare programs needs to take account of the critical differences among the four individual trust funds and, at the same time, the important relationships among them. A key aspect of thinking about future financing of these trust funds is recognition that under current law the timing and magnitude of the financing problems facing the programs are distinctly different. This summary presents the current and projected financial status of these four programs both separately and together in the hope that it will enhance public understanding of them and encourage necessary program reforms.

By the Trustees:

*Robert E. Rubin,
Secretary of the Treasury,
and Managing Trustee*

*Robert B. Reich,
Secretary of Labor,
and Trustee*

*Donna E. Shalala,
Secretary of Health
and Human Services,
and Trustee*

*Shirley S. Chater,
Commissioner of
Social Security,
and Trustee*

*Stanford G. Ross,
Trustee*

*David M. Walker,
Trustee*

**STATUS OF THE SOCIAL SECURITY
AND MEDICARE PROGRAMS**

A SUMMARY OF THE 1995 ANNUAL REPORTS

What Are the Trust Funds? Four trust funds have been established by law to finance the Social Security and Medicare programs. For Social Security, the Federal Old-Age and Survivors Insurance (OASI) Trust Fund pays retirement and survivors benefits; and the Federal Disability Insurance (DI) Trust Fund pays benefits after a worker becomes disabled. When both OASI and DI are considered together, they are called the OASDI program.

For Medicare, the Federal Hospital Insurance (HI) Trust Fund pays for hospital and related care (often called "Part A") for people over 65 and workers who are disabled. The Federal Supplementary Medical Insurance (SMI) Trust Fund pays for physician and outpatient services (often called "Part B") for people over 65 and workers who are disabled. These two trust funds are not usually considered together, because they are funded differently.

Who Are the Boards of Trustees? Six people serve on the Social Security and Medicare Boards of Trustees: the Secretary of the Treasury, the Secretary of Labor, the Secretary of Health and Human Services, the Commissioner of Social Security and two members appointed by the President and confirmed by the Senate to represent the public. The Boards are required by law to report to the Congress each year on the operation of the trust funds during the preceding years and the projected financial status for future years.

What Were the Trust Fund Results in 1994? Assets of all trust funds except SMI increased during calendar year 1994. At the end of the year, 42.9 million people were receiving OASDI benefits and about 37 million people were covered under Medicare. Trust fund operations, in billions of dollars, were (totals may not add due to rounding):

	<u>OASI</u>	<u>DI</u>	<u>OASDI</u>	<u>HI</u>	<u>SMI</u>
Assets (end of 1993)	369.3	9.0	378.3	127.8	24.1
Income during 1994	328.3	52.8	381.1	109.6	55.6
Outgo during 1994	284.1	38.9	323.0	104.5	60.3
Net Increase	44.1	14.0	58.1	5.0	-4.7
Assets (end of 1994)	413.5	22.9	436.4	132.8	19.4

What Were the Administrative Expenses in 1994? The cost of administrative expenses in fiscal year 1994, shown as a percentage of benefit payments from each trust fund, was:

	<u>OASI</u>	<u>DI</u>	<u>OASDI</u>	<u>HI</u>	<u>SMI</u>
Administrative Expenses (FY1994):	0.7	2.8	0.9	1.2	3.0

How Are the Trust Funds Financed? Most OASDI and HI revenue consists of taxes on earnings that are paid by employees, their employers, and the self-employed. The tax rates are set by law and, for OASDI, apply to earnings that do not exceed a certain annual amount. This amount, called the earnings base, rises as average wages increase. In 1995, the earnings base for OASDI is \$61,200. Beginning with 1994, HI taxes are paid on total earnings. The tax rates for employees and employers each under current law are:

Year	<u>OASI</u>	<u>DI</u>	<u>OASDI</u>	<u>HI</u>	<u>Total</u>
1990-93	5.60	0.60	6.20	1.45	7.65
1994-96	5.26	0.94	6.20	1.45	7.65
1997-99	5.35	0.85	6.20	1.45	7.65
2000 and later	5.30	0.90	6.20	1.45	7.65

People who are self-employed are charged the equivalent of the combined employer and employee shares, but only on 92.35 percent of net earnings, and may deduct one-half of the combined tax from income subject to Federal income tax.

All the trust funds receive income from interest earnings on trust fund assets and from miscellaneous sources. The OASI, DI and, beginning in 1994, HI Trust Funds also receive revenue from the taxation of Social Security benefits.

The SMI or Part B program is financed similarly to yearly renewable, term insurance. Participants pay premiums that in 1994 covered about 30 percent of the cost; the rest is paid for by the Federal Government from general revenues. The 1995 monthly premium is \$46.10.

In all trust funds, assets that are not needed to pay current benefits or administrative expenses (the only purposes for which trust funds may be used) are invested in special issue U.S. Government securities

guaranteed as to both principal and interest and backed by the full faith and credit of the U.S. Government.

How Are Estimates of Trust Fund Balances Made? Short-range (10-year) estimates are reported for all funds, and, for the OASI, DI, and HI Trust Funds, long-range (75-year) estimates are reported. *Because the future cannot be predicted with certainty, three alternative sets of economic and demographic assumptions are used to show a range of possibilities.* Assumptions are made about economic growth, wage growth, inflation, unemployment, fertility, immigration, and mortality, as well as specific factors relating to disability, hospital, and medical services costs.

The intermediate assumptions (alternative II) reflect the Trustees' best estimate of what the future experience will be. The low cost alternative is more optimistic; the high cost alternative is more pessimistic; they show how the trust funds would operate if economic and demographic conditions are better or worse than the best estimate.

What Concepts Are Used to Describe the Trust Funds? The measures used to evaluate the financial status of the trust funds are based on several concepts. Some of the important concepts are:

- o **Taxable payroll** is that portion of total wages and self-employment income that is covered and taxed under the OASDI and HI programs.
- o The annual **income rate** is the income to the trust fund from taxes, expressed as a percentage of taxable payroll.
- o The annual **cost rate** is the outgo from the trust fund, also expressed as a percentage of taxable payroll.
- o The **percentage of taxable payroll** is used to measure income rates and cost rates for the OASDI and HI programs. Measuring the funds' income and outgo over long periods of time by describing what portion of taxable earnings they represent is more meaningful than using dollar amounts, because the value of a dollar changes over time.
- o The annual **balance** is the difference between the income rate and the cost rate. If the balance is negative, the trust fund has a **deficit** for that year.

- o The actuarial balance is the difference between the annual income rates and cost rates summarized over a period of up to 75 years, and adjusted to include the beginning fund balance and the cost of ending the projection period with a trust fund balance equal to the next year's outgo; if the balance is negative, the fund has an actuarial deficit.
- o The trust fund ratio is the amount in the trust fund at the beginning of a year divided by the outgo for the year. It shows what percentage of the year's expenditures the trust fund has on hand. For example, a trust fund ratio of 100 percent would reflect an amount equal to 1 year of projected expenditures.
- o The year of exhaustion is the first year a trust fund is projected to run out of funds and to be unable to pay benefits on time and in full.

How Is the Financial Status of the Trust Funds Tested? Several tests, based on the intermediate assumptions, are used to review the financial status of the trust funds.

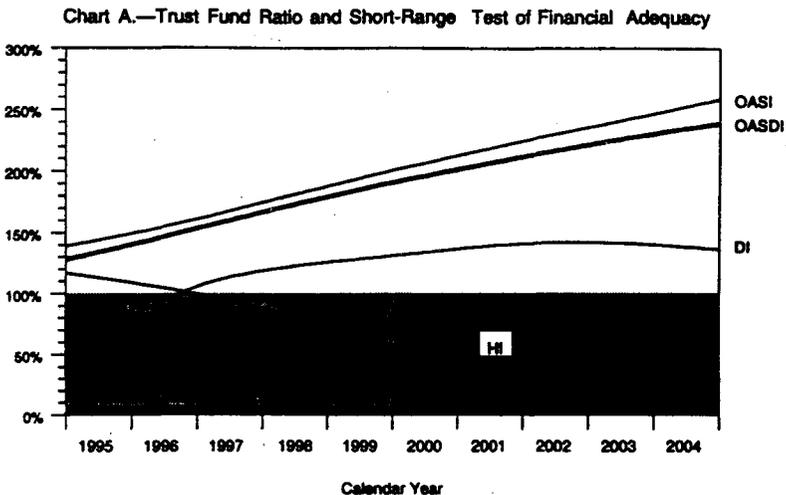
- o The short-range test is met if, throughout the next 10 years, the trust fund ratio is at least 100 percent. Or, if the trust fund ratio is initially less, but reaches 100 percent within the first 5 years and stays at or above 100 percent, and there is enough income to pay benefits on time every month during the 10 years, the short-range test is met.
- o The long-range test is met if a fund has an actuarial deficit of no more than 5 percent of the cost rate over the 75 years, and if the actuarial deficit for any period ending with 10th year or later is less than a graduated amount of 5 percent. If the long-range test is met, the trust fund is in close actuarial balance.
- o The test for SMI actuarial soundness is met for any time period if the trust fund assets and projected income are enough to cover the projected outgo and there are enough assets to cover costs incurred but not yet paid. The adequacy of the SMI Trust Fund is measured only for years for which both the beneficiary premiums and the general revenue contributions have been set.

What Is the Future Outlook for the Trust Funds?

The status of the OASI, DI, and HI Trust Funds is shown together on charts because they are financed the same way. SMI is financed differently, so its status is described separately.

o THE SHORT-RANGE OUTLOOK (1995-2004)

Chart A shows the projected trust fund ratio under the intermediate (alternative II) assumptions for OASI, DI, and HI separately. It also shows the ratio for the combined OASI and DI trust funds.



The OASI trust fund ratio line is over the 100 percent level at the beginning of the 10-year period and stays over that level through the year 2004. Therefore, the OASI Trust Fund meets the short-range test of financial adequacy.

The trust fund ratio line for DI starts at 54 percent, reaches 100 percent in 1996, and remains above that level throughout the remainder of the period. Thus, the DI fund also meets the short-range test.

The trust fund ratio line for the combined OASI and DI Trust Funds begins above the 100 percent level and stays over that level throughout the 10-year period; therefore, the OASDI program, as a whole, meets the short-range test of financial adequacy.

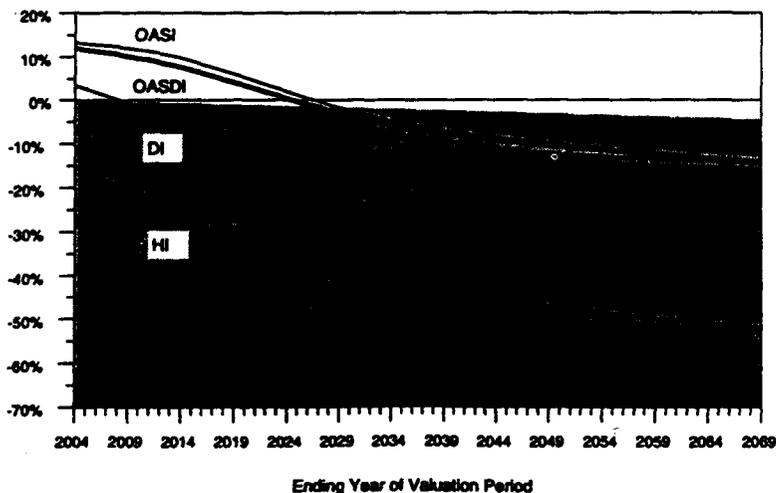
Although the trust fund ratio line for HI is over the 100 percent level at the beginning of the 10-year period, it falls below that level in 1995. As a result, it does not meet the short-range test. Under the intermediate assumptions, the projected year of exhaustion for the HI Trust Fund is 2002; under more adverse conditions, as in the high cost alternative, it could be as soon as 2001.

The financing for the SMI Trust Fund has been set through 1995, and the projected operations of the trust fund meet the test of SMI actuarial soundness.

o THE LONG-RANGE OUTLOOK (1995-2069)

Chart B shows the actuarial balance, as a percentage of the cost rate, for OASI, DI, and HI separately under the intermediate (alternative II) assumptions, as well as for the combined OASI and DI Trust Funds.

Chart B.--Actuarial Balance as a Percentage of Summarized Cost Rate and Long-Range Test of Close Actuarial Balance



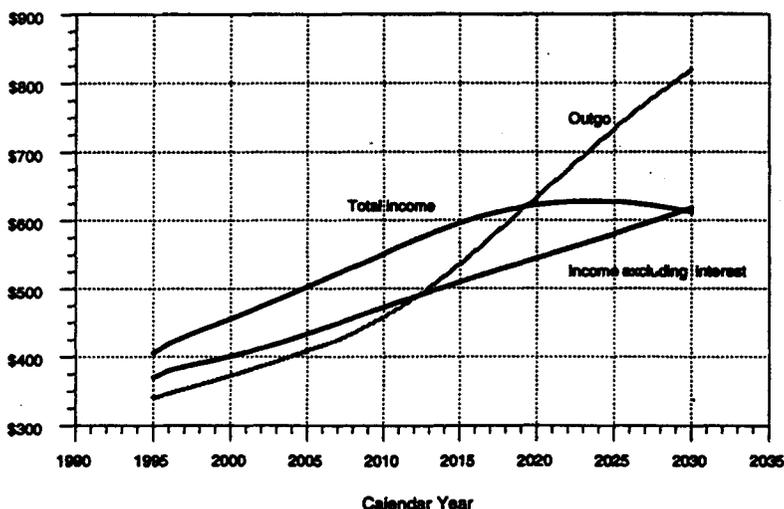
For a trust fund to meet the long-range test of close actuarial balance, the actuarial balance line for that trust fund must stay above the shaded area throughout the 75-year period. The triangle above the shaded area but below the zero percent level shows the range of allowable deficits a fund can have and still be in close actuarial balance.

None of the three trust funds is in close actuarial balance over the next 75 years. However, the chart shows that the actuarial balance line for OASI, as well as for the OASDI program as a whole, stays above the shaded area for many years to come.

The actuarial balance line for DI alone starts above the shaded area but declines below it in about 2009 and continues to decline significantly for about an additional 25 years before the rate of decline slows. The actuarial balance line for HI starts well into the shaded area and declines continuously over the long-range period.

The year of exhaustion for the OASI Trust Fund under intermediate assumptions does not occur until 2031--36 years from now. For the combined OASI and DI Trust Funds, the year of exhaustion would be 2030--in 35 years. However, combined OASDI expenditures will exceed current tax income beginning in 2013. Thus, as Chart C illustrates, current tax income plus a portion of annual interest income will be needed to meet expenditures for years 2013 through 2019, and current tax income, annual interest income, plus a portion of the principal balance in the trust funds will be needed for years 2020-2029.

Chart C.--Estimated OASDI Income and Outgo in Constant Dollars
(in billions)

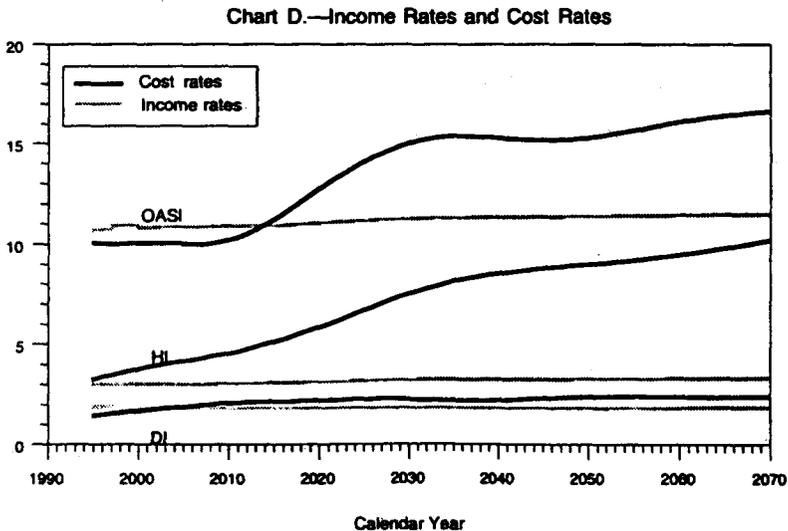


Another useful way to view the outlook of the trust funds is to compare the income rate for each fund with its estimated cost rate. Over the 75-year period the income rates for OASI, DI and HI remain relatively constant, while the cost rates generally rise steadily.

For OASI, the income rate is projected to remain significantly above the cost rate for a number of years. Starting in about 2010, however, the OASI cost rate will begin increasing rapidly as the baby boom generation begins to reach retirement age. In 2014 and later, the cost rate for OASI will exceed the income rate.

The income rate for DI is slightly higher than the cost rate only until 2004, after which the annual shortfall of tax income is projected to increase slowly over the entire 75-year period.

The cost rate for HI is higher than the income rate, by rapidly growing amounts, throughout the 75-year projection period -- by the end of the period, the HI cost rate is projected to be roughly 3 times greater than the HI income rate. Chart D shows the virtually level income rates and rising cost rates for OASI, DI and HI.



An additional way to view the outlook for the trust funds as projected under current law is in relation to the economy as a whole. The table below shows the estimated outgo from each trust fund as a percentage

of estimated gross domestic product (GDP) from 1995 to 2069. OASI and DI increase at about the same rate over this period, while the increases in HI and particularly in SMI are much greater.

OASI, DI, HI AND SMI OUTGO AS A PERCENT OF GROSS DOMESTIC PRODUCT

<u>Trust Fund</u>	<u>1995</u>	<u>2020</u>	<u>2045</u>	<u>2069</u>	<u>% Increase</u>
OASI	4.18	5.05	5.72	5.98	43
DI	0.60	0.87	0.87	0.86	44
HI	1.62	2.83	4.05	4.46	175
SMI	0.99	3.18	4.01	4.29	333

CONCLUSIONS

The status of the Social Security and Medicare programs can be summarized by looking at the results of the tests used to evaluate the financial status of the trust funds and at the number of years before each trust fund is expected to be exhausted under the intermediate assumptions:

FINANCIAL STATUS OF THE OASI, DI, HI, AND SMI PROGRAMS

Is the Test of Financial Adequacy Met:

<u>Trust Fund</u>	<u>Short-Range</u> <u>10 Years</u>	<u>Long-Range</u> <u>75 Years</u>	<u>Years Until</u> <u>Exhaustion</u>
OASI	Yes	No	36
DI	Yes	No	21
OASDI (combined)	Yes	No	35
HI	No	No	7

The SMI Trust Fund meets its test of actuarial soundness.

Based on the Trustees best estimates (alternative II):

The OASI Trust Fund is expected to be able to pay benefits for about the next 36 years while the DI fund will be exhausted in about 21 years. In view of the lack of actuarial balance in the OASDI program over the next 75 years, the Board believes that the long-range deficits in the OASI and DI programs should be addressed. Accordingly, the Board recommended last year that the 1995 Advisory Council on Social Security conduct an extensive review of Social Security financing issues and develop recommendations for achieving long-range financial stability for the OASDI program. The Council will submit its report later this year.

The HI Trust Fund will be able to pay benefits for only about 7 years and is severely out of actuarial balance over the next 75 years. Because of the magnitude of the projected actuarial deficit in the HI program and the high probability that the HI Trust Fund will be exhausted just after the turn of the century, the Trustees urge the Congress to take additional actions designed to control HI program costs and to address the projected financial imbalance in both the short range and the long range through specific program legislation as part of broad-based health care reform.

The SMI program, though actuarially sound, has experienced rapid growth in costs: program outlays have increased 53 percent in the last 5 years and grew 19 percent faster than the economy as a whole. Because this growth shows little sign of abating, the Trustees urge the Congress to take additional actions designed to more effectively control SMI costs through specific program legislation as part of broad-based health care reform.

A MESSAGE FROM THE PUBLIC TRUSTEES:

This is the fifth set of Trust Fund Reports on which we have reported as Public Trustees. It is also, under the terms of our appointment, our last report, and we use this occasion to summarize our views on some major aspects of the Social Security and Medicare programs. As representatives of the public, our efforts have been to assure the American public of the integrity of the process and the credibility of the information in these reports. We feel privileged and honored to have been able to take part in this important exercise in public accountability, and want to provide our best advice on directions for change of these important programs in the years ahead.

The Need For Action

During the past 5 years there has been a trend of deterioration in the long-range financial condition of the Social Security and Medicare programs and an acceleration in the projected dates of exhaustion in the related trust funds. To some extent, this has been predictable because when doing annual 75-year projections, an additional deficit year in the 2060s is being added with each new projection. But to some extent, the increasingly adverse projections have come from unforeseen events and from the absence of prompt action in response to clear warnings that changes are necessary. These adverse trends can be expected to continue and indicate the possibility of a future retirement crisis as the U.S. population begins to age rapidly. We urge that concerted action be taken promptly to address the critical public policy issues raised by the financing projections for these programs.

Projections As A Guide To Action

We believe it is important for the public and the Congress to understand more about what the projections in the Trust Fund Reports really mean and how they are intended to be used. These projections represent the best estimates the Trustees can make based on the best available information and methodologies. We have, during our period of service, attempted to test assumptions, question methodologies and work with the Offices of the Actuary of SSA and HCFA and others in and out of government to seek improvements in the projections. We have also stimulated thought through a symposium and publication of papers on how methods and assumptions might be improved to better estimate the future income and health care needs of the elderly and disabled. Action should be taken to continue and extend survey and

other data development efforts and to improve modeling capability regarding the income and health circumstances of future retirees. Such information is critical to the legislative and regulatory activity that will be required for both public and private income security and health care programs in future years.

However, with even the best data and models, projections ultimately are only estimates and must necessarily reflect the uncertainties of the future. They are useful if understood as a guide to a plausible range of future results and if acted on in a timely and responsible manner. They are not helpful if ignored, or if used improperly, or if distorted. We hope that more policymakers will come to grips with the strengths and limitations of projections such as those in the Trust Fund Reports and how those projections can be used most productively.

Social Security Program

The Old-Age and Survivors Insurance Trust Fund shows a deficit of 1.87 percent of payroll in the long run. It is by far the best financed of the trust funds, and we believe strongly that the OASI program can and should be maintained over the long term. Yet even here reforms should be undertaken sooner rather than later to ease the transition to providing financial stability in the next century. We note the recent work of the Bipartisan Entitlement Commission and the current work of the Advisory Council on Social Security regarding the long-term financing of the OASI program. We hope that this kind of work will continue and that this problem will be addressed in a timely fashion.

The condition of the Disability Insurance Trust Fund is more troublesome. While the Congress acted this past year to restore its short-term financial balance, this necessary action should be viewed as only providing time and opportunity to design and implement substantive reforms that can lead to long-term financial stability. The research undertaken at the request of the Board of Trustees, and particularly of the Public Trustees, shows that there are serious design and administrative problems with the DI program. Changes in our society, the workforce and our economy suggest that adjustments in the program are needed to control long-range program costs. Also, incentives should be changed and the disability decision process improved in the interests of beneficiaries and taxpayers. We hope that this research will be completed promptly, fully presented to Congress and the public, and that the Congress will take action over the next few years to make this program financially stable over the long term.

Medicare Program

The most critical issues, however, relate to the Medicare program. Both the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund show alarming financial results. While the financial status of the HI program improved somewhat in 1994, the HI Trust Fund continues to be severely out of financial balance and is projected to be exhausted in about 7 years. The SMI Trust Fund, while in balance on an annual basis, shows a rate of growth of costs which is clearly unsustainable. Moreover, this fund is projected to be 75 percent or more financed by general revenues, so that given the general budget deficit problem, it is a major contributor to the larger fiscal problems of the nation.

The Medicare program is clearly unsustainable in its present form. We had hoped for several years that comprehensive health care reform would include meaningful Medicare reforms. However, with the results of the last Congress, it is now clear that Medicare reform needs to be addressed urgently as a distinct legislative initiative. We also believe strongly that Medicare reform should be included as an integral part of any broader health care reform initiative which may be considered in the future.

There are basic questions with the scale, structure and administration of the Medicare program that need to be addressed. For example, is it appropriate to have a Part A and Part B today, or should this legacy of the political process that enacted Medicare in the mid-1960s be revised to create a unified program? Is it appropriate to combine participants' social insurance tax contributions for Part A and premium payments for approximately one-quarter of Part B with general revenues? If so, what should be the proper combination of beneficiary premiums, taxpayer social insurance contributions, and general revenues? How are each of these kinds of revenue sources to be justified and what rights to benefits and responsibilities to pay benefits are thereby established? How can the program become more cost-effective? How can fraud, abuse and waste be better controlled?

We feel strongly that comprehensive Medicare reforms should be undertaken to make this program financially sound now and over the long term. The idea that reductions in Medicare expenditures should be available for other purposes, including even other health care purposes, is mistaken. The focus should be on making Medicare itself sustainable, making it compatible with OASDI, and making both Social Security and Medicare financially sound in the long term.

We strongly recommend that the crisis presented by the financial condition of the Medicare Trust Funds be urgently addressed on a comprehensive basis, including a review of the program's financing methods, benefit provisions, and delivery mechanisms. Various groups should be consulted and reform plans developed that will not be disruptive to beneficiaries, will be fair to current taxpayers who will in the future become beneficiaries, and will be compatible with government finances overall.

Institutional Considerations

We have as Public Trustees tried over the past 5 years to provide continuity and improve the institutional framework surrounding the Social Security and Medicare programs. We have bridged two Administrations (one Republican and one Democratic), two Advisory Councils (one appointed by a Republican Administration and one by a Democratic Administration), and many changes in the ex officio Trustees. We have consulted with each of the Advisory Councils, as well as the working group of the prior Public Trustees, the Bipartisan Entitlement Commission, the Notch Commission and many other government entities. We have testified before both the House Ways and Means Committee and the Senate Finance Committee and held regular briefings for Congressional staff on the Trust Fund Reports. We know that with the advent of the new Social Security Administration as an independent agency, many of the institutional relationships in these areas will change. We hope that the Public Trustees in the future will continue to make a contribution towards a coherent institutional structure that serves the interests of the public.

Finally, we note that although the statute provides that one of the Public Trustees must be from each of the major political parties, we have operated as independent professionals on a nonpartisan basis. Every statement we have made over 5 years has been joint and consensual, and without partisan content or political dissonance. We believe these programs are too important to be politicized and urge that a highly professional, nonpartisan approach continue to be followed in future reports to the Congress and the public.

Stanford G. Ross
Trustee

David M. Walker
Trustee

Chairman ARCHER. Mr. King.

STATEMENT OF ROLAND E. "GUY" KING, CONSULTING ACTUARY, ERNST & YOUNG; AND FORMER CHIEF ACTUARY, HEALTH CARE FINANCING ADMINISTRATION

Mr. KING. Thank you, Mr. Chairman, and Members of the Committee. I am an independent consulting actuary and I was chief actuary for the Health Care Financing Administration for 16 years up until 1994.

Before I start, let me commend the Members of this Committee for taking on headlong this very difficult issue. There has been much discussion recently of the need to reform the Medicare Program to bring the cost increases under control. And in particular, there has been discussion of the need to bring the cost of the Hospital Insurance Program under control in order to prevent the imminent depletion of the trust fund.

As you pointed out, Mr. Chairman, the 1995 trustees' report indicates that the fund will be depleted by the year 2002 if nothing is done. Both the congressional leadership and the President seem to agree on the need to reform the Hospital Insurance Program, but they have differing views on the magnitude of the savings needed during the next 7 years.

The House leadership has set a goal of \$270 billion in Medicare savings in Medicare during the next 7 years. And I estimate that the portion of the savings that would accrue to the Hospital Insurance Program would range from \$145 to \$167 billion based on the Hospital Insurance Program's share of total Medicare outlays.

The President has proposed net savings of \$124 billion in Medicare with \$89 billion in savings in the Hospital Insurance Program.

I have prepared projections on the impact of these proposals on the Hospital Insurance Trust Fund under the same assumptions used by the—

Chairman ARCHER. Mr. King, would you suspend for just a moment for a quick clarification.

Are the numbers that you just mentioned both by CBO scoring or is one by OMB and one by CBO?

Mr. KING. No. They are both by—the proposed savings I presume would be by CBO's scoring—

Chairman ARCHER. \$89 billion in the Clinton proposal is scored by CBO?

Mr. KING. No. That was in the—

Chairman ARCHER. It was OMB, was it not?

Mr. KING. Yes.

Chairman ARCHER. And the \$145 billion for the Republican proposal in the House was scored by CBO; is that correct?

Mr. KING. No, that wasn't scored by CBO. That was my best estimate of what the Hospital Insurance Program—

Chairman ARCHER. Is that based on the assumptions that were underlying the OMB analysis of the President's proposal or the assumptions underlying the CBO proposal?

Mr. KING. It is based on the goal of \$270 billion in total savings in Medicare and then it brackets—

Chairman ARCHER. I didn't intend to belabor this and we can get into it in the question period.

Mr. GIBBONS. Let me belabor it a little, if you will, Mr. Chairman.

Mr. King, have you read the Republican bill to do what we are talking about here today?

Mr. KING. No, sir.

Mr. GIBBONS. Nobody has. And you haven't either?

Thank you.

Chairman ARCHER. Mr. King, you may continue, and we will restore the time that I took out of your 5 minutes by my inquiry.

Mr. KING. All of the projections of these proposals on the HI Trust Fund I have made under the assumptions used by the hospital insurance board of trustees, so all of my projections are under the trustees' report assumptions.

Tables 1 and 2, which the Committee Members have, display the estimated future operations of the Hospital Insurance Trust Fund for HI reform proposals that would save \$145 billion and \$167 billion, respectively, during the 7-year period from 1996 to 2002. The \$145 billion level of savings would delay the depletion of the trust fund by 9 years, to 2011, which is the year when the post-World War II baby boom officially first begins to retire. The \$167 billion level of savings would delay the depletion of the Hospital Insurance Trust Fund by 12 years, to 2014.

Table 3 displays the estimated future operations of the Hospital Insurance Trust Fund for the President's proposal for HI savings of \$89 billion. The President's proposals would delay the depletion of the Hospital Insurance Trust Fund by 4 years, to 2006.

These projections show that the President's \$89 billion package of savings does not satisfy the board of trustees' test for financial adequacy in the short-range projection period. The test that is described in the 1995 trustees' report requires that the trust fund ratio, which is the ratio of assets to expenditures, either be at least 100 percent throughout the 10-year period or reach a level of 100 percent within 5 years and then remain at or above the 100-percent level throughout the remainder of the 10-year period. Approximately \$160 billion in HI savings would be required during this 7-year period to meet the trustees' short-range test.

I would like to point out two important caveats that arise from my not knowing the precise composition of any of the reform package. First, I am obviously assuming that the savings targets of all the proposals would, in fact, be achieved, even though it is not possible at this time to evaluate the effectiveness of the reforms that are contemplated.

Second, I assume only the savings initiatives that are taking effect during the 7-year period, 1996 through 2002. That is, I don't assume any reductions in the rate of growth in outlays beyond the period 2002. The savings initiatives that were implemented in the 7-year period ending in 2002—

Chairman ARCHER. Again, would you suspend for a moment?

The Chair has been advised that there is a group in the Committee room that has made inquiry as to what they need to do in order to be arrested. They have asked the police what sort of activity they would have to enter into in order to be arrested. I assume that they are commencing that activity now. It is in violation of the

Committee's rules and the Committee will be in order. This is a warning.

The Committee will stand in recess until the police can restore order.

[Recess.]

Chairman ARCHER. The Committee will come to order.

We must request that our guests take seats and that there be no audible conversation so that the Committee can continue with its business.

Mr. King, my apologies. Your testimony seems to have been disrupted a couple of times and you certainly will have adequate time to complete your verbal statement, and you may proceed.

Mr. KING. Thank you, Mr. Chairman.

As I was saying, I have not assumed any reductions in the rate of growth in outlays after 2002. The savings initiatives that take place in 1996 through 2002 would, of course, continue to produce savings in years after 2002. The program growth after 2002 is projected to be the same as under current law. Without knowing the precise nature of the reform package, it is not possible to determine the impact, if any, on growth rates after 2002.

This concludes my formal remarks, Mr. Chairman. I will be happy to answer any questions.

[The prepared statement and attachments follow:]

TESTIMONY BY
Guy King
Consulting Actuary and
Former Chief Actuary for HCFA
before the
House Committee on Ways and Means
September 21, 1995

Mr. Chairman, my name is Guy King. I am an independent Consulting Actuary. I was the Chief Actuary for the Health Care Financing Administration from 1978 to 1994.

There has been much discussion recently of the need to reform the Medicare program to bring cost increases under control. In particular, there has been discussion of the need to bring the cost of the Hospital Insurance (HI) program under control in order to prevent imminent depletion of the Hospital Insurance Trust Fund. The 1995 HI Trustees Report indicates that the HI Trust Fund will be depleted by 2002 if nothing is done. Both the Congressional leadership and President seem to agree on the need to reform the HI program, but have differing views on the magnitude of the savings needed during the next seven years. The House leadership has set a goal of saving \$270 billion in Medicare during the next seven years. I estimate that the HI portion of the savings would range from \$145 to \$167 billion. The President has proposed net savings of \$124 billion in Medicare, with \$89 billion in savings in the HI program.

I have prepared projections of the impact of these proposals on the HI Trust Fund under the assumptions used by the HI Board of Trustees.

Tables 1 and 2 display the estimated future operations of the HI Trust Fund for HI reform proposals that would save \$145 billion and \$167 billion, respectively during the seven year period 1996-2002. The \$145 billion level of savings would delay the depletion of the trust fund by 9 years, to 2011, when the Post World War II Baby Boom begins to retire. The \$167 billion level of savings would delay the depletion date for the HI Trust Fund by 12 years, to 2014.

Table 3 displays the estimated future operations of the HI Trust Fund for the President's proposal for HI savings of \$89 billion. The President's proposals would delay the depletion date for the HI Trust Fund by 4 years, to 2006.

These projections show that the President's \$89 billion package of savings does not satisfy the Board of Trustees' test for financial adequacy in the short-range projection period. This test requires that the trust fund ratio (ratio of assets to expenditures) either (a) be at least 100 percent throughout the ten year projection period, or (b) reach a level of 100 percent within five years and remain at or above 100 percent throughout the remainder of the ten year period. Approximately \$160 billion in HI savings during the next seven years would be needed to meet the Trustees' short range test.

I would like to point out two caveats to these projections that arise from not knowing the precise composition of the reform packages. First, I obviously assumed that the savings targets would, in fact, be achieved, even though it is not possible to know at this time how effective the reforms will be. Second, I assume only the savings initiatives taking effect during the period 1996-2002. That is, no reductions in the rate of growth in outlays are assumed to take effect after 2002. The savings initiatives taking place in 1996-2002 would, of course, continue to produce savings in years after 2002, but program growth after 2002 is projected to be the same as under current law. Without knowing the precise nature of the reform package, it is not possible to determine the impact, if any, on rates of growth after 2002.

This concludes my formal remarks and I'll be pleased to answer any questions you may have.

TABLE 1: ESTIMATED CALENDAR YEAR OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND UNDER ALTERNATIVE PROPOSALS THAT SAVE \$145 BILLION OVER 7 YEARS

Calendar year	Beginning fund balance	Expenses			Income			Net increase in fund	Ending fund balance
		Benefits payments	Admin. expenses	Total expenses	Payroll taxes, etc	Interest income	Total income		
Actual data									
1994	127.8	103.2	1.3	\$ 104.5	98.9	10.7	109.6	\$ 5.0	\$ 132.8
Projection									
1995	\$ 132.8	112.7	1.2	\$ 113.9	106.3	11.1	117.4	\$ 3.5	\$ 136.3
1996	\$ 136.3	118.3	1.3	\$ 119.6	113.0	11.3	124.3	\$ 4.7	\$ 141.0
1997	\$ 141.0	124.3	1.3	\$ 125.6	118.6	11.5	130.1	\$ 4.5	\$ 145.5
1998	\$ 145.5	130.5	1.4	\$ 131.9	124.7	11.9	136.6	\$ 4.7	\$ 150.2
1999	\$ 150.2	137.0	1.5	\$ 138.5	130.8	12.1	142.9	\$ 4.4	\$ 154.7
2000	\$ 154.7	143.8	1.6	\$ 145.5	137.7	12.4	150.1	\$ 4.6	\$ 159.3
2001	\$ 159.3	151.0	1.7	\$ 152.7	145.4	12.8	158.2	\$ 5.4	\$ 164.7
2002	\$ 164.7	158.6	1.8	\$ 160.4	153.6	14.4	168.0	\$ 7.6	\$ 172.3
2003	\$ 172.3	171.1	1.9	\$ 173.0	162.5	10.9	173.4	\$ 0.3	\$ 172.6
2004	\$ 172.6	184.6	2.0	\$ 186.6	172.1	10.6	182.7	\$ (3.9)	\$ 168.7
2005	\$ 168.7	198.6	2.1	\$ 200.7	182.5	10.2	192.7	\$ (8.0)	\$ 160.7
2006	\$ 160.7	214.1	2.3	\$ 216.3	193.6	9.6	203.2	\$ (13.2)	\$ 147.5
2007	\$ 147.5	230.5	2.4	\$ 232.9	205.3	8.7	214.0	\$ (18.9)	\$ 128.5
2008	\$ 128.5	248.6	2.6	\$ 251.2	217.7	7.3	225.0	\$ (26.2)	\$ 102.4
2009	\$ 102.4	268.0	2.7	\$ 270.7	230.9	5.4	236.3	\$ (34.5)	\$ 67.9
2010	\$ 67.9	288.1	2.9	\$ 291.0	244.9	2.9	247.8	\$ (43.2)	\$ 24.7
2011	\$ 24.7	311.2	3.0	\$ 314.3	259.9	-0.2	259.7	\$ (54.5)	\$ (29.9)
2012	\$ (29.9)	336.2	3.2	\$ 339.4	275.7	-3.9	271.8	\$ (67.6)	\$ (97.5)
2013	\$ (97.5)	363.5	3.4	\$ 366.9	292.4	-8.6	283.8	\$ (83.1)	\$ (180.6)
2014	\$ (180.6)	393.0	3.6	\$ 396.6	310.2	-14.3	295.9	\$ (100.7)	\$ (281.3)
2015	\$ (281.3)	424.8	3.8	\$ 428.7	329.0	-21.2	307.8	\$ (120.9)	\$ (402.2)
2016	\$ (402.2)	459.0	4.1	\$ 463.1	347.3	-29.4	317.9	\$ (145.2)	\$ (547.4)
2017	\$ (547.4)	495.9	4.3	\$ 500.2	366.6	-39.3	327.3	\$ (172.9)	\$ (720.3)
2018	\$ (720.3)	535.7	4.6	\$ 540.3	387.0	-51.0	336.0	\$ (204.3)	\$ (924.6)
2019	\$ (924.6)	578.8	4.9	\$ 583.7	408.5	-64.8	343.7	\$ (239.9)	\$ (1,164.6)
2020	\$ (1,164.6)	625.3	5.1	\$ 630.5	431.3	-80.9	350.4	\$ (280.1)	\$ (1,444.7)

TABLE 2: ESTIMATED CALENDAR YEAR OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND UNDER ALTERNATIVE PROPOSALS THAT SAVE \$167 BILLION OVER 7 YEARS

Calendar year	Beginning fund balance	Expenses			Income			Net increase in fund	Ending fund balance
		Benefit payments	Admin. expenses	Total expenses	Payroll taxes, etc	Interest income	Total income		
Actual data									
1994	\$ 127.8	\$ 103.2	1.3	\$ 104.5	98.9	10.7	109.6	\$ 5.0	\$ 132.8
Projection									
1995	\$ 132.8	112.7	1.2	\$ 113.9	106.3	11.1	117.4	\$ 3.5	\$ 136.3
1996	\$ 136.3	117.7	1.3	\$ 119.0	113.0	11.3	124.3	\$ 5.3	\$ 141.6
1997	\$ 141.6	122.9	1.3	\$ 124.3	118.6	11.7	130.3	\$ 6.0	\$ 147.6
1998	\$ 147.6	128.4	1.4	\$ 129.8	124.7	12.2	136.9	\$ 7.0	\$ 154.6
1999	\$ 154.6	134.1	1.5	\$ 135.6	130.8	12.6	143.4	\$ 7.8	\$ 162.5
2000	\$ 162.5	139.9	1.6	\$ 141.5	137.7	13.2	150.9	\$ 9.3	\$ 171.8
2001	\$ 171.8	146.1	1.7	\$ 147.8	145.4	14.0	159.4	\$ 11.5	\$ 183.3
2002	\$ 183.3	152.6	1.8	\$ 154.4	153.6	16.3	169.9	\$ 15.4	\$ 198.8
2003	\$ 198.8	164.7	1.9	\$ 166.6	162.5	12.8	175.3	\$ 8.7	\$ 207.5
2004	\$ 207.5	177.7	2.0	\$ 179.7	172.1	13.0	185.1	\$ 5.5	\$ 212.9
2005	\$ 212.9	191.1	2.1	\$ 193.3	182.5	13.3	195.8	\$ 2.5	\$ 215.4
2006	\$ 215.4	206.0	2.3	\$ 208.3	193.6	13.3	206.9	\$ (1.4)	\$ 214.1
2007	\$ 214.1	221.9	2.4	\$ 224.3	205.3	13.3	218.6	\$ (5.7)	\$ 208.4
2008	\$ 208.4	239.3	2.6	\$ 241.9	217.7	12.8	230.5	\$ (11.3)	\$ 197.1
2009	\$ 197.1	258.0	2.7	\$ 260.7	230.9	11.8	242.7	\$ (17.9)	\$ 179.2
2010	\$ 179.2	277.3	2.9	\$ 280.2	244.9	10.5	255.4	\$ (24.8)	\$ 154.4
2011	\$ 154.4	299.5	3.0	\$ 302.6	259.9	8.5	268.4	\$ (34.2)	\$ 120.2
2012	\$ 120.2	323.5	3.2	\$ 326.8	275.7	6.1	281.8	\$ (45.0)	\$ 75.2
2013	\$ 75.2	349.8	3.4	\$ 353.2	292.4	2.9	295.3	\$ (58.0)	\$ 17.2
2014	\$ 17.2	378.2	3.6	\$ 381.8	310.2	-1.2	309.0	\$ (72.8)	\$ (55.6)
2015	\$ (55.6)	408.9	3.8	\$ 412.7	329.0	-6.2	322.8	\$ (90.0)	\$ (145.5)
2016	\$ (145.5)	441.8	4.1	\$ 445.8	347.3	-12.5	334.8	\$ (111.0)	\$ (256.5)
2017	\$ (256.5)	477.3	4.3	\$ 481.6	366.6	-20.1	346.5	\$ (135.1)	\$ (391.6)
2018	\$ (391.6)	515.6	4.6	\$ 520.2	387.0	-29.3	357.7	\$ (162.5)	\$ (554.1)
2019	\$ (554.1)	557.1	4.9	\$ 561.9	408.5	-40.4	368.1	\$ (193.8)	\$ (747.9)
2020	\$ (747.9)	601.8	5.1	\$ 607.0	431.3	-53.5	377.8	\$ (229.2)	\$ (977.1)

September, 1995

TABLE 3: ESTIMATED CALENDAR YEAR OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND UNDER ALTERNATIVE PROPOSALS THAT SAVE \$89 BILLION OVER 7 YEARS

Calendar year	Beginning fund balance	Expenses			Income			Net increase in fund	Ending fund balance
		Benefits payments	Admin. expenses	Total expenses	Payroll taxes, etc	Interest income	Total income		
Actual data									
1994	127.8	103.2	1.3	\$ 104.5	98.9	10.7	109.6	\$ 5.0	\$ 132.8
Projection									
1995	\$ 132.8	112.7	1.2	\$ 113.9	106.3	11.1	117.4	\$ 3.5	\$ 136.3
1996	\$ 136.3	119.9	1.3	\$ 121.2	113.0	11.2	124.2	\$ 3.0	\$ 139.3
1997	\$ 139.3	127.6	1.3	\$ 128.9	118.6	11.3	129.9	\$ 0.9	\$ 140.3
1998	\$ 140.3	135.8	1.4	\$ 137.2	124.7	11.3	136.0	\$ (1.2)	\$ 139.0
1999	\$ 139.0	144.5	1.5	\$ 146.0	130.8	10.9	141.7	\$ (4.3)	\$ 134.8
2000	\$ 134.8	153.7	1.6	\$ 155.3	137.7	10.3	148.0	\$ (7.3)	\$ 127.5
2001	\$ 127.5	163.5	1.7	\$ 165.2	145.4	9.6	155.0	\$ (10.2)	\$ 117.3
2002	\$ 117.3	174.0	1.8	\$ 175.8	153.6	9.5	163.1	\$ (12.8)	\$ 104.5
2003	\$ 104.5	187.7	1.9	\$ 189.6	162.5	5.9	168.4	\$ (21.2)	\$ 83.3
2004	\$ 83.3	202.5	2.0	\$ 204.5	172.1	4.3	176.4	\$ (28.1)	\$ 55.2
2005	\$ 55.2	217.9	2.1	\$ 220.0	182.5	2.3	184.8	\$ (35.2)	\$ 20.0
2006	\$ 20.0	234.9	2.3	\$ 237.1	193.6	-0.1	193.5	\$ (43.6)	\$ (23.7)
2007	\$ (23.7)	252.9	2.4	\$ 255.3	205.3	-3.2	202.1	\$ (53.2)	\$ (76.8)
2008	\$ (76.8)	272.8	2.6	\$ 275.3	217.7	-6.9	210.8	\$ (64.6)	\$ (141.4)
2009	\$ (141.4)	294.1	2.7	\$ 296.8	230.9	-11.3	219.6	\$ (77.2)	\$ (218.6)
2010	\$ (218.6)	316.1	2.9	\$ 319.0	244.9	-16.6	228.3	\$ (90.7)	\$ (309.3)
2011	\$ (309.3)	341.5	3.0	\$ 344.5	259.9	-22.5	237.4	\$ (107.1)	\$ (416.5)
2012	\$ (416.5)	368.8	3.2	\$ 372.1	275.7	-29.7	246.0	\$ (126.1)	\$ (542.5)
2013	\$ (542.5)	398.8	3.4	\$ 402.2	292.4	-38.2	254.2	\$ (148.0)	\$ (690.6)
2014	\$ (690.6)	431.1	3.6	\$ 434.8	310.2	-48.2	262.0	\$ (172.7)	\$ (863.3)
2015	\$ (863.3)	466.1	3.8	\$ 470.0	329.0	-59.8	269.2	\$ (200.7)	\$ (1,064.0)
2016	\$ (1,064.0)	503.6	4.1	\$ 507.7	347.3	-73.2	274.1	\$ (233.6)	\$ (1,297.6)
2017	\$ (1,297.6)	544.1	4.3	\$ 548.4	366.6	-88.9	277.7	\$ (270.6)	\$ (1,568.3)
2018	\$ (1,568.3)	587.8	4.6	\$ 592.4	387.0	-106.9	280.1	\$ (312.3)	\$ (1,880.6)
2019	\$ (1,880.6)	635.0	4.9	\$ 639.9	408.5	-127.8	280.7	\$ (359.1)	\$ (2,239.7)
2020	\$ (2,239.7)	686.1	5.1	\$ 691.2	431.3	-151.7	279.6	\$ (411.6)	\$ (2,651.3)

September, 1995

Chairman ARCHER. Thank you very much.

The Chair has just a brief question or two.

Since you are the former chief actuary of the Health Care Financing Administration, could you give the Committee the facts as to where the funds go that are saved by slowing the increased growth in Medicare, because the gentleman from Florida, to my left, commented in his opening statement, they all go into the general treasury in order to accommodate general tax reductions.

Can you, Mr. King, inform the Committee as to the facts of where the savings go by reducing the growth in Medicare?

Mr. KING. Yes, sir. The savings from reducing the rate of growth in the Hospital Insurance Trust Fund go back into the Hospital Insurance Trust Fund and earn interest that increases the reserves available for the payment of future benefits. They cannot, by statute, be used to go into general revenues.

Chairman ARCHER. Thank you very much.

Mr. Thomas may inquire.

Mr. THOMAS. Thank you, Mr. Chairman.

Mr. King, your career transcended political parties occupying the White House; is that correct?

Mr. KING. Yes, sir.

Mr. THOMAS. So as a career civil servant, your function as the head actuary was to be as accurate as possible in supplying data from a professional base. You were never a political appointee; is that correct?

Mr. KING. That is right.

Mr. THOMAS. And based upon your analysis of the numbers supplied to you, notwithstanding the difference of the base and the President's numbers obviously generated by the Office of Management and Budget, my understanding of what you told us was that the President's plan would keep the trust fund solvent to the year 2006; is that correct?

Mr. KING. That is right. The fund would be depleted in 2006 but it would not have adequate reserves as required by minimum financial requirements starting in the late nineties all the way to 2006.

Mr. THOMAS. So whose financial test does the President's plan not meet? Who determines that it is not adequate?

Mr. KING. It is the financial test that is described in the trustees' report and that means that the financial test is endorsed by the board of trustees.

Mr. THOMAS. The board of trustees then have said, according to the test they set up for financial soundness, that the President's plan is not financially sound. Who are the board of trustees?

Mr. KING. The ex-officio members of the board of trustees are the Secretary of Health and Human Services, the Secretary of the Treasury, the Secretary of Labor, and two public trustees, both of whom cannot be from the same political party.

Mr. THOMAS. So you have the public trustees not from the same party, the Commissioner of Social Security as a trustee, and three Cabinet secretaries who have been named to those Cabinet positions by the President of the United States and they say the President's plan is not sound; is that correct?

Mr. KING. They have not said that the President's plan is not sound.

Mr. THOMAS. The President's plan doesn't meet the criteria that the trustees have established which determines whether a plan is sound or not; is that correct?

Mr. KING. Yes, sir.

Mr. THOMAS. And on the other side of the coin, in your examining the structure that we have provided, would you say, then that the Republican plan meets those tests as determined by the President's appointed trustees?

Mr. KING. If the Republican plan were to achieve savings of approximately \$160 billion over the next 7 years, it would achieve the financial requirements by the board of trustees.

Mr. THOMAS. Basically what you have done is created a target for us, and if we hit that target, we will then have achieved the criteria that the President's trustees said is appropriate?

Mr. KING. Yes, sir.

Mr. THOMAS. And based upon your analysis of the Democrats' plan, which they said they would have, or even the approximate numbers or the target of their plan, how does the Democrats' plan compare to what the President has offered? And of course when I say Democrats, I mean the Members of the Democrat party in the House led by Mr. Gephardt, or, for example, any plan offered by any Member on this Committee in conceptual form or otherwise.

Mr. KING. I haven't seen that plan. I haven't seen a description of the goals of the plan, but if I were given the goals of the plan, I would certainly be happy to offer projections on the impact on the HI Trust Fund.

Mr. THOMAS. So based upon the information and the tables you have in front of us, as a career civil servant and an actuary of HCFA, the Republican plan with its target figure will meet the criteria for soundness. The President's plan does not—and you await any kind of a plan that the Ways and Means Democrats might present to you—so you will do an analysis on that as well, is that where we are?

Mr. KING. Yes, sir.

Mr. THOMAS. I look forward to that third analysis.

Thank you very much, Mr. Chairman.

Chairman ARCHER. Mr. Gibbons.

Mr. GIBBONS. Mr. King, can you point out to me any provision of the law that has ever directed you as an actuary to convert this program from a pay-as-you-go program to an actuarially funded program? Any provision of law?

Mr. KING. No, sir. The requirements of the board of trustees are precisely the requirements that you described earlier. They are setting up a criteria that requires the Hospital Insurance Trust Fund to retain a contingency reserve in the trust fund. It is still funded on a pay-as-you-go basis and it requires that it maintain a contingency reserve in that trust fund equal to the following year's outlay. So it is 1 year's worth of benefits, that is the minimum requirement to be retained in the trust fund.

Mr. GIBBONS. Thank you for reinforcing my recollection of this plan. This plan is now and always has been a pay-as-you-go program with a 1-year reserve, and now we have a 7-year reserve and

we are having a funeral? It sounds like we should be having a champagne party, we have 7 years of reserve.

I recognize that there are going to be problems with the baby boomers beginning to mature, but this program that has been outlined in releases to us, as I understand it, and correct me if I am wrong, Mr. King, does nothing about—directly about the baby boom population; is that right?

Mr. KING. It gets you to the baby boom population. It gets you to the point where the baby boom population is beginning to retire.

Mr. GIBBONS. But this plan, this press release that we have seen so far, does nothing about any problem that may arise in the baby boom generation; is that right?

Mr. KING. That is why I didn't make any projections beyond 2002 because I don't know what effect the plan might have beyond 2002.

Mr. GIBBONS. We have established from your testimony that this is a pay-as-you-go program that we were required to keep under law and that we have never changed here in the Congress, a 1-year reserve, and that we have that 1-year reserve and that the program is sound for 7 years out and that it does nothing about the problem of the baby boom generation.

Thank you, Mr. King.

Chairman ARCHER. Mr. Shaw.

Mr. SHAW. Thank you, Mr. Chairman.

I am somewhat confused by Mr. Gibbons' statements about don't worry about it because as long as we are 1 year ahead of disaster, we are all right. That is like saying, Don't worry about jumping off the cliff because the fall isn't going to kill you, it is a sudden stop. That is amazing.

I would like to ask Mr. King, Do you know of any pension plans or anything in the private sector that only looks 1 year ahead, particularly when you see that there is a big balloon of employees that are coming out there that are going to be looking toward retirement?

Mr. KING. No, sir. In fact, that is why the board of trustees required us to make 75-year projections, because they felt that it was prudent to at least be able to look far enough ahead for the sake of generational equity to at least be able to look far enough ahead to see that the people who are paying into the program now could receive benefits under the program.

Mr. SHAW. Generational equity, you mean that the people that are going to be coming into the plan that are paying a lot of money into the plan and will pay actually more money into the plan by the time they retire than those of us who may be going into the plan a little earlier, you are saying that it would not be equitable or fair to them to have them pay into a plan that was going to be broke when they needed it; is that what you are saying?

Mr. KING. Yes, sir. I view the Hospital Insurance Program as a compact that the government forms between generations, and in return for paying for the benefits of the current generation the generation that is working now is promised this same level of benefits that the currently retired generation is promised.

Mr. SHAW. And the people who are in the plan now who plan to live for 7 years or longer, they would be out of luck if this Congress doesn't act; is that correct?

Mr. KING. That is right, sir.

Mr. SHAW. Now, the longer we wait to put the cure into the plan, aren't we looking at more severe consequences? In other words, if we didn't do something now, we would have to, in 4 or 5 years, we would have to change the plan in a dramatic way, which would be either a tremendous burden on the seniors that are in the plan or on the taxpayers whose payroll taxes would be increased at an astronomical level. Is that correct? Aren't those the only two choices that would be available to us if we don't do anything?

Mr. KING. That is correct. The longer you wait, the more difficult the issue becomes, and that is why the issue is so difficult now is because of the long time it has taken to attempt to do something about the problem.

Mr. SHAW. Mr. King, are you saying that if this Congress, when it was controlled by the Democrats, if they had done something several years ago, that the solution would have been even easier than it is today? Is that what you are saying?

Mr. KING. The earlier the action taken to address the problem, the more tractable the problem would be.

Mr. SHAW. I thank you.

You mentioned—in an offhand question that was presented by the Ranking Democrat Member, Mr. Gibbons, you said that you had not seen the bill. What did you base your actuary assumptions on?

Mr. KING. They were based on the assumption that since the Hospital Insurance Program constitutes about 60 percent of the Medicare Program, that roughly 60 percent of the savings would have to come from the Hospital Insurance Program, a little more, a little less. That is why I gave a range.

Mr. SHAW. And exactly what documents did you base your conclusions on?

Mr. KING. I based the projections for the congressional leadership on the goal that was pointed out in the press, the House leadership's goal of \$270 billion in savings in Medicare over the next 7 years, and I based the \$89 billion in savings from the President on a White House press release.

Mr. SHAW. Thank you. Thank you, Mr. King.

Yield back. Mr. Chairman.

Chairman ARCHER. Ms. Johnson.

Mr. Rangel.

Mr. RANGEL. Thank you.

Mr. King, thank you so much for your testimony. In following through with Mr. Shaw's question, did I understand you correctly in saying that the testimony you are giving this morning is not based on any legislation; is that correct?

Mr. KING. Yes.

Mr. RANGEL. You said in part it is based on reports that you read in the newspaper?

Mr. KING. Yes. The \$270 billion goal is a goal that I read in the newspaper and was confirmed by staff.

Mr. RANGEL. And you also said that part of your testimony was based on the House leadership. Could you better describe what the House leadership told you? Did they give you a plan? Did they give you a document? What Mr. Shaw was asking was what document

are you basing your assumptions on? Do you have any document? Was a document given to you to study, to analyze, in order for you to testify, to give your assumptions?

Mr. KING. No. The projections were based on the Hospital Insurance Program's share of the \$270 billion goal for Medicare savings.

Mr. RANGEL. But you had no materials given to you?

Mr. KING. No.

Mr. RANGEL. You have read nothing that has come from the House leadership to testify to this morning; is that correct?

Mr. KING. I don't have legislative language, that is correct.

Mr. RANGEL. I am not saying legislative language.

Are you familiar with a document that was distributed yesterday called the Medicare Preservation Act and in quotes called "A Better Medicare"? I am holding up this 60-page document. Are you able to see it from where you are sitting?

Mr. KING. Yes. I can't read it, of course, but I can see it.

Mr. RANGEL. Have you ever seen this document before?

Mr. KING. I haven't seen that document, no.

Mr. RANGEL. So the Republican leadership has given you nothing to read.

Mr. KING. That is right.

Mr. RANGEL. I have no further questions.

Chairman ARCHER. Mr. Bunning.

Mr. BUNNING. Pass.

Chairman ARCHER. Mr. Houghton.

Mr. HOUGHTON. Pass.

Chairman ARCHER. Mr. Herger.

Mr. HERGER. Just very briefly, Mr. King. I want to make sure I understand why you are here testifying and why we are having a hearing today.

Now, we heard a comment on the minority side just a few minutes ago that stated they didn't think Medicare needed to be saved. They feel that it was basically a partisan issue, that they felt that it needed to be saved from Republicans, that is close to a direct quote, and that the crisis was PR generated.

What is your comment on that? Is this the way you see this situation?

Mr. KING. I believe the report of the board of trustees, the 1995 report of the board of trustees, and previous reports of the board of trustees, show that this is a problem that is recognized both by the administration and by the Congress.

Mr. HERGER. Thank you very much. That is all I have.

Thank you, Mr. Chairman.

Chairman ARCHER. Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

I think, Mr. King, it is interesting that all of this testimony you gave us this morning shows that the Republican outline which you claim to be able to analyze without any numbers extends the date by 1 year if, in fact, you are correct. The problem seems to lie with the creators of this plan, however you may decide to interpret it.

It is obvious that the people trying to foist this scheme off on the public, first, don't understand the Medicare system. Second, they are rank amateurs at the business of drafting legislation, and in general are running a wish league operation with staff that largely

comes from lobbyists and the industry which is being rewarded in this piece of legislation. It wouldn't be so bad, if there wasn't a little humor in all this.

On page 18, they are going to encourage beneficiaries to report fraud and abuse. They say that Medicare provides little emphasis on educating beneficiaries, but obviously doesn't educate any Republicans, either.

If you look in the House Budget Committee report, on page 93, you will see Chairman Kasich says that there is a man in North Carolina who complains that the hospital billed his sister-in-law \$49,435.67, and Mr. Kasich says that is a good reason to encourage beneficiaries to get into the act. But what Mr. Kasich and my Republican colleagues forgot, don't understand, or never took the trouble to learn is that Medicare didn't pay that. Medicare doesn't pay hospital bills.

We happened to call and check and we know that Medicare actually paid \$19,000, \$19,091.12 for a major surgical operation, and the difference between the charge that Mr. Kasich throws around so grandly and which these Republicans swallow without bothering to read the details is some \$30,000.

I would hate to think that anybody on the other side of the aisle in this Committee would have to take a test and explain anything about this Medicare operation, because it is obvious from this silly outline that they don't know what they are talking about.

For many years, the Medicare plan was adjusted and improved every year on a bipartisan basis by people on both sides of the aisle who cared to improve the health care of seniors and devoted some conscientious effort to doing it. It is sad, as people have said, to see this charade being conducted, albeit under rather stern and strict rules.

I would like to further point out as a point of personal privilege that on March 23, the bill, H.R. 3600, was reported from Subcommittee. On April 15, 1994, it was drafted into legislative language by the legislative counsel, and on May 18, the Full Committee began markup and either the Chairman was misinformed or lied.

Thank you.

Chairman ARCHER. Mr. Hancock.

Mr. HANCOCK. Thank you, Mr. Chairman.

Mr. King, I have to assume that you used something inflationary or inflation figures in your analysis for the future.

Mr. KING. Yes, sir.

Mr. HANCOCK. Did you analyze the difference between the amount that we are trying to control and the amount that has been proposed? Which one would be the most inflationary?

Mr. KING. I looked at the difference between the CBO baselines and the baseline projections in the trustees' report. What I found was that in terms of the rate of increase in costs of the Medicare Program between 1995 and 2002, the baselines were virtually identical. The difference in the projections lies in the fact that the CBO's estimates for 1995 are higher to begin with; and then they project essentially the same inflation assumptions off of a higher base, and that higher projection remains in the projections throughout the 7-year period.

The real difference in the baselines has to do with the higher estimates for 1995 and also the fact that CBO projects lower income growth in the latter years of the projection periods, and it makes the trust fund run out a little earlier. But the difference in the two baselines isn't significant enough to make a big difference in the projected year that the trust fund is projected to run out under current law. They are both projections; it is calendar year 2002.

Mr. HANCOCK. Thank you.

Chairman ARCHER. Mr. Camp.

Mr. CAMP. Thank you, Mr. Chairman. I note in your testimony, Mr. King, that you show the President's package, which has \$89 billion of savings; you have testified that that does not satisfy the bipartisan board of trustees' test for financial adequacy in the short-range period.

Mr. KING. Yes, sir.

Mr. CAMP. Is that accurate? Was that \$89 billion figure that you had based on any specific piece of statutory language that you received from the Clinton administration?

Mr. KING. No, it was based on a press release.

Mr. CAMP. And based on the estimates you have made regarding the numbers you received from the Republican proposals and the administration proposals, is it all that unusual for you to make estimates without statutory language?

Mr. KING. I think it serves a purpose in this case because it serves to create a goal for the impact of the legislation.

Mr. CAMP. All right. Thank you and I would be happy to yield to Mr. Thomas.

Mr. THOMAS. I thank the gentleman for yielding. You know, I guess we could go back and forth like a tennis match, but to try to put some definitiveness on what this Committee did with other bills that were before us before, I would like to tell the gentleman from California that in Mr. Gibbons' opening statement, he said we have got to have a bill. He said, "We need a piece of legislation in front of us." It didn't seem to bother him as Chairman, Acting Chairman, of the Ways and Means Committee on June 10. If you will examine the testimony from that time, he said:

Any of the previous marks are not in use, we are dealing with the mark of June 9. This mark was made last night by me as Chair. This is what was presented to this Committee, notwithstanding whatever had been done in the Subcommittee, Mr. Stark.

This is not legislative language. This is not a bill. What this is is a concept paper, just like ours. How short the memories are.

I thank the gentleman for yielding.

Mr. CAMP. Thank you, Mr. Chairman.

Mr. STARK. Mr. Chairman, point of order.

I believe it is a violation of the Committee rules to read from an uncorrected manuscript of Committee proceedings, and particularly where it has not been corrected.

Mr. THOMAS. No, gentleman, I paraphrased from it.

Chairman ARCHER. Mr. Jacobs.

Mr. JACOBS. Thank you, Mr. Chairman. I am going to paraphrase from a couple of ideas, too. It was said that in previous Congresses the only thing that was done to help the Medicare and Social Security system was to raise taxes. If I remember correctly, the last

vote in Congress to raise taxes, FICA taxes, was 1983; and although, if I recall correctly, the Chairman himself opposed the bill, on final passage, generally, Republicans and Democrats in the House supported it. And what is more to the point, President Reagan signed it into law, along with the first tax on Social Security benefits.

I criticize neither party for doing it. Both parties held hands, looked at reality and dealt with reality.

Neither is it correct to say that the only efforts to save the program were on the tax side. In 1983 the Reagan administration came to me as Chairman of the Medicare Subcommittee at the time and asked if I would cooperate and in fact sponsor their proposal for DRGs, the diagnosis related groups, the prospective payment program. Had that not become law, I am sure Mr. King would agree, we would be in very, very bad shape with the HI Trust Fund long since.

The following year, it was the physicians' freeze adjustments for inflation, for reimbursements under part B had exceeded the actual inflation by 80 percent; in 10 years' time, we had a 15-month freeze.

I might say as far as political consequences resulting in the American Medical Association's coming to my town of Indianapolis and spending one-third of \$1 million to get rid of me following that—following that episode, at the time—well, I guess they went after Pete, too, but they credit you with doing things I actually did. You happened to be the incumbent at the time, the Chairman at the time, but I think the record will show who actually did the things that honked them off.

I think I said in one interview, I thought they regarded me as an obstacle between them and the U.S. Treasury and, like tonsils, they thought I had to come out. But the good news was that doctors were not taking tonsils out much anymore.

I say all that to suggest that after all the fussing is over, my mother's favorite quotation is, "There is so much good in the best of us, and so much bad in the worst of us that it hardly becomes any of us to say very much about the rest of us." And once we have passed the emotions, I hope that that precedent of cooperation between a Democratic Congress and the Reagan administration can be reflected in the weeks and months ahead, that we can come together a little more quietly and see if we can work this thing out.

Mr. King, how much trouble is part B in?

Mr. KING. Part B is not in financial trouble because the revenues are redetermined each year at the level required to keep the program sound through the end of the following year. However, the board of trustees did take note of the fact that the rate of growth in the part B outlays of the part B trust fund had unsustainable growth rates and that the outlays of the trust fund were projected to triple as a percent of GDP.

Mr. JACOBS. I got your point. I got your point. In 1978 the premiums under part B paid what percent of the total cost of part B? Or let's just say in the late seventies. I know, and I suppose you know, too.

Mr. KING. At one point, the premiums paid 50 percent of the cost of part B.

Mr. JACOBS. I know that—I was here when it started in 1965. That was a requirement. Let's go to the late seventies. It fell to about 17 percent, didn't it?

Mr. KING. I believe that the lowest it ever fell that was—it is possible my recollection is 25 percent.

Mr. JACOBS. No, we had a bill that took great political courage to vote on about that time to raise the premiums from 17 percent to 25 percent; and that was considered sufficient at the time, the 25-percent portion under the realities that had occurred since 1965.

What percent do the premiums pay now in part B?

Mr. KING. A little over 30 percent.

Mr. JACOBS. Thank you.

Chairman ARCHER. Mr. Ramstad.

Mr. RAMSTAD. No questions, Mr. Chairman.

Chairman ARCHER. Mr. Zimmer.

Mr. ZIMMER. Mr. King, you have come here for the purpose of telling us what the impact of the President's proposal and the Republican proposal and the Democratic proposal, if they choose to give you one, would have on the trust fund under assumptions made by the board of trustees of the trust funds; is that correct?

Mr. KING. That is right.

Mr. ZIMMER. Do you need specific statutory language to do this?

Mr. KING. One of the caveats that I put in my testimony is that I had not received specific statutory language and that if these were—these projections were based on the goals of the two bills.

Mr. ZIMMER. Assuming that the legislation is going to be written to meet those budget targets that are set by the Budget Committee or explained in the President's press release, do you need statutory language to make your judgments?

Mr. KING. In order to make precise projections of the savings and the impact, yes.

Mr. ZIMMER. Within the range that you have given us?

Mr. KING. Yes.

Mr. ZIMMER. If the proportion is 60 percent to 40 percent, part A versus part B, what else do you need? You said that was one assumption you were making to perform your estimate; it might be a little more than 60 percent, it might be a little less than 60 percent. Do you need anything else in the statutory language?

Mr. KING. No. I think the—a set of assumptions in that we can make projections within the statutory language.

Mr. ZIMMER. So what you are saying is that to make these projections, you have assumed that the legislation, as finally drafted, will meet the \$270 billion savings goal of the—established by the budget resolution, that the proportion of savings between part A and part B will be roughly 60 to 40 percent. Do you need pages and pages or any particular detail beyond that to justify the projections that you have given us today?

Mr. KING. No, not with the caveats that I have given.

Mr. ZIMMER. Thank you. Is there statutory language that the President has provided you that enabled you to make your projections based on his proposal?

Mr. KING. No, I haven't seen statutory language.

Mr. ZIMMER. Is there statutory language that the Members of the minority have given you that have allowed you to make any kind of projection whatsoever?

Mr. KING. No.

Mr. ZIMMER. When the Ranking Minority Member of this Committee closed his questioning of you, he made a statement which you did not have an opportunity to answer. He said the program—and I assume he is referring to part A, Medicare, is sound for 7 years. Is that a correct statement?

Mr. KING. No, that is not correct. The fact that the trust fund is not projected to be depleted for 7 more years doesn't mean that it is sound for the next 7 years. As the board of trustees points out in its report, the reserves in the trust fund are projected to get low enough, such that the trust fund could actually run out much sooner than projected because of the inadequacy of the reserves.

Mr. ZIMMER. Did not the trustees also state that the trust fund will start paying out more than it takes in, beginning next year?

Mr. KING. Yes, that projection is in the report.

Mr. ZIMMER. Do you agree with that projection?

Mr. KING. Yes, sir.

Mr. ZIMMER. Thank you very much.

Chairman ARCHER. Mr. Matsui. I am taking the Members in the order in which they were here at the time the gavel went down.

Mr. FORD. Mr. Chairman, Mr. Shaw wasn't here earlier, Mrs. Johnson was not here earlier; and you called on the two of them.

Chairman ARCHER. I would say to the gentleman that they were here when the meeting was called to order. I am following the customary procedure.

The gentleman will be recognized according to that customary procedure. Mr. Matsui.

Mr. FORD. Mr. Chairman, I sat here and listened to you.

Chairman ARCHER. Mr. Matsui is recognized to question.

Mr. FORD. I entered this room before Mr. Shaw and Mrs. Johnson both, Mr. Chairman.

Chairman ARCHER. The Chair recognizes Mr. Matsui for questioning.

Mr. MATSUI. Mr. Chairman, I hate to do this, but would it be appropriate if I yield my time to—

Chairman ARCHER. Of course.

Mr. MATSUI. But then will I be able to—

Chairman ARCHER. The gentleman will then have used his time if he yields. But perhaps he could get Mrs. Kennelly to yield her time to him.

Mr. THOMAS. Isn't there a concept to waive?

Mr. MATSUI. I tried. Thank you, Mr. Chairman.

Mr. King, you indicated you read in press reports and other reports about the \$270 billion in the Republican plan, the savings over a 7-year period. Do you know as a matter of fact how much will be in part A when the bill is finally completed?

Mr. KING. No, you don't know for a fact how much will be in part A.

Mr. MATSUI. Do you know as a matter of fact how much will be in part B?

Mr. KING. No, sir.

Mr. MATSUI. Do you know how much of that will be for tax cuts?

Mr. KING. I am assuming that the split between part A and part B will be in the range of 60 percent, part A; 40 percent, and part B.

Mr. MATSUI. But you don't know that; is that correct?

Mr. KING. No. That is one of my assumptions.

Mr. MATSUI. That assumption is based upon the history breakdown.

Mr. KING. Yes, sir.

Mr. MATSUI. Right. But it is not based upon any document or any conversation you had with the Republican leadership who were drafting this plan.

Mr. KING. No.

Mr. MATSUI. Because in the press today there was a comment made in the Washington Post that, in fact, doctors will be kept pretty much whole. In fact, the President of the AMA indicated that he probably will be reasonably happy. That may alter your judgment of all this. It could; is that right?

Mr. KING. It is possible.

Mr. MATSUI. You obviously study trust funds. When President Reagan was President in 1982, the trustees had a report in January of that year. Do you know how long the solvency—the program would be before it became insolvent—the conclusion of the trustees' report in 1982?

Mr. KING. Yes. My recollection is that it wasn't very many years because at that point in time, the Social Security Trust Fund had just borrowed \$10 or \$12 billion—

Mr. MATSUI. It was 5 years.

Mr. KING [continuing]. From the Hospital Insurance Trust Fund and was projected not to be able to pay it back.

Mr. MATSUI. Let me ask you, so would 1987 be a reasonable number, from your recollection?

Mr. KING. Yes.

Mr. MATSUI. How about 1983, would the trustees' report at the conclusion of—the terms of the solvency under President Reagan, the insolvency would occur in the year 1990, 7 years, does that sound reasonable to you?

Mr. KING. Yes, sir.

Mr. MATSUI. Right. In 1984 the trustees' report said it would become insolvent in 1991, 7 years later. Does that seem reasonable to you, that number?

Mr. KING. It's possible, yes.

Mr. MATSUI. In 1985 because we did the DRG in 1984, if you recall the trustees said insolvency would occur 13 years later in 1998. That sounds reasonable, right?

Mr. KING. Yes, sir.

Mr. MATSUI. In fact, over the last 15 years, the lengthiest period, 1988, that we would find before it would become insolvent, was 17 years. Does that sounds reasonable to you?

Mr. KING. Yes, sir.

Mr. MATSUI. OK. Now, you do know over the eighties we made a number of incremental changes in the Medicare system, right?

Mr. KING. Yes, sir.

Mr. MATSUI. Now, let me ask you, I agree that we need to do something, but what should prevent us from doing this over the next 3 or 4 years? Why do we need to do it—is there any reason in your mind that we need to do it in the next 30 days?

Mr. KING. No, there is no reason why we have to do it in the next 30 days; but as I said, the sooner the problem is addressed, the less the problem is.

Mr. MATSUI. How about 1996; is that OK? I mean, would that create a major problem in your mind in terms of the insolvency issue?

Mr. KING. It is certainly better than not doing anything.

Mr. MATSUI. Right. Exactly.

Now let me ask you a question. Assuming you read some of the documents here, the Republican plan estimates that by the year 2002, the rate of growth of the Medicare Program will be what, 4.3 percent. You heard that number, right?

Mr. KING. I have heard—

Mr. MATSUI. In fact, you are basing a lot of your projections upon that, right?

Mr. KING. Yes.

Mr. MATSUI. OK. It would be a 1.378-percent growth in population and a 3-percent growth in CPI, the consumer price index. That is how you get the 4.37-percent, right, rate of growth?

Mr. KING. Yes, sir.

Mr. MATSUI. Do you know any industrialized country in the world that has had that low of a rate of growth over a period of years—England, Germany, the United States, any industrialized country—Canada?

Mr. KING. Actually, just recently the—

Mr. MATSUI. I am talking about over a period of years, over a period of years. Of course not. Of course not, right?

Mr. KING. Not that I know of.

Mr. MATSUI. OK, fine. Just say that the question that I want to ask you is, does that mean that we are going to have to cut benefits after the year 2002 in order to make this work?

Mr. KING. I don't believe that benefits have to be cut in 2002 if the reforms are done right. They can be done in such a way that the health care of the Medicare population will not suffer. I believe there is enough waste and abuse in the system now that if the reforms are done correctly, substantial waste can be removed from the system and health care won't suffer.

Mr. MATSUI. And that is how we are going to get it under the plan; is that right?

Chairman ARCHER. The gentleman's time has expired.

Mr. Nussle.

Mr. NUSSLE. Thank you, Mr. Chairman.

It is amazing to me the tone that I am hearing from my friends on the other side of the aisle today. It seems very clear to me that their message is that we don't need to fix Medicare. That is what Mr. Gibbons said, we don't need to fix it, we don't need to save it, we don't need to do anything about it. In fact, I haven't seen a plan yet from them.

We have a plan and it seems pretty clear that their attitude is that we don't need to fix it, and they continue to bring up these

arguments about, well, there has always been this worry about Medicare going broke and we put in quick fixes.

It reminds me of the story we have been hearing, as this has been analogized, that it is like a car that was purchased back in 1964. We repainted it a few times, we did a couple of tuneups, we got some new tires, it has been driving pretty well, but the Medicare trustees tell us that that car is going to break down eventually, and instead of just giving it another paint job or giving it another tuneup, we want a new car.

In fact I am referring right now to the trustees' report, and I—you said, Well, we don't have to do it in the next 30 days. Well, the trustees believe—this is right out of the report, right out of their conclusions. The trustees believe that prompt, effective, and decisive action is necessary.

Now, I have got two grandmothers, one is 92, the other is 87. They tell me we need to save Medicare. They tell me we need to fix it. I have my friend Sam Gibbons from Florida who tells me we don't need to save Medicare. Guess who I am going to listen to.

My two grandmothers tell me we need to save it. We are going to save it, and we have a plan. We are different. The fact that we can make a promise and keep it, the fact that the Democrats, who have controlled the House for 40 years, were not able to keep their promises in fixing Medicare does not dissuade me from the task ahead of us which is that we need to save it.

The question I have for you here today is that if it is true that we have got this car that is about to break down and they are looking for another tuneup, which—in the past, tuneups meant more taxes, more tax increases. The question I have for you, since you have had a chance to study this, is how high would we have to raise taxes this year, next year, over the course of the next 7 years in order to save Medicare, in order to fulfill the responsibility that the trustees gave us in this report to get us back on track? How high would we have to raise taxes, or more especially, would the Democrats suggest we would have to raise taxes in order to save Medicare?

Mr. KING. I haven't looked at the tax rate increase that would be required to save Medicare just over the next 7 years, but in the trustees' report, there is a statement that in order to put the Medicare Program, the Hospital Insurance Program, in balance over the next 25 years, would require I believe it is an increase in the FICA tax that goes to Medicare in excess of 40 percent.

Mr. NUSSLE. A 40-percent increase in taxes?

Mr. KING. Yes, I believe that is the number.

Mr. NUSSLE. So if we don't make the market reforms, if we don't make the fraud and abuse reforms, if we don't figure out a way to allow doctors and hospitals to network in a new and exciting way, if we can't figure out a way to give seniors choices, if we in fact cannot buy this new car that we want to call "MedicarePlus" or that we want to purchase that gives us the kinds of options so that we can save it without a tax increase and without copayments, without all of those things that are in our plan we want to be able to do, we would have to raise taxes on working Americans in this country by 40 percent in order to make sure that this fund is solvent, so that my two grandmothers and my father who is 57 years

old, who is going to be in Medicare here around the year 2002, would be able to have quality health care in this country. Is that what you are telling us here today?

Mr. KING. Yes, sir.

Mr. NUSSLE. Thank you.

Mr. KING. But the tax increase based on studies that I have done, the tax-rate increase that would save Medicare for the next 25 years wouldn't be a fair way with regard to generational equity to save the program because the people who would be paying that tax would be the people who would get the least out of the program when it came their time to retire.

Mr. NUSSLE. If that isn't the truest statement I have heard today about fairness—everyone wants to talk about fairness, but raising taxes on working Americans and keeping the same old car and giving it a new paint job certainly isn't fair. I would hope we would see a much better and more aggressive and exciting plan from the Democrats than just raising taxes on working Americans.

Thank you.

Chairman ARCHER. Mrs. Kennelly.

Mrs. KENNELLY. Thank you, Mr. Chairman.

Just so the record is kept straight, there are a number of Democrats—I think almost every Democrat on this Committee, in the 1993 reconciliation bill, voted to extend the Medicare Trust Fund, so it didn't go into bankruptcy, by an additional 3 years; and I believe every Member on the other side of the aisle—some of you weren't on the Committee then—voted no. So in our actions of the past we have shown that we are willing to vote to keep Medicare from going into bankruptcy.

Mr. King, rather than going into the huge numbers that we obviously can go into and will go into as we see the legislation, the number the American people are hearing is \$270 billion; and in your testimony, you take \$145 billion in part A cuts. If you subtract \$145 billion from \$270 billion, you get \$125 billion. Where does that \$125 billion go, in your opinion?

Mr. KING. That is the savings in part B of Medicare.

Mrs. KENNELLY. So in fact, those part B savings don't have anything to do with the part A trust fund.

Mr. KING. No, they have to do with the Medicare Part B Trust Fund.

Mrs. KENNELLY. Well, I thought that B was from general funds and premiums on people who belong to Medicare.

Mr. KING. There is a trust fund and the source of income to the trust fund is general revenues and premiums that beneficiaries pay.

Mrs. KENNELLY. It is an account, though, isn't it, sir?

Mr. KING. It is maintained as a trust fund.

Mrs. KENNELLY. But it isn't the trust fund that we keep saying, which I just said that we helped save in 1993, and there is a great concern by all of us that we want to make sure that it doesn't go bankrupt again. It is a different trust fund?

Mr. KING. Yes. It is financed differently than the HI Trust Fund.

Mrs. KENNELLY. It just leaves me to wonder if we have to do that additional \$125 billion to save part A. Do you think we do?

Mr. KING. I haven't looked at the—I don't think that the savings in part B is necessarily associated with savings in part A.

Mrs. KENNELLY. That is what I think, too, Mr. King.

Thank you.

Mr. Chairman, I would like to request something. You had said that we all could enter into the record our own statements, opening statements.

Chairman ARCHER. Yes.

Mrs. KENNELLY. This morning there was another hearing on the Hill that Secretary of Labor Reich appeared at and some other witnesses. It is not a great, voluminous testimony. May I include in this hearing record an excerpt from that testimony?

Chairman ARCHER. Is there an objection? The Chair hears none.

Mrs. KENNELLY. Thank you, Mr. Chairman. Thank you, Mr. King.

Chairman ARCHER. Mr. Johnson.

Mr. JOHNSON of Texas. Thank you, Mr. Chairman.

Mr. King, you keep talking 60-40 and everybody calls it historic. You are an actuary; is that true?

Mr. KING. Yes, sir.

Mr. JOHNSON of Texas. And has our staff had contact with you to try to get you to help us develop the numbers that you are discussing today?

Mr. KING. Yes.

Mr. JOHNSON of Texas. And they did it for a specific purpose, did they not, so that we could come up with a Medicare proposal that would help the American people; is that true?

Mr. KING. That is right. I think the goals were to meet the criteria for financial soundness in the trustees' report.

Mr. JOHNSON of Texas. Right. Some of the numbers did come from our side, specifically from some of our staff, while they were working through the problem with you, I presume, and they asked you for some actuarial numbers; is that accurate?

Mr. KING. That is right.

Mr. JOHNSON of Texas. OK. Has there ever been a time in history when we have taken money from the trust fund, from the reserve?

Mr. KING. In 1982 there may have been times possibly when the reserves have declined, but in particular in 1982, there was money taken from the HI Trust Fund and placed in the OASDI Trust Fund, which was in trouble.

Mr. JOHNSON of Texas. But that was before it was removed from the Social Security Trust Fund; is that true?

Mr. KING. That is right.

Mr. JOHNSON of Texas. OK, so it is a real trust fund now and according to the trustees' report, that trust fund is going to go berserk next year; in other words, we would have to take money from it if we maintained the payout that we are achieving today?

Mr. KING. Yes, sir.

Mr. JOHNSON of Texas. And it has never been done and that is not the way you run a trust fund, so it is not solvent; is that true? Is that a true statement?

Mr. KING. Technically, the trust fund is not solvent now.

Mr. JOHNSON of Texas. Thank you. Now let me ask a question.

Somebody said that in 1993, Republicans refused to vote for—and I wasn't on the Committee—a proposal which blew the cap off of Social Security and taxed the poor, so that they could maintain 1 year more of solvency in the Medicare fund. Is that all we got out of that tax increase on the poor?

Mr. KING. My recollection was that raising the wage base to an unlimited wage base for HI got 1 or possibly 2 years of additional life for the trust fund.

Mr. JOHNSON of Texas. It didn't fix the problem, as Mr. Nussle said; it didn't even put a new coat of paint on it, much less a new engine, is that true?

Mr. KING. No, I would say it was a stopgap measure.

Mr. JOHNSON of Texas. Short term. According to the trustees' report, we need to fix it as expeditiously as possible; and before we go into that trust fund next year, it would seem to me that we have to fix it this year. Do you agree with that statement?

Mr. KING. I think we have studied the problem enough and we have enough knowledge so that we know what needs to be done to save the trust fund and there is a need to delay until 1996.

Mr. JOHNSON of Texas. Thank you, sir. I appreciate your testimony.

Thank you, Mr. Chairman.

Chairman ARCHER. Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

Mr. King, earlier this year as part of the Contract With America, the Republicans cut taxes on upper income seniors to the tune of about \$87 million. Had that not come about, would part A be relatively more solvent?

Mr. KING. I am not familiar with the change. Did they actually succeed in making the change?

Mr. COYNE. Well, it passed the House of Representatives.

Mr. KING. As I said, I think that the—that that tax was worth maybe 1 year of life to the trust fund.

Mr. COYNE. It would have provided the—

Mr. KING. I believe the tax you are talking about was the one that raised the taxability of Social Security benefits from 50 percent to 85 percent.

Mr. COYNE. If the tax cut for upper income seniors doesn't take effect, will that make the trust fund part A more solvent?

Mr. KING. I believe that repeal of that provision is worth 1 year at most, if that.

Mr. COYNE. But would it help the solvency of the funds that we are being told are going to become insolvent?

Mr. KING. Yes, it would have the minor effect on it.

Mr. COYNE. Under the proposal as you understand it, will seniors pay more under part B?

Mr. KING. Yes, they will pay more than they—it is not clear that they will pay more under part B until we receive the legislative language, but if the—if part of the plan is to raise the—to keep the percent of program expenditures that the part B premium covers the same as it is now, it is scheduled to drop to 25 percent under current law, then all other things being equal in the absence of any other legislation, the premium would increase.

Mr. COYNE. Will those savings go to the solvency of the part A section?

Mr. KING. No.

Mr. COYNE. Is there any reason for that? What is your judgment about a reason for that?

Mr. KING. Well, they go into the part—the savings from that would go into the part B trust fund.

Mr. COYNE. But it is in part A that we are having the financial difficulties.

Mr. KING. Yes.

Mr. COYNE. Wouldn't it be prudent then to use some of those funds for part A?

Mr. KING. That would be unprecedented to place premiums that a beneficiary pays in order to obtain eligibility for part B benefits and not use those funds for savings for part B benefits, instead use them for part A benefits. The programs are very separate and distinct programs.

Mr. COYNE. Fifty percent of all retirees in this country depend on Social Security as their only income, as their only source of income, and 50 percent of those who depend on Social Security earn less than \$7,000 a year. As an actuary, do you think it is prudent for Members of Congress, and the administration for that matter, to have out-of-pocket expenses increased for people earning less than \$7,000?

Mr. KING. I haven't dealt with issues regarding the solvency of the part B trust fund. That is not an area that I have been extensively involved with.

Mr. COYNE. Thank you very much.

Chairman ARCHER. Ms. Dunn.

Ms. DUNN. Thank you very much, Mr. Chairman, and thank you, Mr. King, for your testimony. I think you have clarified a number of points for people who are very interested in our Republican proposal on Medicare reform and how it compares to the press release that was given to you to work from by the President and the administration.

I also was interested in the testimony of Members on the other side who said that earlier reports from the trustees had said that at some time in the near future Medicare would go broke. What I want to make clear right now is that while the Democrat answer has consistently and always been to raise payroll taxes in order to solve the problem in very short term.

For example, in less than 1 year since the new majority was sent here to clean up the problem, I suspect that most would agree that we have used great courage and great common sense in coming up with a proposal to protect Medicare in the long run, to reorganize the system, to make it actuarially sound, at least according to your figures, through the year 2011, while still giving choice to senior citizens to whom this will become very important yet allowing them, if they choose, to remain on the Medicare plan.

I would like to ask you, Mr. King, because we have attempted to do a lot of things in the last 9 months, many of them relating to strengthening the economy here in the Nation, would you say that it is correct to assume that a reinvigorated economy would bring in more FICA revenues through greater employment?

Mr. KING. Yes, if the economy were to perform better, that would have a beneficial result on the HI Trust Fund, all other things being equal.

Ms. DUNN. And that as we seek to propose plans for strengthening the economy, leaving more money in the pockets of employers, for example, which would go to greater employment, would you therefore agree, Mr. King, that the policies that help the economy ultimately will help to strengthen and save Medicare for the future generations?

Mr. KING. Yes, if the policies are effective in strengthening and increasing the rate of growth in the economy, then they would have a beneficial effect on the solvency of the HI Trust Fund.

Ms. DUNN. Thank you, Mr. King.

And that will continue to be our effort.

Thank you, Mr. Chairman.

Chairman ARCHER. Mr. Levin.

Mr. LEVIN. Thank you. Mr. Chairman, I don't think the question is whether there is a problem. The question is whether the medicine that you are proposing is going to damage and perhaps poison the patient and also use the proceeds for some other purpose, a tax cut for very wealthy people.

No one denies there is a problem of some sort in the short run and certainly the long run. But Mr. King, I agree very much with Ms. Dunn, I think your testimony has been very illuminating. I think it very much casts doubt on this effort to use part A to launch into a \$270 billion program of cuts. I don't understand, why didn't you read this so-called plan before you made your estimates?

Mr. KING. I hadn't received it. I made these estimates before yesterday.

Mr. LEVIN. You didn't ask for this document?

Mr. KING. No.

Mr. LEVIN. It wasn't sent to you?

Mr. KING. No, sir.

Mr. LEVIN. So you base it on a rough calculation of 60-40.

Mr. KING. Yes.

Mr. LEVIN. There is a so-called fail-safe mechanism in here, you didn't look at that to see what the impact might be on your calculation?

Mr. KING. I don't believe that that document existed at the time that I made my projections.

Mr. LEVIN. Well, it was out yesterday.

Mr. KING. I made my projections several weeks ago.

Mr. LEVIN. You were still the actuary in 1994?

Mr. KING. Yes.

Mr. LEVIN. The projected years until insolvency were 7 years in 1994?

Mr. KING. That sounds about right.

Mr. LEVIN. Some of my colleagues have referred to the past and I just want to—it has moved me to try to make clear what has been said in the past. There is a quote from the Chairman, I wonder if you would put that up there for everybody to see.

We proposed in 1993 considerably less in Medicare cuts, all of which would have been plowed back into Medicare the first years.

This is what the now- Chairman of this Committee said about what Democrats were proposing:

Make no mistake about it for the elderly in this country, these cuts are going to devastate their program under Medicare. I just don't believe the quality of care and availability of care can survive these additional cuts and that is the price that is going to have to be paid for these cuts.

Again, Mr. King, the number of years until insolvency were the same in 1994 as they are supposedly today, right?

Mr. KING. Yes.

Mr. LEVIN. Just one other quote from another Member of this Committee. And I urge everybody to read this. It surely has a ring to it.

I would love to believe that we could achieve the level of cuts you have in this bill but history tells us that it isn't possible and I think we are just playing games, we are just making the numbers match. You have just estimated the number needed for Medicare to make the numbers match and I and the public understand that.

That was Mr. McCrery in June 1994. Let me just ask you, do you think it might be wise to take a look at legislative language before any firm conclusions are reached?

Mr. KING. Yes, I would like to, as I said in my testimony, these numbers have the caveat that I haven't seen the legislative language yet and therefore can't evaluate the effectiveness of the legislation.

Mr. LEVIN. Good. You can't evaluate the effectiveness of the legislation.

Thank you very much, Mr. King.

Chairman ARCHER. Since the gentleman has mentioned my name, I am going to interject briefly to say that the context of the statement that I made was that the Clinton proposal, in order to have comprehensive health care for all people in this country, was going to take \$490 billion out of Medicare and Medicaid without restructuring Medicare and offering the choices and the alternatives that are a part of our program.

So to selectively pick a quote without relationship to what was happening leaves a false impression. So let it be clear that my quote was related to taking \$490 billion out of Medicare and Medicaid without in any way reforming Medicare or restructuring it.

Mr. LEVIN. Mr. Chairman, there were no cuts.

Chairman ARCHER. Mr. Collins.

Mr. GIBBONS. Before Mr. Collins proceeds, I can understand the necessity for wanting to correct people who quote you, but my name has been mentioned many times here and I have been quoted from and I have never had an opportunity—can I have an opportunity to correct the people who quote me?

Chairman ARCHER. If the gentleman, if your name is referred to specifically, the Chair will grant you the opportunity to respond.

Mr. GIBBONS. Well, Mr. Nussle referred to me and a number of other people over there referred to me, quoting me. I think I ought to be entitled to as much response time as you take.

Chairman ARCHER. The gentleman—I will also say to the gentleman that the gentleman's comments today to me that relate to the specificity of the subject matter before us today certainly are a subject that can be debated. But when my name and a statement I made is not in context of today and is not even in context of what

occurred in 1994 is presented in writing to this Committee, then I certainly should have the right to respond. And should that happen to the gentleman, he will have the right to respond.

Mr. COLLINS.

Mr. COLLINS. Thank you, Mr. Chairman.

Mr. King, we have all established and agree that the trust fund is insolvent but I want to move on to the part B and if I understood and understand the part B portion, the premiums—the funding for part B comes from premiums from Social Security checks and from general funds.

Am I right in that?

Mr. KING. Yes, sir.

Mr. COLLINS. You mentioned that in 1982, 1983, Social Security was heading toward insolvency. Do you see at any time in the future that Social Security will again become insolvent?

Mr. KING. Yes, I believe the trustees' report projects that Social Security will be insolvent, the trust fund will be depleted some time in the next century.

Mr. COLLINS. So that portion of part B funding does have solvency problems?

Mr. KING. Yes, sir.

Mr. COLLINS. And the part that comes from the general fund, is the general fund balanced today?

Mr. KING. No.

Mr. COLLINS. In other words, we are spending more than we take in in the general fund.

Mr. KING. Yes.

Mr. COLLINS. To the tune somewhere between \$400 and \$500 million a day, I believe, would be very close.

We have accumulated something like \$4.9 trillion of debt that has to come from the general fund. Is that not true? Are you aware of those figures?

Mr. KING. I am aware of it, but not the precise figure.

Mr. COLLINS. We have established that part B from Social Security will eventually be insolvent, the budget is unbalanced and the debt is climbing. At what point or what level of debt will part B be in serious trouble?

Mr. KING. I haven't analyzed specifically at what point part B would be in trouble but according to the projections in the trustees' report, it is a major threat to the attempts to bring the Federal budget into balance because it is growing so fast as 1 percent of the Federal budget and as 1 percent of GDP.

Mr. COLLINS. In simple terms, part B does have its problems, too.

Mr. KING. That is right.

Mr. COLLINS. Well, that is not alarming from the standpoint that the same people who have been in charge of the public funds and have created and participated in the accumulation of \$4.9 trillion of debt are very reluctant to address the fact that there is a cash flow shortfall beginning next year with Medicare part A which is going to lead to real problems for the Medicare system altogether.

Thank you, Mr. King.

Chairman ARCHER. Mr. McDermott.

I am sorry, Mr. Cardin is next.

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. King, let me thank you for your testimony. If I understand it, if the goal is to have enough funds in the Medicare Trust Fund to pay for 1 year in advance, we are well ahead of that. If our goal is to have a 10-year solvency, an \$89 billion amount would pretty much cover that, and if our goal is, as you described on short-term solvency, you believe \$160 billion is necessary in the Medicare Trust Fund. Is that generally correct?

Mr. KING. No, that is not exactly correct. The differences between the amount that is required to maintain a 1-year contingency fund throughout the next 10 years versus just delaying the projected depletion of the trust fund for 10 years, if you delay the projected depletion of the trust fund through 2006, but during that period between 1995 and 2006, the trust fund is operating with balances that are below 100 percent in the following years' outlays, then it does not meet the test of financial adequacy.

Mr. CARDIN. I understand. Then for 10 years of solvency versus maintaining a 1-year contingency for 10 years, the difference is between the \$89 billion and the \$160 billion, correct? Or not?

Mr. KING. Yes, the \$160 billion maintains reserves for the next 10 years.

Mr. CARDIN. Now, the \$160 billion assumes the current tax policies on Social Security income remaining in the trust fund?

Mr. KING. Yes.

Mr. CARDIN. Let me go back to 1982 for 1 moment when with you as chief actuary, the trustees made a report indicating insolvency in 1987.

Mr. KING. That sounds about right.

Mr. CARDIN. Did the Medicare Trust Fund go insolvent in 1987?

Mr. KING. No, because reforms were made in the program, the implementation of the DRG program and also Social Security paid back the reserves that had been borrowed.

Mr. CARDIN. Changes were made, and in 1984 the report that was made while you were chief actuary indicated that the Medicare Trust Fund would go insolvent in 1991, is that right?

Mr. KING. Yes.

Mr. CARDIN. Did the Medicare Trust Fund go insolvent in 1991?

Mr. KING. No.

Mr. CARDIN. What happened?

Mr. KING. Some—

Mr. CARDIN. Reforms were made by changes in—

Mr. KING. Incremental changes.

Mr. CARDIN. Didn't Congress make some changes over that period of time?

Mr. KING. That is right.

Mr. CARDIN. In fact, for 5 years while you were chief actuary, the insolvency date was 7 years or shorter in the Medicare Trust Fund and during that period Congress made changes in the system in order to make sure that we extended the life of the Medicare Trust Fund.

Mr. KING. Yes.

Mr. CARDIN. And if you go back to 1982, the actions of Congress not only extended it beyond 1987, they extended it 15 years beyond that date. So is it fair to say that Congress has been responsive to

make sure the solvency of the trust fund has been maintained since you were actuary?

Mr. KING. I would say that Congress has been responsive in preventing the depletion of the trust fund, but it is not fair to say that the program was made solvent.

Mr. CARDIN. In 1982, would you have been satisfied with a 20-year solvency in the Medicare Trust Fund?

Mr. KING. No.

Mr. CARDIN. You wouldn't have been satisfied?

Mr. KING. No.

Mr. CARDIN. You wouldn't have been satisfied in 1982 to have a 20-year reserve?

Mr. KING. No, that—

Mr. CARDIN. Or a 20-year projected insolvency, you wanted more than 20 years?

Mr. KING. Yes.

Mr. CARDIN. I suppose I understand. And we have never ever in the history of Medicare had a report from the trustees that indicated 20 years of solvency, isn't that correct?

Mr. KING. Way back in the beginning of the program when the program first began, only 25-year projections were made and I believe that those projections showed that the trust fund would be solvent throughout the 25-year period.

Mr. CARDIN. I have figures dating back to 1970 and it shows 2 years solvency in 1970 with the Medicare Trust Fund.

Mr. KING. The program began in 1965 and the first trustees' report was issued, I believe, in 1966, and I believe that that report showed the trust fund was not in danger of insolvency.

Mr. CARDIN. In the few seconds that I have left let me just quote, if I might, from one of the trustees, the Secretary of the Treasury, Mr. Rubin, and this is dated yesterday and he says:

Simply, no Member of Congress should vote for \$270 billion of Medicare cuts believing that reduction of this size has been recommended by the Medicare trustees or that such reductions are needed now to prevent an immediate funding crisis. That would be factually incorrect.

Thank you, Mr. Chairman.

[The information follows:]



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C.

SECRETARY OF THE TREASURY

September 21, 1995

The Honorable Newt Gingrich
Speaker of the House
United States House of Representatives
Washington, D.C. 20515

The Honorable Robert Dole
Majority Leader
United States Senate
Washington, D.C. 20510

Dear Mr. Speaker and Mr. Majority Leader:

I understand the House Majority is releasing its plan to restructure Medicare today. I am writing to discuss the condition of the Medicare Hospital Trust Fund in the context of these reform plans.

As Managing Trustee of the Medicare Hospital Insurance (HI) Trust Fund, I am concerned by a growing number of statements by Members of Congress which appear to be based on a misunderstanding of what our annual report said. Because votes for significant changes in Medicare should not be cast without Members knowing the facts, I want to recount briefly what the Trustees reported about the funding status of Medicare.

Simply said, no Member of Congress should vote for \$270 billion in Medicare cuts believing that reductions of this size have been recommended by the Medicare Trustees or that such reductions are needed now to prevent an imminent funding crisis. That would be factually incorrect.

In the annual report to Congress on the financial condition of Medicare, the Trustees concluded that the HI Trust Fund will not be depleted until 2002, seven years from now. When we issued our findings, we asked Congress to take remedial action to fix the HI Trust Fund on a near-term basis and then in the context of health care reform to make long-term changes in the system that would accommodate the influx of "baby-boomer" beneficiaries. At no time did the Trustees call the funding crisis "imminent." Without adequate time for reflection, a responsible, bipartisan, long-term solution to the financing problem could not be structured. We therefore did not imply that cuts of the magnitude being proposed now were needed.

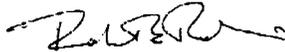
Nonetheless, the Majority is asking for \$270 billion in Medicare cuts, almost three times what is needed to guarantee the life of the Hospital Insurance (Part A) Trust Fund for the next ten years. Moreover, I understand that the \$270 billion of cuts proposed by the Majority includes increases in costs to beneficiaries under Part B of the Medicare program, even though increases in Part B do not contribute to the solvency of the Part A Trust Fund. In this context it is clear that more than \$100 billion in Medicare funding reductions are being used to pay for other purposes -- not to shore up the Medicare HI Trust Fund.

By contrast, the President's proposal, by providing ten years of trust fund security, is consistent with actions by prior Congresses and would afford us far more than sufficient time to propose a bipartisan solution to the long-term fiscal needs of Medicare. Such a bipartisan solution will be needed regardless of whether the President's plan or Congress's plan is finally adopted.

To emphasize, the Trustees did not recommend \$270 billion of Medicare cuts at this time nor state that the funding problems facing Medicare require actions of this magnitude now to deal with a financing problem that occurs in the next century.

I hope this information can be provided to Members of Congress on both sides of the aisle as they review the significant changes in Medicare that are being considered so that Members can have a clear understanding of the facts.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Rubin", with a stylized flourish at the end.

Robert E. Rubin

Chairman ARCHER. Mr. Portman.

Mr. PORTMAN. I thank the Chairman.

Thank you, Mr. King, for your testimony. It has been very useful for those of us who are interested in the actuarial projections.

I would like to make a point, and that is that most of those who have spoken today have addressed the very real fiscal crisis that the Medicare Program faces. I think that is the responsible thing to do.

A few have said it doesn't need to be fixed, but I think most acknowledge it needs to be fixed. The question of timing has come up.

Some have suggested we put this off until 1996, which I think we have seen the kinds of partisan atmosphere we have already in 1995. I am not sure that makes sense. Mr. Cardin just quoted a letter from one of the trustees. Let me quote from the trustees' report: "The Medicare Program is clearly unsustainable in its present form. It is now clear that Medicare reform needs to be addressed urgently as a distinct legislative initiative." What I have found most useful about your testimony is that you took certain assumptions and I think it is fair that we Republicans, as we are drawing up a plan, should be held to those assumptions to the extent we are relying on your testimony.

And that was the \$270 billion figure, that was the 60-40 ratio and using those assumptions, correct me if I am wrong, you made certain projections.

You have said in your testimony there are projections based on our assumptions that the program would be solvent until the year 2011 to 2014. You have also mentioned that these projections show the President's \$89 billion package of savings does not satisfy the board of trustees' test for financial adequacy in the short-range projection period.

I think it is important for us to refocus on solvency, because it is why you are here this morning to explain to us that you have made certain assumptions. You don't need to see, frankly, the legislative language to make those assumptions.

Your analyses are based on what we have told you. We should be held to those to the extent we are relying on your testimony.

The previous speaker also mentioned a lot of changes that were made in the eighties and through the nineties, the prospective payment system, the DRGs, the physician fee schedules, and so on which were in my view fixes to get us through the next 3 or 4 years.

What you are telling us is that we are moving well beyond that period and I would ask you to confirm, based on these assumptions that we have given you—our goal for savings and the ratio you are using with respect to part A and part B, that in fact we are talking about solvency until the period 2011 to 2014.

Mr. KING. Yes, that is correct.

Mr. PORTMAN. I would also say that—and we will hear later from policy experts who will talk about the advantages of the Republican proposal to change Medicare, but I would also say that at this stage, I think it is very important that we focus on the fact that what we are talking about is going up to the baby boomer retirement time period.

Those in my generation who will be retiring after the year 2011, in 2014, will present an additional challenge to this Committee and to this Congress, and for those who say we are going too far, for those who say that 2011 or 2014 is too far down the track, I would just remind them that given the demographic trends, this is the least that we can do as a Congress to be fair to the coming generations, and again, Mr. King, I thank you for being here as an actuary to give us this data.

Mr. KING. Thank you.

Chairman ARCHER. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Being a patient person, I think Mr. Gibbons wanted me to talk about what I am now going to say, and I understand the Chairman says that the problem today is solving the problem of saving Medicare. I have spent 25 years in State legislatures and the U.S. Congress. In every instance, the responsibility for presenting solutions to problems is on the majority. First, they have to lay it out there. I was the Ways and Means Chairman in the State legislature. We had to put the budget out. The Republicans would say, Where is the budget, where is the budget. Well, we put the budget out there and then they made their comments on it. That is the way it operates. You people have to figure that out. You haven't put written language out here with specific numbers. When you put out releases, that doesn't work. You need to have specifics. Our poor actuary out here has made a lot of interesting statements about what he can and cannot do because he doesn't have the numbers. He is just guessing in the dark, and that is why I think you have to have specifics.

Now, there is no need to cut \$270 billion to save Medicare. Every senior citizen who is watching this on C-SPAN should know that. It is not going to go over the cliff if we don't cut \$270 billion. The trustees' report does not say that.

In response to the use of the trustees' report to support \$270 billion in Medicare cuts, the four Clinton administration trustees put out an op-ed piece which I would ask unanimous consent to put in the record from the Los Angeles Times in which they say President Clinton has presented a plan to extend the fund's life.

[The information follows:]

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Los Angeles Times

August 28, 1995, Monday, Home Edition

SECTION: Metro; Part B; Page 5; Op-Ed Desk

LENGTH: 792 words

HEADLINE: PERSPECTIVE ON MEDICARE;
REHABILITATION NEEDED, NOT SURGERY;
THE TRUST FUND'S CRISIS ISN'T NEW; THE PRESIDENT OFFERED A SOLUTION TO
INSOLVENCY.

BYLINE: By ROBERT E. RUBI; DONNA E. SHALALA, ; ROBERT B. REICH, SHIRLEY S.
CHATER, Robert E. Rubin is secretary of the Treasury. Donna E. Shalala is
secretary of health and human services. Robert B. Reich is secretary of labor.
Shirley S. Chater is commissioner of Social Security.

BODY:

Our nation is involved in a serious examination of the status and future of Medicare. Congressional Republicans have called for \$270 billion in cuts over the next seven years, claiming that Medicare is facing a sudden and unprecedented financial crisis that President Clinton has not dealt with, and all of the majority's cuts are necessary to avert it.

While there is a need to address the financial stability of Medicare, the congressional majority's claims are simply mistaken. As trustees of the Part A Medicare Trust Fund which is the subject of the current debate, and authors of an annual report that regrettably has been used to distort the facts, we would like to set the record straight.

* Concerns about the solvency of the Medicare Part A Trust Fund are not new. The solvency of the trust fund is of utmost concern to us all. Each year, the Medicare trustees undertake an examination to determine its short-term and long-term financial health. The most recent report notes that the trust fund is expected to run dry by 2002. While everyone agrees that we must take action to make sure it has adequate resources, the claim that the fund is in a sudden crisis is unfounded.

The Medicare trustees have nine times warned that the trust fund would be insolvent within seven years. On each of those occasions, the sitting President and members of Congress from both political parties took appropriate action to strengthen the fund.

Far from being a sudden crisis, the situation has improved over the past few years. When President Clinton took office in 1993, the Medicare trustees predicted the fund would be exhausted in six years. The President offered a package of reforms to push back that date by three years and the Democrats in Congress passed the plan. In 1994, the President proposed a health reform plan that would have strengthened the fund for an additional five years.

So what has caused some members of Congress to become concerned about the fund? Certainly not the facts in this year's Trustees Report that these members continually cite. The report found that predictions about the solvency of the

Los Angeles Times, August 28, 1995 Los Angeles Times August 28, 1995, M

fund had improved by a year. The only thing that has really changed is the political needs of those who are hoping to use major Medicare cuts for other purposes.

* President Clinton has presented a plan to extend the fund's life. Remarkably, some in Congress have said that the President has no plan to address the Medicare Trust Fund issue. But he most certainly does. Under the President's balanced budget plan, payments from the trust fund would be reduced by \$89 billion over the next seven years to ensure that Medicare benefits would be covered through October 2006 -- 11 years from now.

* The congressional majority's Medicare cuts are excessive; it is not necessary to cut benefits to ensure the fund's solvency. The congressional majority says that all of its proposed \$270 billion in Medicare cuts over seven years are necessary. Certainly, some of those savings would help shore up the fund, just as in the President's plan. But a substantial part of the cuts the Republicans seek -- at least \$100 billion -- would seriously hurt senior citizens without contributing one penny to the fund. None of those savings (taken out of what is called Medicare Part B, which basically covers visits to the doctor) would go to the Part A Trust Fund (which mostly covers hospital stays). As a result, those cuts would not extend the life of the trust fund by one day.

And those Part B cuts would come out of the pockets of Medicare beneficiaries, who might have to pay an average of \$1,650 per person or \$3,300 per couple more over seven years in premiums alone. Total out-of-pocket costs could increase by an average of \$2,825 per person or \$5,650 per couple over seven years. According to a new study by the Department of Health and Human Services, these increases would effectively push at least half a million senior citizens into poverty and dramatically increase the health care burden on all older and disabled Americans and their families. The President's plan, by contrast, protects Medicare beneficiaries from any new cost increases.

As Medicare trustees, we are responsible for making sure that the program continues to be there for our parents and grandparents as well as for our children and grandchildren. The President's balanced budget plan shows that we can address the short-term problems without taking thousands of dollars out of peoples' pockets; that would give us a chance to work on a long-term plan to preserve Medicare's financial health as the baby boom generation ages. By doing that, we can preserve the Medicare Trust Fund without losing the trust of older Americans.

GRAPHIC: Photo, ROBERT E. RUBIN ; Photo, DONNA E. SHALALA ; Photo, ROBERT B. REICH ; Photo, SHIRLEY S. CHATER ; Drawing, (Medicare), TOM TOLES, Buffalo News

LANGUAGE: ENGLISH

LOAD-DATE: August 29, 1995

Mr. MCDERMOTT. Remarkably, some in Congress have said that the President has no plan to address the Medicare Trust Fund issue, but he most certainly does. Under the President's balanced budget plan, payments from the trust fund would be reduced by \$89 billion over the next 7 years to ensure Medicare benefits will be covered for up to October 2006.

Now, we will argue about how much money is going to be spent but they are projecting that \$89 billion will get us to 2006. That is 10 years from now. What is important, I think, in this whole debate is that there is no work being done on what happens in 2010 when the baby boomers get into this system. There needs to be a blue ribbon commission that deals with that issue, just as we did with Social Security. Social Security was predicted to go broke. In 1983 the Congress dealt with that issue and Social Security is now solvent to somewhere around 2040. The \$89 billion in cuts will clearly give us 10 years in which to figure out how we are going to deal with the baby boomers and Medicare. It is not something that we can put off any longer. The issue is in our face. We need to deal with it, but we are not going to go broke in the short run. For \$89 billion, you can stabilize this thing for 10 years, which is longer than it has been predicted to be solvent in most every year that the Congress has dealt with this.

Now, any single Member of the U.S. Congress can come up with a proposal to save \$89 billion from the U.S. Congress. I have a written draft in legislative language, 20 pages, that does it. And anybody who says there is not a proposal or there is not another proposal available is simply not correct, but I will not lay that proposal on the table until you people put a proposal out here with specifics. And I want to ask a question of Mr. King and I will show you why you need specifics.

In response to a question from Mr. Matsui, you stated you could not tell how much of the saving comes from part A or part B. There is no specific breakdown in this 60-page document that they passed out of that. So you have to make a guess about that. Mr. Portman says, Well, count on what we told you. So maybe they told you something that is not in the 60-page press release. But if you don't know how much comes from part A or part B, how can you know what the path of part A actually is? How do you make that judgment?

Mr. KING. I make that judgment on the basis of the 60-40 split between part A and part B and the caveat that this is the goal that—this is my interpretation of the goal for savings for part A, and if that goal is met, this will be the impact on the trust fund.

Mr. MCDERMOTT. So they are taking money—40 percent of the savings is going to come from part B and be put into part A. Is that what you are assuming?

Mr. KING. No.

Mr. MCDERMOTT. Explain it so that my mother, she is watching this, will understand what you just said.

Mr. KING. That if the Congress succeeds in saving \$167 billion from the HI Program over the next 7 years, then the program will remain solvent, it will satisfy the solvency test, and it will delay the depletion of the trust fund until 2014.

Mr. CRANE [presiding]. The time of the gentleman has expired.

Mr. Laughlin.

Mr. LAUGHLIN. Thank you, Mr. Chairman.

Mr. King, I want to talk to you about generational tax fairness. When you use that phrase, are you trying to say that the Medicare system, the benefits, and also the payments going into the fund ought to be fair to both the seniors and to the young people entering the work force who will be paying the payroll tax?

Mr. KING. Yes, sir.

Mr. LAUGHLIN. So when Mr. McDermott says his mother is watching C-SPAN, I suppose mine is, and to put it in terms, often we talk about figures and we talk about the senior citizens. Let me see if I can put it in a—my family terms so that my mother can understand it.

Next month she will be 76 years of age so I think we can easily put my mother into the Medicare senior citizen beneficiary age category, couldn't we?

Mr. KING. Yes.

Mr. LAUGHLIN. And when you talk about generational tax fairness, you are saying to my mother and to Mr. McDermott's mother and others, if they have grandchildren, my mother has six, that if we make no reforms to the current system but rely upon the current system as is, that we should say to my mother that she should expect her six grandchildren over the coming years to have about a 40-percent payroll tax increase in order to sustain the system as we have it today?

Mr. KING. That is right.

Mr. LAUGHLIN. So my mother should look at Mary, Brad, Valerie, Amy, Clark, and Michelle, and say to each of them, If your uncle, your father, and the other Members of Congress make no changes, when you enter the work force in the next couple of years, you should expect your taxes, your payroll taxes, to increase 40 percent to sustain the Medicare system as we know it today if they don't have the courage to make reforms and changes?

Mr. KING. That is right, sir.

Mr. LAUGHLIN. That is what you are telling us?

Mr. KING. Yes.

Mr. LAUGHLIN. Thank you very much, Mr. King.

Mr. CRANE. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. King, you are an employee of Ernst & Young?

Mr. KING. No. I am self-employed.

Mr. KLECZKA. You are self-employed. But you are a consultant to that corporation?

Mr. KING. Yes.

Mr. KLECZKA. Are you aware of Ernst & Young having as its clients any folks that are affected by the changes in Medicare? Do they represent hospitals or physician groups or things of that nature?

Mr. KING. They don't represent them. I would certainly expect they have them as clients.

Mr. KLECZKA. All right. They have them as clients. Do they have them as clients?

Mr. KING. I would expect they would, yes. It is a very large company.

Mr. KLECZKA. My question is, your purpose in testifying, are you testifying here as a former actuary for the Health Care Financing Administration?

Mr. KING. Yes. I am testifying as an actuary.

Mr. KLECZKA. And is your testimony today to indicate to us that the Republican cuts in Medicare will provide solvency not only to part A but also to part B?

Mr. KING. My testimony is to indicate the magnitude of the savings in part A that is needed in order to maintain solvency.

Mr. KLECZKA. You are saying that the Republican legislation will accomplish that?

Mr. KING. Yes. If the Republican legislation achieves the savings on the high side, it will accomplish that.

Mr. KLECZKA. But you are saying this without ever seeing a proposal. I think Mr. Rangel asked you some questions about whether or not you have seen the 60-page document that was distributed yesterday and you indicated no.

Mr. KING. That is right.

Mr. KLECZKA. And this is only an outline. This is not legislative language. There are a lot of unknowns as per this document. So you have never seen this. You have never seen a bill, but you are saying, as an expert actuary, that the Republican plan will restore solvency to the trust fund?

Mr. KING. No, I am not actually saying that. I am saying if the goals of the Republican plan are achieved.

Mr. KLECZKA. You don't know that because you haven't seen the legislation. So the goal could fall short and your testimony wouldn't be accurate.

Mr. KING. My testimony would still be accurate. It is just that I don't know whether those goals will be achieved, not having seen the legislative language.

Mr. KLECZKA. Basically, you are telling us we have problems with the trust fund and that is what your expertise is telling us today, is that—

Mr. KING. I am telling you that there is a solvency problem with the trust fund and that it will require \$160 billion in savings over the next 7 years if that is the number of years over which savings are achieved.

Mr. KLECZKA. But you can't testify today that the Republican plan has \$160 billion in savings for the trust fund, for the part A trust fund, right?

Mr. KING. No. I don't know that.

Mr. KLECZKA. OK. So if in fact you are telling us there is a problem in the trust fund, you are aware that we are knowledgeable on that fact. In fact, we were aware of that in 1994 when you were still an employee, correct?

Mr. KING. That is right.

Mr. KLECZKA. During that period in 1994, we had a lengthy discussion and legislative language on legislation to change the health care system of the country, which in part included changes in the part A trust fund. Are you aware of that?

Mr. KING. Yes.

Mr. KLECZKA. And that legislation of last year, did that provide solvency to the trust fund?

Mr. KING. I believe that it added a couple years. It didn't provide solvency for the trust fund but I believe it did add a couple of years of life to the trust fund.

Mr. KLECZKA. What do you mean when you say "solvency"? Forever and ever? Is that what you talk about when you talk about solvency?

Mr. KING. No. I am talking about both—yes, that is what I would call "solvency." But what I am talking about here—

Mr. KLECZKA. Does the Republican proposal provide for solvency forever and ever or does it extend it 7 years or 9 years or whatever the case might be?

Mr. KING. It meets the board of trustees' short-range solvency standards.

Mr. KLECZKA. So it is for a set period of time?

Mr. KING. Yes.

Mr. KLECZKA. And the proposal last year coauthored by the Democrats on this Committee did the same thing. Maybe not the same period, but it did extend it for a certain period of time; is that correct?

Mr. KING. I don't believe it met the board of trustees' solvency standards.

Mr. KLECZKA. No, but did we in that legislation extend the solvency of the HI Trust Fund?

Mr. KING. I believe it delayed the depletion date of the Hospital Insurance Trust Fund.

Mr. KLECZKA. Did it extend the solvency, yes or no?

Mr. KING. Yes.

Mr. KLECZKA. So there was a plan by the Democrats, even though we are accused of having no plan. We did address the problem. We were knowledgeable. So the point I am trying to make is the problem with the trust fund did not pop up this year. We were aware of it, and the Democrats on this Committee, without the help of any Republicans, did provide a legislative proposal to make that fund more solvent, and, as I indicated, there was no support from the other side.

So for those who say this magically appeared, we have been working on this long before the Republicans took over and will continue to work on it long after they are gone.

Thank you.

Mr. CRANE. Mr. English.

Mr. ENGLISH. Thank you, Mr. Chairman.

Mr. King, I want to express my gratitude to you for taking the time to come and testify today. Obviously, you have been put under fire to some extent because you have come in as an independent actuary and told us what the trustees have already told us, what the two public trustees have already testified to before this Committee, that, in fact, the Medicare system is going bankrupt, that it does need saving, and that this crisis is not simply some sort of a PR stunt. So with that established, I wanted to ask you a couple of specific questions.

I believe that Mr. Matsui, in his comments, elegantly indicated that there had been over time some incremental changes that during the eighties had improved the actuarial position of the Medicare system. Correct me if I am wrong, you were at HCFA at the

time I think those incremental changes were primarily taxes; were they not?

Mr. KING. There were some taxes. There were also some reductions in payments to providers. It was a combination of those.

Mr. ENGLISH. It was a combination of the two, but there was certainly a very heavy reliance on tax increases at that time.

You may not be aware of this, you have been commenting on this trustees' report, which I know you have read, which is the primary object of your testimony here today, but you may not be aware of a study that was recently unveiled, I think in the last week by the U.S. Chamber of Commerce, and I have it here. It is entitled "The Medicare Crisis: The Tax Solution Is No Solution."

Several of the people here have commented on the fact that tax increases would have a substantial impact on people, but I don't think they have put it in human terms. This study demonstrates that in order to save the system long term purely through tax changes, you would have to more than double payroll taxes, and in human terms, what that means is a tax increase of roughly \$1,100 for working families making \$30,000 a year. Small businesses employing 25, the most dynamic sector in our economy, would have a \$13,000 tax increase, and I think it is fair to say that would destroy at least one job in the business, and overall, the impact on the economy would be a 3-percent decline in growth, which from the growth projections we are seeing today suggests that it would push the economy into a recession.

Mr. Chairman, I would like this study included as part of the record of this Committee, if I could, and I would like to introduce it at this point.

Mr. CRANE. Without objection, so ordered.

Mr. ENGLISH. Thank you, Mr. Chairman.

[The information follows:]

The Medicare Crisis: The “Tax Solution” Is No Solution

Martin A. Regalia • Vice President and Chief Economist

Robert D. Barr • Deputy Chief Economist

U.S. Chamber of Commerce • Washington, D.C.

The only solution detailed by the Medicare Board of Trustees for achieving financial balance in Medicare Part A is to raise taxes. Unfortunately, this is no solution at all. Higher taxes will rob working individuals of their hard-won dollars, significantly increase costs on small and large businesses alike and bring the economy to the brink of recession.

The Trustees calculate that balancing the Medicare trust fund for the next 75 years requires us to immediately hike the Medicare payroll tax from 2.90% to 6.42%. While the tax increase may seem to amount to only a few percentage points, it amounts to hundreds of dollars to the typical worker, thousands of dollars to the small business, and billions of dollars for the economy. Analysis by the Economic Policy Division of the U.S. Chamber of Commerce suggests the following impacts on individuals, businesses and the economy:

For a worker making \$30,000 a year, total Medicare payroll taxes paid would jump to \$1,926 from the current \$870.

A small business employing 25 such workers would be liable for an additional \$13,200 tax payment per year.

When aggregated across the entire economy, the effect would be to lower real GDP by \$179.4 billion within two years and hold GDP about \$95 billion lower 10 years later. This amounts to a 3.1% decline in GDP in the short run. With economic growth projected to average less than 3% over the next five years, this decline could easily result in a recession.

These results are even more startling when you consider that they represent an optimistic evaluation, not a worst-case scenario.

Overview of Medicare: Why Reform Is Necessary

Medicare is a nationwide health insurance program for older Americans and certain disabled persons. It is composed of two parts: Part A, the hospital insurance (HI) program, and Part B, the supplementary medical insurance (SMI) program.

Part A covers expenses for the first sixty days of inpatient care less a deductible (\$716 in 1995) for those age 65 and older and for the long-term disabled. It also covers skilled nursing care, home health care and hospice care. The HI program is financed primarily by payroll taxes. Employees and employers each pay 1.45% of taxable earnings, while self-employed persons pay 2.90%. In 1994, the HI earnings caps were eliminated, meaning that the HI tax applies to all payroll earnings.

Part B is a voluntary program which pays for physicians' services, outpatient hospital services, and other medical expenses for persons aged 65 and over and for the long-term disabled. It generally pays 80% of the approved amount for covered services in excess of an annual deductible (\$100). About a quarter of the funding comes from monthly premiums (\$46.10 in 1995); the remainder comes from general tax revenues and interest.

Medicare is not a means-tested program. That is, income is not a factor in determining an individual's eligibility or, for Part B, premium levels. Age is the primary eligibility criteria, with the program also extending to qualified disabled individuals younger than 65.

Over the years, tax revenues for Medicare Part A have exceeded disbursements, and so the remaining revenues have been credited to the Medicare HI Trust Fund. At the end of 1994, the trust fund held \$132.8 billion.

Conclusions of the Trustees

Each year, trustees of Medicare's Hospital Insurance Trust Fund analyze the current status and the long-term outlook for the trust fund, and their findings are published in an annual report. The 1995 edition, issued in April, demonstrated that the Medicare system is in serious financial trouble. The program's six trustees -- four of whom are Clinton appointees (cabinet secretaries Robert Rubin, Robert Reich and Donna Shalala, and commissioner of Social Security, Shirley Chater) -- reported the following conclusions:

Based on the financial projections developed for this report, the Trustees apply an explicit test of short-range financial adequacy. The HI trust fund fails this test by a wide margin. In particular, the trust fund is projected to become insolvent within the next 6 to 11 years. . . (HI Annual Report, pg. 2)

Under the Trustees' intermediate assumptions, the present financing schedule for the HI program is sufficient to ensure the payment of benefits only over the next 7 years. (pg. 3)

The program is severely out of financial balance and substantial measures will be required to increase revenues and/or reduce expenditures. (pg. 18)

... the HI program is severely out of financial balance and the Trustees believe that the Congress must take timely action to establish long-term financial stability for the program. (pg. 28)

The Trustees believe that prompt, effective and decisive action is necessary. (pg. 28)

The same set of Trustees also oversees the Medicare Part B program. In their 1995 Annual Report, they write:

Although the SMI program (Medicare Part B) is currently actuarially sound, the Trustees note with great concern the past and projected rapid growth in the cost of the program. ... Growth rates have been so rapid that outlays of the program have increased 53% in the aggregate and 40% per enrollee in the last 5 years. (SMI Annual Report, pg. 3)

The Trustees believe that prompt, effective and decisive action is necessary. (pg. 3)

Obviously, the Trustees believe that the Medicare program deserves our careful, immediate attention. The following pages present the figures that led the Trustees to their conclusions.

Where Medicare Stands Today

Medicare is a huge federal program. In 1994:

- Medicare expenditures reached \$160 billion, just over half the size of Social Security
- Expenditures grew 11.4% from 1993
- Eleven cents of every dollar spent by the federal government went to Medicare
- Medicare represented one-fifth of total entitlement spending

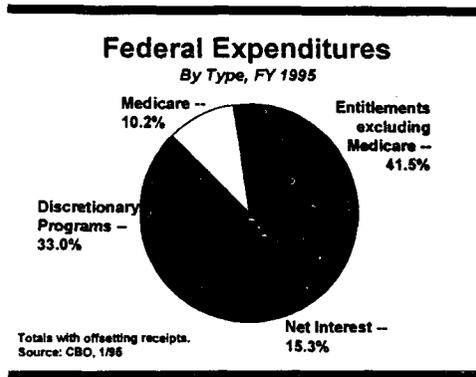
Between 1990 and 1994, Medicare grew at a 10.4% average annual rate, almost three times the 3.6% average inflation rate over the same period and twice the 5.1% average annual growth of the economy as a whole.

Medicare and the Federal Budget

Medicare spending must be addressed as part of the solution to balancing the federal budget. That's because spending on federal entitlements -- such as Medicare, Medicaid and Social Security -- soared 8.4% annually on average between 1990 and 1994. Spending on

discretionary, annually appropriated programs -- such as defense, education and infrastructure -- increased 2.2%, which is less than the rate of inflation. Coming decades will see even more pressure for entitlement growth, as the leading edge of the Baby Boom generation reaches 65 in 2011.

Chart 1



Entitlements are not only the fastest growing portion of the federal budget, they're already its largest component, as shown in the accompanying chart. Just over half of all federal expenditures is spent on entitlements; only a third go to discretionary programs. *If we are going to balance the federal budget -- and keep it in balance over the long term -- entitlement reform must be part of the solution.*

Where Medicare Is Headed If We Do Nothing

Under current law, Medicare is projected by the Congressional Budget Office to grow at a 10.4% average annual rate over the next seven years. In 2002, the CBO projects Medicare spending will reach \$344 billion, claiming almost 16 cents of every dollar spent by the federal government.

Moreover, beginning next year, Medicare HI expenditures will exceed the program's revenues. The HI Trust Fund, which at year-end 1994 held \$132.8 billion, will have to be tapped to cover the projected \$867 million difference.

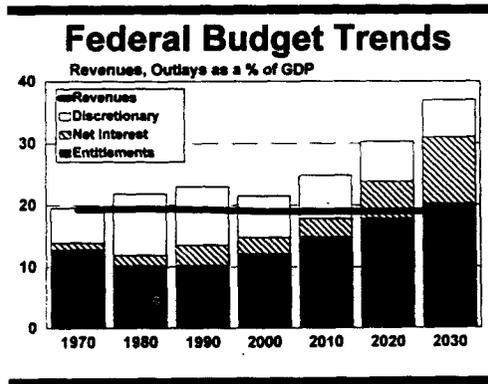
However, according to the Trustees' Annual Report, this shortfall isn't temporary. Instead, it

will balloon to be about seven times larger in 1997, which is just the following year, and more than twenty times larger by 1999. Under assumptions reflecting the most likely demographic and economic trends, 1996 will be the first year of a hemorrhage that will deplete the entire trust fund by 2002 -- just seven years away. The optimistic set of assumptions buys us only a little time, with trust fund depletion projected in 2006. Under the pessimistic scenario, the fund is exhausted as early as 2001. *In other words, within the next 6 to 11 years, it's virtually certain that Medicare will be insolvent -- unless we take action.*

The danger of inaction was made clear last winter when the President's Bipartisan Commission on Entitlement and Tax Reform, chaired by Sen. Bob Kerrey and then-Sen. John Danforth, issued its final report. The focus of the report was to look not years ahead, but decades ahead to assess the impact of federal budget trends. The report is sobering: Under current trends, virtually all federal government revenues are absorbed by entitlement spending and net interest by 2010, as shown in Chart 2. Deficit-financing will be required to cover almost all of the discretionary programs, including defense, health research, the FBI, support for education, and the federal judicial system.

Ten years later, the situation is worse. Growth in entitlements is so explosive that not only would the government have to borrow to pay for discretionary expenses, it would have to borrow funds to pay the lion's share of interest payments on the national debt.

Chart 2



Medicare's Impact on the Pay Stub

In addition to detailing the projected dissipation of the Trust Fund under current law, the Trustees' Report also describes the measures that would be necessary to shore up the trust fund over the next 25, 50 and 75 years. If the expenditure formulas are not altered, then preserving the trust fund can only be done through increases in the payroll tax or additional subsidies from general revenues. Table 1 illustrates the payroll tax increases that would be necessary to balance the trust fund.

Current Law

Currently, the combined (employee and employer) Medicare tax rate is 2.90%, applied to all payroll earnings. A worker earning \$30,000 a year in salary or wages, for instance, is directly taxed 1.45%, or \$435 annually, for Medicare Part A, the hospital insurance program. Employers then match that payment with another \$435, resulting in \$870 of tax revenue earmarked for the Medicare HI trust fund generated by having that worker on the payroll.

The Medicare contributions from both the worker and firm don't stop there, however. Because two-thirds of Medicare Part B (SMI) is financed through general revenues (the other third coming from Medicare premiums and interest), a portion of the worker's and the firm's general income taxes are also financing Medicare. The Trustees reported that \$36.2 billion of general funds were used to pay Medicare Part B claims in 1994.

Table 1
Medicare Hospital Insurance Payroll Taxes

	Current Law Employee + Employer	To Balance the HI Trust Fund Over the Next:					
		25 Years		50 Years		75 Years	
		Additional Tax	Total HI Tax	Additional Tax	Total HI Tax	Additional Tax	Total HI Tax
Tax Rates	2.90%	1.33%	4.23%	2.68%	5.58%	3.52%	6.42%
<i>Percent increase over current law</i>			45.9%		92.4%		121.4%
Payroll Earnings							
\$10,000	\$290	\$133	\$423	\$268	\$558	\$352	\$642
20,000	580	266	848	536	1,116	704	1,284
30,000	870	399	1,269	804	1,674	1,056	1,928
40,000	1,160	532	1,692	1,072	2,232	1,408	2,568
50,000	1,450	665	2,115	1,340	2,790	1,760	3,210
60,000	1,740	798	2,538	1,608	3,348	2,112	3,852
70,000	2,030	931	2,961	1,876	3,908	2,464	4,494
80,000	2,320	1,064	3,384	2,144	4,464	2,816	5,136
90,000	2,610	1,197	3,807	2,412	5,022	3,168	5,778
100,000	2,900	1,330	4,230	2,680	5,580	3,520	6,420

Source (for all tables): 1995 Annual Report of the Board of Trustees, Medicare Hospital Insurance Trust Fund, Table 1.03, page 22
Calculations and macroeconomic simulations by the U.S. Chamber of Commerce

To Balance the Medicare HI Trust Fund for the Next 25 Years (through 2019):

According to the Trustees' analysis, the hospital insurance payroll tax would have to rise from 2.90% to 4.23% (a 46% increase) to keep the HI trust fund in balance for the next 25 years. Further, the increase would have to be made immediately and maintained through the entire 25-year period.

For our \$30,000/year worker for whom \$870 is currently provided to Medicare HI, this increase means an additional tax of \$399, bringing total annual hospital insurance payroll taxes to \$1,269. And that's before any other federal and state payroll taxes (such as unemployment insurance and Social Security) or federal and state income taxes.

However, even this increase in payroll taxes still leaves the trust fund exhausted in 2019, with the oldest of the baby boomers just shy of reaching their life expectancy. Because of this demographic bulge, balancing the HI trust fund over a longer period would require even higher payroll taxes.

To Balance the Medicare Trust Fund for the Next 50 Years (through 2044):

Balancing the trust fund over the next fifty years -- a span long enough to see most of the Baby Boomers through their lifetimes -- would require virtually doubling the hospital insurance payroll tax from 2.90% to 5.58%. The increase would have to be made immediately and remain permanent through the entire 50-year period. Again, for the worker earning \$30,000 a year, the total HI payroll tax rises from \$870 to \$1,674, an increase of 92.4%.

To Balance the Medicare Trust Fund for the Next 75 Years (through 2069):

Balancing the trust fund over the next seventy-five years -- roughly through the life expectancy of an individual born this year, and the usual period for long-term fiscal solvency -- would require an immediate boost in the Medicare tax rate of 121.4%, from 2.90% to 6.42%. Total HI payroll taxes for a worker earning \$30,000 a year would rise from \$870 to \$1,926.

Medicare's Impact on Business

Because it's levied on employment levels, not income, the payroll tax due remains the same through both good and bad economic times. This feature accentuates the pain of a downturn on employers, who need to pay the tax regardless of profitability. Consequently, relative to the income tax, a payroll tax can be particularly punishing to start-up firms or companies trying to weather a drop in business.

Table 2 shows the liability for Medicare HI payroll taxes that would be faced by firms of various sizes. Total liability is shown under current law and under the three tax rates computed by the Trustees to bring the HI trust fund in balance over periods of 25, 50 and 75 years.

For instance, a 25-person firm where the average worker earns \$20,000 per year is currently liable for a \$7,250 tax payment for the Medicare HI program (for their contribution, the workers themselves would be taxed an identical amount). To balance the trust fund over the next 25

Table 2
Medicare Hospital Insurance Payroll Tax
Annual Employer Tax Liability

		Average Salary: \$20,000						
		Number of Employees						
		5	10	25	50	100	500	1,000
Current Law		\$1,450	\$2,900	\$7,250	\$14,500	\$29,000	\$145,000	\$290,000
To Balance Medicare HI Over the Next:								
25 Years		2,115	4,230	10,575	21,150	42,300	211,500	423,000
50 Years		2,790	5,580	13,950	27,900	55,800	279,000	558,000
75 Years		3,210	6,420	16,050	32,100	64,200	321,000	642,000
		Average Salary: \$30,000						
		Number of Employees						
		5	10	25	50	100	500	1,000
Current Law		\$2,175	\$4,350	\$10,875	\$21,750	\$43,500	\$217,500	\$435,000
To Balance Medicare HI Over the Next:								
25 Years		3,173	6,345	15,862	31,725	63,450	317,250	634,500
50 Years		4,185	8,370	20,925	41,850	83,700	418,500	837,000
75 Years		4,815	9,630	24,075	48,150	96,300	481,500	963,000

years, the combined employee and employer tax rate would have to rise from the current 2.90% to 4.23%. Assuming that the liability continues to be evenly split between the employee and employer, the firm will face an HI payroll tax of about 2.11% per worker. For our 25-person firm, the total HI payroll tax would rise from \$7,250 to \$10,575 per year.

Medicare's Impact on the Economy

Raising payroll taxes to keep the Medicare Hospital Insurance trust fund afloat imposes substantial burdens on both workers and firms. To measure what that means for the economy as a whole, we conducted several policy simulations using the highly respected Washington University Macro Model from Laurence H. Meyer & Associates of St. Louis, MO.

The results are striking: The economy would suffer through sharply slower economic growth and higher unemployment in the near term. Over a longer period, the economy is saddled with a permanent loss of production and employment. As shown in Tables 3 and 4, the degree of severity for GDP and employment depends upon the increase in Medicare taxes enacted.

The tables compare each of three alternative tax simulations specified in the Trustees' Annual Report to LHM&A's June 1995 baseline forecast. To demonstrate the policy change working its way through the economy, we display the results for three of the ten years of our simulation: 1997, 2000 and 2004. This gives us snapshots of the short-term, intermediate-term and long-term impacts on economic output and employment. In each case, the imposition of the Medicare payroll tax increase takes place in the fourth quarter of 1995.

Table 3
Impact on Gross Domestic Product
Balancing the HI Trust Fund Through Raising Payroll Tax Rates

Years to Balance HI Trust Fund	Required Medicare Tax Rate	Difference from Baseline in Given Year, Billions of 1987 Dollars			Percent Difference from Baseline in Given Year		
		1997	2000	2004	1997	2000	2004
25 Years	4.23%	-\$68.4	-\$30.1	-\$36.1	-1.2%	-0.5%	-0.5%
50 Years	5.58%	-137.1	-60.5	-72.7	-2.4	-1.0	-1.1
75 Years	6.42%	-179.4	-79.4	-95.6	-3.1	-1.3	-1.4

As shown in Table 3, if the government imposed the most modest payroll tax increase -- enough to keep the Medicare trust fund in balance for the next 25 years -- production in the economy would be 1.2%, or almost \$70 billion, lower in 1997 than it would have been otherwise. By 2000, the percentage-point gap between the alternative closes to within 0.5% of the baseline level of production, but that distance is maintained even ten years after the tax increase took effect.

The short-term loss in output translates into 1.2 million fewer jobs relative to what we would have had otherwise, as shown in Table 4. While this decline, amounting to about 1% of the economy's jobs, moderates over time, the economy appears to have lost over 0.5% of its jobs permanently.

Of course, all of this economic turbulence puts the Medicare HI trust fund in actuarial balance for only the next 25 years. To generate long-term actuarial balance for the full 75-year period, the Medicare payroll tax rate would have to jump from 2.90% to 6.42%, triggering even stronger economic impacts than those described above. Production in the economy would be about 3% lower in 1997 than it would have been otherwise, with the long-term loss in output projected at 1.5%. Over 3 million jobs would be eliminated in 1997 relative to the baseline, with a projected permanent loss of about 1.5% of total employment over the long term.

Table 4
Impact on Employment
Balancing the HI Trust Fund Through Raising Payroll Tax Rates

Years to Balance HI Trust Fund	Required Medicare Tax Rate	Difference from Baseline in Given Year, Millions of Jobs			Percent Difference from Baseline in Given Year		
		1997	2000	2004	1997	2000	2004
25 Years	4.23%	-1.2	-0.6	-0.8	-0.9%	-0.4%	-0.6%
50 Years	5.58%	-2.4	-1.2	-1.6	-1.9	-0.9	-1.2
75 Years	6.42%	-3.2	-1.5	-2.2	-2.5	-1.2	-1.5

As dramatic as these figures are, there's good reason to believe that they are optimistic estimates. Because the macro model used in these simulations treats the Medicare payroll tax like the Social Security payroll tax, the increases in the tax rates apply only to the first \$61,200 earned (in 1995, and rising afterwards). That is, the model is not picking up the economic impact of applying the higher tax rates to incomes over the taxable base. Thus, these results should be considered a minimum measure of the economic impact of raising Medicare payroll taxes. Attempts to account for this problem yield significantly greater job loss and lower GDP. These results are available from the Economic Policy Division of the U.S. Chamber of Commerce.

It is important to note that, even with the set of numbers presented here with its inherent bias toward underestimating the economic impact, we can see that using payroll taxes to balance the Medicare trust fund imposes severe costs on the U.S. economy. These results clearly indicate that the Medicare problem must be solved by fundamental program reform, not tax increases.

Mr. ENGLISH. Mr. King, again, I appreciate your taking the time to come here and comment. As you know, the tax changes that were approved by this Committee earlier this spring included only one tax that actually affects the solvency of the fund, the Medicare fund. I think Mr. Coyne touched on that. But I believe it shows that it would only change by a matter of months the solvency of the fund, and of course what we did was actually cut the taxes passed in 1993 that had been imposed on Social Security, and I believe that tax cut that we passed was supported by AARP.

Thank you for your testimony, and we appreciate your being here.

Mr. CRANE. Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Mr. King, thank you very much for being here, for your testimony. Mr. King, I think many of us believe that Medicare is a sacred contract, I will call it a sacred trust with our seniors and with our families, and I know there are maybe some in this body who want to kill Medicare or destroy it in the name of saving it.

I know you are a very smart person and you are well read. Are you aware that back in 1965 when Medicare was passed during the summer of 1965, I was not here, that the great majority of the Republicans voted against it?

Mr. KING. Yes, I was aware of that.

Mr. LEWIS. And that there was a Democratic President by the name of Lyndon Johnson that signed the Medicare Act into law. Are you aware of that?

Mr. KING. Yes.

Mr. LEWIS. Now, I want to go to a line of questioning that Mr. Rangel, my colleague from New York, raised. Why do you feel so qualified to testify today? You haven't seen or read a bill. You told us you read about it in the paper. How can you be so confident when you haven't seen any detail?

Mr. KING. Well, I felt that I could clarify the question that has arisen over what is the amount of savings that is required in the Hospital Insurance Trust Fund in order to maintain solvency standards, at least in the short range, at the minimum, and that minimum level is \$160 billion over the next 7 years.

Mr. LEWIS. Mr. King, are you aware, or is it true that the Contract With America takes \$37 billion from the Medicare Trust Fund over 7 years, and \$64 billion over 10 years?

Mr. KING. No, I wasn't aware of that.

Mr. LEWIS. If that is the case, that is the case of killing something in order to save it.

Mr. KING. Well, I think in this case I agree with your assessment that the—that the Hospital Insurance Program is a compact. It is a compact between generations, and there are participants in the program who are not yet drawing benefits from the program and those are the taxpayers, and when you view it as a compact between generations and the choice is to either raise taxes or reduce the rate of growth in benefits, what I found through my studies is that the fairest way to keep this compact intact between generations is to reduce the rate of growth in benefits.

Mr. LEWIS. Mr. King, I have an 81-year-old mother living in rural Alabama about 50 miles from Montgomery. Will you explain to her what is going on here?

Mr. KING. I think what I would tell her, Mr. Lewis, is that if the reforms in the Medicare Program are done right, it is not going to hurt the health care of the Medicare population. In fact, it could be beneficial on the rate of increase in health care costs, not only for the Medicare population, but for the entire population, and not only would the Medicare population be better off, but the underage 65 taxpayer would be better off as well.

Mr. LEWIS. Were these cuts that the Republicans are proposing to be put back into the health care delivery system?

Mr. KING. Yes. All of the savings in part A would be put back into the HI Trust Fund and saved and accumulated with interest to pay benefits for future beneficiaries.

Mr. LEWIS. It is the perception, whether it is real or not, that this is a search for revenue, for a \$240 billion tax cut.

Have I been misled or has my mother been misled? Have the American people been misled or told something that is not the case?

Mr. KING. All I can say, Mr. Lewis, is that with regard to the savings in the Hospital Insurance Program, it is not possible to use those savings in order to pay for a tax cut for the wealthy. All of the savings that are achieved in the Hospital Insurance Trust Fund are required by statute to go back into the trust fund and to accumulate with interest to pay benefits for future generations of beneficiaries.

Mr. LEWIS. Thank you, Mr. King.

Mr. GIBBONS. Will the gentleman yield?

Mr. LEWIS. Yes. I yield to my friend from Florida.

Mr. GIBBONS. I think it is preposterous. The Republicans are crying about a distressed trust fund when their legislation, their tax cut they passed this year, out of this Committee, same people, took \$87 billion out of the trust fund that they now say is going broke.

Mr. CRANE. The time of the gentleman has expired. Mr. Christensen—I am sorry. Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

First of all, thank you for being here today and for your testimony. I want to make a brief statement.

I thought it was pretty interesting that one of my colleagues on the other side is talking about the President's plan. I would challenge anybody from the other side that has said that we don't have a plan to show me that the President has a plan when we haven't seen any statutory language from the President, but yet the other side is willing to call this the President's plan while saying that we don't have a plan.

I think that you should be fair when you are discussing our plan, and whether the President has a plan. Because it may not be in statutory language doesn't necessarily mean you don't have a plan. Something is being developed. It is a work in progress, and that is exactly what ours is. It is certainly quite a bit farther along than the President's so-called plan.

I would like to also thank Mr. Matsui. Mr. Matsui was the first person who actually started talking about some of the issues in-

stead of just playing politics with all of this, and he brought up I thought a very interesting point. He addressed the industrialized countries in Europe and he asked you if any of them had been able to maintain their inflation rates. I think it was 4.3 percent in medical costs, and my question to you would be, can you name me an industrialized country that, first of all, doesn't have a third party payer system, that has market forces truly working in the health care system, that is trying some of the innovative approaches that we are trying to bring to the marketplace in Medicare and in our health care system that would bring the patient back in to some accountability for what is going on, that would open up a whole system of choices and market forces? Are there any of those countries out there that have tried that?

Mr. KING. I am not an expert on the health care delivery systems of foreign countries, but I think I can say that the majority of them that I know about are experiencing the same problems with growth in health care costs that we are experiencing in the United States and that they have flaws in their systems just like we have in our system that haven't been addressed yet. And that is why they haven't been able to hold down their rate of increase in health care costs.

Mr. ENSIGN. One of our colleagues from the other side talked earlier about the system not needing savings, and that it is not in trouble. I held many townhall meetings in my district, as a matter of fact I have another one tomorrow morning, and virtually across the board, almost unanimously, people think that there is a tremendous amount of waste, fraud, and abuse in our Medicare system.

Do you feel, as Congress is the steward, we are to be stewards of the taxpayers' dollars? We are stewards of this whole Medicare system that provides so much for so many people that are so dependent on it, and I don't need to invoke my grandparents or my mother and father or anything like that, but so many people are so dependent on this system.

Is it a good use of tax dollars to just say, let's just let the system continue to waste billions and billions and billions of dollars in a system that does that? Are we being good stewards of the taxpayers' money?

Mr. KING. No. I believe that there are many billions of dollars of waste in the Medicare Program and that if reform is done correctly, it can get rid of that waste without damaging the health care of the elderly population.

Mr. ENSIGN. Just real quickly then, they mention that we have these trustees' reports and they made all these fixes over the last 15 years. During that time, did they adequately address the waste, fraud, and abuse by fundamentally changing the system? Did the other side when they were in charge do that?

Mr. KING. No. None of the changes in the system—probably the change in the system that did the most in the way of reform was the implementation of DRGs for the HI Program back in—with the 1983 legislation.

But for the most part, what has been done has been reductions in payment rates to providers that have had no effect on the incentives of the program. They have resulted in the rate of increase in

the Medicare Program going up at the same rate it has been going up just off of a lower base because of the lower payments to providers, and what needs to be done in order to reform the program is something that will change the incentives and that will actually bring about a reduction in the rate of increase in the cost of the system, not just a reduction in the base year.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman ARCHER [presiding]. The gentleman's time has expired. Mr. Payne.

Mr. PAYNE. Thank you very much, Mr. Chairman, and thank you, Mr. King, for your testimony. You mentioned earlier that there are needs for reform, and I certainly agree with that, and you stated that if it is done right, it would be beneficial to present and future beneficiaries, and I agree with that.

I am concerned that if it is not done right, however, it could have some devastating consequences. As one who represents a rural district, a district that 14 of the 17 counties are medically underserved, a number of the rural hospitals are dependent on Medicare for their survival, I want to make sure that we are, in fact, doing this right and it is in that context that I had some questions.

You started by saying that in order to achieve what the trustees tell us we need to achieve to ensure the adequacy of the HI Trust Fund, that we need to find savings of roughly \$160 billion in the Medicare Program; is that correct?

Mr. KING. Over the next 7 years, yes, sir.

Mr. PAYNE. Over the next 7 years. A program then that puts full savings of \$270 billion in would be using savings for something in addition to meeting the financial adequacy standards of the—that the trustees have put forth; is that correct?

Mr. KING. Well, if it has saved more than \$160 billion in the HI Program, those savings could still be used to—the more the better up to a point. Those savings could still be——

Mr. PAYNE. The question is where is that point, though. That is what I am trying to get to.

Mr. KING. Well, the rest of the savings in excess of what is saved in the Hospital Insurance Program is saved in the supplementary Medical Insurance Program, part B of Medicare?

Mr. PAYNE. Right. But as you said earlier, those part B funds aren't addressing what the trustees asked us to address——

Mr. KING. That is right.

Mr. PAYNE [continuing]. Which is the HI Trust Fund. To address what they wanted us to address, roughly \$160 billion is the amount that you stated that we would need to look at.

We will have before us something that suggests that we should be looking at \$270 billion. I am assuming then that more than \$100 billion could be used for other purposes, such as meeting the PAY-GO provisions of the Budget Act to pay for tax cuts or whatever those needs are; is that correct?

Mr. KING. I would expect they could be used for other purposes, yes.

Mr. PAYNE. Now, the next thing I was going to go to, and that is the standard by which we will be judged or the standard we need to meet that states that we have to find \$160 billion in savings. That standard is, one, the financial adequacy standard for

short-range solvency says that we must either have at least 100 percent coverage through a continuing objection period or over 5 years reach that period and stay there for 5 years; is that correct?

Mr. KING. That is basically correct.

Mr. PAYNE. And as I look at the table end of the 1995 trustees' report, over what has happened historically, for the first 20-plus years, that standard was never met in a single year, including the first 10 years that you were the chief actuary; is that correct?

Mr. KING. I wouldn't be surprised.

Mr. PAYNE. So never in the history of Medicare have we ever met the standard of having an adequacy for a 10-year period; is that correct?

Mr. KING. The trustees' report—although this standard didn't exist when the program was first enacted, I would guess that the first trustees' report that was issued probably projected that that standard was met, even though—

Mr. PAYNE. But it was wrong?

Mr. KING [continuing]. It was wrong.

Mr. PAYNE. So there has never been a time in the history of Medicare, according to the chart in their report, where we have met this standard for 10 years. So what we are speaking of here is a very high standard, given the history of Medicare; and Medicare has continued to exist and function over that period of time.

Let me just read quickly in the few seconds I have left from a letter that Secretary Rubin wrote to the Speaker concerning this very matter we are discussing.

Secretary Rubin, who is a managing trustee of the HI Trust Fund says:

Simply said, no Member of Congress should vote for \$270 billion in Medicare cuts believing that reductions of this size have been recommended by the Medicare trustees or that such reductions are needed now to prevent an imminent funding crisis. This would be factually incorrect.

In an annual report to Congress on the financial condition of Medicare, the trustees concluded that the HI Trust Fund will not be depleted until the year 2002. When we issued our findings, we asked Congress to take remedial action to fix the HI Trust Fund on a near-term basis, and then in the context of health care reform, to make long-term changes in the system that would accommodate the influx of baby boomer beneficiaries. At no time did the trustees call this funding crisis imminent.

Without adequate time for reflection, a responsible, bipartisan, long-term solution to the financing problem could not be structured. We therefore did not imply that cuts of the magnitude being proposed now were needed. Nevertheless, the majority is asking for \$270 billion in Medicare cuts, almost three times what is needed to guarantee the life of the Hospital Insurance Trust Fund for the next 10 years.

And it goes on to say, to emphasize,

The trustees did not recommend \$270 billion of Medicare cuts at this time nor state that the financial problems facing Medicare require actions of this magnitude now to deal with a financing problem that occurs in the next century.

I see my time has expired, and thank you very much, Mr. King.
Chairman ARCHER. Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman. I yield to Mr. Thomas.

Mr. THOMAS. I thank the gentleman for yielding.

Briefly, I am quite sure that anyone who is watching this is now fairly confused, based upon the statements made by a number of

Members, and I want to try to pull them together very briefly and to thank the gentleman for yielding.

Mrs. Kennelly said several years ago that there was a program that was voted on to save this trust fund and all the Democrats voted yes and all the Republicans voted no. Mr. Kleczka then said that what we did was to stretch that program. We saved 3 years, didn't we?

Based upon the explanation from you, Mr. King, Mr. Lewis now understands that you can't take funds from the trust fund and use it for other purposes. But Mr. Gibbons' outburst was that Republicans are taking dollars out of the fund.

So how in the world can you reconcile all of these statements? I think it is very simple. What people need to know is that what the Democrats did in 1993 was to raise the income tax on seniors on their portion of Social Security earnings from a 50-percent tax after the threshold to 85 percent. That is what they voted for. That is what we voted against.

They also, in 1983, completely blew the lid off of the payroll tax amount subject to the part A trust fund. In the past, they had crept up on the amount that people earn to be subject to the tax. In 1993, they blew the lid off. All income is subject to the tax and they went after the seniors on the income tax to get their Social Security money. And what did that buy them? Just exactly what Mr. Kleczka said, 3 years. That is the way the Democrats have been trying to fix this fund year after year.

Let's remember what Mrs. Kennelly said, the Democrats all voted yes for that approach, the Republicans all voted no. Now that we are in the majority, we want to make sure we make fundamental, long-term, good changes. And I thank the gentleman for yielding.

Mrs. KENNELLY. Mr. Chairman.

Mr. CHRISTENSEN. Mr. King, reclaiming my time—reclaiming my time, Mr. King.

Mrs. KENNELLY. Mr. Chairman.

Mr. CHRISTENSEN. Reclaiming my time, Mr. King, isn't it true that when this program was formed in 1965, it was projected to cost \$9 billion in 1965?

Mr. KING. Yes, I believe that—

Mr. CHRISTENSEN. In 1995. And what was the actual cost this year?

Mr. KING. The actual cost of the program in calendar year 1995, which isn't over yet, is \$112.7 billion in benefit payments.

Mr. CHRISTENSEN. \$112 billion. And so the projections back in 1965 were off just a little bit, projected at \$9 billion and according to your figures, \$112 billion. Likewise, I believe the average retired two-income-earning couple will take out over \$127,000 more from the system than they paid in; is that correct?

Mr. KING. I don't know the exact figure, but I know that the average retiree in 1994 receives back in benefits about \$5 for every dollar that they paid in in taxes.

Mr. CHRISTENSEN. \$5 for every dollar they paid in in taxes?

There have been some Members on both sides, and I want to express my thanks for the constructive comments on the other side, and especially my friend Andy Jacobs, who I think represents a lot

of good that is going on in this country. People want to see a solution to this problem. They don't want people to ignore the problem, stick their heads in the sand, and demagog; and I think this week's Washington Post editorial describes some of the people that we are hearing from.

The Post—and Mr. Chairman, I would like to have this entered into the record; it was called “Medagogues” and, believe it or the or not, the Washington Post, which is not the most conservative paper in the country, stated that the Democrats are basing their campaign on distortion and on fear. The editorial continues, stating “They're engaged in demagoguery big time.”

And then the Post finishes off its editorial, stating but the Republicans,

They have a plan. Enough is known about it to say it's credible; it's gutsy and in some respects inventive—and it addresses a genuine problem that is only going to get worse.

And then the last paragraph declares:

If the program isn't to become less generous over time, how do the Democrats propose to finance it and continue, as well, to finance the rest of the Federal activities they espouse? That's the question. You listen in vain for a real response. It's irresponsible.

And it is entitled “Medagogues,” and I think in light of the Ranking Minority Member's comments, that he said a 1-year reserve is adequate for funding, I think the editorial fits his comments perfectly.

Thank you, Mr. Chairman.

[The information follows:]

House
REPUBLICAN
Conference

John Boehner, Chairman
8th District, Ohio

F.Y.I.

September 15, 1995

From this morning's *Washington Post*

Medagogues

NEWTT GINGRICH and Bob Dole accused the Democrats and their allies yesterday of conducting a campaign based on distortion and fear to block the cuts in projected Medicare spending that are the core of the Republican effort to balance the budget in the next seven years. They're right; that's precisely what the Democrats are doing—it's pretty much all they're doing—and it's crummy stuff.

There's plenty to be said about the proposals the Republicans are making; there's a legitimate debate to be had about what ought to be the future of Medicare and federal aid to the elderly generally. But that's not what the Democrats are engaged in. They're engaged in demagoguery, big time. And it's wrong—as wrong on their part now as it was a year ago when other people did it to them on some of the same health care issues. Then, they were the ones who indignantly complained.

Medicare and Medicaid costs have got to be controlled, as do health care costs in the economy generally. The federal programs represent a double whammy, because they, more than any other factor, account for the budget deficits projected for the years ahead. They are therefore driving up interest costs even as they continue to rise powerfully themselves. But figuring out how to contain them is enormously difficult. More than a fourth of the population depends on the programs for health care; hospitals and other health care institutions depend on them for income; and you cut their costs with care. Politically, Medicare is especially hard to deal with because the elderly—and their children who must help care for them to the extent the government doesn't—are so potent a voting bloc.

The congressional Republicans have confounded

the skeptics who said they would never attack a program benefiting the broad middle class. They have come up with a plan to cut projected Medicare costs by (depending on whose estimates you believe) anywhere from \$190 billion to \$270 billion over the seven-year period. It's true that they're also proposing a large and indiscriminate tax cut that is a bad idea and that the Medicare cuts would indirectly help to finance. And it's true that their cost-cutting plan would do—in our judgment—some harm as well as good.

But they have a plan. Enough is known about it to say it's credible; it's gutsy and in some respects inventive—and it addresses a genuine problem that is only going to get worse. What the Democrats have instead is a lot of expostulation, TV ads and scare talk. The fight is about "what's going to happen to the senior citizens in this country," Dick Gephardt said yesterday. "The rural hospitals. The community health centers. The teaching hospitals . . ." The Republicans "are going to decimate [Medicare] for a tax break for the wealthiest people, take it right out of the pockets of senior citizens. . . ." The American people "don't want to lose their Medicare. They don't want Medicare costs to be increased by \$1,000 a person. They don't want to lose the choice of their doctor."

But there isn't any evidence that they would "lose their Medicare" or lose their choice of doctor under the Republican plan. If the program isn't to become less generous over time, how do the Democrats propose to finance it and continue as well to finance the rest of the federal activities they espouse? That's the question. You listen in vain for a real response. It's irresponsible.

Mrs. KENNELLY. Mr. Chairman.

Chairman ARCHER. Mr. Neal is—Mrs. Kennelly, what is the purpose of your inquiry?

Mrs. KENNELLY. Mr. Chairman, I believe you said earlier in the hearing, if our names were mentioned and we were quoted, that we had a right to respond.

Chairman ARCHER. Let me explain to the gentlelady that whatever is said today, in context, in debate, I think is fair game for other Members to refer to in the debate today. But any quote that is taken out of context from a previous debate where the entire context of the debate is not before the Committee should be subject to a response.

Mr. Christensen—I am sorry. Mr. Neal.

Mr. NEAL. Thank you very much, Mr. Chairman, and let me begin by saying I think that Mr. Jacobs also approached this challenge from the right perspective today, and my sense is that at the end of the day, there are enough people of goodwill who wish to resolve this issue.

But let me call attention to the hearing today and call attention to your presence, Mr. King. You have impeccable credentials and you certainly have offered illuminating testimony here today, but let me ask you specifically, Have you seen the details of the Republican legislation?

Mr. KING. No, I haven't.

Mr. NEAL. You haven't seen any details of the Republican plan or legislation?

Mr. KING. No.

Mr. NEAL. And you are an actuary?

Mr. KING. Yes.

Mr. NEAL. And hold a fairly exalted position in this society? I mean, you can agree or disagree with that statement. This is your chance. Let me ask you this. How important are details to an actuary?

Mr. KING. At some point, they become important.

Mr. NEAL. At some point, they become important.

Mr. KING. Yes.

Mr. NEAL. But you are the leadoff witness here today to comment on a bill that you have never seen.

Mr. KING. I wasn't asked to comment on the bill that I hadn't seen. I was asked to comment on the level of savings that would be required in that bill.

Mr. NEAL. Let me go back to a specific question on details.

How important a detail is it that you can't yet tell how the so-called fail-safe rate of growth limit is allocated between hospitals, doctors, clinical labs, or home health agencies?

Mr. KING. That would be a detail that—

Mr. NEAL. A major detail?

Mr. KING [continuing]. In being able to establish how effective the legislation was going to be in achieving its goals.

Mr. NEAL. OK. So how are you able to tell what effect it will have on Medicare part A?

Mr. KING. The way I projected the impact on Medicare part A is taking the goals of the bill and analyzing what impact the goals of

the bill would have on part A financing if those goals were achieved, and I very carefully stated that caveat in my testimony.

Mr. NEAL. You said you haven't seen the bill?

Mr. KING. Yes.

Mr. NEAL. What do we know of the goals of the bill?

Mr. KING. Well, the goals of the bill are to——

Mr. NEAL. We haven't seen the bill.

Mr. KING [continuing]. Reduce the rate of growth in the outlays in the Hospital Insurance Trust Fund——

Mr. NEAL. But we haven't seen the bill.

Mr. KING [continuing]. And to save the program.

Mr. NEAL. That is a stated desire of every member of this panel. But let me ask you again, if I can, go back to the opening statements that were offered and to the questions that were asked. At this stage, you have not seen the details of the Republican measure?

Mr. KING. That is right.

Mr. NEAL. Thank you.

Chairman ARCHER. Mr. Crane.

Mr. CRANE. I have no questions of the witness, Mr. Chairman.

Chairman ARCHER. Mr. Ford.

Mr. FORD. Thank you, Mr. Chairman.

Mr. King, explain to me the savings in Medicare part B once again. I looked at the tables in your testimony and, one, two and three, I see how you make reference to the Republican plan and the plan that has been proposed by the administration as well. What about the Medicare part B premiums? Some questions have already come to you in reference to that on those savings. What happens to the savings? What are those savings in Medicare part B in this whole scenario?

Mr. KING. The savings, savings from Medicare part B reduce the rate of growth in the Medicare Trust Fund and the impact of those savings would be to reduce the rate of increase in future premiums paid by beneficiaries and, in general, revenue contributions to the trust fund.

Mr. FORD. But for some of those savings in Medicare part B, we will see some premium increases over the next 5 or 7 years; is that not true?

Mr. KING. As I said, I haven't seen the details of the bill. I have seen reports in the press that——

Mr. FORD. We know.

Mr. KING [continuing]. The proposal was to maintain the part B premium at 30 percent of cost instead of allowing it to go down to 25 percent of cost, so that the effect of—if that were part of the legislative package, that wouldn't be a proposal that would have the effect of increasing premiums. It would have the effect of preventing a decrease in premiums.

Mr. FORD. So you don't foresee, or are you suggesting that there will be no increase in Medicare part B premiums?

Mr. KING. I would have to see the legislative proposal and then I would have to evaluate the impact of that on the outlays in the part B trust fund in order to make that assessment.

Mr. FORD. Mr. King, who invited you here today to testify before this Committee?

Mr. KING. The staff of the Ways and Means Committee.

Mr. FORD. You received a letter or phone call from the staff?

Mr. KING. Yes. Well, I received a letter from the Chairman of the Committee. The staff invited me initially.

Mr. FORD. Did they invite you or did they invite Ernst & Young for whom you work for?

Mr. KING. No. They invited me.

Mr. FORD. You indicated to one of the other Members that you did not work for Ernst & Young, and that you were self-employed.

Mr. KING. That is right.

Mr. FORD. I called Ernst & Young and they told me you did work there. As a matter of fact, they connected me to your secretary at Ernst & Young.

Mr. KING. I left—at the end of July, I left Ernst & Young and became self-employed. I am a consultant with Ernst & Young, but I do not work for Ernst & Young.

Mr. FORD. Are you a Republican or a Democrat?

Mr. KING. I am a Republican.

Mr. FORD. You sound like one.

Thank you.

Chairman ARCHER. Mrs. Johnson.

The questioning has now been completed by Members who wish to question on both sides.

Mr. King, I am grateful for your coming to the Committee. Irrespective of your party affiliation, you have background as a professional, as a nonpolitical appointee in your job as an actuary of HCFA; and irrespective of the debate, which is appropriate, as to what happened in the past and what should be the alternatives for the future, which we spent a lot of time on, I think to recap where your professional input can be helpful to the Committee in general as an actuary.

What do you believe to safeguard and create stability and security for Medicare in the years ahead is a responsible action for the Congress to take at this time? Just from a numbers standpoint, not from the specificity of what might be in the approach or the alternatives, what would be the responsible action from an actuarial standpoint, numbers-wise, that the Congress, in your opinion, should take at this time?

Mr. KING. I believe that as a minimum, the savings in the Hospital Insurance Program should be achieved that would satisfy the short-range financial requirements of the board of trustees that would maintain the trust fund at 100 percent of the following year's outlays level at least for the next 10 years. If in fact reforms can be enacted that would reduce the rate of increase in outlays of the Hospital Insurance Trust Fund beyond 2002 and begin to address the problems that exist even beyond that, that would be so much the better. It doesn't all have to be achieved in the first 7 years, but a minimum of \$160 billion has to be achieved in the first 7 years in order to maintain a viable reserve in the trust fund and to be reasonably assured that it is not going to run out sooner than expected.

Chairman ARCHER. In your opinion, how much can the amount of money per beneficiary increase annually in order to bring this about?

Mr. KING. I am not sure I understand the question.

Chairman ARCHER. From current levels, in order to accomplish the broader comments or goals that you just mentioned, how much can the payments by Medicare on behalf of beneficiaries increase over the forthcoming years above what they currently are annually?

Mr. KING. The one thing that I have looked at is that over the next 7 years, achieving savings over the next 7 years, the average—in order to achieve the \$160 billion in savings, the average increase in payments per beneficiary has to be in the vicinity of 3 percent, assuming that the rate of growth in beneficiaries is about 1.5 percent, which is what it is projected to be during the next 10 years or so.

Chairman ARCHER. Thank you very much.

Mr. GIBBONS. Chairman Archer, I assume since you started back on the second round of questioning, that that applies to the rest of us.

Chairman ARCHER. I was merely recapping on my time that I did not use in the beginning, but certainly Mr. Gibbons, should you wish to question for a couple of minutes, you may do so.

Mr. GIBBONS. Very briefly.

Mr. King, you are the third Guy King I have known, and all of them are fine people; and I respect what you have said here today, and the goals of this program are to cut \$270 billion out of Medicare. How much of that \$270 billion is required to make, under your assumptions, the Medicare Trust Fund viable for 10 years?

Mr. KING. Well, \$160 billion.

Mr. GIBBONS. \$160 billion. So we have got \$110 billion still lying on the table to be used for something else other than making the trust fund viable for 10 years?

Mr. KING. Well, yes. The \$160 billion addresses the HI Trust Fund.

Mr. GIBBONS. And that is all you were talking about is the HI Trust Fund; is that right?

Mr. KING. That is right.

Mr. GIBBONS. Thank you very much.

Mr. FORD. Mr. Chairman, I want to recap on my time.

Chairman ARCHER. Mr. King, we thank you for your testimony and you are excused.

Mr. FORD. Mr. Chairman

Chairman ARCHER. Our next panel is composed of Gail Wilensky and Stuart Altman, if you would come to the witness table.

Ms. Wilensky, if you are prepared to proceed, the Committee would be pleased to have your testimony. We would encourage you to keep your oral presentation to 5 minutes and your entire statement can be entered in the record without objection.

Ms. Wilensky.

STATEMENT OF GAIL R. WILENSKY, PH.D., CHAIR, PHYSICIAN PAYMENT REVIEW COMMISSION; ACCOMPANIED BY LAUREN LeROY

Ms. WILENSKY. Thank you, Mr. Chairman and Members of the Committee. As you have indicated, I would like you to have my detailed testimony and I would be glad to answer any questions.

What I would like to do is to summarize a few points that were contained in that testimony.

I am here as the chair of the Physician Payment Review Commission, and in that role, I see us trying to provide assistance in two general areas: First, trying to help the Congress understand broad implications of the proposed reforms; and second, try to provide technical assistance regarding some of the details of how these changes would be implemented.

I was pleased that there are many changes that over the years PPRC has been recommending which appear to have been included in the plan, as it has been described in documents that we have received, and let me mention just a few of these.

First, there have been the specific recommendations regarding the decoupling of payments to capitated plans from the fee-for-service, which we had discussed in numerous hearings, which are important to achieve.

We also think that it has been important to change the size of the geographical area that the capitated payment, the AAPCC, is referencing to a larger area because it will help to stabilize the payment.

A third specific that appears to be included is to change the nature of the spending target for physicians, the volume performance standard, and to have it become a more stable goal, to move to a single growth rate and an update factor that applies to all physician services, rather than the current three-part conversion factor and standard.

In addition, we think it has been very important to eliminate the size of the adjustments that can be made to the conversion factor and to put some restraints on it. But in addition to some specific changes that PPRC has recommended over the last several years, we think there are areas in which we can be helpful, as the Committee moves forward, trying to put specification on some of the broader issues that have been raised, and these relate to a fail-safe mechanism, to issues relating to risk adjustment, to issues relating to expanding choice, and also some changes in the graduate medical education. I just want to touch on these for a couple of minutes.

It has been important in terms of the fail-safe to look at exactly how you are going to apply the fail-safe to a number of sectors and to the adjustments that you will do. In the past, there has been some work done by the commission in relation to earlier attempts to put something like the fail-safe in place, and we hope that you will find it useful.

A second area I just want to touch on has to do with risk adjustment. Risk adjustment is an issue that has come up before the Committee in numerous ways concerning HMOs and whether or not they are being paid the proper amount.

As you go forward and expand the number of choices available to seniors, as has been described in documents that again have been made available to us—and especially including the use of a Medisave plan, but not limited to that—it becomes extremely important to be able to make some adjustments for potential risk selection. This is an area in which PPRC is doing work now with the highest priority. We hope to have some of the work available in the next month or two, and we will, of course, make it available to your

staff and to you as soon as it is available. But we would like to make the point that while we think it is important to go ahead with risk adjustment, we want to urge your consideration of using risk adjustment strategies as they are available, to not wait until there is the perfect risk adjustment strategy available to take on this very important problem.

We think that you can make improvements in this. It will become very important as you expand the number of options, and we urge your consideration in not waiting until the final, perfect risk adjustment mechanism is available.

In addition, as you expand options, there are a number of areas where we think you will need to consider, and we just want to touch on those: Coordinating the open season, making sure there is information available to seniors so that they can know how their choices should be made; to make sure that there is an adequate range of choices; and to make sure that there are consumer protections.

We at the PPRC, and I know as well my colleague Stuart Altman at ProPAC, stand ready to help you as you go forward in helping to assess the specific details as to how you will implement these plans and to how you will assure access and quality to the seniors of the country.

Thank you.

[The prepared statement follows:]

**STATEMENT OF GAIL R. WILENSKY, PH.D
CHAIR, PHYSICIAN PAYMENT REVIEW COMMISSION**

Mr. Chairman, I appreciate the opportunity to be here this morning to present the Physician Payment Review Commission's views on proposed reforms in the Medicare program. Since its creation in 1986, the Commission has devoted considerable thought to many of the issues raised by this proposal and has made recommendations in several key areas. In addition, we are now at work on several projects that will provide the Congress with information it can use as it seeks to broaden the array of choices available to Medicare beneficiaries.

As we speak, the U.S. health care system is undergoing major changes. Employers are fundamentally altering the way they purchase health services. Managed-care plans are growing rapidly and evolving toward more integrated systems of care. Physicians and hospitals are joining together in new types of organizations, transforming the way care is delivered. The design of the Medicare program, by contrast, continues to reflect the financing and delivery system that were in place at the time of its enactment thirty years ago.

Although managed care is now only a small part of Medicare, its rapid growth suggests that the time may be ripe for policy changes that will help guide this program into the next century. Much can be done to make changes in Medicare consistent with innovations in the private sector, and to ensure that the program acts as a prudent purchaser in responding to the changing health care marketplace. The challenge that lies ahead will be to expand the number of choices available to beneficiaries and encourage the use of cost-effective providers, and to do so in ways that protect the fiscal integrity of the program and preserve beneficiaries' access to high-quality care.

As this Committee considers substantial changes in the Medicare program, it faces many tough decisions, some political, some technical. I see the role of the Physician Payment Review Commission as assisting you in two key tasks: understanding the broad implications of proposed reforms and providing technical assistance in developing the many details that will define how these changes would be implemented.

My testimony today reflects both these roles. First, I will present the Commission's views in several areas where it has done significant work over a number of years. These include setting payment rates for managed-care plans, constraining growth in spending for Medicare physicians' services, constraining overall growth in Medicare spending, and Medicare financing of graduate medical education (GME). In the second section, I will discuss a number of issues that the Commission has begun to consider more recently in context of expanding the range of choices available to Medicare beneficiaries. While we have not yet made recommendations in these areas, I can offer some insights about the questions that we will be considering and the analyses we plan to undertake.

In all of its work, the Commission has been guided by a series of goals, many of which it first elucidated when it began consideration of reforms in physician payment policy almost ten years ago. In assessing options for reforms designed to improve the performance of the Medicare program, the following goals have served as guideposts. Reforms should:

- ensure that all beneficiaries have access to medical care,
- maintain or improve the quality of care provided to Medicare beneficiaries,
- maintain financial protection for beneficiaries. Although some patient responsibility for the cost of care is appropriate, levels of responsibility should not be so high that they prevent beneficiaries from gaining access to care or impose significant economic hardship.
- slow growth in federal outlays for physicians' services (and more broadly, in other types of services financed by Medicare),

- make the program easier for physicians, providers, and the general public to understand,
- be orderly and coherent, with short-term changes consistent with long-term goals, and
- accommodate the various ways health care services are organized.

Setting Payment Rates for Managed Care Plans

As Members of this Committee are aware, current Medicare payment policies for managed-care plans are fundamentally flawed, and have contributed to problems of limited participation of health maintenance organizations (HMOs) (and thus low beneficiary enrollment rates), and higher costs per enrollee than their fee-for-service costs would have been. These problems include:

- the linking of managed-care payment rates to Medicare fee-for-service expenditures, so that the cost efficiencies achieved by HMOs do not result in savings for Medicare;
- wide geographic variation in payment rates due to local variations in fee-for-service patterns of use;
- highly volatile county-level payment rates, particularly for those with small Medicare populations;
- inadequate risk adjustment methods; and
- unrestricted movement between risk and cost contracts, resulting in HMOs with risk contracts attracting patients with less expensive patterns of use.

The proposed Medicare Preservation Act would take some important steps toward correcting these problems. The establishment of payment rates for a baseline year, together with budgeted annual updates thereafter, will unlink HMO payments from Medicare fee-for-service expenditures. This will allow Medicare payment rates to be set for managed-care plans in a manner that better reflects the cost savings that can be achieved by participating plans. In addition, breaking the link eliminates the problem of payment volatility over time. More consistent and predictable payment rates should encourage participation in the Medicare program by risk contracting health plans and also help increase enrollment in those plans by beneficiaries.

Payment rates established for the baseline year will have a long-term influence on future payments. Although the proposal would reduce geographic variation in payment rates, it may not go far enough to modify those rates that are very high or low due to historical differences in patterns of service use for local counties.

The Commission has some suggestions to make to this Committee on how it could reduce the range of payment rates across the country; these methods include blends of national and local payment rates, differential updates for areas with high or low rates, and replacing counties with larger regional geographic areas. In its 1995 annual report, the Commission recommended blended payment rates as the most sound and administratively flexible approach. Although it would be desirable to develop baseline payment rates that are as correct as possible, the changes could be introduced over a transition period to ease financial dislocations for existing plans that now serve beneficiaries in markets where current Medicare capitation rates are very high.

Also at issue is the fact that teaching-related and disproportionate share (DSH) payments do not always reflect the actual costs incurred by managed-care plans, depending on their use of these institutions. Their inclusion in the calculation of managed-care payment rates has therefore led to both overpayment and underpayment in the current program. While the impact of retaining these special payments will diminish over time under the new approach to setting payment rates, they will have a lingering effect. If the Committee were to choose to remove them, one approach would be to provide direct payments to eligible hospitals when they provide services to managed-care enrollees.

As experience is gained with the new payment system, the Commission looks forward to working with the Congress to continue refining and improving the payment policy. Among the alternatives that could be explored are market-based payment methods that would enable Medicare payment rates to better reflect the costs of efficient health plans in competitive markets.

Mechanisms for Constraining Spending for Physicians' Services

The proposal would substantially improve the mechanism for constraining spending for physicians' services in the fee-for-service sector. As you know, the proposal would repeal the current volume performance standard (VPS) system and replace it with reasonable budgetary goals that fully account for all spending for physicians' services. This new system conforms to all of the Commission's recommendations for improving the VPS.

The proposed system has two components: a sustainable growth rate and a conversion factor update. A single growth rate and update would apply to all physicians' services.

The sustainable growth rate would be calculated to reflect changes in physicians' fees, enrollment, and law. It would also allow for reasonable and affordable growth in the volume and intensity of services by using projected growth in real gross domestic product (GDP) per capita plus two percentage points, instead of relying on historical growth rates used under the current system. Over the next decade, the expenditure targets under this proposed system would hold annual growth in Medicare spending for physicians' services to between 6 percent and 7 percent per year.

The second component of the system is an annual conversion factor update designed to hold total spending to its budget. The new system would eliminate the two-year delay, thereby increasing the timeliness of the adjustment to the conversion factor. It also has a better mechanism for addressing the inherent volatility in annual expenditure growth by limiting the size of the adjustments that would be made to the conversion factor each year. Unlike the current system, excesses and surpluses that are not made up in one year would be made up in subsequent years. Assuming inflation remains between 2 percent and 3 percent each year, conversion factor updates would hold increases or reductions to no more than 5 percent per year.

Currently, physicians face reductions in the conversion factor even if they hold volume growth to just 4 percent per year (Table 1). Under the proposed system, holding growth to 4 percent would actually lead to modest increases over the next decade. That is, the new approach would provide physicians the opportunity to receive increases in payment if volume and intensity growth is held to reasonable levels. If annual volume growth increases at unreasonable rates (10 percent or more), however, this system would provide maximum reductions of 5 percent per year.

Table 1. Comparison of Conversion Factors Updates Under Current Law and Under the New Approach Assuming 4 Percent Volume Growth (percentage)

Year	Current Law	New Approach
1997	-2.2	2.8
1998	-3.0	1.6
1999	-3.0	2.3
2000	-3.0	2.4
2001	-2.0	2.4
2002	-2.0	2.4
2003	-2.0	2.4
2004	-2.0	2.4
2005	-2.0	2.4

SOURCE: Physician Payment Review Commission analysis.

Another improvement is the adoption of a single conversion factor beginning in 1996, providing a single growth rate and update thereafter. This step would eliminate distortions to the Medicare Fee Schedule that have occurred under the current system. That is, a relative value for surgical services would once again be paid the same amount as a relative value for primary care services.

Finally, the proposal includes a "failsafe" provision which instructs the Secretary to reduce payments for each of ten sectors when overall budgetary goals are not met. This provision may conflict with the mechanism for constraining growth in physician spending. As this policy is further developed, it is important to consider the interaction between the failsafe and the mechanism for constraining growth in spending for physicians' services.

Mechanisms for Constraining Overall Growth in Medicare Expenditures

The House proposal includes mechanisms for constraining overall growth in Medicare expenditures. As now understood by the Commission, the so-called failsafe mechanism includes (1) fixed government payments and updates for Medicare Plus plans; (2) fixed fee-for-service prices, based generally on existing methods, set at a level designed to ensure that targets set in law for each sector of services are met; and (3) a lookback mechanism that would reduce spending by lowering provider payment increases in traditional Medicare if overall spending in a particular sector exceeds the targets. Both the setting of prices and the lookback may be necessary to account for increases in the volume of services.

Based on its previous analyses, the Commission wants to comment on two issues. One is how the mechanisms to constrain spending are structured. In 1993, the Commission completed work for this committee that addressed similar mechanisms for constraining overall growth in Medicare expenditures. The second issue addresses how to account for differences in risk between beneficiaries enrolled in Medicare Plus and those selecting traditional Medicare. The Commission's ongoing work on risk adjustment provides a foundation for this discussion.

In its 1993 report to this committee, the Commission concluded that, if sector-specific methods were used to constrain spending growth, relatively few categories should be established. Doing so would give incentives to groups of providers while keeping most substitution of services within, rather than across categories. Where substitution occurs across categories of services, inequities may be created for certain categories of providers. For example, the substitution of lithotripsy for surgical treatment of kidney stones in the 1980s appropriately shifted services from hospital to outpatient settings. A process should be established for tracking substitution across categories.

A second issue is how to establish targets for each sector of services. Based on the Commission's experience with the VPS, it is important to set separate baselines for each category. Doing so recognizes that spending appropriately grows at different rates for different service sectors. The accuracy of baselines is also an issue, especially if they are derived from

current projections, because it may be difficult to anticipate accurately future trends in service delivery. Accordingly, a process may be needed to make corrections or adjustments over time.

Finally, given that the failsafe mechanisms in this proposal will "guarantee" a certain level of spending, any future policy initiatives on the fee-for-service side (e.g., case management) that produce savings for traditional Medicare would probably not be scored as savings. In fact, they may be scored as costing the program money if they add administrative costs even if those are more than offset by actual reductions in service use. This scoring situation would tend to reduce the incentive to find these savings. It may be useful to create some incentive to continue pursuing such improvements in traditional Medicare as under the proposed mechanism for constraining physician payments.

The Commission is also concerned that the failsafe mechanisms might be triggered if healthier-than-average people enroll in managed-care plans. This uncorrected risk selection (i.e., that due to factors other than those such as age, sex, and institutional status that have been included in Medicare's method for paying managed-care plans) would thus lead to increases in the volume of services and thus to provider payment reductions and potential reductions in beneficiaries' access to services. In fact, this could also be a complicating factor in efforts to constrain growth in spending for physicians' services.

Evidence published in 1993 showed that prior costs for HMO enrollees were lower than for nonenrollees in the same market areas, even after adjusting for the risk factors used in the current payment system. Enrollees were also less likely to rate their health as poor and to have a history of cancer, heart disease, or stroke. As a result, the Health Care Financing Administration (HCFA) has paid an estimated 5.7 percent more, on average, for Medicare HMO enrollees than it would have paid under fee for service. Changes in the market since this study was conducted have raised questions as to whether these results still apply today. The Commission is working on analysis of selection issues using recent enrollment and survey data and claims analysis.

Considerable research has been done on several different approaches to incorporating risk adjusters for health status. It seems appropriate that risk adjusters for health status could be incorporated in the short term, even as development of better methods continues. To do so would mean incorporating the best available risk adjusters instead of questioning whether risk adjusters are "good enough." Some form of reinsurance or partial capitation might also serve, either alone or alongside risk adjusters, as a way to reduce the effects of risk selection.

Financing Graduate Medical Education

Since the Commission's mandate was expanded in 1990 to include consideration of Medicare financing of graduate medical education, we have developed substantial expertise on these issues, particularly with regard to Medicare payments for the direct costs of medical education. As we understand them, the proposed reforms would make three key changes in current policy. Specifically, they would:

- freeze the number of residents supported by Medicare;
- limit Medicare payment to residents seeking their initial specialty certification; and
- limit Medicare payment to international medical graduates.

In addition, the proposal calls for reductions in the indirect medical education adjustment similar to those proposed in budget debates over the past several years. Moreover, the creation of a new independent commission suggests that these changes are short-term measures until broader changes in GME financing can be agreed upon.

The Physician Payment Review Commission has long noted the need for a link between decisions about GME financing and those affecting the number and mix of residents. These reforms begin to make such a step by setting limits on the type of training that the Medicare program will support.

While it is unclear how changes in Medicare financing will affect the actual number and specialty distribution of trainees, the Commission has estimated that they will have a substantial impact on Medicare-supported positions. Paying only for graduates of U.S. medical schools in their initial period of training will reduce the number of full-time equivalents (FTEs) supported by Medicare by one-third from the baseline under the Omnibus Budget Reconciliation Act of 1993 (OBRA93). While all specialties will experience reductions (including primary care with losses of 42 percent for internal medicine, 43 percent in pediatrics, and 25 percent in family practice), these range from about 11 percent of positions in orthopedic surgery to 100 percent of positions in medical and surgical subspecialties such as cardiology, gastroenterology, and thoracic surgery. At the state level, reductions range from just 8 percent of residents in South Dakota, 20 percent in Texas, 26 percent in California, to 42 percent in Connecticut, 47 percent in New York, and fully 59 percent in New Jersey.

The new independent commission that would be created by this legislation will face a number of important challenges. The first of these will be to evaluate whether the short-term solutions included in this proposal should be extended or modified. In addition, it should consider additional reforms such as moving from institution-specific per resident payment amounts to standardized rates, and mechanisms for shifting support to training in ambulatory settings. This commission will also face the fundamental question about the appropriate role of the federal government in financing physician training.

Issues Affecting Medicare Plus

In the past few months, the Commission has been working in a variety of areas related to development of a Medicare system which includes an expanded array of insurance options. These issues fall into three broad groupings: guaranteeing choice, ensuring access, and assuring quality.

Guaranteeing Choice. The proposal is designed to expand the array of choices available to Medicare beneficiaries by creating Medicare Plus as an alternative to traditional Medicare. Medicare Plus expands on the current Medicare risk contracting program by offering a wider variety of managed-care plans, as well as new types of plans referred to as provider-sponsored networks and medical savings accounts.

As the details of this multiple-choice system are worked out, it is important to consider provisions that would help guarantee that beneficiaries have a real ability to make choices. One is the establishment of a coordinated open season in which all options are made available to beneficiaries. The proposal creates such an open season and provides that all plans would be offered together on an annual basis.

A second factor is that beneficiaries have adequate information on available options to make an intelligent choice. The bill addresses this need by sending beneficiaries each year a booklet describing the approved plans available in their area. Such a booklet should provide information on (1) premiums in a form that allows comparisons to be made; (2) benefits offered, including a clear explanation of added benefits and network restrictions for obtaining these benefits; (3) quality, including disenrollment rates, consumer satisfaction, and performance reports; and (4) beneficiary rights and responsibilities, including grievance processes. Given the difficulty of comparing plans with different supplemental benefits, steps should be considered to make comparisons easier for beneficiaries. Because such information is so critical to the success of a multiple choice system, it is important to ensure that the resources will be available to develop and disseminate these materials.

A third component is to provide every beneficiary with an adequate range of choices. The proposal suggests that every beneficiary will be able to pick at least between traditional Medicare and medical savings accounts and expands the number of other private plan options open to them, including point-of-service plans. Combined with changes in the payment methodology, these steps should greatly broaden the range of options available to most beneficiaries. Nevertheless, it may be important to monitor how many plans become available, especially in areas where choices have historically been limited.

Finally are several important consumer protections. In the proposal, plans will be required to accept beneficiaries regardless of health status or other factors, and beneficiaries will apparently be able to switch back to traditional Medicare after a "cooling off" period. The Commission has spoken previously about the importance of these protections. In dropping the right to disenroll on a monthly basis, however, consideration should be given to options that protect beneficiaries in circumstances where access, quality, or continuity of care is threatened. In addition, given marketing abuses reported by the Inspector General and others, protections against inappropriate marketing will be needed. Finally, the Committee may want to include provisions to help those beneficiaries (such as those who are institutionalized or disabled) who may have special difficulties evaluating and making choices under this new system.

The creation of provider-sponsored networks, part of a strategy to increase the range of choices, raises two important issues. First, the rationale for creating different standards for access and quality for these plans is unclear. The second relates to antitrust policy. In last year's annual report, the Commission concluded that current laws and enforcement policies have not deterred the formation of provider-sponsored networks when they assume risk. Therefore, it found no compelling reasons for creating exemptions from the antitrust laws for such networks. It did suggest that enforcement agencies gather and make available to the public information on antitrust problems brought about by the evolving structure of health care markets. Changing current policy should be done with care because it may result in unintended increases in anticompetitive practices. In particular, even if a change applies only to the Medicare market, it may be difficult to keep potentially anticompetitive practices from spilling into other markets served by the networks.

Finally, the MediSave option – a medical savings account for Medicare beneficiaries – would be a new and very different option for Medicare beneficiaries and therefore one of the most uncertain. A number of recent studies show a wide range of predicted costs, and the Commission has only just begun its analyses of a medical savings account for Medicare beneficiaries. There are many design issues that will need thoughtful consideration including, among other things, the nature of the involvement of managed care with MediSave.

The impact of beneficial selection is a key policy consideration in designing medical savings accounts. As the American Academy of Actuaries has noted, medical savings accounts would provide the greatest monetary surplus to the healthiest beneficiaries. If indeed MediSave draws a healthier-than-average population, inadequacies of current risk adjustment techniques could lead to Medicare losing money on the MediSave option. Because selection is more likely the more frequently beneficiaries can switch into or out of the MediSave option, you may wish to consider setting a longer enrollment period for MediSave than for other options. For example, MediSave could be made available at five-year intervals or even only once in a lifetime decision, subject to some short cooling-off period after enrollment.

Ensuring Access. Previously when the Congress made significant changes in the Medicare program, it also established a process of monitoring to track the impact of such changes. Given the magnitude of changes in this proposal, it appears prudent to set up a strategy for monitoring beneficiaries' access to care in traditional Medicare, in Medicare Plus plans, and for those electing medical savings accounts. Monitoring would provide policymakers with information necessary to ensure successful implementation of structural changes in Medicare. It could be conducted by either HCFA or a Medicare commission, or both. One example is provided by

OBRA89 which required HCFA to monitor and report to Congress on access under the Medicare Fee Schedule, and this Commission to comment on HCFA's access report.

The Commission is ready to assist the Congress in this area. In response to its OBRA89 mandate, it has a track record of monitoring access under the traditional Medicare program. Now it is extending that work by developing a strategy to monitor access of beneficiaries enrolled in managed-care plans. First, it will assess which indicators measure access most effectively and efficiently in managed-care plans. This includes assessing the capacity of managed-care information systems to generate the data that would be needed to measure access. Second, the Commission will develop and test a questionnaire for use in surveying Medicare beneficiaries enrolled in or disenrolled from HMOs. This survey will develop baseline information on access issues and will generate information on how the Medicare Current Beneficiary Survey could be modified to permit the regular collection of information specific to Medicare managed-care enrollees.

Assuring Quality. Medicare reform presents a unique opportunity to accelerate the development and diffusion of tools to enhance quality of care, building on efforts of the private sector. In developing a quality assurance system, there are two major decisions that Congress has to make (1) what strategies of quality assurance will be adopted? and (2) what roles should different organizations play in quality assurance efforts?

Three basic strategies for ensuring the provision of high-quality health care have been adopted by innovative purchasers. The first consists of a process for measuring and reporting health plan performance. Report cards containing externally validated, comparable data on plans would empower beneficiaries to make informed decisions in choosing a health plan. The second strategy requires health plans to have internal quality assurance programs that meet specified standards. Health plans' internal quality assurance programs are important both in ensuring the quality of care provided and serving as a mechanism through which plans undertake quality improvement. The third strategy is an external quality assurance program which provides an independent check on quality.

These three strategies are not mutually exclusive. A mixed system might enhance the value of each approach. Such a system would facilitate consumer choice and provide the opportunity to improve quality, while guaranteeing at least a minimum threshold of quality for all plans.

The second question that the Congress needs to decide is who will be responsible for quality assurance. Government could play a role in oversight of quality. A decision about the degree of government involvement would have to be made. The government could run the quality assurance program, although, even in the current program, Medicare contracts that function to regional professional review organizations. At minimum the federal government could establish the framework and basic goals for quality assurance program, and oversee monitoring conducted by other bodies. Private accrediting organizations also could play a role in quality assurance. Today accreditation is voluntary, although an increasing number of employers and several states require it. A quality assurance program could involve a combination of government regulation and private accreditation. The federal government could give accredited plans deemed status that frees them from further quality review. This approach would simplify the review process for many plans, relieving them of multiple reviews for employers and the federal government.

While the Commission has never recommended which level of government should conduct oversight of the quality assurance process, it collected information on state regulations that may be helpful to Congress in making this decision. Eight states do not regulate the quality of care in any type of health plan. Of the remaining states, only a few regulate quality in health plans other than HMOs and there is a wide variation in approaches and requirements to their HMO regulation.

One last thought on quality assurance focuses on its tone. Previously, most quality assurance efforts rested on identifying the "bad" actors with utilization review programs. These traditional

efforts hassled physicians, were intrusive, and did little to improve the overall quality of care. By contrast, state of the art quality assurance programs emphasize continuous quality improvement and, therefore, should play a key role in any quality assurance system.

Medical Liability Reform

The proposal's provisions on medical liability reform are similar to the recommendations the Commission has previously made to the Congress. The principal difference is that the Commission recommends that the cap on noneconomic damages be replaced, when feasible, by a schedule that takes into account the severity of the injury.

The Commission sees enacting tort reforms as an important short-term goal. Over the longer term, however, steps should be taken to put in place a medical liability system that includes a fast, efficient administrative system to compensate patients and a complementary system to detect and prevent medical injuries.

Looking Ahead

In conclusion, Medicare cannot remain unchanged if the markets and organizations with which it deals are evolving rapidly. While the reforms included in this proposal will make new types of delivery systems available to Medicare beneficiaries, it is critical that the legislation include a strategy for assessing future changes in the marketplace. The health care system is likely to continue changing at a rapid pace, and Medicare needs to be able to adapt to both the current state of affairs as well as to any trends that are expected to continue.

Chairman ARCHER. Thank you, Ms. Wilensky.
Mr. Altman.

**STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN,
PROSPECTIVE PAYMENT ASSESSMENT COMMISSION;
ACCOMPANIED BY DONALD A. YOUNG, M.D., EXECUTIVE
DIRECTOR**

Mr. ALTMAN. Mr. Chairman, I want to first thank you and the Committee for the privilege of serving you for 12 years as chairman of ProPac, the Prospective Payment Assessment Commission, and make it very clear that my staff and I have worked very closely with your staff and they have given us as quickly as they can every bit of information that they have available. I would say, however, that with the changing plan, we don't know every aspect, but I have never found your staff or Mr. Thomas to be in any way holding back information. It is a privilege we have had with the Democrats and it has been shared equally with your staff. We have tried to do the best we can with what we have available, and we do know a lot about your plan thanks to the staff.

First, let me say that we at ProPAC support a lot of what is in this plan in terms of the restructuring of the home health benefits and the skilled nursing care. It is a very intricate—I don't have the time in 5 minutes to go through it. We think it goes a long way toward making the kinds of change that needs to be made in those benefits.

We also want to commend you with respect to restructuring the managed care emphasis of Medicare. We have long supported moving more forward in this area and expanding the availability of these benefits. I would point out, however, that we have some concerns. We don't believe that the change in the payment method for geographic areas as we understand it is enough. We would like to see more changes made. We think there is too much geographic variation. We think it leads to unfairness depending on what part of the country you are in. We would hope that you would give us the opportunity to work with your staff to make this plan better.

Finally, let me focus most of my time on an important area, the hospitals of this country. We have tried the best we can to estimate what would happen to the hospitals in this country if your plan was implemented. We have supplied you, and in the testimony, with several charts and graphs to do that. I will say that this is happening so fast that my staff changed their estimates last night at 11 p.m. I apologize. We have given you some new tables that revise it slightly, but let me try to summarize what we have found.

For the last 2 years, thanks in part to the pressure in the marketplace, hospitals have reduced their costs below inflation, for the first time in our history below inflation for 2 years at about 1 to 2 percent growth. Under your plan the Medicare Program would pay hospitals at inflation minus 2 percent. This is a very tough standard but we think it is doable. It would put pressure on American hospitals but it seems like the kind of pressure that they are now able to withstand.

Our concern, though, is with the look-back provision. To be honest with you, Mr. Chairman, that part of the plan is troubling. We don't know, and I would say with all due respect nobody knows ex-

actly what that look-back will look like. It depends upon how well the rest of the system works. If that look-back comes back and hits hospitals with 3-, 4-, and 5-percent reductions beyond the market basket minus 2, to be honest with you, Mr. Chairman, we cannot say that that will not have a significantly negative impact in accessing quality of care. The look-back is a troubling aspect of this plan. I know why it is there, but I cannot in good conscience say that in and of itself it will lead to the kind of care that everybody wants.

With respect to the teaching hospitals, I think Mr. Thomas and the staff have gone very far to address the needs of teaching hospitals. We have testified before him several times that we believe the Medicare payments were too high for teaching hospitals, but as has been pointed out by other Members, teaching hospitals are being hit from all sides. They are being hit from cutbacks from managed care and expansion in terms of research and so on. And as we understand it, the proposal now includes a substantial amount of extra funds for teaching hospitals. It is that change that we put in here in the—at 11 o'clock. If you include those funds into the proposal, then it is true that teaching hospitals ought to be able to maintain the quality of care and access that we now come to expect of our finest institutions. So that part we are supportive of.

What we don't know, though, is what is going to hit them on the private side and that is why our modeling is inadequate. It is not inadequate because of lack of information from your staff. It is inadequate because we are dealing with so much uncertainty out there. We have tried the best we can.

Our concerns are in other areas as well. We are concerned with this new medical savings account, not that it exists. That makes some sense. But what we are concerned with is that if you provide them with the same average payment rate as you do for the managed care part and these people are less sick and healthier and younger than the population, you could wind up hitting the fee for service with a disproportionate number of sick people while you let the medical savings account people receive payments that are higher than intended. That is troubling.

We suggest that you look hard at that medical savings account and adjust those premiums based on health status, as my colleagues talked about.

We also are concerned with health status when it comes to the managed care programs. I won't go into that; Gail has gone into that.

So there are important suggested changes. Overall, there are some very good features in here. As I said, the look-back provision is very troubling.

Thank you, Mr. Chairman.

[The prepared statement and attachments follow:]

STATEMENT OF STUART H. ALTMAN, PH.D
CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Good morning, Mr. Chairman. I am Stuart Altman, Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied by Donald Young, M.D., Executive Director of ProPAC. I am pleased to be here again today to discuss the Committee's proposed changes to slow the growth in Medicare spending and to ensure the solvency of the Hospital Insurance Trust Fund.

For many years, public and private spending for health care in this country has been growing much faster than can be accounted for by increases in inflation and population growth. Recently, the private sector has experienced success in slowing the growth in its health care costs, especially in areas with extensive managed care arrangements. The Congressional Budget Office (CBO), however, forecasts that the growth in Medicare spending will average 10 percent a year between 1996 and 2002. There are large differences, however, in this rate of growth across hospitals, physicians, nursing homes, and other providers that must be considered. There now is wide agreement that this level of spending growth is not sustainable and that the Medicare program must control its costs.

The Committee's Proposals

The Committee's proposals would lower this growth to an average of about 6.4 percent per year between 1996 and 2002. During this time, inflation and increases in the number and age of Medicare enrollees can be expected to increase spending by about 5 percent annually, leaving about 1.4 percent additional growth each year for new technology, increases in the number or intensity of services furnished, and greater increases in the price of medical goods and services than those in the general economy.

To reduce spending growth by 35% requires new policies that will determine payments to providers and plans, or from Medicare enrollees, for the next seven years. This is not an easy task. It is especially difficult now, given the dynamic changes that are occurring in the financing and delivery of health care services. At the same time, however, it is these changes that are allowing the private sector to

control health care spending. Some of these changes also can be used by Medicare to control its spending.

As you requested, I will provide my general views on your approach and then focus on the effects of the proposal on hospitals, nursing facilities, and home health agencies. I must note, however, that there are a number of areas in which the effects of the proposal depend on specific details that I have not seen.

We have indicated to you in previous testimony that much of the rise in Medicare expenditures is due to continued increases in the number of Medicare enrollees obtaining services and the growth in the number and intensity of the services these beneficiaries receive. This growth in service volume and intensity has been aided by Medicare's traditional fee-for-service payment system. The continuing increases in fee-for-service spending also have driven up the cost of Medicare's risk contracting program, since the capitated payments to risk plans currently are based on fee-for-service spending.

Growth in Managed Care Plans

Although the number of beneficiaries enrolling in managed care plans is growing rapidly (Chart 1), many Medicare enrollees are likely to prefer the traditional system for some time to come. Further, in many areas of the country there is limited or no opportunity for individuals in the public or private sectors to enroll in competing capitated arrangements. Consequently, the Medicare fee-for-service payment system will continue for the time being to pay for the care furnished to many beneficiaries. Therefore, changes in this program also are necessary to achieve slower program growth.

Your proposal addresses both of these areas. Until now, Medicare enrollees' choice of capitated payment arrangements was limited. Your proposal would expand the type of plans and arrangements that are available and break the link with patterns of fee-for-service spending at the county level. Consequently, payments would be more stable and predictable over time. Nevertheless, payments would still be related

to historic patterns of spending that may not be an appropriate basis for future payments. I also encourage you to reduce the excessively wide variation in geographic payment rates, which generate substantially greater benefits for Medicare beneficiaries that live in geographic areas with high levels of fee-for-service spending and choose capitated plans.

Adjusting for Health Status

I share the concern of many analysts that we continue to lack a robust measure to adjust capitated payments to plans based on an enrollee's health status and the expected costs of furnishing appropriate care. This lack of a good risk adjustor financially disadvantages plans that enroll a disproportionate share of sicker individuals and could discourage plans in some areas from participating. It also provides undesirable incentives for plans regarding where they choose to locate and how they choose to market their services.

Also, younger and healthier Medicare beneficiaries are more likely to select capitated arrangements. One of the reasons for this is that many of the new plan enrollees are in managed care arrangements when they become eligible for Medicare, and they will continue in these plans, especially as you broaden the opportunities for them to do so. To the extent that plans do enroll a healthier than average Medicare population, the capitated rates will be higher than you intended. If this process of selection occurs, it will increase spending per beneficiary in the fee-for-service sector, since a sicker population will remain there. This will make it more difficult for the fee-for-service sector to function within the spending limits included in your proposal. I will return to a more detailed discussion of the fee-for-service sector in a few minutes.

As a result of these issues it is more important than ever to adjust the capitated payment amount and the fee-for-service limits to recognize differences in the health status and risk of costly illness across the populations covered under these two payment methods. The absence of such an adjustor has not been regarded as a major problem in the private sector. However, the variation in health status, and

particularly the number of individuals in the Medicare population with chronic, recognizable illnesses, creates a special problem, and the adjustments made as part of the current Medicare risk contracting program require improvements.

I should note, Mr. Chairman, that the improved enrollment policies and the process of averaging within geographic areas that are included in your proposal will help deal with this problem as it effects payments across plans. Such is not the case when a capitated payment is made to specific individuals, as with contributions to a medical savings account (MSA). If the contribution to the MSA does not recognize health status, then younger and healthier enrollees may choose this option because it is financially attractive at the time they make the choice. Again, this would increase spending per person in the fee-for-service program. In addition, over time, some of these individuals may develop costly, chronic illnesses that they did not plan for, and they may not be financially prepared to meet the out of pocket expenses required by their catastrophic coverage. The specific effects on Medicare beneficiaries, however, depend on policies regarding allowing individuals to revoke their decision to choose a MSA. I would caution you about allowing individuals too much choice once they have chosen this option.

I fully support your plans to offer Medicare enrollees the broad array of capitated payment and managed care choices available in the private sector. The major differences in health status between the general population and the Medicare population, however, create substantial problems. Ongoing modifications are likely to be needed to protect the financial integrity of the Medicare program and to ensure that Medicare's beneficiaries receive needed care.

Fee-For-Service Payment Policies

I would like to turn now to your proposals for changes in the fee-for-service payment system, especially those that affect hospitals and other providers. As I have described in previous testimony, the Medicare program has had some success in controlling its payment for each unit of service furnished. Spending increases for

inpatient hospital and other services, which slowed substantially in the late 1980s, again have accelerated. Much of this growth is due to increases in the number of services furnished, especially for hospital outpatient, nursing facility, and home health care. Unfortunately, placing controls on the price of individual services is not an effective way to control spending growth that is driven by volume increases. These controls also may introduce undesirable distortions in the medical market place as well as the practice of medicine.

Payments to Hospitals

Your proposals do adjust Medicare payments to bring them in line with the recent slowing in the growth of hospital costs. For many years, hospital costs per discharge have increased faster than the rate of inflation in the general economy. In the past two years, competition in the private sector, together with continuing payment constraints by the Medicare and Medicaid programs, have led to a large decline in cost growth (Chart 2). In the past year, hospital costs per adjusted admission have increased almost 2 percentage points less than inflation. Because of previous actions by the Congress, the increase in payments under the Medicare prospective payment system (PPS) in the last four years has been greater than the increase in hospital costs. Consequently, hospitals are now making a profit on their Medicare PPS patients. ProPAC estimates that hospital cost reductions will increase PPS margins from 0.3 percent in 1993 to 3.0 percent in 1995, their highest level since 1988 (Chart 3).

In anticipation of this testimony, we have attempted to estimate what PPS margins would be with the payment policies included in your proposal. To do so, we used two sets of cost increase assumptions. In the first, we assumed costs per discharge would rise slightly faster than the current level of increase, that is at about the level of hospital input price inflation (measured by the hospital market basket index) minus 1 percentage point. In the second analysis, costs were assumed to return to somewhat faster growth -- at the level of the hospital market basket index. The payment policies

we used for this analysis include an annual PPS update factor equal to the market basket minus 2.5 percentage points for 1996, the market basket minus 2.0 for the next four years, and the market basket thereafter. We also assumed a gradual reduction in the level of the disproportionate share (DSH) adjustment to 70 percent of its current level. This reduction would return the DSH adjustment to the same percentage of total PPS payments that was in place in the early 1990s, shortly before Congress substantially increased DSH payments. For purposes of comparison, we also included Medicare's share as well as the general revenue share of indirect medical education (IME) payments that would be paid from the proposed Graduate Medical Education and Teaching Hospital Fund.

As shown in Chart 4-A, even with these policies, hospitals generally will maintain positive PPS margins if their costs per case grow at the market basket minus one percentage point. By 2002, the PPS margin would be higher than the current level. This financial performance, however, depends on the ability of hospitals to continue to restrain their cost growth. If costs per case increase at the level of the market basket, the PPS margin would be below zero in 2002 (Chart 4-B). The ability of hospitals to make a profit on their Medicare PPS business, therefore, is critically dependent on their ability to keep cost per case growth at current levels.

These are very tough policies, Mr. Chairman. Until the past year, hospitals have never kept their cost growth at the level your proposal requires. At the present time, I believe this level is appropriate. I am concerned, however, whether it will be appropriate as we move into the next century.

Of even greater concern to me, however, is the fail safe budget mechanism. While I am not aware of all of the details, as I understand it each major provider sector has a budget limit based on projections of the sector's share of the overall Medicare budget target. It is likely that achieving this budget target will require further reductions in payments per case beyond those you have already included in your bill. I am very concerned about the effect that would have on hospitals and the care received by Medicare beneficiaries.

It is important to note also that the effects of the proposed changes are not felt equally across all types of hospitals. In Chart 5-A, we display the simulated PPS margins for different groups of hospitals, assuming costs increase at market basket minus 1 percentage point. Major teaching hospitals do the best of all under PPS, with a PPS margin of 18.5 percent in 2002, compared with their 1995 margin of 14.6 percent. Disproportionate share hospitals also do slightly better on their PPS margins than they did in 1995. PPS margins for all groups, except major teaching and disproportionate share hospitals, become negative if average cost increases over this time return to the level of the market basket (Chart 5-B).

I continue to be concerned that the formula that we use to distribute disproportionate share payments is not targeting the funds to the hospitals most in need. Since the measure we use includes Medicaid hospital days, this problem is likely to worsen as states obtain Medicaid managed care waivers and Congress enacts fundamental changes in this program. During the summer, ProPAC conducted extensive analyses to attempt to devise a better formula. We concluded that improvements are not possible until new data become available to construct a better measure.

I would like to note also, Mr. Chairman, that your proposal breaks new ground in public support for teaching hospitals by creating a Graduate Medical Education and Teaching Hospital Fund that provides a new source of funding from general revenues. This fund continues, at a modestly reduced level, Medicare's support for both the indirect costs of caring for Medicare patients under the prospective payment system and the direct costs hospitals incur to maintain a graduate medical education program. It also authorizes important demonstration projects to test the feasibility of providing these payments to consortia of teaching hospitals and other entities with an interest in graduate medical education in the community. ProPAC supports such a fund and is pleased you have this provision in your proposal.

ProPAC also has attempted to assess the impact of your proposal on the overall financial condition of hospitals, as measured by their total margins. We are not able

to simulate total margins with precision, since they rely on trends in costs and revenues from private payers. We did, however, simulate what the effects of your proposal would be on hospital total margins under a set of very specific assumptions. We applied the same assumptions used in our analysis of PPS margins and factored in the proposed changes in Medicare hospital outpatient, capital, bad debt, and graduate medical education payment policies. We also assumed that other hospital revenues from all sources combined will increase in proportion to non-Medicare expenses. This method allows us to isolate the impact of Medicare's hospital payment policy changes on total margins in 2002, if other payers' policies did not change.

Using this approach, in 2002 the PPS and other changes contained in your proposal would result in total margins of 3.9 percent if hospitals hold their cost growth to market basket minus 1 percent (Chart 5-A). If costs increase at the level of the market basket, the total margin would decline in 2002 to 2.4 percent (Chart 5-B). Today, major teaching hospitals have the highest PPS margins but the lowest total margin of 2.6 percent. That pattern would continue, with total margins in 2002 of 2.6 percent under the market basket minus 1 cost growth scenario. If costs increased at the level of the market basket, the total margin for teaching hospitals in 2002 would be 1.3 percent.

It is important to note, however, that this approach is not intended to project what total margins actually will be in 2002. Depending on the numerous other potential changes that might be expected, these simulations may significantly overstate financial performance, particularly for teaching hospitals. It is likely that the growth in revenues that these hospitals receive from private payers will slow as more payers adopt managed care payment systems and become unwilling to recognize the extra costs these hospitals incur to maintain their teaching mission. I believe that the new contributions from general revenues to the Graduate Medical Education and Teaching Hospital are intended to help offset this likely decline in teaching hospital revenue growth as the number of individuals choosing managed care plans increases. We have included these new funds in our calculations, but we were not able to include

any estimates of the lower revenues from private payers. Consequently, the total margins that teaching hospitals face in the future may be lower than our analysis indicates.

Skilled Nursing Facilities

As ProPAC has reported, since 1988 Medicare spending for skilled nursing facility services has grown extremely rapidly (Chart 6). This growth has been fueled by increases in the number of persons served as well the number of days per person served. In addition, we recently have described large increases in skilled nursing facility reimbursement per day. Our analysis indicates that much of the increase is due to a substantial expansion in the utilization of ancillary services.

The Medicare program continues to reimburse skilled nursing facilities on a cost basis, with separate policies governing routine, capital, and ancillary costs. Currently, routine costs are subject to certain limits and your proposal would provide further incentives for SNFs to control their routine costs by extending the freeze on these limits for an additional year. In contrast to routine costs, where there have been some limits, capital costs have been fully reimbursed. In the late 1980s, Congress took action to reduce hospital capital spending. Your proposal would, for the first time, reduce capital spending for skilled nursing facilities. Consequently, these facilities now would have an incentive to carefully evaluate their capital spending.

The most important aspect of your proposal, however, is that for the first time it will place certain ancillary services under the routine cost limits. In addition, ancillary therapy services will be subject to aggregate payment limits. Facilities that are able to stay under the limit will share in the savings with the Medicare program. I believe the approach you have selected is a sound one. It is also an important first step in developing policies with financial incentives for nursing facilities to control the rapidly growing volume of SNF services. Nevertheless, these limits may not be sufficient by themselves to bring the rapid growth in this sector in line with overall budget limits. While your proposal includes within the failsafe provision further limits

on spending growth in this sector, additional policy changes may be necessary to bring growth in this sector more in line with that in other sectors.

Home Health Services

Your proposal also makes a significant advance in Medicare's home health payment policies. Rather than imposing new cost sharing requirements on beneficiaries to control the volume of services furnished, you propose to establish prospectively determined per visit rates that are subject to aggregate limits per episode of care. Currently, the Medicare program pays home health agencies the costs they incur (subject to certain limits) to provide different types of visits to Medicare beneficiaries. This approach encourages agencies to increase the number of visits. It also fails to reward agencies for improving their efficiency. Consequently, over the past five years Medicare spending for home health services has grown an average of almost 40 percent a year (Chart 7).

The proposed policies would control this spending growth by providing incentives and rewards for agencies to improve their efficiency in providing each service as well as the total number of services over an episode of care. Agencies would have a strong incentive to keep their costs below the prospective per visit rate. In addition, a target payment limit would be calculated for an episode of 120 days of care for each home health agency. Consequently, agencies would have a strong incentive to keep their costs below the target limit. As a further incentive, they would share in the savings if they reduce their costs below the limit.

You have made a good start in providing the correct incentives to control the increase in the volume of skilled nursing facility, home health, and other post acute care services. We at ProPAC are continuing our analysis of this growth of services and their relationship to a prior hospital stay. I believe it is likely we can develop additional policies with the incentives to control volume growth. We also will be examining the changing patterns of service delivery to identify the modifications in

budget allocations across sectors that may be called for as the health care system continues to evolve and we improve our ability to control the growth in service volume.

Modifying Policies in the Future

As I noted earlier, Mr. Chairman, the financing and delivery of health care services is undergoing dramatic changes at the current time. Your proposals will continue the process of reshaping the Medicare program and allowing it to reap the benefits of a more competitive health care system. Your proposed changes in the capitated payment programs and in the payment policies for hospitals, skilled nursing facilities, and home health services do just that. Seven years in the rapidly evolving health care system, however, is a very long time. It is likely the changes we are witnessing in the private sector as well as other changes we can not anticipate now will require adjustments in these policies over time.

Your proposal sets updates for capitated and fee-for-service payment rates and addresses some of the unknown factors through a fail safe budget mechanism that is intended to provide incentives for providers to ensure that Medicare fee-for-service spending remains within the sector specific targets you have specified. I am not certain, however, that this kind of aggregate incentive, by itself, will result in the necessary behavioral change.

As I noted earlier, changes in Medicare's payment rates can control the price per unit of service. The problem, however, is the growth in the number of units of service being furnished. Controls on the prices paid for individual units of service will have only a small effect at best on reducing increases in the number of services. If this growth continues, the failsafe reduction mechanism could result in payments per unit of service that are actually lower than they are today.

A sector budget control also provides incentives for providers to shift services to other sectors to avoid penalties. Therefore, it is critical that the allocation among sectors be appropriate. In the past few years, spending for acute inpatient hospital care has grown more slowly than other sectors as the growth in admissions declined

and hospitals slowed the rise in costs and reduced lengths of stay. I am especially concerned that setting their future sector target based on this past improved performance may place them at a particular disadvantage in the future. We need to monitor carefully the effects of your proposal on access to quality care across sectors and be prepared at some point in the future to make the policy adjustments that I believe will be necessary.

As I described earlier, I also believe that the capitated payment rates should be adjusted to reflect the health status of the individuals selecting these options. The failure to do so will place those beneficiaries who choose to remain in the fee-for-service sector at a disadvantage if the average fee-for-service patient becomes sicker and the necessary costs to provide care to a sicker population triggers the failsafe budget mechanism.

In conclusion, Mr. Chairman, in the past several months the Commission has provided testimony and extensive background information and analyses concerning Medicare's managed care and fee-for-service programs to the Committee as you developed your proposal. We stand ready to provide you with additional assistance as the health care system changes and further adjustments to Medicare policies are called for. I would be pleased to answer any questions.

Prospective Payment Assessment Commission

Chart 1. Medicare Risk Contract Enrollment and Payments, Fiscal Years 1990-1995

Year	Enrollees (In Millions)	Percent Change	Payments (In Billions)	Percent Change
1990	1.2	—	\$4.2	—
1991	1.3	8.3%	4.9	16.7%
1992	1.5	15.4	5.7	16.3
1993	1.7	13.3	7.2	26.3
1994	2.1	23.5	9.1	26.4
October 1994 to June 1995	2.7	*	8.8	*

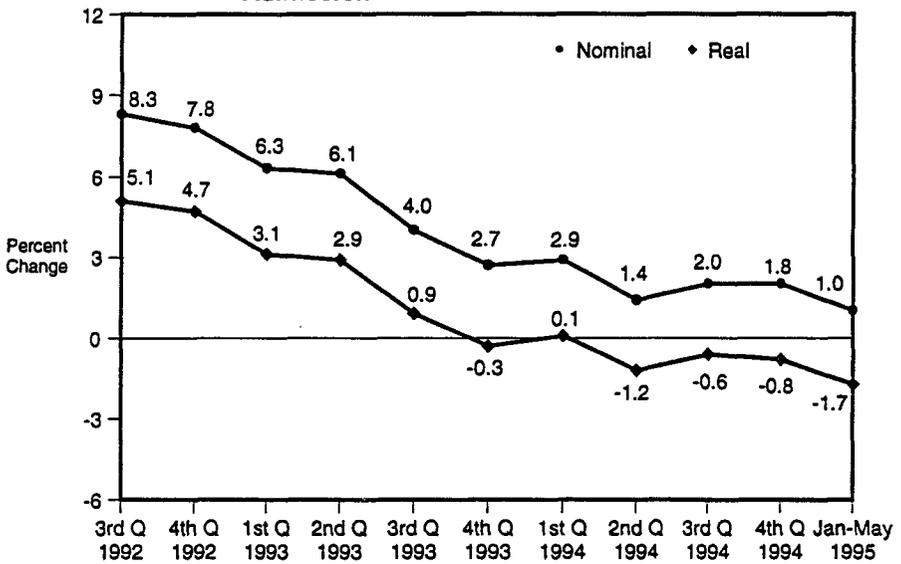
Note: Annual data are as of September for each year.

* Not calculated as 1995 data are not complete.

SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of Managed Care.

Prospective Payment Assessment Commission

Chart 2. Quarterly Change in Hospital Cost Per Adjusted Admission

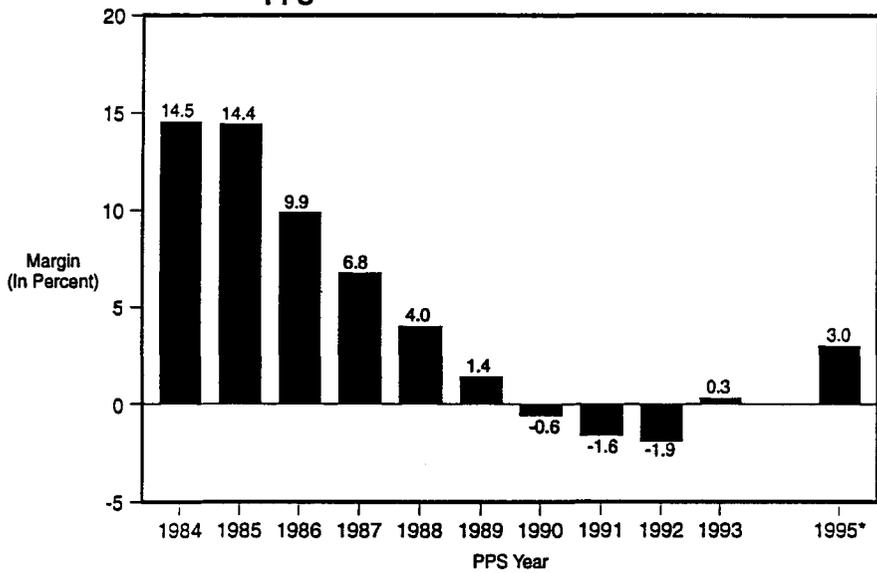


Note: Each period is compared to the same period the previous year.

SOURCE: American Hospital Association Hospital Panel Survey.

Prospective Payment Assessment Commission

Chart 3. PPS Margins for All Hospitals, First Ten Years of PPS



* Estimated

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Prospective Payment Assessment Commission

Chart 4-A. Estimated PPS Margins for all Hospitals, 1995-2002 (With Costs Increasing at PPS Market Basket Minus 1)

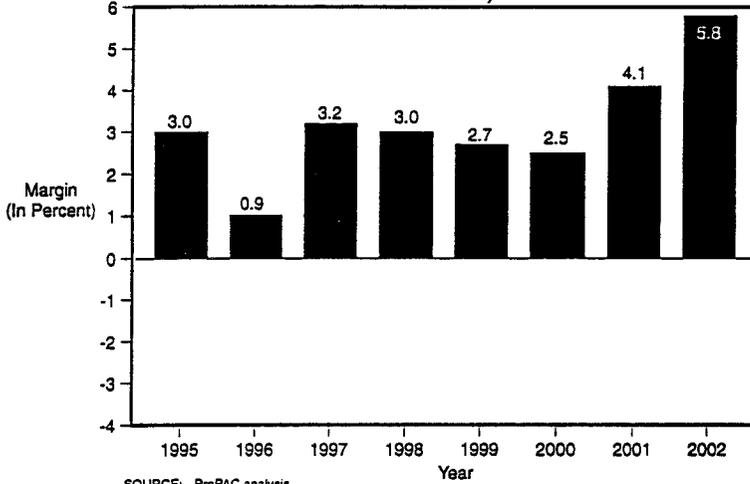
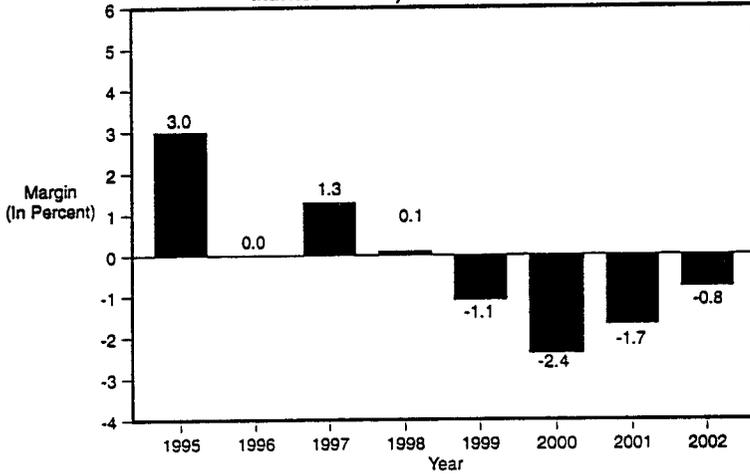


Chart 4-B. Estimated PPS Margins for all Hospitals, 1995-2002 (With Costs Increasing at PPS Market Basket)



Prospective Payment Assessment Commission

Chart 5-A. PPS and Total Margins by Hospital Group, Before and After Payment Policy Changes (Market Basket Minus 1 Scenario)

Hospital Group	PPS Margin			Total Margin		
	Actual 1993	Estimated 1995	Simulated 2002	Actual 1993	Estimated 1995	Simulated 2002
All hospitals	0.2%	3.0%	5.8%	4.3%	4.3%	4.1%
Urban	0.6	3.1	6.0	4.2	4.2	4.0
Rural	-1.8	1.9	4.8	5.0	5.2	4.8
Major teaching	11.7	14.6	18.5	2.7	2.6	3.2
Other teaching	0.5	2.7	5.7	4.6	4.5	4.4
Non-teaching	-4.0	-1.0	1.3	4.6	4.9	4.3
DSH government	4.5	7.7	9.3	4.6	4.5	4.3
DSH non-government	4.7	7.4	9.3	3.9	4.0	3.6
Non-DSH	-5.1	-2.5	1.7	4.7	4.7	4.6

Note: The figures in this table are based on the estimated impacts of potential Medicare hospital payment policy changes in 2002 compared to baseline PPS and total hospital margins. The baseline margins are not predictions but illustrations of what PPS and total margins would be in 2002 under certain assumptions about the growth of Medicare and other hospital costs and revenues. These assumptions include: Hospital cost growth (both Medicare operating and other expenses) between 1995 and 2002 at a rate equal to one percentage point less than the PPS hospital market basket index, or an average of 2.6 percent per year. Medicare operating payment growth according to current law. Other hospital revenue growth at a rate equal to one percentage point less than the PPS hospital market basket index. The resulting baseline margins can then be adjusted to reflect alternative assumptions about costs and payments, including but not limited to the Medicare changes examined here: PPS Operating—Update reduced to MB-2.5/MB-2/MB; IME reduced to 6.5/6.0, with new funding added; DSH reduced by 15 percent/10 percent/15 percent/ 20 percent/ 25 percent/ 30 percent. Capital—Reduced 15 percent from baseline. GME—Reduced 25 percent from baseline, with new funding added. Bad Debt—Reduced 50 percent from baseline. OPD/Surgical, Radiology, Diagnostic—Continuation of current operating and capital reductions, correct formula-driven overpayment.

SOURCE: ProPAC analysis.

Chart 5-B. PPS and Total Margins by Hospital Group, Before and After Payment Policy Changes (Market Basket Scenario)

Hospital Group	PPS Margin			Total Margin		
	Actual 1993	Estimated 1995	Simulated 2002	Actual 1993	Estimated 1995	Simulation 2002
All hospitals	0.2%	3.0%	-0.8%	4.3%	4.3%	2.6%
Urban	0.6	3.1	-0.6	4.2	4.2	2.5
Rural	-1.8	1.9	-1.9	5.0	5.2	3.2
Major teaching	11.7	14.6	12.8	2.7	2.6	1.9
Other teaching	0.5	2.7	-1.0	4.6	4.5	2.8
Non-teaching	-4.0	-1.0	-5.6	4.6	4.9	2.7
DSH government	4.5	7.7	2.9	4.6	4.5	3.2
DSH non-government	4.7	7.4	3.0	3.9	4.0	2.1
Non-DSH	-5.1	-2.5	-5.2	4.7	4.7	3.0

Note: The figures in this table are based on the estimated impacts of potential Medicare hospital payment policy changes in 2002 compared to baseline PPS and total hospital margins. The baseline margins are not predictions but illustrations of what PPS and total margins would be in 2002 under certain assumptions about the growth of Medicare and other hospital costs and revenues. These assumptions include: Hospital cost growth (both Medicare operating and other expenses) between 1995 and 2002 at a rate equal to the PPS hospital market basket index, estimated by the CBO to average 3.6 percent per year. Medicare operating payment growth according to current law. Other hospital revenue growth at a rate equal to the PPS hospital market basket index. The resulting baseline margins can then be adjusted to reflect alternative assumptions about costs and payments, including but not limited to the Medicare changes examined here: PPS Operating—Update reduced to MB-2.5/MB-2/MB; IME reduced to 6.5/6.0, with new funding added; DSH reduced by 15 percent/10 percent/15 percent/ 20 percent/ 25 percent. Capital—Reduced 15 percent from baseline. GME—Reduced 25 percent from baseline, with new funding added. Bad Debt—Reduced 50 percent from baseline. OPD/Surgical, Radiology, Diagnostic—Continuation of current operating and capital reductions, correct formula-driven overpayment.

SOURCE: ProPAC analysis.

Prospective Payment Assessment Commission

Chart 6. Medicare Skilled Nursing Facility Utilization, 1980-1994

Year	Persons Served		Days	
	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per Person Served
1980	257	9	8,645	33.6
1981	251	9	8,518	33.9
1982	252	9	8,814	35.0
1983	265	9	9,314	35.1
1984	299	10	9,640	32.2
1985	314	10	8,927	28.4
1986	304	10	8,160	26.8
1987	293	9	7,445	25.4
1988	384	12	10,667	27.8
1989	636	19	27,780	43.7
1990	638	19	25,200	39.5
1991	671	20	23,700	35.3
1992	785	22	28,960	36.9
1993	870	24	34,437	39.6
1994*	925	25	36,865	39.9

* Estimated

SOURCE: Health Care Financing Administration, Office of the Actuary.

Prospective Payment Assessment Commission

Chart 7. Medicare Home Health Care Utilization and Payments Per Visit, 1983-1994

Year of Service	People Served		Visits			Payments Per Visit	
	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per 1,000 Enrollees	Per Person Served	Amount	Percent Change
1983	1,318	45	36,898	1,234	28	\$43	—
1984	1,498	50	40,422	1,330	27	46	7.3%
1985	1,549	50	39,449	1,274	25	49	6.5
1986	1,571	50	38,000	1,204	24	51	3.3
1987	1,544	48	35,591	1,104	23	54	5.5
1988	1,582	48	37,132	1,130	23	56	4.1
1989	1,685	50	46,199	1,379	27	56	-0.5
1990	1,940	57	69,565	2,038	36	57	1.7
1991	2,223	64	100,044	2,875	45	57	0.3
1992	2,523	71	134,844	3,796	53	59	3.5
1993	2,900	80	173,953	4,804	60	61	4.3
1994*	3,220	87	209,149	5,765	65	62	1.6

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Prospective Payment Assessment Commission

Chart 4-A. Estimated PPS Margins for all Hospitals With and Without New Medical Education Funding, 1995-2002 (With Costs Increasing at PPS Market Basket Minus 1)

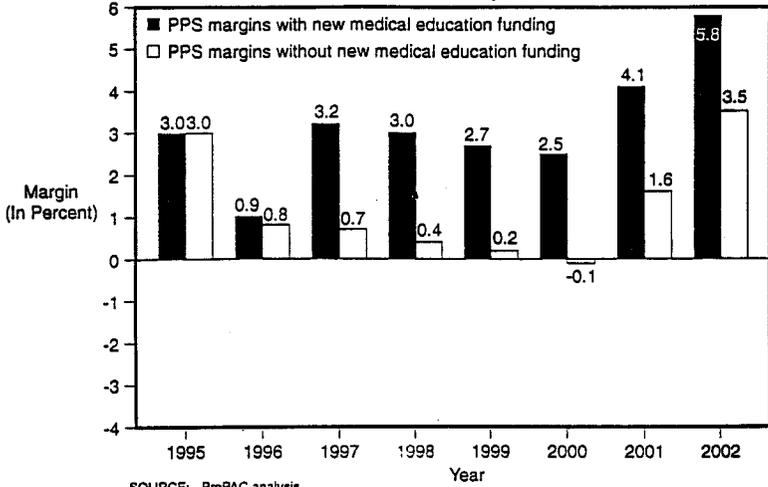
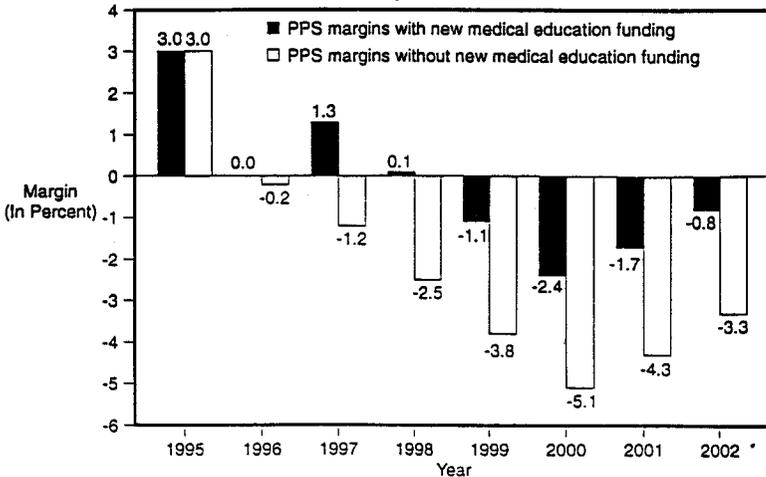


Chart 4-B. Estimated PPS Margins for all Hospitals With and Without New Medical Education Funding, 1995-2002 (With Costs Increasing at PPS Market Basket)



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PPS and Total Margins by Hospital Group, Before and After Payment Policy Changes, With and Without New Medical Education Funding (Market Basket Minus 1 Scenario)		Actual 1993		Estimated 1995		Simulated 2002		Actual 1993		Estimated 1995		Simulated 2002		
Hospital Group		PPS Margin		Total Margin		Total Margin		Actual 1993	Estimated 1995	Simulated 2002	With	Without	With	Without
		Actual 1993	Estimated 1995	Simulated 2002	With	Without	With							
All hospitals		0.2%	3.0%	5.8%	3.5%	4.3%	4.3%	4.3%	4.3%	4.1%	4.1%	3.3%	3.3%	
Urban		0.6%	3.1%	6.0%	3.3%	4.2%	4.2%	4.2%	4.2%	4.0%	4.0%	3.1%	3.1%	
Rural		-1.8%	1.9%	4.8%	4.6%	5.0%	5.0%	5.0%	5.2%	4.8%	4.8%	4.7%	4.7%	
Major teaching		11.7%	14.6%	18.5%	10.8%	2.7%	2.7%	2.6%	2.6%	3.2%	3.2%	0.6%	0.6%	
Other teaching		0.5%	2.7%	5.7%	3.2%	4.6%	4.6%	4.6%	4.6%	4.4%	4.4%	3.5%	3.5%	
Non-teaching		-4.0%	-1.0%	1.3%	1.3%	4.8%	4.8%	4.8%	4.9%	4.3%	4.3%	4.3%	4.3%	
DSH government		4.5%	7.7%	9.3%	5.3%	4.6%	4.6%	4.6%	4.5%	4.3%	4.3%	3.3%	3.3%	
DSH non-government		4.7%	7.4%	9.3%	6.4%	3.9%	3.9%	3.9%	4.0%	3.6%	3.6%	2.5%	2.5%	
Non-DSH		-5.1%	-2.5%	1.7%	0.3%	4.7%	4.7%	4.7%	4.7%	4.6%	4.6%	4.1%	4.1%	
<p>The figures in this table are based on the estimated impacts of potential Medicare hospital payment policy changes in 2002 compared to baseline PPS and total hospital margins. The baseline margins are not predictions but illustrations of what PPS and total margins would be in 2002 under certain assumptions about the growth of Medicare and other hospital costs and revenues.</p> <p>These assumptions include:</p> <ul style="list-style-type: none"> Hospital cost growth (both Medicare operating and other expenses) between 1995 and 2002 at a rate equal to one percentage point less than the PPS hospital market basket index, or an average of 2.6 percent per year. Medicare operating payment growth according to current law. Other hospital revenue growth at a rate equal to one percentage point less than the PPS hospital market basket index. <p>The resulting baseline margins can then be adjusted to reflect alternative assumptions about costs and payments, including but not limited to the Medicare changes examined here:</p> <ul style="list-style-type: none"> PPS Operating--Upstate reduced to MB-2.5/MB-2/MB; IME reduced to 6.5/6.0; DSH reduced by 15%/10%/15%/20%/25%/30%. Capital--Reduced 15% from baseline. GME--Reduced 25% from baseline. Bad Debt--Reduced 50% from baseline. OP/Surgical, Radiology, Diagnostic--Continuation of current operating and capital reductions, correct formula-driven overpayment. 														

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PPS and Total Margins by Hospital Group, Before and After Payment Policy Changes, With and Without New Medical Education Funding (Market Basket Scenario)		PPS Margin		Total Margin				
Hospital Group	Actual 1993	Estimated 1995	Simulated 2002		Actual 1993	Estimated 1995	Simulated 2002	
			With	Without			With	Without
All hospitals	0.2%	3.0%	-0.8%	-3.3%	4.3%	4.3%	2.6%	1.8%
Urban	0.6%	3.1%	-0.6%	-3.5%	4.2%	4.2%	2.5%	1.6%
Rural	-1.8%	1.9%	-1.9%	-2.1%	5.0%	5.2%	3.2%	3.1%
Major teaching	11.7%	14.6%	12.8%	4.5%	2.7%	2.6%	1.9%	-0.6%
Other teaching	0.5%	2.7%	-1.0%	-3.6%	4.6%	4.5%	2.8%	2.0%
Non-teaching	-4.0%	-1.0%	-5.6%	-5.6%	4.8%	4.9%	2.7%	2.7%
DSH government	4.5%	7.7%	2.9%	-1.4%	4.6%	4.5%	3.2%	2.2%
DSH non-government	4.7%	7.4%	3.0%	-0.2%	3.9%	4.0%	2.1%	1.0%
Non-DSH	-5.1%	-2.5%	-5.2%	-6.7%	4.7%	4.7%	3.0%	2.5%

The figures in this table are based on the estimated impacts of potential Medicare hospital payment policy changes in 2002 compared to baseline PPS and total hospital margins. The baseline margins are not predictions but illustrations of what PPS and total margins would be in 2002 under certain assumptions about the growth of Medicare and other hospital costs and revenues. These assumptions include:

- Hospital cost growth (both Medicare operating and other expenses) between 1995 and 2002 at a rate equal to the PPS hospital market basket index, estimated by the CBO to average 3.6 percent per year.
- Medicare operating payment growth according to current law.
- Other hospital revenue growth at a rate equal to the PPS hospital market basket index.

The resulting baseline margins can then be adjusted to reflect alternative assumptions about costs and payments, including but not limited to the Medicare changes examined here:

- PPS Operating--Update reduced to MB-2.5/MB-2/MB: IME reduced to 6.5/6.0;
- DSH reduced by 15%/10%/15%/20%/25%/30%.
- Capital--Reduced 15% from baseline.
- GME--Reduced 25% from baseline.
- Bad Debt--Reduced 50% from baseline.
- OPD/Surgical, Radiology, Diagnostic--Continuation of current operating and capital reductions, correct formula-driven overpayment.

Chairman ARCHER. Thank you, Dr. Altman.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

I want to thank both of you, and it probably would be useful to whenever I ask a question if either of you feel you want to respond, do, although it appears as though it is divided between physicians on one commission and hospitals on the other.

As you well know, in all of those hearings that we have had, we kind of carry on a discussion about desired changes and wishes. In fact, I remember when we were in the minority there was the discussion about whether or not this managed care trend was going to stay, whether it was a permanent adjustment in the system.

Mr. ALTMAN. Right.

Mr. THOMAS. You and I agreed that it probably was and that was a couple of years ago and it is moving even more rapidly than we thought.

First of all, thank you in terms of the nice comments that you made, and as you might expect, I have some concerns about the very areas that you have some concerns about. We are making change. We are making change because we need to make change.

I personally think the prospective payment structure we put in for home health care was kind of elegant. I think we have done a pretty good job there. I would say we couldn't do as good a job in the skilled nursing facility area, but we just didn't have the data and, of course, that is always troubling, as you know. We would like to have more. We are going to try to get more.

Your concern about the medical savings accounts and the risk adjustment method, which was a point that Dr. Wilensky focused on, we know that under the managed care type payment tied to fee-for-service which is adjusted by age, sex, geography, and institutional condition there are problems. We are looking for some assistance in working on a risk adjustment mechanism that is far better than what we have now.

If any of you could give us an update as to where you are in providing us with that. Obviously, we are anxious to get any newer model that you might have, but I agree with Dr. Wilensky that if you waited for that perfect risk adjustment model, you would be waiting forever.

We are moving forward with the understanding we have some problem areas, but we are going to focus on them and we are going to resolve them as rapidly as we can. So, let me give you the mike for a minute or two if you have any response to where we are now on risk adjustment mechanisms.

Ms. WILENSKY. There are activities going on at HCFA and, obviously, you should follow through with the administration, but PPRC has some studies that are underway. The first of them should be completed within 1 month. Some additional studies looking at claims data and trying to assess the status of people before they go into HMOs and those that leave HMOs so that we understand both, whether there is self-selection in but maybe there may be favorable or unfavorable selection out, should be available over the next several months.

Again, let me urge you that if you look at the notion of risk adjustment as looking at distributions of people who choose plans and

making an adjustment after the fact, it will be far easier than if you try to be able to predict beforehand at an individual level. I think many of the analysts on PPRC and commissioners as well as others believe that that after-the-fact adjustment will be far easier.

Again, to the extent that you can make some improvement, let me urge you to do so and to improve as you go along. As you open up greater choices, point-of-service, PPOs, other types of flexible managed care in addition to Medisave, it will become more and more important to make adjustments for health status so that you don't send some of the plans in death spirals.

Mr. THOMAS. Stu, on the adjusted average per capita cost formula, we obviously agree that we have big problems, and one of the big ones is the geography is by county. We are going to move to a metropolitan statistical area, which is an easy fix and it starts us moving.

I believe you know that in the bill we have a commission to look into some kind of a new formula, and we are going to rely on the expertise that is embodied in you folks as the core of that commission and then bring additional folk in to work on some kind of a fair allocation under a formula dealing with a number of different models. I think we are behind the curve on that, and I look forward once again to any input that you folks can give us on a fair formula.

But I hope you understand that at the beginning we have to take what we have been given and make whatever adjustments we can to live with it until you give us a better model.

Mr. ALTMAN. I appreciate that. Mr. Thomas, we testified before you regarding our concern that in certain parts of the country, the current payment rate is so far in excess of what it costs the managed care plans to provide the services that some beneficiaries are getting \$140 per month of extra benefits. Now you might say, well, they are getting extra benefits, that is fine. But in another county right around the corner or around the block or halfway around the country, they are getting none of those benefits, and I think over time if you don't fix this problem quickly, you are going to have a very different Medicare Program depending upon where you live.

Mr. THOMAS. Once again, you understand we are aware of the problem. We have what we believe to be current adjustments that are possible. We have a commission to look into it. We inherited this problem and we have set up a structure I think that will resolve it.

I want to thank both of you for your testimony, not just today, but for all those other times we enjoyed having a discussion about the way in which Medicare ought to be reformed.

Chairman ARCHER. Mr. Gibbons.

Mr. GIBBONS. Dr. Altman, the last witness testified that to make this part B trust fund sound, it would take \$160 billion, not \$280 billion.

Mr. ALTMAN. The part A trust fund, sir?

Mr. GIBBONS. That is right. The trust fund, the thing that they are all weeping and wailing over, it would take \$160 billion. So we have still got \$110 billion that is coming out of this program more than what is needed to make the trust fund sound. That is their witness. They called him. He identified himself as being a coworker

of theirs and a member of their own political party, and he is a fine fellow and he has had lots of experience so I trust his figure of \$160 billion.

I am not going to ask you why the other \$110 billion is coming out of this program. But I am intrigued with what both you and Ms. Wilensky said about the problems you are having with the Republican draft that none of us up here and the public has ever seen. Can you elaborate a little more for me about the problems you are having?

Mr. ALTMAN. Well, as I tried to say, we have tried to model the implications of the cuts mostly in the part A trust fund. And as I said, most of the reductions in the rate of increase—and that is what they are—seem to us to make sense. The hospitals, much of the cuts in the growth rate in the hospital payments are in line with where the market is today; they are not unreasonable. Where we get uncomfortable is in the look-back provision, if it is necessary, and also in the fact that it is sector by sector.

We had a long discussion with Mr. Stark about that and I understand why it is done. I think the government is pushed into that by the scoring mechanism that sits on high. From an economic point of view, it is bad business because it lacks flexibility; therefore, you have to give the flexibility back to somebody else.

Now, I think I understand that when we see the legislative language it will say that the secretary will have the authority to change those sector allocations. I encourage you to have those words in there because there is no way we can anticipate 3, 4, 5 years down what those sectors ought to look like. You could wind up wiping out the hospital industry while the home health benefits go berserk or the other way around. So those look-back provisions to the extent they are sector specific and they are earmarked can lead to serious problems to our health care delivery system. That is our concern.

Ms. WILENSKY. I would like to add a comment with regard to that. PPRC, in response to some earlier requests to something that was like a look-back in previous years, had suggested trying not to have too many sectors, again because of the concern that Stuart Altman raised as to whether or not you will put very difficult burdens. To the extent there is some flexibility allowed to the Secretary, that would, I think, alleviate that concern.

The staff at PPRC have worked closely with the staff of the House Subcommittee in trying to provide technical assistance and have felt that that working relationship has continued as it has in the past, and we have not felt a difficulty other than the fact that not all of the details have been finalized and therefore changes occur over time.

Mr. GIBBONS. But as I interpret your testimony, both of you professionals are uncomfortable with the program that you know of that none of us have ever seen.

Thank you.

Ms. WILENSKY. Well, I think that there are aspects in there that incorporate changes that relate to our specific recommendations, and we are very pleased to see that, and there are other aspects that are not finalized or don't go as far as we would like to see and as we think the Committee or at least the Committee staff would

like to see because we don't have the technical information. Risk adjustment is one of them. We know we need to get better.

But I think all of us encourage the Committee not to wait until you have the perfect adjustment. We know the AAPCC needs to become more equal across the country, but you have to move from where you are to where you want to be, and I think there seem to be some signs that that is being built in.

Chairman ARCHER. Mr. Shaw.

Mr. SHAW. Mr. Chairman, I would like to ask the witnesses to clarify something Mr. Gibbons asked in quoting the actuary as to \$160 billion being all that was necessary, and I believe the question was phrased as to the—as to one part of the Medicare plan and for 10 years. The question then comes up what is done with the extra \$110 billion because the total package is—creates a savings of \$270 billion. Can either one of these witnesses respond, Dr. Wilensky?

Ms. WILENSKY. Well, let me respond as an economist rather than a PPRC chair with regard to that answer. Right now the Medicare Program is growing at about 10.5 percent per year. It is about 9-percent growth per person, 1.5 percent reflecting the aging of the population.

The issue, in addition to the fact that there is a trust fund that has a funding problem which has gotten a lot of attention, has to do with the question of how fast does the program need to grow in the aggregate or per person in order to provide the services we have promised the elderly. It is important to get a sustainable spending level per person. I think many of us think 9 percent per year is too much, is too fast, not just because of current budgetary concerns but because we all know the boomers are coming along and that even when we get a sustainable level of spending per person, we are going to have to worry about the bulge in the population. So that while you may need a certain amount of money, and I will trust Guy King's estimate as to what that is, to solve a certain funding problem in the trust fund, it begs the broader issue, which is how fast does Medicare need to increase per person each year in order to deliver the services, and that the present rate of increase I believe is too fast and unsustainable. What the right rate is is obviously a more difficult question that people can argue about.

Mr. SHAW. But in the plan, the so-called Republican plan or the MedicarePlus Program, the growth is still approaching 6 percent per year so there is still a growth pattern and there are no actual cuts.

Ms. WILENSKY. It is about 5 percent per person, 6½ percent per person in the aggregate. It is 2 percent above inflation, maybe 2.5 percent depending exactly on what is inflation in terms of real growth. It is growth per person. It is obviously slower growth per person than we have seen in the past. The question is is it enough, is it fast enough?

Mr. SHAW. And the payments that are made go into a trust fund under part A and part B; is that correct?

Ms. WILENSKY. Well, there is technically a part B trust fund. It works in a different manner. It is funded each year out of the general fund and out of premiums. There is a very well-known part A

trust fund that comes from 1.45 percent of the wage tax by the employer and employee and goes directly into a trust fund for hospitals.

Mr. SHAW. Thank you, Mr. Chairman.

Chairman ARCHER. With the balance of the gentleman's time, would he yield to me?

Mr. SHAW. I yield to the gentleman the balance of my time.

Chairman ARCHER. I think this gets into some very important areas for us, for the understanding of the American people. Currently, Medicare is growing at over 10 percent per year; is that correct?

Mr. ALTMAN. That is right.

Ms. WILENSKY. That is right.

Chairman ARCHER. That is more than three times the rate of inflation; is that correct?

Ms. WILENSKY. Approximately.

Chairman ARCHER. In order to save Medicare, if we let the growth approximate roughly twice the rate of inflation, we can get the job done; is that a fair statement?

Mr. ALTMAN. That is true, yes.

Chairman ARCHER. All right. So any plan necessary to save Medicare under the projections and assumptions of the actuaries—we just had one in front of us today—that will let Medicare grow at roughly twice the rate of inflation and will still get the job done; is that a fair statement?

Mr. ALTMAN. I think it is a fair statement, although I would caution that we need to talk about per beneficiary as opposed to the program.

Chairman ARCHER. No, I understand. But even per beneficiary, it can continue to grow at a figure that I believe Ms. Wilensky said was 2.5 percent above the rate of inflation.

Mr. ALTMAN. That is right.

Chairman ARCHER. And accomplish the job.

Mr. ALTMAN. That is right.

Chairman ARCHER. I think that is very, very important.

And the question that Mr. King was not permitted to answer by the questioner when he began to say, actually, could it be that he was referring to what has actually occurred in the private sector in this country relative to the growth of the rate of spending on health care as a model that shows that we can do better, would that be a fair statement, than we are doing currently?

Mr. ALTMAN. Since the early nineties, the rate of growth in the Medicare Program has been 2 to 3 percentage points faster than in the private sector. Much of it, though, has been because of volume, which I think Mr. Thomas tried to get at, and I think we need to focus on that because I think that volume growth needs to be dealt with more in a managed care environment. It can't be dealt with in a price environment. But you are absolutely correct.

Chairman ARCHER. Thank you very much.

Mr. Rangel.

Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

Stuart, I think the assumption is that hospital admissions have a rate of increase, I don't know what it is, but this can vary be-

cause of disasters and other things, and I also believe that the baseline growth in this proposal is based on an inflation rate of about 3 percent. I don't know that but that is a guess.

Under this bill, we are now limited in hospital payments to exact dollar amounts. We have never been limited that way in the past. We have always adjusted by population or inflation growth.

Would it not have a serious effect and possibly result in payment decreases if the inflation rate was 4 or 5 percent or if we had an additional 1 or 2 percent in a certain area of hospital admissions, without any ability to correct? Could you not, because of the specific dollar amounts, end up cutting payments to hospitals?

Mr. ALTMAN. I am very troubled by the box that I think this Committee is in in terms of the scoring mechanism by having to live with an artificial growth curve built into the CBO estimates where they have estimates they have no idea what will actually happen, not because they are not smart, because nobody knows. I would have felt much better if this was tied to inflation.

The idea that we have absolute dollar amounts could be very troubling. If—and I can't say anything else—if inflation were to double and you wind up with a situation where you have an absolute dollar amount and you have to come back with this look-back, you could actually, yes, you could have absolute reductions in payments to hospitals. I think everybody would be better protected if we could do this in real terms.

I understand the problem the Committee gets into. They don't have any choice. But from a public policy point of view, I would feel much more comfortable if it was in real terms.

Mr. STARK. Gail, on your side, after 2002, you are limiting the cuts—I mean, the increases to 4.3 percent. The figure you gave us is good until 2002. But after that, your fail-safe cuts will always be lower than the recommended updates and you are going to, in this bill, limit those increases.

Now, that may be good, but it may be bad and there is nothing you can do about it. Would you share Stuart's concern that we ought to build some kind of indexing or flexibility into the program?

Ms. WILENSKY. I think the need for flexibility is important. Frankly, if the situation that Stuart described arose, I suspect you would change this legislation in a hurry. That if in fact the presumptions about inflation were to change dramatically, you could not withstand these set dollar amounts.

Mr. STARK. Could we not achieve what one would anticipate the Republican outline wants to achieve and still use some guidelines or indexing? Now, this may cause a budget scoring problem, I am not sure. And it was my feeling that this could be done.

Let me ask Gail one more question. You didn't summarize your testimony on Medisave. But if I could paraphrase your testimony, you suggest that because we don't have accurate risk selection programs, that we ought to require Medisave enrollment for at least 5 years and possibly make it a once-in-a-lifetime decision. Can you elaborate?

Ms. WILENSKY. Yes. I actually have said this, I believe, to at least the Subcommittee before. I am a strong supporter of the option of Medisave. It exacerbates the problem of risk selection, if it

occurs, and until we can get a reasonable risk adjustment mechanism, one way to try to protect the rest of the choices would be to have a longer term choice pattern, to have a cooling off period of at least a couple of years, maybe 5 years. Initially, I had advocated a once in a lifetime. I think I have changed my mind since then that that may be excessive. But to have an annual enrollment at this point in time with the sophistication of our risk adjustment ability I think is asking for trouble. But I do think it is an important option and I think it can be worked out. I am anxious to see what CBO does with regard to the scoring of this as to whether they think it will cause increased expenditures to occur elsewhere.

Mr. STARK. Just one question. Do either of you belong to an HMO?

Ms. WILENSKY. I belong to a PPO, a network.

Mr. STARK. An HMO?

Ms. WILENSKY. No.

Mr. ALTMAN. Fee-for-service.

Mr. STARK. So do all the Democrats. I have not asked the Republicans. I have a hunch that nobody in the room belongs to an HMO, but I am going to find that out later.

Chairman ARCHER. The gentleman's time has expired.

Mr. ALTMAN. All my children work for HMOs, though. I think that is the future.

Chairman ARCHER. I think if we took a poll, most of us up here on the Committee are covered by a PPO. I know that I am. But let me just quickly say this. What Ms. Wilensky said is so very important for all of us to understand, irrespective of our persuasions on this. We cannot lock in a program for 7 years that will not be adjusted and changed as we move along.

Mr. ALTMAN. Absolutely, yes.

Chairman ARCHER. That has got to be assumed. Every year the Congress is going to be looking and adjusting whatever program is put in place.

Mrs. Johnson.

Mrs. JOHNSON of Connecticut. Thank you, Mr. Chairman.

In regard to your foregoing comment, I think it is appropriate also to remind the Committee, as well as to remind the listening public, that should there be a sudden rise in costs for any reason, whether it was because of inflation or some other factor, Congress would respond. Every time there is a serious rise in unemployment, this Committee meets, reports out new legislation, and alters the program and extends the benefits. So whenever there is a significant aberration in our economic circumstances that affects the lives of the people, we respond. And if there is any significant change from the assumptions that we are operating on in the real world, we will certainly respond.

It is also true that of course as inflation rises so do contributions to the Medicare Trust Fund as a percent of wages and so more money does come in without increasing taxes and that helps to offset the inflation of the medical costs. So I don't worry about what happens during the 7 years because we will all be here together deciding what is going to happen if we are under those circumstances.

But I do want to ask you both to comment on an issue that you have raised that is at the heart of what we are doing. To me, it is the core cost driver in Medicare. Of course we have more seniors and of course there are things like that. But it is our extraordinary ability to diagnose and treat illnesses that are driving rising costs in health care for every group in the population.

Now, in Medicare we have tried to control the costs of volume, that is, the number of new visits, the amount of new tests, the number of specialists, the use of specialists. We have tried to control all of that by regulating rates. We have a long history of price controls, some of which were put in place explicitly for the purpose of controlling volume.

Now, I have anecdotal evidence that we are at the point where prices in some areas are so low that there is diminishing access to the service to the physician or to the product. I am interested in whether there is yet, since our data is 2 years behind or 1 year behind reality, whether you are seeing any evidence in your data of reduced access to service as a result of price controls. And then I would like you to comment on the mechanism of volume control through price control versus the mechanism of volume control through integrated care systems.

Mr. ALTMAN. Well, Mrs. Johnson, first in the areas that we have focused on, hospital care, nursing home care, and home care, quite the opposite is true. The payment rate on the part of the government has gotten quite generous and what we see is exactly the opposite.

Mrs. JOHNSON of Connecticut. You mean so the rates are encouraging use?

Mr. ALTMAN. Hospitals—the rates have been held fairly constant. Their costs have come down. For the first time in several years, hospitals are making quite substantial profits on Medicare and they are making very substantial profits when we go to the skilled nursing and home care. So it is the opposite. We are seeing tremendous increases in volume.

Now Gail may have a different picture on the physician side, but in our side, the opposite is true.

Ms. WILENSKY. The interesting thing is that while Medicare has been relatively constant in its treatment, the private sector has been very aggressive, and the upshot is that our worries which in principle are very appropriate and should be remembered in the future, in fact there is absolutely no indication that there is an access difficulty. In fact, when I go around and speak, physicians are now telling me that Medicare is frequently the best payer in town. So while it is something that could happen, it is not happening at the moment.

Now, there is an issue with regard to volume price tradeoff, and in the past, Medicare has tried through a direct control system to limit spending, focusing on prices, except for physicians where they link prices and volume. In general, it doesn't work very well because volume is what has driven expenditures for the most part in this country. It is why a lot of people think integrated delivery systems, the whole range of managed care and Medisave accounts which have people using their own money for the noncatastrophic, is a way to try to go after this volume problem by either having

the individual or the plan at risk rather than trying only to control through price controls. We haven't had in general in our history as much success as we have liked. That is why you are facing the difficulty you are facing.

Mrs. JOHNSON of Connecticut. Thank you. Thank you, Mr. Chairman.

Chairman ARCHER. The gentlewoman's time has expired. The gentleman from Kentucky.

Mr. BUNNING. Thank you.

My good friend, Mrs. Johnson, has said that she will be here in 7 years. I don't know if any of us will be here in 7 years, but I congratulate her on winning her next three elections.

Let me get to the point of what the present law says. If we get to the year 2002 and we don't alter what we have in front of us and the projections show the funding continuing to spiral downward, what does the present law say in regard to paying benefits? I want this on the record because I want everybody to understand what the alternative is. Anyone on the panel?

Mr. ALTMAN. My sense of the law is that if the trust fund is out of money, Medicare will not pay its bills.

Ms. WILENSKY. There is no legal authority. You have two economists speaking.

Mr. ALTMAN. We don't know anything about the law.

Ms. WILENSKY. There is no real authority to spend money out of the trust fund when it has depleted the funds.

Mr. BUNNING. In other words, if we fail to act, then there will be no money at all, by your projections, in the trust fund in the year 2002. I want to just make sure that that is on the record because I don't believe it has been brought out.

Look-back provisions. If we do run into a problem where inflation erodes the increase that we are building into the projection—in other words, the 6.5-percent increase—I suspect that whoever is sitting on this Committee at that time will listen to the Secretary of Health and Human Services as we have this year and say, We have to do something to correct that.

Do you all feel that that is not going to be the case?

Mr. ALTMAN. There are two parts to the look-back provision. One is that the look-back provision could be implemented even without inflation.

Mr. BUNNING. Correct.

Mr. ALTMAN. One aspect of this that I do not know—and I have never seen added up—will all the savings reach the goals. So I don't know whether you will need the look-back without inflation. If you need the look-back without inflation, then what we are talking about are reductions that are going to be greater than we have modeled. Now, as I said, I haven't seen them. They are by sector. It may be that the hospitals are fine, the nursing homes. I don't know that. I would hope that when we see the final proposal, the dollar growth reductions that are in place will be adequate to meet your goals and that the look-back provision will not be necessary.

Ms. WILENSKY. Let me say I believe the look-back will be necessary because the fee-for-service system has the same lack of incentives to moderate spending it has always had, and, therefore, in

all likelihood the growth in spending in that sector will be greater than what is presumed in the budget.

The question of whether or not the look-back mechanism provides enough flexibility will depend on exactly how you write that language. I presume that if what you have put in place produces reductions that are intolerable and that can't be accommodated by the flexibility, the Members of this Committee will meet and make some changes.

Mr. ALTMAN. But I want to add something. We see different sides of this animal. I think the proposals that are in this plan in terms of home health care and skilled nursing will reverse much of the pressure points that fee-for-service generates.

Ms. WILENSKY. That is true.

Mr. ALTMAN. It is also the hospital care. Hospital growth has not been the driver of inflation. So the driver has been in the home health and skilled nursing, and as I said earlier, those proposals do have a crack at making significant restructuring. And so, therefore, there is a reasonable shot that you might see the savings. But I don't know, I have never seen the addup. And the look-back, if it is needed, could cause real problems.

Ms. WILENSKY. But again I think—while there are some behavioral changes that may help, I believe that it is in place not only because you need it for scoring purposes, but it is prudent to expect that you might not have quite the slowdown in spending that is presumed.

Again, I think the real issue is, do you have some flexibility in how the look-back is implemented? It may be that as we can look at the legislation and have the two commissions' help, we may be able to offer some assistance to make sure the least harm is done if you have to invoke the look-back. So I think we are both offering help to try to make this as easy a system as we can.

Mr. BUNNING. Thank you both.

Chairman ARCHER. The gentleman's time has expired.

Does the gentleman from Indiana wish to inquire?

Mr. JACOBS. Did somebody just misspeak now and say if no action is taken there will be no money at all for Medicare part A in 2002?

Did you mean to say that?

Ms. WILENSKY. No. I think what we said, based on what we understand of the actuary's projections, is that the trust fund will be depleted, the surplus will be depleted by the year 2002.

Mr. JACOBS. The surplus, but the tax would still be in place. There won't be enough money, it is not that there will be no money at all.

Ms. WILENSKY. The problem is that the incoming funds are smaller than the outgrowth, and it is only the surplus that keeps us out of difficulty.

Mr. JACOBS. Well, Mr. Chairman, as my contribution to the progress of this hearing, I have no other questions, only one comment.

Gail, it is nice to see you again.

Ms. WILENSKY. Thank you. Nice to be here.

Chairman ARCHER. I thank the gentleman from Indiana.

Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Yes, thank you, Mr. Chairman.

We have had a series of hearings and this is the last one, and it is a very important hearing. And what I would like to do is to get your judgment rather than a litany of figures.

If I understand, Ms. Wilensky and Mr. Altman, what you have been saying is that you do not expect people to react to the new product line the way we might like them to; therefore, you are worried that we will have to go back into a thing called a fall-back or the look-back.

I guess the question I want to ask of you is this: Do you think that there are sufficient incentives or motivations in this system, if they are properly orchestrated, to make this plan work? Because it is only because people believe in it and feel that they are going to get something new out of it that it will work. I would like your reaction.

Mr. ALTMAN. Well, I have not read the specifics. I did read the document that came out yesterday; I have not worked with it.

I don't see a significant number of new incentives. They are to expand managed care. I think managed care is growing and is going to continue to grow rapidly under the existing incentives. So don't get me wrong, I think we are going to see a substantial growth in managed care under the Medicare Program, to a large extent because you get much more benefit out of it. The legislation helps it along by—my sense is, by making it clearer what kind of benefits, making it easier for people to join.

But what I haven't seen, and maybe it is in your legislation, are the financial incentives that I was hoping to see to make it even more attractive for people to go into. Maybe it is there. So I think we are on a growth path, and as we see more plans come in and more areas with plans, you are going to see more and more growth.

But I don't know whether in the foreseeable future, clearly in the next 7 to 10 years you are going to see 50 percent or anywhere near 50 percent of the Medicare population in managed care. So, therefore, I think you need to recognize that for the foreseeable future, the majority of spending in Medicare will be in what we call the fee-for-service plan.

Ms. WILENSKY. Let me respond. I don't fundamentally disagree, but I think that the introduction of new options, more flexible options of managed care—including however it is arranged, the use of a Medisave—will attract seniors who have previously not been attracted to go into managed care. What would have been necessary, if you wanted to complete the circle, to change people faster, would be to have seniors face higher prices, higher costs. If the fee-for-service system, the classic Medicare, is more expensive, as we expect over time it will be, the way to have made that other part of Medichoice—or MedicarePlus, I guess is what it is now called—more attractive would have been to have seniors face the additional prices and costs of being in the classic Medicare. For a series of very understandable reasons, that is not the mechanism in place.

I think you will get substantial growth in the choice plans. But even under the most optimistic assumptions, you are going to have at least 50 percent of the population in the fee-for-service system in all probability at the end of the decade. And therefore the issues

about how you keep spending in line with projections, or for the fee-for-service world, the look-back, the fail-safe mechanism becomes relevant. I think it is there. Maybe it will be 35 percent, maybe it will be 50 percent that goes into the choice plan, but in all probability, there will be a big number that is left in classic Medicare.

Mr. HOUGHTON. Well, it obviously takes a tremendous amount of time to turn a battleship around, and that is what we are trying to do now.

Ms. WILENSKY. Yes.

Mr. HOUGHTON. But it seems to me we are trying to reach for those same incentives that the private sector has used to keep its costs under control. Do you agree with that?

Ms. WILENSKY. Well, sort of. I mean, the fact is, there are a lot of different strategies the private sector has used. Some companies pay a fixed amount. The employee can choose whatever plan they want, sort of like the Federal Government's plan and the choice part of Medicare.

Sometimes employers go and drive the best bargain they can with a single plan, and that is the only choice that people have. There are some companies that are using old-fashioned indemnity schedules where they set the reimbursement at the 50 percentile, and if you want to go more expensive, you pay the difference. And some companies have used Medisave kinds of accounts.

So what companies are trying to do is to be aggressive purchasers, and that underlies a lot of what Medicare is doing, but there isn't one strategy that they follow.

Mr. ALTMAN. I want to emphasize what Gail said, although I think—in retrospect, I think the Committee, the proposal came out right. I don't think you can get away with, and I don't think it is good public policy to have expected Medicare to follow completely what the private sector does.

Let's face it, in more and more companies around the country, they are being economically pressured to go into managed care. I think to do that as quickly as the private sector has done for Medicare would have been very dangerous. And so, in retrospect, I think going slowly is probably the better movement.

Ms. WILENSKY. Certainly dangerous politically.

Mr. THOMAS [presiding]. The gentleman's time has expired.

Will the gentleman from Michigan yield very briefly?

Mr. CAMP. Yes, I will yield.

Mr. THOMAS. I thank the gentleman. I want to make the point you just made and I want to underscore it.

Obviously, we are talking about trying to modify a program in a political context. Had we, as Dr. Wilensky said, increased the side on fee-for-service so that people would be forced to make a choice, we would be accused of driving people out of the fee-for-service and herding them into managed care.

Ms. WILENSKY. Right.

Mr. THOMAS. Had we created a bunch of incentives on the managed care side, as I said, toasters, microwaves, big cash-back arrangements, we would have been accused of setting up systems which would have induced people to go into a program that wasn't very good for them. What we did do was examine what options we

could make, and clearly the reason beneficiaries select these options as you said, Dr. Altman, in large part is because of the additional health care that they do receive—paid prescriptions, vision, dental.

But in our plan—and you may not have picked it up yet—what we do say is that since we continue the part B premium at the 31.5-percent rate, which is currently \$46.10 a month, that amount could be——

Mr. ALTMAN. I did see that.

Mr. THOMAS [continuing]. Part of the managed care. So you at least, in essence, get a rebate of the premium you would have already paid, along with those other benefits.

You are going to be criticized no matter what you do, and I believe we have the mix about as right as you can get it right now. Hopefully, if we could enter into a bipartisan examination of the area without the worry of the partisan attacks, we could have done something slightly different; but given the environment that we have now, I think your final analysis is correct.

I thank the gentleman for yielding.

Mr. CAMP. Thank you, Mr. Chairman. I want to thank Dr. Wilensky and Dr. Altman for coming here and testifying, and I appreciate your testimony.

Dr. Wilensky, you mention that when Medicare was enacted some 30 years ago that basically the current medical financing and delivery system was placed into law and pretty much froze there for the last 30 years. Yet you also mentioned, in the marketplace or in the private sector, we are seeing our health system changing and undergoing dramatic reform.

I just wondered if you could briefly state for the record what are some of the options that are available now that aren't available to seniors under a basic fee-for-service plan?

Ms. WILENSKY. Basically, seniors now have two choices. They can stay in the a la carte fee-for-service direct control system that characterizes Medicare, or they can choose a classic HMO with very little variation in between. They can go into an individual practice association, which is not quite as tightly organized as the group staff model, but that is the only variation.

In the private sector, you have seen much more flexible arrangements develop: Preferred provider organizations, other network plans where you get a good buy in the network but you can leave at any point, pay a little more, and go outside of the network.

There are indemnity schedules where the insurance is paid at a specific level. The person can leave and pay the difference if they go to a more expensive physician or facility.

There are some plans that incorporate the Medisave principle where there is an amount set aside to be under the control of the individual along with the catastrophic insurance to try to encourage people to be more cost conscious in the noncatastrophic part.

There is a lot of variety that the private sector has been developing in trying to find ways to constrain spending, almost none of which is, by law, available to seniors.

Mr. CAMP. Thank you. That is very helpful.

I yield back.

Mr. THOMAS. Does the gentleman from California wish to inquire?

Mr. MATSUI. Thank you, Mr. Chairman. I would like to ask Dr. Altman a couple questions.

The medical inflation today is 10 percent—I think both you and Dr. Wilensky had indicated that—6.4 percent will be what we are projecting under this proposal, what the proposed proposal is for the next 6, 7 years, from this year to 2002. After that, the projection is 4.3 percent.

Do you believe that that is a credible number, perhaps we are looking 7 years away?

Mr. ALTMAN. I am sorry, I am having trouble. Where did the 4.3 percent come from?

Mr. MATSUI. Apparently from what we understand.

Ms. WILENSKY. I haven't heard that, either.

Mr. MATSUI. From what we understand—maybe this was in the document that we received earlier this week—after the year 2002, the 6.4 percent will change to 4.3 percent in terms of Medicare growth. That is, 3 percent CPI growth and 1.3 percent growth in population.

That is not your understanding?

Ms. WILENSKY. That is—

Mr. ALTMAN. I have never seen that, sorry, sir.

Ms. WILENSKY. I have not seen that. That sounds like a Medicaid number rather than a Medicare number. I may be wrong, Mr. Matsui. I haven't seen the number.

Mr. MATSUI. In fact, I believe Mr. King had verified that with me.

Ms. WILENSKY. I will—I guess I am willing to make a comment with regards to the numbers I know, maybe in the spirit of that, but I don't know.

Mr. MATSUI. I understand. Dr. Altman, are you reading from a—

Mr. ALTMAN. I—we have not modeled anything beyond 2002 and—

Mr. MATSUI. I notice that in your statement, because you do go up to 2002 and that is why I am—

Mr. ALTMAN [continuing]. And it is—I would have to go back and look. I have just never—I am having enough trouble figuring out what is going to happen in 2002.

Mr. MATSUI. If I may just have a moment—OK, it is on page 58 of the document.

Mr. ALTMAN. I have just been shown it, and it is the first time I have seen it.

Mr. MATSUI. That being the case, however, is that a realistic number 7 years from now?

Mr. ALTMAN. It is a tough number.

Mr. MATSUI. It is. The 6.4-percent number is a tough number.

Ms. WILENSKY. It is.

Mr. MATSUI. You indicated that is possible to achieve?

Ms. WILENSKY. I think my comment to you is going to be, the number that I was aware of, which is 6.4 percent, I think, is a reach, a stretch.

Mr. MATSUI. Right.

Ms. WILENSKY. But not beyond the pale.

Mr. MATSUI. Right.

Ms. WILENSKY. The issue of whether we can go to zero real growth would again—I have just looked at this very briefly; the enrollment and inflation only is something less than I have contemplated and that I have seen experienced.

Mr. MATSUI. I guess what troubled me a little bit is that if you combine the reach-back with the 4.3 percent, that does create an interesting problem, I believe, for whomever happens to be in the administration in the year 2003. Do you have any comment on that? Because I think if we are serious about solving this problem for 14, 18, or 20 years—20 years, I guess it is—7 years from now we had better know exactly what we are looking at.

Mr. ALTMAN. I do. I think we need to take a broader view about this program.

We are talking about our health care system. Medicare is not a trivial part of our health care system, and I—and the reason why I was supportive of many parts of the Republicans' plan, when they realized they had a problem with the teaching, they dealt with it.

I think we are going to have 7 years to deal with a very tough set of numbers, maybe even impossible to get to even in themselves. I would hope that this Committee and every other Committee in the Congress would take a hard look way before then, and I hope you would do that and say, what are we doing—forget about the Medicare Program. Is this viable for our hospitals and our doctors and our home care?

And so, therefore, I do believe that we—you know, as you get out beyond the year 2000, quite frankly, we are dealing with a world that—

Mr. MATSUI. Stuart, hold on 1 minute now, wait 1 minute. Because that is exactly what has been happening over the last 15 years. We have been going 7 years, 8 years, up to 14 years in terms of the solvency of the system. So, I mean, we have been doing that.

Now, if you are suggesting that all of a sudden you can't go beyond the year 2002, then why are we into this debate?

Mr. ALTMAN. I think you need to—well, first of all, actuaries are actuaries.

Mr. MATSUI. So you are refuting—

Mr. ALTMAN. I realize they have a higher claim to the economy.

Mr. MATSUI [continuing]. So you are refuting the last testimony.

Mr. THOMAS. The gentleman's time has expired. We need a succinct answer.

Ms. WILENSKY. I think that as I understand it, what is being proposed are specific proposals with regard to the 7-year period.

Now, I will be honest, I have not seen this before. I have not heard this. I think a proposal that has zero real growth, I would like to understand what was driving that rationale.

I do want to make it clear to the Committee that what is being contemplated now in the 7-year proposal is getting sustainable spending per person and that the other shoe to drop, that I think most of you expect to be facing, is what we do to face the population bulge that comes at the end of the next decade. Because even if you get sustainable spending per person at, say, 5 percent per

person under Medicare, that is not going to solve the problem of the boomers starting to retire at the end of the decade.

Now, I don't understand what is behind this, so I guess I would feel—I will say I am uncomfortable with the notion of no real growth. I have never heard it as part of this plan, so I just would like to know more about it.

Mr. MATSUI. Thank you.

Mr. THOMAS. Thank you. The gentleman's time has expired.

Does the gentleman from Minnesota wish to inquire?

Mr. RAMSTAD. Thank you.

First, Dr. Wilensky and Dr. Altman, I want to thank you both for participating in this process. Certainly your intellect, your pragmatism and your expertise are refreshing, especially when your input is contrasted with some of the unfortunate political posturing and political bickering that has characterized this debate. And I, as one Member, truly hope we can work in a spirit of bipartisanship, in a pragmatic way to craft the final legislative package, and we will get into that next week.

I would like to focus, Dr. Wilensky, on your written testimony and also your exchange briefly, Dr. Altman, with Mr. Thomas.

In your written testimony, you outline concerns about the inequitable Medicare reimbursement rates for managed care. We have discussed this many times in the past, Dr. Wilensky, and I appreciate your counsel on this. We all know that the current system, which is based on fee-for-service payments, fails to capture the savings generated by managed care. It penalizes those counties that have historically provided cost-effective fee-for-service care.

And of course, a State like Minnesota, which has historically delivered very cost-effective fee-for-service medicine, in fact, one of the most efficient delivery systems with some of the highest quality medicine in the country, is hit hard by this inequitable formula.

Senator Durenberger used to tell us, you get 2½ surgeries at the Mayo clinic for every similar procedure in Miami or some of the other places, and, in fact, all but two counties in Minnesota received less than the national average payment.

My question is this, Ms. Wilensky. What methodology would you suggest to correct this disparity? I mean, how, once and for all, can we get at this problem?

Ms. WILENSKY. The specific methodology I would recommend is to use a blended rate between the average payment and the local payment so that you get closer to accounting for differences in prices and only some, but not all, of the differences in volume, which is why the spending is so much higher per person in Florida as opposed to Minnesota.

But I would caution. It is easier to make a leveler playingfield across the country for these capitated payments, but if the payments in the fee-for-service remain as unequal as they had been, which is how we got into this problem in the first place, you will make going into the capitated system less attractive than staying in the fee-for-service. That is why, if you don't address that part of the problem as well, you will make it more equitable across the country, but you will drive people out of the capitated system and into the classic Medicare if you don't address that at the same time. So that is my one caution.

Mr. ALTMAN. Let me add, we at ProPAC have just completed a study which demonstrates that even if you accept differences in spending between different parts of the country, it is still true that the higher spending areas get even more money, and areas in Minnesota and Portland and others, Oregon, wind up getting much tighter reimbursements under the AAPCC, which gives you much less flexibility if you run a managed care plan in those areas to provide the extra benefits. That is what we have been working on with the staff.

And I personally would like to see us begin to move, not so much in the artificial blended—not blended, but I think we ought to make it more even around the United States, that the level of extra benefits needs to be more even in all parts of the country and not related to where you live.

Mr. RAMSTAD. Well, thank you both. I couldn't agree more. It is unbelievable when you look at the Medicare payment rates to HMOs now, the variances from a low of \$176 per month in the lowest county to a high of \$647 per month in the highest. That is a difference of about 370 percent.

As I said, in Minnesota, all but two of our counties receive less than the national average payment. So I truly hope we can address this problem in the final package and I thank you both for your important counsel and expertise on that point particularly.

Thank you, Mr. Chairman.

I yield back.

Mr. THOMAS [presiding]. Does the gentleman from New Jersey wish to inquire?

Mr. ZIMMER. No, I do not. I just want to make one comment about the remarks of the gentleman from Minnesota who said that you can get 2½ surgeries in the Mayo Clinic for every one surgery in Miami. I would just hope I would not be the recipient of the half surgery.

I yield back.

Mr. RAMSTAD. Mr. Zimmer, I can assure you our doctors never quit.

Mr. THOMAS. Does the gentlewoman from Connecticut wish to inquire?

Mrs. KENNELLY. Thank you, Mr. Chairman.

Dr. Wilensky, as you well know and you remember when you were at HCFA, a number of us put in our own health reform care bills, and we had a terrible time with risk adjusters. It would just stymie us. I remember calling your office and it was very difficult. We look at this Medicare population and roughly 10 percent of the people in Medicare spend 70 percent of the money.

Now, you say to us, don't expect to get the perfect risk adjuster. Now, I don't know if there is a perfect risk adjuster, but I know it is very hard to come to the conclusion of what it should be. Aren't you worried if we don't get it right Medicare will suffer? You said roughly at the end of the decade, 50 percent of the Medicare population would still be in the fee-for-service. We know that 10 percent, the older, frailer, sicker will be in the fee-for-service.

Aren't you afraid if we don't get it at least close to right that you are going to end up with the sicker beneficiaries in the Medicare

traditional fund, making costs rise, while the healthier, younger are in new choices?

Our Subcommittee Chairman, Mr. Thomas, said we are going to do it. Are we going to do it?

Ms. WILENSKY. I am worried and I want to say that this is not—it is probably the single most serious issue in the proposal and the reforms that are being considered. PPRC, both in their staff and with one of their commissioners in particular, Professor Newhouse from Harvard, is spending a lot of time on this issue.

I talked to him about this and with the staff and I believe that by concentrating on looking at the distribution of people in a plan at the end of the year and looking for health diagnoses that are associated with high expenditures, we can, in fact, make adjustments not today, but within the next few years, that will keep the worst of this problem from happening.

I actually don't agree that they will all be in fee-for-service, but I think the concern is a very legitimate one that they will more than proportionately stay in fee-for-service because they are older or sicker.

If we can't do it, we are going to have to come back and struggle with this, but I wish to caution you that any choice, any kind of a choice plan requires us to be able to do this and that in the Federal Employees Health Benefit Program, which not only has a large distribution, but has a substantial number of retirees, there has been less of a risk selection with no attempt to adjust than you might have expected.

So I regard it as very serious, I don't think we can put too many resources to resolve it. But to not think that you can solve this problem means basically no choices for the seniors. Any amount of choice for the seniors and for the under 65 population requires a risk adjustment or you can get into a death spiral.

Mrs. KENNELLY. I know from experience you have to have it right, but here we are, you are talking about 1 year, another year. We are going to do this legislation next week. How does this work in that we haven't gotten the right risk adjuster at this point.

How does this fit in with the process as we see it today in passing a Medicare reform bill this year and moving on?

Ms. WILENSKY. Well, the fact of the matter is this year we are at 7 percent in the non-fee-for-service and next year we are going to be at some growth, but not—you know, may be small, two digits. It will take a couple of years to put a lot of these plans in place, to have the offerings.

If by the end of 2 to 3 years we aren't ready to make some adjustments, then I think the potential for a real problem will be there. And again, you meet each year and if there isn't some evidence, I think that is going to force some reassessment of what is happening to the plan because it could become very expensive.

Mr. ALTMAN. Let me make a suggestion here. And I think it goes back to the idea that we are going to have to watch this. When we introduced the DRG system in 1983, you gave me a very part-time job that has taken up most of my time and I am very pleased to be part of this system, because we were moving into areas that we didn't completely understand.

I would strongly urge that there be a constant monitoring. The biggest concern about these risk adjusters is that you unfairly reward one sector and unfairly penalize the other sector. You are going to be able to watch that. We are going to be able to—whoever is here doing that is going—if you have good monitors in there, and you may, and hopefully you will decide to reallocate the dollars, push down the dollars that are going into the sector that is getting the healthier population and give more of the dollars to ones that have the sicker population. That is the key.

Mrs. KENNELLY. Thank you, but let me remind you. We had a terrible time in health care reform when we had the whole population. We are now dealing with a population 65 roughly to 90, so this is going to be hard, and I just hope—

Mr. ALTMAN. But we can see where—we can see the diagnoses of the people who stay in the program. We have the capacity now to do a much faster and better job of knowing, and if all of a sudden we can watch the tilting of the system—

Mrs. KENNELLY. Mr. Altman, that is what worries me. Mr. Gibbons had said that at one point this week, you know by the time you have gotten to 65, you have records—not you, but companies have records. The word is out there what your health care situation is, and as a result, we are going to have some plans that might avoid that risk. Thank you very much. Take it seriously, as I know you all will.

Mr. THOMAS. Does the gentleman from Iowa wish to inquire? Would you yield briefly?

Mr. NUSSLE. I would be happy to yield.

Mr. THOMAS. Since we are now in the process of asking questions and trying to understand the plan, just a couple of comments in this area.

Our problem is that this is a government program and that most of the real knowledge, in my opinion, about adverse risk selection is in private hands, and that managed-care companies with their knowledge in terms of how they deal with preventive care are way ahead of us. We need to look at outcomes, based research. We need to do these exit examinations so that we can begin to get a better understanding. We haven't had any real world input and that is going to occur.

Very briefly, I tell the gentleman from California, Mr. Matsui, on the page 58 question that you had, since we do have a commission that we have asked to look at the baby boomer question and that we want to deal with it in the outyears, rather than trying to run an exhaustive number of dollar amounts. What you have on page 58 is the Consumer Price Index for urban, and that will be an automatic adjustment, plus whatever else is adjusted for the simple purpose of scoring through the Congressional Budget Office, rather than running an exhaustive number of years that may or may not apply.

The assumption is that the Baby Boomer Commission will come in and make suggestions about the changes that will occur on a prospective basis after 2002. So if they do their job, we don't need it, but if they don't do it right away, you have a fail-safe mechanism to carry you on the Consumer Price Index. And I didn't want

to interject myself in that conversation, but once you understand that, I think you will see the nodding heads out there.

Mr. MATSUI. It makes more sense.

Mr. ALTMAN. But let that commission deal with that problem.

Mr. MATSUI. Mr. Thomas, the only problem is, though, that becomes a baseline and the 4.3 percent is part of that baseline, and somehow you have to deal with that.

Is that correct?

Ms. WILENSKY. As I understand, the formal part of this program goes to 2002. If, in fact, you find yourself in the position after 2002 of actually living with that amount, you will have a big struggle.

Mr. MATSUI. And you are going to have a problem, obviously. You are going to have to deal with this problem. But you can't say you will have the problem solved until the year 2014 and not deal with it.

Mr. ALTMAN. That is going to be a small part of the problem. The problem is the numbers, too. I mean, it is—we all know it is a serious problem that needs to be dealt with.

Mr. THOMAS. I thank the gentleman for yielding.

Mr. NUSSLE. If I could reclaim my time, I just wanted to ask a couple of questions.

One of the—there are a couple of side—I realize, believe it or not, there are side issues to all of this. Maybe we are not aware of that, but it is not just Medicare from what my providers back home tell me, and let me give you a for instance and then I would like to get your comments on this, because it seems to me that solving—or saving Medicare is part of a bigger picture in health care and health care economics right now, because of what is happening in the area of cost shifting. I may be making this way too simple. It is probably because my understanding of it may still be simple. I am learning like I think many Americans are.

But it is my understanding that because we have not had a holistic solution to Medicare in the past, that the ways we have tried to reduce cost have been ratcheting down of reimbursements and payments to providers, and so forth, and as they have found less money for similar services and their expanding costs, they have tried to figure out ways to shift those costs elsewhere.

My question to you would be: If in fact—and this is for the non-Medicare public—you and me and others that end up paying for them from an economic model, what we are not—it is just like a tax increase again on somebody else.

Mr. ALTMAN. That is exactly what is going to happen.

Mr. NUSSLE. What would happen if we are not successful in dealing with this problem, in saving Medicare, what would it mean for a family out there? What would it mean for the rest of health care economics?

I would invite both people to—both my respected friends and witnesses here to respond.

Mr. ALTMAN. Let me try to respond the best I can. We at ProPAC have been estimating the so-called cost-shifting numbers and our estimates are that for the year 1992, the private patient paid about 31 percent more than the cost of care in the hospital to make up for a \$26 billion shortfall that hospitals incurred in providing care to Medicare patients, and they felt they didn't get adequately reim-

bursed, Medicaid patients and for the uninsured. \$26 billion they got.

Now, what happens as we move into the future? You have two things happening. First of all, the private sector itself is getting a lot tougher and they are saying, we have had it, we are not going to be patsies anymore. We are going to come in and we are going to aggressively push down on what we pay.

Whether they do that or not is up for grabs because, interestingly enough, in the last few years, I mentioned to Mrs. Johnson, Medicare has become a relatively better payer, and so the pressure on the private sector has actually been reduced.

One of the concerns you have to have, and I hate to tell you this but you have got to have it, is that as Medicare squeezes down on what it is willing to pay, hospitals are not going to lay over and die. They are going to try to get money where they can and I think they are going to go after the private payers.

And so the private payers are going to be faced with a tougher onslaught than they have ever been faced with before. If they succeed in holding back that onslaught, then the hospitals are in trouble.

This is an interconnected system, and that is what I was trying to say. Medicare is a critical part now of the delivery system of health care and how Medicare pays affects your health care too. It does.

Ms. WILENSKY. Let me also—I don't—

Mr. THOMAS. The gentleman's time has expired.

Mr. NUSSLE. Mr. Chairman, I asked both witnesses to respond.

Mr. THOMAS. Brief response. Brief response.

Ms. WILENSKY. There is overcapacity in the health care system. If the private sector doesn't cave in, what you will see is some downsizing in this overcapacity health care system. You should want that but the people who are being impacted won't like it.

Mr. THOMAS. The gentleman's time has expired.

Does the gentleman from New York wish to inquire?

Mr. RANGEL. Thank you so much, Mr. Chairman.

Am I to assume that all of the testimony we hear today is not based at all on the document that was distributed by the Republican leadership yesterday? This testimony has nothing to do with any legislation, which of course we don't have either, but you are not basing—I mean, have all of you had an opportunity to study this?

Ms. WILENSKY. Yes.

Mr. ALTMAN. Yes.

Mr. RANGEL. And are all of you familiar with this?

Ms. WILENSKY. We have been working with the Committee staff as part of our commission's work, while we have not had a chance to study every line, but more or less.

Mr. RANGEL. You are just the people I want to talk with. Having read this, can you share with me how the plight of the inner-city hospitals works out? Because the people that I had read this for me, they said, with the disproportionate share hospitals, that they don't do too well under the better Medicare plan that is before us.

Has anyone addressed that issue?

Mr. ALTMAN. We looked very—Mr. Rangel, we at ProPAC are very concerned about inner-city health care and have been watching the plight of inner-city hospitals from our inception, and it is fair to say that it is difficult to completely understand all aspects of the plan from that document, and as Gail—

Mr. RANGEL. Let me interrupt. You keep saying we. Am I talking to you as someone that has studied the plan or am I talking to the author of the plan?

Mr. ALTMAN. You are not talking to the author—not from me. We are on the other—

Mr. RANGEL. I just—

Mr. ALTMAN. When I say we, I mean the staff and the commissioners at ProPAC. I do not mean a collective we that goes beyond that.

Mr. RANGEL. Well, so many people have brought in their mothers and their grandmothers, and of course everyone is concerned about the trust fund, but most of the people that have looked at this are concerned about the inner-city hospitals, the doctors that have been—come from other countries but they service the poor, the poor patients.

There is a lot of concern, too, about the inability for older people to bargain for their health maintenance organizations. There is concern that they may not know where to go or to take advantage of the great savings that are here. But specifically as it relates to hospitals, it is my understanding that the doctors are very pleased with this plan as it relates to their reimbursement, but my phone is ringing off the hook.

New York City is a hospital town and I am not returning the calls because I knew you experts would be here to tell me, Should they be worried about this new Medicare plan? Are they treated fairly in your opinion?

Mr. ALTMAN. As a former New Yorker and as someone who spends a lot of time in New York, I have had more than a few discussions with them myself, and I think as of 2 or 3 weeks ago, New York was in a panic.

New York and New York hospitals have been the largest benefactors, I think very appropriate, I might add, of the teaching adjustments and the disproportionate share adjustment. I have to go back there. My mother lives there so—

Mr. RANGEL. Come on. It is the best stop in the world.

Mr. ALTMAN. Now, as of 2 or 3 weeks ago, they were in a panic because it looked like the teaching adjustment was taken down, the disproportionate share was being cut back, but I will tell you this. In the last, I don't know, 48 to 62 hours, there have been substantial improvements in the money that flows back to disproportionate share and teaching hospitals, and as of my understanding, I can—as of—

Mr. RANGEL. What page? To what page are we referring? You see—

Mr. ALTMAN. It is in my testimony, but—

Mr. RANGEL. No, it is not in your testimony.

Mr. ALTMAN. I didn't write that document.

Mr. RANGEL. I am not being critical of you. I just want to be certain we are reading from the same page.

Mr. THOMAS. Page 32.

Mr. RANGEL. Page 32? This is the better bill, or whatever you call it, the better Medicare?

Mr. THOMAS. Will the gentleman yield?

Mr. RANGEL. Sure.

Mr. THOMAS. Yes. In the document on page 32 under subtitle E, reform of payment for graduate medical education and teaching hospital payment.

Mr. RANGEL. I am talking about disproportionate share, what page would that be on?

Mr. THOMAS. What you will find is that we have separated disproportionate share from teaching hospitals. It is long overdue. We have created a whole new funding mechanism for teaching hospitals while maintaining disproportionate share and not using it as an excuse for funding hospitals.

Mr. RANGEL. Where will the disproportionate share hospitals—how, under this bill, and on what page would it be? And that is why we enjoy working from a bill but I will work from this. In places where hospitals have more than their share of sick people and older people and therefore have more illness and more expenses, where is that taken care of in the better Medicare plan? That is what I want to know.

Mr. THOMAS. The gentleman's time is expired, but we do need an answer for this. The disproportionate share hospital formula has been adjusted. Basically, I believe it was a ProPAC recommendation, and we followed the recommendation of ProPAC while maintaining the disproportionate share.

You want to react to that?

Mr. ALTMAN. Well, it wasn't our—as much as I would like to get credit for that—

Mr. RANGEL. Just 1 minute. Mr. Chairman, I appreciate your trying to help me out, but you are referring to some discussions that you and Mr. Altman had, and I can't make all of the meetings, not even the Democratic meetings, much less the Republican meetings.

Now, if I wasn't—

Mr. THOMAS. If the gentleman would yield, it was a Health Subcommittee hearing. It wasn't some private meeting. It was those 16 hearings that we held on the subject.

Mr. RANGEL. Let me apologize to you because since this Committee has had no hearings at all, some of the things that the Acting Chairman is talking about, I haven't the slightest idea where the meeting took place.

Mr. THOMAS. In this room.

Mr. RANGEL. But not with the Ways and Means Committee. That is my problem.

Mr. THOMAS. With the Health Subcommittee of the Ways and Means Committee.

Mr. RANGEL. I am willing to concede that the Health Subcommittee has done a wonderful job, but I haven't the slightest idea what that has to do with the Full Committee when I am just trying to find out what went on in the Subcommittee.

So just—I beg your indulgence because Mr. Nussle on television said that we are 14, 20, 30. We on the Ways and Means had hearings, and I assume because he is new to the Committee—

Mr. NUSSLE. Will the gentleman yield?

Mr. RANGEL [continuing]. The Subcommittee, the Full Committee.

Mr. THOMAS. The Chair will indicate, the light is——

Mr. RANGEL. For whatever happened in the Subcommittee, if you can kind of get a little memo out and share it with us so that the next time I have any questions, I will refer to the Subcommittee paper or something.

Mr. THOMAS. I tell the gentleman, what he has in front of him is the accumulation of the 16 hearings of the Health Subcommittee which is what we are now discussing in Full Committee.

Mr. RANGEL. And I am asking what happened to the disproportionate share, and you asked Mr. Altman, what did we do in our discussions?

Mr. THOMAS. Now we are back to square one. Would either of you like to discuss the disproportionate share?

Mr. ALTMAN. Yes, I would like to take a shot.

Mr. RANGEL. I don't want to take the Committee's time. All I want is the page. Could you give me the page and then you two can talk about your previous discussions?

Mr. THOMAS. Excuse me. It goes 32, 33, 34 and then 35. Those are the pages that cover this.

Mr. RANGEL. Very good. And now I will listen to Mr. Altman and I will have the document in front of me.

Thank you.

Mr. ALTMAN. I think it is on——

Mr. RANGEL. Thirty-five. Do I hear 36? 35. Why don't you just go ahead. I will catch up with you. Go ahead, really. You couldn't have done a better job. It is the page after 30.

Thank you.

Mr. Chairman, when you have another hearing at another time, maybe we will have something better so we can follow the good work that you have done in the Subcommittee.

Mr. THOMAS. The gentleman has the material in front of him. Would he like an answer to his question? His time has expired.

Mr. RANGEL. Yes.

Mr. THOMAS. Go ahead. The gentleman's time has expired.

Does the gentlewoman from Washington wish to inquire?

Does the gentleman from Georgia wish to inquire?

Ms. DUNN. I do want to, thank you.

Mr. Altman, I do want you to answer the disproportionate share question but I also want to get into my 5 minutes—which seem to expire very quickly—my question to Dr. Wilensky, because I would like her to comment on the medical malpractice liability reform that we have included in this bill. So why don't we do disproportionate share. That is important in my district.

We have a hospital called Harbor View and we are in daily contact with them and I was beginning to get the indication that you are much more comfortable with how we have handled disproportionate share since we have taken the teaching, medical education funds out of that and put them into a trust fund.

Mr. ALTMAN. First of all, from the hospital's point of view, you cannot separate out the dollar flows that come from disproportionate share and that come from teaching. Many of our teaching hos-

pitals are the ones that also provide large numbers of care to the disproportionate. They are the same hospitals that get much of the disproportionate share payment, which according to the plan, is reduced by 25 percent. However, the teaching part is now higher.

We have modeled, and in my testimony, I show what we expect the margins to be for the disproportionate share hospitals and they grow. So if you combine the total impact of the disproportionate share payments and the teaching payments that go to those types of hospitals, they will be better off, and the New York hospitals will not be in the dire straits that they thought they would have been in 2 weeks ago.

Ms. DUNN. Great. That was a great precise answer and exactly answered our questions. Right, Charlie?

Mr. RANGEL. I want to thank you Ms. Dunn, and Mr. Chairman, for pursuing that, because it is the pages between 44 and—

Ms. DUNN. No, I haven't yielded, but I think he is absolutely right.

Dr. Wilensky, could you take a look at the liability reform that has been put into this plan and comment on it, please?

Ms. WILENSKY. The plan's liability reform is very similar to the recommendations that PPRC has made previously to the Congress. The main difference is that the commission has recommended that rather than just have a cap on noneconomic damages, that when it is feasible, you include a schedule that takes into account the severity of the injury rather than just putting a flat cap on the limit of noneconomic damages.

But this is a short-term reform. We think it is an important reform, but it is one in the short term. We think that in the long term what we need to do is find a way to compensate patients faster and to also detect and prevent medical injuries.

And whether that is through outcomes analysis or using a very different system such as one that allows an agreement to occur between the patient and the provider that settles the economic damages but puts any other issue off the table, as has been proposed in the late eighties as a strategy, is something we think needs to happen. But this is a good, short-term start on malpractice reform.

Ms. DUNN. Thank you, Mr. Chairman.

Mr. THOMAS. Thank the gentlewoman.

Does the gentleman from Georgia wish to inquire?

Mr. COLLINS. I pass.

Mr. THOMAS. Does the gentleman from Michigan wish to inquire?

Mr. LEVIN. Thank you, Bill.

Dr. Altman, let me ask you a few questions getting back to what I think has become the nub of this part of the hearing, and I only wish that we had had a chance to do this before the Republican proposal was drafted. Because I think if we had had this discussion and we could have moved some of the political charge out of this, there might have been some opportunity to work together, and I am afraid because we were not in the process, that chance has been blown. I hope not for much, much longer. At some point, we are going to have to try to come together.

So let's talk about the—we are talking about the cost factors here for A and B. We are talking about a system where there would be specified amounts that could be expended under the fee-for-service

the next 6 years, 7 years, and then a percentage after that, a CPI urban, nothing beyond it. A CPI at zero-plus growth in the numbers in the plan. And you have a so-called fail-safe, a trigger throughout this period, both the first 7 years and then thereafter. And you were saying you were very troubled by the box.

Take the worst case scenario and that these figures can't be met, aren't met. Look at it from the point of view of the Medicare beneficiary for 1 minute, the person who is supposed to be the one who has worked for this program and helped.

What could happen if these targets prove to be very unrealistic? From their point of view, what can happen?

Mr. ALTMAN. Well, I think we need to focus on the implications for the hospital industry and for the other industries, and what they do to meet these targets.

Mr. LEVIN. Quickly, because we are going to run out of time.

Mr. ALTMAN. If they can bring about the efficiencies that these numbers require without affecting quality of care, I think that there is the potential—Gail pointed out, we have 40, 45 percent excess capacity. We can reduce that substantially if you can bring down the inefficiencies, as they seem to be doing.

Mr. LEVIN. The CPI plus zero is—

Mr. ALTMAN. I don't want to comment on that because I just—it hasn't sort of seeped in yet. That is a very tight number. I need to know more about that. So all I can comment about is up to the year 2002, which is more than CPI, but it is still a very tight number.

Don't get me wrong. The 6.4 percent as opposed to 10 is a reduction of 35 percent of the rate of growth, so we are not talking about a—

Mr. LEVIN. So what happens to the beneficiary? This plan calls for something beyond 2002 at zero plus zero. Now, tell us from the point of view of the beneficiary, what happens?

Mr. ALTMAN. I think the key here is what I said. It is the impact on the delivery system and how the delivery system responds. If it responds by efficiencies without generating serious reductions, that is one thing, but if it winds up closing its doors, having no nurses, reducing quality, it could have a deleterious effect. That is why I am urging this Committee not to go to sleep.

You have got to—this is—this program is as significant a program as I have ever seen, and its implications for the delivery system and, therefore, for the beneficiaries could be good or bad depending upon how the delivery system responds.

Mr. LEVIN. But if it can't respond to meet these targets, what happens?

Mr. ALTMAN. Then you are going to see a health care delivery system that squeezes itself back because it won't have the money, and it is going to have negative implications in access, in quality.

Mr. LEVIN. I think what has happened, for the first 7 years and thereafter, it is kind of an iron box. And then the suggestion is, we can come back and fix it. However, the worst time to try that is during a recession. Contrary to what has been said here, we have not always been able to respond to recessions. And so this is, I think, in addition to the part B premium increase, the reason sen-

iors are most concerned, access and quality of care. That means choice, right, Doctor?

Mr. ALTMAN. Yes.

Mr. LEVIN. Thank you.

Mr. THOMAS. Does the gentleman from Texas wish to inquire?

Mr. LAUGHLIN. Thank you, Mr. Chairman.

I want to thank my friend from New York City, Mr. Rangel, for asking about the problem with inner-city hospitals, and while I don't have any inner cities—because I don't have any cities, I represent a very large rural area—the problems, I think, from all I have heard, are very similar.

Mr. ALTMAN. Very similar, yes, sir.

Mr. LAUGHLIN. I guess, first, I ought to say, since you are from New York and have assured Mr. Rangel that the inner-city hospital's worries have been cured in the last few weeks, tell me what you see for the rural hospitals when, in fact, many of us represent large counties that don't even have one hospital in the county. What do you see for the rural hospitals?

Mr. ALTMAN. Let me make it clear that ProPAC has spent more time on the rural delivery system than any other part of the system because in the beginning of the DRG system, it did adversely affect them. So do not be misled by my upbringing in terms of where I have been spending my time.

Rural hospitals, as we understand it, would go as follows: In 1995 the Medicare margins, which are the funds above their costs, are slightly less than 2 percent; that under the 2002 simulation, their margins would grow to about 4.8 percent; so this plan does provide funds, as we see it, for the rural system to survive.

Mr. LAUGHLIN. Mr. Altman, over the years I have become a strong believer in home health care and its benefits, particularly to the senior citizen, and I think back to the many that I have visited in hospitals over the years. One of the first things they want to talk about is when they are going to go home.

In your statement you have talked about over the last 5 years, Medicare spending for home health services has increased an average of 40 percent per year. Realizing the importance of home health care services, will that same percentage of increase in spending exist or can it be sustained if we make no reforms?

Mr. ALTMAN. Well, you start multiplying 40 times 40, and what started out as a very small part of the Medicare Program can very quickly become and is already becoming a major part. As I indicated in my testimony and in previous statements, the big growth items of home care and skilled nursing care are where the Medicare Program has blown out of control; it has not been on hospital payments and physician payments. I don't think it is sustainable.

I, too, am a supporter of home care, but I think the current reimbursement system has no incentives for anything but spending money. I personally would like to see home care put much more into a managed care environment. I realize that in the short run we can't do that, and therefore there are a number of changes that are proposed here that bring about—change the incentive structure by putting in rates of services more related to how sick the patient is and holding the home health agency accountable for not only providing extra services.

Mr. LAUGHLIN. In the remaining time, can you tell us some of the incentives you support? Because as I interpret what you are saying, those incentives are part of the reforms that you recommend to the Medicare system.

Mr. ALTMAN. Well, we have seen in a managed care environment where a deliverer has complete flexibility between services. When they use the home care benefits, they reduce the hospital services, or vice versa. Under the current situation, you have a very tight limit on the hospitals, but you have a fee-for-services system on the home care benefits; and there is more and more evidence, much as we would like the opposite, that a lot of the service that is being provided in home care is, let's say, marginal benefits compared to other uses of that money, and therefore, you need to put into that side of the sector the same kind of incentives as you have on hospital care. This plan goes part of the way there; my own view is, it doesn't go far enough.

Mr. LAUGHLIN. What would you do to go far enough?

Mr. ALTMAN. I would like to see it put into a managed care environment with a budget. But I know it is very difficult to do that.

Mr. THOMAS. The gentleman's time has expired.

Does the gentleman from Pennsylvania wish to inquire?

Mr. ENGLISH. Yes. Thank you, Mr. Chairman.

Mr. Altman, I appreciated your insights as provided by a line of questioning, originating with Mr. Rangel, regarding disproportionate share payments.

It is my understanding that the Medicare Preservation Act calls for a 25-percent reduction in disproportionate share payments. I believe your testimony anticipated a 30-percent reduction. I have a strong interest in this because I have three fairly significant urban hospitals in my congressional district. I forwarded to the Health Subcommittee a proposal supported by the Heritage Foundation that called for the targeting of this reduction.

In your view, is what is in the legislation fairly close to what Heritage proposed?

Mr. ALTMAN. I am sorry, sir. I don't know the Heritage—I know Heritage generally, but I don't know the specifics of the disproportionate share.

Mr. ENGLISH. Then I appreciate it. I will move on.

With regard to indirect medical education, will the institutions that bear the cost of running the IME or the graduate medical education programs receive this funding, or as you understand it, will it be diverted to a third or intermediate party such as a medical school dean and distributed to those affiliated from there?

Mr. ALTMAN. My sense is that part of it will go—maybe Dr. Young may want to comment on this. He has been spending more time on that part than I have.

Dr. YOUNG. Under the standard fee-for-service Medicare Program, it will continue to be directed to the hospital. The Committee's proposal, however, includes a demonstration for consortia to develop a better mechanism to pay communities and to let the community work together to decide how they want teaching to function, and their manpower needs, so that the money traditionally—under the traditional fee-for-service system, goes to the hospital.

The consortia is a new mechanism. Under managed care, the managed care entity negotiates.

Mr. ENGLISH. Thank you.

Ms. Wilensky, the Medicare Program has been growing, as we know, by 10 percent yearly in the aggregate. How does this growth translate to actual payment increases received by a physician, hospital, long-term care organization, or home health care provider?

Ms. WILENSKY. Well, the growth for those various sectors varies in terms of how the pricing works. In hospitals, it has been through a DRG mechanism, which is an admission payment per hospital. The rate is set, but there has been some increase because of increase in coding and increase in severity.

It is set in Congress, though, how much the per-case increase goes up. For physicians, we have a relative value scale. It is still a fee schedule, but it was changed to try to help the primary care physicians relative to specialists, and the rural relative to urban to try to reweight some of the relative payments. Again, the structure, once set in place, is increased according to the schedule that Congress puts in place.

That is, for the most part, generally true of the other major sectors. In fee-for-service medicine, usually they have cost limits. Clinical labs have cost limits; home care has cost limits, so it is a blend between what the charges are, subject to a limit.

The difficulty has been that while Congress targets its sights on prices, in Medicare, as in all of health care—most of health care in the United States, there has been a large volume growth; and so there is a tendency to focus on what you can control directly, prices. But what determines expenditures is prices and quantity, and it has been much harder to control quantity.

Mr. ENGLISH. How has that volume growth been distributed through the system? Who have been the biggest winners and who have been the biggest losers?

Ms. WILENSKY. Well, for awhile it had been physicians and hospitals, but because they have been the subject of considerable congressional oversight, we are seeing smaller growth in terms of—hospital admissions have initially declined and now increased at a very slow rate. The physician spending right in this particular window is very low, although it is projected to grow higher. There has been very substantial growth in home care, in skilled nursing homes, in both volume, prices, and number of services provided per person. Clinical labs and durable medical equipment has also grown very quickly.

So the smaller spending areas of home care, skilled nursing, clinical labs, durable medical equipment have grown very rapidly in the nineties.

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

Mr. THOMAS. I thank the gentleman.

Does gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. Altman, you were very kind in your opening comments about both the Democrats and Republicans and working with us. I want to thank you for your help over the years that I have been on this Committee in trying to analyze what we can do in order to try to bring down the cost, particularly of hospital care, under Medicare.

I must tell you, though, I am concerned that the proposal that will be coming forward by the Republicans could have a very damaging effect on the viability of hospitals in our community and the access to care for our seniors, whether in fact they are going to be able to obtain quality health care services with the types of recommendations that are being made. The prior witness indicated that the goal of the Republican proposal is to save \$160 billion over the next 7 years in part A. When you add to that the \$30 billion that has been taken out of part A under the Contract With America, that means basically we need to do \$190 billion in part A cuts in the next 7 years. If, in fact, private health insurance rises at 7.1 percent, which is the projection, can we do those types of cuts?

Can you tell us how we can do those types of cuts while trying to give me some security as to my concerns as to whether that won't mean hospitals are going to close in our communities and that our Medicare beneficiaries are not going to be denied access to care?

Mr. ALTMAN. Mr. Cardin, as you know, I don't shrink from answering many questions. What I don't know is how all these things add up. I haven't seen that table, whether it adds up to \$160 or \$190 billion.

I think I have tried in our testimony to make several points. One is that market basket minus 2 is a very tough goal, which I think is possible given the fact that hospitals have been controlling their costs much better over the last 2 years, and if they keep that up through this 7-year period, their financial situation would not be such that we would see the concerns that you raise.

Mr. CARDIN. But that is more than \$30 billion dollars over 7 years or something like that. I think it is \$35 billion.

Mr. ALTMAN. It is at that point—I haven't seen—we haven't seen the scoring from CBO and I don't know whether it is 35 or it is 35 to 50. I don't know what that number is. I think it is closer to between 35 and 50. I think it may get that far.

Mr. CARDIN. How do we get the other—

Mr. ALTMAN. But there are other things in there. There is the reduction in the capital payment. There is a whole bunch of—

Ms. WILENSKY. Skilled nursing and home care.

Mr. ALTMAN. It adds up to significantly more than 30. But the issue is when you go beyond that, and I think I—if hospitals don't control their costs to that level, then we are talking about serious problems, and the concern that I have raised, and I would like to see the numbers, is that if that does not take you all the way to where the plan says it has to go and you need that fail-safe to come back and do that, and this goes to market basket minus 3, 4, 5 percent, we have never seen reductions of that magnitude, and at that point I do get concerned, yes, very concerned.

Mr. CARDIN. And by getting concerned, what could happen? Are we talking about hospitals closing?

Mr. ALTMAN. Absolutely. Now, as Gail pointed out, we are going to see, and should see, substantial closing of hospitals to bring about efficiency and probably better quality care.

Mr. CARDIN. I understand that, but there is a point to efficiency. Are we talking about rural America being without hospitals? Are we talking about urban centers being without hospitals? It is more

efficient to run an urban hospital than an inner-city hospital for some very obvious reasons. Are we talking about only having hospitals located in certain communities? I mean, is that a real risk if the Republicans are wrong and you can't get that savings and you start to get minus 3, minus 4, minus 5 percent?

Mr. ALTMAN. You could have that kind of cut in different ways. You could have a lot of hospitals with fairly shallow staffs. We have only begun to see the efficiencies, so that there is a possibility that that minus 1 could go to minus 2. I don't want to paint the blackest picture that you could paint.

Mr. CARDIN. My time is running out, so let me just make the point. Minus 2 is going to be in the \$40 to \$50 billion range. The proposed cuts, if my percentage of \$160 billion is correct, plus \$30 billion, \$190 billion, we are not even close.

Mr. ALTMAN. Let's be fair, that 30 to 50 is just on the hospital side. Then you have to add the skilled nursing care, the home care, capital part.

Mr. THOMAS. The gentleman's time has expired.

Does the gentleman from Nevada wish to inquire?

Mr. ENSIGN. Thank you, Mr. Chairman.

I just want to toss out a few numbers here on Medicare. People toss around the goal of \$270 billion in savings over the next 7 years. Total Medicare spending is projected on the CBO baseline to be close to \$2,100,000,000 over the next 7 years, just quick arithmetic, that is about an 11-percent decrease, the \$270 billion out of total Medicare spending over 7 years.

My question is, is Medicare a system that is so efficient today that 11 percent of its growth or 11 percent out of that total spending package could not be achieved?

Ms. WILENSKY. Well, neither of us think that Medicare is a particularly efficient system. It has had a very unhelpful incentive structure attached to it. What we see proposed is not undoable. I think both of us would say it is a reach, it is a strand so forthh, but it is not undoable.

As we see the specifics laid out about exactly what happens if more people stay in fee-for-service classic Medicare rather than taking advantage of the options and some of these fail-safe mechanisms start kicking in place, how would it work, those are the kinds of answers that could help us.

But I think the notion of, can you achieve the kind of savings that are laid out and have a high-quality system providing services to the seniors, the answer is yes, although it is a reach. It is a reach because now we are growing at 9 percent per person and this suggests being able to grow at 5 percent per person, which is real growth of at least a couple percent, but certainly not an unreasonable growth when you think about what is going on elsewhere in the Federal budget. The rest of the Federal budget, except for health care and interest on the debt, is, due to growth, 3.5 percent per year. So what we are seeing is twice that in the Medicare Program. But again, relative to where we have been, it would be saying we expect you to get a lot more efficient.

Mr. ENSIGN. Let me ask a question. If there are not major fundamental changes made in our Medicare system, is there virtually any way to save it when the baby boomers retire?

Ms. WILENSKY. I think the impact of the boomers hitting, if we haven't gotten to a sustainable spending per person covered, it will be impossible to achieve. We must get this first step.

Mr. ENSIGN. My other question along those lines is, if we don't test some of these market forces, even though there is disagreement whether some of the things we are going to introduce into the market, whether those will be able to control costs, whether some of the inefficiencies can be eliminated, whether some of the waste and the fraud and abuse can be gotten out, whether some of these market forces will bring in such competitions that prices will be much lower than they are currently projected. If we don't answer those questions in the next 7 years, with 7 or 8 years after that before the baby boomers start retiring, if we don't have those questions answered, is there any possible way, with the huge demographic shift that will take place, unless you make taxes skyrocket or cut benefits dramatically to save Medicare?

Ms. WILENSKY. I think that what we need to be sure of, as we are trying all of this change, is that we are monitoring the effects on access and quality, as Stuart Altman suggested.

Mr. ALTMAN. Let me take a different twist because I think we can get lost. Medicare has been asked to take on a lot of social values. For example, it has become the major protector of our teaching hospitals. One of the things that I like about this new proposal is it breaks that nexus. I am sorry Mr. Blaun isn't here. Medicare now is sustaining many of our rural hospitals. Medicare is being asked to take on very good, in my view, social values. My preference would be to disentangle them. It also is supporting a lot of basic research. In a way, you are blaming Medicare unfairly. This is an absolute—

Mr. ENSIGN. Let me make one comment.

Mr. ALTMAN. My sense is it ought to be separated. Medicare ought to be run like a business, you are right.

Mr. ENSIGN. Let me make one comment on that. How do you think that the vast majority of senior citizens in this country would react to a plan that the previous majority had set up—undergraduate medical education that was basically subsidizing noncitizen medical graduates educated in other countries, who come to this hospital, do residencies, and that money was coming out of their Medicare system? Fundamental question.

I think that the vast majority of Medicare recipients would be outraged that people from other countries are coming to this country and their Medicare Program is subsidizing them.

Thank you, Mr. Chairman.

Mr. THOMAS. The gentleman's time has expired.

Does the gentleman from Washington wish to inquire?

Mr. MCDERMOTT. I would just remind the gentleman that health care delivered by those foreign-born medical graduates—they are people who have passed all the exams in this country. You can't practice medicine in an American hospital if you haven't passed the exams.

But let me ask both Mr. Altman and Ms. Wilensky what you think of CBO's analysis, generally speaking, about health care costs? Do you generally trust them?

Ms. WILENSKY. Well, I sometimes—the answer is I think they are nonpartisan. I occasionally think they are too staid in their thinking not allowing for behavioral changes, but I believe they are nonpartisan in their errors. Bipartisan in their errors.

Mr. MCDERMOTT. Is that what you are saying, CBO's numbers are too conservative?

Ms. WILENSKY. I think they are too conservative in terms of how they take on behavioral change.

Mr. MCDERMOTT. I have had the staff put up a graph and I have given you a copy of it and I would like to talk to you about it. We will make some assumptions because right now you have both said at various points you don't have a single number and so you have had to make a lot of guesses in your testimony today, and so I want you to assume a couple things.

In the chart before you, which is being distributed to the Members, we assumed from the numbers on page 58 of the Republican press release the dollar amount that will be given to senior citizens for health care from 1996 to the year 2002, and we asked CBO, What are the health premiums going to be in the private sector during that same period?

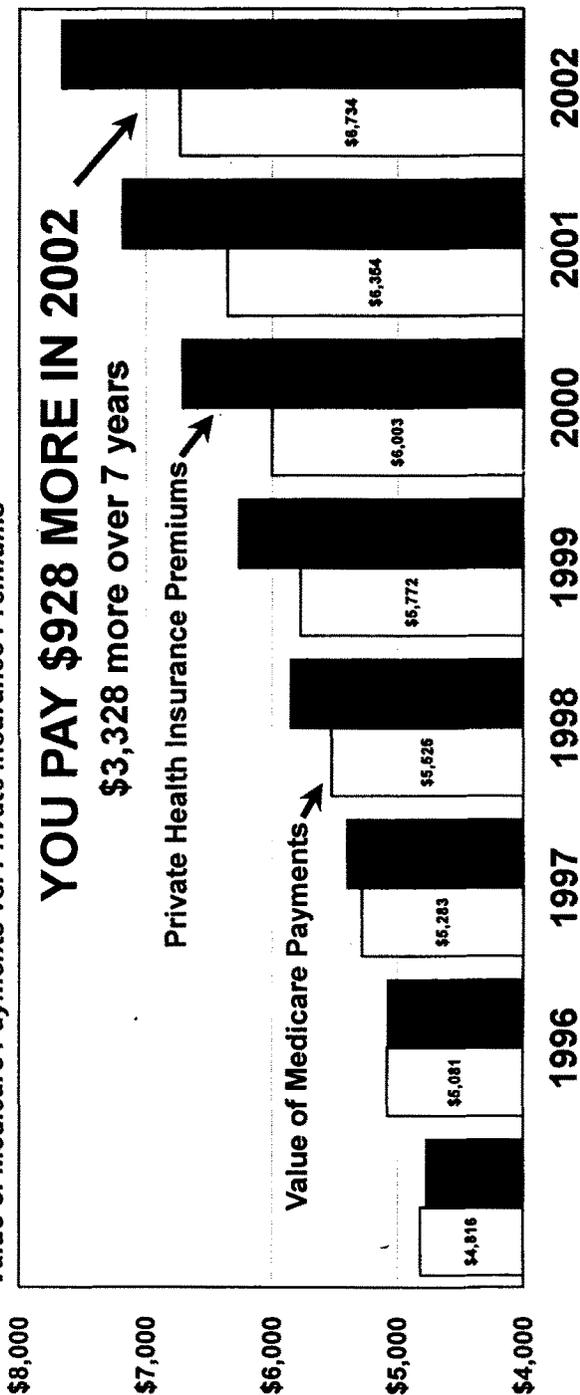
If you look at this graph, in 1996, you start about at the same amount of money, but by the year 2002, private premiums for a comparable health care plan are almost \$1,000, \$928 more.

Now, I want to know from you if this graph is correct, and we will make the assumption it is. If it is correct, where will that money be made up? How will the health care system get that \$928? Will it be from the pockets of senior citizens or from changes in the law in the Congress? What will happen to make up that difference?

[The information follows:]

REPUBLICAN PLAN ERODES SENIORS' MEDICARE COVERAGE

Value of Medicare Payments vs. Private Insurance Premiums



Budgeted Increase in Value of Medicare Payments
 Projected Increase in Private Health Insurance Premiums

Source: Republican press release on "The Medicare Preservation Act" compared with actual Congressional Budget Office NHE projections of private health insurance, adjusted by HCFA age and enrollment projections.

Ms. WILENSKY. Well, the presumption, and I am glad I made the statement, not knowing that you were going to distribute this because it really goes to the heart of CBO's projections for the private sector, which I think are far higher than I believe will occur and they have just reestimated them downward over what had been a few months before.

Mr. McDERMOTT. When did they reestimate them?

Ms. WILENSKY. They reestimated them in March or April to lower the growth of private spending over the even higher rates. I still think that they are projecting too high a growth in the private sector. They have too little change that is going on because of the aggressive changes by employers. I have shared that thought with them. I think that their—I think that the shaded bar is higher than what will occur, but it is what they project. I am not questioning that.

Mr. McDERMOTT. And so what would you say we should do? I mean, what kind of guess would you put in there for 10 percent less; 20 percent less than they estimate—

Ms. WILENSKY. Well, if you look at the differential growth in the early nineties.

Mr. McDERMOTT. We are talking about hospital payments now. They have been squeezing hospitals for the last 10 years since DRGs came in.

Ms. WILENSKY. But the issue of hospitals is that they are running on average at 40 percent empty beds, and in some areas of the country, their occupancy is in the neighborhood of 30 and 40 percent. These are very high-fixed cost institutions. If we don't try to downsize, I guess some people call it "rightsize," to get rid of some of that excess capacity, it will be very hard to have spending grow at lower levels.

Mr. McDERMOTT. So you are expecting that there will be a lot of hospitals closed. Mr. Cardin's question is absolutely correct. Rural hospitals that are running at 30 percent are going to close. That is basically what you expect, right?

Ms. WILENSKY. I think that rural hospitals, because they tend to be very small, tend to be easier to keep around. Some rural hospitals will, in fact, close, as some rural hospitals have been closing. But you look in this area and you look in Washington, DC, and a 15-minute ride from Sibley Hospital to Columbia Hospital, there are four hospitals that are like 12 minutes apart by car.

Mr. McDERMOTT. I could take you to parts of the State of Washington where the hospitals are 150 miles apart so—

Ms. WILENSKY. We have to make sure, as I believe there is a—

Mr. McDERMOTT. But how is that money going to be—

Mr. THOMAS. The gentleman's time has expired.

The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Just briefly, these numbers that the doctor has passed out are based on the old CBO numbers and would not be truly accurate of the current projection that the CBO has come out with, isn't that correct?

Ms. WILENSKY. It is—it is not based on any projections that CBO will be doing. It was, I believe, the baseline TV estimates they put out in March.

Mr. MCDERMOTT. If the gentleman would yield?

These are the updated numbers.

Mr. CHRISTENSEN. I was under the understanding that the CBO will be coming out with revised numbers and that this chart would not be accurate at that time; is that correct?

Ms. WILENSKY. Yes.

Mr. CHRISTENSEN. Thank you.

Chairman ARCHER. Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Chairman and Members, I have two concerns I would like to raise at this point, and the panel has alluded to one or both of them. The first is the idea of medical savings accounts.

I know, Gail, you had some portion of your testimony dealing with that. My fear is if in fact this proposal in total is to retain and restrain costs for the program, this is one item that might have a lot of political sex appeal, but I think once people get this scam down, it is going to be abused and it is going to be a costly abuse. And the abuse I envision is if I am retiring at age 65 and I am in relatively good health, what I am going to do is I am going to roll the dice for 5 years. I am going to take the high deductible plan plus the medical savings account, which although taxable, I can make some money on it, and I am going to say that for 5 years, between 65 and 70, I should be OK, maybe. However, what I am going to do as soon as I turn 70, I am going to go into the fee-for-service plan, knowing full well it is going to take 12 months to get into that plan. Is that scenario that I have just painted totally off base?

Ms. WILENSKY. Well, I mean, I think the issue of—

Mr. KLECZKA. Briefly, because I want one more point.

Ms. WILENSKY. OK. If it is only the healthy people who go in and if there is not an adjustment to the payment to reflect the fact that they are a healthier risk, you will end up putting pressure on the fee-for-service market. Frankly, I think most seniors won't want to do it. They don't like big deductibles.

Mr. KLECZKA. Stu.

Mr. ALTMAN. I am concerned. I think you need to adjust and really push the rates down that they get because they are good risks, they should get a lot less money and, therefore, they won't have a lot of extra money to put into those medical savings accounts.

Mr. KLECZKA. What I am hearing and again, it is only rumor because there is nothing solid before us, is they are going to the per capita payment, whatever it is, and we are looking at \$4,800.

Ms. WILENSKY. It is the payment that says they will get a risk-adjusted premium. What that means and how they will do it, I don't know. But there is the term risk-adjusted premium. Somebody understood that they had to use that phrase.

Mr. KLECZKA. OK.

The other concern which has been mentioned is the fee-for-service program. I think that, first of all, if this should pass, the bulk of the seniors are going to stay in fee-for-service so we are going to start off with a big group in that service.

For those who start shopping around for an HMO which has maybe better benefits through the selection process, the sicker of those seniors are not going to be permitted or accepted into the HMO. They are going to have to stay into the fee-for-service. So not only are we going to get a high volume of people in fee-for-service, but after a period of time, the sickest of the seniors are going to be in fee-for-service.

Mr. ALTMAN. I think that is a real concern unless we adjust the payment better. It is not that sick people are necessarily losers. It is only in relationship to what they—the plan gets paid. So if you paid the plan a decent amount of money for the sickest members, I think you potentially can save more money with the sickest members than you can with the healthiest members. The key is the payment.

Mr. KLECZKA. Given the scenario that these folks are going to be stuck in or decide to stay in the fee-for-service, again I haven't seen any part of the plan or a plan. But reading the Wall Street Journal today, they indicate that each fee-for-service program would be permitted to consume a preset sum of money, if that is capitation or whatever, and if in fact the spending is higher than projected, Medicare payments naturally would be reduced automatically.

My question is what happens at that point? If in fact a per capita or this preset dollar amount is expended, do the providers have the option to shift the additional cost to the patient or do they have to accept the liability themselves and what do they do, stop accepting patients?

Ms. WILENSKY. The pressure will be on reducing payments for providers. I think we both agree that if there is not a risk adjustment and healthier people go in one type of plan or the capitated plan, there will be artificial reductions in the fee-for-service over what should occur.

Mr. KLECZKA. And I agree with all that. But what happens to the beneficiary?

Ms. WILENSKY. They cannot charge more. It will only be a question of whether they will have trouble getting access.

Mr. KLECZKA. Do the physicians fail to accept any new Medicare patients?

Ms. WILENSKY. It is always the right of a physician. There is again the—right now, Medicare is.

Mr. KLECZKA. This is like a balloon. If you keep punching it, it is going to come out somewhere. I am wondering when it pops out, that one side of the balloon, who is going to be affected by the big pop?

Ms. WILENSKY. Probably what will happen is those physicians who will feel they are being punched will go find managed care plans to join and take their patients with them. If there is not risk adjustment and risk selection occurs, there will be a problem, absolutely.

Mr. THOMAS [presiding]. The gentleman's time has expired. Does the gentleman from Georgia wish to inquire?

Mr. COLLINS. Thank you, Mr. Chairman.

Ms. Wilensky, the current Medicare system is funded by a payroll tax.

Ms. WILENSKY. For part A.

Mr. COLLINS. Part A. Well, when you get down to the bottom line for America—

Ms. WILENSKY. For part B it is from the Treasury.

Mr. COLLINS. That is right. But they pay into the Treasury, too. How many workers do we have today per beneficiary?

Ms. WILENSKY. I think it is about 3½ or 4 to 1. When the program started it was closer to 5 to 1.

Mr. COLLINS. And that will continually get closer and closer in ratio?

Ms. WILENSKY. Right.

Mr. COLLINS. I have seen the figure somewhere, but based on a couple, a two-income couple that would retire in 1995, what is the estimated benefit cost to Medicare for that couple in their retirement age versus the amount of funds they paid in through a payroll tax as premiums?

Ms. WILENSKY. As I recall the numbers, they would receive about \$100,000 more than what they put in. I think Mr. King indicated that for an individual who is retiring in 1990, he can expect to get out five times what he himself or she put into the trust fund. If you count the employer's contribution, it is 2½ times more than what they put in. So there is a substantial increase in terms of what you get vis-a-vis what you put in.

Mr. COLLINS. Based on those numbers, there is no way that the system can survive.

Ms. WILENSKY. Well, it is the problem of having started with a large number of workers supporting a small number of retirees and moving into a system where that is getting closer and closer to a 1-to-1 ratio.

Mr. COLLINS. It is kind of like Mr. Laughlin said, the farther you go, the more it is going to cost.

Ms. WILENSKY. Right.

Mr. COLLINS. The younger people today who are possibly looking forward to having Medicare in their retirement age.

Ms. WILENSKY. Right. And of course compounded by Social Security.

Mr. COLLINS. Thank you very much.

Thank you, Mr. Chairman.

Mr. THOMAS. Does the gentleman from Georgia Mr. Lewis wish to inquire?

Mr. LEWIS. Thank you, Mr. Chairman.

Dr. Wilensky, does this plan help or hurt this fight against waste and abuse? If so, can you describe that?

Ms. WILENSKY. I believe there are several measures to try to go after waste and abuse, so I think it attempts to reduce waste and abuse.

Mr. LEWIS. Have you read the plan?

Ms. WILENSKY. Yes, I have read it, although I have obviously had a limited time to read the document that was distributed yesterday.

Mr. LEWIS. When did you first receive the plan?

Ms. WILENSKY. Well, I received the document that was distributed yesterday. There was an earlier distribution on Monday that was of a more general nature.

As Dr. Altman has said, the PPRC and ProPAC staffs have been working with the Committee staff, so there are some parts that we have known about for a longer time.

Mr. LEWIS. Thank you very much.

Dr. Altman, would teaching hospitals like Emory and Morehouse in Atlanta be hurt by this proposal?

Mr. ALTMAN. As I indicated, the current numbers suggest that teaching hospitals like Emory and Morehouse will actually be big benefactors of the plan but that is because of this new fund that has been established. So they do not lose.

Mr. LEWIS. Could you tell me, I notice on page 33, a new fund would be established. Could you tell me how it would be funded? Is there an ongoing source of funding?

Mr. ALTMAN. My reading of it—Don, you may want to correct me—is that it is made up of several sources of funds. Part of it will be the traditional funds that flow into the indirect medical education adjustment and to the direct medical education adjustment, and part of it will come from general revenues to be established which will flow both into the indirect medical education fund and the direct medical education fund, and then the direct one will be split into two parts, some of which will go the more traditional way and some into this demonstration. Don, is that—

Mr. LEWIS. Dr. Altman, I think you told Ms. Dunn, and maybe Mr. Rangel, that the New York hospitals were doing OK under Medicare, everything was all right, they don't have anything to worry about, but I am concerned about the safety-net hospital in my district. What would happen, combined with the large cut in Medicaid, at a place like Grady?

Mr. ALTMAN. Well, I think we need to look at the total impact of the three forces: One is Medicare; two is Medicaid; three is what is happening to the number of uninsured; and the fourth factor of course is to the extent that they have any private patients. We haven't modeled the implications of the Medicaid because we don't know what that looks like. It has only been recently put out in terms of the numbers.

You start worrying about block grants and what the States choose to do with the money, at some point we need to look at the totality of it and it is quite possible that some safety-net hospitals could be in trouble. I think the proposal for adding this extra money for teaching will help that, make it less of a problem, but it is something to look at hard. I don't think we can be assured that all those safety-net hospitals are going to do fine.

Mr. LEWIS. So are you suggesting that some of these safety-net hospitals may not survive, they may close in the inner cities, in rural areas and small towns?

Mr. ALTMAN. I think we are already seeing the problem in Los Angeles County, and I think the issue is developing. Part of the issue, though, is that we have built up in some areas a fair amount of excess capacity and a fair amount of waste. But I am concerned about the safety net and I think everybody should be concerned about it, that we don't do harm to what is really needed. And I am also concerned that the number of uninsured in this country could grow substantially and—

Mr. LEWIS. Under this proposal?

Mr. ALTMAN. No, it is not related to this proposal. This is what I was trying to say before, there are bigger, there are other forces. This proposal helps those institutions.

Mr. LEWIS. I thought you indicated, Dr. Altman, that this would maybe increase the tempo of closure for some of these inner-city safety-net hospitals.

Mr. ALTMAN. No. I said when you combine the potential impact of Medicaid and the growing number of uninsured and the reduced number of people willing to pay on the private side, some could close. That goes way beyond this proposal.

This proposal is part of a mosaic, and I for one cannot—I would never say that our safety net is secure. I think there are potential problems down the road for our safety-net institutions. But this proposal in and of itself does not, under the current form, it will actually help inner-city teaching hospitals that also are a disproportionate share because of the new money that has been put in.

Mr. THOMAS. The gentleman's time has expired.

Does the gentleman from Ohio wish to inquire?

Mr. PORTMAN. I thank the Chair, and I thank both of our panelists for their excellent testimony today. And I think this has been a good dialog among us. I learned a lot and I think it was the kind of hearing that we needed on the proposal.

I would just say as many members of the panels have, I have a Medicare as well as a health care task force back home. I represent Cincinnati, which I view as a relatively sophisticated and progressive health care community, both on the provider side and the business side, frankly. Our health care costs in the private sector now are well below inflation. In fact, our hospital costs, including outpatient last year, increased about 1.9 percent.

Many of our companies are now putting request proposals at zero percent health care increase and primarily that has come from increased competition, more managed care, many of the factors you have talked about. So I guess I have to put myself down as a believer that in fact the market forces can work, and that is why I am excited about this proposal. I probably would have gone further—and we talked earlier about your views as to the blends here and how far we went or didn't go in terms of providing incentives and disincentives for fee-for-service as compared to various coordinated care options.

I guess I would just ask you sort of a summary question. Do you believe, Dr. Altman, that this plan goes too far in terms of encouraging people who are currently in the fee-for-service option, which is 90 percent of Medicare beneficiaries, to move into some coordinated care option?

Mr. ALTMAN. No, I don't think it goes too far. As I said in answer, I think it continues a set of incentives that are in place today. It does not add some of the others in terms of extra cash benefits. It depends on what part of the country you are in, though, and I would have to take a look at Cincinnati relative to its AAPCC, relative to its costs, whether it is a winner or loser under this game. My sense is that the current Medicare badly needs to change or over the next 10 years you are going to see very different Medicare Programs in different parts of the country.

Mr. PORTMAN. Do you think, Dr. Wilensky, that the so-called "look-back" provision, as I understand it, do you think that that mechanism is properly adjusted given what you think will happen in terms of the managed care options and the other coordinated care options so that it will not create an undue problem for providers in the system?

Ms. WILENSKY. Well, I think that the specifics and the flexibility that may be in there needs to be looked at.

I would hope that the reasons why you did not go perhaps farther in terms of encouraging the choice structure that seniors pay is something that you might be willing to reconsider in 2 or 3 years. I agree, the realistic and political assessment, it would have been an error, but I would have liked to have seen you go farther. I think especially if that happens in 2 or 3 years, the likelihood of engaging the fail-safe mechanisms becomes less and therefore it is less of a concern.

I think you can accommodate these concerns by putting in some flexibility, and again monitoring each year what is going on and if there are sides of access problems, quality problems, intervene as you can as a Congress.

Mr. PORTMAN. I thank you both very much.

I think there is a general consensus on the monitoring and the ability to look at outcomes and look at the data over time so that we can be flexible.

Thank you for your testimony.

Mr. THOMAS. Does the gentleman from Virginia wish to inquire?

Mr. PAYNE. Thank you, Mr. Chairman, and thank you Dr. Wilensky.

Dr. Altman, I think your testimony has been very, very helpful, and I do appreciate it. Dr. Altman, you began by saying that you had an opportunity to look at some of the details and consequently were able to comment on some specifics of the plan. My perspective on this issue is as someone who represents an area that is medically underserved.

I am from a rural area, out of 17 counties, 14 have been deemed medically underserved. Our hospitals are all disproportionate-share hospitals. Many are sole community-provider hospitals, and we have rural referral centers there as well. And I am concerned because a very high percentage of their revenues come from Medicare and to some extent Medicaid. You mentioned that you thought that the provision, the market basket minus 2 provision, was one that could be sustained by the hospitals in general. Does that mean that there will be some that will and some that won't, or do you think that hospitals, such as the ones I have just described, would be able to sustain themselves in that kind of environment?

Mr. ALTMAN. Well, there have been a number of special provisions that have been added to the DRG system over the last 10 years to help out rural hospitals in your district in terms of treating them more like urban hospitals, allowing the update to be adjusted. So—and as a result of that, the rural hospitals have been able to do much better after those adjustments were made. To the extent that they stay in place, I think it will be OK.

I want to modify my answer to Mr. Lewis. My comments are without regard to that fail-safe. If that fail-safe comes in and comes

in big, substantially beyond what we have seen in the market basket minus 2, I can't make the comments I have made in terms of that. That is why I, if it was up to me, I wouldn't have a fail-safe—unless you found behavior changes on the part of institutions that were making money on the other side. There a fail-safe is OK. But if that fail-safe is needed to cut and make it market basket minus 3, 4 or 5 percent, then all bets are off.

Mr. PAYNE. So when you say you wouldn't have a fail-safe, then you wouldn't recommend that we cut \$270 or—

Mr. ALTMAN. I don't know. I haven't seen that part so I can't say. I don't know what the programs add up to because there are many—we had a pretty good sense of what the basic ideas were, but I have not seen them added up, so I do not know how far the specifics take you to the \$270 billion and how much is needed beyond that for the fail-safe.

Mr. PAYNE. So at this point you couldn't comment on the appropriateness of the \$270 billion number.

Mr. ALTMAN. I can't. I honestly cannot.

Mr. PAYNE. As you look at market basket minus 2—

Mr. ALTMAN. Yes.

Mr. PAYNE [continuing]. And thought about that and decided that it is pushing it to the edge, and did you factor in the fact that Medicaid also is being looked at and likely those payments may be reduced as well?

Mr. ALTMAN. We did not and that is something that needs to be done. We could not because we have no idea what this will look like under the revised system.

I mean, the States may turn out, if you were to block grant it, they might give more money to these institutions and less to the others. And besides, we just found out the numbers—we knew the overall numbers. We, in our modeling effort, we have pretty much kept Medicaid where it was. So if we have time, we are going to go back and redo those models. But even at best, we are going to be guessing a lot because there is much more uncertainty on the Medicaid side in terms of its impact on institutions.

Mr. PAYNE. Well, like you, I will be very interested in seeing those numbers or the numbers of this bill, the Medicare bill, to be able to make some judgment about what the impact might be, and particularly this look-back or fail-safe mechanism and how that is proposed to work and what that might do in the event that—

Mr. ALTMAN. Well, that is why I have been cautioning about the need for constant vigilance on the part of the Congress, because there are many unknowns that have nothing to do with this proposal, by the way, in terms of how efficient the system is, how many uninsured become available, what happens. And you can't just write this legislation and decide you are now retired—it would be a big mistake.

Mr. PAYNE. Well, this is critically important to many of us because this is not only a health issue, this is an economic development issue, if we don't have our hospitals.

Mr. ALTMAN. This is a health care system issue.

Mr. PAYNE. It is the health care system, but it is also whether we would be able to attract new businesses and expand the ones

we have. So this is critically important, and I think we need to get it right.

Thank you.

Mr. THOMAS. The gentleman's time has expired.

Does the gentleman from Massachusetts wish to inquire?

Mr. NEAL. I do.

Thank you, Mr. Chairman.

A question for Dr. Altman.

Massachusetts, as you know, is heavily dependent on the health care industry.

Mr. ALTMAN. I do know.

Mr. NEAL. Massachusetts is the perfect microcosm of the best things that take place in American health care every single day. You indicated in your opening statement that you thought there had been some change of heart during the last 60 or 72 hours.

Mr. ALTMAN. Yes.

Mr. NEAL. On the part of the teaching hospitals.

Mr. ALTMAN. Yes, substantial. As a resident of Massachusetts, I am well aware of the issues and I was very pleasantly surprised to learn that the proposal now includes this new graduate medical education fund which would be partially funded by general revenues. It is an area where I have long believed we need to be establishing the recognition that graduate medical education should be shared and should not be the sole burden of the Medicare Trust Fund and I think this is a big step forward.

We have tried to estimate what that would do to teaching hospitals. One of the things we couldn't figure out, though, is while we are adding money on one side, if the private sector is going to pull it out on the other side, is it going to be a wash; is it going to be a net plus or a net minus?

We did the best we could but I think our estimates that are in your testimony are too high in terms of the impact on teaching hospitals because they don't take account of the potential reduction on the private side. But I applaud the proposal and I hope that it becomes the basis of any new legislation that we move to the recognition that teaching and research should be a shared responsibility, and then let the market work.

I believe in that market. I think that those market forces should work, but you can't count on the market to fund social goods. It—what little economics I remember, that is what I was taught, and I believe it.

Mr. NEAL. Well, thank you for the last sentence you offered.

Mr. ALTMAN. The little economics I remember?

Mr. NEAL. No, no, that you can't depend upon the private sector sometimes to properly finance social goods.

Mr. ALTMAN. It should be financed socially.

Mr. NEAL. Exactly. Keep going, you are doing fine.

My point is I was caught by the description you said over the last 2 or 3 days because I thought last night while I watched Speaker Gingrich and Chairman Archer on the rerun of C-SPAN that Speaker Gingrich indicated that that issue was more than 1 year away from being resolved.

Mr. ALTMAN. What?

Mr. NEAL. Graduate medical education.

Ms. WILENSKY. Because I think it is proposed that there will be a special commission set up to look at the longer term issues, so the question of what ultimately is the role of the Federal Government for graduate medical education, there are other issues but the change in the funding occurred because of the setup of the separate fund and the infusion of new funds. So it is something that will be revisited.

Mr. ALTMAN. The issue that I think the Speaker was referring to is a second complicated issue about how—should we give more money for a certain kind of training than others. Should we impose any kind of top-down restrictions on our medical schools in terms of what specialties they fund? And that is a very complicated issue. I was referring to the dollars that flow to the teaching hospitals. And I think that is automatic. That is fair.

Mr. NEAL. I know the panelists don't need any reminder, but when Raisa Gorbachev was ill, she came to Massachusetts, and when Elizabeth Dole was ill, she came to Massachusetts. And we want to ensure that that high quality is maintained. And that the point that you raised in your concluding sentence about not being able to look to the private sector to fund some of those social goods is terribly important. I thank you for at least that aspect of your testimony.

Thank you, Mr. Chairman.

Mr. THOMAS. I believe that all Members who wish to inquire have inquired.

I want to thank both of you once again. You have done an excellent job. We look forward to hearing from you again as we continue to remodel this sector.

It is not going to be something that, as you said, Mr. Altman, you do once and then just walk away from it. We are going to be at it for a while, but I think we are at least moving in the right direction, and I want to thank you.

The next panel, Peter J. Ferrara, National Center for Policy Analysis; Joyce L. Hansen, assistant vice president, Reliastar Financial from Minnesota; and Karen Davis, who is the president of the Commonwealth Fund, New York, New York.

And if I might, I would yield to our colleague from Minneapolis, Minnesota.

Mr. RAMSTAD. Mr. Chairman, I thank you for yielding for the opportunity to introduce a constituent who is truly an expert witness. I am glad to see Joyce Hansen here today from Reliastar Financial, which is a major company in Minneapolis, Minnesota, specializing in health and life insurance. Joyce will testify on a critical component of the Medicare Preservation Act, the provisions designed to combat fraud and abuse.

Mr. Chairman, as all of us know, fraud and abuse currently consume literally billions of taxpayer dollars. We are fortunate to have Joyce Hansen here today because she is an expert in this area. As assistant vice president of Reliastar, with 18 years of experience, she is a certified fraud examiner. She designed and established the Special Investigations Unit at Northwestern National Life. Joyce is a cofounder and president of the Midwest Insurance Fraud Prevention Association and she serves as the 1995 chair of the National Health Care Antifraud Association.

So it is a real pleasure to welcome you, Joyce, to today's hearing. I look forward to your important input on the Medicare Preservation Act as well as to the other witnesses.

Thank you, Mr. Chairman.

Yield back.

Mr. THOMAS. Certainly.

And I do want to indicate that added to this panel, Dr. Mullins, who is the executive vice chancellor for Health Affairs, University of Texas System, and I should mention out of Austin. And Dr. Cohen, who is the president and chief executive officer of the Association of American Medical Colleges.

Each of you has 5 minutes to inform the Committee as you see fit, and your written statements will be made a part of the record.

And I will just start with you, Mr. Ferrara, and move across the panel.

**STATEMENT OF PETER J. FERRARA, SENIOR FELLOW,
NATIONAL CENTER FOR POLICY ANALYSIS**

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

I would like to focus today on a study that we did at the National Center for Policy Analysis along with the actuarial firm of Milliman and Robertson. They are the top actuarial firm in the country. These are one of the firms that insurance companies go to when they want to find out how to structure their insurance plans or what they should charge and that type of thing, and our study was on medical savings accounts.

And what we did was we looked to see what kind of medical savings account you could purchase with the money that you would be able to withdraw from Medicare under the Republican proposal. What kind of features would it have?

We discussed this matter with the staff, Committee staff, to obtain the estimates of what these funds would be. And in the charts over here, we have the main conclusions of the study.

In the first chart, this is a medical savings account with a fee-for-service plan. And what Milliman and Robertson does is that with the funds you could withdraw from Medicare you would be able to purchase a fee-for-service catastrophic plan covering all expenses above \$3,000 and you see the blue part. That is the catastrophic plan covering all expenses above \$3,000 and still have \$1,500 left to put in the medical savings account to cover expenses below the deductible.

Now, what is fascinating about this is this benefit structure is better than the benefit structure of Medicare in at least five ways: First of all, it provides complete catastrophic coverage, all expenses above \$3,000. Medicare, as you know, does not provide complete catastrophic coverage.

Second, it provides a cap on out-of-pocket expenses. An elderly beneficiary with this cap, with this plan would never have to spend more than \$1,500 out of pocket, which is the difference between the amount in the medical savings account and the amount of the deductible. As you know, Medicare has no cap on out-of-pocket expenses. In fact, an elderly recipient can be liable for tens of thousands of dollars each year in costs for services that are supposed

to be covered by Medicare. That is why 70 percent of the elderly purchase private Medigap insurance. These are all 1996 numbers.

The average premium for that insurance will be \$1,200. You wouldn't need to buy that at all with this medical savings account plan or you could put the \$1,200 in the plan and you—into the medical savings account and you would have \$2,700 and that would almost be equal to the deductible itself.

A third way in which it is better is that the funds in the medical savings account can be used for any health expense, not just health expenses covered by Medicare. So, for example, if you have a constituent that has a high cost for prescription drugs, maybe that constituent doesn't have too many other costs during the year but it is \$500 to \$600 to pay for, say, medicine for a heart condition, they could use the funds in the medical savings account to pay for that, whereas Medicare would not pay for that. In addition, whatever funds are left in the account at the end of the year above a certain threshold, they could withdraw those funds and use them for any purpose. This is a reward to the elderly for helping to control health costs within the budget targets, and so this is another benefit.

In addition, in the private market they would not be subject to any of the payment restrictions, the payment limitations, the delays in approval of new technologies and other matters that, in my opinion, are reducing the quality of care under Medicare.

Now, what is fascinating also about these medical savings accounts is they are already in use in the private sector. Over 1,000 employers nationwide have these medical savings accounts. They are getting bigger cost reductions with these medical savings accounts than is targeted for the budget under Medicare, targeted for Medicare under the budget. Instead of reducing costs just from 10 percent to 6.5 percent, the private employers are reducing costs with medical savings accounts that are increasing at a range of 15 to 20 percent down to zero percent and even less. That shows that these medical savings accounts will stay within the budget-limited voucher amounts over time. The elderly will be able to buy these benefits that are better than Medicare with the amounts that they get out of Medicare.

The second chart shows what would happen if you bought a managed care plan covering all expenses above \$3,000 and put the rest in the medical savings account. In that case you would have \$2,100 left over in the medical savings account which provides even more funds to pay for health expenses.

Now, one key point to make out of this: This shows the medical savings account is more attractive for sick people than Medicare. If you were sick, you would rather be—have the catastrophic coverage. You would rather have the cap on out-of-pocket expenses. You would rather be able to use the funds in the account to pay for the expenses you—whatever expenses you want and all these other factors.

Because it is more attractive for the sick people than Medicare, this addresses many of the concerns we have heard up until now. This data has not been available to many of the people, to people who have been testifying up until now. But this greatly reduces the risk selection problem because I would argue that the majority of

people, it is more attractive for sick people than Medicare, and Milliman and Robertson will back this up.

The actuaries at Milliman and Robertson also agree the medical savings account plan will be more attractive to sick people than Medicare. So the risk selection problem, the sick are going to stay in Medicare, is greatly reduced as a result of this.

It reduces the concern over risk adjustment. You don't have the same concern. It reduces the concern about—in fact provider—the limitation, once providers—Milliman and Robertson estimates that by 2002—I will finish on this sentence—that 80 percent of the people in Medicare will have chosen the private options.

Now, I tell you again this is the top actuarial firm in the country and because this is more attractive for sick people as well as healthy people, that is the key reason why they assume that. So most of the people in Medicare today will be in the private sector where they are—where the hospitals and doctors are not subject to these provider limitations and thereby greatly easing that problem as well.

Thank you very much, Mr. Chairman.

[The prepared statement follows.]

**STATEMENT OF PETER J. FERRARA
SENIOR FELLOW
NATIONAL CENTER FOR POLICY ANALYSIS**

Better Than Medicare

The Republicans have now accomplished what no one in the Washington establishment contemplated when the Republican budget blueprint was adopted by Congress earlier this year. They have proposed a Medicare reform plan that actually offers the elderly a better system than Medicare, while still meeting the budget targets.

The essence of the plan is that it shifts power and control over Medicare and its funds away from the government, the hospitals and the doctors, to the elderly themselves.

The key features of the plan are:

- The elderly would each have the freedom to take their share of funds out of Medicare and use it to buy any of the full range of private alternatives for their health coverage.
- The proposal is not based on HMOs or managed care. Managed care is only one option on a level playing field with all of the others.
- Other options include Medical Savings Accounts (MSAs), traditional fee-for-service insurers, preferred provider networks, provider service networks (where doctors and hospitals in an area organize to provide health coverage directly), and plans offered by associations such as AARP, or unions, or employers.
- The elderly would each be perfectly free to stay in the current Medicare system if they prefer, foregoing the private options entirely.
- The private plans must provide at least the same benefits as Medicare, and can provide more. They must accept all Medicare-covered retirees who choose them during an annual open enrollment period, regardless of health condition.
- The share of funds the elderly can each withdraw from Medicare to pay for these private plans would vary depending at least on age, geographic location, and certain health factors. So the older and sicker would get more and the younger and healthier would get less, reflecting what they would each have to pay for the private coverage.
- If a chosen plan costs less than the amount withdrawn from Medicare, the beneficiary can keep the difference, up to a maximum limit equal to the Medicare Part B premium, which will be around \$600 per retiree next year.
- The amounts that can be withdrawn from Medicare for these private options are limited to grow no faster than the budget targets. So these targets will be automatically met to the extent that retirees choose the private options.
- Medicare premiums would be kept at their current level of 31.5% of costs for Medicare Part B. So they would increase over time at the rate at which costs for Medicare Part B grow, which is the same rate as they have grown in the past. By 2002, this would leave premiums \$7 - \$10 per month higher than if the target percentage for the premiums had dropped to 25% of Part B costs. While such a decline to 25% was putatively scheduled under current law, with the Medicare financing crisis and the drive to balance the budget, this decline was never going to happen anyway.
- Premiums would be raised substantially more for high income retirees with incomes over \$150,000 per year for couples and \$75,000 per year for singles.

- As of this moment, the plan includes no increase in Medicare deductibles and co-payments, even though Part B has a ridiculously low deductible of \$100 that should have been raised substantially.
- To offset higher costs for those who choose to stay in Medicare, expected increases in payments to doctors and hospitals would be reduced to the extent necessary to ensure that budget targets are met.
- Overall, these changes will reduce the rate of growth of Medicare from about 10% per year to 6.4%. This lower growth rate will be sufficient to cover benefits because that is about the rate at which costs have been growing in private health plans.
- This reduced growth rate means Medicare would spend approximately \$270 billion less over the next 7 years than it would have otherwise. But total Medicare spending would still grow sharply over that time. By 2002, Medicare would be spending over 50% more than today. Medicare spending per retiree would grow by about 40%, from \$4,800 per person today to \$6,700 per person in 2002.

The key to this plan is that it allows the elderly to take advantage of the incentives, competition, efficiencies and innovation of the private sector. Because of these factors, many of the private plans will be able to provide even better benefits than Medicare, while still staying within the budget targets.

For example, the NCPA study done by Milliman and Robertson, the nation's top actuarial firm, shows that with the funds retirees can withdraw from Medicare, they will be able to buy an MSA plan that provides full insurance coverage for all expenses over \$3,000 per year, with \$1,500 left in the MSA to pay for expenses below \$3,000. This plan provide better benefits than Medicare in at least 5 ways.

- It provides complete catastrophic coverage for all expenses over \$3,000, while Medicare does not. Medicare coverage runs out after various caps and limitations.
- It provides a maximum cap on out-of-pocket expenses by the elderly themselves of \$1,500 per year (the difference between the \$3,000 deductible and the \$1,500 in the MSA). Medicare has no cap on out-of-pocket expenses. The elderly can be liable for tens of thousands in expenses themselves with Medicare and more. That is why 70% of the elderly pay almost \$1,200 per year on average for private insurance to supplement Medicare. With the MSA, the elderly can keep that \$1,200 per year. Or they could put it in the MSA, providing a total of \$2,700 to cover expenses below the \$3,000 deductible, virtually eliminating any further out-of-pocket expenses.
- The funds in the MSA can be used for health care, often preventative in nature, which are not covered by Medicare, such as prescription drugs.
- Unspent funds in the MSA at the end of the year would belong to the retiree, and could be saved for future expenses, or withdrawn for any purpose, subject to certain minimum balance requirements in the House bill. This allows the elderly to share directly in the reward for controlling health costs.
- MSAs would not be subject to the payment and reimbursement limitations of Medicare, or the outdated limitations on what new services and treatments the program covers. These limitations and controls are reducing access to care and quality of care under Medicare, effectively rationing health care for the elderly.

Experience with HMOs and other managed care options shows that they can provide better benefits than Medicare as well, while also staying within the budget limits. They will likely be able to add catastrophic coverage and prescription drugs to the Medicare package for what the elderly will be able to withdraw from Medicare each year.

The elderly can consequently get better benefits from a range of private plans. They can benefit directly from controlling costs through cash rebates from the MSAs and other private plans. They can gain complete control over their health care through the private

plans, escaping the rationing that is increasingly occurring under Medicare. They would have freedom of choice to pick the health plan best suited to their needs and preferences, with complete choice as well over doctors, hospitals, treatments and services. The Medicare financing crisis would be averted for today's retirees, while their premiums in fact would continue to increase at the same rate as in the past (except for the highest income retirees). These are the reasons why the Republican reform plan offers the elderly a better system than Medicare.

For the rest of us, all of this is accomplished without any increase in taxes. To the extent retirees choose the private options, the insurance function of Medicare would be shifted to the private sector. Medicare would become an innovative voucher system that classically minimizes government interference in the health care market. And the new system includes a very strong MSA that will likely lead the way in creating a real health care market. Finally, this freedom of choice system creates a powerful precedent for future entitlement reform. This is a proposal, therefore, that conservatives and free market reformers, as well as the general public, can and must ardently support.

Some fret that the proposal relies too heavily on reducing reimbursements for doctors and hospitals to reduce costs for those who stay in Medicare. But this is looking at the proposal out the back window of the train. Overall, instead of effectively tightening overly restrictive reimbursement limitation further, the reforms are a means for abolishing the controls altogether. That is because the reforms allow the elderly options and choice in private alternatives where the reimbursement limitations do not apply.

You heard it here first. Within 5 years, 80-90% of the retirees will be in the private options. Among other implications, that will effectively nullify the reimbursement limitations.

Mr. SHAW [presiding]. Thank you.
Ms. Hansen.

STATEMENT OF JOYCE L. HANSEN, ASSISTANT VICE PRESIDENT, RELIASTAR FINANCIAL, MINNEAPOLIS, MINNESOTA

Ms. JOYCE HANSEN. First of all, I would like to thank the Members of this distinguished Committee for the opportunity to speak with you today on issues relating to fraud and abuse in the Medicare system. I commend this Committee for its willingness to confront this important and costly matter.

I developed the fraud and abuse detection program for Reliastar over 10 years ago and today I would like to share some of our tools and techniques that have proven effective in reducing the amount of money lost to fraud and abuse for our clients.

Health insurance fraud has been hitting the public programs and private industry hard over the last 5 years. To place this debate in its proper context, this Committee is charged with the daunting task of achieving \$270 billion in savings within the next 7 years in the Medicare Program.

Recently, the HHS Office of Inspector General estimates over the next 7 years if nothing changes, Medicare will lose \$138 billion to fraud. Members of the Committee, that figure represents over one-half of the total savings this Committee plans to achieve. In order to address the fraud problem, efforts must be made to aggressively pursue those who perpetrate fraud.

The proposed legislation is a good first step. It displays a viable effort by the Committee to address the issue of fraud in Medicare. The education efforts and Antifraud and Abuse Trust Fund are important elements. But there are additional steps that could make this proposal even more truly proactive.

At Reliastar our approach to detecting and preventing fraud and abuse centers on a proactive approach. We achieve success by identifying problematic providers and thoroughly investigating their claims prior to payment. By placing the claims in a pending status and ensuring a thorough audit of the claims, we have reduced the number of fraudulent claims that would otherwise get paid. As a result, we saved our clients, we have 400 clients, millions and millions of dollars.

The most effective fraud prevention program is to identify the fraudulent claim before it is ever paid. It is a two-step process. It is screening the claims and having well-trained staff to investigate. We also employ the use of sophisticated technology designed to detect fraud and abuse through a retrospective analysis of claims data. Let me give you a couple of examples.

We looked specifically at chiropractors in the Los Angeles area and we found—this was during 1993—we found a chiropractor who 100 percent of the claims he had submitted to Reliastar were for patients who lived 50 miles or more from his office. Well, after we looked into it, we found out that he had moved his practice but he kept billing for those same patients.

We found another chiropractor in the Los Angeles area, through this systematic technology. Twenty-five percent of the claims he submitted to our company in 1993 were for services on Sundays and holidays, but he didn't have office hours on Sundays and holi-

days. These claims went undetected before we had this technology. Fraud and abuse technology is able to detect these aberrant practices.

We have been using sophisticated technology for just over 1 year because it has just been brought into the marketplace in the last 18 to 24 months. In that time, we have seen an increase in savings of over 500 percent for some of our internal clients and an overall increase in savings of 41 percent in the last year for our whole block of business.

By implementing effective training, investigation and system identification programs, I would estimate that the total medical expenditure could be reduced by one-half of 1 percent within 24 months. For example, if total expenditures in 1995 are 177 billion, the amount that could be saved due to fraud prevention measures would be \$885 million. Please keep in mind this is a very conservative estimate. The percentage of savings would likely increase to 2 to 4 percent of the total annual expenditures in the following years.

Through years of experience in a program where we have seen increases in savings every year, I can assure you in order to stay on top of this sophistication of schemes, you have to have effective tools. Sophisticated schemes take sophisticated approaches to solve.

I hope I was able to provide additional insight on how to address this problem with my suggestions and comments.

Thank you.

[The prepared statement follows:]

**STATEMENT OF JOYCE L. HANSEN
ASSISTANT VICE PRESIDENT
RELIASTAR FINANCIAL**

INTRODUCTION

I would like to thank the members of this distinguished committee for the opportunity to speak on the issue of Medicare fraud. I commend this committee for its willingness to confront this important, and costly, matter.

I am Joyce Hansen, Assistant Vice President, Reliastar Financial. I oversee the investigative area of the Employee Benefits Division of Reliastar. We provide investigative services, training, and system identification of questionable providers for our group-insurance customers, as well as for external clients.

Reliastar Financial is headquartered in Minneapolis and has been in the insurance business since 1885. We were known formerly as Northwestern National Life (NWNL). The Employee Benefits Division provides products and services that include life, health, disability, long term care insurance, claim administration, national and regional managed care programs, and, as previously mentioned, health care fraud detection and investigation services.

I have been with Reliastar for 12 years. I started the company's anti-fraud program in 1985, becoming the first special investigator in the Employee Benefits Division. We presently have 8 full time investigators. Our goal is to identify providers, participating in both indemnity and managed care plans, who are engaged in questionable practices and to ensure thorough and timely review of their claims prior to our payment of benefit dollars. Through the comprehensive review of questionable claims, we are able to prevent the expenditure of company and clients' funds on ineligible charges.

In 1990, I was instrumental in the formation of a regional fraud prevention association. The Midwest Insurance Fraud Prevention Association draws insurance representatives in health, life and disability markets from Minnesota, Wisconsin, and North Dakota. We hold quarterly meetings to discuss fraud investigation techniques, to network on a regional basis and to involve regional law enforcement personnel in our activities. I am currently President of the Association.

In addition, in 1990 Reliastar became a corporate member of the National Health Care Anti-Fraud Association (NHCAA). This association has furthered our commitment to improve the detection, prevention, and prosecution of health care fraud. The NHCAA, with approximately 70 corporate members and over 700 individual members representing both the private and public sectors, plays a critical role in public education and in directing the resources of the insurance industry's fraud detection efforts. I am currently serving as Chairperson of the NHCAA.

NHCAA was established in 1985. It is not a trade association, nor is it a lobbying organization. Rather, it is an issue-based cooperative association whose member organizations account for most of the private and public health insurance benefits paid in the U.S., and whose objective is to improve the private and public sectors' ability to detect, investigate, prosecute (both civilly and criminally) and, ultimately, prevent health care fraud.

My discussion today will focus on:

- Reliastar's approach to the identification, prevention and detection of health care fraud;
- The use of technology to enhance the detection of questionable providers;
and
- Anticipated savings through fraud prevention.

OVERVIEW OF FRAUD IN MEDICARE

Although most providers supplying services to Medicare beneficiaries are honest, it is the minority of dishonest providers that have created a massive and expensive problem. Approximately 20 years ago, the Health and Human Services Inspector General indicated that 10% of Medicare expenditures were lost to fraud and abuse. At the time, that translated into \$3 billion to \$4 billion annually. That 10% statistic still holds true today. However, the monetary loss is now nearly \$17 billion. Further, the Office of the Inspector General estimates that within the next seven years, Medicare will lose \$138 billion to fraud.

In order to address this problem, subsequently reducing the amount of Medicare dollars lost to fraud each year, efforts must be made to aggressively pursue those who make concentrated, intentional attempts to abuse the system or bend the rules for financial gain.

The sources of fraud and abuse in Medicare come from a variety of places which include: providers such as physicians and hospitals, suppliers of medical devices, home health care agencies, laboratories, and pharmacies.

FRAUD PREVENTION

Our focus at Reliastar is a proactive approach. We believe in preventing the benefit dollars from being paid on questionable claims. We achieve this goal by identifying problematic providers and thoroughly investigating their claims prior to payment. By placing those claims on "pending" status and ensuring complete review of the providers' submissions, we have successfully reduced the likelihood of our paying fraudulent claims. Although this practice does not guarantee the elimination of fraud, it has helped to save our clients several million dollars.

The practice of pending questionable claims is an effective tool in fighting health care fraud and would be advantageous to reducing Medicare's expenditures. Why should Medicare pay for claims to a provider known to bill for services not rendered until those claims can be scrutinized? Why should Medicare be charged for a more costly procedure if a less expensive procedure was actually administered? Is it fair that Medicare beneficiaries are continually subjected to procedures that are not medically necessary? Obviously, the answer to those questions is that Medicare should not pay for inappropriate practices. Unfortunately, the questions represent scenarios that occur daily and are costing taxpayers billions.

To prevent the payment of fraudulent claims, three things need to occur. First, claims data need to be analyzed to identify those providers that have suspicious practices. This will be discussed in more detail later. Second, future claims from those providers identified as questionable should be reviewed and investigated to determine the validity of the claims. This must occur prior to payment of the benefits. The investigation needs can be met internally, if the claims payer has a

Special Investigations Unit, or through an external organization that would conduct the investigation. Third, claims examiners and adjusters need to be trained in fraud detection, in various types of fraud, and in characteristics of specific fraud schemes. Again, this can be conducted with internal special investigators or referred to an external training entity.

Through the implementation of claims-data analysis, investigation of pended claims, and the training of examiners and adjusters, Medicare expenditures could be reduced by several billion dollars annually. This reduction would be completed prospectively, thus minimizing the less efficient practice of trying to recover fraudulent claims that have already been paid.

USING TECHNOLOGY TO DETECT FRAUD

As previously stated, technology should be used to identify those providers that have questionable practices. Specifically, at Reliastar we review providers by specialty and geographic location, and we compare them to each other through the analysis of their utilization, diagnosis, radiology, and billing practices. In addition, we look at "suspect provider practices"—which include, for example, the percentage of claimants that live more than XX miles from the provider's office and the percent of patients to whom the provider administers services on Sundays and/or holidays. We do not use medical management or billing thresholds to determine the results. Instead, we rely on the practices of peers to establish scores.

This comparison of providers to their peers based on submitted claim data and measured against practice patterns that were designated to detect fraudulent and abusive practices allows us to compare "apples to apples." It further identifies providers whose professional behavior warrants prospective review. In a sense, we use retrospective data to prevent future losses. By systematically analyzing an entire population of providers and statistically measuring them against the practices of their peers, the perception of a "witch hunt" is eliminated. A provider whose practices are inconsistent with his colleagues has only his own claim submissions to blame.

ANTICIPATED SAVINGS THROUGH FRAUD PREVENTION

We have been using sophisticated technology for approximately one year. In that time, we have seen an increase in savings of over 500% to our internal clients that have purchased our services, due to our ability to detect and identify more questionable providers. Further, we have seen an increase in savings of 41% for all of our group-insurance clients over last year.

By implementing effective training, investigation and system identification programs, I would estimate that the total annual Medicare health care expenditure could be reduced by one-half of one percent within 24 months. For example, if total expenditures in 1995 are \$177 billion, the amount that could be saved due to fraud-prevention measures would be \$885 million. The percentage of savings would likely increase to 2% to 4% of the total annual expenditures in the following years.

FRAUD IN MANAGED CARE

The managed care evolution is occurring rapidly, and many people are of the opinion that managed care will eliminate fraud and abuse in the health care field. This is a very common misconception.

The NHCAA analyzed this subject over a one-year period and determined that fee-for-service transactions continue to figure significantly in virtually any managed care system; there are few "pure" managed care models, in which every patient service is delivered on a pre-paid and/or fixed-cost basis.

Managed health care delivery still features many incentives and opportunities for unscrupulous health care providers to commit fraud. The same questionable providers in our fee-for-service system are the ones participating in managed care networks. For example, most HMO's still exclusively offer point of service plans.

HMO members, given incentives to obtain services from providers in the network, seek out the appropriate specialty. The provider in turn still bills the payer on a

claim basis. Even though the claims are "re-priced" by the payer based on the agreed amount for the service, the provider can still commit many of the same fraudulent misrepresentations—such as billing for services not rendered, and falsification of the diagnosis—that one sees in the traditional indemnity business.

As you can see, even in the managed care environment certain indemnity fraud indicators will remain valid. However, other indicators of potential fraud in managed care dealings may be more subtle. This is especially true as you move into a fixed "capitated" environment where a provider is paid a fixed payment for potentially unlimited treatment of a given patient. In these instances, it is our opinion that the incentive for the unscrupulous provider is to provide less care in return for the payment—i.e., to under-serve the patient.

The most important issue to remember with respect to fraud in managed care is that much of the system still manages under point-of-service products that give participants choices within their respective health plans. This meets a critical customer issue, but it also means continued vulnerability to unscrupulous providers.

CONCLUSION

Fraud will continue to escalate and to create negative repercussions in Medicare unless it is forcefully confronted by effective detection and prevention techniques. I hope I was able to provide additional insight on how to address this problem with my suggestions and comments. Again, it was my pleasure to be here with you today. As the Chairperson of the NHCAA, an officer of Reliastar Financial, and a concerned taxpayer, please accept my heartfelt appreciation for your interest in this subject.

Mr. THOMAS [presiding]. Thank you very much, Ms. Hansen.
Dr. Davis.

**STATEMENT OF KAREN DAVIS, PRESIDENT, COMMONWEALTH
FUND, NEW YORK, NEW YORK**

Ms. DAVIS. Thank you, Mr. Chairman, for this opportunity to testify on the importance of the Medicare Program during its 30th anniversary.

Today we have heard a lot about money, we have heard a lot about providers, we have now heard about fraud, private insurance, and medical savings accounts. I would like to focus on the beneficiaries of this program and how they would be affected by the changes under consideration by the Committee.

I would like to, in the interest of time, just turn to some charts at the back of my testimony.

The first chart reminds us that one in five Medicare beneficiaries is either under age 65 and disabled or over age 85 and frail. Most Medicare beneficiaries have modest incomes; 83 percent of Medicare dollars go for services to people with incomes under \$25,000; only 3 percent of Medicare outlays go for services to beneficiaries whose incomes exceed \$50,000.

Most of Medicare in fact goes for essential services, hospital and physician services, and a small fraction for home health and outpatient care, although that has been growing rapidly. Because of Medicare's noncovered services and deductibles, Medicare only pays 45 percent of the expenses of the elderly; 12 percent is paid by Medicaid for certain low-income, elderly and disabled beneficiaries. The rest is paid out of pocket or from private insurance.

This comes about because Medicare has a hospital deductible that currently exceeds \$700, a physician deductible of \$100, a physician annual premium of \$550. So to avoid these large payments, most Medicare beneficiaries buy private coverage at over \$800 a year to pick up their deductibles and coinsurance. In fact, about 43 percent of Medicare beneficiaries have retiree health care coverage, another 38 percent buy private coverage. But despite this coverage we know low-income Medicare beneficiaries already pay one-third of their incomes out of pocket on health care. In fact, on average, Medicare beneficiaries today spend over \$2,000 per person on health care expenses, far more than younger adults.

The other important thing to know about Medicare beneficiaries is that there are some who are healthy and some who are sick; 10 percent of beneficiaries account for 70 percent of outlays. For the 10 percent of beneficiaries who are the sickest, the average expenditure in 1993 was \$28,000. For the 90 percent who are healthiest, the average expenditure was \$1,300. This has tremendous implications for medical savings accounts, creates incentives for marketing to healthier people, and with an average voucher, making money for insurance companies but costing the Medicare Program and taxpayers additional costs.

Medicare is a popular program. In fact, in a survey the Commonwealth Fund did, it is the most popular of all forms of health insurance coverage; 52 percent of beneficiaries are very satisfied, compared with 44 percent of people in employer plans, and only 30 per-

cent of people in individual plans like the one that Mr. Ferrara would have the elderly buy.

Medicare has a good record on efficiency. It has 2 percent administrative costs, well below that of private coverage. It has a good system of physician payment that is better than most managed care plans. Despite some testimony we have heard today, chart 14 points out the fact Medicare's costs are not growing faster than private insurance.

How would the changes affect Medicare beneficiaries? Chart 16 indicates that if you are going to have beneficiaries pay more, premiums are more evenly spread, but it is important Medicaid be there to pick up cost sharing and premiums for low-income Medicare beneficiaries and that that is protected in any type of block grant legislation. If provider payments are too tight, you run the problem of financial instability of hospitals, but you also run the risk that eventually physicians and others will not participate in the program. While information on choices is good, expansion to loosely organized managed care plans will run into this favorable selection problem, and cost the Medicare Program.

Vouchers are an even greater problem for people that go into medical savings accounts. They are likely to cost the Medicare Program, skim off the healthiest beneficiaries and leave beneficiaries with bad debts when they cannot pay a \$3,000 deductible on top of \$2,000 of out-of-pocket expenses, and it opens beneficiaries to marketing abuses.

Thank you.

[The prepared statement and attachments follow:]

MEDICARE BUDGETARY SAVINGS: IMPLICATIONS FOR BENEFICIARIES
Before U. S. House of Representatives Committee on Ways and Means
Hearing on Medicare, September 22, 1995

Statement of Karen Davis
 President, The Commonwealth Fund
 One East 75th Street
 New York, NY 10021

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

Medicare beneficiaries differ in important respects from the working population. It is important that changes to Medicare be grounded in a clear understanding of the nature of the health and economic status of beneficiaries, and that the gains in access to care and quality of life that Medicare has helped bring about are not lost in a short-sighted effort to obtain budgetary savings. Health care for the elderly and disabled is expensive for Medicare and it is expensive for beneficiaries. Understanding why this is the case is fundamental to any attempt to modify the program.

Who and What is Covered by Medicare?

It is particularly important to keep in mind an accurate picture of the people Medicare serves. Among the 37 million Medicare beneficiaries are those with limited financial resources, those with very serious disabling conditions, and those for whom catastrophic medical expenses are commonplace. One in five Medicare beneficiaries is disabled and under age 65 or over age 85 (see Chart 1).

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

The high concentration of low-income elderly, and the fact that such elderly are more likely to be in poor health and need more health care services, means that Medicare outlays are concentrated on relatively low-income beneficiaries. Eighty-three percent of Medicare outlays go to beneficiaries with incomes of \$25,000 or less. Only 3 percent goes to elderly individuals or couples with incomes in excess of \$50,000 (see Chart 2).

Low-income elderly and disabled beneficiaries have increasingly relied on the Medicaid program to supplement their Medicare benefits. The Qualified Medicare Beneficiary (QMB) program entitles all poor Medicare beneficiaries to supplemental Medicaid coverage for cost-sharing. Beneficiaries with incomes up to 120 percent of the poverty level are eligible for Medicare Part B premium subsidies from Medicaid. Today, more than two-thirds of all Medicaid outlays are for the elderly and disabled.

Only about half of aged Medicare beneficiaries with incomes of under \$5,000 are enrolled in Medicaid. A Commonwealth Fund study in the late 1980s found that the most common reasons why elderly poor are not covered by public benefit programs are that they are unfamiliar with the programs or do not think they are eligible. Better outreach to those who are qualified for Medicaid supplementation to Medicare is important.

Medicaid and Medicare have also been important financers of long-term care for the frail elderly and those suffering from chronic and disabling physical and mental conditions. Together, the two programs account for half of long-term care expenditures; private health insurance coverage for long-term care is negligible. Medicaid is the only significant source of coverage for nursing

home care or for personal care such as that provided by a home care aide, but to qualify an elderly person must become destitute. Medicare nursing home benefits are restricted to skilled nursing care, although Medicare does pay for about one-third of home health services for older Americans.

Medicare's benefits go largely for hospital and physician services needed by this high risk population (see Chart 3). In the last 15 years home health and hospital outpatient care have been relatively rapidly growing parts of Medicare, while hospital inpatient outlays have grown more slowly.

Financial Burden of Health Costs on Medicare Beneficiaries

It is not well understood that the elderly pay far more for their own health care than the non-elderly—even with important coverage from Medicare. This happens because Medicare pays only 45 percent of the health care bills of the elderly (see Chart 4). Beneficiaries incur substantial out-of-pocket costs for Medicare cost-sharing and for services not covered by Medicare.

As shown in Chart 5, the hospital deductible under Medicare is \$716, the Part B deductible is \$100 per year, and the Part B premium is \$550 per year. The average Medi-Gap premium is now \$840. Given non-covered services such as prescription drugs, premiums and out-of-pocket costs for Medicare beneficiaries averages over \$2000 per year. For a elderly woman with an income of \$10,000, this is clearly an excessive and burdensome cost.

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

Out-of-pocket costs can pose a serious financial burden. About 9 percent of Medicare beneficiaries have no health insurance to supplement Medicare—either from Medicaid or from private coverage through a retiree health plan or through individually purchased Medi-Gap coverage (see Chart 6). These beneficiaries are concentrated in incomes under \$10,000.

As shown in Chart 7, poor elderly households spend over a third of their incomes on health care. The average for non-elderly households is 8 percent of income, while the average for the elderly is 21 percent.

The financial burden of health care costs for Medicare beneficiaries is very unevenly distributed. Some elderly enjoy good health and rarely use health care services. Others are seriously disabled and require extensive treatment. Because Medicare beneficiaries have very different needs for health care, health expenditures are very skewed. In 1993, 10 percent of Medicare beneficiaries accounted for 70 percent of outlays (see Chart 8). One-fourth of beneficiaries accounted for 91 percent of outlays.

The average expenditure in 1993 for all Medicare beneficiaries was \$4,020 (see Chart 9). For the ten percent of Medicare beneficiaries with the highest outlays, the average expenditure was \$28,120. This is contrasted with \$1,340 for the 90 percent of Medicare beneficiaries with the lowest outlays.

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

For those elderly with long-term care needs, costs can be even higher. About 40 percent of all nursing home expenses are paid directly by patients and families. For those elderly with functional impairment living at home, costs can also be high. Over one-third of poor elderly people living at home report being restricted in one or more activities of daily living compared to 17 percent of those with moderate or high incomes.

Inadequate Medicare benefits not only mean financial burdens, but also barriers to needed care. The significant deductible and coinsurance provisions in Medicare deter some of the elderly poor and near poor from obtaining care. Low-income and minority elderly are less likely to get preventive services such as Pap smears and mammograms, in part because of the financial barrier posed by out-of-pocket costs. A recent study supported by The Commonwealth Fund found that elderly women without Medicaid or supplemental private health insurance were much less likely to get mammograms. The financial barriers posed by deductibles and copayments for cancer screening contribute to failure to detect cancer in an early stage when recovery chances are higher. Rates of ambulatory sensitive hospital admission rates are particularly high for poor and minority elderly—indicating inadequate access to primary care.

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

Beneficiary Views of Medicare

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

Medicare's Record of Performance

Medicare has opened the door to health care and greater economic security for the nation's elderly and disabled populations for three decades. Particularly striking has been the program's success in improving access to care for low-income and minority elderly Americans. Racial disparities in care for elderly Americans have largely been eliminated, and Medicare has been instrumental in spurring desegregation of medical facilities for all minority Americans.

Medicare has also contributed to the development of research and innovation, through its funding of medical education and allowances for teaching hospitals. Technological innovation such as cataract surgery, joint replacements, and treatments for coronary artery disease, financed by Medicare, have improved the quality of life and functioning of millions of elderly people.

As the American population ages and lives longer, Medicare has financed the care of an ever older and frailer group of beneficiaries. Admittedly, the cost of covering this high risk group has grown rapidly over time. Yet the underlying cause is primarily health care cost inflation in the system as a whole, not inefficiency by Medicare.

Medicare in fact has an excellent record of low administrative costs. Medicare's administrative costs average 2 percent of program outlays, compared with 25 percent in small group market plans and 30-50 percent in individual insurance plans (see Chart 11).

Medicare has also been an innovator in provider payment. Its system of physician payment has been increasingly accepted by physicians as payment in full (see Chart 12). It has also formed the basis for managed care plan payment to physicians. A survey of managed care plans finds that Medicare still obtains the best "discounts" from physicians -- with most managed care plans paying physicians in excess of Medicare rates (see Chart 13).

Most significantly, Medicare outlays per enrollee for a similar package of services have grown more slowly than private health insurance outlays for these services in the decade from 1984 to 1993 (see Chart 14). Spending on inpatient hospital and physician services have moderated considerably. Certainly the new methods of paying hospitals and physicians introduced in 1984 and 1992 respectively have had an impact. The major areas where Medicare is now growing rapidly are for those services not covered by prospective payment approaches—particularly home health and skilled nursing facilities services. When long-term care services are excluded from the Medicare benefit package and prescription drugs are excluded from private insurance packages, even in the most recent 1991 to 1993 period Medicare expenditures per enrollee for a similar set of services have increased more slowly than private insurance.

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

Medicare Budgetary Changes

Medicare does face genuine short run and long run financial problems (see Chart 15). The Hospital Trust Fund will be insolvent by 2002. Medicare is one of the most rapidly growing components of the federal budget. When the baby boom generation reaches retirement beginning in 2010, the program will face even greater challenges.

Preparing Medicare for the next century, however, requires an in-depth, thoughtful examination of a full array of policy options. It is important that changes made now to address Medicare's short-run problems not set the program on the wrong course, or inflict harm on vulnerable beneficiaries.

Higher Beneficiary Payments

Beneficiaries already bear substantial out-of-pocket costs for Medicare premiums, cost-sharing and noncovered services. If additional payments from beneficiaries are required for budgetary reasons, care should be taken to see that those costs do not fall on those already most heavily burdened -- the poor and chronically ill. Premiums are the fairest type of beneficiary payments, in that they are spread across all 37 million beneficiaries. Cost-sharing such as increased deductibles or copayments on physician services fall more heavily on sick beneficiaries. Copayments on home health services are targeted on the most seriously ill, who already typically face large payments for such noncovered services as prescription drugs.

It is particularly important that Medicaid supplementation to pay Medicare premiums and cost-sharing for low-income beneficiaries be assured if beneficiaries are required to pay a greater portion of Medicare costs. A block grant to states could leave over 4 million low-income beneficiaries without financial access to care. Federalizing this portion of the Medicaid program could be an important complement to any provision to increase beneficiary payments.

Tighter provider payments

Another budgetary option is to curtail payments to Medicare providers. Presently nearly all hospitals, physicians, and eligible health care providers participate in the Medicare program. Medicare pays physicians at 68 percent of the rate of private insurers. Yet, surveys of physicians indicate a continued willingness to see Medicare patients.

Medicaid's experience, however, has been that once payments fall markedly relative to payment rates of private insurers many providers are no longer willing to serve beneficiaries or do not provide quality services. There are limits, therefore, on how much and how quickly Medicare provider payment rates can be tightened further. The financial stability of hospitals and other providers heavily dependent on Medicare—such as rural hospitals and academic health centers—could be undermined by major reductions in Medicare payments.

Medicare's prospective payment methods for hospitals and physicians have been remarkably successful in providing incentives for efficiency and slowing growth in costs. One possibility is to extend these methods to other services including home health care where rates of increase have been

very rapid. Other techniques such as profiling, appropriateness guidelines, high cost case management may also generate further savings.

Managed Care

Medicare has been criticized for not promoting aggressively enough managed care alternatives for its beneficiaries. Yet, Medicare is itself similar to a preferred provider managed care plan. With the recent reforms in provider payment, Medicare sets prospective prices for hospitals and physicians at a substantial "discount" to usual charges. Medicare's physician payment fees, for example, average 68 percent of fees paid under private health insurance plans. All providers who are willing to participate at these rates are permitted to enroll. Physicians who agree to take "discounted" payments as payments in full become participating physicians and are listed in directories of preferred providers. This has worked remarkably well, to the extent that 92 percent of all Medicare physician services are now on assignment.

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

Some expansion of Medicare's managed care options seems warranted. Medicare could systematically make information available to beneficiaries about choices in their geographic area, and conduct a formal annual enrollment process. HMOS with a Point of Service feature could be added. It is important, however, that plans be held to high quality standards, and that information on plan performance be provided to beneficiaries. Starting slowly is important. Expanding coverage to loosely organized managed care plans such as preferred provider organizations or to indemnity insurance plans does not seem warranted, until many of the problems with current capitation payment are resolved and adequate quality standards established and an enforcement mechanism instituted.

Even if enrollment were to expand more markedly, it is unlikely that there would be savings to the program, and in fact might cost the Medicare program. A recent study finds that the actual cost of serving Medicare beneficiaries who opt for HMO enrollment is 5.7 percent more than Medicare would have had paid for these same beneficiaries had they been covered under fee-for-service Medicare coverage. Instead of saving Medicare money, the program loses almost 6 percent for every Medicare managed care enrollee.

Given the extreme variability in health outlays among beneficiaries, there is great leeway for plans to select relatively healthier beneficiaries for whom capitated rates exceed true costs. If managed care plans succeed in attracting and retaining relatively healthier Medicare beneficiaries which they have very strong incentives to do, Medicare will be overpaying for those under managed care, and yet paying the full cost of the sickest Medicare beneficiaries who are unattractive to managed care plans. Managed care plans have the option of switching to a fee-for-service method of payment from a capitated risk contract if they experience adverse selection and would receive higher payment under Medicare's fee-for-service provider payment rules. Monthly disenrollment by Medicare beneficiaries also means that managed care plans can encourage sicker patients to leave the plan and be cared for on a fee-for-service basis. In the case of network-model HMOs the same physician might even continue to care for the patient when he or she disenrolls.

The current method of paying managed care plans for Medicare patients is seriously flawed. Its primary weakness is that it does not adequately adjust for differences in the health status of beneficiaries. Unfortunately, a good method of setting capitation rates to adjust for differences in beneficiary health status seems years away.

The current method of Medicare HMO payment includes allowances for the direct and indirect costs of medical education even though managed care plans do not incur these costs; The payment rate also includes an allowance for disproportionate share payments even though managed care plans do not cover the uninsured, and in general are open only to those who can afford the premium or have employers or public programs that pay the premium on their behalf. These factors

represent about a four percent overpayment to HMOs with Medicare risk contracts.

If budgetary savings are required, serious consideration should be given to lowering the Medicare HMO payment rate. It is currently set at 95 percent of Medicare projected expenditures for beneficiaries with average health status. Given the favorable selection that occurs, reducing this to 85 to 90 percent could be considered.

The extent of managed care abuses could be curbed by lowering capitation payment rates and imposing penalties on plans for high disenrollment rates, but the basic underlying incentives are unlikely to be substantially altered. Nor has the long-term success of managed care in controlling costs (aside from getting provider price discounts) yet been demonstrated.

Vouchers, Medical Savings Accounts, Catastrophic Coverage

In a difficult federal budgetary climate, capping the federal budget obligation for Medicare on first examination has appeal as a policy option. Vouchers or giving beneficiaries the actuarial value of Medicare to invest in medical savings accounts and purchase private catastrophic coverage represent mechanisms for capping and limiting growth in budget outlays, shifting financial risks to beneficiaries, and creating incentives for individuals to control costs.

Vouchers would provide more choices for beneficiaries, including wider choices among benefit packages, but also shift more financial risk to individuals. Vouchers to purchase catastrophic health coverage with the balance invested in medical savings accounts raise particular concerns.

First, such provisions are likely to be costly to the Medicare program. While a mandatory voucher system could be designed to guarantee savings, a voluntary voucher program is almost certain to be attractive only to relatively healthier beneficiaries. Setting the voucher at an average level could result in very substantial overpayments. Medicare currently spends very little on the healthiest 50 percent of Medicare beneficiaries. If they were to take vouchers, the cost to the program could be extraordinary. For example, if 18 million beneficiaries collected vouchers of \$5,000, the cost would be \$90 billion -- yet these beneficiaries currently cost the Medicare program virtually nothing. Skimming off the healthiest Medicare beneficiaries undermines the advantages of risk pooling that Medicare as a universal program now achieves.

Nor is there reason to believe that the private sector will be successful in holding down costs as compared to the current Medicare program. First, private insurers will almost surely have higher administrative overhead costs than does Medicare. Medicare's administrative costs average less than 2 percent of outlays, while individual insurance administrative costs for the elderly often runs 30-50 percent. Insurers will need to advertise and promote their plans. They will face a smaller risk pool that may require them to make more conservative decisions regarding reserves and other protections against losses over time. They will not have the advantage of Medicare's scale and governmental authority in imposing steep provider price discounts. For example, Medicare's physician payment rates are 68 percent of those of private insurers, and lower than managed care plans that use the Medicare system to pay physicians. These plans expect to return a profit to shareholders. All of these factors work against private companies performing better than Medicare.

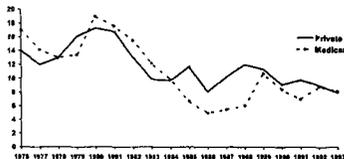
The most serious potential problem with vouchers is that the market would begin to divide beneficiaries in ways that put the most vulnerable beneficiaries—those in poor health and with modest incomes at particular risk. If vouchers or other types of specialized plans like medical savings accounts skim off the healthier, wealthier beneficiaries, many Medicare enrollees who now have reasonable coverage for acute care costs, but who are the less desirable risks, would face much higher costs due to the market segmentation. A two tier system of care could result in which modest income families are forced to choose less desirable plans.

Catastrophic coverage is unlikely to be attractive to many beneficiaries. After all 90 percent of Medicare beneficiaries now obtain supplemental coverage to avoid the \$716 Part A deductible and \$100 Part B deductible. Few beneficiaries who truly understand that a plan has a \$3,000 or \$4,000 deductible are likely to find it attractive. Nor is it affordable for the three-fourths of Medicare beneficiaries with incomes below \$25,000. If beneficiaries were to experience a serious illness, they could face financial bankruptcy and bad debts to providers. Providing financial protection for beneficiaries was the major rationale for creating Medicare. It should not be abandoned now.

PHYSICIAN FEE SCHEDULE CONVERSION FACTORS FOR MANAGED CARE PLANS USING A RESOURCE-BASED RELATIVE VALUE SCALE, 1994

<u>Conversion Factor</u>	<u>% of Plans</u>
● Lower than Medicare	0
● Same as Medicare	20
● Up to \$14 Higher than Medicare	44
● \$15 to \$29 Higher than Medicare	28
● Greater than \$29 Higher than Medicare	8

Per Capita Outlay Growth Rates for Services Covered by Both Medicare and Private Insurance 1976-1993



**MEDICARE:
SHORT RUN AND LONG RUN PROBLEMS**

Short Run:

- Hospital Insurance Insolvency in 2002
- Federal Budget Deficit

Long Run:

- Retirement of Baby Boom Generation

**Medicare Budget Options:
Considerations and Concerns**

- Higher beneficiary payments
 - Premiums pose less burden on sick than increased deductibles and coinsurance
 - Medicaid supplementation is essential to protect low-income beneficiaries
- Tighter provider payments
 - Magnitude of change important in assessing impact on financial stability of hospitals and willingness of providers to take Medicare beneficiaries
- Managed care
 - Choice, formal enrollment, information, quality standards useful
 - Some expansion to HMO (point-of-service may be warranted); premiums to expand to loosely organized managed care plans or indemnity plans
 - Likely to cost Medicare not save money
 - Could lower AAPCC to 85-90% if wast savings
- Voucher/medical savings accounts/catastrophic coverage
 - Likely to cost Medicare program
 - Likely to skin off healthiest beneficiaries; undermines benefits of risk pooling
 - Private coverage less efficient than Medicare
 - Could leave beneficiaries with bad debt, excessive financial burdens
 - Opens beneficiaries to marketing abuses

**BUILDING ON MEDICARE'S
STRENGTHS**

- Improving Medicare's Fee For Service Option
- Expanding Medicare's Managed Care Options
- Minimizing Risk Selection
- Financing Options

Further, the experience with sale of private MediGap coverage to beneficiaries is that without stringent safeguards marketing abuses are likely. Confused or scared, some beneficiaries could take options which are not in their best interests -- nor genuinely preferred by them.

On balance, vouchers offer little in the way of guarantees for continued protection under Medicare. Further, the federal government's role in influencing the course of our health care system would be substantially diminished. For some, this is a major positive advantage of such reforms. But the history of Medicare is one in which the public sector has often played a positive role as well, first insuring those largely rejected by the private sector and then leading the way in many cost containment efforts. But most troubling is the likelihood that the principle of offering a universal benefit would be seriously undermined.

Building on Medicare's Strengths

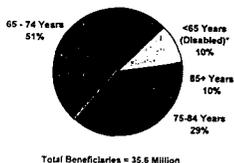
At present, too little attention is being focused on how to improve the functioning of the basic Medicare program, rather than departing radically from its basic structure. The goal should be preserving genuine choice for all Medicare beneficiaries to be cared for by physicians or a health system of their choice while guaranteeing quality care at a reasonable cost to beneficiaries and to taxpayers. Fee-for-service care has the disadvantage of creating incentives for too much care at too high cost; capitated managed care has the disadvantage of creating incentives for too little care at substandard quality. Providing a genuine informed choice for beneficiaries of both options may counter the harmful consequences of either extreme.

Major issues include: 1) how to improve the fee-for-service option within Medicare; 2) how to expand Medicare managed care choices while assuring quality standards; 3) how to minimize the difficulties posed by risk selection; and 4) what financial contribution Medicare beneficiaries and taxpayers can reasonably be expected to make (see Chart 17).

What should be preserved is the essential role that Medicare plays in guaranteeing access to health care services and protecting from the financial hardship that inadequate insurance can generate for our nation's most vulnerable elderly and disabled people. No American should become destitute because of uncovered medical bills nor be denied access to essential health care services. Medicare is a model of success. It should not be hastily jettisoned in an ill-conceived and short-sighted effort to obtain federal budgetary savings. Instead a full array of options needs to be carefully analyzed, critiqued, and debated.

Thank you.

COMPOSITION OF THE MEDICARE POPULATION, 1992
One Out of Five is Disabled or Over Age 85



Source: Social Security Administration, Office of the Actuary, 1991.

The Commonwealth Fund

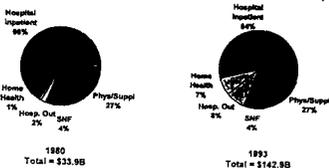
MEDICARE EXPENDITURES BY BENEFICIARIES' INCOME, 1992
83% of Medicare Expenditures Are for Beneficiaries With Annual Incomes Under \$25,000



Source: Social Security Administration, Office of the Actuary, 1992.

The Commonwealth Fund

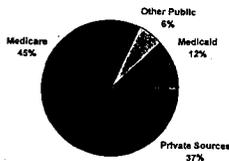
WHERE THE MEDICARE DOLLAR GOES, 1980 and 1993



Source: HCFA, Office of the Actuary, 1993.

The Commonwealth Fund

HEALTH CARE SPENDING FOR THE ELDERLY, 1987
Who Pays the Bill?



Source: Social Security Administration, Office of the Actuary, 1987.

The Commonwealth Fund

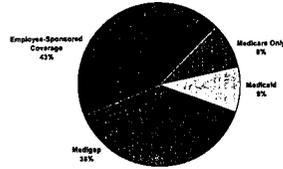
MEDICARE COST SHARING, 1995

- Inpatient Hospital Deductible = \$716 per benefit period
- Part B Deductible = \$100 per year
- Part B Premium = \$553 per year
- In addition, beneficiaries pay copayments for SNF, extended hospital stays, and co-insurance for physician, durable medical equipment, supplier, and hospital outpatient services.
- Average Medigap premium (1992) = \$840 per year

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The Commonwealth Fund

MEDICARE BENEFICIARIES BY TYPE OF SUPPLEMENTAL COVERAGE, 1992 One in Ten Have No Supplemental Coverage

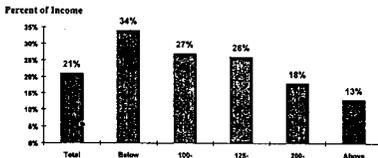


Source: Prospective Payment System Conclusions, March 1993

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The Commonwealth Fund

PERCENT OF INCOME SPENT ON OUT-OF-POCKET COSTS, ADULTS 65 AND OLDER, 1994 Poor and Near Poor Older Americans Spend High Percent of Income on Out-of-Pocket Costs

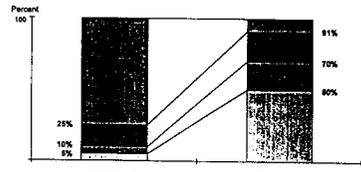


Source: Annualized Analysis of Federal Taxes and Urban Health, February 1995

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The Commonwealth Fund

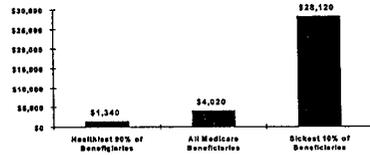
DISTRIBUTION OF MEDICARE EXPENDITURES BY TOP PERCENTILES OF ENROLLEES, 1993



Source: HCFA Office of the Actuary, 1993

The Commonwealth Fund

AVERAGE MEDICARE OUTLAYS PER BENEFICIARY BY HEALTH STATUS, 1993

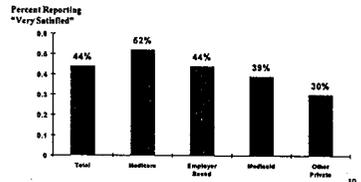


Source: Calculated by Evans Dahl from HCFA's Medicare A Profile, February 1995

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The Commonwealth Fund

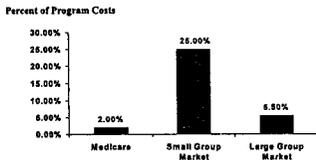
PERCENT OF POPULATION VERY SATISFIED WITH HEALTH INSURANCE, BY TYPE OF INSURANCE, 1993 Medicare Beneficiaries Most Satisfied With Coverage



Source: Kaiser Family Foundation/Commonwealth Fund Health Insurance Survey, 1993

The Commonwealth Fund

ADMINISTRATIVE COSTS Medicare vs. Private Plans



Small group market = 50 employees; Large group market = 5000-10000 employees
Source: HCFA Office of the Actuary and Congressional Research Service
*Data and Graphs of Changing Health Insurance Coverage, 1990

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The Commonwealth Fund

ASSIGNMENT RATES FOR PHYSICIAN SERVICES, 1986-1993



Source: Physician Payment Review Commission, 1993 Annual Report to Congress

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The Commonwealth Fund

Mr. THOMAS. Thank you very much, Dr. Davis.
Dr. Mullins.

STATEMENT OF CHARLES B. MULLINS, M.D., EXECUTIVE VICE CHANCELLOR FOR HEALTH AFFAIRS, UNIVERSITY OF TEXAS SYSTEM; ACCOMPANIED BY JORDON J. COHEN, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. MULLINS. Chairman Thomas and Members of the Committee—

Mr. THOMAS. Doctor, I would say that these microphones are very unidirectional and you will just need to talk directly into it.

Dr. MULLINS. Thank you.

I am Dr. Charles Mullins, executive vice chancellor for Health Affairs for the University of Texas System, up here with Dr. Jordan Cohen, who is the chief executive officer and President of AAMC, the Association of American Medical Colleges.

The AAMC welcomes the opportunity to comment on the Medicare Preservation Act, subsection E, the reform of payments for graduate medical and teaching hospitals.

The AAMC represents all of the Nation's 125 accredited medical schools, 300 major teaching hospitals, and 160,000 medical educators, students, and residents.

The University of Texas System is a large academic medical and teaching system that will be significantly impacted by changes in the national health care financing. The UT system includes 6,300 faculty, 1,100 medical residents in training, 3,200 medical students, and 10 primary care teaching hospitals.

Last year, the University of Texas faculty cared for over 2 million outpatients and provided 500,000 inpatient hospital days and delivered over \$700 million in charity care services. The AAMC is pleased that Chairman Archer and the Committee along with Chairman Thomas and Representatives Nancy Johnson and McCrery have recognized that teaching hospitals and medical schools face unique and serious problems in maintaining their crucial mission in a rapidly changing health care environment. We thank you for your efforts.

This Committee has devised an innovative plan to establish a trust fund intended to assist teaching hospitals and medical schools in the meeting of special costs associated with medical education. The AAMC has long endorsed the need for an approach to finance equitably the clinical training for future health care providers and we believe that the proposed trust fund is a real step forward in the direction of a true sharing of this societal responsibility.

We would like to express our appreciation of the Committee's leadership in recognizing that teaching hospitals face unique and potentially devastating problems in maintaining their crucial missions in the new and fiercely competitive market, health care marketplace.

The AAMC understands the difficulty Congress faces in reducing the rate of growth in the Medicare Program to protect the Medicare Trust Fund. The proposed magnitude of the reductions and projected expenditures for Medicare and as well Medicaid is likely to have a major impact on the Nation's teaching hospitals and medi-

cal schools. Teaching hospitals serve large numbers of poor and elderly and depend heavily on Medicare patient payments for direct graduate medical education and indirect medical education and disproportionate share of funds.

For members of the AAMC Council of Teaching Hospitals, Medicaid and Medicare payments on the average of 1993, constituted 48 percent or almost one-half of their net patient revenue. AAMC believes the Committee's trust fund for graduate medical education would open up the way for shared responsibility by all parts of the health care delivery system to participate in the financing of clinical training.

The AAMC has long endorsed the need for an all-payer system, equitable financing and clinical training for future health care providers, and we believe that the proposed trust fund is a real step forward in the development of a true sharing of this societal responsibility.

In reviewing the summary of the Medicare Preservation Act, we were encouraged to learn that the proposal includes the creation of a legislative commission to study and make recommendations on alternative broad-based sources of graduate medical education financing and including the urgent need to determine the dependence of schools on service-generated income.

The same economic challenges entertained by teaching hospitals also affect the ability of medical schools to maintain their essential infrastructure for education and research and to reorient their educational training programs for managed care. The AAMC agrees that among other responsibilities, the new commission should examine the Federal policies regarding international medical graduates and the feasibility and desirability of reducing payments for high-cost residency programs.

The intermediate termination of Medicare support for specialty training and in the 4-year phasing out of Medicare support for non-U.S. residents would have an untoward effect on certain specific institutions and their ability to provide care to Medicare beneficiaries and others. Our review of subtitle E indicates that there are a number of specific issues and details which will need to be addressed, and we look forward to working with the Committee on these details.

The AAMC is concerned about the omission in the House proposal to carve out the indirect medical education, direct medical education, and the disproportionate share payments from adjusted average per capita payment for Medicare risk contractors. The AAMC believes that the education-related payments should be maintained for the specific purposes mandated by Congress and should be removed from the calculation of the per capita cost rate and paid directly to teaching hospitals when they provide services to Medicare risk plan enrollees.

In conclusion, the AAMC appreciates the efforts of the Chairman and the Committee in the difficult task of designing a plan to sustain the Medicare Program, providing support for graduate medical education in the face of many competing priorities. The academic medical community looks forward to working with you on ways to strengthen the medical care program and ensure that the American health care delivery system remains the best in the world.

Thank you.

[The prepared statement follows:]

**STATEMENT OF CHARLES B. MULLINS, M.D.
EXECUTIVE VICE CHANCELLOR FOR HEALTH AFFAIRS
UNIVERSITY OF TEXAS SYSTEM; AND JORDON J. COHEN, M.D.
PRESIDENT AND CEO, ASSOCIATION OF AMERICAN MEDICAL COLLEGES**

Mr. Chairman and members of the Committee, I am Dr. Charles Mullins, executive vice chancellor for health affairs at the University of Texas System. I appear with Dr. Jordan Cohen, president and chief executive officer of the Association of American Medical Colleges (AAMC). The AAMC welcomes the opportunity to comment on the Medicare Preservation Act, Subtitle E--Reform of Payments for Graduate Medical Education and Teaching Hospitals. The AAMC represents all of the nation's 125 accredited medical schools; 300 major teaching hospitals that participate in the Medicare and Medicaid programs; the faculty of these institutions through 92 constituent academic society members; and the more than 160,000 men and women in medical education as students and residents.

The University of Texas (UT) System is a large academic medical and teaching hospital system that will be affected significantly by changes in national health care financing. The UT System includes 6,300 faculty; 1,110 medical residents in training; 3,200 medical students; and 10 primary teaching hospitals. Last year, the UT faculty cared for over 2 million outpatients, provided 500,000 inpatient hospital days, and delivered over \$700 million in charity care services.

Before commenting on the specific proposal, we would like to express our appreciation to the Committee for recognizing that teaching hospitals face unique and potentially devastating problems in maintaining their crucial missions in the new, fiercely competitive health care marketplace. We would like to give special thanks to Chairman Bill Archer and Representatives Thomas and Johnson for their leadership and concern.

The AAMC understands the difficulty Congress faces in reducing the rate of growth in the Medicare program to protect the Medicare Trust Fund. The proposed magnitude of the reductions in projected expenditures for Medicare, as well as Medicaid, will have a major impact on the U.S. health care system. Moreover, the changes contemplated would have especially profound effects on the nation's teaching hospitals and medical schools. Teaching hospitals serve large numbers of the poor and the elderly, and depend heavily on Medicare payments for direct graduate medical education (DGME), indirect medical education (IME), and disproportionate share (DSH). Many teaching hospitals also serve large segments of the Medicaid population. For members of the AAMC's Council of Teaching Hospitals (COTH), Medicare and Medicaid payments on average in 1993 constituted 48 percent, or nearly one-half of all their net patient revenue.

The Ways and Means Committee has devised a novel plan to assist teaching hospitals in meeting the special costs associated with their education mission. The AAMC recognizes that the creation of a trust fund for graduate medical education, which includes non-Medicare revenue, is designed to ameliorate the impact of anticipated reductions in Medicare DGME and IME payments. A trust fund also would open the way for shared responsibility by all parts of the health care delivery system to participate in the financing of clinical training. Shared responsibility for clinical education is an essential ingredient in a competitive delivery environment. The AAMC has long endorsed the need for an all-payer approach to finance equitably the clinical training of future health care providers. We believe that the proposed trust fund is a real step forward in the development of a true sharing of this societal responsibility.

In reviewing the summary of the Medicare Preservation Act, the AAMC was pleased to learn that it includes the creation of a legislative commission to study and to make recommendations on alternative broad-based sources of graduate medical education financing, including the urgent need to determine the dependence of schools of medicine on service-generated income. The same economic challenges encountered by teaching hospitals also affect the ability of medical schools to maintain their essential infrastructure for education and research and to reorient their educational programs.

The AAMC agrees that, among other responsibilities, the new commission should examine federal policies regarding international medical graduates and the feasibility and desirability of reducing payments for "high cost" residency programs. The immediate termination of Medicare support for specialty training and the four-year phasing out of Medicare support for non-U.S. citizens would have untoward, adverse effects on specific institutions and their ability to provide care to Medicare beneficiaries and others. The commission should examine immediately the impact of these provisions.

The AAMC is pleased that this plan retains the structure and methodology of the current Medicare payment system for graduate medical education, namely the continued formula-driven contributions of separate DGME and IME payments. The AAMC has long held that these two payments with an educational label serve separate and distinct purposes and should continue to be paid as individual contributions to a new trust fund.

Our review of subtitle E indicates that there are a number of specific issues and details that will need to be addressed. We are prepared to work with the committee to clarify issues ranging from the appropriate base year to the definition of "non-U.S. citizen medical graduates." We look forward to additional information on the magnitude of the non-Medicare revenue funding that would be placed in the trust fund.

As noted above, the AAMC is concerned about the ability of teaching hospitals to maintain their missions, faced with expected reductions in Medicare payments and being unable to capture the IME, DGME, and DSH payments embedded in the Adjusted Average Per Capita Cost (AAPCC), the payment rate for Medicare risk contractors. The AAMC believes that these mission-related payments should be preserved for the specific purposes mandated by Congress and should be removed from the calculation of the AAPCC rate and paid directly to teaching hospitals when they provide services to Medicare risk plan enrollees. A recent analysis by the Prospective Payment Assessment Commission (ProPAC) showed that, on average, excluding teaching-related and DSH payments from the rate would have resulted in a decrease of \$21 in the U.S. per capita cost, or 5.3 percent, in the AAPCC in 1995. In the aggregate, this means teaching hospitals lost \$545 million in mission-related payments in 1995, and ProPAC's estimate is based on only 2 million risk plan enrollees. As Medicare beneficiaries increase their participation in managed care plans, or exercise other options such as Medical Savings Accounts (MSAs), and fee-for-service payments decline, the mission-related dollars lost by teaching hospitals will increase substantially. Over time, it will become more difficult to "carve out" these payments and redirect them, as Congress originally intended, to teaching hospitals. We hope that this important issue will be a priority of the new commission.

In conclusion, the AAMC appreciates the efforts of the chairman and the committee in the extraordinarily difficult task of designing a plan to provide support for graduate medical education in the face of many competing priorities. The academic medical community looks forward to working with you on ways to strengthen the Medicare program and to ensure that the American health care system continues to provide the best health care in the world.

Mr. THOMAS. Thank you, Dr. Mullins.

The Chairman asks unanimous consent to place in the record at this point a letter from the University of California, from Dr. Cornelius Hopper, who is the vice president of Health Affairs, referencing the teaching hospital portion of the bill.

[The information follows:]

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September 21, 1995

Honorable William B. Thomas
Chairman
Subcommittee on Health
Committee on Ways and Means
House of Representatives
2208 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

The University of California has expressed its concern to you and your staff over the last several weeks regarding the overall impact sharp reductions in the rate of growth in the Medicare program could have on California's teaching hospitals. We have also expressed our concerns about the critical importance of ensuring that funds designated for sustaining our crucial missions in Medicare's present method for calculating the adjusted average per capita cost (AAPCC) be addressed as part of the budget reconciliation process. We would like to take this opportunity to express our appreciation to you for your leadership and your willingness to work with us in an effort to address many of these concerns.

We believe the Medicare Preservation Act includes a unique and novel approach in establishing a trust fund that is intended to assist teaching hospitals in meeting the special costs associated with our education mission. We further believe, that with adequate protections, the trust fund concept could help us to sustain our unique missions. The University of California hopes that this innovative proposal will be a first step toward establishing an all-payer approach to finance clinical training.

We continue to have concerns about the AAPCC calculation and hope that as the Medicare proposal moves through the legislative process in the House and the Senate, we can work with you and your staff to attempt to resolve a situation that continues to have significant impact on teaching hospitals in California.

The University of California would like to thank you for your strong commitment to the clinical training of future health care providers.

Sincerely,

A handwritten signature in cursive script that reads "Con Hopper".

Cornelius L. Hopper, M.D.
Vice President, Health Affairs

Mr. THOMAS. Does the gentleman from Illinois wish to inquire? Does the gentleman from Florida wish to inquire?

Mr. GIBBONS. Oh, absolutely.

Ms. Davis, I want to say that I have listened to witnesses on this subject for 26 years and I have listened to hundreds of different witnesses on this subject, and you are the best and most understandable that I have ever heard in all this time. You hit the points. So I am going to take your testimony home with me tonight and read it.

Mr. Ferrara, last year I insisted that we put the medical savings account in the program that we put forward. I—of course, that program was rejected by my Republican friends entirely. But let me ask you some things about your medical savings account.

I assume that once you choose a medical savings account, you have got to stay in that for the rest of your life, is that right?

Mr. FERRARA. No.

Mr. GIBBONS. Oh, oh?

Mr. FERRARA. There would be an annual open enrollment program.

Mr. GIBBONS. The insurance companies want to get out of it, every year, is that right?

Mr. FERRARA. No, the beneficiaries would have the choice. The insurance companies would have to continue to insure the beneficiaries if they wanted to stay in the plan.

Mr. GIBBONS. Well, at what rate would they insure?

Mr. FERRARA. They would have to continue to insure them under a guaranteed renewability policy, which means that they would have to—they could not raise rates selectively for the people who were insured. They would have to have the same rate increase for everybody. They could not say, well, you are sick so we are going to massively increase your rate, and so forth, and so forth. They would have to continue to insure them if they wanted to stay and they would have to continue to insure them at a standard rate rather than a selective rate.

Mr. GIBBONS. And standard for what?

Mr. FERRARA. In other words, everybody in MSA, the medical savings account plan, has to be charged the same rate. You cannot say, well, this person here is sick, I am going to charge them 10 times what I am going to charge somebody else.

Mr. GIBBONS. You mean the standard rate in Tampa, Florida, it would be the same rate as the standard rate say in Los Angeles or New York—

Mr. FERRARA. Let me try to take it, answer your question this way. Under the study that we did with Milliman and Robertson, what we have here, the medical savings accounts you see on the charts here are what would be financed from the funds that would be withdrawn from Medicare. The beneficiary wouldn't be paying anything to get the medical savings accounts. The Medicare system would be paying for this. And so just with those funds alone, this is what Milliman and Robertson calculates you could get.

Mr. GIBBONS. You are not answering my question. My question is, Are you going to guarantee them for a lifetime that you will insure them, but at what rate will we be paying or they be paying?

Mr. FERRARA. The beneficiary?

Mr. GIBBONS. Yes.

Mr. FERRARA. Zero. The beneficiary wouldn't pay anything. These are the benefits that are going to be financed out of the funds that would be withdrawn from Medicare.

Mr. GIBBONS. So the Medicare Trust Fund would be picking up any rate differential, is that right?

Mr. FERRARA. What do you mean by rate differentials?

Mr. GIBBONS. Well, if I contracted bone marrow leukemia or something like that, where I would have to have a bone marrow transplant.

Mr. FERRARA. OK, I understand.

Mr. GIBBONS. You would continue to insure me just like you insure everybody else.

Mr. FERRARA. Yes. The answer to that question is the medical savings accounts get the same voucher amounts, if I could use that term, as any other plan. Medicare is going to set out in the beginning, here is the amount we are going to pay for the private plans and we are—it will be risk adjusted according to age and according to geographic location, whatever else it is, but it would be the same for MSAs as for anything else. So when the elderly person picks an MSA plan, they get the amount that Medicare has designated for that elderly person regardless of which option they choose.

Ms. DAVIS. If I could pick up on that.

Mr. GIBBONS. Yes, Ms. Davis.

Ms. DAVIS. I think what is guaranteed under the medical savings account is that the beneficiary would face an upfront deductible of \$3,000 or \$4,000. There is no guarantee over time under this proposal that the Medicare voucher would even be enough to cover the catastrophic health insurance plan. There is no control, as I understand it, on the premium that an insurance company could set for a catastrophic health insurance plan while the value of the voucher would be tightly squeezed over time.

Mr. FERRARA. There is no control, that is—

Ms. DAVIS. The beneficiary knows they are out the deductible because they are buying into a policy with \$3,000, \$4,000 out of pocket, plus they have got to pay any noncovered services, like prescription drugs, nursing home care, dental care, dentures, hearing aids, so that the beneficiary is not protected under this scheme. There is not a ceiling on the total amount they have to pay, and many of them, particularly those who are ill, if they are misled into buying a plan like this, are going to have ruinous out-of-pocket medical expenses.

Mr. FERRARA. Our study shows that everything you just said, Ms. Davis, is completely wrong, as a matter of fact. I wish you would read the study, because Milliman and Robertson is the top actuarial firm in the country. These are not just some professors making this up off in a closet.

Mr. GIBBONS. You are speaking so fast, I can't understand you. Would you talk a little slower like Ms. Davis does? I can understand her.

Mr. FERRARA. Well, under the plan, they calculated what benefits you would be able to buy with the funds that you can withdraw from Medicare each year over 7 years, and they calculated that after you pay for the cost of the catastrophic insurance out of that

voucher amount withdrawn from Medicare, you would have \$1,500 left over if you bought a fee-for-service plan, you would have \$2,100 left over if you bought a managed care plan. This is what the real insurance actuaries calculated, not some think tank person making up some numbers.

These are the people who advise the insurance companies and tell them what to charge and how to design their plans. They projected it out over 7 years and they showed what the benefits would be.

Under this chart, these charts right here, you have a cap on out-of-pocket expenses of \$1,500 under the fee-for-service plan and \$900 on the managed care plan. This is what the real actuaries have calculated and these are better benefits than Medicare for the five reasons I described.

Mr. GIBBONS. You are not just going to cherrypick the elderly in Medicare?

Mr. FERRARA. No, they cannot cherrypick. They have to accept everybody from Medicare who chooses them no matter what their condition. If they want to play and participate, they have to accept everybody who chooses them.

Mr. GIBBONS. And Medicare, the government won't pay any more for the insurance while it is in force, no matter how sick that person is?

Mr. FERRARA. Medicare will pay the risk-adjusted amounts that Medicare determines that they will pay for any private plan, whether it is medical savings accounts or anything, and Milliman and Robertson took all that into account when they did their actuarial calculations as to what would be covered.

Mr. GIBBONS. I am interested in the taxpayers' point of view. Is the taxpayer going to have to pick up more of the cost from your insurance companies as they have to pick up sicker and sicker people in those Medicare savings accounts?

Mr. FERRARA. It is going to be the same for all the plan. Let me try to explain, answer your question this way.

Mr. GIBBONS. I am talking about what are the ground rules here.

Mr. FERRARA. Let me try to answer the question this way.

Medicare will say in the beginning we are going to spend this much on average and then we are going to risk adjust it, and if the person is of a certain age we are going to pay this much more, and if they are a certain—and they may adjust it for health status as well, and if they got this illness we will pay this much more and they will specify that for everybody at the beginning regardless of what they choose. So Medicare will determine all that so that the total amount is consistent with the budget targets.

They will set an average and then they will set risk adjustments around that average, taking into account health status and age, so that when you total it all up, it is no more than the total budget targets, and then regardless of which private plan the beneficiary picks, that is the amount that goes to that plan. If it is an MSA, they get the amount that Medicare has determined in the beginning they are going to pay for everybody that is—so that it will cost no more than the budget targets.

Mr. CRANE [presiding]. The time of the gentleman has expired.

Mr. GIBBONS. I wish somebody would explain to me what he said. I tried to listen to him.

Ms. Davis, can you explain to me what he said?

Ms. DAVIS. There is a concern here about risk selection, will the government save money on Medicare. Can you think about a sales person going bed-to-bed in a nursing home and marketing to the 1.5 million elderly in nursing homes?

If not, the average amount that is being paid in this voucher is going to be overstated and the government is going to be paying \$5,000 for people who take this voucher, for people whose expenses on my chart in my testimony were \$1,300. The government will lose \$2,000 or \$3,000 on every person who does that because no sound insurance company is going to try to market to people who are bed-bound, who are in nursing homes.

They are going to market to people who come down and get free coffee at the coffee shop, who are ambulatory, cognizant of what the options are.

Mr. FERRARA. That is all wrong. That is not what the plan is going to do.

Ms. DAVIS. It is going to cost the Medicare Program money.

Mr. CRANE. The time of the gentleman has expired.

Mr. Shaw.

Mr. SHAW. Just very, very briefly, Mr. Chairman. I would point out to my friend from Florida that if it is not in the bill that it is guaranteed renewable, he certainly would be able to offer an amendment to that effect, and I think it would be a good amendment. So I mean, we could sit here and have a fight or argument over whether it is going to be guaranteed renewable or not, but if we put it in the bill that that is the condition of the issuance, then that is the condition of the issuance and the argument is over and I would support such an amendment.

And I yield back.

Mr. GIBBONS. Good.

Thank you.

Mr. RANGEL. It is always good to see you, Ms. Davis. Could you amplify the voucher aspect of this suggestion that is coming from the Republican leadership? With Medicare dealing with the problems of the older citizens and with younger people that do not know the options of health plans that we have now, it is hard for me to see these dramatic savings where people must leave their doctors to join the HMOs to find out which HMO is the best for them.

And the older you get, I just assume with exceptions like Mr. Ferrara's organization, but the older you get, I assume that the for-profit organizations would rather be dealing with younger people, and the more sick you are, I would gather that they would not encourage sick old people to join up with them, not because they don't like them, but because it is just more expensive.

How do you see this dramatic reduction in cost as outlined in this proposal by using the voucher system? Is the voucher system a practical tool to use to reduce the cost of Medicare in your opinion?

Mr. DAVIS. Well, I will look forward to the Congressional Budget Office's estimates of things like Medisave and also the expansion

of managed-care options. I am concerned that both Medisave and the expansion of many managed-care options will cost the Medicare Program.

It is particularly a concern with the Medisave because no one who expects to hit that deductible is going to sign up for a policy that is going to make them pay \$3,000 or \$4,000 every year. But with regard to the managed care plans, I think some of the provisions that I understand are in the proposal to give people information, that there be an annual enrollment process, the Health Care Financing Administration explain the HMOs that are available, that is good.

I think what we will need to work on is getting quality standards for the HMOs and getting information to patients so that they can actually know what they are signing up for.

In studies we supported at the Commonwealth Fund, we just found a lot of variability from one plan to another. Some consumers were satisfied, whereas others weren't, and certainly I think your concern about the plans preferring to enroll healthier people has been Medicare's experience with HMOs to date, and it is one of the reasons that HMOs cost the Medicare Program 6 percent for every beneficiary who joins an HMO.

Mr. RANGEL. Let me just ask one question of the panel. I guess most all of you have read in the newspapers or have had an opportunity to read the document that has been distributed by the Republicans, and most all of you, one way or the other, are experts in the fields that you testified.

Based on what you know now, would you be prepared to vote aye just on this package just based on the knowledge? Or in your opinion, would it be necessary for you to get additional information before you decided one way or the other? How about you Mr. Ferrara?

Mr. FERRARA. I have been working closely with several people working on this plan so I have a lot of information on what it will be, but I vote aye on this plan.

Mr. RANGEL. Ms. Hansen.

Ms. JOYCE HANSEN. I think I am pretty pleased with what we have seen proposed so far.

Mr. RANGEL. Oh, no. I mean a lot of people are. But Mr. Ferrara, he just speaks from what he knows, what he has seen, this is the way to go. You don't need any more information, no more hearings, no nothing. You are ready to go, right?

Mr. FERRARA. I am ready to go.

Mr. RANGEL. Especially with the sure amendment.

Ms. Hansen, are you ready to go, ready for an aye vote? Ms. Davis.

Mr. DAVIS. I would like to know the price tag of anything I am buying, so the first thing I want are cost estimates.

Mr. RANGEL. Have you seen anything, Mr. Ferrara, from the Congressional Budget Office?

Mr. FERRARA. No, I haven't, but I have a good idea what this is going to cost. While we have our study done by Milliman & Robertson, they have cost estimates and they estimate that these vouchers would reduce spending by over \$200 billion over 7 years, and the reason they reached that conclusion is because, based on their actuarial judgment, they estimate by 2002, 80 percent of people

will choose the private options. And I greatly concur with that. I think a lot of these places where they have allowed private options to people to opt into private systems, you get that same result.

Mr. RANGEL. I think you are the only person I have met that talks faster than I do.

Mr. Mullins, are you ready to go with this?

Mr. MULLINS. I think I would like to have some more information. The truth about it, I haven't read the entire document that was distributed yesterday.

Mr. RANGEL. Mr. Cohen.

Dr. COHEN. I think we also need to have more information. I think the issues that we are concerned about in terms of the trust fund for graduate medical education are targeted to relieve some of the blows on academic medical centers, but there are a whole lot of other aspects to what is being proposed that have a complex set of facts. We would need more information.

Mr. CRANE [presiding]. The time of the gentleman has expired.

Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

To Mr. Cohen and Mr. Mullins, I would say thank you for your testimony and I look forward to your input in the next week and the week thereafter.

In terms of the graduate medical education proposal, we have now our first real study from a program done in a short period of time, showing that you do very well under our proposal the first 3 years, because of the fund that we have put in place to make up any losses due to migration into managed care plans.

We weren't able at this point to deal with the AAPCC issue, but we do understand it and we have put money in place so that where there is migration, we have substituted cash. But during that time, we have a commission that is going to look at how we capture our ME and DME into a general fund and develop a broad-based separate flow of dollars for medical education which also can be distributed, not through the Medicare patients' reimbursement, because as you get fewer and fewer of those into the hospital and they save less and less time and so forth, this is not going to work in the long run.

And so the kinds of reforms that the Committee has known we needed and that we know we needed, we have a way to develop. But in the short term, while philosophically I agree, American taxpayers should not be subsidizing 6,000 to 7,000 foreign medical graduates, most of whom are also noncitizens; nonetheless, the disparate institution of withdrawing support for foreign medical graduates is a significant problem. We look to you to help us identify the institutions that would be most affected and how we can spread that until we have the input from this commission to help us look at, over the long run, how we withdraw that subsidy from the system, reduce the number of doctors whose education we are subsidizing since we are actually turning out too many now anyway. How do we do this in a way that preserves our centers of excellence and our strong training facilities?

There will be some mergers of training facilities. They are already going on. There will be reduction in the number of plans. We

want that to happen right, not as the result of irrational reimbursement policies.

So we are aware of refinements that have to go on and will look carefully at the mandate of that commission. And as the preceding panel said, this is not legislation we can pass and forget tomorrow. It is going to be an ongoing involvement and endeavor.

Ms. Davis, thank you for being here. I heard well the testimony of the other two and agree with you. I do want to talk to Ms. Davis a little bit about her comments in regard to MSAs particularly. One of my fears about the MSA, and I share the concerns about risk selection that both you and the preceding panel brought up. This is a great deal for a very sick elderly person, because for the cash portion, you can deduct anything eligible for a medical deduction under the Tax Code. So you can deduct a great array of things that no health care plan currently offers.

If you are going to spend \$3,000 on Medicare deductibles and Medicare copayments anyway and on prescription drugs, which many people end up doing, you are much better off doing it under a medical savings account because you can do things that are very user friendly, and then in the end the policy picks up everything.

Now, I have no question but that the Medicare premium will be capable of buying some catastrophic care, but I think we are going to have to watch very carefully who buys it. Because in the first studies of Medicare Select, we are beginning to see that Medicare Select actually is attracting the sicker, not the less sick, which we feared, and I just add that we are interested in your thoughts on governance of these plans.

At this point, we are adopting all the governance of the current risk contract plans. We will watch how they advertise. We will publish and advertise for them so that they won't be able to select to where they market.

But given that ability to put on the market plans that can't discriminate, and you are perfectly right, Mr. Ferrara, we will not allow anyone to participate who won't take all Medicare recipients, given that, and the governance that the government has been able to develop over plans assuring that you offer the benefits that you say you are going to, that there is quality assurance, that there are consumer protections, that there is marketing equity. Given those things, we think a Medicare Choice Program has the opportunity to offer to seniors better benefits than Medicare can, and you have been a longtime observer of this Committee.

You know it took us 4 years to even get mammograms. It will be forever before we modernize the benefit structure of Medicare.

So I hope you work with us and with your friends on the other side of the aisle and help us refine the Medichoice option and expand it at a far more rapid rate than HCFA has been willing to expand it or able to expand it in recent years.

Mrs. KENNELLY. Will the gentleman yield?

Mrs. JOHNSON. I would be happy to.

Mrs. KENNELLY. I have been listening to your statement, Mrs. Johnson, and I share your concerns, but I just wanted to get in the mix that I believe—I think Connecticut has 42 percent international medical students.

Mrs. JOHNSON. International what?

Mrs. KENNELLY. I think it is a little higher than you think about having international medical students in our mix. I just wanted to add that to your—that we do have a number of medical students that are——

Mrs. JOHNSON. Absolutely. Fifty-five percent of our residents at University of Connecticut and it is institution-specific. I am very concerned about it, but it is in the bill the way it is because it sends the philosophical message that the issue here is that out of our 25,000 residencies that we are subsidizing, 7,000 are for the training of non-U.S. citizens and we do have to raise that issue. It is a legitimate issue, but how we are implementing it right now has some temporary defects.

Mrs. KENNELLY. Thank you.

Mr. DAVIS. I look forward to working with the Congresswoman, but I think you can't just extrapolate from the working population to the elderly population, so tax breaks for the working population mean a different thing than most elderly people at the lower end of the range who aren't paying taxes because of various kinds of treatment of Social Security and other income.

So with three-fourths of Medicare beneficiaries with incomes below \$25,000, to subject these people off the top to \$3,000, \$4,000, it is not going to help them much to say, But the amount you pay out of pocket for prescription drugs is tax deductible.

Mrs. JOHNSON. Reclaiming my time, we are subjecting no one to anything. This is totally voluntary. They can stay in the current Medicare plan without signing a paper, making a telephone call. And furthermore, low-income people get their premiums paid by the government.

Mr. THOMAS. The time of the gentlewoman has expired.

Mr. DAVIS. Medicaid payment of Medicare premiums for low-income beneficiaries is not protected in the future under the block grant. So one of my concerns is that the cost sharing for Medicaid dual beneficiaries will no longer be guaranteed to be paid by States for 4 million low-income Medicare beneficiaries. So I think we can't extrapolate from the working population to the elderly population.

Mr. THOMAS [presiding]. The gentlewoman's time has expired.

Does the gentleman from California wish to inquire? No questions.

Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Yes. Thank you, Mr. Chairman.

I have got a couple of questions. The first involves the State. You know, this is not just a Federal, but a State program. For example, New York has its all-payer system, which I understand is going to sort of expire next year, and what it has done is drive a lot of these hospitals into public funding, and I guess the question I have is that we are concentrating on Federal moneys and Federal programs, but is anybody working with the Governor of New York—I happen to come from New York—on this issue? Because it is very, very critical.

Mr. DAVIS. You are referring to the Medicaid block grant?

Mr. HOUGHTON. I am talking to the New York all-payer system.

Mr. DAVIS. Certainly, I think the all-payer systems, particularly in Maryland, I know Congressman Cardin is particularly familiar with the system there, has worked reasonably well and I am not

sure exactly what the provisions in this proposal would be as they would affect States that have their own system of paying hospitals under Medicare.

Mr. HOUGHTON. I think it is part of the overall package that we have got to look at because I think in New York State, which I am associated with, there have been very, very tight restrictions, and some of these financing obligations have driven people in certain ways, and if this program is going to end, obviously it is going to be a problem for us.

Let me just ask my second question and I guess it rides on questions that have been asked previously. If I understand it, the alien international medical graduates, that program is going to stop. There are wide disparities in New York.

For example, a hospital for special surgery has no alien international medical graduates. The New York Methodist Hospital, 78 percent of their population is international. As far as the north-central Bronx hospital, they have got zero, but 50 percent are in the United States, medical graduates, people who are already citizens.

Again, there is such wide variety here. Tell me again, will you, how we are going to get through this period of adjusting to a different system? I don't know whether you would like for Mr. Ferrara—

Mr. COHEN. I will take a crack at that, if I could, Mr. Houghton. I think it is going to be a difficult transition and I think, as has been pointed out, the particular problems are in those institutions that are serving vulnerable populations and are, because of the way the system is currently structured, are dependent heavily on foreign medical graduates, whether they are U.S. citizens or non-U.S. citizens as the case may be.

I think the point that has been made by Mrs. Johnson is that we currently have a system where we have at least 40, perhaps 45 percent more entry level positions in our graduate medical education system than we have graduates of our own medical schools, and all of the evidence clearly suggests that we are heading for a very large oversupply of physicians.

So the near-term savings that occur by using doctors that are educated abroad to solve these local acute medical service problems is compounded by all these physicians who are in practice in this country, adding further to the impetus for raising health care costs.

So I think the issue is trying to balance the long-term problems against the short-term issues, and other providers of those services, it seems to us, it would be a more intelligent way in the long run to deal with that service delivery problem than to depend upon foreign-trained physicians.

Mr. HOUGHTON. Well, I think it is particularly critical in New York because—and I hate to be parochial here, but this is the State I represent. Since I understand it, over 40 percent—upward of 50 percent of all the foreign residents are in New York City. So it is going to be a very difficult adjustment period.

Dr. COHEN. I think there is no question about it and I think any system that would attempt to try to change that in a hurry would lead to very great dislocations. I think we have to be sensitive to

the institutions that are serving these social missions and we have to find ways to solve their problems.

Mr. HOUGHTON. Fine. I will yield.

Mr. JOHNSON of Texas. Thank you. The States obviously control most of the students that come into the process because most of them are State-run institutions, at least in Texas. Are they in New York as well?

Dr. COHEN. It varies there. It is certainly not exclusively a problem of government-sponsored institutions, but even—I mean, the States are not the ones that are permitting these individuals to come into the country to train.

Mr. JOHNSON of Texas. I guess what I am asking is, is there a way to control the influx of foreign graduate students through the systems at the State level?

Dr. COHEN. No way that I am aware of other than if the State chose to reduce the number of trained positions that it offered available to the foreign medical graduates.

There are, in this country, certified to be trained a large excess of foreign graduate physicians who are eligible for training for whom there are no positions even now available. So the issue is not a question of allowing foreign-trained physicians who were well-qualified and pass all the examinations to gain entrance to the country. The question is how many positions are there for them to—it depends on how dependent the institution is on the funding for Medicare. There is funding for these institutions as well.

Mr. THOMAS. Does the gentleman from Pennsylvania wish to inquire?

Mr. COYNE. Thank you, Mr. Chairman.

Mr. Mullins, in the district I represent, we have 22 hospitals. Some of them are teaching hospitals. We are going to be returning to our districts after this hearing today for a few days and I am sure the people back in our districts are going to want to know, particularly people from the teaching hospitals, how teaching hospitals reimbursed under this plan are going to be able to treat charity cases. What would you respond to them if you were asked that question?

Mr. MULLINS. As I understand it, in the document I read yesterday, there will be a reduction in the indirect medical education funding from about 7.7 percent down to 6.5 to 6 percent between 1996 and 1997, I believe. So there will be some reduction there.

The direct medical education doesn't change except it puts restrictions on funding foreign medical graduates over a period of 4 years.

The disproportionate share portion—and all these funds go to hospitals. The disproportionate share funds are about \$3 billion a year right now and will be reduced in the plan by 25 percent over a 7-year period of time. Then there is an additional fund from non-Medicare funds that will supplement the Medical Education Program.

So I don't have the details of it, but it looks as if it might well be a wash in terms of where we stand right now, or pretty close to it. The disproportionate share hospitals under Medicare are a little different than under Medicaid, but there is an approximation.

Most of the money that comes from disproportionate share comes from the Medicaid Program and not from the Medicare Program.

Mr. THOMAS. Will the gentleman yield briefly for a correction and then we will go forward?

Mr. COYNE. Sure.

Mr. THOMAS. In terms of the direct medical education, it would apply to all foreign medical graduates. It will be for noncitizens, and there will be a phaseout of 25 percent a year over 4 years. It will be taxpayers' dollars not funding noncitizens rather than foreign graduates.

Mr. COYNE. Do you think the administrators of these hospitals ought to be concerned, that is, the teaching hospitals, about the fact that there is no dedicated source of revenue to pay for the obligation of the teaching hospitals to teach doctors?

Mr. MULLINS. The separate trust fund proposed in here is a dedicated fund, very similar, and it does incorporate the current IME, DME funding, as well as adding to it an additional funding that comes from general revenue as I understand it.

Mr. COYNE. So the general revenues will make up any shortfall for those teaching hospitals?

Mr. MULLINS. I don't have that detail, but there will be a fund.

Mr. COYNE. So detail is not a part of the proposal as you understand it?

Mr. MULLINS. Well, not what I have read. It may be there.

Mr. COYNE. Thank you.

Mr. THOMAS. Does the gentleman from Minnesota wish to inquire?

Mr. RAMSTAD. Thank you, Mr. Chairman.

I would like to thank all the witnesses for your helpful testimony. Ms. Hansen. Your testimony corroborated what the General Accounting Office has told us, that if we don't go after the fraud and abuse, it is going to cost taxpayers, beneficiaries of Medicare, about \$138 billion over the next 7 years. That is how much will be lost to fraud and abuse, as you testified and the GAO's study shows.

Your results certainly in terms of fraud detection and prevention techniques have been very impressive. I was wondering if you could briefly describe—you didn't get a chance within the limits of your testimony—if you could briefly describe for the panel the programs you developed to detect and eliminate fraud, and then tell us if you believe the antifraud technology that you have used and developed could be applied more generally to the Medicare system to identify providers with questionable practices and make some of those savings in terms of fraud and abuse.

Ms. JOYCE HANSEN. We actually developed our program 10 years ago so it has evolved greatly. There is a lot of change in the industry today as well as in terms of perpetrators of fraud. We have found the most effective tools and techniques—and we have had a lot of successes—is to use training, training those people that are looking at claims every day.

We have sophisticated investigators that have backgrounds in law enforcement, medicine and claims working together, but what makes a big difference is the technology piece. Two years ago I went to our senior management and said, "The schemes have be-

come so sophisticated that if you do not have technology to detect fraud, you might as well give up on what you are doing." And there are some great systems out there. There are some great services that can be employed. I definitely think that it could be applied toward the Medicare system, absolutely.

The perpetrators of fraud that are hitting the system today are hitting public programs as well as the private programs. The providers are not saying, Well, you know, this is a private carrier so I am going to bill them differently, or this is a carrier that was rendering services for a Medicare patient. And so, the bottom line is we have to look at what is happening here and technology has just proven to be fantastic. It is something that Medicare and the public program should really think about seriously.

Mr. RAMSTAD. Well, certainly that is helpful. We need to bring those kind of advancements into the system and certainly we can't afford to lose \$138 billion to fraud and abuse over the next 7 years. Certainly the seniors of America and the taxpayers deserve much better.

I would also like to ask you about a statement in your written testimony. I know that there are some people around here who believe that somehow magically managed care will eliminate fraud and abuse in health care. You state in your testimony that that is a very common misconception. Could you expand upon that?

Ms. JOYCE HANSEN. Certainly. There is a real misconception out there that now that we have got managed care, we are not going to have any more fraud and abuse. But if you look at it, many of the HMOs and the managed-care entities are offering point-of-service plans where patients are allowed to go to that particular provider and they are billed on a claim-specific basis. So anyone perpetrating fraud can add whatever they want into that claim, billing for services not rendered and falsifying the diagnosis.

In addition, with the HMOs and when you are looking at capitated plans, we strongly believe, and are now starting to find specific evidence, that there is a real problem with underutilization, not having convenient office hours for patients within the plan, not having convenient locations, and that is going to be something that we are going to have to start looking at in the future.

Mr. RAMSTAD. Thank you again, Ms. Hansen, and to the other witnesses as well. I yield back, Mr. Chairman.

Mr. THOMAS. Thank you very much.

Does the gentleman from Michigan wish to inquire?

Mr. LEVIN. I do. I am just going to ask a question of Mr. Ferrara and Ms. Davis because your testimony is in such contrast.

So, Mr. Ferrara, you say the essence of the plan is that it shifts power and control over Medicare away from the government, hospitals, and doctors to the elderly themselves.

Ms. Davis, you say that this plan places beneficiaries at enormous risk. So sum up for us, if you would, we get 1 minute sometimes on the floor, how you would respond to the other on this?

Mr. Ferrara, why don't you take a crack? Why are you at 180 degrees?

Mr. FERRARA. These private options like the medical savings accounts reduce the risk that the elderly face. Under Medicare, they are subject to a lot of out-of-pocket cost. They don't have complete

catastrophic coverage. They have unlimited out-of-pocket coverage, and you can see that the elderly believe this themselves because 70 percent of them shell out a lot of money to get additional coverage to cover that exposure they have under Medicare.

Under this medical savings account, which again, this is Milliman & Robertson's numbers. They are the actuaries. They are like the Harvard of actuarial firms. The most out-of-pocket expenses they would have to pay if they got a fee-for-service plan would be \$1,500 because they have got insurance paying for everything over \$3,000. They have got \$1,500 in the savings account to pay for expenses below \$3,000, so that leaves at the most \$1,500. That is less risk exposure than they have under Medicare, and that is why it is a better program, particularly for the sick, and once you recognize that, there are so many implications that come out of that.

It reduces the dangers of risk selection, for one. It reduces the pressure that you would have on the risk adjustment mechanism so it doesn't have to be as perfect as it might be otherwise, and so that is why I disagree with her statement that it puts them in enormous risk.

Mr. LEVIN. Let her respond. Ms. Davis, tell us why you think there would be an enormous risk for beneficiaries.

Mr. DAVIS. I think if beneficiaries understand what they get when they get into a Medisave account—

Mr. LEVIN. Do you think this whole plan places Medicare beneficiaries at risk?

Mr. DAVIS. I think any time you are fixing what the government is paying and you are not controlling health care costs, the person who is vulnerable to the difference is the beneficiary. So I guess my fundamental concern is savings to the program that are proposed cannot be achieved and without doing anything about the health care system the beneficiaries will be harmed. So that is the broad point.

The specific point on medical savings accounts is that I don't think people want plans with \$3,000 deductibles. Now they have a \$700 hospital deductible, \$100 physician deductible. It is why 80 to 90 percent of beneficiaries go out and buy supplemental coverage. They don't want those deductibles.

But I think we have seen with Medigap policies, you can find an elderly person who, before some of the reforms there, were buying 30 or 40 policies. They just didn't understand what they were getting, and so I am concerned that we could open up to a lot of marketing abuses, get people inadequate coverage, and undermine the whole reason Medicare was started in the first place, which was to make sure that nobody had to worry about bills, nobody was bankrupted by bills, that Medicare was there to provide health and economic security.

Mr. FERRARA. May I respond to that?

Mr. LEVIN. Well, my time is up basically. Thank you.

Chairman ARCHER. The gentleman's time has expired.

Does the gentleman from Texas wish to inquire?

Mr. LAUGHLIN. Thank you, Mr. Chairman. Dr. Mullins, as the vice chancellor of the medical schools at the University of Texas,

could you tell us why teaching hospitals and academic health centers are at risk now when they have been so successful in the past?

Mr. MULLINS. Well, it is because of managed care and the intensity of the managed-care market, which under contract is moving some of their traditional patients away from many of the safety-net hospitals that are in our University of Texas System by group contracting, and potentially can group contract large segments of the Medicaid population which our teaching hospitals have traditionally cared for under the supervision of our faculty.

Mr. LAUGHLIN. Why should Medicare be solely responsible for paying the cost of graduate medical education?

Mr. MULLINS. Well, I personally don't think it should be solely responsible. I would think it should be an all-payer system in which all insurance companies, both public and private, help fund the medical education expense of the country rather than having it just on the Federal tax roll.

Mr. LAUGHLIN. Ms. Hansen, I missed part of your testimony, but I heard part of it where you were talking about managed care. Is there any fraud in managed care? And if so, could you briefly explain the problem?

Ms. JOYCE HANSEN. As I mentioned earlier, there is fraud in managed care. What we see is overutilization and underutilization. Most HMOs and managed-care entities today still offer plans where everything is submitted on a per claim basis, so, you know, it is an open checkbook basically at that point in terms of what kinds of things can be billed for.

From the capitated standpoint, there is a lot of concern about underutilization. Those of us in the detection industry are trying to beef up our staff and beef up our technologies so that we are able to attack fraud from that perspective. It is a real different perspective from what we have worked on for the last 10 years, and I think it is critical that Medicare stay on top of that. HCFA must be able to respond to both types of fraud.

Mr. LAUGHLIN. Could you elaborate on your proactive approach to fighting fraud and what makes your program so unique?

Ms. JOYCE HANSEN. Well, we have been extremely successful over the last 10 years by applying different tools and techniques. Our savings have increased considerably year after year, and it has been such a successful program that we are actually doing these services for other insurance companies, third-party administrators, HMOs, and managed care entities. We are currently discussing some of our services with the State of Georgia in their Medicaid assistance program and trying to help out some of the other payers in the industry today.

I think once we went in and talked about what our savings are and what we can do for people, there has been a lot of interest in applying our techniques so that people aren't reinventing the wheel.

Mr. LAUGHLIN. As I listened to you talk about the examples of chiropractic fraud in Los Angeles, it occurred to me that some of the people involved in paying for the services are more involved in paying for the services than they are in looking for the fraud. Sometimes doctors are more involved in treating patients than they are in looking at their expenses or whether they are getting paid.

Is part of your success the fact that you are specialized at looking for the fraud in the program and paying for patients' service on Sunday when their office isn't open on Sunday? And you had another example, and do you suggest that there ought to be more antifraud specialists within the system rather than expecting the person writing the checks to look for the fraud?

Ms. JOYCE HANSEN. Absolutely. It is a cost-management tool, and our approach has been that we have to put the right tools and techniques in place in order to detect the fraud. So it has got to be at the point that the claim is being reviewed from a payment standpoint or the point prior to that. You have to have the right tools and techniques in place to review the claim at that early point. To pay and chase is not the way to go.

Mr. LAUGHLIN. Just the last 10-second answer to the question. How much money do you estimate your program saves, and where you have investigated or would save in the system?

Ms. JOYCE HANSEN. This year our programs are going to save \$3 million. I did a quick estimate for the Medicare system, and over the next 7 years, applying the tools and techniques I talked about, it is about \$18 billion in savings.

Mr. LAUGHLIN. Thank you very much.

Thank you, Mr. Chairman.

Mr. THOMAS. Certainly.

Does the gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman. I do indeed. First, Mr. Mullins, let me thank you for mentioning the all-payer needs for graduate medical education. Mr. Cohen, I compliment you for the work you have been doing on behalf of the academic centers. As a Congressman that represents Maryland, with an all-payer hospital rate system, I have been trying my best to educate the Committee on the merits of all-payer rate system. Clearly, the example of Maryland and how we finance our hospital reimbursement system is one that offers a lot of merit for other uses, and I strongly support an all-payer revenue source for graduate medical education.

I want to compliment Mr. Thomas, the Chairman of our Subcommittee on Health Care, for recognizing the need to change the way that we finance graduate medical education in our country. I would have hoped we would have had an all-payer revenue source in the Republican bill, but there is an acknowledgment that we need to set up a separate type of funding source for graduate medical education, and I am glad to see that at least in that direction the bill moves us, I think, in a positive step. Enough with the compliments. I now go to some areas of concern.

Ms. Davis, you have helped us in Maryland and always have been extremely forthcoming, I think, on good advice. I am concerned by something in your testimony. You point out something that maybe my constituents don't fully understand, and that is that our elderly pay more for their own health care out of pocket than any other group of Americans. They are the only group that has comprehensive insurance, and yet they have more out-of-pocket costs. You point out that 45 percent of their health bills are paid by Medicare, and that the average out-of-pocket cost is \$2,000 a year.

I guess my question to you, bottom line, if we do \$270 billion in Medicare cuts over the next 7 years, what is likely to happen? If we get that number, if we do \$270 billion, what is likely to happen to seniors' out-of-pocket costs? That is, how much out-of-pocket cost are seniors likely to incur in order to meet their health care needs. Is that number going to go up? Is it going to go up slightly, radically? What is likely to happen?

Mr. DAVIS. Well, I think it will go up just because we aren't doing anything to solve the underlying problem of health care costs, so the hospital deductible at a minimum is going to go up every year. That means Medigap premiums are going to go up. Out-of-pocket costs for prescription drugs are going to go up as well.

One of the things it would be nice to get from the Congressional Budget Office are the premium increases in this bill, how much of the Social Security increases over the next 7 years will be eaten up by that Medicare premium.

The way the Medicare premium works, it is deducted from the Social Security check. So every year there is a slight increase for the cost of living in the Social Security check, but if you are increasing that premium every year pretty substantially, how much of that increase or more is being picked up in the increase in the Medicare premium? So there is some additional information on that that I think is important to get.

Mr. CARDIN. So our seniors are going to receive a larger reduction from their Social Security checks. The Senate Finance Committee Republicans released their plan today and they have higher deductibles and they start the premium increases at lower income levels than the Republicans here. I think they are trying to fill the black box in a more direct way. I guess my point is, you are likely to see our seniors not only pay more of a deduction on their Social Security income, but they are going to have higher out-of-pocket cost either because of copayments and deductible increases or services that are no longer covered or supplemental insurance that they now feel obligated to purchase.

Is that a reasonable assumption? Am I correct in that?

Mr. DAVIS. I haven't had an opportunity to look at the Senate proposal, but I think one of the nice characteristics of the Committee proposal is that it focuses on premiums and not deductibles.

When you increase deductibles, when you increase copayments on home health services, you are targeting your budgetary savings on increased payments from a smaller group of beneficiaries who are already paying the most out of pocket. So it is \$2,000 and average, but if you are a person who is very sick, has heart disease, cancer, you are in and out of the hospital, you may be paying \$3,000 out of pocket. Then, if you have to pay 20 percent of the cost of the home health aide, if you have to have a higher \$150 physician deductible, it is increasing costs on the sick.

So if you are going to have beneficiaries pay more, the question is how much more is it reasonable to ask, spread it over all beneficiaries through premiums, protect the poor beneficiaries by making sure that Medicaid remains to pick up Medicare premiums and Medicare cost sharing for the 4 million poor beneficiaries covered by both programs.

Mr. CARDIN. We don't have Medicaid before our Committee, but the cuts there will also come down. Thank you.

Thank you, Mr. Chairman.

Mr. THOMAS. Does the gentleman from Pennsylvania wish to inquire?

Mr. ENGLISH. Thank you, Mr. Chairman. I appreciate the opportunity. Ms. Hansen, I appreciate your being here and your testimony. I was the first Member of the House to drop in a bill going after Medicare fraud. I think this is a very serious component in this solution because these are costs going out that are simply not received by the beneficiaries. So they are a dead loss to the system.

I don't know if you are aware of it, but the GAO just came out with a new study that I think addresses this, talking about the unnecessary Medicare payments, describing Medicare as an appealing target for abuse, indicating that Medicare does not adequately check claims and does not adequately screen providers for credibility.

One of the examples they use, and I don't know if you have had experience along these lines, a therapy company added \$170,000 to its Medicare reimbursement over 6 months, providing no additional services, by creating a paper corporation.

Medicare, under this report, is scored for its slow and bureaucratic response to problems. And I wonder, looking at the broad sweep, given the fact that the Medicare proposal before us does provide for an exclusion for fraud as my bill does, does not go as far as my bill does in increasing the monetary penalties for fraud. Do you feel we could go further in this bill in cracking down on fraud?

Ms. JOYCE HANSEN. Oh, absolutely. But I think my approach is that there is a lot more that can be caught if you put proactive measures in place versus the reactive penalties. I think it is very—I like the idea that even in this bill the penalties were increased from, I believe, \$25,000 to \$250,000. That is important.

My concern is at the same time we not concentrate so much on the back end, kind of the pay and chase, because in the meantime, there are hundreds of thousands of dollars being lost in the system today that are continuing to flow right through the system. So I think the approach has to be a real balanced approach with an emphasis on the proactive.

Mr. ENGLISH. And I agree with you and again, I appreciate your expertise on this.

Mr. Ferrara, it is a delight to see you here and as always, your testimony is powerful.

Mr. FERRARA. Thank you.

Mr. ENGLISH. You argue that under MedicarePlus, you feel confident that premiums are going to go up only \$7 per month by 2002 for Medicare part B relative to where the President's proposal roughly would put them, and that copays and deductibles are not going to be increasing. You are fairly confident that this system will work and constrain costs within those parameters.

Mr. FERRARA. Let me make a point about that, that in fact, under the proposal from the Republican side on premiums, they will go up in the future at the same rate as they have gone up in the past. They won't go up any faster because it is 31.5 percent of

the part B costs. Premiums are going to go up at the same rate as part B costs.

Medicare premiums have always gone up at the same rate as part B costs. It will be \$7 more per month than if you had reduced the 31.5 to 25 percent, which would be an irresponsible thing to do in the midst of current crisis, but the fact is, the rate of increase will be no greater than in the past.

Mr. ENGLISH. Very good. Let me do a quick followup because I am running out of time. I know that under the MedicarePlus plan, limited enrollment plans, the inclusion of unions and associations being able to participate and offer their own networks and provider-sponsored networks in communities is considered an important part of the solution, and I would like you to amplify on that.

Also, can you say with these networks, should they be regulated in any way at the State level under conventional insurance regulation?

Mr. FERRARA. Well, these other options you describe are important options. They give people the freedom to choose what is best suited to them, and that is why I started out in my comments here—I didn't talk about some of the written points. I think that the plan that the Republicans are offering offers a better system in Medicare for several reasons.

Many of the options are going to offer better benefits than Medicare. The medical savings account option will. As Ms. Davis says, their out-of-pocket costs will go up. Quite to the contrary. Medical savings accounts, out-of-pocket costs will go down.

With many HMOs and managed care plans, out-of-pocket costs will go down, and yet they can get additional benefits from many of those plans as well, such as catastrophic coverage and prescription drugs, and these other options you are talking about are other parts where people have the freedom to choose what best suits them.

Now, I think that most people, in fact, are going to end up picking the medical savings accounts. Ms. Davis says they don't like them. Well, let's just allow people the freedom of choice and we will see who is right 5 years from now.

Mr. ENGLISH. I am out of time. But again, if you could speak to the last part of my question. As part of the oversight of these networks, do you think—

Mr. THOMAS. The gentleman's time has expired.

Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Mr. Chairman, I have no questions of the panel except to thank them for their testimony. However, I do want to caution the Members of the Committee on this whole question of medical savings accounts.

I mean, if you sat and listened to the experts in the previous panel, all that glitters is not gold, and here we have the National Center for Policy Analysis coming forward today. Who funds them, I don't know, but this is a walking commercial for MSAs, and if, in fact, you think they are a good thing, you have a right to say they are a good thing. But, the caution to the Members is, what I see happening here, and the panel has somewhat agreed with me, is that the younger senior, the healthier senior will go into the MSA, will stay there for a period of time, knowing full well that

once age advances, health deteriorates. At that point they are going to opt to go back to the fee-for-service or look around for something else.

So these things are flashes in a pan, and to say that this catastrophic insurance underwriter just wants all these risks, all these unhealthy people in there, that is baloney. I worked for an insurance company years ago before my legislative days. Insurance companies are in it to make money and they don't want risk, an avalanche of risk.

So to think that these folks are just going to have an open door policy to every sick senior in the country, you are full of baloney. They don't want those folks. They want the healthy ones. Once they start popping off in the later years some of the medical costs, they are not going to make money.

So let's not buy this commercial we are hearing from the National Center for Policy Analysis on MSAs because I think we can get burned on them, and clearly in application, we might find out they are expensive and not cost saving for the whole Federal scheme.

Mr. FERRARA. Mr. Chairman, may I respond to that briefly?

Mr. KLECZKA. There wasn't a question, Mr. Chairman.

Mr. THOMAS. The gentleman from Wisconsin says he didn't ask a question. He knows that he didn't ask a question.

Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Ferrara, how long have you been working on this MSA idea?

Mr. FERRARA. I have been working on it for over 10 years, and no matter where I have worked, I have worked in the National Center of Policy Council for 1 year, but I have been working on this study for over 10 years.

Mr. CHRISTENSEN. What companies out there have had an experience with MSAs and are currently using them?

Mr. FERRARA. There are 1,000 accounts. I produced a paper about medical savings accounts which discusses over a dozen examples. One of the best examples is Golden Rule Insurance Co., which uses medical savings accounts for their own employees. And where they have allowed them the choice there at Golden Rule, they have over a thousand employees at Golden Rule, ninety percent of the workers have chosen the medical savings account plan.

They can choose the typical fee-for-service plan instead, but over 90 percent of the workers, sick or healthy or whatever, have chosen the private—the medical savings account plan. And one of the reasons they do this, and that is in answer to this gentleman over here, is that as these studies show, people are not going to stay in medical savings accounts for 5 years and then shift to the HMOs or to Medicare because the medical savings accounts are better for the sick than Medicare plan.

That is what these studies show, and it is not just the NCPA doing this. That is why we had Milliman & Robertson do these calculations for us. They are the actuaries that do these things for the insurance companies. That benefit structure that you see up there on the chart is better for sick people than Medicare for the five reasons I discussed. And that is why when they choose them, they are going to stay with them, and that is the experience, according to

Golden Rule and these other places, sick as well as healthy people have chosen them and stayed with them.

Mr. CHRISTENSEN. Do you think there will be any difference between the private market under age 65 and the emerging MSA for the senior market? Will there be any difference in—did the studies show any kind of difference as far as Milliman & Robertson?

Mr. FERRARA. You see, Milliman & Robertson examined this in the context of seniors, and they have the cost data under Medicare and they have the—they know the incidents of the illness and the cost. And so they were able to calculate this.

There is no fundamental difference in the way MSAs work. The reason why they have such a big impact in cost is because people have control of this money. It is their money in the account. They don't want to waste it. So they have a new cost incentive now that they don't have under traditional insurance. Because they have this incentive, even more importantly, the doctors and hospitals will start to compete because the patients will now be concerned about cost as well as quality.

Mr. CHRISTENSEN. You have studied this for over 10 years. There are over a thousand companies using this. In your opinion, is there any area of the MSA idea that could be gamed in the system, either by insurance companies or by individuals? Where do you think we need to focus if there is an area of weakness in the MSA approach?

Mr. FERRARA. Well, there is no danger, gaming it under the rules that I know the Committee staff has sort of developed, to apply this option. The rules you need to say is that the company has to accept everybody who comes out of Medicare who chooses them. They can't just take the healthy and refuse the sick. The company has to accept guaranteed renewability, which means if they want to stay with the plan, they have to stay with the plan, that whatever premium they set for people who are in their plan already from year to year cannot be different for some people than for others.

As long as you have these basic rules that the Committee staff has developed, then there is no risk of gaming the system.

Mr. CHRISTENSEN. I wanted to follow up on Representative English's last question about the State regulations and the provider-sponsored networks complying with them or not complying with them. Where do you see the problem there? If the insurance companies have to comply with State regulations and the provider-sponsored networks don't have to comply, will there be a problem or potential problem there?

Mr. FERRARA. Well, I am not as expert on PSNs as on the MSAs. What I could say is that I think you should examine the degree to which the provider service networks are different than the insurance companies, so that where regulation is not necessary to apply to them, that they not be burdened unnecessarily with the same regulation.

On the other hand, you don't want to give them an unfair advantage over other providers in the market. You want to put all the providers on a level playingfield. So within those two principles, I would have to examine the details more to give you a definitive answer.

Mr. CHRISTENSEN. Ms. Davis, were you one of the members of the task force last year on health care?

Mr. DAVIS. No, I was not.

Mr. CHRISTENSEN. Thank you.

Thank you, Mr. Chairman.

Mr. THOMAS. Does the gentleman from Georgia want to inquire?
Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Ms. Davis, earlier this week, the Republican proposal eliminated Medicaid. They are replacing it with block grants. How would that affect senior citizens, the elderly?

Mr. DAVIS. Two-thirds of Medicaid spending goes for the elderly and disabled. So first of all, if you have on average 30 percent cuts in Medicaid funding in the year 2002 relative to what it otherwise would have been, two-thirds of that is coming out of benefits for elderly and disabled people.

The provisions in Medicaid that are particularly important for Medicare beneficiaries are, first of all, anyone below the poverty level is eligible to have their full Medicare premium, their Medicare hospital deductible, their physician deductible and coinsurance picked up by Medicaid. As I understand it, that is not protected, particularly the cost-sharing provisions, in the block grant as the Commerce Committee has considered it.

In addition, Medicaid picks up prescription drugs for low-income elderly and disabled beneficiaries. That wouldn't be protected specifically. It has provisions which are called spousal impoverishment. If your spouse goes into a nursing home, people in the past were driven into poverty because it ate up all of their own income and assets. There is protection for that in the Medicaid law. I don't believe that has been protected in the new block grant provisions.

There are quality standards on nursing homes. Those aren't being protected in the new block grant. There is no guarantee that the funding is actually there for nursing home and home health and other long-term care services.

So I think there are a lot of interconnections between Medicaid and Medicare that people don't realize and that a block grant will affect it.

On the provider side, if you are cutting payments to hospitals for disproportionate share and you are squeezing the DRG payment rate and the States are forced to cut as well because they have got less money to work with, the payment rates to hospitals, and you have got a growing number of uninsured, who are going to certain kinds of public hospitals or others for care, you are going to have real financial problems to have all of these things hitting public hospitals, community health centers, and other institutions that serve low-income communities all at once.

Mr. LEWIS. Thank you very much, Ms. Davis.

Mr. Ferrara, could you tell me, I know you think this is a good deal. You came across as a believer. Do you believe there is a strong role for the National Government to play in the delivery of health care to all of its citizens?

Mr. FERRARA. Yes. I think that the government, Federal and State working together, should develop policies that will assure that all citizens will have access to health care, and we have writ-

ten on this in how you can have universal—effectively what we call universal coverage through a private market system.

Mr. LEWIS. What are your feelings about delivering health care using block grants?

Mr. FERRARA. Well, in terms of Medicaid, we support block granting Medicaid to the States because we think that the—in Medicaid, you have a special—the greatest difficulty, because you have got a conjunction of health care problems and welfare problems, so you have got a tremendous mix of problems.

We think the welfare system as a whole needs to be revised from the ground up, and that Medicaid is a central part of that system, and that it ought to be integrated with the entire system. We think the States ought to have the freedom—we think all the major welfare programs ought to be block granted to the States: AFDC, food stamps, housing, and so forth, and allow the States to redesign integrated programs, taking all those factors into account.

What I would do if I was Governor of a State with a Medicaid block grant, my program would be a voucher program. I would give all the people at the lowest income level a voucher that they could use to buy any plan in the private sector that they chose. This would be much better for low-income beneficiaries because they would be free to participate in the same middle-class health care system as everyone else.

Under Medicaid today, because assistance reimbursements are so low, they are often shunted off into second-class health care. They don't have the same access to care and quality of care as the middle class.

If they had a voucher system, they could go to Blue Cross, they could go to a medical savings account, they could go to a managed care plan if they want, the same ones as the middle class, and participate in the same system.

This is one area where—I am very fiscally conservative as you might guess, but this is one area where——

Mr. THOMAS. The gentleman's time has expired. One sentence.

Mr. FERRARA [continuing]. This is just one area where I would try to assure that there were enough funds so that no one would have inadequate financing to purchase essential health coverage.

Mr. LEWIS. Mr. Chairman, since the witness went on so long, let me just have another question, another minute here.

Mr. THOMAS. Without objection, Mr. Lewis gets to ask the last question.

Mr. LEWIS. You do believe in certain national standards. You wouldn't want the people in Alabama, Mississippi, or Georgia to have a different quality of health care than the people in California or New York?

Mr. FERRARA. Well, I would not want them to have a different quality of health care, but I don't believe the Federal Government is able to deliver that. I believe that the same people who are electing Congressmen and Senators are also electing State legislators, and if they can be trusted to elect Congressmen and Senators who will take into account the interests of all the people, they can be trusted to elect State representatives who will take into account the interests of all the people, and, therefore, I believe that these

State governments will adopt sound policies with the block grant program.

Mr. LEWIS. Mr. Ferrara, in another period of our history, we had a concepts of States' rights, and some people were mistreated during that period and weren't treated so well.

Mr. THOMAS. And the gentleman's time has expired.

Mr. FERRARA. I support national civil rights standards.

Mr. THOMAS. Does the gentleman from Virginia wish to inquire?

Mr. PAYNE. Thank you very much, Mr. Chairman, and I want to thank these witnesses for their testimony.

Mr. Chairman, I wanted to thank you as well for the work that you have done on graduate medical education and the concept that is being put forth now, and I look forward to seeing the bill and the details at some early time, but I do appreciate the work you have done.

And I yield back the balance of my time.

Mr. THOMAS. Since I didn't take any time earlier, I wanted to say several things.

Miss Davis, I was pleased to see that there is at least one portion of this plan you like. That is, that we focus on the premiums and put in prospective payment structures for home health care and others and stay away from the deductibles and the copays that others had suggested.

Ms. DAVIS. I also mentioned the importance of information. I think it is important as choices are given to Medicare beneficiaries to make sure that there are quality standards and good information. So I think that is an important provision.

Mr. THOMAS. We are going to an educational program. That is one of the reasons we didn't go to a voucher program, because we wanted to maintain that contract relationship with the Federal Government for our seniors. But today you can turn over a program every 30 days.

What we want to do is provide a model, using the Federal employees health benefit program, which would give you a layout of what it is that is offered. In that context, I think you will find Mr. Ferrara's program as an option. There are a number of asterisks in the various categories where programs would offer benefits with an explanation for what it was.

Right now, seniors are signed up for the fee-for-service program by doing nothing in essence. We don't even educate them about coordinated care and managed care options. That, I think, is the fault of the current system. We are going to make sure that we have adequate information for our seniors. I know you are concerned about those folk, and I just hope you will focus on some portions of this new program which emphasizes I think some things that in prior hearings we have talked about that you had concerns about.

Ms. DAVIS. I did mention I do like the formal annual enrollment process. I think it is important we are talking about a benefit package that is as good as the Medicare package, that we are talking about a real delivery system like a health maintenance organization and not an indemnity or a catastrophic health plan.

But I think the notion of letting people know what choices there are, giving them information on how consumers feel about those HMOs, what they have experienced with them, that those would be

good measures. But I think we ought to move slowly about expanding what is an eligible managed care organization under Medicare. I think there is some merit to expanding it to the point-of-service option for HMOs, but as for very loosely organized managed care plans, I think until we have better quality standards, better enforcement mechanisms, and a better way of setting the capitation rate that we shouldn't move too quickly in that direction.

Mr. THOMAS. And you heard the previous panel in terms of their concerns, and we are working together to make sure that we try to coordinate them.

Dr. Mullins, in your testimony I heard some fairly good comments and then in terms of responses I was concerned. I would ask unanimous consent to submit for the record a letter from the Association of American Medical Colleges signed by Dr. Cohen which says, in part, the AAMC, the Association of American Medical Colleges, endorses the trust fund concept and applauds the House Ways and Means and Commerce Committees for their commitment to the clinical training of future health care providers.

[The information follows:]



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Jordan J. Cohen, M.D., President

September 21, 1995

Honorable William B. Thomas
Chairman
Subcommittee on Health
Committee on Ways and Means
House of Representatives
2208 Rayburn House Office Building
Washington, D. C. 20515-0521

Dear Mr. Chairman:

The Association of American Medical Colleges (AAMC) understands the difficulty Congress and the Administration face in their efforts to preserve and protect the Medicare Trust Fund. We continue to be concerned that sharp reductions in the rate of growth in the Medicare program could have a major impact on the U.S. health care system. Moreover, the changes being contemplated would have especially profound effects on the nation's medical schools and teaching hospitals.

Proposals now being advanced in the House of Representatives have been designed to attenuate some of these effects by recognizing that teaching hospitals face unique challenges in maintaining their crucial missions of patient care, education and research in the new, fiercely competitive health care marketplace. Indeed, Medicare's present method for calculating the adjusted average per capita cost (AAPCC) to establish rates for Medicare risk contractors includes the graduate medical education and disproportionate share payments intended for teaching hospitals under Medicare fee-for-service. Diverting these payments away from teaching hospitals accentuates the competitive disadvantages they face.

The Republican Leadership, the Ways and Means Committee, and the Commerce Committee have devised a plan to establish a trust fund that is intended to assist teaching hospitals in meeting the special costs associated with their education mission. The AAMC endorses the trust fund concept and applauds the House Ways and Means and Commerce Committees for their commitment to the clinical training of future health care providers. Our hope is that this innovative proposal will be a first step toward establishing the principle of shared responsibility and toward creating an all-payer approach to equitably financing clinical training.

Sincerely,

Jordan J. Cohen, M.D.

Mr. THOMAS. Do you like what we are trying to do in terms of getting away from Medicare being the funder for medical education and trying to move to another system or should we just kind of not spend more time in that area and leave it the way it is?

Dr. MULLINS. No, sir, I think it is a wonderful concept, and I support it 100 percent.

Mr. THOMAS. That is sufficient. I thank you very much.

Any additional questioners?

I want to thank all of you for your testimony.

The Chair has been informed that several of our witnesses are beginning to bump into transportation concerns, based upon the amount of interest Members have shown in each of the panels in their discussion. So, without objection, the Chair would suggest that we combine the next panel of senior citizens and the panel after that so that we would have one panel. Is there any objection?

Mr. GIBBONS. Reserving the right to object, Mr. Chairman.

Mr. THOMAS. The gentleman from Florida.

Mr. GIBBONS. And I don't want to prolong this any longer than we have to. But I can't help feeling a little resentment toward Chairman Archer and the Republicans on the Committee for having tried to cram all of this in 1 day. We took 5 hours to hear three witnesses. We have 20 witnesses scheduled here. I don't know where Chairman Archer is. The rumor is he has taken off and gone to Texas. If so, I hope he has a nice trip.

Mr. THOMAS. Does the gentleman object to combining the panels?

Mr. GIBBONS. Reserving the right to object, Mr. Chairman, and I may object if I get pushed too hard.

Mr. THOMAS. Well, it is your call.

Mr. GIBBONS. Reserving the right to object. I think it is ridiculous that these hearings were scheduled like this and planned like this. This is an imposition upon the witnesses. It is an imposition upon the American public because—

Mr. THOMAS. The gentleman is taking additional time from the panel so that we can question them. Does the gentleman object?

Mr. GIBBONS. The gentleman may object if you keep pushing me too far, Mr. Thomas.

Mr. THOMAS. Your point is being lost by the time that you are consuming. I thought we wanted to move on.

Mr. GIBBONS. Chairman Archer—Mr. Thomas, if you push me too far I am going to object. I am using this time to express my indignation for the way you, the Republicans, and Chairman Archer particularly arranged this hearing and jammed it down our throat. We are not examining any legislative material. Everybody is coming here with a wish list. And the only thing they have to go off of is some press release statement that some public relations firm put out for you all.

This is a ridiculous hearing. It has been drawn to the ridiculous extreme. The best testimony of that is that the Chairman, who called all this, has taken off and gone somewhere. It doesn't make any sense. It is not good government. It is not what ought to be done for the American people. We have got 40 million people whose life and whose health depends on this program. This is a serious, serious matter, and these hearings are just a farce.

Mr. THOMAS. The Chair will renew its request. Is there any objection to combining the two panels because of the witnesses scheduled?

The Chair hears no objection. The first panel then was to be Mr. Lehrmann, president of the American Association of Retired Persons; Mr. Hansen, vice president, Government Affairs, Seniors Coalition; and Hon. Beau Boulter, former Member of Congress, Legislative Counsel, the United Seniors Association.

If the Chair might then request Mary Nell Lehnhard, senior vice president of Blue Cross & Blue Shield Association; Karen Ignagni, chairman and chief executive officer of the Group Health Association of America; and John Troy, executive vice president, Health Insurance Association of America, if they would come to the table as well.

Thank you all for attending. I believe every one of you, perhaps with one exception, have been in previous health care Subcommittee meetings. We welcome you in front of the full Ways and Means Committee. Any written testimony that you may have will be made a part of the record, and you will have 5 minutes in which to inform the Committee in any manner that you see fit.

And I guess the most appropriate way would be, Beau, to start with you, and then we would move across the panel.

STATEMENT OF HON. BEAU BOULTER, LEGISLATIVE COUNSEL, UNITED SENIORS ASSOCIATION, INC.; AND FORMER MEMBER OF CONGRESS

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

I just want to thank Members of the Committee and especially your Subcommittee for this Republican proposal. I mean it is a Republican proposal. I don't know what else to call it. I do thank you for allowing the United Seniors Association to participate in the process so far.

I look back to the time that started last July, and it seems like since then through the August work period and up until now that the understanding of the American people and especially the senior community has been raised by your effort in spite of a lot of attacks. And so I just think in the weeks ahead that it is going to be important for you and all of us to keep educating people.

I don't think that they used to know, for example—and I think this is important to understanding the senior community. They didn't know that an average couple retiring in 1995, for example, would take out of the Medicare system \$117,000 more than were paid in in premiums and taxes. They didn't know that. They didn't know that Medicare expenses were growing at 10.5 percent, but Medicare population only grows at 1.5 percent. That is a 9-percent-per-year increase on each beneficiary. That simply is not sustainable.

And so facts like these have been coming out, and I think it has helped the cause a lot. I think a lot of people now understand that Medicare is not being cut, that the growth is being reduced because it is simply unsustainable. So, to me, the only other choice that you had, given the trustees' report and given the fact that the baby boomers are going to be retiring in 2010 or so, the only other choice

you had was to raise taxes or reduce benefits drastically, and that was not a good choice.

So I want to thank you for the United Seniors Association. We have had our plan; and I hope, Mr. Chairman, if there is no objection that it might be made a part of the record. It is written by Dr. Peter Ferrara.

I am pleased to say that while we do not agree by the way with everything in your proposal, I mean we think it could be improved and hope it will be, still the fundamentals of our plan coincide with the fundamentals of your plan. And mainly it gives control of funds to the seniors. It gives them choice.

We were a big supporter of the medical savings account. I cannot talk as fast as Dr. Ferrara, being as I am from west Texas, but he wrote this and would like it in the record if there is no objection.

Mr. CRANE [presiding]. Without objection, so ordered.

[A Proposal for Reform: Resolving the Medicare Crisis is being held in the Committee's files.]

Mr. BOULTER. We think it will be a good deal.

We participated in many of your townhall meetings and focus groups. We have a national television show. We are in contact with seniors is what I am trying to say, and I believe that because of the work that is being done that seniors will give you very strong support.

We thank you. We are pretty pleased and appreciate the opportunity to participate.

[The prepared statement follows:]

**Testimony of The Honorable Beau Boulter
on behalf of United Seniors Association, Inc.**

**Before the
House Ways and Means Committee**

**Hearing on Saving and Reforming Medicare
Friday, September 22, 1995**

Chairman Archer and Members of the Committee, I am Beau Boulter, Legislative Counsel for the United Seniors Association (USA, Inc.). I want to thank you for the opportunity to testify today on the critical issue of saving and reforming Medicare.

As we all know, the Medicare system faces an impending financial collapse. Indeed, Medicare Part A starts going bankrupt next year, with outlays exceeding revenues collected from the 2.9% payroll tax. The Medicare Trust Fund is expected to be exhausted in 2002.

While some individuals have questioned the seriousness of Medicare's financial condition, the conclusions by the program's Board of Trustees, including three members of President Clinton's cabinet, are exceptionally clear and unambiguous. In order to save Medicare it must be reformed now. To fail to do so will result in a fiscal catastrophe, and only make the future changes that much more painful and severe.

As a former Congressman, I know that it is difficult dealing with issues such as Medicare. One only has to recall the fight over the Balanced Budget Amendment and the efforts by many to scare seniors, claiming that if passed, their Social Security would be endangered.

It has taken courage to make the hard decisions needed to begin a systematic reform of Medicare because there are those who will attack any changes for political reasons. Such as it is, there are those who see political advantage in scaring seniors.

Those who do this - who do it in the full knowledge that a failure to act now could doom this system to bankruptcy - are cynically exploiting the fears of those they claim to be protecting. The facts are the long term impact of your reforms will effectively rebut and eventually discredit such attacks.

I believe that adopting reforms to strengthen, and yes, improve Medicare will ultimately give you the credit you deserve from America's seniors. To do nothing now would simply be irresponsible and a disservice to seniors as well as their children and grandchildren. Our members, and I believe seniors in general, weren't born yesterday. They know that to really protect their legitimate interests we have to recognize these problems and work with you to find solutions to them.

That is why in June of 1994 USA, Inc. put forth a comprehensive and responsible plan to deal with Medicare's financial crisis. Our plan had several key components, many of which appear to be in the House Republican proposals. Our plan would implement market-oriented reforms that would fundamentally change Medicare's structure and improve seniors' access to high quality, affordable health care.

The essence of the House Republican plan is that it shifts power and control over Medicare and its funds away from the government, the hospitals, the doctors, the politicians and the bureaucrats to the elderly themselves. By doing so, you give seniors the best of all worlds through a wide range of choices, including: staying in the traditional fee for service Medicare; various managed care arrangements; and other private options, including a Medical Savings Account. The advantage of giving Medicare recipients additional choices is that by doing so you will generate competition, which will help slow the growth in Medicare's costs. With Medicare's costs rising 10.5% a year, it's the only alternative to the current command

and control system.

Just as important, you allow the elderly to take advantage of the incentives, competition, efficiencies and innovation of the private sector. Because of these factors, it is likely that many of the private plans will provide better benefits than Medicare. While opponents might question this assumption, we believe that if the plan is implemented, millions of seniors themselves will opt for choices not open to them today.

For those who stay in the traditional fee for service Medicare, the House Republican plan calls for no changes in copayments, deductibles or the rate paid by beneficiaries for Part B premiums, which is currently 31.5%. While the latter point is appropriate, considering Part B's exploding costs, USA, Inc.'s Medicare reform plan called for raising deductibles as opposed to premiums.

Today, Medicare encourages over-consumption of medical services through low deductibles and coverage of routine care. Our approach would replace the current benefit structure with comprehensive coverage of all listed benefits once beneficiaries have satisfied a reasonable deductible.

No one wants to pay more for anything, but most seniors will pay more for better coverage if they know that by doing so, they are saving the system on which they rely.

Raising deductibles should not be a hardship on the elderly. Considering the premiums that seniors pay for Medigap policies, combined with capping future Part B increases, seniors would have significant cash reserves to pay the higher deductibles. However, you should know that we also advocate special assistance to help low income seniors handle these higher payments.

Our proposal would also allow the Medicare deductible to increase in the future to cover real cost increases. While none of us want to see this happen, we see it as necessary to real reform. We also propose expanding current IRAs to allow baby boomers and younger workers to save now in preparation for the deductibles they will pay after retirement.

There are several other components of the House Republican plan that we enthusiastically support. One is the fact that it deals with Medicare's financial problem without raising taxes. Already the 2.9% payroll tax is a disincentive to hiring workers and onerous to those who are employed. Raising taxes is the escape door to be used by those who refuse to implement market-oriented reforms. And it is a dangerous door to open.

While these increases do not directly affect retired seniors, imposing an unreasonable tax burden on younger working Americans has serious political as well as economic consequences. We are concerned about anything that increases inter-generational tensions, which are good for neither our country nor for our seniors.

The other area of great concern is waste, fraud and abuse. As USA, Inc. testified before the Commerce Subcommittees on Health and Environment and Oversight and Investigations, this problem poses a clear and present danger to the Medicare program.

It is clear that tougher penalties and additional resources for law enforcement and auditing are desperately needed to combat fraud. In addition, doctors, labs and equipment providers found guilty of fraud should be permanently disbarred from participating in the Medicare program.

In addition to the steps outlined above, a system must be established whereby Medicare's beneficiaries are rewarded for rooting out waste, fraud and abuse. It is evident that the government can't solve this problem alone. Rewarding beneficiaries who expose waste, fraud and abuse will go a long way toward eliminating this problem.

In conclusion, we believe that the House Republican plan is a giant step in the right direction. It allows us to avoid the otherwise certain bankruptcy of Medicare in 2002, provides choices and control for seniors over their health care plans and benefits, and will greatly improve the quality of care available to them.

Through our town hall meetings, newsletters, national television show and letters we get from seniors, we know that seniors are concerned not only about their benefits but for the world their children and grandchildren will inherit. Many also know that Medicare needs to

be fixed, that something is wrong, and that they will bear the burden if the system collapses under its own weight.

In this town, Mr. Chairman, the conventional wisdom is that seniors are unreasonable when it comes to dealing with "their" programs. Well, we also know that the conventional wisdom is often wrong. Your plan is one that we believe will garner support from seniors around the country.

Thank you.

Mr. CRANE. Thank you both.
Mr. Hansen.

**STATEMENT OF JAKE HANSEN, VICE PRESIDENT,
GOVERNMENT AFFAIRS, SENIORS COALITION**

Mr. JAKE HANSEN. Well, thank you, Mr. Chairman.

My name is Jake Hansen, and I am vice president of the Seniors Coalition, an organization representing over 2 million older Americans.

I want to take this opportunity to thank the leadership of the House for the work and effort that has gone into developing the Medicare Preservation Act. It is a dramatic step which will improve the health care and lives of older Americans throughout the country. It took a great deal of courage on the part of those who drafted this bill, courage to face head on the impending catastrophe that Medicare's bankruptcy would cause and the courage to tackle the mammoth bureaucracy and reshape it into a system that is both flexible and responsive.

Our members and supporters, Mr. Chairman, want and need real change in the way Medicare operates. They demand that Medicare be saved and not through some quick-fix or hocus-pocus cost shifting that merely puts off the disaster until after the next couple of elections.

Seniors are real people. They are not an objectified population group. They are extremely diverse in their opinions, habits and needs, more different perhaps than they are alike, and no one group or organization, not even the Seniors Coalition, speaks for all of them. We recognize and honor such diversity among younger people, yet we have not tolerated it among the Nation's elderly. We have told them that they must adopt their needs to a one-size-fits-all plan regardless of their health status, geographic location, financial acumen, or personal wishes and values. We have disenfranchised them as consumers of health care, and they are fed up.

We celebrate the introduction of a bill which restores full citizenship to America's elderly.

We are particularly pleased to see real, substantive, and positive change in the following areas:

One, providing real choice to seniors for the first time ever.

Two, using competition to control costs and encourage the addition of more benefits such as coverage for prescription drugs and eyeglasses.

Three, restoring to seniors the power of the purse in their health care expenditures.

Four, safeguarding the health of seniors through reasonable, not burdensome regulations of health care providers.

Five, offering complete consumer protection and creating a health care buyers' market, for the first time, through the provision of annual open seasons.

Six, empowering and rewarding Medicare beneficiaries for policing their bills and establishing stiffer penalties for those who would take advantage of them.

Seven, creating a solution that will force no one to leave traditional Medicare unless they so choose.

Eight, resisting the easy way out by refusing to increase copayments or deductibles.

Nine, boldly increasing Medicare spending per senior by nearly \$2,000 over the next 7 years.

And, 10, making all participants in the Medicare system, patients and providers, responsible for addressing the skyrocketing costs of health care and giving them the tools to do something about it.

The Medicare Preservation Act is the most important development in health care for seniors since Medicare was enacted 30 years ago, and it will no doubt be a legislative landmark in health care reform. We welcome the opportunity to participate in the advancement of this extraordinary measure.

Thank you.

[The prepared statement follows:]

**STATEMENT OF JAKE HANSEN
VICE PRESIDENT, SENIORS COALITION**

Mr. Chairman,

Thank you for inviting me to speak today. I am Jake Hansen, Vice President for Government Affairs of The Seniors Coalition, an organization representing over 2 million older Americans.

Mr. Chairman, I want to take this opportunity to thank the leadership of the House for the work and effort that has gone into the development of the Medicare Preservation Act. It is a dramatic step which will improve the healthcare and lives of older Americans throughout the country. It took a great deal of courage on the part of those who drafted this bill -- courage to face head on the impending catastrophe that Medicare's bankruptcy would cause and courage to tackle a mammoth bureaucracy and reshape it into a system that is both flexible and responsive.

Our members and supporters, Mr. Chairman, want and need real change in the way Medicare operates. They demand that Medicare be saved, and not through some quick-fix, hocus-pocus cost shifting that merely puts off the disaster until after the next Presidential election or two.

Seniors are real people Mr. Chairman, they are not an objectified population group. They are extremely diverse in their opinions, habits and needs... more different, perhaps than they are alike, and no one group or organization, not even my own, speaks for all of them. We recognize and honor such diversity among younger people, yet we have not tolerated it among our nation's elderly. We have told them that they must adopt their needs to a one-size-fits-all plan regardless of their health status, geographic location, financial acumen or personal wishes and values. We have disenfranchised them as consumers of healthcare and they are fed up.

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We are particularly pleased to see real and substantive form in the following areas:

- 1) Providing real choice to seniors for their first time ever;
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- 3) Restoring to seniors the power of the purse in their healthcare expenditures;
- 4) Safeguarding the health of seniors through reasonable, not burdensome regulations on healthcare providers;
- 5) Offering complete consumer protection and creating a healthcare buyers market -- for the first time -- through the provision of annual open seasons;
- 6) Empowering and rewarding Medicare beneficiaries for policing their bills and establishing stiffer penalties for those who would take advantage of them;
- 7) Creating a solution that will force no one to leave traditional Medicare unless they so choose;
- 8) Resisting the easy way out by refusing to increase co-payments or deductibles;
- 9) Boldly increasing Medicare spending per senior over nearly \$2000 over the next seven years;
- 10) Making all participants in the Medicare system, patients and providers responsible for addressing the skyrocketing costs of healthcare -- and giving them the tools to do something about it.

The Medicare Preservation Act is the most important development in healthcare for seniors since Medicare was enacted 30 years ago and will no doubt be a legislative landmark in healthcare. We welcome the opportunity to participate in the advancement of this historic measure.

Mr. CRANE. Thank you, Mr. Hansen.
Mr. Lehrmann.

**STATEMENT OF EUGENE LEHRMANN, PRESIDENT, AMERICAN
ASSOCIATION OF RETIRED PERSONS**

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

Good afternoon. I am Gene Lehrmann from Madison, Wisconsin. I am the president of AARP, the American Association of Retired Persons.

I appreciate the opportunity to testify on the restructuring of Medicare. Today's hearing provides an important opportunity to learn more about the House leadership's proposal.

Because the plan is still unfolding and there is much detail that we do not have, I will focus on what we know so far. AARP will continue to analyze the proposal as more details are made available.

The stability of Medicare and its ability to offer quality, affordable health care to older and disabled Americans is of premier importance to AARP and our members. Our previous testimony has underscored our conviction that \$270 billion in Medicare spending reductions is too much, too fast. We are deeply concerned that it is more than the program can absorb. Moreover, according to the trustees' report, it is far more than is necessary to keep the trust fund solvent for the next 10 years.

We are also troubled by how the \$270 billion would be achieved. The proposed cap on Medicare fee-for-service spending raises serious concerns about how much savings would be generated through this mechanism and what the effect would be on beneficiaries. We caution you about adopting a cost containment structure that would create hidden costs and access problems for Medicare beneficiaries.

AARP continues to believe that the long-term strength and stability of Medicare would be best preserved and protected through a two-stage approach. First, we could trim roughly \$110 billion from part A spending, then move to the second step of making changes in the program to address the needs of the soon-to-be-retiring baby boomer generation.

With respect to specific reforms, we are pleased to see that the House leadership proposal takes some steps to limit direct increases in beneficiary out-of-pocket costs, maintain the current Medicare benefit package, and continue the current fee-for-service option. We are concerned, however, about what protections would be in place for low-income Medicare beneficiaries, particularly those who now rely on Medicaid's QMB protection.

AARP also urges you not to overlook indirect beneficiary out-of-pocket costs which also jeopardize the financial security of older persons. We are particularly concerned about the additional costs that could result from relaxing or eliminating the Medicare balanced billing limits, and we are troubled by the fact that the proposal does nothing to fix and, in fact, it worsens the problem with beneficiary hospital outpatient coinsurance.

The leadership proposal suggests that Medicare beneficiaries would have a greater range of coverage options. While AARP supports a broader range of coverage, Medicare choices, we need to

know much more about how these new plans would work and the long-term effect on beneficiaries. We have included specific questions in our written statement.

Over the course of the next few weeks, as we learn more about the House leadership plan, we will educate our members about what the changes would mean to them as we seek their input. Medicare beneficiaries need to know what changes are being proposed, what they are designed to build upon, not erode promise of financial protection and solid health care coverage now and in the future.

It is in everyone's interest that we take the time to explain this proposal to the Medicare beneficiaries and their families. Rushing forward will not yield good policy. Ultimately, AARP wants to ensure that we achieve a stronger, healthier Medicare for current and future generations.

Thank you very much, Mr. Chairman.

[The prepared statement follows:]

**STATEMENT OF EUGENE LEHRMANN
PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS**

Good morning. I am Gene Lehrmann from Madison, Wisconsin. I am President of the American Association of Retired Persons (AARP). I appreciate the opportunity to testify before the Committee on the restructuring of Medicare.

Today's hearing provides an important opportunity to learn more about the House Leadership's proposal. Since no bill language is available and we have only had an opportunity to review the summary of the plan, many questions about what the proposed changes will mean to the Medicare program and to beneficiaries remain unanswered. Medicare beneficiaries need all of the facts -- and adequate time to consider them -- in order to make informed judgments about the proposal.

Members of the Ways and Means Committee, along with the House Commerce and Senate Finance Committees and the President, are the elected "Trustees" of the Medicare program. Older Americans, our members and your constituents, will look to you to make sure that any changes to Medicare are made cautiously, carefully, and in the interest of strengthening Medicare for current and future beneficiaries and their families.

When AARP testified before this Committee in July, we raised several issues and questions about proposed changes to Medicare. Our testimony today revisits many of these issues based on what we now know about the House leadership proposal.

Trust Fund Solvency

Before I comment on specific program changes, I want to reiterate the Association's position on the proposed Medicare spending reductions. AARP continues to be concerned that the \$270 billion in Medicare spending reductions -- whether they are called "cuts" or "slowing the rate of growth" -- is beyond what the program can absorb without jeopardizing quality and access and without endangering the ability to achieve real program reform. It is also more than is necessary to keep the HI Trust Fund solvent for the next ten years. In short, it is too much, too fast.

The spending cuts needed to hit the \$270 billion Medicare target -- along with the \$182 billion Medicaid target -- are also a serious threat to our national health care delivery system. We should move with caution in our efforts to slow the growth of health costs in ways that do not jeopardize access, quality or affordability.

Ensuring the stability of Medicare remains a high priority for AARP. We recommended in previous testimony that Congress address the solvency issue in a two-stage process -- first, assuring solvency for the next decade; and second, proceeding on a separate track to deal with the longer-term financial stability of the program.

The first step -- assuring solvency in the program for the next ten years -- would return Medicare to its historic average term for solvency as reported in the annual Trustees' Report. The 1995 Trustees' Report indicates that Part A savings of approximately \$110 billion over the next seven years would improve the near-term status of the fund by delaying until 2001 the date when the program has to begin dipping into reserves. This spending reduction would extend the life of the Fund through 2005 -- a decade from now -- and even with some Part B savings would be far less than the \$270 billion in Medicare spending reductions in the Budget Resolution.

Extending the near-term solvency of the Trust Fund would provide sufficient time for Congress to move to the second stage. This second stage includes engaging the public -- particularly the baby boom generation -- in a discussion about Medicare's future and then crafting the best policy for longer-term financial stability. The public needs time to understand how proposed changes in Medicare could affect them and their families. Public opinion research conducted by DYG, Inc. for AARP, clearly demonstrates that Medicare is as vital to financial security in retirement as Social Security.

For the average older person, the fact that Medicare helps to provide affordable health care ensures that they don't have to be dependent on their children.

Fail-Safe Mechanism

The size of the spending reductions in the Budget Resolution also raises the question of how these reductions are to be achieved. The proposed "fail-safe" mechanism included in the plan is more than a means to assure "scorable" savings which might otherwise occur from increasing the number of beneficiaries enrolling in managed care plans. It now appears to be an outright cap on spending in the traditional fee-for-service program with little apparent relationship to actual movement into managed care. As we understand it, the fail-safe mechanism has serious potential for eroding traditional fee-for-service Medicare.

Formula-driven approaches to budget cutting have always concerned AARP, in part, because of the rigidities they build into the system and their inherent potential for error and misestimation. For example, the Committee proposal requires the Secretary to estimate how much will be spent on "Medicare Plus" each year and subtract that from the benefit budget. This seems to put the fee-for-service program at risk under the "fail-safe" if the Secretary overestimates the shift into Medicare Plus. Does the Committee bill contain any mechanism for correcting such mistakes?

Allocating the benefit budget among various sectors of the fee-for-service program -- inpatient hospital, physicians' services, etc. -- can also produce distortions. Allocations based on current spending patterns fail to reflect the rapid changes occurring in the health care delivery system. On the other hand, allocations based on a five-year trend line -- while less static -- will often lag behind what the current trend actually is. How does the Committee bill address these problems?

Direct Beneficiary Out-of-Pocket Costs

We are pleased to see that the House Leadership proposal takes an important step to limit direct increases in beneficiary out-of-pocket costs. According to the outline, as well as statements by the Speaker, the average beneficiary would not pay additional Medicare deductibles or coinsurance. Beneficiaries would pay a monthly Part B premium equal to 31.5% of program costs -- roughly \$90-\$93 per month or \$1100 per year -- in 2002. Given that the average beneficiary already today spends \$2,750 out-of-pocket for health care costs, limiting additional expenses is a key element of Medicare reform.

Low-income Medicare beneficiaries, in particular, are affected by higher out-of-pocket costs. Currently, Medicare beneficiaries with incomes below 120 percent of the federal poverty level are eligible for Medicaid coverage of their Medicare premiums. Those with incomes below the federal poverty level can get Medicaid coverage for deductibles and coinsurance as well. The proposed increase in Medicare premiums, combined with substantial cuts in the program, will dramatically reduce funding in the Qualified Medicare Beneficiary (QMB) program in Medicaid and leave low-income Medicare beneficiaries without the ability to pay Medicare's premiums and cost-sharing.

As we understand it, the House Commerce Committee's Medicaid proposal would require that states spend a minimum share of Medicaid dollars on Medicare premiums for low-income beneficiaries, but this amount would fall well below what is needed. Moreover, the current requirement that the Medicaid program pay Medicare's deductibles or coinsurance for poor beneficiaries will be scaled back, if it remains at all. The goal of Medicare and Medicaid reform must be to provide access to quality, affordable care. "Reform" will be a step backward if it costs the federal budget less but diminishes access, quality and affordability.

The Leadership proposal's treatment of the Medicare home health benefit could also mean higher out-of-pocket costs for beneficiaries. It is our understanding that after 120

days, payments to home health agencies would cease. Almost one-third of Medicare home health users have episodes of illness longer than 120 days. If Medicare would no longer pay for care over 120 days, what kind of out-of-pocket costs will over one million beneficiaries, most of whom are lower-income women over the age of 75, face?

The Leadership proposal also suggests an “affluence test” for higher income Medicare beneficiaries – with thresholds set at \$75,000 for singles and \$125,000 for couples. What is not clear is whether this higher premium would mean the complete elimination of all general revenue financing of Part B services for these beneficiaries.

We believe this “affluence test” raises an issue of equity – particularly since federal subsidies for health care costs for those under age 65 would continue, regardless of an individual’s income. These subsidies are direct for federal employees – including Members of Congress – or indirect in the form of the tax deduction for employer-provided health insurance and the exclusion of health benefits from individual taxes. If higher income Medicare beneficiaries are going to be asked to pay more for their health care, a parallel obligation to reduce these federal health care subsidies should also apply to individuals under the age of 65.

Indirect Beneficiary Costs

The House Leadership proposal indicates that Medicare’s Part B premium would be set at 31.5 percent of program costs and a new “affluence test” premium would be imposed on higher income beneficiaries, as discussed above. The outline goes on to say that there would be no change in Medicare copayments and deductibles. AARP is pleased that the proposal would limit these direct increases in beneficiary out-of-pocket costs, but we urge members of the Committee not to overlook the potential of indirect beneficiary out-of-pocket costs that would jeopardize the financial security of older persons.

In addition to the potential out-of-pocket increases from a fee-for-service fail-safe mechanism, we are concerned about the additional out-of-pocket costs that could result from relaxing or eliminating the Medicare balance billing limits. The proposal does not appear to indicate whether the Medicare balance billing limits would remain in place in the fee-for-service program, nor does it indicate whether these limits would be applied to the other Medicare Plus coverage options as well. Failure to maintain the balance billing limits set in current law would be an invitation to providers to shift higher costs onto beneficiaries and violates one of the principle objectives of this year’s debate -- restraining the growth of health care costs.

Prior to the enactment of the physician payment reform law in 1989, Medicare beneficiaries spent over \$2 billion out-of-pocket costs for physician balance billing charges. Congress sought to relieve this burden by limiting the amount beneficiaries could be “extra billed” to 15 percent. Physicians who do not accept Medicare assignment can now collect Medicare’s payment amount, the beneficiary’s 20 percent coinsurance, plus an additional 15 percent from the beneficiary. Some in the physician and provider community have proposed lifting the current balance billing limit. This could occur at three levels:

- doctors could “negotiate” fees directly with patients so they are able to charge beneficiaries additional amounts over and above Medicare payments;
- Medicare Plus plans – whose payments are ratcheted down under the new Medicare caps – could accept the “cuts” but insist on the right to charge beneficiaries higher premiums and/or copays; and
- practitioners who provide care as part of a Medicare Plus plan could balance bill beneficiaries in excess of the health plan’s payment.

Absent these limits, beneficiaries will end up shouldering the burden of provider payment reductions. AARP is also concerned that the Leadership proposal does not correct -- and in fact worsens -- the inequity that exists in beneficiary coinsurance for hospital outpatient services. Because beneficiary coinsurance for hospital outpatient services is based on the amount the hospital charges, older people are now paying more than 50 percent in coinsurance rather than the standard 20 percent. We believe that this problem needs to be corrected.

Because so many older Americans view Medicare as vital to their financial security, limiting out-of-pocket expenditures -- both direct and indirect -- is crucial to any Medicare reform package. AARP urges the Committee to keep this in mind as the proposal continues to evolve.

Benefits Package

According to the Leadership proposal -- the Medicare benefits package would be maintained in Medicare fee-for-service and in Medicare Plus plans. The Association welcomes this decision to maintain the fundamental principle of a defined benefits package in Medicare, with leeway for plans to offer additional coverage. We would further urge that any changes in Medicare's reimbursement policy reinforce this decision by guaranteeing that Medicare payment also be adequate to pay for the Medicare benefits package in fee-for-service and Medicare Plus plans. Together, these steps will help to ensure that the program remains a health care plan on which older and disabled Americans can rely now and in future years.

Older Americans view Medicare as a cornerstone of their financial security in addition to relying on the program for health care coverage. If Medicare were transformed from a program that provides a guaranteed package of benefits to a system where government "contributions" no longer paid for needed health care and costs were simply shifted onto beneficiaries, then we would be violating a fundamental tenet of Medicare. At the same time, we are concerned that erosion in the benefits package not be the ultimate result of the greatly reduced growth rate in the program. The 6.1 percent growth rate provided for in the Budget Resolution, provides very little room for Medicare program growth, considering a projected 3.4 percent rate of general inflation and 2 percent growth in the older population. The growth rate does not recognize or leave room for factors that could have a direct bearing on Medicare spending, such as unpredictable trends in health care needs, the development of new technology and a rise in general inflation.

Beneficiary Choice

AARP believes that genuine choice is critical. Many older persons have forged long-standing relationships with providers who understand the breadth of the patient's health care needs. The Leadership proposal suggests that efforts have been taken to initially protect beneficiary choice of plan and provider. The fee-for-service option has been maintained and the outline indicates that Medicare beneficiaries who remain in traditional Medicare will not be required to pay higher deductibles or copays.

This is certainly a step in the right direction, but Medicare's payment policy in both fee-for-service and Medicare Plus could have a powerful influence on beneficiaries' choice and quality of care in the future. AARP continues to be concerned that the cap on Medicare fee-for-service spending could, in time, force beneficiaries -- who prefer fee-for-service -- to leave the coverage option of their choice and sever physician-patient relationships because they could no longer afford to remain in that plan. As we understand the proposal, annual fee-for-service spending would be capped. If spending exceeds the cap, the Secretary would change the payment rates for fee-for-service. It is not clear whether the Secretary could increase beneficiary copayments as well. If so, or if balance billing does not continue to be capped at 15 percent, then the fail-safe mechanism could mean higher out-of-pocket costs for beneficiaries. It could also prove to be a disincentive for providers to treat Medicare beneficiaries in a fee-for-

service setting. In this way, the fail-safe mechanism could result in less beneficiary choice since many beneficiaries would no longer be able to afford fee-for-service. Those that could might well have difficulty finding physicians willing to treat Medicare fee-for-service patients once reimbursement is cut severely to accommodate the Medicare spending reductions required in the Budget Resolution and enforced by the fail-safe mechanism.

Coverage Options

Under the Leadership proposal, Medicare beneficiaries would have a greater range of coverage options – including expanded managed care, medical savings accounts (MSAs) and provider service networks (PSNs) – through the creation of a new Medicare Plus program. While AARP supports a broader range of coverage choices for beneficiaries, we need to know much more about how the new coordinated care plans, MSAs and PSNs would work. Who would oversee the administration of the various options? Who would negotiate on behalf of beneficiaries?

We are also concerned about the standards and quality criteria that would apply to Medicare Plus plans and how these standards would be enforced. We have appended to this statement a set of recommendations on quality and consumer protection standards.

It appears from the proposal that federal quality standards would be established but that certification, oversight and enforcement would be left up to the states. What is not clear is what the specific standards would be and whether there would be federal oversight of state certification and enforcement activities.

We are also interested in knowing how a beneficiary would navigate this new system. Could beneficiaries move back and forth between fee-for-service and the various Medicare Plus plans? Would they be expected to “negotiate” payment rates with their providers? Would there be a month-to-month enrollment option to assure that beneficiaries are not locked into a plan that is providing poor service or quality care? What changes, if any, would affect Medicare beneficiaries’ ability to purchase Medigap policies? What plans would be in place for data collection and monitoring activities to assess the program? In general, we believe that to the extent that the legislation facilitates movement by beneficiaries between fee-for-service and Medicare Plus, it will promote beneficiary willingness to consider Medicare Plus options.

Because some of the new plan options are relatively untested, there are a number of questions about the specific proposals that need to be raised as well.

Medical Savings Accounts (MSAs): We are pleased that the proposal indicates that a beneficiary who chooses an MSA option would not be expected to pay coinsurance in addition to the premiums for the catastrophic policy and would have a capped deductible. We are concerned, however, about the potential for risk selection within this option.

What is unclear from the proposal, and deserves further attention, is whether Medicare’s payment amount for beneficiaries would fully cover the catastrophic insurance policy, how much of the deductible it would cover, whether all beneficiaries choosing this option would pay community-rated premiums for a given plan, and whether the Medicare payments to plans are risk-adjusted. The Leadership proposal indicates that it is possible that beneficiaries who choose this option could find themselves with considerable out-of-pocket expenses if the cost of the plan and the deductible exceed Medicare’s payment.

Other questions include: Will plans guarantee issue and renewal to all beneficiaries? How would Medicare’s contribution to an MSA be determined? What would the deductible be and what expenses would count toward it? Who will make these administrative decisions?

Given that MSAs are relatively untested in the private market, we believe it is imperative to determine how the catastrophic plans that are part of an MSA option would be structured and whether plans would be subject to state insurance laws.

Expanded Managed Care: The Leadership document also states that several new managed care plans would be available to beneficiaries. We believe that the Medicare program could benefit from some of the innovations occurring in the private health care market, but we also recognize that Medicare's payment structure for managed care needs to be changed in order to make these new options viable for the program and for beneficiaries. The Leadership outline does not address how Medicare's managed care payment system would be changed. Such changes will, of course, be fundamental to the availability of new managed care plans and their success in serving Medicare beneficiaries.

We are pleased that managed care plans will be required to offer the minimum Medicare benefits package but may also offer beneficiaries more generous coverage. Given current trends, however, it is uncertain whether after a few years many plans -- if any -- would be able to offer additional benefits without charging extra for them. For example, fewer Medicare risk contracts now cover prescription drugs. We would caution against marketing coordinated care to beneficiaries on the basis of their ability to get additional benefits for little or no extra cost when this promise may be difficult to keep within a few short years. While reform or complete replacement of the AAPCC is clearly in order, it is as yet unclear how the "proxy premium" system the plan proposes using for payment to managed care plans.

Provider Service Networks: The third option outlined in the Leadership document is the Provider Service Network. AARP is particularly interested in how these entities would be structured and what specific consumer safeguards -- particularly solvency, capital and marketing requirements -- would apply. The proposal is also unclear about whether these entities would be required to be licensed by states.

Union or Association Sponsors: The Leadership proposal would allow health plans sponsored by unions or associations to offer coverage to their Medicare eligible members. The plans would be eligible to contract with Medicare and assume risk for providing health care coverage to beneficiaries who are members of the union or association. While this provision may provide an additional avenue of coverage for some beneficiaries, AARP's concern and focus will continue to be Medicare reform in the broader context.

Fraud and Abuse

AARP is pleased that the proposal addresses fraud and abuse. It is important to note that fraud and abuse prevention activities generate only limited savings, and that improved enforcement will add up-front costs. But left unaddressed, fraud and abuse within the Medicare and Medicaid systems have a corrosive effect on the program and on the public's view of government stewardship generally. Moreover, signaling to the public that this issue is being pursued more aggressively is a necessary first step before the public will be willing to consider other, more contentious strategies to reduce program spending and the deficit.

Conclusion

There is concern and even skepticism on the part of many Medicare beneficiaries about how proposed changes in a program that they have come to depend on will affect them. These beneficiaries and their families need time to understand the changes and assess whether the proposal would build upon -- not erode -- Medicare's promise of financial protection.

AARP and its members also want to ensure that we strengthen Medicare for current and future beneficiaries and their families. To fully achieve this, we need to look beyond the Medicare program to ways in which we can improve our health care system as well by: exploring new approaches and ideas, such as outcomes research that offer the prospect of better medical and program management in the future; establishing mechanisms that assure that the market, with its competing plans, works; and last but not least, that we are able to lower the projected cost of health care while preserving access, quality, choice and affordability.

We believe continued dialogue is critical and we look forward to working with all members of the Committee and other Members of Congress in this effort.

Mr. THOMAS [presiding]. Thank you very much, Mr. Lehrmann. Miss Lehnhard.

STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, POLICY AND REPRESENTATION, BLUE CROSS & BLUE SHIELD ASSOCIATION

Ms. LEHNHARD. Mr. Chairman, Members of the Committee, I am Mary Nell Lehnhard, senior vice president of the Blue Cross & Blue Shield Association. I am here representing the 67 independent Blue Cross & Blue Shield programs. Collectively, our plans provide health benefits for 65 million Americans, including 7 million Medicare beneficiaries with Medicare supplemental coverage and 200,000 Medicare beneficiaries in our Blue Cross & Blue Shield HMOs.

The Medicare Program faces a troubled future. The combination of relentless increases in health care costs and the aging of the population make it imperative to take action. The program needs to be made secure for the future. The leadership's proposal moves us in the right direction. It builds on the proven ability of health care—private health plans to offer high quality, lower cost coverage through formal relationships with physicians, hospitals and other types of health care providers.

The leadership's proposal addresses the need to control the cost of the program. It wisely retains the basic program and the historic mission to assure that all senior citizens have access to a comprehensive range of medical care.

Given the complexity of the issues before us, we will want to examine the legislative language. However, we believe that the leadership has charted a course that is simultaneously incremental and innovating and will be reassuring to senior citizens.

The proposal, first of all, leaves in place the traditional program as an alternative available to all beneficiaries. Second, it expands the private health care options that are available to beneficiaries as a voluntary alternative. Third, we believe it succeeds in harnessing the innovative energy of the private sector to improve the quality and affordability of coverage for seniors.

We believe that competition among health care plans that meet high standards of quality of care and financial stability is the best way to secure the future of the program.

A recently completed survey of Medicare beneficiaries in Blue Cross & Blue Shield HMOs confirms that private health plans can offer more comprehensive benefits at lower cost and with a high level of satisfaction. According to our survey, more Blue Cross & Blue Shield HMO members are very satisfied with their health care coverage than those enrolled in the traditional program, 72 percent compared to 62 percent. And, importantly, satisfaction is high regardless of the individual's health status. But those in poor health, according to the survey, are more likely to be satisfied with their care if they are enrolled in the HMO coverage than in the traditional program, 87 percent versus 81 percent.

In addition, beneficiaries enrolled in HMOs are more satisfied than those in the traditional program when it comes to overall quality of care, access to the latest technology, quality of special-

ists, and their ability to get to specialists when they feel they need them.

We highly support the direction of the proposal, but there are areas we would like to continue to work on with you.

First of all, we believe a broad range of health care options is essential to a healthy, competitive market. However, we believe that all the options should meet the same standards for quality and financial stability. A competitive market strategy won't work if there are different rules for participants.

We find the argument of the National Association of Insurance Commissioners compelling, the urging that all entities engaged in the insurance risk of accepting a Medicare capitation payment in exchange for the promise to pay future benefits to be licensed by the State and meet the quality and financial stability standards for HMOs.

In addition, we urge that current antitrust rules that protect the consumer and, importantly for this proposal, a healthy, competitive marketplace not be changed. We agree with the Physician Payment Review Commission that the existing antitrust law and rules allow the development of any modified health plan.

In conclusion, we commend the leadership for assembling a proposal which is a serious attempt to address the pressing problem of the Medicare Program. We believe this proposal is the first one that will bring Medicare into the mainstream of private health care coverage where every senior citizen can choose their own health care program and, second, one that offers a framework as long as everyone meets the standards. Again, we urge to reward health plans that keep their subscribers highly satisfied.

Thank you.

[The prepared statement follows:]

**STATEMENT OF MARY NELL LEHNHARD
SENIOR VICE PRESIDENT
BLUE CROSS & BLUE SHIELD ASSOCIATION**

Mr. Chairmen, and members of the committees, I am Mary Nell Lehnhard, Senior Vice President, of the Blue Cross and Blue Shield Association, the coordinating organization for the 67 independent Blue Cross and Blue Shield Plans. Collectively, the Plans provide health benefits protection for 65 million people — including more than 7 million Medicare subscribers with supplemental (MediGap) insurance coverage and 200,000 beneficiaries enrolled in Blue Cross and Blue Shield HMOs. I appreciate the opportunity to testify before you on the House Republican Leadership's Medicare proposal.

The Medicare program faces a troubled future. The combination of relentless increases in health care costs and the aging of the population make action to secure the future of the program imperative. The Leadership's proposal moves in the right direction by building on the proven ability of private health plans in offering millions of Americans under the age of 65 a choice of innovative, high value coverage options.

The Medicare program extends to virtually all seniors the security of knowing that they will always have coverage for needed acute medical care. This security is particularly important to people over the age of sixty-five for whom serious illness is a virtual certainty and not merely a remote possibility. The Leadership has wisely charted a course that renews this commitment.

The Leadership's proposal enables the 104th Congress to reaffirm the goal that was embraced by the 89th Congress thirty years ago: providing the nation's seniors with access to mainstream health care and health care coverage. As we noted in our testimony last July, since 1965 the mainstream of health care coverage has shifted, but Medicare has not. The Leadership's proposal returns Medicare to the mainstream by bringing the program into the 1990s and preparing it to face the 21st Century.

We strongly support the general direction taken in the extensive outline of the Leadership package. Obviously, given the complexity of the issues, we will want to examine the actual legislative language before providing more specific comments and endorsements. However, in general we believe that the Leadership has wisely pursued a strategy that is simultaneously incremental and innovative:

- It leaves in place the existing program as an alternative that will be available to all current and future beneficiaries.
- It expands the private health plan options that are available to Medicare beneficiaries as a voluntary alternative to coverage under the traditional program.
- It strives to harness the innovative energy of private enterprise to continuously improve both the quality and affordability of the coverage available to the nation's seniors.

We believe this is the right way to go. We believe that competition among participating health plans on a level playing field is the best means of securing the future of the Medicare program and meeting the needs of Medicare's current and future beneficiaries. As we review the details of the plan in the days ahead, we will be most concerned in seeing that these goals — which we share with the Leadership — are achieved.

Medicare should expand the range of private health plan options that provide a high value alternative to traditional coverage.

We believe that private health plans can offer Medicare beneficiaries a high value option that may better meet the needs of many beneficiaries than the

combination of traditional coverage with MediGap coverage. We reported in our July testimony that private health plans offer consumers a more comprehensive set of benefits, lower out-of-pocket costs, and a lower premium than the combination of traditional coverage supplemented by a MediGap policy. A recently completed survey comparing Medicare beneficiaries enrolled in Blue Cross and Blue Shield sponsored HMOs to beneficiaries enrolled in the traditional program dramatically confirms this.

- More Blue Cross and Blue Shield Medicare HMO members are 'very satisfied' with their health coverage and medical care than traditional Medicare recipients: 72 percent compared to 62 percent.
- Satisfaction is high regardless of the individual's health status — but those in poor health are more likely to be satisfied with the care and coverage if they are enrolled in an HMO: 87 percent of HMO members in poor health are satisfied, compared to 81 percent of those enrolled in traditional Medicare.
- Subscribers with chronic medical conditions are more likely to be very satisfied with their care and coverage if they are enrolled in an HMO than if they are enrolled in traditional Medicare.

Even more telling are the results for beneficiaries' satisfaction with specific aspects of their care and coverage. Compared to beneficiaries enrolled in traditional Medicare, beneficiaries enrolled in HMOs are:

- 70 percent more likely to be very satisfied with the amount of paperwork they have to cope with;
- 60 percent more likely to be very satisfied with the overall cost of their care and coverage;
- 44 percent more likely to be very satisfied with the cost of preventive care and routine office visits; and,
- 29 percent more likely to be very satisfied with coverage of prescription drugs and education on preventive services.

In addition, beneficiaries enrolled in HMOs are more satisfied than beneficiaries enrolled in traditional Medicare when it comes to the overall quality of care, access to the latest technology, coordination of care, the quality of specialists, the quality of their personal physician, the time they spend with doctors and other staff, and their ability to see specialists. In fact, over 76 percent of HMO enrollees reported being very satisfied with the overall quality of their care — compared to only 66 percent of those enrolled in the traditional program.

We believe that these findings conclusively demonstrate the value that private health plans can deliver — and are already delivering today. They are also strong evidence that the existing requirements of section 1876 for Medicare HMOs are an appropriate framework for assuring quality that should be extended to all health plans that want to enroll Medicare beneficiaries.

We applaud the direction outlined in the Leadership's proposal that would expand the range of health plans available to beneficiaries to include some of the most popular options available to the under-65 population today but denied those enrolled in Medicare: Preferred Provider Organization options and Point-of-Service health plans.

All private health plans should meet the same high standards.

Section 1876 of the Social Security Act establishes a comprehensive set of standards that all (non-supplemental) health plans offered to Medicare beneficiaries must meet. These standards are extensive. The most important of them include:

- coverage by the private health plan of the services that are covered by Parts A and B of the traditional program;
- access to health care "24 hours a day, 7 days a week";
- coverage of emergency services from any provider when it is not reasonable to delay treatment until the patient can reach their health plan provider;
- clear explanation of benefits, utilization review procedures, and requirements to use network providers;
- procedures for resolving consumer complaints and grievances;
- solvency and other financial standards, including state licensure, that assure beneficiaries that their health plan will be able to provide benefits tomorrow as well as today;
- open enrollment that allows any beneficiary to choose any participating health plan — or to leave that health plan if it does not meet their needs; and,
- oversight of health plan marketing to prevent health plans from offering coverage only to the healthy.

We believe that all health plans offered to Medicare beneficiaries should meet these same high standards. We believe that the administrative procedures for approval of new health plans can be streamlined, but that the standards that are applied to all health plans should be the same. We do not believe that additional requirements are necessary. The extraordinarily high level of satisfaction revealed by our recent study demonstrates that the existing standards are working to protect vital consumer interests.

In particular, we applaud the efforts that have been made to streamline and simplify the requirements governing the calculation of health plan premiums and contributions. Medicare contributions will be adjusted for geographic and risk factors. The level of Medicare contributions will be 'decoupled' from costs in the traditional program, and instead increase by a defined percentage each year. We believe that this could both simplify the administration of the program and increase predictability for beneficiaries and health plans.

In examining the provisions implementing these changes, we will be particularly concerned to make sure that Medicare's contribution to private health plans increases at the same rate as payments under the traditional program. We also believe that it is particularly important to implement changes in the contribution formula in a way that (1) increases the predictability of payment amounts, and (2) reduces the magnitude of geographic variations in Medicare contributions without disrupting the ability of HMOs to offer the benefits that they offer today.

While we support the direction of the Leadership proposal, we would raise three areas of concern.

While we heartily support the general direction of the Leadership package, there are three areas that we believe need to be closely and critically examined. We believe that these provisions could, if not appropriately structured, cause problems for Medicare in the future.

Unlicensed Health Plans

The Leadership's proposal would allow two new types of entities that would be able to offer coverage: Provider Sponsored Networks and Limited Enrollment Plans. We welcome these new enterprises — as potential customers, partners, colleagues, and — yes — rivals. We believe that they should meet the same high standards that we and other competitors in the market have to meet, including the requirements designed to assure quality and financial stability. We believe that we share with beneficiaries and the Leadership a common commitment to applying the same contracting and quality standards to all entities offering MedicarePlus coverage. Where we may differ with the direction outlined in the proposal is in the application of financial and other standards that are designed to ensure the financial stability of the products that are available to beneficiaries.

We believe that the best, simplest, and most efficient means of achieving this goal of financial stability is to require all health plans to be offered by licensed HMOs or insurers. The fact is that all organizations participating in Medicare will bear risk — which is the hallmark of insurance. That is, they will all accept a capitation payment from Medicare in exchange for a promise to pay future benefits. The fact that they are sponsored by providers does not alter their need for reserves and adequate capital resources.

The National Association of Insurance Commissioners has noted with respect to Provider Sponsored Networks that

"The states have had a wealth of experience with the effects of similarly unregulated entities, and the experience has not been a good one for consumers... [T]here does not appear to be any regulatory reason to treat these entities differently than their close relatives, health maintenance organizations (HMOs). In fact, in appearance, structure, and services provided, many of these entities are virtually identical to HMOs. Any difference in the appropriate capital and solvency requirements for these entities due to the unique structure of their assets can be accounted for through risk-based capital requirements for the diverse health care organizations in today's market."

There is little question that the financial standards that are applied to insurers must be appropriate to the types of entities offering coverage and the risks that they bear. This is the reason that many states have adopted separate standards for Health Maintenance Organizations. This is also the reason that we have actively supported the development of new 'risk-based capital standards' by the National Association of Insurance Commissioners that would be applied to health companies — a process in which organizations representing providers are active participants. These standards have been under development for over a year, and we expect that they will be completed next year. They are designed to reflect the risk that is assumed by all types of health plan sponsors, including HMOs. The standards specifically are designed to acknowledge that an organizations need for capital may be lessened by adopting different types of provider payment methods.

While we support state licensure for all MedicarePlus options, we recommend three modifications to the Leadership's proposal.

First, the interim standards applied to PSNs — including standards for financial stability — must be equivalent to the requirements that are defined by the NAIC's Model Act for Health Maintenance Organizations.

Second, PSNs must be required to be fully at risk for the costs of the benefits they promise to beneficiaries. That is, the PSN must accept a capitation

payment out of which it will cover the cost of covered services. Medicare should not act as a stop-loss reinsurer for these plans.

Third, there should be a firm sunset on the federal process of certification of these health plans with states assuming ultimate responsibility for regulatory oversight of them.

Medical Savings Accounts

We do not believe that the new options to be made available immediately should include Medical Savings Accounts. Both PPO health plans and POS health plans have a proven track record in the private market. The same cannot be said about MSAs. We believe that the appropriate course is to conduct demonstration projects, as has been done with other significant 'new ideas' such as Medicare Risk Contracting, Social Health Maintenance Organizations, Medicare Hospice Benefits, and Medicare Select.

An evaluation would allow Congress to assess the extent to which these products would offer an option that meets the real needs of beneficiaries and the impact that these products would have on both the traditional program and on competition among private health plans available to beneficiaries. It would allow, for example, a careful assessment of the impact of allowing beneficiaries to use funds deposited in the MSA for non-medical purposes as would be allowed under the Leadership's proposal.

Changes in Anti-trust Guidelines

We believe that anti-trust law is vital for the development of a truly competitive market place that is responsive to consumer demands.

The Department of Justice and Federal Trade Commission have issued interpretive guidelines in both 1993 and 1994 to clarify how the anti-trust law applies to the health care industry. These guidelines recognize that the competitive structure of health care financing and delivery is evolving rapidly and allow for the development of a wide range of innovative arrangements among providers or between providers and health plans. They would allow the formation of virtually any PSN that agrees to accept a capitation payment.

Consequently, we believe that current law and regulation does not present a barrier to *bona fide* efforts by health plans to develop innovative arrangements that will benefit consumers. The Physician Payment Review Commission concluded in their 1995 report that there is no evidence to support contentions that changes are needed in the current anti-trust laws.

Conclusion

In closing, we commend the House Leadership for assembling a proposal that seriously attempts to address the pressing problems of the Medicare program without threatening the characteristics that have been the source of the program's strength. We strongly support efforts to expand the choice of options available to Medicare beneficiaries as consistent with the original goal of the program: to provide seniors with access to mainstream health care and health care coverage.

Mr. SHAW [presiding]. Thank you.
Miss Ignagni.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Ms. IGNAGNI. Thank you, Mr. Chairman.

Mr. SHAW. Please correct me if I mispronounced your name. It is a bit unusual.

Ms. IGNAGNI. No, you did very well. Thank you very much.

My name is Karen Ignagni. I am president of GHAA, the Group Health Association of America. We represent 385 HMOs and other managed care organizations providing services to almost 50 million people around the country. We also represent virtually all of the current participants in the Medicare HMO Program.

I would like to say on behalf of GHAA, Mr. Chairman, that we recognize that the proposal before us is a work in progress. We have attempted to offer our comments in that spirit.

I would like to indicate as a beginning point that we believe that the fundamental principle that the proposal advocates, which is building on the best of what the private sector offers and what working Americans have access to now, is a fundamental starting point that deserves to be commended. There is quite a track record out there with respect to performance of plans, with respect to satisfaction, quality, particularly with respect to the point that we are, in many cases, now providing better opportunities for seniors in terms of comprehensiveness and performance of health plans, broader benefits to seniors and particularly with respect to the accomplishments with respect to what our plans have done in terms of driving down overall health care costs in the Medicare Program.

I would like to raise some specific comments which I believe, in listening to previous panelists, in many cases reiterates points that were made before, but I would like to go through them quickly and itemize them for you.

I think choice is a very important principle for our members. The notion of putting in beneficiaries' hands the information that they are going to need to fully evaluate what is out there in the market is a principle that we believe is fundamental and fully support.

Standards are very important, we believe, in terms of moving forward to truly establishing a level playingfield in a competitive market that works where consumers can compare one plan to another. We have in previous testimonies indicated and testified on the importance of a level playingfield across the entire system. There has been major discussion about that principle. And I do concur with Miss Lehnhard's observations that we, too, have concerns about setting up a new structure with respect to regulating new entities. On the other hand, we are encouraged that you are looking to HMO standards as a model.

So we look forward to learning more details, but we do want to flag that as an issue that we would like to continue to talk with you about and provide whatever assistance we can.

In terms of the much debated antimanaged care initiatives that have surfaced both last year and this year and at the State level, we are delighted that the proposal recognizes that antimanaged

care provisions are not a step forward in the debate and would only turn back the clock on the progress that has been made. We hope that that principle will be upheld, and we would like to continue to provide assistance to the Members of this Committee about the implications of those provisions.

On payments, we are very encouraged that the proposal seems to not try to attempt to take a piecemeal approach to payment and to imbue the principle across the delivery system about a level playingfield and the importance of a level playingfield on the fee-for-service side and the so-called managed care side and everything in between.

We do commend the attention to a technical issue which seems small but has been long discussed with respect to current payment methodology which is the notion of moving from a county basis for payment methodology to metropolitan statistical areas. Again, it seems like a technical point, but we believe it is terribly important in terms of dealing with issues that have been raised.

The Metropolitan Statistical Area, or MSA adjustment, is indeed different from the MSA proposal that the last panelist spent so much time talking about; and we would like to flag that, but from the perspective of potential unintended consequences, and would like to engage in continued discussion on that issue as well. We believe as the proposal is further developed that—and the details are fleshed out—there is quite a lot to be encouraged about, quite a lot that takes the accomplishments from the private sector that have worked so well for working Americans. We look forward to commenting on those details and look forward to working with each and every one of you.

Thank you, Mr. Chairman.

[The prepared statement follows:]

**STATEMENT OF KAREN IGNAGNI
PRESIDENT AND CHIEF EXECUTIVE OFFICER
GROUP HEALTH ASSOCIATION OF AMERICA, INC.**

Mr. Chairman and members of the Committee, I am Karen Ignagni, President and CEO of the Group Health Association of America. GHAA is the principal national association of health maintenance organizations. Our 385 member plans serve 80 percent of the more than 50 million Americans receiving health care through HMOs today. We represent most of the largest HMOs in the country and many of the very smallest plans.

I very much appreciate your invitation to comment on the proposed Medicare Preservation Act. Recognizing that the Act is a work in progress, we propose to comment in that spirit. Many details, some of them very important, are being ironed out; we look forward to working with you as this process continues.

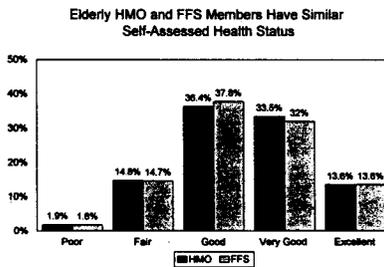
The Medicare Preservation Act is built on a foundation of expanded health plan choices that brings to beneficiaries the best of what the private sector has to offer by recognizing the strengths of the current program -- and adding to it by providing beneficiaries the opportunity to choose the plan that best meets their needs from an array of coverage options.

The Strength of the Current Medicare HMO Program

Over the past two years, the number of beneficiaries enrolled in Medicare HMOs has grown by twenty-five percent. Today, over 3 million Medicare beneficiaries have chosen to enroll in Medicare HMOs.

HMO Medicare enrollees benefit from the many advantages offered by our plans, including an emphasis on preventive services and early intervention when health conditions arise, affordable and predictable out-of-pocket costs, little or no paperwork, and access to a coordinated care system. These advantages for beneficiaries are the foundation for the success of the present Medicare HMO contracting program. This success has been demonstrated in a number of ways -- through its broad enrollment base, member satisfaction, documented quality and savings.

Broad enrollment base: The National Research Corporation found that seniors enrolled in HMOs and in fee-for-service Medicare are very similar in terms of overall self-reported health status and incidence of chronic medical conditions. As shown below, 47.1 percent of HMO members reported that they were in "excellent" or "very good" health, compared with 45.6 percent of fee-for-service enrollees. The percentage in both populations reporting "poor" health was the same, slightly less than 2 percent.



Source: National Research Corporation Healthcare Market Guide, 1994.

Satisfaction: Medicare HMOs attract a broad mix of enrollees, and those enrollees are satisfied with their care. During the past year, numerous groups have conducted patient satisfaction surveys, all of which show that HMO subscribers overall are more satisfied with their health plan than fee-for-service subscribers. A recent study on American attitudes toward managed care looked at the numerous enrollee satisfaction surveys and concluded that managed care participants are "overwhelmingly satisfied with their health care."

Quality: Medicare HMOs offer high quality health care. A recent study by the Health Care Financing Administration showed that elderly HMO members with cancer are more likely

to be diagnosed at an early stage than those in the fee-for-service sector. This is due to coverage of and improved access to preventive care under comprehensive HMO coverage, which is also highlighted in a study by the Centers for Disease Control (CDC) and the National Center for Health Statistics that showed that women in HMOs are more likely to obtain mammograms, pap smears, and clinical breast exams than those in the fee-for-service sector. Another study, comparing care for patients age 65 and older with acute myocardial infarction (heart attack), concluded that HMO patients received better care than that received by patients in a national fee-for-service sample.

Savings: One important way HMOs lower the rate of increase in spending is by producing savings in the marketplace as a whole (the so-called "spillover" effect).

By promoting competition in an area, HMOs lead to reductions in fee-for-service Medicare costs. A recent study by Price Waterhouse showed that for every 10 percent increase in Medicare HMO penetration there is a 7.6 percent reduction in fee-for-service Medicare costs. Based on the findings of this study, if the percentage of beneficiaries receiving care in Medicare risk HMOs were to increase from its current 6 percent to 20 percent, Medicare would save about \$17 billion. This initial decline would be followed by additional yearly savings over current projected costs.

Other studies support this finding. W.P. Welch of the Urban Institute estimated that for metropolitan statistical areas with more than 25 percent of the population enrolled in the Medicare risk program, fee-for-service costs decline by 10 percent. Studies by Glenn Melnick and James Robinson found that hospital costs increased less rapidly in areas of California where HMOs had a larger market share. Jack Hadley and Darrel Gaston of Georgetown University report that hospital costs per admission increased 69 percent in high HMO penetration markets from 1984 to 1993, compared with 96 percent for low HMO penetration markets.

GHAA's Comments on the Medicare Preservation Act

GHAA agrees with the fundamental premise of the Medicare Preservation Act, that Medicare can be strengthened by giving beneficiaries the same kinds of choices that already are available to millions of working Americans both in the private sector and in the federal government. To this end, GHAA agrees that Medicare ought to be reoriented toward a model in which beneficiaries have the opportunity to choose from a broad array of options that compete on the basis of quality, service, and cost, and are held to comparable accountability standards.

When beneficiaries can choose the option that best meets their needs, Medicare will benefit from the progress that has been made in the private sector. As GHAA has testified previously, Medicare reform should embody the following principles:

- o **Beneficiary choices:** Medicare reform should be consistent with the promise of providing access to basic Medicare benefits that meet the needs of elderly and disabled Americans and offering beneficiaries choices comparable to those available to the working-age population.
- o **Comparable standards:** All organized systems of care, as well as providers under the fee-for-service Medicare program, should meet comparable standards in areas such as quality of care, access, grievance procedures, and solvency. Attempts to limit choice by inhibiting the development of HMOs and other organized systems of care, such as anti-managed care proposals and changes to current antitrust law, should be rejected; where such anti-managed care laws exist, they should be preempted.
- o **Equitable payments:** To foster an expanded array of choices for Medicare beneficiaries there should be parity among payments to all options available to Medicare beneficiaries. The Medicare program should act in a fashion similar to private sector purchasers. This can be done by establishing the amount of funding available for benefits for all beneficiaries on both an aggregate and per beneficiary basis, with an equitable allocation of resources between organized delivery system options and the traditional fee-for-service Medicare program.

We have reviewed the outline in light of these principles and would like to make the following preliminary comments:

Expanding choices for Medicare beneficiaries. The expansion of choices through the addition of MedicarePlus plans envisioned in the proposal is critical for improving the current program and enhancing the delivery of care provided to beneficiaries. GHAA fully supports the principle that Medicare beneficiaries be given the opportunity to choose the coverage option best suited to their individual needs. Moreover, the private sector market has done much to lower the growth of health care costs and improve quality of care by allowing employers and employees to select among different coverage options on the basis of cost and quality. Many employers and employees have benefited from the ability to choose among different types of coverage options and have been increasingly turning to HMOs and other managed care arrangements to obtain comprehensive, cost-effective, quality care.

Standards for options participating in Medicare. The Act recognizes the need for standards to safeguard the interests of beneficiaries and to ensure that all coverage options remain viable. It also contributes to the establishment of a well-grounded, competitive marketplace by stipulating that all options available to beneficiaries must cover the full range of Medicare Part A and Part B services and assume full risk for providing such coverage. Moreover, we are encouraged that the Act references existing HMO Act standards as a basis for standards for all options.

However, we believe that as the infrastructure of offerings to Medicare beneficiaries expands, it is vitally important to maintain strong and comparable standards for all options. Medicare beneficiaries need to be assured that all of the plans they are choosing from meet the same standards regarding access, quality of care, solvency, and grievance procedures. Failure to address these kinds of problems in advance could lead to an erosion in public confidence and a backlash against reform.

Historically, states have performed the function of ensuring that entities entering the market are able to provide adequately as well as to finance the delivery of health care. Meanwhile, HCFA has provided an overall regulatory framework to oversee participation in federal public programs. This current two-tiered regulatory scheme -- federal standards with state oversight responsibility -- has proven effective in ensuring that Medicare beneficiaries are receiving promised benefits and services from viable entities, no matter where they are in the country. The Medicare Preservation Act appears to weaken this structure by allowing selected entities to bypass state licensure. In addition, we are concerned that the existing federal regulatory framework cannot absorb the additional burden of overseeing all aspects of regulation of provider-sponsored options.

Anti-managed care: Expansion of the array of HMOs and other organized systems of care available to Medicare beneficiaries is at the heart of the Medicare Preservation Act. We are pleased that the sponsors of this Act have recognized that the inclusion of provisions that limit choice by inhibiting the development of such systems of care, such as anti-managed care provisions, are counterproductive and undermine the delivery of high quality, cost-effective care through HMOs. However, we believe that provisions that preempt state anti-managed care laws and preempt clinical mandates should be included to ensure that barriers at the state level do not hinder efforts to broaden the choices available to Medicare beneficiaries and to allow all options to compete on the basis of cost and quality.

We are concerned, however, with the Act's inclusion of provisions that weaken current antitrust laws to encourage the development of provider-sponsored networks. Current antitrust laws have proven successful in protecting the interests of consumers. Weakening or eliminating the current structure will create an unlevel playing field, having a negative impact on the quality of health care, and increasing overall program costs. The increasing number of provider-sponsored health plans and physician-directed provider networks is clear evidence that the current structure does not restrict the establishment of such ventures.

MSAs: Medical savings accounts that are linked to catastrophic coverage with very high deductibles merit scrutiny to determine whether, when offered as a health care coverage choice, they could have unintended consequences. Although such an option may appeal to individuals who want to take charge of their own health care finances, it may leave beneficiaries with significant financial obligations. People who choose MSAs may postpone needed checkups and other preventive care in order to "save" money, and may end up with a much more severe

condition, requiring much costlier treatment. Moreover, to the extent that healthy beneficiaries opt out of more comprehensive coverage arrangements, they create an adverse selection problem for the Medicare program as a whole — increasing its costs for everyone else.

GHAA recommends that the Committee consider introducing the Medicare MSA option as a demonstration program in certain areas. This would provide an opportunity to study the actual effects of the design elements of this option on the Medicare marketplace and allow Congress to develop an option that mitigates any negative consequences of the availability of MSA/catastrophic options.

Payment methodologies: The Medicare Preservation Act provides important payment improvements. These include establishing the principle of comparable rates of growth between fee-for-service and MedicarePlus plans, providing predictability in the future rate of growth in plan payment, changing the rating areas from counties to larger geographic areas, building on the current methodology for reimbursing HMOs and competitive medical plans, and beginning to comprehensively address graduate medical education reform, rather than disaggregating the AAPCC. The proposal also recognizes the need to narrow the variation in payment across urban and rural markets. It is important as specifics are developed that the payment policy ensure that the program will be viable on a national basis while not disrupting existing markets in which significant numbers of beneficiaries rely on plans for Medicare services.

Conclusion

The Medicare Preservation Act provides a significant opportunity to increase choices for Medicare beneficiaries, while providing information to beneficiaries to ensure that they can make appropriate choices for themselves. GHAA supports the proposal's fundamental premise of choice and look forward to working with the Committee to help refine the proposal to ensure that a well-structured, competitive market will be established to provide high quality, cost-effective choices for Medicare beneficiaries. We would be pleased to answer any questions that you may have. Thank you.

Mr. THOMAS [presiding]. Thank you, Miss Ignagni, and I appreciate your contributions in the past.

Mr. Troy.

**STATEMENT OF JOHN F. TROY, EXECUTIVE VICE PRESIDENT,
HEALTH INSURANCE ASSOCIATION OF AMERICA**

Mr. TROY. Thank you, Mr. Chairman.

I am John Troy, executive vice president of HIAA, the Health Insurance Association of America. I am delighted to participate in this important hearing on the future of Medicare.

As it turns 30, Medicare is in financial trouble. It needs reform if it is to provide security into the next century. We applaud Congress for taking on this task. We believe you have achieved a balanced and responsible approach to reform.

Medicare is in trouble because it hasn't changed with the times. In its reliance on fee-for-service medicine, it has denied beneficiaries access to newer forms of health care delivery. One way to rejuvenate Medicare is to return to the original vision of ensuring that all seniors have access to health plan options enjoyed by working Americans. Your proposal adopts that concept.

Options available to beneficiaries should include HMOs, point-of-service plans, PPOs, and managed fee-for-service plans. Reform should encourage development of additional alternatives. Beneficiaries should be able to choose the traditional fee-for-service program as well as products that supplement Medicare coverage, including Medicare Select. Over 26 million Americans now have purchased some form of Medicare supplement insurance.

Regarding managed care options, in a recently released survey of Americans' attitudes toward managed care, 5 well-known pollsters combined data from 40 different public opinion studies. They concluded, "Americans in managed care are satisfied with their health care coverage." They went on, "Overwhelmingly the weight of evidence indicates that those enrolled in managed care plans are as satisfied with their health care arrangements as are other Americans."

Obviously, it is difficult to comment on the specifics of a bill when we have not seen legislative language. We are still reviewing the outline in detail.

We are pleased to know, as Karen Ignagni has said, that antimanager care provisions are not generally included. We hope you will continue this position. These proposals undermine the ability of managed care organizations to deliver high-quality care. The private market is already addressing many of the act's concerns as employers and consumers demand higher quality.

HIAA is extremely pleased that the proposal contains malpractice reform. Malpractice reform would reduce health care costs and improve consumer access.

We are also supportive of the initiatives to eliminate health care fraud and abuse. The overwhelming majority of insurers have developed successful antifraud programs. We are supportive of your proposals which increase beneficiary awareness and your incentives which will complement the increased awareness efforts.

Health care plans have traditionally been marketed and delivered at the local level. Health insurance agents have an under-

standing of people's health insurance needs. Under a reformed Medicare, seniors are going to need help in understanding the plans being offered. Congress should encourage agent participation in the new program.

We welcome competition in the marketplace from provider-sponsored networks. We do understand the need to recognize legitimate differences between PSNs and insurance companies. Currently, there are over 500 PHOs operating in the country, with as many as 1,000 in the process of being formed. While we welcome competition, the public interest will not be served by an unlevel regulatory environment.

Currently, health plans for Medicare beneficiaries conform to Federal and State requirements designed to protect beneficiaries. States have established standards for plan solvency, marketing, quality assurance, and consumer protection. The industry has voluntarily supplemented regulations with effective private accreditation programs.

We believe that all entities that assume risk should be subject to the same standards. The experience of California two decades ago with Prepaid Health Plans, which had minimal operating requirements and profited at the expense of tens of thousands of consumers, teaches us that all entities should be held to the same high standards that are in place today in the marketplace.

Concerning application of antitrust laws, marketplace competition results in lowering cost. The market is constantly changing, with new types of entities forming to provide health care services. Current antitrust law has allowed hundreds of organizations, including many developed by providers, to integrate financially to form networks that are successfully competing in the marketplace. Changing antitrust laws to benefit any new or existing health care entity could allow those entities to circumvent valid protections in place under current law.

We are pleased to see recognition of the need to base government contributions on legitimate risk factors and that the contribution structure is based on the current AAPCC system. We support study of further refinement to the AAPCC methodology. The gradual approach taken to controlling long-term costs by restraining the annual rate of contribution growth is superior to a one-time cut in plan reimbursement rates, which could disrupt markets.

We are also pleased that the MedicarePlus Program recognizes the dangers of beneficiary risk selection between high deductible plans and managed care programs. This recognition, along with appropriate pricing based on beneficiary risk, is vital to ensuring the stability of the program.

Reforming our Medicare system is a monumental task. The Medicare Preservation Act works to achieve a balance between new horizons and maintaining a secure health care system for our Nation's senior citizens. We look forward to working with Congress as it refines its proposal through the legislative process.

Thank you, Mr. Chairman.

[The prepared statement follows:]

**STATEMENT OF JOHN F. TROY
EXECUTIVE VICE PRESIDENT
HEALTH INSURANCE ASSOCIATION OF AMERICA**

I am John F. Troy, Executive Vice President of the Health Insurance Association of America (HIAA). The HIAA represents 230 of the nation's leading health insurers, covering 55 million Americans. I am delighted to have the opportunity to participate in this important hearing on the future of the Medicare program.

HIAA member companies are involved in all aspects of Medicare: as carriers and intermediaries for the fee-for-service segment of the program; as providers of the supplemental insurance that beneficiaries purchase to augment their Medicare fee-for-service benefits; and as providers of the Medicare HMO, CMP and Medicare Select managed care options that have been available to beneficiaries in many parts of the country.

Among the HIAA member companies involved in Medicare managed care are Bankers Life and Casualty, Healthsource, Humana, Intergroup, New York Life, Principal Health Care, Sierra Health and Life, and Wellpoint. Outside of Medicare, our member companies have enrolled over 25 million of the 100 million Americans estimated to be in the private managed care plans. Their record in Medicare is similar. They have enrolled nearly 700,000 of the 3 million seniors covered by plans under contract with Medicare. HIAA member companies provide needed Medicare Supplemental Insurance to nearly 2.5 million Americans.

As it turns 30, Medicare is in financial trouble. It urgently needs reform if it is to provide medical security to its elderly and disabled beneficiaries into the next century. HIAA applauds the Congress for taking on this monumental task. We believe you have achieved a balanced and responsible approach to reforming this critical program.

Medicare is in trouble because it hasn't changed with the times. In its almost exclusive reliance on fee-for-service medicine, it has denied beneficiaries access to newer forms of health care delivery. While Medicare has been stuck in the 1960s, the private sector has moved forward, coming up with innovative ways to provide affordable, quality health care. Thus, one way to rejuvenate Medicare is to return to its original vision: while preserving current options, ensure that all the nation's seniors have access to the same range of health plan options enjoyed today by working Americans. "The Medicare Preservation Act of 1995" does just that.

Taxpayers and beneficiaries alike will be better off if spending for Medicare can be slowed down. To bring cost increases in Medicare in line with those in private sector health care, program options must incorporate both provider and beneficiary incentives for the cost-conscious selection of services. In addition, private sector initiatives to improve quality (while controlling costs) must be applied throughout.

The key to reforming Medicare is harnessing the price and quality competition that has helped to stabilize the cost of coverage and enhance the quality of services in private sector health care.

We agree that Medicare beneficiaries should have access to the full range of health plan options that are available to working Americans. These options should

include HMOs, point-of-service plans, PPOs, and managed fee-for-service plans; reform should also encourage future development of additional creative alternatives. Beneficiaries must also be able to choose the traditional fee-for-service Medicare program as well as private products that supplement Medicare coverage, including Medicare Select.

Harnessing private sector creativity and innovation is the best way to reform Medicare. We can do that by giving beneficiaries broader plan choices - both of comprehensive plans that replace traditional Medicare and of supplemental plans that enhance it and by giving them a financial stake in the choices they make.

Clearly, no single change can solve all of Medicare's problems. Taken together, however, the steps outlined in the proposal will go a long way toward accomplishing the goal of restoring Medicare's financial viability, so that beneficiaries can continue to be assured of coverage that will provide quality services to meet their medical needs.

As managed care networks and Medicare risk contracting becomes more common, and as MediSave emerges, consumers will be faced with more choices. HIAA supports giving consumers more flexibility and additional choices to meet their changing needs. At the same time, we appreciate the fact that this outline recognizes that consumers also want the ability to choose the familiar. That is why we support efforts to give seniors a choice of keeping their Medicare Supplemental insurance policies or Medigap policies. Over 26 million Americans have purchased some form of Medicare Supplemental insurance to protect themselves from rising medical expenses.

For some years, the Medicare Supplemental insurance industry has had additional regulation at the state and federal level to ensure that consumers are protected and claims are paid. These important consumer protections have worked well to ensure that seniors receive value for the premiums they pay.

HIAA believes that seniors will want choices to meet their changing needs. Flexibility and consumer protection are key in this debate. Just as consumers seek to find new benefits at better values, the Medicare Supplemental insurance market also should have an opportunity to have more flexibility and latitude to enter the managed care arena, while ensuring that quality health care services are delivered with proper consumer protections.

One final thought on the supplemental insurance side of the Medicare reform package, we want to express our thanks for the Committee's willingness to work to resolve confusion in the supplemental insurance and long-term care insurance markets as it relates to Medicare nonduplication rules. Although we have not seen the details of the proposal, we believe that corrective legislation is necessary to ensure that all consumers, including those on Medicare, have the option of purchasing supplemental insurance that pays benefits regardless of other coverage and long-term care insurance products that coordinate against Medicare.

Obviously, it is extremely difficult to comment on specifics of a bill when we have not seen legislative language. The outline we received is general in nature, and we have not had time to review it in detail.

The HIAA is extremely pleased that the bill expands options for seniors to mirror those available in the private sector. In a recently released survey of "American Attitudes Toward Managed Care" five well-known pollsters pulled together data from approximately 40 different public opinion studies from the beginning of 1993 to the present. Their conclusion was "Americans in managed care are satisfied with their health care coverage. Overwhelmingly, the weight of evidence indicates that those enrolled in managed care plans are as satisfied with their health care arrangements as are other Americans." We agree that it is time for Medicare beneficiaries to have expanded access to these types of plans.

It is also important to note that beneficiaries who choose to do so can remain in traditional fee-for-service Medicare. Change is difficult for all Americans, particularly our senior population. We are pleased that remaining in fee-for-service Medicare will be an option in the reformed system.

We also believe that the Medisave plan or Medical Savings Accounts (MSAs) for Medicare beneficiaries will provide another important health care option for seniors. The Medisave plan will help make funds available to seniors for routine care when needed, and empower seniors to make choices that best suits their needs.

In designing the Medisave plan, we applaud the Leadership for recognizing the potential dangers of adverse risk selection and the need for special rules for opting in and out of Medisave plans in order to minimize selection problems. In order to protect the underlying MedicarePlus system and taxpayers from the problems associated with adverse risk, the Medisave plan should go further to discourage individuals from switching back and forth between Medisave and another MedicarePlus plans. Finally, Medisave plan option could be strengthened to protect taxpayers by ensuring that Medisave plans are only used for medical needs.

We were also pleased to note that onerous Patient Protection Act (PPA) standards or other anti-managed care provisions were not included in the outline. We hope that you will be vigilant in keeping anti-managed care provisions from being attached to the bill as it moves through the legislative process. Patient Protection Act proposals compromise patient protection by undermining the ability of managed care organizations to deliver high quality care. Most of the Act's provisions are designed to protect providers, not consumers. The private market is already addressing many of the Act's concerns as employers and consumers demand higher quality health care.

Managed care organizations ensure delivery of quality care by choosing providers who are best qualified and most suited to serve the needs of their members. These providers are willing to have the quality of their care measured to ensure continuous quality improvement. Proposals such as the PPA, however, are anti-competitive and hinder managed care organizations from ensuring the high quality of providers in their networks.

HIAA is extremely pleased the proposal contains malpractice reform. We have served for several years on the Executive Committee of the Health Care Liability Alliance. Enacting malpractice reform is essential to reduce health care costs and improve consumer access to health care services. Effective federal health care liability

reform will enhance the fairness, timeliness and cost effectiveness of the civil justice system in resolving health care injury disputes. Everyone bears the burden of high malpractice costs. These costs are reflected in higher insurance premiums, increasing defensive medicine, and high costs for health products and services. Further, health care liability costs do not result in productive use of our health care dollars. Only 43 cents of every dollar awarded in lawsuits actually goes to the injured party. Even a meritless lawsuit can tie up a physician in court for years, directly taking away from the physicians' ability to provide care to patients.

The bill's provisions would place a statute of limitations on filing claims, limit non-economic damages to \$250,000, limit defendant liability for non-economic damages to a proportionate amount, cap punitive damages, and allow periodic payment of non-economic damages, rather than in a lump sum. Many of these provisions build on the "Cox liability amendment" contained in the tort reform bill previously passed by the House. HIAA strongly supports malpractice reform and its application to all defendants, for all claims, under Medicare or otherwise, in claims arising from an injury incurred in the delivery of health care.

HIAA is very supportive of efforts to combat health care fraud and abuse and supports initiatives to eliminate health care fraud and abuse in the government and private sectors. HIAA maintains statistics about fraud in the private health insurance system. As you may know, the overwhelming majority of private health insurers have developed anti-fraud programs, which have been very successful in achieving savings through their anti-fraud activities.

HIAA is supportive of proposals which increase awareness of health care fraud such as the proposal to increase beneficiary awareness of fraud and abuse. This will enable us to educate beneficiaries so that they may become better consumers and be better able to detect fraud and abuse in the health care system. Beneficiaries should be the most informed individuals regarding the types of health care services which they receive and their increased participation is crucial to eliminating fraud and abuse in the health care system. Proposed beneficiary incentives will complement the increased awareness efforts.

HIAA also supports the proposed Medicare Integrity Program, which requires the use of private sector companies, technologies, and software best suited to performing anti-fraud and abuse activities. As I noted before, the private sector has been very successful in developing anti-fraud programs to decrease health care fraud and abuse. HIAA believes that the federal government will benefit by following the lead of the private sector in this area.

According to a report released by the General Accounting Office (GAO) in May, 1992, medical fraud and abuse cost the nation as much as \$70 billion, equaling 10 percent of the money the nation spends on health care annually. The GAO estimates that this year the loss could rise to \$100 billion. The GAO report concluded that "only a fraction of the fraud and abuse committed against the health care system is identified," and of those abuses that are discovered, fewer still are prosecuted.

Health care fraud affects every citizen because each of us pays the price for health care in the United States: taxpayers who pay for public programs such as Medicare and Medicaid; persons who pay health insurance premiums; and organizations who buy health care coverage for their employees. Every one of us pays higher premiums because of fraud.

According to an HIAA survey, anti-fraud programs implemented by health insurance companies saved \$112 million in 1992. These savings represent a cost/benefit ratio of 1 to 9. This is an example of a "good" administrative cost expenditure by the health insurance industry; one that will help keep health insurance premiums low.

The proposal envisions a 2-year transition period before 12-month enrollment becomes the norm. From a practical standpoint, allowing beneficiaries to disenroll and enroll monthly could entail substantial administrative costs to HCFA and private plans. It would also greatly increase uncertainties related to establishing premiums, as MedicarePlus plans could experience significant shifts in the risk-mix of their enrollees during the course of a year.

Health care in this country has traditionally been developed, marketed, regulated, and delivered at the state and local level. Health insurance agents, in particular know people personally and have a good understanding of their health needs and the insurance that would most appropriately meet those needs. Under the reformed Medicare plan, seniors are going to need help in understanding the maze of different and competing plans being offered. The health insurance agent is best situated, has the most knowledge, and is the most appropriate individual to provide such assistance. Congress should encourage agent participation in the new program.

HIAA welcomes additional competition in the marketplace from provider sponsored networks (PSNs). We understand the concerns raised in the draft about recognizing legitimate differences between PSNs and insurance companies. Currently, there are 500 PHOs operating in today's market, with as many as 1,000 in the process of being formed. While we welcome competition, we do not welcome competition in an unlevel regulatory environment. If these new entities are not required to operate in the same regulatory environment as others in the market, and can operate under different or perhaps less stringent rules, they will have a market advantage. The National Association of Insurance Commissioners (NAIC) stated in a letter dated September 19, 1995, that the unlevel playing field created by an exemption from state regulation "would likely have unforeseen and potentially negative consequences on the health care market." "A dangerous precedent would be set by such an exemption. Medicare beneficiaries deserve the same protections which state laws affords to other citizens of the states."

Currently, health plans providing health care delivery to Medicare beneficiaries conform to federal and state statutes and regulations designed to protect these beneficiaries. All states have established standards affecting health plan solvency, plan offerings, marketing activities, quality assurance, consumer protection, and other important consumer safeguards. The managed care industry has voluntarily supplemented these statutes and regulations with national, private accreditation programs that have had a significant effect on the way the industry evaluates itself. Medicare managed care plans are required to offer adequate access to services, monitor the quality of care, respond to consumer grievances, and evaluate outcomes.

The HIAA believes that all entities that assume risk for the payment and provision of health services to the public should be subject to the same kind of consumer protection standards. We are concerned that in the eagerness to implement Medicare restructuring, these hard won consumer protection standards, including requirements relating to capitalization, solvency, financial reporting and disclosure not fall victim to the experience of California two decades ago with Prepaid Health Plans, or PHPs. PHPs, which had minimal operating requirements, profited at the expense of tens of thousands of consumers. If the PHP experience teaches us anything, it is that all entities taking on risk to provide services should be held to the same high standards that are in place for insurers and HMOs in the Medicare marketplace.

HIAA recognizes that market based competition between health care financing and delivery systems results in the lowering of health care costs to consumers. The market is constantly changing, with new types of health care entities constantly forming to provide a range of health care services to all consumers, including Medicare beneficiaries. Current antitrust law has allowed hundreds of organizations, including ones developed by physicians, hospitals, and allied health professionals, to integrate financially to form networks that are successfully competing in the market place. However, changing antitrust law to benefit any new or existing health care entity, including those seeking to provide health care services to Medicare beneficiaries, would allow those entities to circumvent protections in place under current law.

We would like to continue to work with the Committee and the Leadership to modify the provisions as they are drafted into legislative language.

We are pleased to see that the need to base contributions on legitimate beneficiary risk factors such as age and geographic location has been clearly recognized. We are particularly pleased to see that the MedicarePlus government contribution structure is based on the current, well-established AAPCC system. We support efforts to study further refinement of the current AAPCC methodology to better reflect beneficiary health care needs. The gradual approach taken to controlling long term costs by restraining the annual rate of contribution growth is superior to an arbitrary, one time cut in plan reimbursement rates, which could disrupt markets, damage the existing managed care infrastructure, and reduce beneficiary access to managed care alternatives.

We are also very pleased that the MedicarePlus program implicitly recognizes the dangers of beneficiary risk selection between high deductible plans and managed care programs. This recognition, along with appropriate pricing based on beneficiary risk, is vital to ensure the stability and cost effectiveness of the total Medicare program.

We agree with the notion that Part B premiums will be set to maintain the portion of Part B costs covered by beneficiaries at 31%. This provision will preserve cost consciousness among beneficiaries while at the same time preserving the affordability of Part B coverage.

The industry recognizes the need to control costs throughout the Medicare program and applauds the drafters' efforts to embrace private sector cost containment

techniques like managed health care. However, the changes to the Medicare Volume Performance Standard and the Hospital Outpatient Formula, and the caps on reimbursement for durable medical equipment, orthotics, prosthetics, and clinical laboratory services could have a significant impact on the supplemental coverage policies seniors purchase to cover costs that Medicare does not reimburse. While it is not possible to quantify this impact at this time, we intend to study the extent of this impact and will provide further analysis to the Committee.

Reforming our Medicare system is a monumental task. "The Medicare Preservation Act of 1995" works to achieve a balance between new horizons and maintaining a secure health care system for our nation's senior citizens. It also attempts to look to the future and deal with the retiring baby-boom generation. HIAA looks forward to working with the Congress as it refines this proposal through the legislative process.

Mr. THOMAS. Thank you, Mr. Troy.

I thank all of the witnesses for their testimony.

I would say, Mr. Troy, that as we looked at new ways in which to provide health care delivery service to seniors approximately two decades ago, the whole concept of managed care HMOs was a new concept; and at that time there was a plea not to be treated like the folk who had been there in the past because you are different.

Notwithstanding the obvious comparison in terms of today's structure, I do want to seriously underscore our commitment, I think, as you have seen in this and you will see later, to make sure we have consumer protection, quality standards, and adequate resources. And we look to you folks to assist us in examining this new structure. It may not be exactly the same, but we want to know your growth experiences during your early days so that we would not commit any of the obvious mistakes that you folks had lived through. It would be a good idea, because I think you are very sound now. You understand what you are doing. You are a very mature operation. And I cannot conceive of a choice structure for Medicare that would not make you folks a major component in it.

Mr. Lehrmann, I want to thank you for your testimony where you say you are pleased to see that we are trying to hold down the direct cost to beneficiaries. As opposed to other projects in town right now, who are examining options on increasing copays and increasing the deductible, we thought it was more important to reform the programs, to put them in a prospective payment structure where they look for savings within a fixed structure rather than trying to get additional funds from beneficiaries. And I appreciate your recognizing our focus in that area.

Mr. LEHRMANN. We did see it, and we wanted to recognize it and let you know that that was one of the targets we had to work on.

Mr. THOMAS. Thank you very much.

Does the gentleman from Florida wish to inquire?

Mr. GIBBONS. Mr. Troy, I am skeptical of your association. I think you are just going to go out and cherrypick the Medicare people. You are going to insure all the healthy ones, and you are going to dump all of the unhealthy ones back on the government. Now, what is to prevent you from doing that?

Mr. TROY. Of course there will be the requirements, the guarantee issue to all comers. And I think we have acknowledged that the subject of risk selection—

Mr. GIBBONS. But at what rate? What will they have to pay?

Mr. TROY. The marketplace we believe is the best place to set the premium rates for the products.

Mr. GIBBONS. In other words, you will be able to cherrypick them because you all are a collusion anyway. You have no antitrust laws. You can put—get together on prices. You can cherrypick the market. You have got all of—you have got the health records of every senior in the United States, and you could go out and cherrypick the market, and you can charge them different rates. That is what you are telling me.

Mr. TROY. The program includes risk adjustors now. We have indicated favorable—

Mr. GIBBONS. Risk adjustment means cherrypicking to me. What is it? What is going to stop you from cherrypicking the market?

Mr. TROY. Well, the guaranteed issue requirements plus the application of any appropriate risk adjustment. In other words, where you adjust premiums to the plans based on the risk of the beneficiaries that they assume. There are risk adjustors in the program now, and we have indicated that there—that subject should be studied and refined further.

Mr. GIBBONS. You are going to risk adjust on the basis of age, aren't you?

Mr. TROY. Yes, sir, that is appropriate.

Mr. GIBBONS. That means that all of the really sick people in Medicare won't get in, because your premium will just be too high on them. Sure, you don't want them. I don't blame your industry for not wanting them. You won't insure some 90-year-old man for anything near a reasonable price that everybody else pays, will you?

Mr. TROY. Mr. Gibbons, I don't think the record shows any favorable risk selection in favor of the HMOs that are in the marketplace now, surely, with respect to the under-65 market.

Mr. GIBBONS. I am not talking about HMOs. People in my area that are in HMOs, most of them are anxious to get out, get out as quickly as they can.

Mr. TROY. The demographic profile of people in HMOs matches the demographic profile of people not in HMOs across the country. There is no indication at all of risk selection on a broad basis in favor of HMOs.

Mr. GIBBONS. Aren't most of the people in HMOs today young and healthy?

Mr. TROY. No. I think, broadly speaking, the profile of the under-65 market pretty much matches.

Mr. GIBBONS. Aren't most of the people who are in HMOs much healthier, much younger, than all the people as a whole that are covered by insurance?

Mr. TROY. I don't think so, Mr. Gibbons.

Mr. GIBBONS. Well, yes or no? Are they? I think they are. I have been told that they are, that the young and healthy people pick an HMO if they have any choice. You all are just going to cherrypick the market. You might as well admit it. Tell me I am wrong. Tell me how I am wrong.

Mr. TROY. I don't think the record supports it with respect to—

Mr. GIBBONS. I am not talking about the record. I am talking about what is in this legislation. What in this legislation is going to stop your insurance companies from cherrypicking the market and leaving the Federal Government, the taxpayers of the Federal Government, to pick up the bill for all the sick people? Tell me what is in there.

Mr. TROY. The ability to apply an appropriate risk adjustment factor if, in fact, a healthier population is going to one plan versus another or with respect to the people remaining in the Medicare fee-for-service program. The plan provides for that.

Ms. IGNAGNI. Mr. Gibbons, perhaps I could add some data to the discussion with respect to your question about who is in HMOs and who are we serving presently.

There is a study that we submitted to the Committee during our last testimony about 1 month ago. I would be delighted to send it

to you. It is based on 1994 data. It is the most comprehensive survey that has been done about the question you posed—14,000 households. It looked at elderly people over 65 in HMOs versus fee-for-service, and it showed on a disease basis, and on a chronic condition basis, they disaggregated by very specific conditions, and they showed that it was an equal match in HMOs and fee-for-service.

Mr. GIBBONS. What—did you all survey yourselves?

Ms. IGNAGNI. No, sir. It was done by the National Research Council, I think, a very respected organization in Wisconsin, 14,000 households; and I would be delighted to provide it to you for the record.

Mr. GIBBONS. Send it up, I will be happy to read it.

Ms. IGNAGNI. Thank you, sir.

[The following was subsequently received:]

Enrollment/Disenrollment Patterns for Medicare Risk Plans

I. Findings

This study provides an analysis of 1994 enrollment/disenrollment patterns for Medicare Risk plans. The results show that 90 percent of members continued in an HMO plan in their area, with 84 percent remaining in the same plan and six percent switching to another area plan. An additional six percent disenrolled due to beneficiary-related factors, and four percent disenrolled to join another fee-for-service plan in the area. These results are consistent with other research studies.

II. Background

Currently, 2.5 million Medicare beneficiaries receive their care through the Medicare Risk program. As the government considers alternative approaches to ensuring the future financial viability of the Medicare program, expanded use of HMOs is one potential option. Therefore, the ability of HMOs to meet the needs of the elderly is an issue of major interest.

Actual experience in the Medicare program provides the best basis for assessing managed care's potential to effectively serve the Medicare population. Accordingly, this study uses 1994 data to look at disenrollment patterns for Medicare HMOs. In contrast to participants in many private-sector plans, Medicare Risk members are permitted to leave the program at any time. The choices they make provide one indication of their satisfaction with the care they are receiving.

Below, the study methods and results are discussed. Then, the findings are compared to those of previous studies.

III. Methods

To determine the overall disenrollment rate for the Medicare Risk program, the study uses data from the Health Care Financing Administration's (HCFA) "Disenrollment Rates Report: National -- Risk HMOs" for the full year 1994. The disenrollment rate is calculated by comparing the total number of disenrollments over the year to the average of beginning of the year enrollment and end of the year enrollment.

To break down the disenrollment further, data were collected from four large risk plans. These plans represent about 40 percent of the risk enrollees nationwide and have a combined disenrollment rate that is similar to the nationwide rate. HCFA Regions 4 and 9 (Atlanta and San Francisco) account for about 93 percent of the enrollment of the sample plans. In comparison, the two regions account for about 68 percent of enrollment for the overall

Medicare Risk program.

The plan data reflect information collected as part of ongoing plan operations. Therefore, the exact approach and organization of the data varies across plans. To aggregate the data, disenrollments were classified into three groupings:

- "Involuntary" disenrollments due to such factors as failure to pay premium, ineligibility, a move out of the service area and death. These disenrollments are beneficiary-related, not plan-related.
- Disenrollments to move to another risk plan in the area.
- Disenrollments to move to fee-for-service care in the area.

For each category, the plan data were used to derive a weighted average rate.

IV. Results

Overall Enrollment/Disenrollment Pattern

As shown in the attached figure, the HCFA data and plan data can be combined to look at the overall enrollment/disenrollment pattern for all enrollees in a year:

- Eighty-four percent of risk plan enrollees remain in their plan.
- Six percent of risk plan enrollees leave their plan to join another risk plan in the area.
- Another six percent of risk plan members leave their plan due to "involuntary" causes, including change in Social Security status, relocation out of their plan's service area, failure to pay plan premiums, and death.
- About four percent of risk plan enrollees leave their plan to switch to fee-for-service care in the area.

Background Analysis

HCFA data shows that 16 percent of Medicare beneficiaries disenrolled in 1994. Based on the plan-specific data, the enrollment/disenrollment pattern for the year can be further broken down:

- About 38 percent of disenrollees leave their plan to join another risk plan in the area.
- Another 37 percent of disenrollees leave their plan due to "involuntary" causes, including change in Social Security status, relocation out of their plan's service area, failure to pay plan premiums, and death.
- About 25 percent of disenrollees leave their plan to switch to fee-for-service care in the area. Thus, looking at voluntary disenrollments, about 60 percent switch to HMOs and 40 percent switch to fee-for-service care.

As noted above, the plan-specific data principally reflects enrollments in HCFA Regions 4 and 9, areas where most Medicare Risk enrollment is concentrated. In other regions, patterns may differ.

V. Comparison to Other Studies

The plan-specific data can be compared to other studies of disenrollment from Medicare risk plans:

The Office of the Inspector General (1995) studied a sample of 1,915 beneficiaries who had disenrolled from Medicare Risk plans. The sample is based on the 87 risk HMOs participating in the program in February 1993. HMOs were stratified into three categories according to disenrollment rate. A sample of beneficiaries from 15 HMOs was then selected randomly from each category. Sixty-one percent of the sample, 1,177 disenrollees, responded to the survey. The study excluded beneficiaries who had died.

The study results are consistent with the findings presented in *Section III*:

- Excluding deaths, the Office of Inspector General study (OIG) finds that 29 percent of disenrollments are for involuntary reasons such as moving and clerical errors. This figure is consistent with findings presented in *Section III* which reports 37 percent of disenrollments are involuntary when deaths are included.
- The OIG study finds that 58 percent of disenrollments involve a switch to another HMO and 42 percent involve a switch to fee-for-service care. These figures are consistent with the findings presented in *Section III* which reports that 60 percent of voluntary disenrollments involve a switch to another HMO and 40 percent involve a switch to fee-for-service care. It should be noted that the OIG figures are not adjusted for involuntary enrollments other than death.

A HCFA-funded Brandeis study (1992) looked at a sample of 17,400 beneficiaries who disenrolled between December 1988 and May 1989. The survey was stratified to reflect the geographic distribution of disenrollments. Disenrollments due to death, administrative error, and termination of Medicare coverage were excluded. For most survey questions, there were over 5,600 respondents.

The study results are consistent with the findings presented in *Section III*:

- The Brandeis study finds that 46 percent of disenrollees switched to another HMO and 54 percent switched to fee-for-service. For beneficiaries with an option of switching to another HMO, however, 62 percent switched to another HMO and 38 percent switched to fee-for-service. These figures are consistent with the findings presented in *Section III* which reports that 60 percent of voluntary disenrollments involve a switch to another HMO and 40 percent involve a switch to fee-for-service care.

HCFA's "*Disenrollment Rates Report: National – Risk HMOs*" breaks down disenrollments into three broad categories: switch to another HMO, switch to fee-for-service, and selected involuntary factors (e.g., death, ineligibility).

For 1994, the HCFA administrative data shows 33.4 percent of enrollees switch to another HMO, 51.2 percent switch to fee-for-service, and 15.4 percent leave involuntarily. Compared to the survey findings presented in *Section III*, these results show a higher share of disenrollment involving a shift to fee-for-service care and a lower share involving involuntary disenrollment.

Two factors may contribute to the difference. First, in the HCFA study, disenrollments due to some beneficiary-related factors such as a move out of the area appear to be included in the shifts to a new plan rather than in involuntary disenrollments. Second, in the HCFA study, the death-figures are lower than those reported by the plans. This discrepancy may reflect the time lag for noting deaths in the HCFA information system.

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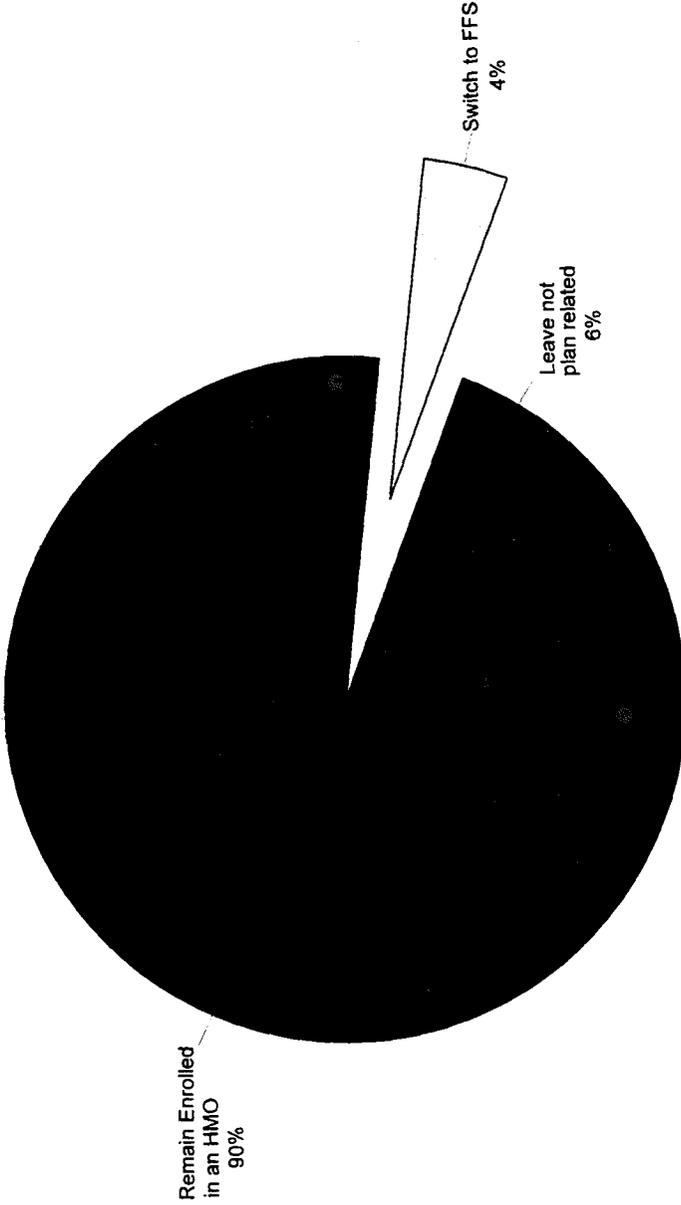
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Enrollment Patterns In Medicare HMOs*



* 1994 "Disenrollment Rates Report: National -- Risk HMOs" (HCFA)
1994 Data from four large Medicare risk plans

April 27, 1995

RH 6-95

**Chronic Illness in the Medicare Population:
Study Finds No Difference Between HMOs and the FFS Sector**

Analysis of unpublished data from a National Research Corporation (NRC) survey reveals that elderly individuals are similar in terms of self-assessed health status and the prevalence of chronic medical conditions regardless of health plan type; whether HMOs or fee-for-service (FFS) plans.

I. Background

As part of its Healthcare Market Guide V Survey, the National Research Corporation (NRC) gathered data on health status, service utilization, and plan satisfaction from 200,000 households, a representative sample of the 48 contiguous states. The number of responses was 132,014; a response rate of 66 percent. NRC did not follow up with nonrespondents. The households were balanced to match the U.S. Census percentage distribution in total and within each geographic division with regard to market size, age of household head, annual household income, and household size.

Respondents reported the name and type of their health plan; NRC categorized the plans as HMOs, PPOs, or FFS plans. The primary health care decision maker for each household was asked a series of satisfaction questions and evaluated the performance of the household's primary health care plan. In addition, the survey collected data on up to five household members regarding thirteen specific chronic medical conditions and overall health status.

II. Methods

The results reported here focus only on respondents who are primary health care decision makers over age 65. In order to more accurately compare characteristics of this population group across HMOs and FFS coverage, the analysis examines only those metropolitan statistical areas (MSAs) where there were responses for both types of plan. MSAs with respondents enrolled exclusively in an HMO or FFS plan were excluded. Of the 318 MSAs sampled in NRC's survey, 230 MSAs had elderly, primary decision makers enrolled in an HMO or in FFS coverage (72.3% MSAs represented). This resulted in a sample size of 14,695 observations or approximately 11.1% of the total responses for the NRC survey.

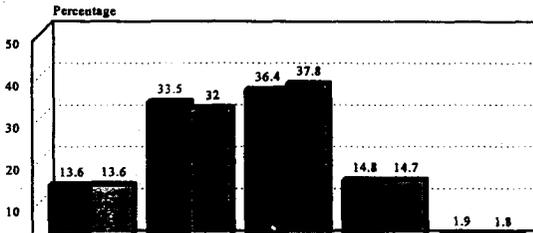
III. Results

The study found that in terms of overall self-reported health status and incidence of chronic conditions, HMOs and FFS populations were very similar. The differences between HMOs and FFS plans were not statistically significant. Some of these comparisons are illustrated in the attached table:

- Elderly members in HMOs and FFS coverage have similar perceived health status:
 - + 16.7% of HMO members reported they were in excellent or very good health, compared to 16.5% of FFS enrollees. The percentage in both populations reporting poor health was the same, at 13.6%.

- Individuals with chronic health conditions also look similar in HMOs and FFS coverage:
 - + 19.5% of HMO members reported chronic back pain, compared with 18.3% of FFS members;
 - + 49.2% of HMO members reported arthritis, compared to 49.1% of FFS members;
 - + High blood pressure was reported by 38.6% of HMO members and 39% of FFS enrollees; and
 - + Diabetes was reported by 11.2% of HMO members and 10.4% of FFS enrollees.

Elderly Members in an HMO or FFS Have Similar Perceived Health Status



Mr. THOMAS. Will the gentleman yield back?

Mr. GIBBONS. Yes.

Mr. THOMAS. Does the gentleman from Florida wish to inquire?

Mr. SHAW. I have no questions except to congratulate the panel of witnesses for a very enlightening testimony. Thank you.

Mr. THOMAS. Does the gentleman from Kentucky wish to inquire?

Mr. BUNNING. Yes, thank you.

I want to ask Hon. Beau Boulter and Jake Hansen, do you have anybody in your groups that are in alternative health care plans rather than Medicare?

Mr. BOULTER. Well, I mean, I know that the United Seniors Association does. You mean among the membership?

Mr. BUNNING. Among your membership, yes.

Mr. BOULTER. Yes, I can; but I can't give you how many.

Mr. BUNNING. In other words, is everybody, 100 percent of your membership, in Medicare? Or do people who continue to work after 65 have employers' sponsored plans and they stay in there?

Mr. BOULTER. The vast majority are in Medicare, but not everybody is in Medicare. Some are in HMOs.

Mr. BUNNING. Mr. Hansen.

Mr. JAKE HANSEN. I would say that is accurate. A lot of people are taking advantage of Medicare Select.

Mr. BUNNING. Of course. Mr. Lehrmann.

Mr. LEHRMANN. We certainly would say about the same thing as far as AARP is concerned.

Mr. BUNNING. Do all three of you have any idea how many people in your organizations also have what are called Medigap Programs?

Mr. BOULTER. Nearly everybody.

Mr. JAKE HANSEN. Over 80 percent.

Mr. LEHRMANN. I would say it is very high, yes.

Mr. BUNNING. Let me ask, how many people in Medicare have anything but fee-for-service? In other words, where the provider would have the ability of an HMO or PPO or whatever it might be.

Mr. BOULTER. Currently?

Mr. BUNNING. Currently.

Mr. BOULTER. About 10 percent.

Ms. IGNAGNI. Ten percent.

Mr. BUNNING. Ten percent. Is that the answer? There is only 10 percent in anything but fee-for-service nationwide?

Ms. IGNAGNI. That is right.

Mr. BUNNING. Mr. Lehrmann, do you think we should have a program that has more options than just Medicare part A and Medicare part B for senior citizens?

Mr. LEHRMANN. Senior citizens——

Mr. BUNNING. Sixty-five and older.

Mr. LEHRMANN. Seniors and older people want to have some choices, and if there are choices that they can utilize appropriately they certainly would take a look at it. We certainly don't object to proposals that include HMOs and other approaches. If they can be appropriately documented and it is a good choice for our members, that is certainly the direction that we would like to move in.

Mr. BUNNING. Wouldn't it be nice if prescription drugs were available to those that are in Medicare?

Mr. LEHRMANN. It has always been a target of ours to include prescription drugs, because prescription drugs create a special problem for older persons.

Mr. BUNNING. Not only for older persons but for anyone who has a maintenance problem.

Mr. LEHRMANN. Yes, yes, persons with diabetes and the like. Absolutely, that is a serious problem.

Mr. BUNNING. There are some provisions, obviously, in this mark, this proposal, that would address prescription drugs in some manner; and I think that we ought to take a strong look and see if it is positive for those that would be covered by Medicare.

Thank you all for your testimony.

Mr. THOMAS. Does the gentleman from New York wish to inquire?

Mr. RANGEL. Just a few questions.

Mr. Hansen, who is the president of your group?

Mr. JAKE HANSEN. A gentleman by the name of Jim Aldige.

Mr. RANGEL. Where is your headquarters?

Mr. JAKE HANSEN. We have headquarters in Fairfax, Virginia. We have our legislative office here on Capitol Hill.

Mr. RANGEL. Outside of those two offices, do you have other offices?

Mr. JAKE HANSEN. No, we do not.

Mr. RANGEL. But your membership is two and a half—how many in your membership?

Mr. JAKE HANSEN. It is 2 million members and supporters. One million people who have paid dues.

Mr. RANGEL. They pay dues?

Mr. JAKE HANSEN. One million who have paid dues, and 1 million who may not be able to afford to, but they want to support and believe in what we believe in.

Mr. RANGEL. Are you organized under the laws of Virginia?

Mr. JAKE HANSEN. Yes, we are.

Mr. RANGEL. Is it a 501(c)(3)?

Mr. JAKE HANSEN. It is a 501(c)(4).

Mr. RANGEL. Do you have a letterhead or post office box or anything?

Mr. JAKE HANSEN. Yes, we have all of those things.

Mr. RANGEL. How long have you been with this Seniors Coalition?

Mr. JAKE HANSEN. I have been with them pretty much since its inception, so about 5 years.

Mr. RANGEL. It is a coalition of many, many different senior groups?

Mr. JAKE HANSEN. It is a coalition of many individual members. Just citizens and people who believe and care.

Mr. RANGEL. No offices in Chicago. If I wanted to find out who from New York was in your coalition, where could—what would I have to do?

Mr. JAKE HANSEN. You would have to contact our office. Either our Washington, DC, or Fairfax office.

Mr. RANGEL. Would it be a problem to send to me the members who come from the New York area?

Mr. JAKE HANSEN. We—as a general rule, we don't just basically make that available; but we would certainly be willing to talk with you about it. You have heard from thousands of our members, and I assume—

Mr. RANGEL. I have?

Mr. JAKE HANSEN. I am sure you have. I can—and that would be easy enough to check.

Mr. RANGEL. They identified themselves as a part of your coalition?

Mr. JAKE HANSEN. Yes, they would.

Mr. THOMAS. Would the gentleman yield? Would you like him to have all those people in New York send you a letter?

Mr. RANGEL. No, I really—if it is on a letter—listen, if seniors are excited about it, and it has just been 60 pages about something I don't know about, and they come from my district, then maybe they can tell me as well as you have testified how great this thing is. So I hope, though, there would be a letterhead or something other than what I have here, because there is not even a telephone number here.

Mr. JAKE HANSEN. I will tell you what. I will send you a package of information about our organization, and I will see if I can find some people—

Mr. RANGEL. Let me add, though, there is not a name or telephone number on their package, either, so we are in good company. Thank you.

Mr. THOMAS. Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Yes. Mr. Chairman, I would like to ask the panelists a question, all of you, if you could listen just a second.

There have been a lot of informational questions, specific things that come up, and I am not going to do that. But I have been sort of keeping a list of the general morals that have come out of this session all day.

The first is, don't go to sleep. Let Congress keep on top of this issue. It is important. It is not just a 1-day or a one-bill issue. Second is, go slow, be careful. Third, hinder those who try to play the system. And, fourth, communicate, communicate, communicate.

Would you like to add a moral to that list? Yes, Beau.

Mr. BOULTER. I would. I think it is included in everything you are saying but is just let the marketplace work, give it enough flexibility, keep enough flexibility in there to make sure that the incentives have a chance to work as people experiment, enroll, get out and join these various plans.

Mr. JAKE HANSEN. I would say, believe in seniors. They are a group of people who have had more experience than most and, being consumers, they know what they want. They know what works for them. They will find a way to make sure that they get a product that meets their needs.

Mr. HOUGHTON. Thank you.

Mr. LEHRMANN. I would certainly add that we want to make certain that we protect the people that we are working with, the beneficiaries of Medicare.

Ms. LEHNHARD. I would say follow through on the framework of using the competitive forces of the private sector and create a healthy marketplace, a level playingfield.

Mr. HOUGHTON. OK.

Ms. IGNAGNI. I would say build on what works.

Mr. TROY. I would just underscore letting the marketplace work. It is just starting to work in the last few years, and I think it can bring great benefits to society here.

Mr. HOUGHTON. Thank you very much.

Mr. THOMAS. Thank the gentleman. Does the gentleman from California wish to inquire?

Mr. MATSUI. Thank you. I would like to—Mr. Hansen, you say you support the proposal that is advanced by the Republican leadership?

Mr. JAKE HANSEN. Yes, what we have seen so far we are quite happy with.

Mr. MATSUI. What have you seen?

Mr. JAKE HANSEN. We have seen the 60-page plan that has been—

Mr. MATSUI. This document, the Medicare Preservation Act, a better Medicare, right?

Mr. JAKE HANSEN. That is correct.

Mr. MATSUI. OK. You have been able to base your support on these 60 pages?

Mr. JAKE HANSEN. Yes, we can.

Mr. MATSUI. I see. Well, could you tell me what the rate of increase will be from 1996 to the year 2002?

Mr. JAKE HANSEN. I guess in part it depends—I have seen and talked—

Mr. MATSUI. No, do you know what it is?

Mr. JAKE HANSEN. Not exactly.

Mr. MATSUI. Do you know what it will be from the year 2002 beyond and in the indefinite future?

Mr. JAKE HANSEN. No.

Mr. MATSUI. Do you know what the premium increase will be for the average senior citizen when this plan is in effect?

Mr. JAKE HANSEN. Well, let me tell you—

Mr. MATSUI. No, do you know, just yes or no?

Mr. JAKE HANSEN. No.

Mr. MATSUI. Do you happen to know—that is interesting. Do you happen to know how many seniors currently receive Medicare?

Mr. JAKE HANSEN. Yes.

Mr. MATSUI. How many?

Mr. JAKE HANSEN. 37 million people are on Medicare.

Mr. MATSUI. OK. So I am glad you know that number because that at least shows me that you have some knowledge of this issue.

Do you know how much will be taken out of part A in terms of the savings?

Mr. JAKE HANSEN. I don't believe that the savings are coming out of part A. I think the savings are coming out of giving people choices and introducing the market.

Mr. MATSUI. You say there are no savings out of part A, that is your understanding? Is that your understanding?

Mr. JAKE HANSEN. Well, I don't think—

Mr. MATSUI. No, it is a yes or no question. Is it or isn't it? Is that your understanding? I am trying to get an answer. Are you saying there is no money being taken out of part A or no cut in the rate of increase out of part A, let me say that?

Mr. JAKE HANSEN. There will definitely be a cut in increase.

Mr. MATSUI. OK. Do you know how much that is?

Mr. JAKE HANSEN. I don't think we can project that.

Mr. MATSUI. OK. Do you know what the cuts in the rate of increase will be out of part B?

Mr. JAKE HANSEN. We can't entirely project that.

Mr. MATSUI. You don't know that, either? Do you know, if I gave you the number 4.3 percent, that that will be the rate of growth for Medicare beyond the year 2002, that will be the new baseline? Do you know what baseline means?

Mr. JAKE HANSEN. Yes.

Mr. MATSUI. OK. That will be the new baseline. Can you tell me what impact that might have? Does that give it a 2-percent rate of growth, real rate of growth or zero or minus four or six or what?

Mr. JAKE HANSEN. I think you are going to come up with a very low rate of growth. I can't tell you an exact number. I think it is going to be very good.

Mr. MATSUI. Let me ask you, of your 2 million members, how many are senior citizens?

Mr. JAKE HANSEN. Nearly all of them.

Mr. MATSUI. How many, percentagewise?

Mr. JAKE HANSEN. Sixty-nine percent of our members are over 69 years of age. Eleven percent of our members are under 65 years of age.

Mr. MATSUI. Now, you have—I am assuming you must have a staff that has analyzed this 60-page document so that there is a knowledge base. That is why you came here. You are testifying before the Committee that next week is going to make a decision on cutting \$270 billion out of the rate of growth of Medicare, so I am assuming that you at least took the time on behalf of these 69 percent of the 69-year-olds or older, the 2 million people you represent, to analyze this, right?

Mr. JAKE HANSEN. We have taken a lot of time to look at this, yes.

Mr. MATSUI. Right. But you don't know how much is going to be taken out of part A, how much is going to be taken out of part B, you don't know what the actual rate of growth will be over the next 7 years or beyond that.

Mr. JAKE HANSEN. We know that Medicare will be bankrupt in 2002, we know that Medicare has significant problems.

Mr. MATSUI. Have you read the trustee report?

Mr. JAKE HANSEN. Yes.

Mr. MATSUI. Oh, good.

Mr. THOMAS. Does the gentleman relinquish the rest of his time?

Mr. MATSUI. I yield.

Mr. THOMAS. Yield back, thank you. Does the gentleman from Iowa wish to inquire?

Mr. NUSSLE. Thank you, Mr. Chairman. I am kind of puzzled. I think maybe America has been watching the O.J. Simpson trial too long. I thought this was a hearing.

Is there a witness at the table who is under subpoena? Are any of you here under subpoena? I think you are all citizens of this country and I don't think any of you are hostile witnesses that I am aware of. Is anyone aware of a hostile witness? You all came here to give us your best advice.

I listened to your testimony, and I learned from it. For 1 minute there I thought I was going to hear the gentleman from New York ask you if you have now been or if you have ever been a member of a senior organization. I thought we were going to go into double jeopardy there for 1 minute just 1 minute ago, can you answer this question, can you answer that question. I mean, we are here to learn, to listen to the seniors and to the country about what to do to save Medicare, and we are getting—you know what is interesting about this, one of the questions that was asked, I am going to ask you the same question, they said have you seen this plan, have you seen the 60-page document?

Is there anyone here that has seen the plan that the Minority Leader said the House Ways and Means Democrats were going to present to us today? Has anyone seen the Democrat plan, an alternative plan? Could you raise your hand if you have? No one has seen a plan? The Democrats don't have a plan, is that what you are telling us?

You have seen our plan, at least some of you have had a chance to look through it. Some of you are going to continue to look through it, but not one of you has seen a plan. Has anyone seen a plan? No one has seen a plan. Well, it is interesting to me that—you know, I have got a statement here from the Minority Leader, Representative Gephardt, on McNeil-Lehrer on September 15, 1995, saying we are going to have an alternative in the Ways and Means Committee, and there is still no plan from the Democrats.

Now, let me turn to our plan, and I would like to ask in particular from Mr. Lehrmann, and this is only a little small nuance, and I guess my first observation, let me say, is that I am very happy, I have met with my AARP members back home in Iowa. They came and they gave me their list that you provided us here today and we talked through it and had a great discussion. I learned a lot; hopefully they learned a lot, but I am sure I learned more.

The thing that impressed me is that they are keeping an open mind, and what I am hearing from you today in your testimony, sir, and what I am hearing from the other senior organizations here today is that you are keeping an open mind, you are looking at the plan, you are studying it, you want to see it continue to develop, but you understand it is a work in progress and you are keeping an open mind; is that correct?

Mr. LEHRMANN. Obviously, we are following what is going on. Truly I haven't had a chance to read the 60-page plan that you are talking about. I am aware of it, and as we go through this process, we are going to analyze the points that I raised each step of the way.

Mr. NUSSLE. The comments I have heard in the newspaper that your organization has made, maybe not through you, and I am not trying to say it was you, personally have been, I would say, surprisingly positive about our efforts so far, and if I am not characterizing it correctly, please characterize it for me, but I didn't hear as

in past efforts—I know your organization in particular has come out when there was a senior issue, and if it was not something you liked, boy, you just—you laid on it right away. I get the impression that that is not the case this time, that you are either happy with our efforts or, you know, you want to at least give us a chance to look through this; is that right?

Mr. LEHRMANN. Well, we are certainly open minded about it. We want to see what is developing and we told you what some of the limitations are, and we are going to pursue those questions with you, not only here, but our members in Iowa will be talking to you I am sure.

Mr. NUSSLE. I have no doubt. They are very good at making sure I know exactly what we need to do. One thing I just wanted to ask, you mentioned that you would be willing to consider \$110 billion, what you said trimming the growth. You called our \$270 billion a cut.

Now, I just want to—I am not trying to quibble with you, don't get me wrong, but \$110 billion trimming the growth and \$270—if we only trimmed the growth at \$110 billion, would that be the same trim growth or would that be a cut? I just want to make sure that we are talking about the same thing.

Mr. LEHRMANN. We are certainly, if we are reducing the amount that is available to the Hospital Insurance Trust Fund, then on the basis of what we have been having, there will certainly be some adjustments which you could refer to as cuts, yes.

Mr. NUSSLE. OK, so you would be supportive of cutting Medicare at \$110 billion is what you are suggesting?

Mr. LEHRMANN. We obviously know that something has to be done. We read the trustees' report, just as you read the trustees' report, and we know that we have to do something in order to keep the program solvent for the next 10 years. You noticed our second statement was that we would go slow as we take the next step, though, because we are looking out many years into the future as we deal with the issues of the baby boomers coming on line, so, yes, we realize that that is a reduction or a cut, whatever you want to call it.

Mr. NUSSLE. We have a plan. We want to get moving, but when you don't have a plan time may not be quite as much a factor, but we have got a plan we want to get moving and we appreciate all your testimony here today.

Thank you.

Mr. LEHRMANN. You're welcome.

Mr. THOMAS. Thank you. Does the gentleman from Pennsylvania wish to inquire?

Mr. COYNE. Thank you, Mr. Chairman. I would like to address this question to any of the panelists who care to respond. Presently we have 11 million beneficiaries of the Medicare Program who earn income under \$8,000 a year, mostly they are widowed women or single women. This plan that is being proposed here seems to double the part B premium by the year 2002.

Do any of you think it is fair to ask people who have an income of \$8,000 or less per year to absorb a doubling of the part B premium for doctors care?

Mr. BOULTER. If I may, one thing that we were sort of looking at at United Seniors Association is we were hoping that there would be no premium increases. I don't think it is so much an issue of fairness as it is, I think, to create market incentives. You have got to give people an incentive to make a different choice. They don't have to make a different choice, but it is not quite the question you are asking, but I wanted you to understand that that is one thing that we don't like about the plan, although we do think it is a good plan. But it would be better, I think, if it didn't rely on increased premiums.

Mr. COYNE. Anyone else care to comment on that?

Mr. LEHRMANN. Well, we were supportive of the Medicare, qualified Medicare beneficiary plan to help relieve that problem for lower income people, and we certainly believe that is an important part of this.

Mr. JAKE HANSEN. I agree with that, the QMB Program is very important for lower income seniors.

Mr. COYNE. Maybe the better question is do you think people who have incomes of less than \$8,000 a year are in any position to absorb a doubling of their premium? Anyone believe that?

Mr. LEHRMANN. Frankly, I don't see how these people can.

Mr. COYNE. Thank you.

Mr. THOMAS. Thank you. Does the gentleman from Ohio wish to inquire?

Mr. PORTMAN. I thank the Chair. I appreciate all the witnesses being so patient with us today and for your good testimony. I have a number of questions.

First of all, with regard to the conversation you had with Mr. Bunning and Mr. Gibbons on managed care, do you have any information—anyone can jump in—as to the level of satisfaction among those 10 percent of seniors who are in some kind of coordinated or managed care?

Ms. IGNAGNI. We do. We have quite a lot of information that has been gleaned by particular plans as well as impartial surveyors, which is quite compelling in terms of a real testimonial for the satisfaction.

The other piece I think that is very relevant that you haven't asked about, but it is the question of whether people stay in HMOs in particular, which is the option now available under Medicare, and what we are finding is that 96 percent of the individuals that have made the choice remain in the HMO environment, which seems to me a real vote of confidence about the satisfaction and the accomplishments of the plans.

Mr. PORTMAN. I have a Medicare task force at home as well. In fact, of our 33 members, 2 are representatives of the local AARP. They have been very constructive. We have had a good dialog over the last few months. One thing they tell me is that although in Cincinnati we don't have an active managed-care option available under Medicare, in Cleveland there is one, and the approval rates, in fact, are slightly higher, one point higher for HMOs with Medicare than they are for HMO for those under 65, which I thought was interesting because I thought although the approval rates were relatively high nationally, I thought perhaps they would be just the opposite with regard to those in Medicare.

Ms. LEHNHARD. Yes, we just completed a survey of Blue Cross & Blue Shield subscribers in our Medicare HMOs in 13 States, and we surveyed both the beneficiaries in HMO and people who are in the traditional program, and we found the satisfaction rate higher among those in HMOs, but the most important thing we found was that those with chronic illnesses had a higher satisfaction rate with the HMO.

In all this talk about whether you have access to specialists or not, the chronically ill in the HMOs were highly satisfied at an 87 percent versus 81 percent of the traditional program, so the sicker they were, the more they liked their HMO.

Mr. PORTMAN. Mr. Lehrmann.

Mr. LEHRMANN. I would just comment there was some question, I thought I heard earlier today, that there aren't very many people in an HMO. I have been in a cost HMO for the last 11 years in Madison, Wisconsin, and for me it has worked quite well. Having said that, I would not say it is for everybody, but it has worked out all right as far as I am concerned.

Mr. PORTMAN. That is fascinating. I wonder why—and I know there is some availability or access issues here—but why we are only at 10 percent then among the Medicare-eligible population in terms of HMOs? Could someone give us an answer to that?

Ms. LEHNHARD. I think they don't know about the availability. There is no organized effort to get out information about HMOs. I would go back to the earlier point about adverse selection. We think the best way to make sure that adverse selection doesn't occur, and we don't think it occurs now, but the best way to protect against that is to have a very organized effort to inform beneficiaries that they have these choices.

If you put a program, we know this with the Federal employees program, we have 4 million Federal employees in our coverage. If you put a scale, a chart in front of them and say these are your extra benefits in an HMO, and it includes prescription drugs, we know we are going to enroll people who will use prescription drugs. We welcome that kind of mass merchandising to Medicare beneficiaries to let them know it is available.

Mr. PORTMAN. Let me ask one more question with regard to the affluence test that we haven't touched on in this hearing. I read the AARP testimony. It is interesting a lot of seniors with whom I have talked at town meetings and even in my task force support affluence testing. Mr. Lehrmann, you seem to be saying that as long as there isn't affluence testing among those under 65 in the health care area, it wasn't fair for seniors to be subject to it under Medicare. I wonder what your personal thoughts are on it and whether there has been some discussion of that within your organization.

Mr. LEHRMANN. Yes, our organization has talked about it, and we believe that in fairness if you are going to use the affluence test for Medicare beneficiaries, then what about those who are wealthier in the rest of society, shouldn't they be put to the same test because they are getting their health care benefits paid for and are not paying any taxes on that benefit?

Mr. PORTMAN. You suggest that the subsidy should be changed with regard to income?

Mr. LEHRMANN. That is right.

Mr. PORTMAN. I would say in some respects the affluence testing is the flip side to Mr. Coyne's concerns, and I think the two actually go well together. I have many more questions, but I want to thank you all for being here and thank the Chair.

Mr. THOMAS. Thank the gentleman. Does the gentleman from Michigan wish to inquire?

Mr. LEVIN. Yes, thank you. Thank you, Mr. Chairman. Mr. Boulter, does your organization support the portion of the Republican plan that would increase the premiums?

Mr. BOULTER. Well, as I have said earlier, Mr. Levin, if you just isolate that, no, we do not. We are not for increasing the premium.

Mr. LEVIN. All right, that is a straight answer. So you oppose that part of the proposal?

Mr. BOULTER. Maybe that will get changed. It is a work in progress, it probably won't. It won't stop us from supporting the plan, but we have been on record for a long, long time in opposing premium increases, and we do oppose them.

Mr. THOMAS. Will the gentleman yield? I don't know where in our plan there is an increased premium. The premium remains the same.

Mr. LEVIN. It does over current law, under current law the premiums go back to 25 percent and then to the cost of living.

Mr. THOMAS. Is that in effect now?

Mr. LEVIN. That is the current law.

Mr. THOMAS. It is 31.5—

Mr. LEVIN. The premium works out to 31.5. Under current law it reverts to 25 percent and then to the COLA.

Mr. BOULTER. If I may, just to complete the answer, we think that is appropriate, that you maintain it at 31.5.

Mr. LEVIN. That is the increase, Mr. Boulter. I don't quite understand that. Under current law the premium in 2002, this is an estimate, would be about \$61. Under the Republican proposal the estimate is, this depends in part on the overall cost of part B, it would be \$93 to \$95 to \$97. That is an increase of \$32, \$33 over current law.

Mr. BOULTER. What I am trying to say is that we can understand if you are wanting to reduce cost why the Committee or Members of Congress might want to maintain it at 31 percent. However, our position would be that in the best of all worlds what we would rather see, frankly, is raising, you won't like this either, raising copayments or raising deductibles.

Mr. LEVIN. I take it that you don't support the premium portion, but let's leave your testimony as it is. Let me just ask you then about raising deductibles. You say in your statement that it should not be a hardship on the elderly. However, you should know that we also advocate special assistance to help low-income seniors handle these higher payments.

Are you aware that the majority proposal on Medicaid would eliminate those Federal supports?

Mr. BOULTER. I am sorry, I am not hearing you. Say that again, please.

Mr. LEVIN. Are you aware that the majority's Medicaid proposal would eliminate Federal support for the payment of those premiums for low-income seniors, are you aware of that?

Mr. BOULTER. I am not an expert at this Medicaid reform, but my understanding is that I believe in the block grant program that the States will be required to maintain a certain level of funding for those people.

Mr. LEVIN. There weren't hearings on that bill, either, so it is hard to tell.

Mr. BOULTER. If I am right.

Mr. LEVIN. I am not sure, it just came out of Committee. Mr. Hansen, let me just ask you quickly, does your organization receive its moneys only from individuals?

Mr. JAKE HANSEN. That is correct. Ninety-eight percent of our money comes from individuals.

Mr. LEVIN. You receive no organizational—

Mr. JAKE HANSEN. A small amount we have received money from, we have advertising in our newspaper and there have been a few corporations that have made small contributions to us, relatively small.

Mr. LEVIN. Mr. Boulter, does your organization?

Mr. BOULTER. One hundred percent.

Mr. LEVIN. Let me just ask, I understand the Senate majority bill would raise the eligibility age for Medicare so that it would be in 19—2003, it would start increasing from 65 to 67. This is for Medicare now. Paralleling the Social Security old age cash benefits. Does your organization support that?

Mr. BOULTER. United Seniors Association does support that.

Mr. LEVIN. Mr. Hansen.

Mr. JAKE HANSEN. I would think it makes a great deal of sense to have the eligibility age track along the Social Security.

Mr. LEVIN. Mr. Lehrmann.

Mr. LEHRMANN. We haven't decided exactly what our position would be on Medicare. It is one of the components in the long-term correction of this problem that would have to be taken into consideration.

Mr. LEVIN. OK, thank you very much.

Mr. THOMAS. The gentleman from Texas.

Mr. LAUGHLIN. Thank you, Mr. Chairman. Mr. Lehrmann, as president of the American Association of Retired Persons, does your organization discuss or have any position on the generational tax fairness that Mr. King testified about this morning? Were you here when he testified?

Mr. LEHRMANN. I didn't hear all of his testimony.

Mr. LAUGHLIN. Are you familiar with that terminology?

Mr. LEHRMANN. No, I am not.

Mr. LAUGHLIN. Can you tell us whether your organization has taken any position on whether the senior citizens are receiving benefits and the younger people entering the work force are paying a disproportionately higher payroll tax to support the benefits? That hasn't entered into your organization's discussion?

Mr. LEHRMANN. We haven't taken a position on that.

Mr. LAUGHLIN. All right. In fairness I won't ask you any more on that. Mr. Hansen, has your organization discussed generational tax fairness?

Mr. JAKE HANSEN. We have discussed that, and we have asked our members what they feel about that.

Mr. LAUGHLIN. What are your members telling you?

Mr. JAKE HANSEN. That there is definitely concern. They want to leave a better world for their children. They aren't particularly interested in leaving their children massive amounts of debt. They are concerned about what type of life their children are going to have. There is definitely that awareness and concern about that.

Mr. LAUGHLIN. What is the general age range of your membership? Is there a minimum age that you have to achieve before you can join?

Mr. JAKE HANSEN. We suggest that people have to be interested and concerned about the issues, and that generally translates to people over 65, and the majority of our people are over 69 years of age, but we were surprised to find out that we have got, you know, a big chunk of people who are under 65.

Mr. LAUGHLIN. Well, Congressman Boulter, does your organization take any position on generational tax fairness?

Mr. BOULTER. No. We have discussed it a lot. We haven't polled our members, but we have discussed it a lot. It just makes sense to us that you have got to have the support of the younger working Americans for this program, and if you just keep raising the payroll tax, you will lose that support. We think it is an important issue. That is one reason we do like your plan because it does not do that.

Mr. LAUGHLIN. I would just ask Mr. Lehrmann, Mr. Hansen, or Congressman Boulter, if you have an opinion as to whether it would be a major concern to your senior citizen membership if Congress were to make no changes and it became necessary to have a 40-percent payroll tax increase to support the current system with no reform. Would that be of concern to your membership?

Mr. LEHRMANN. Oh, yes, yes. Certainly if there was substantial increase of that magnitude, we certainly would be concerned about it.

Mr. JAKE HANSEN. That would be tragic.

Mr. LAUGHLIN. Congressman Boulter.

Mr. BOULTER. It would destroy the program.

Mr. LAUGHLIN. That is all the questions I have.

Thank you, Mr. Chairman.

Mr. THOMAS. Thank the gentleman.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. KENNELLY. Yes, thank you, Mr. Chairman.

Looking at this group before me I can see they have very intergenerational interests. I wonder if any of you would like to comment on the \$270 billion of Medicare cuts and the \$180 billion of Medicaid cuts we are looking at.

I read a Lewin study not too long ago that suggests that this could result in higher premiums for individuals not involved in the Medicare Program and could possibly impact on wages because we are having this—really \$450 billion is a huge shift in dollars. So I wonder if any of you had read that account or if not, if you thought that when we are facing this number of dollars in shifts

that we might see some things that we might not want to see down the line.

Mr. Troy, you were with an insurance company, so you understand cost shifts.

Mr. TROY. Yes, Congresswoman, I guess that the general concept of the proposal which involves applying marketplace forces fully to the Medicare Program, we feel that that will have a very favorable long-term effect on the rates of increase of health care costs, so that—

Mrs. KENNELLY. Could you just explain that just a little bit more. A favorable impact? The Lewin report said there might be a negative impact on wages and on cost shifts from Medicare patients to younger sick people.

Mr. TROY. We believe that long term that the changes that are involved in this will reduce the overall rate of inflation on health care costs from what it would have been without offering these kind of options to the Medicare beneficiaries, so long term it has positive effects I think both on the Medicare costs and on the cost of private insurance premiums for those not on Medicare.

Ms. IGNAGNI. Mrs. Kennelly, to amplify what Mr. Troy has just observed, we have just submitted to the Congressional Budget Office a study that was done for us by Price Waterhouse, which I believe is one of the most comprehensive studies on the so-called spillover effect which is the impact of what is happening in managed care and the impact that it has on total Medicare costs, which definitely shows a significant downward pressure, and I would be delighted to submit it for the record here.

[The Price Waterhouse study dated September 11, 1995, is being held in the Committee's files.]

Mrs. KENNELLY. Well, thank you, and I certainly hope that is the results that we see, and I guess there is a difference of opinion in some of these reports, but certainly we all would hope that the costs would be lower for people.

Thank you very much.

Mr. THOMAS. The gentlewoman relinquishes her time. Does the gentleman from Pennsylvania wish to inquire?

Mr. ENGLISH. Thank you, Mr. Chairman. I appreciate that opportunity.

Mr. Lehrmann, Mr. Hansen, Congressman Boulter, I am delighted to find you here because we have been having this day-long hearing, and you are here as the representatives of the beneficiaries more than any other witnesses that we have had here today.

I am not sure every person on this Committee is delighted you are here, but I certainly am, and I appreciate your taking the time to represent your constituents. A couple of features of the MedicarePlus Program that I would like you to comment on.

I think, Mr. Lehrmann, you have already commented on the affluence test, but for all three of you, I would like you to comment on the affluence test for Medicare beneficiaries who already have an upper income and, second of all, the feature that there is no increase in deductibles and copays over the 7-year period.

Mr. Boulter.

Mr. BOULTER. I personally don't think there is anything philosophically wrong or unfair about the affluence test, but having said that, I just think it is not a good reform. I don't think it is what is needed to reform the Medicare system, and I don't think you get that much money out of it, either, and as I have said, I think it is better to rely on an increase in the deductible, for example, and I think maybe if there needs to be, that some assistance could be given to lower end people, lower income people, but I would rather go that route. So I don't object on a fairness basis personally, but I don't think it is a significant reform.

Mr. ENGLISH. Mr. Hansen.

Mr. JAKE HANSEN. I think you have to take it as a part of the whole, and as a part of the whole of saving Medicare. It is something that is probably needed to be done. It is important to keep in mind that Medicare part B comes out of the general treasury. It is not part of a trust fund. We would not look very kindly on means testing of a trust fund.

Mr. ENGLISH. Mr. Lehrmann.

Mr. LEHRMANN. Well, you heard my comment before on that. As far as raising deductibles and copayments, we certainly think that that is not a route to go because you really, if you do that, target those who are the most vulnerable, those who are the sickest and neediest in the whole process.

Mr. ENGLISH. I agree with you, and I think most of the seniors in my district agree as well. I have been out and I have had myself a Medicare task force which, by the way, also has the representative of your organization for our congressional district involved, and I think she has played a very valuable role in our deliberations.

Mr. Lehrmann, in commenting on fraud and abuse, which I think is part of the solution to this problem, you raised the concern that fraud and abuse enforcement might raise up front costs. In my bill I use additional fines to finance the fraud and abuse effort. Would your organization find that acceptable?

Mr. LEHRMANN. Well, we certainly agree that we ought to do what we can to deal with this issue of fraud and abuse, and I don't know that we have actually taken a position on what you suggested, Mr. English, but we certainly would take a look at it, but by all means we believe we ought to address this issue.

Mr. ENGLISH. Thank you. I appreciate your comments. They have been thoughtful and responsible.

Ms. Lehnhard, Ms. Ignagni and Mr. Troy, a question for you. Given that in the MedicarePlus proposal there is the option of limited enrollment plans and provider-sponsored networks, could you comment on what is the appropriate level of regulation of those sorts of organizations?

Ms. IGNAGNI. To state it very simply, we believe there should be a consistent level of regulation, a uniform level of regulation across the spectrum of participants in the health care arena to assure consumer protection, adequacy of performance within the system, and to assure that we can compare as consumers one plan to another.

Ms. LEHNHARD. I would agree with that, and I would note that the—I think NAIC, the National Association of Insurance Commissioners, has recognized this. They have done a great deal of work

on what they call the risk-based capital adjustments and very simply in lay persons terms this would mean that you could apply this risk-based capital test to any type of entity. A big insurance company would have to have a lot of reserves. A PSN wouldn't have to have very many reserves, but the State could apply this across the board, and apply the same quality and contracting standards to everyone, but the solvency test would fluctuate.

That is what we think should be done, the State should do it all, but recognize that not everybody has to have the big reserves of an insurance company.

Mr. TROY. I think where the plan is heading and where the proposal is heading is trying to create a competitive marketplace, as much of a competitive marketplace as possible, and I think that absolutely requires a level playingfield in terms of the regulations in order to make the marketplace work properly, and that will result in the savings that you are looking for.

Mr. ENGLISH. Thank you so much.

Mr. THOMAS. The gentleman's time has expired. Does the gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman. I think all of us understand that the Medicare system is going to change. It is not only going to change over the next 7 years, it is going to change over time, and all of us hope that there are more opportunities and choice for our seniors and more participation and types of plans the seniors can participate in.

We are at a disadvantage at this hearing because we don't have the specifics of the Republican proposal, but one of my major concerns is whether seniors under that proposal will have more choice or whether they are going to be forced into plans that will give them less choice of their health care provider than they want. They may be, in effect, required to go into that type of plan because the fee-for-service option is going to erode so much that health care providers won't participate in the fee-for-service plans, doctors won't participate, or the cost factors will become such that seniors will be forced into a managed care plan because of cost, not because of additional benefits coming into that plan.

I guess that is my major concern about the parameters of trying to implement a \$270 billion cut, and we have been talking in rather abstract terms, and I agree that there is a lot to be gained by more competition and more opportunities from the private sector.

My question is, if we could just agree or assume for purposes of this question, you start with the same base. Is it reasonable to assume that Medicare can grow at a slower growth rate than private insurance can grow? If we start with the same base, is there something about the elderly that we can assume that their health care needs can grow at a slower growth rate than the under 65 population, again, assuming we start at the same base?

We can argue whether Medicare has performed or outperformed private insurance. It has worked differently than private insurance, but let's assume we can start at the same base and go forward. Is there something about our seniors that their health care can grow at a slower growth rate than the people under 65?

Ms. LEHNHARD. Mr. Cardin, I can't give you the specific numbers, and I can't even tell you that you can grow Medicare at a

slower rate than the private sector, but I would make the observation, and our Blue Cross & Blue Shield plans have told me this, that Medicare hasn't had the exposure to market competition. There is very little energy from managed care in Medicare and they make the observation constantly that you could maintain a very high level of quality in Medicare, reduce the length of stay, reduce the use of services, increase the satisfaction.

Mr. CARDIN. I want to start at the same base. I don't mean to interrupt you, but—

Ms. LEHNHARD. The base is very high.

Mr. CARDIN. Some of the best witnesses we had before our Committee were some of the people who testified from the private employment marketplace and how well they were doing in their private companies. The question I asked at that time was, Is there anyone here from a private company who would take their employees or retirees once they reach 65 at what they are spending, and we will give you the same growth rate that is in the Republican bill here, would they take that employee and keep that employee in their private health care plan at a growth rate of about 4 percent, and I didn't have any takers.

For purposes of my question, I want to assume we start at the same base because we could argue whether we are at the same base or not. Can you keep senior health care at a slower growth rate than those under 65 if we start at the same base? Someone who is in your plan today turns 65, can you manage their health care at a slower growth rate than someone under 65?

Mr. TROY. I would assume that the growth rates would be fairly similar between the over and under 65. However, as Mary now said, if you currently have a higher base because you haven't introduced as much competition into that market, then there would be a short-term lower rate of growth expected under that scenario.

Mr. CARDIN. I acknowledge that. I tried for purposes of assumption to assume that we are at the same base. I understand your arguments.

Ms. IGNAGNI. Mr. Cardin, one of the observations I would make that has long been discussed throughout the last several years about Medicare in particular, we have not yet moved forward on the following agenda, is the notion of marrying part A and B, the efficiencies that would result, the many aspects of the private sector plans that have been incorporated into whether it is HMOs, PPOs, other kinds of alternative delivery systems or coordinated care where you are doing case management, where you are looking at the appropriate utilization of services, where you are concentrating on bringing people in at the earliest stage.

There are a lot of things, and actually to acknowledge the statement that I believe Bruce Vladeck made rather recently, I know HCFA is moving and beginning to move in this direction, and I believe that there are considerable savings to result directly related to your question of getting at the base before we begin in terms of looking at the profiles on both sides, and I think that initiative that puts us on the same footing and that is to say that looks at rate of growth across the spectrum of alternatives, fee-for-service and managed care, whatever that might be in that block of managed

care would be very much relevant and very much the same sort of strategy that—

Mr. CARDIN. My time has expired, but the bottom line is if we start at the same base there is no reason to expect seniors' health care to grow at a slower growth rate than private insurance, if we start at the same base?

Thank you, Mr. Chairman.

Mr. THOMAS. Certainly. Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Yes, thank you, Mr. Chairman. I also want to thank the panel for their time today and waiting until this late hour. Mr. Lehrmann, I also want to thank you for your help because it has been a constructive addition to this whole dilemma that we have been faced with this past year.

I also had a Medicare Advisory Council this year and one of the members on the Medicare Advisory Council was Mary Jane O'Gara, who represents the AARP in the Omaha area. She had a lot of constructive input. We didn't always agree, but we worked together and we are still working together, and that is a part of this whole process.

I wanted to ask Miss Lehnhard, Miss Ignagni, and Mr. Troy about the PSN provision and how you thought it would impact the rural area. Even though I don't represent a rural area, I come from rural Nebraska and so I am very concerned about where we are moving in that area as well.

I think PSNs, provider-sponsored networks, may be something that can be very, very attractive for the rural area as well as medical savings accounts. Do you have a favorite of those two or which one do you think might be a better approach for rural America?

Ms. LEHNHARD. We welcome the competition from PSNs, and, in fact, we are partnering with them in many places, including rural areas. We always cover the entire State, and often have managed-care arrangements in the rural areas, and again, as we have said, as I have said earlier, we welcome their participation in Medicare. We just want the same rules applied to them.

I would say that I think PSNs are probably one of the options for rural areas. I can't comment so much on medical savings accounts because, again, that is going to be, we believe it is going to be very difficult to manage the risk selection in MSAs, and we have suggested that there be demonstration projects and perhaps rural areas are an ideal place to start with those demonstration projects.

Ms. IGNAGNI. As you know, Mr. Christensen, there is quite a lot of activity now with respect to plans to develop alternative delivery systems in rural areas. A number of our plans have moved and have plans to move very directly into rural areas to offer the benefit package that has worked so well in other areas. We also welcome the competition, but do believe that there is a matter of fair play here, uniform standards, and that is the principle that we are advocating, that, indeed, that there be a multiplicity of players in the system.

The point is that we would hope that the Committee might consider standards that would ensure that there is fair play, and there is no competitive advantage that would be associated with one delivery system versus another. I was very encouraged to hear the

Chairman's observation that he is interested in some feedback from us, and I think speaking for my colleagues, we plan to provide assistance with respect to the definitions of particular elements of those standards, and we look forward to working with you on that.

Mr. CHRISTENSEN. Mr. Troy.

Mr. TROY. Yes, I would underscore the fact that managed care is very active in many rural areas. I think some of the Members of Congress have traveled out to New Mexico to see the extent of managed care in that State, which is one of the most rural States. Also, there are, of course, many HMOs today which are provider-sponsored plans which are what you would call the PSNs in this bill which have become licensed in the States and are fully competitive with HMOs that aren't sponsored by providers.

Mr. CHRISTENSEN. Thank you. And thank you again for your testimony here today.

Mr. THOMAS. The gentleman from Georgia, Mr. Lewis, does he wish to inquire?

Mr. LEWIS. Thank you, Mr. Chairman. Mr. Chairman, I yield to Barbara Kennelly, my colleague from Connecticut.

Mrs. KENNELLY. Thank you. I will try to be quick. Thank you very much, Mr. Lewis.

Mr. Troy and some of the other members who have experience in this, Dr. Gail Wilensky was with us today and as you know she has a strong background in health care. She cautioned us the most difficult thing that will be before us is to find a risk adjuster for these new choices if we don't want to find all the older, sicker, frailer people in the traditional Medicare Program and the healthy people in the other choices.

Mr. Troy, I know you have had a long number of years in insurance. Now, you should understand that risk adjuster concept very well. Could you share with us how we might meet this challenge?

Mr. TROY. Thank you, Congresswoman, and I appreciate the comments previously made by Mr. Gibbons on this same subject. We do agree that an appropriate risk adjustment mechanism between the options, including the fee-for-service option is needed, necessary for the long-term viability of the program. There are risk adjusters that apply, that are applied now, and further study should be made.

With respect to Medicare, you would have the health history, for example, of all of the beneficiaries, their permanent health histories. This could be applied as a prospective risk adjuster. There are also fairly simple retrospective risk adjusters that could be applied if it turned out that a plan, for example, based on specified diagnoses—categories ended up with much more or much less numbers of these categories of high cost or low cost cases than the average would call for.

These have been tried, for example, in New York with some success where New York has a combination of a risk adjuster, which includes a specified disease mechanism and a reinsurance program with some other demographic adjustments built in, so it is a very important subject. No one would downplay it, but I do not consider it an Achilles heel of going forward with the choices.

Mrs. KENNELLY. Thank you, Mr. Troy. Thank you very much, Mr. Lewis.

Mr. LEWIS. Thank you.

Mr. Hansen, you said earlier that about one-half of your members couldn't afford to pay dues, yet my colleague from Pennsylvania, Mr. Coyne, pointed out that this plan would include higher premiums for seniors, that combined with the end of help for seniors through Medicaid would hurt seniors. Don't you think this would hurt your membership?

Mr. HANSEN. Well, we are concerned and we will watch that, but we are more concerned about what would happen if Medicare just wasn't there. We think it is imperative to have a Medicare and we think the way to control the costs of Medicare is to try to get the market to help push that down.

We think that some of the alternatives that are going to arise will actually end up helping the poorest seniors more. Some of the managed-care options are going to make it unnecessary to purchase Medigap-type policies and I think there are going to be a lot of powerful and positive things to come from it. And it is certainly far more important to do something and do it now and start moving down the track than to get to the point where we are at 2002 and we have nothing to turn to.

Mr. LEWIS. Mr. Hansen, I don't know much about your organization, but let me just—I received some cards in my office in Atlanta and some cards here in Washington, maybe a few hundred. Did you poll your membership about this plan?

Mr. JAKE HANSEN. We have had extensive communications with our membership. We have done polling, we have done focus groups, we have had questionnaires in our newspaper.

Mr. LEWIS. Have you polled them since yesterday? You just got this 60-page—

Mr. JAKE HANSEN. What we have done is we have talked to our members about the basic ideas that we know, the basic set of ideas.

Mr. LEWIS. Before my time expires, how many members do you have in the State of Georgia?

Mr. JAKE HANSEN. I can't tell you off the top of my head.

Mr. LEWIS. Let me ask you another question, is it true that this organization was investigated by the attorney general of the State of New York for involvement in a pattern of fraud and abuse?

Mr. JAKE HANSEN. It is true that there were investigations and nothing came of them.

Mr. LEWIS. Were you fined by the State of Pennsylvania?

Mr. JAKE HANSEN. There were fines right as we were founded because we were several days late with—

Mr. LEWIS. Were you also prohibited from soliciting forms in the State of Maryland?

Mr. JAKE HANSEN. For about 2 days, then the Attorney General apologized.

Mr. LEWIS. And you feel that you are qualified to come here and testify on behalf of the senior citizens of America?

Mr. JAKE HANSEN. Absolutely.

Mr. LEWIS. Thank you, Mr. Hansen.

Mr. THOMAS. Does the gentleman from Georgia wish to inquire?

Mr. COLLINS. No.

Mr. THOMAS. Does the gentleman from Virginia wish to inquire?

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

When we were back home in August, I spent a number of days with some of Mr. Lehrmann's members in AARP and to talk about how they felt about Medicare and Medicare changes and so forth, and one of the issues that continued to come up was the issue of choice, and the plan that is before us is in some ways dealing with the issue of choice.

However, in an area like mine, which is a medically underserved rural area that generally has very low reimbursement rates in terms of the AAPCC, it seems that it is probably unlikely that there will be more choices available for the citizens that I represent as a result of this plan or I should say perhaps there will be. This is a question. And so I was interested in what Ms. Lehnhard or what Ms. Ignagni might say concerning that particular observation on my part and do you think that is correct, and what has been done in this plan to perhaps improve choice for rural underserved areas, like the one that I represent?

Ms. IGNAGNI. Two points. I believe that what struck us as we read the document, the first is the technical change that I referred to that sounds small, but can have some major impacts in areas such as yours, which is the change from a countywide basis to a metropolitan statistical area, point number one.

Point number two, the notion of looking at the variation in payment and trying to deal with the challenge that exists for rural areas, and we were very much interested in the observation in the paper with respect to that principle and point of view and plan to work very closely with all Members of the Committee to provide whatever assistance and help we can to get on to that job.

Mr. PAYNE. So the change that occurs here is the change from the county to the MSA generally, do you think? You said it is small, but it may be significant. Is that significant enough that in an area like mine—and I know you don't know the demographics in the area I represent—but areas that are rural underserved, do you think it is likely there will be some immediate differences as a result of this or is this more likely to be looked at in the second phase as the AAPCC amounts are generally looked at and hopefully try to make it more uniform across the country?

Ms. IGNAGNI. I think you have asked a very important question, and there are a series of answers to it. The technical observations I made with respect to the basis for payment as well as the way we compute payments and look at dealing with the challenges of rural areas. The second is expanding the choices and seeing the trend toward more participants and more entities, whether they be HMO, PPO, PSN, or physician-operated delivery systems offering services and providing some real interest in offering services in those areas.

The third is to put in the beneficiaries' hands the information they need to compare the spectrum of plans in particular areas, so I think it would be wrong to conclude from anything certainly I have observed that there is just the technical issue that would solve this problem, that would be terribly presumptuous.

I see it as a package of initiatives that were referred to in the paper that I think are very encouraging in terms of dealing with many of the challenges that you have raised, and indeed actually

put together some of the proposals that have been discussed over the last several years, which we think is very encouraging.

Ms. LEHNHARD. I would also say since we cover the entire State in all cases that the products that we have found most popular and most feasible to put in place in rural areas aren't allowed under Medicare, and that is the point-of-service option and the PPO option, and we think our plans would have immediate interest in those, particularly in rural areas.

Mr. PAYNE. You are saying they are not allowed under Medicare today?

Ms. LEHNHARD. Right now the only option is the closed panel HMO, and that is one of the things we are excited about is that we would be able to introduce the most popular product on the market, which is the point-of-service option.

Mr. PAYNE. But don't you think those areas that have the lowest reimbursement rates likely will be the last ones to find that they have the most choices?

Ms. LEHNHARD. I think you have to couple what I said about the product with the technical—not only the technical but the important changes in the move from county to metropolitan, statistical metropolitan area calculation, and those two things combined you will see some action.

Mr. PAYNE. And, beyond that, don't you think we need to continue to look at some of these reimbursement rates to make sure that they are more equitable across the country?

Ms. LEHNHARD. Absolutely. It is not only the counties to city issue, it is the State to State issue, and you may be running into that in your State, also.

Mr. PAYNE. Thank you very much.

Thank you, Mr. Chairman.

Mr. THOMAS. If no other Member wishes to inquire, I want to thank the panel.

Just as a footnote, obviously, we are searching for that formula which would allow us to determine what portion of risk. If we had that, that would make our lives a lot easier. Good luck in trying to find it. And I am hopeful that these are the kinds of structures that we will have in the future that will allow us an honest relative assessment so that we can maximize the number of options available to seniors. I want to thank those representing the seniors as well.

I will ask the last panel of the day to come forward. The last panel consists of Gail Warden, chairman, Board of Trustees, American Hospital Association—good to see you again; Dr. John Seward, chairman, Board of Trustees, American Medical Association; Tom Scully, president and chief executive officer of the Federation of American Health Systems; Sister Carol Keehan, president and chief executive officer, Providence Hospital and the Carrol Manor Nursing Home in Washington, DC; and Dr. Gerald Thomson, president, American College of Physicians.

I want to welcome all of you to the Ways and Means Committee hearing on Medicare, and I would say that your written statement will be made a part of the record in its entirety and that you will have 5 minutes to enlighten and inform the Committee in any way you see fit.

Gail, if you would like to begin.

STATEMENT OF GAIL WARDEN, CHAIRMAN, BOARD OF TRUSTEES, AMERICAN HOSPITAL ASSOCIATION

Mr. WARDEN. Thank you, Mr. Chairman.

I am Gail Warden, the president of the Henry Ford Health System in Detroit and the chairman of the American Hospital Association. On behalf of America's hospitals I want to thank the Committee for inviting us to testify today as we have had an opportunity to do on a number of occasions about the future of Medicare.

As we approach this subject, I suppose one way to put it is we have both some good news and some bad news about the Medicare spending proposal, and I will start with the bad news and then go to the good news.

We feel that hospitals and health systems are facing a double whammy. Providers, including hospitals, are going to bear the brunt of reductions made in the overall program and then hospitals will bear the brunt of most of the reductions that are made to providers. Quite frankly, this is not what we had understood it would be. We have throughout the budget process maintained that the burden of Medicare reductions should be shared by everyone with a stake in Medicare.

Based on a quick estimate of the Medicare Preservation Act, hospital reductions are in excess of \$75 billion over 7 years, and we are still counting. This does not include the reductions that may be made as a result of the look-back mechanism, as pointed out by Mr. Altman this afternoon. In fact, the reductions in Medicare payments to hospitals may be so steep that they won't even keep up with general inflation, because Medicare spending for hospitals is already growing much slower than the rest of the program, about 6.9 percent a year over the next 7 years, compared to 10 percent for the program overall according to CBO.

Deep reductions in hospital payments could lead to such small rates of increase that they do not even cover inflation, which is projected to average 3.3 percent annually as measured by the CPI. In economic terms, this means a real cut. And as a health care provider, not a lobbyist, I can assure you that in health care terms they do mean a cut.

What do these reductions mean to a typical 150-bed hospital? They mean about \$11 million less revenue between 1996 and 2002; for a 250-bed hospital, it is \$17 million; and for the typical hospital with 300 or more beds, it is \$49 million less revenue. For my own organization, it is \$234 million over 7 years. For all types of hospitals, these reductions, obviously, are threats to access and service, to their ability to form networks in many areas, to their very existence.

We strongly urge the Committee to keep its promise that hospitals would not be cut in this budget process. We support restructuring the health care system, and we certainly support restructuring Medicare, but to do it we need strong hospitals and health systems.

We also need the tools to do the job right, and this is where I get to the good news. The package included provider-sponsored networks as an option for Medicare beneficiaries, and you have talked

about them throughout the day. This is a key tool, and we congratulate you for recognizing it as such.

These networks, PSNs as we call them, are local affiliations of providers organized and operated to provide health care services in their communities. They provide a good opportunity to ensure patient choice, to give a patient more choice of plans, an opportunity to avoid disruption of the relationship between the patient, the physician, the hospital, and the community. PSNs offer an opportunity to provide choice in areas that do not have a coordinated care plan. And they also are important to us because in many States it takes as much as 2 years or more to get an HMO license. We are pleased to see that these are included in the budget plan. However, of course, the devil is in the details.

We also believe that PSNs can offer us a solid middle ground for seniors somewhere between fee-for-service and full-fledged HMO, and we are concerned that the PSNs may be treated more like insurance companies than health care providers. Obviously, clarification needs to be made about these programs and how they might work and how they would be regulated.

We are also pleased with the effort you have made to remove barriers to network building, such as modifications to self-referral and the antikickback law. We were particularly pleased about the changes that were made in liability reform.

But we do have one other concern and that relates to the concept of the look-back mechanism. We understand that it would apply to all Medicare spending in excess of targets. We feel that it should only be applied to those programs that relate to managed care. The total amount that can be recaptured should be capped at the targeted savings for managed care, which we believe is \$60 billion—an amount the program could reasonably expect managed care to save over 7 years.

Beyond that, we believe an independent commission like that proposed by Representative Phil English is best suited to objectively determine how to allocate—among all stakeholders—the spending reductions a look-back may call for.

Mr. Chairman, hospitals and health systems share this panel's goal of restructuring Medicare. Given the right tools, we believe we can help you get the job done; but the ability of hospitals to provide even basic care could be jeopardized by what we see as real spending cuts. We urge you to consider the important changes we have outlined as the plan is debated in the Committee and on the floor.

Thank you.

[The prepared statement follows:]

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**Statement
 of the
 American Hospital Association
 before the
 Committee on Ways and Means
 of the
 United States House of Representatives
 on
 Saving Medicare**

September 22, 1995

Mr. Chairman, I am Gail Warden, president of the Henry Ford Health System in Detroit, Michigan, and chairman of the American Hospital Association. AHA includes in its membership 5,000 hospitals, health systems, networks and other providers of care. I am pleased to testify today on their behalf.

America's hospitals and health systems are at the forefront of change in the way health care is being delivered. In communities all across the country, hospitals and health systems are looking for new and better ways to do their job. They are forming partnerships and creating integrated systems of care that are designed not just to treat illness and injury, but to make the communities they serve healthier.

This is health care reform at its finest -- and Congress should be commended for recognizing that it is time for Medicare to take part in this progress. There has been a lot said about restructuring the Medicare program, and we understand there are some positive steps being considered that move toward that goal in the Medicare Preservation Act. That's the good news. The bad news is that the plan apparently does not go far enough to help us continue those reforms. More importantly, we have to question the Congress' commitment to those reforms when, in the same plan, it appears that a level of spending reductions in Medicare is proposed that could affect quality and access to care for millions of Americans.

THE BAD NEWS -- MEDICARE SPENDING REDUCTIONS

Although the proposed reductions have been referred to as a slowdown in the rate of growth of Medicare spending -- from 10 percent annually to 6.4 percent annually -- the fact is that for hospitals and health systems, they could translate into real cuts if payments don't keep up with general inflation.

How could this happen when the budget resolution would allow per-beneficiary spending to increase 40 percent over the next seven years, from \$4800 to \$6700? Because Medicare spending for hospital services is growing much more slowly than the rest of the program. CBO projects that, under current law, Medicare spending for hospital services will grow 6.9 percent a year over the 1996-2002 period, compared with about 10 percent for the Medicare program overall. On a per-beneficiary basis, under current law, payments to hospitals are projected to grow by only 5.5 percent each year, compared with more than 8 percent for the program overall.

The deep reductions in payments for Medicare hospital services that are being considered could, therefore, lead to such small rates of increase for hospitals that they do not even cover

general inflation -- which is projected to average 3.3 percent annually, as measured by the Consumer Price Index. Payments that do not at least cover inflation will force hospitals to try and provide the same range and quality of services with fewer and fewer resources, an extremely difficult if not impossible task -- and one that most hospitals are already struggling with in the current market.

Based on a quick estimate of the Medicare Preservation Act, the specific hospitals reductions are in excess of \$75 billion over seven years -- and we're still counting. This does not include further reductions that would be made in hospital payments as a result of the fail-safe, or "look-back," mechanism.

What do these reductions mean to the typical 150-bed hospital?

- \$11 million less revenue between 1996 and 2002.

What do these reductions mean to the typical 250-bed hospital?

- \$17 million less revenue between 1996 and 2002.

What do these reductions mean to the typical hospital with 300 or more beds?

- \$49 million less revenue between 1996 and 2002.

While this committee deals with Medicare and not Medicaid, I must point out that proposed Medicaid reductions, when added to the Medicare reductions being considered, will increase these losses substantially.

For all types of hospitals, these reductions could:

- Threaten the very future of hospitals in the neediest communities. Large cuts in Medicare spending hit the most financially vulnerable hospitals hardest, often the ones that need to remain open to ensure access and coverage to underserved populations.
- Restrict access or availability of important services often offered at a financial loss -- including trauma care, burn units and neonatal intensive care.
- Limit the ability of hospitals to focus on the health of their community. Prevention, health promotion, community outreach and education may be scaled back or sacrificed in cost-cutting efforts.
- Jeopardize the local economy through forced layoffs and cutbacks in purchasing. As major employers and purchasers of goods, hospitals are a vital part of the economic fabric of their communities.
- Stymie their efforts to collaborate within the community to provide cost-effective and patient-friendly networks of care.

Shared responsibility

America's hospitals and health systems have urged throughout this budget process that shared responsibility should be the guiding principle behind any reductions in Medicare spending. It has been our understanding that Congress agreed. However, the reports that we are getting about the realities of the Medicare Preservation Act concern us. Hospitals face a double-whammy: a disproportionate share of the overall Medicare reductions would be borne by providers -- including hospitals and health systems; and a disproportionate share of provider reductions would be borne by hospitals and health systems. In fact, we estimate that hospitals face in excess of \$75 billion in reductions through traditional means -- a figure that does not include potential reductions from a look-back mechanism, but is already disproportionately higher than reductions to others with a stake in Medicare.

Hospitals and health systems are willing to work to both reduce the budget deficit and ensure that the Hospital Insurance Trust Fund remains solvent. But both goals must be arrived at through shared responsibility.

Initiatives that move Medicare toward our vision of coordinated health care can serve patients better *and* save money. But, saving the current goal of \$270 billion over seven years should mean a financial effect on everyone with a stake in Medicare -- hospitals and health systems, physicians, other providers, and beneficiaries. Doing business the old-fashioned way -- just

cutting provider payments -- is not the answer. To address Medicare's long-term problems, everything must be on the table: program structure, benefits, beneficiary cost-sharing, eligibility, and program revenues, as well as provider payments.

In the past, hospitals coped with Medicare spending reductions by passing the difference on to other payers, like non-Medicare patients and their employers. That's called cost-shifting. But those days are fast disappearing, and these reductions are unprecedented. The market is shutting down the cost-shift option. Managed care contracts and a growing number of employers and private insurers who negotiate discounted prices are making it a thing of the past. They're tired of shouldering the burden of government underfunding.

This leaves hospitals with unpalatable options: reduce the size of the work force; reduce services and programs; or, ultimately, shut their doors altogether. Any one of these options takes us further from our mission of providing the highest-quality care to the people we serve, including America's elderly, poor and disabled. At the same time, deep reductions to provider payments could stifle the local innovation and progress that are key to restructuring the Medicare program.

THE GOOD NEWS: EXPANDING COORDINATED CARE OPTIONS

Hospitals and health care systems have a great deal at stake in expanding coordinated care options under the Medicare program. First and foremost, we believe that locally based coordinated care systems hold great promise in improving the quality and continuity of care, as well as improving the efficiency of health care delivery. The document released yesterday suggests that the Medicare Preservation Act recognizes that promise, at least conceptually.

However, we need to ensure that Congress provides the specific tools needed to make coordinated care options available to beneficiaries, and to encourage beneficiaries to select those options.

Provider-Sponsored Networks

Medicare beneficiaries who want to choose coordinated care rather than fee-for-service coverage have just two choices: a health maintenance organization (HMO) or a competitive medical plan (CMP). These plans are important elements in a restructured health care delivery system, but Medicare must look beyond these two options.

The Medicare Preservation Act recognizes the benefits and savings that can be achieved through locally based networks of care -- what we call provider-sponsored networks. PSNs are formal affiliations of health care providers, organized and operated to provide health care services. These networks commonly take the form of physician-hospital organizations or independent practice associations, and are often called integrated delivery systems.

Many PSNs have formed HMOs, or have become partners with insurers to do so. But still more have not become HMOs. Some serve populations that are too small or too sick to support the full risk of an HMO. Some are in states where it reportedly takes up to two years to get an HMO license. Others are in areas where Medicare's HMO payment is simply too low to provide adequate care. Others are in areas where it could be economic suicide to compete with local insurers for private enrollees.

The Medicare program should take full advantage of the health care innovations and efficiencies offered by PSNs by allowing them to contract directly with Medicare. Medicare will need many new entrants into the coordinated care market in order to give seniors a wide range of health plan choices.

We agree that any entity delivering care to Medicare beneficiaries must meet high standards. But current regulatory thinking could limit the ability of PSNs to serve Medicare beneficiaries.

We propose that PSNs would have to meet all the same consumer protection standards as currently required by Medicare for other risk contractors, except that PSNs would meet

higher quality standards and different but comparable solvency standards, and they would not be required to have at least as many private enrollees as Medicare and Medicaid enrollees (Medicare's so-called "50/50" rule).

A modified solvency standard is important because PSNs directly provide, not buy, most of the services that are covered. As a result, the standard should recognize that most of a PSN's assets need to be invested in its capacity to deliver health care services, not in the more liquid assets needed by insurers to pay claims to providers. It is their receipt of capitated payment that many insurance regulators equate with an insurance function, which triggers the perceived need for insurer-like solvency requirements. PSNs are actually paid in many ways, not just capitation, so it is important to put this in context with the rest of their operation. The solvency standard we have proposed is generally equivalent to the national model HMO act (which is actually higher than some state HMO requirements), with changes to reflect the primary PSN function of health care delivery and avoid any unreasonable financial barrier for rural PSNs.

A key difference between our proposed PSN direct contracts and other Medicare risk contractors is that PSNs would not be required to directly enroll private individuals. In the private sector, PSNs contract to deliver coordinated care to enrollees of HMOs, self-insured employers, and other health plans. They do not generally engage in enrolling individuals. Medicare's current "50/50 requirement" forces PSNs to directly compete for the private enrollees of the same plans with whom they have contracts to deliver services -- a step that generally disrupts those contractual relationships.

PSNs, while required to meet federal standards, should not also be required to be licensed by the state in order to direct contract with Medicare. State HMO licensure is a process that can be burdensome, slow and unsuitable for PSNs -- blocking the availability of a broader range of options for America's seniors. And we fear that the state regulatory process will become more problematic, as state insurance regulators try to force new and evolving health care delivery structures into existing regulatory structures.

Thus far, we have seen only a conceptual description of the budget plan's approach to provider-sponsored networks. We greatly appreciate that PSNs are included in the Medicare Preservation Act, but we continue to have real concerns that the promise of provider-sponsored networks may not be realized under the Medicare program.

For example:

- **Timeline that provides a jump start for insurers.** The description indicates that insurers would be allowed to offer expanded options to Medicare beneficiaries well before PSNs would be allowed to do so (as much as 11 months), allowing them to corner the market before PSNs are allowed to compete. To ensure a level playing field, all new Medicare private plan options should be required to become available simultaneously to Medicare beneficiaries.
- **Timing of PSN standards.** In an earlier draft document made available to AHA, the framework of regulatory deadlines and effective dates indicated that PSNs would be subject to a set of transitional standards that would take six months to issue, even though they are based predominantly on the current HMO/CMP standards, and another six months to apply in the certification process -- only to be supplanted two years later by a permanent set of standards, the development of which would be turned over to state insurance regulators under the auspices of the National Association of Insurance Commissioners (NAIC). The secretary of Health and Human Services (HHS) would not have any authority to reject or modify NAIC's standards. This would tie up PSNs in a process of constantly changing regulatory requirements for the first three to four years. PSNs need a lengthy period of stable federal oversight (preempting state regulation) to ensure substantial PSN participation in markets around the country; NAIC's role should be limited to an advisory one. PSN standards should be issued on a fast-track basis (by April 1, 1996).

- **Solvency standard.** The description also indicated that the American Academy of Actuaries (AAA) would be given the open-ended task of developing a PSN solvency standard, again without any apparent ability on the part of the HHS secretary to reject or modify it. The provision that AAA develop the PSN solvency standard should be significantly altered. AAA should modify the current NAIC model HMO solvency standard only to the extent necessary to conform to the provider service delivery environment of a PSN, and to avoid any unreasonably high financial hurdle for rural PSNs. It also should be clarified that the role of AAA is advisory to the HHS secretary.
- **Shared-risk payment arrangements.** We understand that some in Congress may be unwilling to allow a shared-risk as well as full-risk payment option for PSNs. We believe that is unfortunate, because shared risk may be the only means of bringing coordinated care arrangements to some rural and chronic care Medicare populations. If Congress insists on excluding shared-risk arrangements for PSNs at the outset, we urge that HHS be given explicit demonstration authority to develop and demonstrate such arrangements.

Barriers to integration

There are other barriers that discourage the creation of coordinated care networks by inhibiting provider cooperation -- the heart of coordinated care.

For instance:

- The provision of health care services has long been considered a charitable and, therefore, tax-exempt activity. However, current tax exemption guidelines for non-profit providers have not kept pace with the trend toward coordinated care. Tax policy should create opportunities for non-profit health care providers to integrate and provide coordinated care services. Not-for-profit HMOs currently enjoy tax exemption, and should continue to do so. In addition, we support including in the budget plan a provision giving statutory tax exemption to provider-sponsored networks that meet vigorous community benefit requirements.
- We are pleased to see modifications to the physician self-referral law, which prohibits referrals when a financial relationship exists between the physician and the entity to which the physician refers a patient. For example, the Medicare Preservation Act removes from the law's jurisdiction referrals based on compensation arrangements, which are already covered under anti-kickback law, and pares back the list of services to which the law applies. However, it is unclear whether the modification that expands the exception for prepaid plans would cover the variety of risk-sharing arrangements, including PSNs, that can be developed with incentives to prevent excessive and inappropriate utilization of services. This issue needs to be addressed.
- Modifications to the "anti-kickback" law, which prohibits payment in exchange for referrals of Medicare and Medicaid patients, are heartily welcomed. The federal government is actively--and properly--working to ferret out waste, fraud and abuse. However, a vague law, broad interpretations, and expansion of the law's reach and sanctions without clarification, have combined to create confusion over what kinds of arrangements providers may establish. We're very pleased that the Medicare Preservation Act provides for an advisory opinion process and calls for various clarifications in the enforcement of the anti-kickback law. Again, however, we need to be certain that the exemption for certain managed care arrangements adequately covers the variety of risk-sharing arrangements, like PSNs, that ensure appropriate utilization.
- The Medicare Preservation Act indicates that current antitrust law is a barrier to the formation of PSNs. Because we do not know the details of how PSNs will be defined, we cannot speak to whether the proposed relief is necessary, adequate or anti-competitive. However, we continue to believe that a process for getting specific

approval for appropriate provider arrangements could offer protection from expensive and time-consuming antitrust challenges.

- Although it may not necessarily be a barrier to integration, the threat of liability lawsuits is felt heavily by hospitals and health systems and can certainly be a barrier to the efficient delivery of health care. We are very pleased to see that a number of liability reforms are planned in the budget proposal. These include limiting a defendant's liability for non-economic damages to its proportionate share of fault; limiting non-economic damages to \$250,000; modification of the collateral source rule to allow defendants to introduce evidence of insurance payments to a claimant; modifying the statute of limitations so that claims can not be filed more than two years after an injury is discovered or five years after the initial injury occurred; and allowing non-economic damages of more than \$50,000 to be paid periodically rather than in a lump sum.

The look-back

If the budget plan provides the tools we feel are necessary, then we are confident that the program will save money by moving Medicare toward coordinated care. That is why we supported the concept of a "look-back" mechanism during deliberation of the budget to ensure the savings anticipated from moving more Medicare beneficiaries into coordinated care. But the "look-back" should not be used to overpromise savings that can be reasonably achieved through coordinated care in seven years. The specific amount of targeted savings we had suggested from a look-back mechanism is \$60 billion through 2002. However, we are concerned that the budget plan may go well beyond this. All Medicare spending in excess of specified target amounts would be recaptured through the look-back, triggering future reductions in payments to providers. This would effectively turn the entire Medicare program into a capped entitlement.

Under this approach, factors beyond the control of hospitals and other providers could cause budget targets to be exceeded and trigger a look-back sequester: unanticipated inflation in the prices of goods and services hospitals must purchase (inflation is currently projected to average a relatively low 3.3 percent over the next seven years); unanticipated admission increases (for example, as the result of a flu epidemic); and errors by the Congressional Budget Office in estimating the savings associated with specific proposals.

The look-back should be limited to its original purpose: guaranteeing savings that can be reasonably achieved by moving Medicare beneficiaries into coordinated care plans. Therefore, the total amount that can be recaptured from hospitals and other providers in a look-back should be limited and capped at the targeted savings -- our suggestion of \$60 billion over seven years. All stakeholders should play a role in contributing to the look-back if it becomes necessary. And an independent commission -- like the one proposed by Rep. Phil English (R-PA) in his Commission to Save Medicare Act of 1995 (HR 2152) -- would be best-suited to objectively and efficiently determine how to allocate among the various stakeholders the automatic spending reductions a look-back would call for.

CONCLUSION

Mr. Chairman, America's hospitals and health systems share this committee's goal of restructuring Medicare. But the current budget plan as we understand it won't bring some of the key changes needed to achieve this result. We urge you to consider the very important changes we've outlined in this statement as the plan is debated in committees and on the floor.

We continue to be concerned about the impact of reductions of \$270 billion on quality and access. At the same time, given the right tools, America's hospitals and health systems are confident that the Medicare program can be restructured in a way that increases efficiency and improves access and quality. The millions of Americans who rely on Medicare, and those who will rely on it in the future, deserve no less.

Mr. THOMAS. Thank you, Mr. Warden.
Dr. Seward.

STATEMENT OF P. JOHN SEWARD, M.D., CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. SEWARD. Thank you, Mr. Chairman and Members of the Committee.

My name is John Seward. I am a practicing family physician in Rockford, Illinois. I am also chairman of the board of AMA, the American Medical Association.

While the legislative language must still be seen and analyzed before any definitive judgment can be rendered, overall, the Medicare Preservation Act appears to be an important step toward fulfilling the promise of protecting and strengthening the Medicare Program for present and future beneficiaries.

We appreciate that both physician and patient input has been considered in putting together this legislative outline. We believe the outline supports the AMA's long-term concerns, the preservation of patient choice and the sustaining of quality medical care in a changing marketplace.

We are pleased to note the Committee's emphasis on choice. This is reflected in provisions calling for patient information and protections in dealing with managed care plans. Informed patients are empowered patients. This also serves to enhance the patient-physician relationship which the AMA believes is the core of good medical care.

In addition, the MedicarePlus option begins to introduce seniors to a variety of health plans available in the private sector. We believe the Committee has been sensitized to incentives that could encourage patients to choose a broad range of options. As long as the choice that we are talking about is informed and truly voluntary, then we won't cross the line from financial incentives to financial coercion.

The AMA is particularly pleased to see the medical savings account as one of the choices that will be available to seniors. Chairman Archer and Representative Jacobs have long supported this option, and we commend the Committee's efforts to extend this valuable health financing option to all Americans.

The outline of the Medicare Preservation Act includes significant health care liability reforms which we understand will apply to the entire health care system, including a \$250,000 cap on non-economic damages which the House passed overwhelmingly early this year. This has our enthusiastic endorsement, as piecemeal reforms of the system would only shift liability to other sectors.

The outline also reduces unnecessary and burdensome government regulations. Physician self-referral law, for example, would continue to prohibit inappropriate referral practices but will be modified to remove those provisions that have not only failed to protect patients, but have actually impeded their ability and access to appropriate care. We applaud these changes.

We also support modification to CLIA which would relieve the onerous administrative burdens placed on physician office clinical laboratories. We commend Chairman Archer for taking the lead on this important issue.

We are pleased that the outline reflects many of the antifraud and abuse measures AMA has advocated in its proposal "Transforming Medicare." We will look forward to continuing our efforts with Congress and law enforcement to prevent and detect fraudulent activity.

We believe the outline makes a measured approach to graduate medical education funding. Limiting Federal residency funding to the first board certification of 5 years is a fair one. We are particularly excited to see the exception for geriatric training, recognizing the importance of this particular kind of training in serving the Medicare population.

While we have not yet seen the details, we are concerned about potential reductions to physician payments in the legislation. However, we are extremely pleased to see several corrections of policy from the past that also just haven't worked. This includes a repeal of the MVPS and a move to a single conversion factor. We want to work with the Committee and HCFA on the appropriate and timely implementation of these changes. We believe the fail-safe provision could take a constructive approach by isolating high-growth services within the Medicare Program.

However, Mr. Chairman, physicians do have limited control over the number of times a fee-for-service patient can access the Medicare system. We believe individuals are much more prudent consumers of medical care when they have a financial interest in that care.

Finally, we are pleased that the outline supports the formation of the provider-sponsored networks. Federal standards must allow for all providers to compete in a revolving health care marketplace. The AMA looks forward to seeing the specific legislative language on this important issue.

Again, I want to thank you, Mr. Chairman, for this opportunity to testify. The AMA looks forward to continuing working with the Committee Members and Congress as this historic legislative initiative unfolds.

I thank you, Mr. Chairman.

[The prepared statement follows:]

Statement
of the
American Medical Association
to the
Committee on Ways and Means

RE: MEDICARE SOLVENCY AND BUDGET RECONCILIATION

Presented by: P. John Seward, MD

September 22, 1995

Mr. Chairman and Members of the Committee, my name is P. John Seward, MD, and I am a practicing family physician from Rockford, Illinois. I am also the Chairman of the Board of Trustees of the American Medical Association (AMA), representing over 300,000 physicians and medical students.

Thank you for inviting the AMA to come before you today to respond to the outline of the "Medicare Preservation Act of 1995" distributed yesterday. We appreciate that both physician and patient input has been a vital element in your deliberations and hope that we can continue to provide counsel and feedback as the budget reconciliation process continues.

While the legislative language must be seen and analyzed before any definitive judgment can be rendered, overall, the Act's outline is one which the AMA believes fulfills the promise of protecting and strengthening the Medicare program for present and future beneficiaries. Many elements of the outline appear to be in concert with physicians' concerns regarding the preservation of patient choice and the sustaining of quality medical care in a changing marketplace.

CHOICE FOR PATIENTS

The AMA is pleased to note the emphasis on choice in the outline and the multiple strategies presented to preserve choice throughout the Medicare program. This is reflected in provisions calling for patient information and protections in their dealings with plans offered under the "Medicare Plus" portion of the outline. The AMA endorses the idea that informed patients can make informed choices about their health care; it is this vision which we believe is the foundation for true and meaningful choice in the Medicare marketplace. While we have not seen the specific legislative language, we are pleased to note that the Act's outline includes several patient protections such as disclosure to patients of plan information; rights and responsibilities; access to all medically necessary services for all covered benefits; qualification of utilization review programs; and a requirement for plans to provide written policies on notice and appeals processes for terminated physicians.

Clearly, the issue of patient choice and autonomy is a key issue to Medicare beneficiaries. The broad range of options available to seniors under the proposed "Medicare Plus" is a progressive step toward employing private sector cost savings mechanisms in the Medicare program. A system premised on choice and individual responsibility can offer savings to the Medicare program. The outline we have reviewed appears to allow everyone the right to choose, without forcing anyone to choose.

We believe the Committee has been sensitized to the range of incentives available to encourage patients to choose managed care plans, understanding that the line beyond which incentives become financial coercion can become blurred. As long as "choice" is informed and truly voluntary, the patient can become a more prudent user of limited health care resources and

physicians can increase their efficiency. In short, the marketplace can work without the burden of previously imposed distortions.

MEDICAL SAVINGS ACCOUNTS

The AMA is very pleased to see the inclusion of Medical Savings Accounts (MSAs) as an option for seniors in the financing of their health care needs. Coupled with a catastrophic policy, MSAs will undoubtedly prove attractive to many beneficiaries because they could provide funds for purchase of items and services formerly not covered by Medicare, such as prescription drugs or extended long-term care. For almost a decade, the AMA has been on record as supporting adoption of MSAs as an option in our health care system. We believe MSAs not only represent a cost effective approach to providing health care, but also strengthen the market for medical care by assuring patients more freedom of choice and promoting competition among health care providers. We are extremely pleased that MSAs were made a part of the Committee's tax package passed Tuesday, making this valuable health financing option available to the non-Medicare population, as well.

LIABILITY REFORM

We applaud the inclusion of health care liability reform, including a \$250,000 cap on non-economic damages and other provisions that have proven effective in the States that have tried them. These reforms are a very significant step forward that clearly will play a part in stabilizing the cost of health care services. The cap on non-economic damages will ensure that Medicare beneficiaries who may be injured in the course of receiving health care services would receive full and fair compensation for all out of pocket losses, yet it places a needed control on the few cases that fuel the lawsuit "lottery" mentality. These reforms should also promote faster settlement of claims, an important issue for elder Americans, who are particularly disadvantaged by the backlog in the civil justice system.

The AMA supports the decision to include all parts of the health care community, including medical product manufacturers and the biotechnology services sector, under the same umbrella of common reforms. The AMA is always concerned that piece-meal reform may have unintended consequences. This more comprehensive approach should help reduce the growing incentives among different parts of the health care community to inappropriately attempt to shift liability through onerous indemnity or "hold harmless" arrangements.

We understand that this section of the Act is not confined in application to Medicare beneficiaries, but applies to all claims of personal injury arising from the delivery of health care services. The AMA supports this approach, which ensures that the basic reforms included in the Act truly will apply nationwide. It is important, however, that States be left with the flexibility to craft additional civil justice reforms or implement alternative approaches that are equally effective in promoting access to health care services, reducing their cost and expediting the resolution of health care liability claims. Some states have already implemented alternative or more extensive reform programs, and these should not be disturbed.

PHYSICIAN SELF-REFERRAL AND REGULATORY RELIEF

The AMA is very pleased that the outline of the Act includes major improvements to the federal law on physician self-referral as well as regulatory relief provisions. The Act would remove barriers to arrangements between and among providers in the developing health care marketplace where there is little or no evidence that increased volume is due to inappropriate referrals. In particular, the Act would eliminate the prohibition on referrals based on compensation arrangements, would reduce the categories of designated health services subject to the law, and would repeal the site of service and direct supervision requirements for the in-office ancillary services exception. The AMA has long supported two of the new exceptions outlined in the Act, the first of which would allow for the legitimate use of shared office facilities by physicians, and

the second of which would create a "community need" exception for communities that are without access to designated health services facilities. In addition, we strongly support the Act's provisions that would require the Secretary of HHS to provide advisory opinions on physician ownership and referral arrangements, and which would prohibit the Secretary from enforcing the physician self-referral provisions passed in OBRA 93 until regulations are promulgated.

Finally, the AMA strongly supports the modification of the Clinical Laboratory Improvement Amendments of 1988 (CLIA-88) to relieve the burden of onerous regulations imposed on physician office clinical laboratories. Many physicians have eliminated all or some types of in-office testing because the administrative burdens and costs of complying with CLIA-88 outweigh the benefits. Consequently patients have had to suffer the inconvenience of going to outside laboratories and hospital emergency rooms to have laboratory specimens obtained and analyzed. We commend Chairman Archer for taking the lead on this important issue by introducing the Clinical Laboratory Improvement Act Amendments of 1995, H.R. 1386.

FRAUD AND ABUSE

The AMA strongly supports measures to intensify efforts in tracking and punishing fraudulent abusers of the system. We particularly appreciate the apparent distinction emphasized between intentional fraud, which is a fair target for punishment, and inappropriate use of the system, which is generally a quality issue that is more properly addressed through educational rather than punitive measures. Again, while we have not seen the specific legislative language, we are pleased to see that the outline includes so many of the anti-fraud and abuse provisions advocated in the AMA's Transforming Medicare proposal. This includes the establishment of a coordinated Fraud and Abuse law enforcement effort in which the AMA hopes to continue its role as a private sector partner in the prevention and detection of fraudulent activities. The outline earmarks fines and penalties to directly fund some of these activities. As a footnote, we would request that the Committee consider requiring an appropriations process for the use of Trust Fund monies, so as to minimize the potential for the creation of inappropriate incentives.

We also appreciate the inclusion of a patient protection for which the AMA has advocated for some time: authorizing HCFA's Office of Research to contract for a study of health plan quality assurance systems currently in place to assure that utilization control features do not result in the inappropriate denial of care. Review mechanisms must be established to assure that physicians are not offered incentives to limit care inappropriately.

GRADUATE MEDICAL EDUCATION AND TEACHING HOSPITALS

Our review of the outline's Graduate Medical Education (GME) provisions reveals a measured approach to what will certainly be sizeable shifts of funding over time for GME programs. We believe that the provisions limiting residency funding to first board certification or five years is fair. We are particularly excited to see the exception retained for up to three years additional funding for specialists in geriatrics, reflecting the Committee's recognition of the importance of geriatrics training for physicians who will be serving the Medicare population.

Another element of the GME proposed language that is gratifying to note is the ability for "Direct Account" monies to go to consortia, allowing GME payments to "follow the services" to the place where they are provided. This will clearly encourage residency training at needed non-hospital sites previously disadvantaged by payment policies. The legislative commission designated in the outline to study and make recommendations on a broad array of GME issues is laudable. This commission requires high public credibility. To this end, the AMA hopes that the formal membership on this commission will reflect all the major parties that have a stake in the redesign of GME financing, including medical professional and trade associations, private payers and representatives from state and local governments.

PHYSICIAN PAYMENTS

The AMA is very pleased with a number of provisions included in the outline of the Act which

affect payments to physicians under the traditional Medicare program.

Repeal of the Medicare Volume Performance Standard (MVPS)

The outline provides that the Act would repeal the MVPS and instead adopt the Physician Payment Review Commission's (PPRC) recommendation that physician updates should be set by a formula linked to the projected growth of real domestic product per capita increased by two percent annually as well as changes in enrollment and inflation. The AMA strongly supports this change to the current flawed MVPS formula. Because of changes to the MVPS made by the Omnibus Budget Reconciliation Act of 1993, Medicare physician payments, without modification, are projected to drop by 2-3% annually through 2002 and beyond. According to the PPRC, projections based on current MVPS formulas show that within the next ten years, the conversion factor could fall below \$31, the level established when the Medicare Resource-Based Relative Value Scale (RBRVS) system was first implemented. The AMA applauds the Committee for addressing this important issue and eliminating the flawed MVPS formula.

Move to Single Conversion Factor

The outline also states that the Act would implement a single conversion factor for all Medicare physician fee schedule services (i.e. surgical, primary care, and non-surgical). The AMA's Transforming Medicare proposal, along with longstanding AMA policy, calls for the Medicare payment schedule to utilize a single conversion factor. Because of past differential updates, the primary care conversion factor is currently 14 percent lower, and other non-surgical 8 percent lower, than the conversion factor for surgical services. The AMA is concerned that this divergence undermines the original intent of the Medicare physician fee schedule. The AMA would welcome the opportunity to work with the Committee and HCFA to discuss how best to design a transition from the current multiple MVPSs that take appropriate account of the potential disruptions for physicians who provide a large proportion of services in the surgical MVPS, as well as consider changes due to the five-year review of the RBRVS payment system. In its recent proposal for Medicare transformation, the AMA proposed a timetable that would achieve implementation of a single conversion factor by 1998. We look forward to working with the Committee and HCFA on an appropriate, timely, and carefully considered implementation of a single conversion factor.

Physician Payment Reductions

While the AMA strongly supports the physician payment changes discussed above, we are nevertheless concerned about potential reductions to physician payments which are not described in the Act. Year after year, physicians have contributed their fair share to the budget deficit effort. Physicians, who account for 23% of Medicare outlays, have absorbed 32% of Medicare provider cuts over the last decade. According to the PPRC, Medicare's physician payment rates are currently only 68% of those of private insurers. Further reductions to Medicare physician payments would only increase the gap between Medicare's rates and private rates, limiting physicians' willingness to accept Medicare beneficiaries and limiting Medicare beneficiaries' access to health care.

PROVIDER SERVICE NETWORKS

We are pleased that the outline of the Act reflects consideration of an evolving marketplace that would include the formation of "Provider Sponsored Networks" (PSNs). As noted in the outline of the Medicare Preservation Act, it is crucial that special consideration be given to the major differences between insurance companies and PSNs, especially in the areas of financial solvency, definition of risk-based capital and issues of reinsurance. In addition, given the acknowledged precedent at the federal level for promoting an environment in which competition should be allowed to flourish in an evolving health care marketplace, the AMA looks forward to working with the Committee in developing specific legislative language that will fulfill the intent of the outline's promise.

"FAIL SAFE" PROVISION

The AMA believes that the "fail safe" provision in the Act takes a constructive approach by setting spending growth rates for separate provider categories, such as inpatient hospital services, physician services, home health care, durable medical equipment and laboratory services. If services within a category exceed designated spending growth targets, the Secretary of Health and Human Services would be required to change the payment updates for that category for future budget years. We believe this properly isolates high growth services and better identifies sources of growth within the Medicare program. At the same time, we are disappointed that the outline does not more directly address Medicare's basic lack of price competition. We appreciate and understand the goal of reducing growth, however, physicians have only a limited control over the number of times a fee-for-service patient can access the Medicare system. Individuals are much more likely to be prudent consumers of medical care if they have a financial interest in their care.

In addition, the limited cost-sharing in the current Medicare program has been largely nullified by the widespread purchase of Medigap coverage which transforms Medicare into first-dollar coverage. As a result, some beneficiaries consume more medical services than they otherwise would. We believe it is inappropriate to penalize physicians for providing medical services sought by seniors, as well as basing the fee-for-service option on what is a de facto expenditure target.

CONCLUSION

The AMA recognizes the fact that Medicare has been a great success in meeting its originally declared mission of improving the health status of our elderly Americans. The goal to protect and strengthen the Medicare program for present and future generations of beneficiaries is paramount. The AMA looks forward to continuing our work with the Committee and the Congress as this historic legislative initiative moves forward.

Mr. THOMAS. Thank you very much, Doctor.
Mr. Scully.

STATEMENT OF THOMAS SCULLY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, FEDERATION OF AMERICAN HEALTH SYSTEMS

Mr. SCULLY. Mr. Chairman, thank you very much for having us testify today. I am president of the Federation of American Health Systems, which represents 1,700 investor-owned hospitals and health systems nationwide.

We also have kind of a mixed message today. We still haven't seen all the details, but our initial reaction is that the Committee's package does a very good job of restructuring the health care system and puts us on a road toward what we think will be a much more dynamic and better health care system 7 years from now.

In the interim, we have some pretty serious concerns. I guess that is where the mixed message comes from.

We very much like the restructured package. We very much like a lot of the changes you have made in giving seniors the ability to choose private sector health plans. But that excitement is tempered by the fact that we are not exactly happy about the level of reductions.

We certainly still think, as we have stated all year, that the \$270 billion in the package is large, is excessive on local community hospitals; and we certainly hope, through the course of the debate that the level of reductions, the level of budget savings will come down. If the reduction is more reasonable, I can say that our hospitals would certainly be out leading the brass band in support of this plan, because we do think it is very well structured and will significantly improve the performance of the health care system.

Let me comment additionally beyond the generic comments on four very specific issues. The first one, the two previous witnesses have mentioned, is provider-sponsored networks. This is an enormous, enormous issue for hospitals.

Just to clarify what this issue is, essentially, the Committee package would open the new market in the next year to 33 million new seniors into a new, competitive health care system. How you get access to that system for your local community hospitals to offer a comprehensive health care package is very, very important.

Our concern is that we not be left at the starting gate. The insurance industry would tell you what we should do is go back to every State and get an HMO list. What is going to happen there, basically, is we are going to be left 1 year, 2 years behind. If we have to go back, if a community hospital and community health system have to go to its State to get an HMO license, the reality is the market may be completely gone and the game will be over long before the hospitals get in to compete for the new beneficiaries.

So while we are very supportive of the new plan, we are, I would say, very strong in our efforts to make sure we gain fair access; and we don't want to be wandering around State capitals getting HMO licenses 2 years from now when every local senior signed up for private choice.

Second is fraud and abuse. We are very supportive of what the Chairman put in the mark for the fraud and abuse package. We

think a lot of the current fraud and abuse laws are very helpful in the fee-for-service environment, but they are very detrimental if you are trying to put together an integrated service network, and that is what we all hope to do in the next 7 years. The incentives are just totally different. When you are looking at managed care networks and integrated environments, I think there should be two totally different sets of standards.

Third, liability reform. We have strongly supported liability reform for years. We believe the public support for that is very strong nationwide. We worked very closely with the AMA and the AHA on that for the last couple of years. We are very excited to see that in the package, and we hope it will stay in. We also think we will have significant savings, probably much more than CBO, OMB, what everyone else will ever acknowledge.

Fourth and finally, one thing I would like to focus on most is the fail-safe mechanism. We have—certainly the AHA and the federation have worked a lot in the last 6 months to try to find a way to help develop a fail-safe mechanism or look-back, as it is sometimes called. We think it is a very good idea. We are concerned how it is structured. We haven't seen the details. We think it could help make for a much more flexible and rational way to reduce the spending in the Medicare Program by \$270 billion if it is crafted correctly. We think it would be a disaster if it is crafted incorrectly.

We would very much like to work with you on this in the coming couple weeks. And we believe if it is crafted—and I attached some numbers in the back.

I had the fortune—or misfortune—of being the associate director of OMB for 4 years and oversaw the Medicare Program. I can tell you that I think a lot of this and how it is done has to do with what the various assumptions are for the next 7 years. There is a right way to do it, and I think if it is done right it will be an enormous help in making your package work in a way that can make this survivable for hospitals, physicians, and the rest of the health care community.

Thank you, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY
of
Thomas Scully, President & CEO
Federation of American Health Systems
before
The House Ways and Means Committee
hearing on
Medicare Reform: "Medicare Preservation Act"
Friday, September 22, 1995

Mr. Chairman and Members of the Ways and Means Committee: Thank you for giving the Federation of American Health Systems, which represents 1700 investor-owned and managed hospitals, the opportunity to comment on the essential changes and restructuring that you are undertaking in the Medicare program.

The Committee and House leadership should be commended for putting forth a proposal that appears to be a thorough effort to restructure the Medicare system. The Republican plan, if followed for the next seven years, is a blueprint that can ensure a stronger Medicare health care delivery system that will offer beneficiaries more choices in a more efficient market.

Not having seen the final legislation, I feel a little like a diner at an expensive restaurant. Much of the menu looks appealing, but there are no prices listed and I'm a little afraid that I may not be as happy when the bill arrives. As you know, we still do not know the specific amount of the hospital reimbursement changes in the package.

As a result, the Federation has a mixed message today. Despite the positive aspects of restructuring, the Federation remains very concerned about the size of the budget reductions Congress has proposed for Medicare. These reductions are unprecedented in their size and appear to have a disparate impact on the average community hospital. As the Medicare debate continues, the Federation hopes that the overall target of \$270 billion will be reduced, and that the specific reductions will be more equitably distributed.

If the reductions were more reasonable, or showed a better balance between hospitals, physicians, other providers and beneficiaries, the Federation might be leading a brass band in support of the plan. However, we are concerned that budget reductions of this magnitude will contribute to a cumulative effect that will accelerate the existing trend of hospital employee layoffs, and cause quality to deteriorate.

Let me briefly comment on four issues that are most sensitive to our hospitals. These are areas where the committee seems to be heading in the right direction toward creating an environment where true restructuring can eventually be accomplished.

ISSUE ONE Provider sponsored networks: If you are to open a truly competitive market--one that can best serve the 33 million seniors--all new market participants, whether insurance carriers, HMOs or provider sponsored networks, must be given fair access to develop service

networks. Fair access requires putting all of these competing systems at the starting line at the same time. If the new Medicare market opens next spring, all worthy participants should be admitted at the same time.

ISSUE TWO Fraud and abuse: Many of these laws serve a purpose in the fee-for-service market, but will hinder the development of integrated networks. Modifying the anti-kickback and so-called "Stark" laws would remove a number of roadblocks in the health care market that prevent health care organizations from providing more efficient and cost-effective care. Because the Medicare proposal will open the door to many new and hybrid health care relationships, it is vitally important that risk-sharing arrangements that include incentives for appropriate utilization be allowed under these statutes. We also recommend establishing an advisory opinion process that would provide more guidance than the broad and general statutory language and regulations currently allow.

ISSUE THREE Liability reform: The bill contains a proposal limiting liability for health care providers. These reforms are overdue, enjoy strong public support, and have long been advocated by hospitals nationwide. We urge the Congress to include these reforms in the legislation.

ISSUE FOUR Finally, your "fail safe" budget mechanism, or what has also been called a "lookback," is an important part of creating a budget package that will allow Congress to lock in absolute spending limits for seven years. \$270 billion is a very large number. The fail safe gives Congress the flexibility of reaching this number with a guarantee that you will not exceed spending caps. The better Congress and the public understand how completely this insurance policy guarantees savings, the more support it will garner. (See attached chart). As a former Associate Director of OMB, who oversaw Medicare, I can assure you that these savings are not only real--they are absolutely certain.

However, for this to work, there must be a fair balance between providers and beneficiaries, and there must be a rational limit on the amount of savings that can be achieved through this mechanism. Furthermore, the fail safe should contain clearly defined targets by category of service. Groups operating efficiently within the new Medicare rules should not be subjected to balancing the budget for less efficient groups.

CONCLUSION: From what the Federation has seen, the restructuring contained in your proposal, if the details are handled correctly, will allow the Medicare program to utilize private-market competition to lower costs and improve quality. But the package would be far better if savings targets were more reasonable.

The Federation would urge members from both parties to embrace the restructuring elements of this proposal and begin working out the differences they will understandably have, given the size and scope of this legislation. The reforms contained in this plan are long overdue.

The Federation looks forward to working with the committee in completing this important restructuring of the Medicare program.

Mr. THOMAS. Thank you very much, Mr. Scully. I know we will receive input from you as we move forward.

Sister Keehan, thank you for coming.

STATEMENT OF SISTER CAROL KEEHAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PROVIDENCE HOSPITAL; AND CARROL MANOR NURSING HOME, WASHINGTON, DC

Sister KEEHAN. Thank you. Good evening, thank you very much for the opportunity to be here. I am Sister Carol Keehan, president and chief executive officer of Providence Hospital here in the District of Columbia.

We must preserve Medicare, the program itself and the quality of it. We must assure that the health security of elderly Americans of all socioeconomic levels remains intact. The cuts in this bill are entirely too large and will significantly undermine the quality of the program, especially for the most vulnerable.

I applaud your desire to balance the budget. I also acknowledge that there are real opportunities to improve Medicare and realize some savings. There are inefficiencies to correct and, sadly, some fraud to eradicate as there is in almost any business, school system, military or government operation, but there is not \$270 billion to be saved.

In truth, a number of the measures outlined could increase some of the inefficiencies. The savings goal in this bill is not derived from quality studies that have demonstrated specific dollar savings tied to program modifications that have no detrimental effect on the accessibility and quality of the Medicare Program. It is an arbitrarily determined dollar savings needed.

Those who will most suffer are the poor and those of multiple, severe, chronic illnesses. These are the elderly who most need the safety nets that now exist in Medicare, the ability to get care, tests, and services when and where they need it is critical.

Many of the gatekeeper functions and other market-driven characteristics of managed care as we know it are not compatible with the needs of the elderly. There is no argument that coordinated care systems are best for all Americans. That is different from systems of care that are designed by the market.

We also have no evidence that the managed care industry can render the same level of care and produce savings to the Medicare Trust Fund from those patients whose care constitutes the bulk of Medicare expenditures.

It is also not fair to assure Medicare recipients that they can keep the current program if they want. The current program is lost with this proposal. The fee-for-service option retained is not the same program from many points of view.

While the poor and seriously ill will suffer most from these changes, make no mistake, all Medicare patients will feel their effect. The dramatically reduced reimbursements in major areas will change the character of many of our health care services. When you factor in the significant cuts proposed in Medicaid, this phenomenon is guaranteed.

Many aspects comprise the wonderful health care enjoyed by most elderly Americans. Whether you look at medical education programs, the mix of professionals rendering care versus on-the-job

trained care workers, or the multiple programs aimed at the special needs of the elderly, it is obvious we have made great strides in developing quality programs for the elderly.

Medicare deserves much of the credit for this. Make no mistake. These changes will undermine those gains in significant ways. An additional \$7 per month will be the most minimum change recipients will feel. With the growth of managed care, we have seen diminishing community service programs, significant shifts in the number and educational level of staff caring for patients, and marketing away from the poor.

You must understand that meeting patients' needs, especially the elderly with multiple problems, cannot simply be programmed. Patient and family education, obtaining services and equipment is time consuming, whether it is getting a diabetic a glucose monitor, supplies, diet education, transporting, or evaluating the compatibility of the myriad of drugs a patient is on. It takes time and educated staff.

Patients with multiple complex problems may find themselves avoided and/or a portion of their problems not addressed because they consume so much time. If they are poor as well, the supports of social services to arrange transportation, assistance in housing, food stamps, outpatient dialysis will be hard for providers to afford to offer.

These concrete examples may seem naive in these great chambers, but I assure you they are the everyday life of the elderly and their primary concerns. Whether these needs are better met after you change Medicare or not is how they will judge the outcome of your decision.

I urge you to look at a more courageous and compassionate approach to this issue. Put this draconian approach on hold this year and put in more modest cuts. Fund some high-quality studies for the next 2 years focusing on multiple delivery systems and how well they meet our most challenging Medicare patients. This will give you accurate information to use in designing the long-term strategy. You will know what works best, what is essential, what is not compatible with meeting the needs of the elderly.

It will also give you time to focus on regulations that fail the cost-benefit test, make health care more expensive, structure malpractice laws, and to structure laws that make it possible for not-for-profit providers to set up delivery networks that retain any profit for community benefit.

I urge you to take the time to do this well. A balanced budget and/or a tax cut will be no credit to you if it has cost elderly Americans their health security.

Thank you.

[The prepared statement follows:]

**STATEMENT OF SISTER CAROL KEEHAN
PRESIDENT AND CEO
PROVIDENCE HOSPITAL AND CARROL MANOR NURSING HOME**

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Make no mistake -- these changes will undermine those gains in significant ways. An additional \$7 per month will be the most minimal change that recipients will feel. With the growth of managed care, we have seen diminishing community service programs, significant shifts in the numbers and educational level of staff, and marketing away from the poor. The diminishment of medical education programs is something we will all pay for in the future.

You must understand that meeting patient's needs, especially the elderly with multiple problems, cannot simply be programmed -- patient and family education, obtaining services and equipment is time consuming. Whether it is getting a diabetic a glucose monitor, supplies, diet education, transportation or evaluating the compatibility of the myriad of drugs a patient is on, it takes time and educated staff.

Patients with multiple complex problems may find themselves avoided and/or a portion of their problems not addressed because they consume so much time. If they are poor as well, the supports of social services to arrange transportation, assistance in housing, food stamps, outpatient dialysis, etc., will be hard for providers to afford to offer.

These concrete examples may seem naive in these great chambers but I assure you they are the everyday life of the elderly and their primary concerns. Whether these needs are better met after you change Medicare or not is how they will judge the outcome of your decision.

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approach to this issue.

Put this draconian approach on hold this year, put in more modest cuts, fund some high quality studies for the next two years focusing on multiple delivery systems and how well they meet the needs of our most challenging Medicare patients. This will give you very accurate information to use in designing a long term strategy. You will know what works best, what is essential and what is not compatible with meeting the needs of the elderly.

It will also give you the time to focus on regulations that fail the cost benefit test and make health care more expensive, to structure reasonable malpractice laws and to structure laws that make it possible for not-for-profit providers to set up delivery networks that retain any profit for community benefit.

In this regard, the current ambiguous tax laws and IRS policies severely limit the kinds of integration that can qualify for tax exemption. As a result, many providers join for-profit managed care arrangements out of necessity.

There is concern that, over time, integration into for-profit structures will threaten the original charitable mission of the not-for-profit hospitals, which have served communities across this country well.

We need provisions which:

- allow not-for-profit hospitals to form tax exempt IDNs; and
- require tax exempt IDNs to meet strong statutory requirements regarding their charitable purpose, including an annual report on charitable activities.

This would include the concept of intermediate sanctions as a strong protection against private inurement and private benefit in tax exempt organizations.

I urge you to take the time to do this well. A balanced budget and/or a tax cut will be no credit to you if it has cost elderly Americans their health security.

Thank you.

Mr. THOMAS. Thank you very much, Sister.
Dr. Thomson.

**STATEMENT OF GERALD E. THOMSON, M.D., PRESIDENT,
AMERICAN COLLEGE OF PHYSICIANS**

Dr. THOMSON. Mr. Chairman, Representative Gibbons, and Members of the Committee, I am Dr. Gerald Thomson. I am president of the American College of Physicians, and we are pleased to have the opportunity to share with you the college's very serious concerns about proposals to cut deeply into Medicare.

The American College of Physicians is the Nation's largest specialty society group, with over 85,000 members, almost all trained in internal medicine. This group of physicians, internists, who provide more care for Medicare patients than any other physicians, are not on board with the proposed budget reductions in the public insurance programs.

We think that cuts of this magnitude call into question our ability to provide the world class medical care enjoyed by many but not nearly all Americans. The college opposes Medicare restructuring that starts from a target number driven by the demands for a balanced budget and tax cuts, and then tries to engineer changes that meet that target.

We believe in the opposite approach. Start with changes that derive from health care system goals, then estimate the savings that would be produced within the context of what is best with a rationale health care system. Neither Medicare patients nor their health delivery system can absorb the magnitude of budget cuts proposed, even if one assumes a large-scale transition of Medicare patients to managed care plans.

Medicare patients already spend as much as 21 percent of their incomes on out-of-pocket costs, and the vast majority of patients are in relatively low incomes. With a median income of about \$18,000 a year, most Medicare patients cannot afford higher out-of-pocket payments.

Health care providers have paid more than their fair share toward deficit reduction. To ratchet down reimbursement further will threaten the ability of both doctors and hospitals to treat current and especially new Medicare patients. Particularly vulnerable are the poor with disproportionate numbers of minorities, the very old and disabled. Those living in rural and urban poverty areas, all groups whose access and health problems have been so well documented.

Another significant impact of the proposed cost-cutting effort will be increases in out-of-pocket expenses and lost wages for all Americans. A recent study by Lewin VHI, commissioned by the National Leadership Coalition on Health Care, showed that more than \$90 billion in costs would be shifted to the private sector from the \$450 billion in cuts proposed for both Medicare and Medicaid.

This \$90 billion cost shift will fall on America's employers and America's families. An even higher price will be paid by those least able to afford it. There will be an increase in the projected number of uninsured. The Lewin VHI study projects an additional half a million people will lose coverage as a result of the cost shifting.

Just over 1 year ago, the American College of Physicians appeared before this and other Committees to support efforts to bring America closer to universal coverage, a goal that had universal support.

Today, we struggle to avert a cost-cutting proposal that will move the country backward from the goal of health care for every one.

I must say that the proposed cuts in Medicaid, while not within the jurisdiction of this Committee, are also of grave concern. We do not believe that a 4-percent growth rate can be achieved in the near term as proposed. Cuts of this size will force States to move ahead with poorly conceived managed care plans instead of implementing a careful transition that early experience suggests is essential.

We also oppose block grant proposals that eliminate the guarantee of coverage for patients who meet eligibility criteria, and without a guarantee, a recession of even minor proportions will force waves of additional people out from the umbrella of employer-provided health care coverage.

In sum, Mr. Chairman, the American College of Physicians cannot support short-term budget cuts that target patients, physicians, hospitals, and others and risk serious harm to patient care.

We urge you to forgo the inclusion of these programs in this budget cutting exercise and explore and eventually enact Medicare and Medicaid reforms that are consistent with and indeed may lead the way to more fundamental health care system changes.

The American College of Physician's recommendations are summarized in our written statement but I would simply indicate that—by listening to our suggestions.

First, the college supports managed care plans that are comprehensive and assure coordinated, quality care.

Second, recognizing that Medicare patients now have complete and open choice of physicians and hospitals, a point sometimes lost in these discussions. The college supports the gradual transition of Medicare and Medicaid to systems which offer beneficiaries, on a volunteer basis, a variety of options among different types of health care plans, including additional plans.

Third, the American College of Physicians believes that a national discussion should be undertaken to address the very difficult issues surrounding prioritization of health care, prioritization of health care services for all populations, not simply the elderly, not simply the poor. A national consensus must be reached on how to decide when care becomes futile at any age and when other care options should be chosen to preserve individual dignity and comfort.

Fourth, the potential for savings through administrative simplification remains to be exploited.

Fifth, Medicare and Medicaid should evaluate and adopt, as appropriate, prudent private sector purchaser initiatives, such as quality indicators and service performance standards, the use of standards of excellence, specialize services contracting, and case management for high-cost services.

Now, we recognize that the changes that we recommend may not be as quantifiable for short-term deficit reduction. We hope, though, that Congress and the administration will establish the private-public mechanisms to plan for long-term reforms in these vital public programs.

Thank you for the opportunity to share our views with the Committee.

[The prepared statement follows:]

Statement of Gerald E. Thomson, MD
President, American College of Physicians
Committee on Ways and Means
U.S. House of Representatives
September 22, 1995

PROPOSED MEDICARE BUDGET REDUCTIONS

Good morning Chairman Archer, Representative Gibbons and members of the Committee. I am Dr. Gerald E. Thomson, President of the American College of Physicians. I am pleased to have the opportunity to share with you the College's very serious concerns about proposals to cut deeply into Medicare.

Let me first remind you that the American College of Physicians is the nation's largest medical specialty society with 85,000 members trained in internal medicine and its subspecialties. We are dedicated to continuing medical education -- we publish the *Annals of Internal Medicine* -- and to advocacy of responsible public policy.

Let me say in all seriousness that this group of physicians -- internists who provide more care for Medicare patients than any other physicians -- are *not* on board with the proposed budget reductions in the public insurance programs. We think that cuts of this magnitude call into question our ability to provide the world class medical care enjoyed by many, but not nearly all, Americans. Further, these cuts move us away from, not towards, assuring health care for all Americans, which remains an overarching goal of the American College of Physicians.

The College is concerned about an approach to Medicare restructuring that starts from a target number driven by the demands for a balanced budget and tax cuts, and then tries to engineer changes to meet that target. We believe in the opposite approach: start with changes that derive from health care system goals, and then estimate the savings that would be produced. The College was one of the first physician organizations to commit itself to cost containment, but we have insisted that cost containment not be the starting point for proposed changes. Rather, well conceived and carefully implemented reforms, designed to reduce excess capacity and utilization of services, promise savings based on a real reduction in costs rather than arbitrary budget cuts. In sum, we have to change the growth curve in health care costs and forego budget cuts that produce short term savings but no lasting cost containment or reform.

Neither Medicare patients nor the health delivery system can absorb the magnitude of budget cuts proposed, even with a large-scale transition of Medicare patients to managed care plans.

Medicare patients already spend as much as 21 percent of their incomes on out-of-pocket costs, and the vast majority of patients are at relatively low incomes. The median income of Medicare beneficiaries is about \$18,000. Nor do the elderly have substantial assets. The typical household in pre-retirement years has assets of \$17,300; the comparable figure for African-American and Hispanic households is \$500. Income-related premiums may make sense for the small number of beneficiaries at higher income levels, but that will produce only modest revenue.

It is proposed that reimbursements to health care providers be reduced through both government caps and market forces. There is a limit to what can be taken from the health care system in a given period of time. We suggest that proposed approaches to cost containment may prove to be very costly in terms of access to care and impact on the private sector.

Health care providers have paid more than their fair share towards deficit reduction. Physicians have absorbed 32 percent of recent budget reductions while they account for only 23 percent of Medicare spending. Medicare payment to physicians averages fully one third less than private sector payment. To ratchet down reimbursement further will threaten the ability of both doctors and hospitals to treat current and especially new Medicare patients. Particularly vulnerable are the poor, with disproportionate numbers of African-Americans and other minority groups, the very old, the disabled, and those living in rural and urban poverty areas -- all groups whose access problems have been documented (Physician Payment Review Commission, 1994, 1995).

Another significant cost of the proposed 'cost-cutting' effort will be steep increases in out-of-pocket expenses and lost wages for all Americans. A recent study by Lewin/VHI, commissioned by the National Leadership Coalition on Health Care -- a nonpartisan group that includes large corporations -- showed that more than \$90 billion in costs would be shifted to the private sector from the \$450 billion cuts proposed for both Medicare and Medicaid. This cost shift takes place even under assumptions of large numbers of Medicare patients moving into managed care plans and sizable reductions in

reimbursement to providers; significantly, only a portion of the reimbursement reduction is included in the cost-shift amount.

This \$90 billion cost shift is a tax increase. What's worse, it is a hidden tax increase, and it will fall on America's employers and families.

As distasteful and harmful to the economy as the cost-shift is -- it is not the greatest cost of proposed budget cuts. The highest price, paid by those least able to afford it, will be an increase in the number of uninsured. Already, one-sixth of the non-elderly population lacks health coverage. The Lewin/VHI study projects an *additional half-million people* will lose coverage as a result of the cost -shift. Just over a year ago, the American College of Physicians appeared before this and other committees to support efforts to bring America closer to universal coverage -- a goal that had bipartisan support. Today, we struggle to avert a cost-cutting proposal that will move the country backward from the goal of health care for everyone.

As in Medicare, the proposed cuts in Medicaid also are of grave concern. We do not believe that a four percent growth rate can be achieved in the near term, as proposed. People have claimed -- but no one has shown -- how the states, "freed" from federal requirements, can save that amount of money. Cuts of this size will force states to move ahead with poorly conceived managed care plans, instead of implementing a careful transition that early experience, such as TennCare, suggests is essential. We also oppose block grant proposals that eliminate the guarantee of coverage for patients who meet

eligibility criteria. Without a guarantee, a recession of even minor proportions will force waves of additional people out from the umbrella of employer-provided health coverage.

In sum, Mr. Chairman, the American College of Physicians cannot support short-term budget cuts that target patients, physicians, hospitals, and others, bring about no meaningful change, and risk serious harm to patient care.

We urge you to forego the inclusion of these programs in this budget cutting exercise and explore and eventually enact Medicare and Medicaid reforms that are consistent with, and indeed may lead the way to, more fundamental health system changes. We must reduce excess capacity and utilization if we are to achieve meaningful, lasting cost containment. I will summarize briefly the ACP recommendations for long term reforms.

First, the College supports managed care plans that are comprehensive and assure coordinated quality care. We think that this approach to delivery of services potentially can improve access and quality for Medicare and Medicaid patients and, at the same time, control spending by reducing excess capacity and utilization. Federal standards for high quality care are essential, and the ACP's Task Force on Aging has made recommendations on what Medicare managed care should look like. We have also proposed standards for Medicaid managed care.

Second, recognizing that Medicare patients now have complete and open choice of physicians and hospitals -- a point sometimes lost in the current debate -- the College supports the gradual transition of Medicare and Medicaid to systems which offer beneficiaries, on a voluntary basis, a variety of options among different types of health care plans, including traditional plans. We have real concerns about the ability of more vulnerable elderly patients to adjust to such a system, and believe that an administrative mechanism such as a purchasing pool is a necessary component of this approach. However, we have reservations about the medical savings account option. This approach contradicts the principles served by quality managed care. MSAs may discourage comprehensive care. Moreover, they have the potential of draining the healthier and wealthier beneficiaries from the rest of the Medicare risk pool, undermining the ability of Medicare to survive. The College recommends MSAs be tried on a demonstration basis to gather more information about their effects on the health status of those who use them and on the health coverage of those who do not.

Third, ACP believes that a national debate should be undertaken to address the difficult issue of prioritizing health care services for all populations, not simply the elderly or poor. A national consensus must be reached on how to decide when care becomes futile, at any age, and when other care options should be chosen to preserve individual dignity and comfort. Alternatives to acute care treatments are critical, so that patients are not forced to choose between high tech care and no care.

Fourth, the potential for savings through administrative simplification remains to be exploited.

Strategies for savings include uniform claims forms and electronic processing, utilization review based on patterns of care rather than case-by-case review, and incentives to promote economies of scale.

Fifth, Medicare and Medicaid should evaluate and adopt, as appropriate, prudent private sector purchaser initiatives such as quality indicators and service performance standards, use of centers of excellence, specialized services contracting, and case management for high cost services.

To summarize, the American College of Physicians believes that the goal of Medicare and Medicaid changes should be quality care for those in need and the long-term solvency and viability of those programs. Restructuring must be considered in light of its effects on the larger health care system. We recognize that the changes we recommend may not be quantifiable by CBO for short-term deficit reduction, and we know we are bucking the tide to insist that deficit-reduction is not the appropriate goal for changes in these programs. Many proposals which are so easily scored by CBO are arbitrary program cuts that harm patients, health care professionals and institutions, and the larger health care system. We hope that Congress and the Administration establish the private-public mechanisms to plan for long-term reforms in these vital public programs.

Thank you for the opportunity to share our views with the committee.

Mr. THOMAS. Thank you, Doctor.

I thank the panel.

Does the gentleman from Florida wish to inquire?

Mr. GIBBONS. First, I want to thank the whole panel and all the others, the four Republicans and the eight Democrats that are still here. I regret that the Chairman had to fulfill a social engagement down in Texas. I thought these hearings were more important than that, but, Sister Keehan, I am glad that you and Mr. Thomson both put a human face on what we are talking about here.

We too often here in Congress tend to talk in budgetary terms rather than human face terms. Now that I have condemned myself for talking too much in budget terms, I want to say to Mr. Warden and Mr. Seward, most of this is going to come out of your folks and the hides of human beings that are going to be affected by this.

Mr. Thomson, you mentioned the cuts in Medicaid. It used to be before the unfortunate reform around here we handled the Medicaid Program. The Medicaid Program started right here at this dais. And when you take the Medicaid cuts and the Medicare cuts, they amount to almost \$½ trillion, \$½ trillion.

Now, assuming—and I don't, but assuming that \$160 billion is needed to put the Medicare Trust Fund in balance, that still leaves roughly some \$390 billion that is cut out of Medicare and Medicaid and out of people's benefits, a large part of it for a tax reduction for very wealthy people. When you compare the fact that we are talking about what is coming out of the pockets or the services to the sick, the elderly, to the disabled, it just doesn't make any social sense or economic sense or political sense to do that.

We can vastly reduce the burden on you, which is largely being driven, \$390 billion of it, just by budget figures alone; \$390 billion is being driven by budget figures alone, if we took out the 250 billion dollars' worth of tax cuts that will go to very limited upper income people.

So I think you begin to see the injustices and why at times I get very disturbed about what I am seeing happening here. I have left out the \$23 billion that these folks voted yesterday or the day before yesterday to take out of the pockets of the working middle-class families here in America.

So this is an assault upon working middle-class families, upon sick people and elderly people; \$1½ trillion.

Sister Keehan, I am eternally grateful for the human face you put on all this. I know where your Providence Hospital is. I know the kind of people that you end up treating and I just regret that the Chairman didn't stick around for this, that we don't have a piece of legislation to talk about. We are just talking about concepts and ideas and releases. No way to run a government.

I yield back the balance of my time.

Mr. THOMAS. The gentleman yields back the balance of his time.

Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Yes. I have a question, but you know, I would just like to say something.

Mr. Gibbons, I know how deeply you feel about these issues. I respect you tremendously and you have led the way for many of us, but the way I look at this, this is not an assault on the working-

class people, the middle-class people. I think we are all trying to struggle with getting something accomplished and saving a system.

The degree to which we save the system may be different in your estimation than it is in mine, but you know, the question is how much and how fast, and it is not a metallic issue. It is a people issue.

I just wanted to say that because I just don't want to constantly be put in the position of ignoring whole groups of people with which I grew up and work every day.

Now, let me get to my question. A lot of us have been interested in these provider service networks. From my standpoint, representing a rural area, they are very, very important, and I understand that Mr. Warden, Seward, Scully all think these are pretty good ideas and maybe Sister and Mr. Thomson, you think that they are also.

From a practical standpoint, since they are so important—I mean, they tend to resolve the issue between the provider and the insurance company. They tend to knock down some of these problems of financing from the outside, profits going elsewhere and would instead leave them in the community. How fast, practically, if we were to say go now, would these things be able to get up and going? Do you see a reasonably short period of time or do you see us struggling?

Mr. WARDEN. Mr. Houghton, I think that in many places around the country, these networks have already been formed. In a very short period of time, as little as 6 months, I think that other provider-sponsored networks could be formed, arrangements could be made with HCFA for the Medicare population and it could move forward. And a good example, for instance, in rural America might be the Laurel Health System which is in Wellsboro, Pennsylvania.

Mr. HOUGHTON. I know it well.

Mr. WARDEN. That particular network came together over the last several years. It is a case of a community working with the providers and the social agencies, and is a good example of what could be done. Laurel Health is a network, for instance, that could move ahead very quickly.

That is the case throughout the country in many, many communities. And the problem is that in many, many communities, there isn't a managed care alternative; and if we provide a more flexible approach to contracting for Medicare, there have got to be entities ready to put that approach into place. We are not asking for special privileges in terms of the regulatory mechanisms. We believe that we can meet the same kind of regulatory requirements that HMOs and insurance companies have had to respond to in terms of quality and consumer protection and solvency.

What is important is the understanding that the capital requirements and reserve requirements should be somewhat less because most of the capital of a provider-sponsored network is reinvested in the delivery system—and is being used to take care of those people who are enrolled in it. And the other thing that is necessary, of course, is in many States, to have a less hostile regulatory environment—because the State insurance commissioners have such strict approaches to the development of anything that has an insur-

ance mechanism. And we have seen this in Blue Cross plans for years.

Mr. HOUGHTON. Anybody else?

Mr. SEWARD. Yes. I will be quick, Mr. Houghton.

I agree with what my colleagues said here, but there is one other thing that has to be—many of our providers are literally waiting to do this, but there are certain impediments in the law that have to do with antitrust, not that you need an exemption, but—

It would be in conflict with antitrust rules. So that if we could address some of those areas, not to give absolute exemptions from doing illegal business practices, but to help take away that impediment would increase the validity at how fast these come up.

Mr. HOUGHTON. Mr. Scully, would you like—

Mr. SCULLY. Yes, just quickly.

I would say the issue for us is clearly market access. There are lot of HMOs; I know Gail has one in Detroit—lots of hospitals that have HMOs. They could get in right away. Many hospital systems have chosen not to get HMO licenses and the issue for us is, do we have to spend 2 years getting one.

We have one system, Columbia HCA, that is a \$17 billion a year operation. They clearly are more solvent than probably any insurance company in the country. They don't have an HMO license that I know of anyway.

There are a lot of places, for instance, Houston, where they have 40 hospitals. They could put together a network tomorrow but they have to get a license first. Down in Charleston, in Mr. Payne's district where I went to school, the University of Virginia, which I don't believe has an HMO license, could probably put together a local provider network there in about 1½ hours, but they would have to get a State HMO license first. For us it is purely a matter of timing and varied success as far as the time.

Mr. THOMAS. The gentleman's time has expired.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. KENNELLY. Thank you, Mr. Thomas.

The previous panel, when I asked them about taking \$270 billion cuts in Medicare or \$180 billion cuts in Medicaid, which would add up to \$450 billion, a staggering amount of money, kind of gave me a not-to-worry answer.

Sister, I would like to ask you the same question. If Providence Hospital in fact had to, over the next 7 years, deal with \$450 billion of cuts in Medicaid and Medicare, what is the future of Providence Hospital?

Sister KEEHAN. Providence Hospital was established at around the time of the Civil War when Abraham Lincoln signed our charter, so when we were established, we weren't sure we were going to have a country, so I have to continue to believe in God. But I can tell you that we are testing that at Providence quite a bit with these. We have looked at the impact.

If we survived those cuts, we would survive with the character of the institution dramatically changed. All the safety-net programs we have that help our citizens and that help our elderly who don't—who are not the grandmothers of Congressmen. I smile when I hear Congressmen talking about worrying about their grandmothers. Don't worry about your grandmother. Worry about

the people that don't have grandchildren, those people who, when you tell them they need dialysis or they need wound care, we have to provide that. We have to provide every bit of education, we have to provide every bit of the social support, have to provide their transportation to the physicians.

We will not be able to do that. We will not be able to provide things like palliative care. We will not be able to keep the same level of registered nurses. We will have to resort to much more of on-the-job training, lesser skilled people, if we can still afford the graduate medical education program.

There are multiple, multiple changes. People will not be able to come to the doctor with the increased costs out of pocket. They will not be able to meet the market-driven kind of structures that HMOs—that the market-driven HMOs impose on them. We will have to have more safety net and we will be able to afford less.

Mrs. KENNELLY. Thank you, Sister.

The panel seems almost unanimous in their acceptance of these new provider networks, and I have a hospital similar to your hospital, St. Francis in Hartford, Connecticut. My grandfather helped found the hospital. They are under a lot of stress and they are doing a very good job, but it is a constant struggle, things that they have to do with being an urban hospital, and that is how your hospital sounds, and I know it is the same thing.

Now, these new provider networks, will you have time—now, Mr. Scully says, hey, get a license, everything will be good. Somebody can do it in 1½ hours. Will you have time to set up these provider networks?

How much time do you have when you have got these changes coming, these stresses that you have got on your system? Explain to me—and I want to know, it is a good idea, you said?

Sister KEEHAN. Absolutely. I cut that portion of my testimony because of the lights that were flashing, but yes, I think that it is.

Mr. THOMAS. Tell the gentlewoman that she can go ahead and give us that part of the testimony.

Sister KEEHAN. I believe that is going to be a very important piece to allow provider service networks. Again, the devil is in the details. If the requirements for developing provider service networks are kept reasonable and are balanced, we can do that very quickly.

We have adjusted to multiple new systems, new delivery methods. We can do that very quickly.

But if they are so onerous and if they replicate some of the capital requirements that are free and simple, we will not be able to do it. What we have to remember in looking at capital requirements, the hospitals are not going to be paying out themselves. They are bringing that to the table, and so that is going to be a very important piece.

Mrs. KENNELLY. Thank you, Sister. I am glad to hear that from you.

Mr. Scully, you talked about the look-back, the fail-safe. We have called it two things today, the possibility down the line, if the cuts—or if what should have happened doesn't happen, if HHS or somebody is going to have to look back, and you seemed more or less content with this. Yet I hear many of the providers worried

about this, afraid that they will get a double hit if in fact the bill is \$80 billion short.

Mr. SCULLY. I think it depends on how it is structured. I think again the details are important. I attached a chart to the back of my testimony. The issue for us is if you are going to take \$270 billion out of the system, that there are a number of ways to do it, and we believe that—we have advocated along with the AHA for some 6 months now, that you should determine some amount of money you should take out of the system. And we suggested somewhat less than is being taken out, but the point is, there should be—the chart suggests that if you took, say, \$200 billion, roughly, out of the system in specific cuts, nobody knows 7 years out what is going to happen and Congress is trying to hit specific budget targets.

What we have basically suggested is take out 80 percent of the amount with specific budget targets and leave the rest flexible on a year-by-year basis, and if the move to managed care works, you are going to save the money. If the OMB's baseline, which is a little lower, happens to be more right than CBO's and inflation doesn't go up, you are not going to need to save the money. In the alternative, you could have a little sequester to take the rest.

But the likelihood is, there is no reason to go out and say specifically \$270 billion on specific provider cuts off a baseline that is not certain because it is going to change over the next 7 years, so we have suggested you have a more flexible chunk for the last 20 percent of the savings, and if it turns out that OMB is more right than CBO, great, it won't happen.

If the managed care changes happen, you won't need the money. And the alternative is a backup mechanism to make sure CBO can score it. We suggested putting in the sequester mechanism to save the last 20 percent, but in any case, just from a provider's point of view, we are not happy about the reductions but it is either pay me now or pay me later, and we would rather roll the dice on maybe managed care will work, roll the dice on maybe OMB is right, not CBO, and then as a third alternative, do a sequester.

Mrs. KENNELLY. I want to thank the panel.

We have all spent 9 hours together in this room and I am so glad you stayed and your testimony was excellent, and I just appreciate your being here and staying with us.

Mr. THOMAS. Thank the gentlelady.

Does the gentleman from Georgia wish to inquire?

Mr. COLLINS. Thank you, Mr. Chairman.

I, too, want to say thank you to those of you for staying this long length of time just to testify before this Committee, and all the others that have been here today. Your testimony, your advice, your comments are all very helpful.

My colleagues on the other side of the aisle, their comments, too, are very helpful. In fact, I recall back earlier this year I had an opportunity to spend some time with the President. We were traveling together in Georgia and the first thing that I told him, because I wanted to spend some time and I wanted to get right into some issues, was that, Mr. President, we have a difference of philosophy. We will just get that out to start with. But that is not bad because the difference in philosophy means that we will be bring-

ing different ideas to the table, and the more ideas we bring to the table, the more debate we have, the better solution we will come up with for the problems that we face. I fully believe that that is what is happening here, is what has happened in the past, is what has happened in a lot of the meetings that we have held in this room this year.

Mr. Gibbons said that the way we are going about this is not the way to run a government. Well, I reckon, again, the proof will be in the details down the road, the results. But when I go back home, I hear people tell me that they like what we are doing because we are doing something. They may not know exactly what, but they know we are doing something and they know we are doing something different than has been done in the past.

And what has been done in the past? We sat here in this town as a Congress and we have spent taxpayers—\$5 trillion into debt. We are spending from \$400 to \$500 million a day more than we take in in revenue from those taxpayers. However, when taxpayers pay their bills at the end of the month, when they run out of money, they have to stop writing checks. They can't do what we do with their money, continuously putting them in debt as taxpayers.

So is it irresponsible to address the problems of this country? I think not. I think it would be irresponsible to sit here and do the same old thing over and over and over again.

Sure, we are reducing the growth of spending in the area of health care. We must. We are reducing the growth of spending in all areas of government and we must.

We are reducing taxation, and we must, because we are putting moneys back into the budgets of families who are writing those checks at the end of the month to pay their bills. They need those funds, just like you need your funds.

I know, Sister, you need your funds and you are doing a good service and we don't want that service disrupted. But we know that if we keep doing the same thing that has been done in the past here continuously, you won't be able to provide that service and look to us for help, because it won't be here.

If we keep spending the money in the way and the rate that we have been spending it, this government will go bottom-side up. It can't exist. What will we do then?

We may not be doing everything to satisfy everyone, but at least we are doing something and we are addressing a problem and we are addressing it head on.

Thank you for your time.

Mr. THOMAS. Thank the gentleman.

Doctor, I understand you may have a time constraint on an airplane, so if you feel you have to leave, no one will think it is because you either don't want to answer a question or that you don't like them. We will understand.

Mr. SEWARD. Thank you, Mr. Chairman. I do have a speaking engagement in your State, but the trouble is, I do have to stop in Illinois to pick up some clothes.

Mr. SCULLY. We will represent the AMA.

Mr. SEWARD. I think I will stay then, Mr. Chairman.

Mr. THOMAS. Smart decision.

Does the gentleman from California wish to inquire?

Mr. MATSUI. Thank you, Mr. Chairman.

I would like to thank all five members of the panel as well. I thought your testimony was very thoughtful, very helpful, and I particularly would like to thank Sister Keehan for her testimony. Certainly Providence Hospital is one of the outstanding hospitals in the United States, and please give my regards to Dr. Simmons who is a friend of mine and certainly one of the outstanding physicians.

I would like to ask Mr. Scully, if I may, in the testimony, the second panel we had today, Dr. Wilensky and Dr. Altman testified basically that over the next 7 years the rate of growth will be 6.4, 5 percent for inflation and population growth and 1.4 percent for technology and other needs for the hospital and health care industry. They both testified that it will be very, very difficult, but doable, to meet that goal, and obviously we have the fail-safe with the look-back to deal with that.

In addition, in the document that we were handed out, the 60-page document, after the year 2002, instead of 6.4, as you know, the rate of growth will become 3 point—excuse me, 4.3 percent, which is 2 percent below even what they say will be very, very difficult.

And the reason I am asking you, Mr. Scully, is because you are familiar with the congressional budget process, not to say the others aren't, but you certainly are. That will be built into the baseline in the year 2002 and beyond, or as soon as we begin the 5-year projection and we hit the year 2002.

Being in the baseline, that means either taxes will have to be raised, fees will have to be raised, or more cuts in programs in the area of Medicare. I would like your thoughts on that because, 7 years seems like a long ways, in fact, Dr. Altman said, that is a long ways from now.

It is hard for me to make that projection, but it is built into the year 2014 in order to get those long-term savings and in order to make sure that the system is stable. I mean, that is the biggest selling point of this plan that is being—hopefully, we will receive next week, and I think of the DRGs. That has been in existence now for 13 years and—

Mr. THOMAS. Will the gentleman yield?

Mr. MATSUI. Let me just finish. And at that time, of course, we certainly—well, 7, 8 years, but now it has been in place for 13 years. Perhaps you could comment on that, if you would.

Mr. THOMAS. Will the gentleman yield briefly?

Mr. MATSUI. Sure, I will be happy to yield.

Mr. THOMAS. Based upon the gentleman's emphasis on that point, and one of the nice things about a conceptual document, rather than legislative language, I think the gentleman will find that when the legislative language is presented to us, that that number will change. It was a number that was put in assuming that the commission would change it, and I think the gentleman's point has been made several times and is a well-taken point and that number will change.

Mr. MATSUI. Do you know what the number will be?

Mr. THOMAS. It will be more than it is.

Mr. MATSUI. What will that—do you know the number?

Mr. THOMAS. I don't know. I know that the Consumer Price Index on the urban rating now, and it will be more than that when we make an analysis, assuming the commission doesn't do its job as outlined in this structure.

Mr. MATSUI. I hope I will be able to maintain my time.

Mr. THOMAS. Certainly. I just thought the gentleman would like to know.

Mr. MATSUI. I appreciate that. But it would help, because you see, this is an important issue to me and I think it is going to be an important issue to the hospital, the doctors, all the providers. I think we should know what that number is. It is going to be built into the baseline of it. If it isn't 4.3—

Mr. THOMAS. If the gentleman wants to work with us in terms of cooperatively structuring the bill and is on board, I would love to have him in the room when we make that decision.

Mr. MATSUI. In other words, that decision isn't made; we just know it is going to be increased?

Mr. THOMAS. I am going to carry back the gentleman's arguments and I believe will carry the day in making that number larger, just as we did in terms of the teaching hospitals and the structural changes that we have made there.

Mr. MATSUI. It would be my hope then that after we see that, because that number obviously has been built into this 60-page document, that maybe we can get these witnesses back and ask them the impact on the new number because that number is going to be built in for the next 20, 30 years, or whatever the year 2014 is.

Mr. THOMAS. I think you will find that the testimony that is given today will reflect the structural changes that will be made. But I thank the gentleman for yielding, and Mr. Scully, if you want to respond to his question.

Mr. SCULLY. I am much happier with the Committee's new position. It was one of the first things—I think you are right—CPI-U after 2002 is extremely, extremely tough. We raised those, one of the first things we raised when we saw the document. I think we raised it with the Subcommittee Chairman and we have raised it with the leadership and we were told it was going to be looked at, but I think you are right; it will be beyond tough.

Mr. MATSUI. Let me ask you this. This will be my final question. I know everybody is absolutely exhausted at this time. But under the 6.4 percent, do you believe that there will be additional cost shifts?

It would be very difficult, I suppose, because obviously that is what the private sector is, but where will the cost shift occur if, in fact—unless hospitals will close. That is an option. I know that Dr. Wilensky suggested that that could happen.

Mr. SCULLY. We hate to cry wolf and say hospitals will close down.

Mr. MATSUI. She said that was an option obviously.

Mr. SCULLY. There is definitely going to be a squeeze and I think our concern is—the argument is Medicare is growing at 10 percent a year. Well, the average growth total hospital spending this year for all hospital spending is about 5.5 percent, and if you ratchet

down the growth to 6.4, we think the hospital spending is probably closer to 3 percent or less.

There is going to be a squeeze. Hospitals are closing already because managed care is squeezing, the market is squeezing. We think it is increasingly much more difficult, especially in urban markets, to cost shift. It has almost disappeared. So there isn't anyplace else left to shift the cost.

I think in most major cities, you will find that hospitals are laying people off and cutting back staff. That is not so bad. We are trying to become more efficient and adapt and do what you all want us to do, which is to save money. This is obviously going to speed it up. We are obviously concerned it might speed it up too quickly. So I think the market is squeezing us and we are concerned that this might be going too far too fast.

Mr. MATSUI. I appreciate that. My only hope would be that hospitals like Providence will remain open. You see, that is the real frustration because I think that is the one that becomes—could become vulnerable in this process, and obviously they are the ones that are taking, uncompensated, those people that are really at the edge of life.

I do appreciate the testimony of all of us, and certainly, Mr. Chairman, I look forward to seeing what that new number is because that will help us determine perhaps what the long-term projections will be.

Thank you.

Mr. THOMAS. I do know, and I know he may not be pleased. He will be closer to pleased than he is now.

Does the gentleman from Pennsylvania wish to inquire?

Mr. COYNE. Thank you, Mr. Chairman.

Dr. Thomson, the document that Speaker Gingrich made public yesterday and which has been the subject of discussion here today tends to steer people, elderly people, beneficiaries, into managed care programs. In your judgment, is that the most efficient way to give care to seniors who tend to need more care, more medical care in their elderly years?

Dr. THOMSON. I am not sure we know the answer to that completely, Congressman. It certainly appears to be on the surface a more efficient way to deliver care. What we need to do, though, is apply standards to the way in which managed care is applied to the elderly to be certain that the decisions that are made are not purely cost directed and have quality and standards as a basis for those decisions. So we are not certain what the—what managed care, what impact managed care will have on the elderly, but it is certainly worth an effort.

Mr. COYNE. Well, would one of those requirements possibly be more flexible choices in choosing your health care professional? Would you recommend that they have more flexibility in choosing their health care professional if they are steered into managed care programs?

Dr. THOMSON. Certainly, yes.

Mr. COYNE. Thank you.

Mr. THOMAS. Does the gentleman from Texas wish to inquire?

Mr. LAUGHLIN. Thank you, Mr. Chairman.

Dr. Thomson, I want to ask you about your fifth recommendation because I represent a very large rural area, and your recommendations, I visualize how that will work in the big cities, but when you talk about Medicare or Medicaid should evaluate and adopt through private sector purchaser initiatives, and I would like you to explain what that is in the concept of small rural hospitals, such as quality indicators, service performance standards, use of centers of excellence, specialized services, contracting and case management; how do you visualize that will work in the small hospitals in rural America?

Dr. THOMSON. We are talking about the use of centers of excellence, for example, in which patients could be referred, although it is much more difficult in a rural area admittedly, to a center, a regional center, as opposed to developing that service within the institution.

Mr. LAUGHLIN. Would you establish a liaison or other relationship?

The gentleman from Washington State on the Democratic side this morning was talking about out in his district or in the eastern part of his State, that some areas are more than 150 miles from hospitals. I have heard that same figure in the western part of my State, but how did they get those type relationships where they get the excellence you are talking about and the cost-saving factors?

Dr. THOMSON. Well, they need to have a relationship with a major academic medical center in the region to which they could refer patients.

Mr. LAUGHLIN. And this will—I still don't figure.

Dr. THOMSON. This would obviate the need for the local institution to develop the expertise, to expend the funds to develop the capacity to care for very complicated patients as opposed to having them referred to a center in the region for care.

Mr. LAUGHLIN. I was hoping you were talking about some of the cost problems that some of our hospitals have because they don't have a big purchasing base. When I saw your purchaser initiatives, I was hopeful that you were coming with some idea. I don't know the size of the Sister's hospital, but we have some in Houston some miles from my district that are very large, and they have a substantial purchasing power and they get things at a substantially lower cost than the much smaller hospital purchasing. You didn't have any ideas along that line that you would recommend for cost saving for small hospitals?

Dr. THOMSON. As a network of hospitals together that could then purchase services at a lower rate, yes, that certainly could be done.

Mr. LAUGHLIN. Mr. Scully, do you—

Mr. SCULLY. We do have a couple hospitals in your district, and I believe Columbia has two; I am not sure. Yes, I think the market for rural hospitals is just totally different. I think it helps to get in the purchasing networks, you know, one of our chains with a voluntary a hospital association, or MHS. There are a lot of opportunities that many rural hospitals are getting in purchasing co-operatives to get the same purchasing power and kind of a joint venture mode that they might have in an urban area.

But I also think the reality is, a lot of these things are going to hit rural hospitals much harder than everybody else. I hope Congress is sensitive to that. It is just a different system.

If somebody has a 40-percent occupancy rate in an urban area, that is a problem, then they may well consolidate and someone else would help them out. In a rural area, nobody wants to close the hospital and have somebody drive 150 miles to the next hospital. So we are certainly concerned about the impact on rural hospitals.

Mr. LAUGHLIN. Were you going to add to that, Dr. Thomson?

Dr. THOMSON. Just that the use of quality indicators and service performance standards also would hold out some hope for containment of costs as well.

Mr. LAUGHLIN. In your fifth recommendation, did you have any transfer of technology to rural areas in mind when you were talking about service performance standards? One program they are experimenting with in my area is, I think they call it telemedicine—where they have the hookups to the big hospitals where they have specialty advice. Is that something that you had in mind in your fifth recommendation?

Dr. THOMSON. That is certainly a coming technology that is going to help a great deal. We are now able to transmit all sorts of images back and forth between institutions, so it is no longer necessary to send a patient from a rural institution, for example, to another institution for an imaging procedure, like an x ray, an MRI, or a CAT scan.

We also are looking forward to the opportunity or the possibility of having consultations done by telemedicine as well, that patients might actually be seen in their local setting by a consultant in a center of excellence that is at some distance from that patient.

Mr. LAUGHLIN. I wanted to raise those points with you because, as I listened to your testimony and looked through your written testimony, it appeared to me that the American College of Physicians was certainly far more focused on the big city areas than the rural area and so I appreciate your comments.

Thank you very much.

Thank you, Mr. Chairman.

Mr. THOMAS. Thank the gentleman.

Does the gentleman from Michigan wish to inquire?

Mr. LEVIN. Thank you. Thank you very much.

This has been an excellent panel. I wish in many respects you had been the first. I think it would have been better for you, and I think it would have been better for us. You know, the four of you who are left I think have said what, Mr. Scully, you said too far, too fast.

Mr. Thomas, I would hope you might take a look at it before the year 2003 as well as after it.

Mr. THOMAS. Will the gentleman yield?

One to a customer.

Mr. Matsui got to me first.

Mr. LEVIN. No. But you responded post the 7-year period.

Mr. THOMAS. I didn't look at it.

Mr. LEVIN. This testimony is that that relates to the period now through 2002.

Mr. Warden, I especially welcome you. You specifically say you are concerned about the impact of reductions of \$270 billion on quality and access. That is this first period of time, not the period of time after 2002, and I hope that you might take another look.

This issue has become, I think, frightfully polarized and maybe hopelessly so. But the testimony of this panel is that you should take another look.

Mr. Scully, you were with OMB. When were you there?

Mr. SCULLY. From the first day of the Bush administration to the last of the Bush administration.

Mr. LEVIN. So you don't come here as a partisan Democrat, I take it?

Mr. SCULLY. Some people who are Republicans might take issue, but—

Mr. LEVIN. Your experience was in the Bush administration, not the Clinton or the Carter?

Mr. SCULLY. In the Bush administration.

Mr. LEVIN. I don't say that except I think it adds to your credibility when you say the package would be far better if saving targets were more reasonable, and I think that is a frightfully reasonable statement, as yours are, Mr. Thomson.

If I might just ask you, Sister, I had the privilege of serving on the advisory board of Providence in Southfield, and I knew one of your predecessors in Washington, but you know, I am afraid there may be a tendency to say, Well, what you have said is just true of your hospital in Washington. Your powerful testimony that I hope everybody in this country will read, you say, "While the poor and seriously ill will suffer most from these changes, make no mistake, all Medicare patients will feel their effect." Are you talking about Medicare patients just at Providence Hospital in Washington?

Sister KEEHAN. Oh, no. No.

Mr. LEVIN. So tell us a bit more about the universality, in your judgment, of your statement if it isn't only about your hospital.

Sister KEEHAN. This country could go on well without one hospital, even as great a hospital as Providence, so there would be no need for me to be here if that was the issue.

The issue is, for the poor and the vulnerable, most of the hospitals that serve them have set up wonderful safety nets. It is one thing to say you have Medicare and you can go to the doctor you want at Providence or at any other hospital. But we run three buses a day picking up senior citizens.

We have to be the person who provides for many of the social service things. We have to deal with their housing. We have to deal with them with palliative care. We have to deal with them with home care and the supplies.

You just can't tell senior citizens who have no income, or are very low income and have no supportive families, that your wound needs to be redressed every day and come on into the wound care center, we will take care of it because Medicare covers it. You can't.

In addition, you are going to have, and you are already seeing with the squeeze of the lack of reimbursement in managed care, you are going to have fewer and fewer people at the bedsides of these patients in the emergency room, in the health centers who

are trained professionals. You are going to have more on-the-job trainees because you have to substitute to live with this \$270 billion cut, plus the Medicaid cut.

How long will hospitals run transportation, will run stroke clubs, will run health screenings and wellness programs for the elderly with these cuts? I don't think it is going to be very long. I think that those things are going to be impacted at all the major hospitals, particularly those who have high percentages of people on Medicare who are poor, and so I don't think that it is a Providence phenomenon. It is going to be a phenomenon all across the country.

Mr. LEVIN. When you say poor, 87 percent—and I will finish with it—of the seniors in Michigan have incomes under \$25,000, and 70 percent under \$15,000.

Thank you.

Sister KEEHAN. Those are the people that need the screenings, they need the transportation, they need all the safety-net services that made Medicare work.

Mr. THOMAS. Thank you.

The gentleman's time has expired.

Does the gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman.

Let me follow up with Mr. Levin for 1 moment and say that I found this panel to be extremely helpful. All of your testimonies have been, I think, enlightening as to what the plan before us—when we finally get the details—will mean.

Four of you remaining all agree that \$270 billion over 7 years, it is too much. You represent provider groups and they are just not going to be able to do that without some dramatic consequences.

And I personally don't think we should be beating up on you, Mr. Chairman, on that number. The \$270 billion is in the budget resolution and this Committee is instructed to come in with \$270 billion. I find that wrong.

I think the testimony earlier has pointed out that that is not needed as far as the solvency of the trust fund. In fact, a large part of the \$270 billion has nothing to do with the Medicare Trust Fund, as has been pointed out by previous testimony. A significant part is necessary in order to bring about the tax cut that the Republicans have in their budget resolution. So I think that is pretty clear.

I find that the testimony here, though, of this panel points out the tragedy of that \$270 billion number. It is clearly going to mean that hospitals are going to close. It is clearly going to mean that less physicians are going to be willing to treat Medicare patients. It truly means that some people are going to go without care, as the sister has pointed out, particularly when you combine these cuts with the cuts in the Medicaid Program.

But let me, I guess, quote from the sister, if I might, one line that you put in the letter, and I think you know better than just about any of the other people who have testified or commented because you deal on a day-to-day basis with people who must rely upon Medicare in order to get their health care needs met. You know what it is going to mean if the system is not there to provide the type of care that they get today. And I just want to quote you one line that I think is the most disturbing, because I think you

are more likely to be correct than the other people who have voiced their views, including both the Democratic and Republican Members of this Committee when you say, "It is also not fair to assure Medicare recipients that they can keep the current program if they want. The current program is lost with this proposal." I think that is the fear that I think my constituents have.

I thank you very much for your testimony.

I yield back my time.

Mr. THOMAS. Thank the gentleman.

Does the gentleman from Pennsylvania wish to inquire?

Mr. ENGLISH. Thank you.

I would also like to congratulate this panel because I know all of you are out in the trenches. All of you I think care very deeply about this, and I think all of you appreciate perhaps more vividly than anyone involved in this Committee the consequences if the system were to actually go bankrupt in 7 years, and I think we have all seen the trustees' report. I think we all understand its significance, and my hope is that we could rise above partisan politics and check maybe a little bit of our philosophy at the door, come up with a way of addressing this problem.

I think that the majority in the leadership have offered a proposal that tries to get at the core of this problem, but I think in the long run there is also a terrible need for the whole Medicare issue to be addressed long term. I don't think we can allow this program to remain on the brink of insolvency on an ongoing basis. And that is why, Mr. Warden, I appreciate your comments in support of my independent commission bill that would create a commission above politics to assess the Medicare Program on an annual basis, and like the BRAC Commission, send recommendations directly to the floor of the House and Senate for action.

Now, having said that, Mr. Warden, I would like to visit with you how you feel this commission idea could be integrated with the notion of a look-back or fail-safe provision as appears in this legislation and to what extent you think they might be compatible or one might be a replacement for the other.

Mr. WARDEN. I think they could be very compatible. The look-back mechanism or fail-safe mechanism is obviously aimed at recovering the reductions if they do not occur through the other approaches that have been designated in the proposal. And the reason why the commission could be very important is because it would be in a position to take into consideration the kinds of things that would make the look-back mechanism so problematic for providers.

For instance, a misprediction by CBO on what the costs are, or, more likely an increase in inflation that is greater than what was projected, or even the fact that nobody decides to enroll in all these new kinds of alternatives that we provide for them in managed care plans. Each one of those kinds of things could have an impact on what the look-back amount is going to be and what will need to be done with it.

And I think that the commission would be the best approach to looking at those kinds of issues on an annual basis and then being able to make some judgment about why the problem occurred, how much money there is available, how many beneficiaries have to be

covered, what differences there are in different regions around the country, and then make some judgment about what the best approach is for the look-back mechanism for that year.

Mr. ENGLISH. I feel that in today's hearing we have seen some validation for the notion that we need to bring this whole process a little bit above the partisan political fray. Some of those validations perhaps were inadvertent. But I think, clearly, we need to bring this whole process of tying resources to services very much above the fray; and I appreciate your comments.

One last question. I know that many of your comments have focused on the need for hospitals to restructure. Why is this so important? And, Sister, I would like to follow up on that, too.

Mr. WARDEN. Well, the restructuring is important because the real way to reduce the cost in the system is to develop a continuum of care that integrates the system, integrates the services into a continuum instead of having them fragmented. Because it is the problems in the pass off from one level of care to another that creates additional costs, sometimes ruins quality, impacts patient satisfaction. And the coordination is essential, particularly when we have not only pressures of Medicare but also the pressures of the marketplace; and we, obviously, have got to reduce the cost of health care while maintaining the quality.

Mr. ENGLISH. Sure.

Mr. WARDEN. And by having coordinated services we are able to do it much more effectively.

Mr. ENGLISH. Sister, would you like to add to that?

Sister KEEHAN. I can only echo it, to tell you the truth.

The one thing I would like to tell you, your notion for a commission would be very, very helpful. I would hope the first thing it would look at would be some type of experiment with the most costly Medicare recipients, that very small percentage, and take the largest percent and see how the different level or different method of delivering care could be as effective, more effective or less effective before we change the whole thing and drop the safety net.

Mr. ENGLISH. Thank you very much.

Mr. THOMAS. The gentleman's time has expired.

Does the gentleman from Georgia wish to inquire?

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

Like my colleagues, Mr. Chairman, I want to thank members of this panel for their wonderful and moving testimony. I want to agree with Mr. Gibbons and want to be associated with his words.

Sister, you and Dr. Thomson put a human face on what this debate is all about. Sister, you in particular reminded me of the words of Hubert Humphrey, who said that the moral test of a government is how we treat those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadow of life, the needy and the handicapped. I think if we fail to meet this moral test during the next few weeks and months and maybe the years to come, the judgment of history will not be kind to any of us.

So I thank you, Mr. Chairman.

Mr. THOMAS. Thank the gentleman from Georgia.

Does the gentleman from Virginia wish to inquire?

Mr. PAYNE. Yes, thank you very much, Mr. Chairman.

And I, too, want to add my word of thanks and appreciation for this panel. I think it has been excellent. You all have been here a very long time. We have been here since 10 o'clock this morning, and I do appreciate the fine job that you have done.

I just want to recap just a little bit of what I have learned here today. We started this morning with a plan, and this plan begins by saying that the board of trustees of the Medicare Hospital Insurance Fund has urged the Congress to take some action to ensure that the fund is solvent. And I agree with that, and I think we need to do that, and I think most of the people who have been here today have said the same thing.

We have learned that if we, over 7 years, look at ways to save \$90 billion that we can prolong the life of that fund by 3 years, give us some time then to have a commission to study many of the factors that will be facing us as the baby boomers become Medicare recipients, and that would then give us an opportunity to make some good, long-term decisions.

The standard that was set out by the actuaries says that if you want to have 100 percent coverage of assets to the annual expenditures for each year over a 10-year period, then you would have to reduce the cost by \$160 billion. This is a very tough standard, a standard Medicare has never met since it has been in existence, but this is a standard that was set out in the trustees' report. And to meet this tough, relatively new standard, the savings would be \$160 billion.

What we are looking at today is a plan that goes far beyond either of those, and it is a \$270 billion plan which we must then assume not only deals with Medicare and the things that need to be done to deal with the trust fund but over \$100 billion is used for other purposes, for tax cuts and things that, in my judgment, in the judgment I think of others, don't need to be done at this particular time.

Mr. Scully says we are moving too far and too fast. I think he is exactly right about that. We are taking on a great deal of risk for Medicare, a great deal of risk I think for our whole health care system as we take on risk for Medicare. And for areas like mine, rural areas that are so dependent on health care and dependent on having good health care systems in order to be able to attract new people, to have our businesses grow and so forth, we are putting at risk our whole way of life.

So I think while we need changes and we need reforms, and I think there are some good ones in the plan that has been put before us today, this \$270 billion is much too great. That is what we need to examine. And I look forward to working with the other members on this panel as we move forward to find an acceptable way to make sure that we get this right.

I realize I am the only thing standing between us and us being able to leave for the weekend, and so I will yield back the balance of my time.

Mr. THOMAS. Thank you. Thank the gentleman for yielding, and I want to thank all of the Members, and I do want to thank this panel as well. In fact, I want to thank all of the people who participated today.

It is kind of a culmination of those 16 Subcommittee hearings that we held with many of the same folk meeting time after time. It is a kind of a culmination because we discussed these issues repeatedly, and now we have pulled them together in a single structure.

But underlying all of the discussion today, notwithstanding the concern about particulars, is the fact that entitlements are the single largest area of the Federal Government. They are the single fastest growing area of the Federal Government. Medicare is the second largest entitlement, and we do have to deal with it. Even if we are not going bankrupt, the growth rate is unsustainable with the demands that it would make on the Treasury. But it is also going bankrupt, as the trustees clearly indicated.

I was pleased that after the initial discussion we got to some particulars. The gentleman from New York began looking at page 32, 33, 34, 35; and there is contained an effort in this bill to rethink the way in which we finance graduate medical education. It made no sense to me at all to use Medicare as the vehicle to meet a broader societal need and that we ought to change that. We are beginning the process of doing that with the downpayment of a large amount of general fund money to begin the shift.

The gentleman from California—in examining the mechanism that we have set up that Mr. Scully explained allows us to watch the managed care choices made by seniors and that if more choose than the Congressional Budget Office believes, the fail-safe mechanism is not needed. That is why it is called a fail-safe. If the fail-safe is needed, then we want to make sure that the structure of that fail-safe is a good one; and I am pleased that the gentleman from California and several panels focused on that number. I had not focused on it in the way that he presented it. As I indicated to him, we would change. We will then debate the legislative language, and you will look at the particulars as well.

But what we are doing, as the gentleman from Georgia indicated, is what the American people want us to do. They want to make sure that Medicare is there. A lot of the discussion is over needs and wants. Change is hard. It is very difficult. Sometimes when we are challenged we are able to do things we never thought we would be able to do and that coming out the other side we say we are better for it.

Our plan took the problem of community hospitals and doctors not seeing a bright future, of not knowing where they are going to go, waiting to be swallowed up by a managed care plan, going out of business, and we have created now a new opportunity in these provider service networks.

I was pleased, Sister Keehan, that you see this as a real opportunity in restructuring so that you might be able, in the savings of that restructuring, to direct some money to the very support-needed services that you indicated. And you are nodding. Is that one of the things that you would be looking at, to make sure that the money was directed to those things that you wanted to do?

Sister KEEHAN. Yes.

Mr. THOMAS. That is the kind of thing we need to do, rethink the way in which we have operated. The idea of having seniors provided with choice, not forced into programs but letting them choose,

I think, will be a very healthy operation in which seniors with adequate information and support and education can choose between a more historical managed care structure, HMOs or others, the provider service networks, medical savings accounts. I think it is an exciting part of this plan.

Because what it does is it says that Medicare will now be shaped by the marketplace, that the marketplace will help the government keep the cost down. That is how we are going to make sure that, first, Medicare doesn't go bankrupt; but, second, in this one change, we will make sure that Medicare is sound until we need to examine it again when the baby boomers retire.

In this same plan, we have a commission to examine how we should adapt. It makes no sense at all for us to come occasionally together in this Committee and clash over what we should do. We have decided to build in a commission way ahead of its needed findings so that we can plan for the future, 1 day at a time or 1 year at a time.

Staying ahead of the piper is not the way to deal with a program like this. To say that we are going to have a 1-year solvency test and that if you made it this year then you are doing a good job I don't believe is an approach that the American people, once they know that is the way it had been operated, would approve of.

What we want to do—and we are looking for cooperation, if not support—is to make sure that in this examination of a restructuring of Medicare, notwithstanding the concerns my colleagues on the other side of the aisle have, is that we make those fundamental changes in the program that guarantee that seniors through choice and through the marketplace will assist us in making sure that Medicare is there for them.

Sister Keehan, I would also say that one of the things that we have to make sure of is that in this society, having witnessed the largest resources shift in the history of any generation in the world from one to the next, that this current senior generation has to make sure that in the way in which they consumed the resources of this society that there is something there for the younger generation coming along. And we are going to try to make sure that that occurs as well.

And all Members having used their time——

Mr. GIBBONS. No, Mr. Chairman, I——

Mr. THOMAS. This was my 5 minutes that was allotted to each Member.

Mr. GIBBONS. The rules of this Committee don't just require us to talk when we have used—stop when we have used our time, and I don't intend to.

Mr. THOMAS. Is the gentleman requesting——

Mr. GIBBONS. I am not requesting. I am just using my constitutional prerogatives here.

Mr. THOMAS. Well, the Chair recognizes the gentleman.

Mr. GIBBONS. Thank you. It is now 9 hours and 28 minutes since—or, excuse me, 10 hours and 28 minutes since we started this meeting. Three Republicans, eight Democrats survived. Four witnesses survived. We even lost one of them in all of this.

I am sorry that the Chairman sought to fulfill a social engagement in his district rather than staying here and listening, particularly to this last panel. That was a mistake on his part, I believe.

I think, Mr. Thomas, you thoroughly failed to establish that, first, the Medicare Trust Fund is broke. Your first witness didn't do that. He hedged around at it, admitted in his opening testimony that the law requires a 1-year reserve and that we have a 7-year reserve. That is the law today.

Second, your first witness said that it would—in his estimate, it would take \$160 billion to correct the trust fund; and you are taking out of medical care for aged and for poor and for elderly \$450 billion—I mean, your party. That is unconscionable. That leaves some \$320 billion laying on the table to cut taxes with, that you have already taken \$250 billion of that \$310 billion off the table to cut taxes.

And you know what I think of that. When the American public understands what is in that tax cut they will think the same thing.

I just think it is unconscionable that you would take the most vulnerable part of our population, the old and the sick and the poor, and use that much for a rich people's tax cut. I don't understand it. All of the wonderful things that you are advocating and have been in your mind for some time can all have been done without this kind of retribution against the sick. We could have tried them all without any kind of retribution against the sick and the elderly. I wonder where justice has gone. I wonder where the social contract in America has gone.

I yield back the balance of my time.

Mr. THOMAS. Any other Member wish to be heard at the end of this hearing?

Without objection, the hearing is adjourned.

[Whereupon, at 8:33 p.m., the hearing was adjourned.]

[Submissions for the record follow:]



American Association of Clinical Endocrinologists

**Testimony before the Ways and Means Committee
on the Republican 1995 Budget Reconciliation proposal
by the American Association of Clinical Endocrinologists**

September 22, 1995

INTRODUCTION

1 The American Association of Clinical Endocrinologists provides a unified voice for clinical
2 endocrinologists on issues affecting health care and the practice of endocrinology. As advocates
3 for our patients, we are deeply concerned about maintaining necessary access to an
4 endocrinologist for people with endocrine disorders, including diabetes, thyroid disease,
5 cholesterol disorders, osteoporosis and other metabolic disorders.

6 The Medicare proposal submitted to the Committee for consideration today provides an excellent
7 guideline for discussion with other congressional leaders and health policy makers on how best to
8 reform Medicare. In light of increasing demand for deficit reduction and limitations in expenditures
9 on federal entitlements. The proposal includes several provisions long-supported by the AACE.
10 AACE strongly supports the plan's clarification of the self-referral law that will allow physicians to
11 provide Durable Medical Equipment to their patients from their offices. AACE supports the CLJA
12 provisions found in the plan. AACE is pleased that the proposal contains language mandating
13 the use of a single conversion factor within the Medicare Fee Schedule. AACE is appreciative of
14 the proposal's reform of medical liability issues. Further, AACE believes the addition of Physician
15 Sponsored Networks in the marketplace will provide additional competition with health plans for
16 Medicare beneficiaries business. There are, of course, some provisions in the Republican
17 proposal which give us cause for concern. We are concerned over how the "Look Back"
18 mechanism could arbitrarily reduce physicians fees. Additionally, AACE is concerned that the
19 proposal does not include language mandating that a Point-of-Service option rider be attached to
20 all Medicare managed care plans. A POS is critical to ensuring that patients have the choice to
21 see the physician best trained to treat their diseases. We will elaborate on these issues below.

22 The AACE would like to thank the Ways and Means Committee for this opportunity to provide
23 written testimony. We offer the following comments on the Republican proposal and hope that
24 you will keep our views in mind as the budget reconciliation process goes through the inevitable
25 refinement process.

26

MANDATORY POINT-OF-SERVICE

27 The AACE notes that the Republican proposal did not contain a mandatory Point-of-Service
28 provision. AACE has long advocated for this provision and we hope Congress will agree to
29 mandate a POS in all Medicare managed health plans.

30 AACE's longstanding concern has been the provision of optimal, cost-effective health care to
31 patients with endocrine disorders, including diabetes, thyroid disease, cholesterol disorders,
32 osteoporosis and other metabolic disorders. As an example of these endocrine disorders,
33 diabetes is a complex metabolic disease that often leads to devastating health consequences. It
34 is the sixth leading cause of death in the United States and its annual cost to society in terms of
35 medical care and lost productivity is estimated between \$20-25 billion. It has also been proven in
36 a National Institutes of Health (NIH) sponsored study that intensive regulation of blood sugar
37 levels results in better outcomes for diabetes patients. This type of regulation is best done by a
38 specially trained endocrinologist; it is, therefore, critical to insure the right of patients with diabetes
39 to have access to an endocrinologist.

40 To insure that this access is available, AACE supports a Point-of-Service (POS) rider be attached
41 to all Medicare managed care plans. The POS allows endocrinology patients to obtain the most
42 medically effective and cost effective way to combat this disease. Furthermore, AACE has
43 developed a proposal to strengthen the POS option. In order to guarantee access to an
44 endocrinologist for all chronic endocrine patients, we believe that legislation is necessary that
45 would allow low-income endocrine patients to waive the co-payments and co-insurance payments
46 typically found in the POS option if they choose to go out of a network plan to receive care from
47 an endocrinologist. This would ensure that all endocrine patients who need specialized care from
48 an endocrinologist could obtain it. Otherwise those who can not afford a POS option plan must
49 accept their care from a "gatekeeper" who may or may not refer them to a specialist best trained
50 for the patient's medical needs.

1 We note that in surveys of public attitudes about health care, choice of physician appears
 2 consistently among the top priorities of patients and consumers. A POS is responsive to patient's
 3 desires for freedom in selecting their caregivers. It also ensures that all health plan enrollees will
 4 enjoy that choice, not just those who can afford a higher priced fee-for-service.

5 FEE SCHEDULE IMPROVEMENTS

6 AACE is very pleased that the proposal includes a budget neutral single conversion factor for the
 7 Medicare Fee Schedule and replacement of the current volume performance standard with growth
 8 targets based on the gross domestic products plus two percent. As the Committee knows, the
 9 MVPS and separate conversion factors for surgery, primary care and non-surgery have served to
 10 severely distort the original intention of resource-based relative value system. We note however,
 11 that the proposal does not specify an implementation date for this change and makes reference
 12 only to upper and lower limits being placed on annual adjustments to "ensure reasonable updates
 13 and to reduce volatility." AACE urges the Committee to clarify that the implementation date for the
 14 single conversion factor will be January 1, 1996 and also to specify a lower limit on annual
 15 updates to the conversion factor to assure that the updates remain reasonable.

16 AACE also expresses its support for the replacement of the VPS with updates based on GDP plus
 17 two percentage points. This move has been endorsed by the Physician Payment Review
 18 Commission.

19 MEDICAL LIABILITY

20 The AACE is very pleased to see the inclusion of health care liability reform in the Republican
 21 proposal. As the Committee is well aware, our tort system is laded with excessive attorney costs,
 22 potentially huge punitive damage costs, and increased filing of non-meritorious claims against
 23 physicians. Further, the current tort system inadequately compensates deserving plaintiffs and
 24 imposes unnecessarily high litigation costs on all parties. The cost of these judgements are then
 25 passed on to the consumer in the form of increased prices, and decreased productivity of the
 26 work force. Fear of suits has lead many physicians to practice "defensive medicine" adding
 27 between \$20 to \$25 billion dollars per year to the health care system. Physicians pay an
 28 estimated \$10 billion in liability premiums per year. By reforming the medical liability laws, with
 29 limits on how much juries can award for non-economic damages and providing guarantees that
 30 most of the monetary awards will go to patients rather than their trial attorneys, the Republican
 31 proposal offers real liability relief to the medical community. Such relief will result in more efficient
 32 and less costly care.

33 PHYSICIAN SELF-REFERRAL AND OWNERSHIP

34 AACE applauds the Proposals improvement of the Physician Self-Referral and Ownership
 35 provision of OBRA 93. The proposals treatment of that burdensome law will allow
 36 endocrinologists to provide blood glucose monitors to their patients and ensure their proper use.

37 As you know, Stark II prohibits physician referral of Durable Medical Equipment. This provision
 38 would effectively prohibit situations where an endocrinologist supplies his or her patients with
 39 blood glucose monitors in the physician's office. As a matter of practice, clinical endocrinologists
 40 diagnose and treat a significant amount of diabetic patients through the control and management
 41 of blood glucose levels. Frequently, the endocrinologist supplies the blood glucose monitor to
 42 the patient and then provides patient education activities related to the specific patient
 43 requirements for blood glucose monitors to ensure accurate, understandable, and timely results.

44 Vendors of blood glucose monitoring devices cannot provide the level of instruction necessary to
 45 properly educate the patient with respect to the intricacies of his or her condition. The
 46 enforcement of Stark II will disjoint the patient education process and leave patients to decide
 47 upon the choice of monitor without the technical background to make an informed choice.
 48 Patients who do not receive physician education on these monitors often find themselves back in
 49 the physician's office, realizing too late that their choice of equipment may have been either less
 50 than required or too elaborate for their condition.

51 Permitting physician practices to deliver blood glucose monitors and other DME within the office
 52 would recognize that these services are often an integral part of the physician's treatment of their
 53 patient, and are frequently dispensed to the patient in the physician's office at the time the
 54 physician services are provided. Restricting the provision of DME in physician practices may
 55 diminish quality of care, inconvenience patients, and increase rather than reduce health care
 56 costs.

1 We again thank the leadership for the positive way in which they have dealt with the Stark II law.
 2 These improvements in the law will allow endocrinologists and all other physicians to provide their
 3 patients with the best quality care possible.

4
 5 **CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988 RELIEF**

6 AACE applauds the inclusion of CLIA relief in the Republican Medicare proposal. The AACE has
 7 been concerned by the large number of physicians' practices that have sharply limited or
 8 discontinued essential patient testing because of burdensome CLIA requirements. As a result,
 9 patients are referred to outside laboratories for routine patient testing which could be done during
 10 the office visit for far less cost and would enable the physician to treat the patient immediately.
 11 AACE believes it is critical that the regulatory burdens imposed by CLIA on physicians and other
 12 health care providers be eased so they can return to providing the laboratory tests that they are
 13 trained to perform as a part of their clinical examination. These tests are the basic tools used by
 14 the physician for immediate evaluation and diagnosis of a patient's medical condition. CLIA has
 15 unintentionally caused many physicians and other health care providers to stop offering the
 16 routine laboratory tests they need to provide patients with high quality care in an efficient and
 17 cost-effective manner.

18 CLIA has resulted in significantly higher costs for those physicians operating physician office
 19 laboratories. The government concluded that CLIA will add approximately \$1.3 billion annually to
 20 the cost of health care. Despite this cost of complying with CLIA, there is little, if any,
 21 documentation that CLIA has resulted in improved patient care. The provision included in the
 22 Republican proposal will provide much needed relief for physicians who want to offer their
 23 patients laboratory testing in a timely and cost-conscious manner.

24 **THE "LOOK BACK" MECHANISM**

25 AACE urges the committee not to subject the Medicare program to a "look back sequester" if
 26 spending under the program exceeds estimated budget targets. Budget targets may be
 27 exceeded for various reasons such as the availability of new expensive technologies, increased
 28 use of services by beneficiaries, and if initially, insufficient numbers of beneficiaries enroll in the
 29 program. Indiscriminately cutting reimbursement rates to providers are likely to result in access
 30 problems for beneficiaries as physicians find it financially impossible to participate in health plans
 31 accepting Medicare vouchers. AACE recommends that if spending is higher than projected
 32 because of new useful technologies or increased patient utilization of services deemed medically
 33 necessary, Congress should provide the funds necessary to reimburse for these services.

34 **CONCLUSION**

35 The AACE commends the leadership for drafting their proposal on transforming Medicare. The
 36 document contains many provisions which AACE has long supported and we applaud your goal
 37 of preserving and strengthening Medicare for present and future beneficiaries. We are aware that
 38 this year's budget process is just underway and that this proposal will undergo change. The
 39 AACE looks forward to working with Congress on this crucial issue as the debate over Medicare
 40 continues.

**STATEMENT OF AMERICAN ASSOCIATION OF COLLEGES OF NURSING AND
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS**

**STATEMENT ON USING EXISTING MEDICARE SUPPORT FOR NURSING
EDUCATION TO PREPARE ADVANCED PRACTICE NURSES**

The American Association of Colleges of Nursing (AACN), representing 472 baccalaureate and graduate nursing institutions, and the American Association of Nurse Anesthetists (AANA), representing 26,000 certified registered nurse anesthetists, urge that existing Medicare funds presently going mostly to undergraduate nursing education be redirected for graduate nurse education. This innovation would help Medicare support for nursing education be more relevant to the Medicare population, and provide a stable, on-going revenue source to expand the production of advanced practice nurses (APNs), a vital resource for meeting future Medicare population needs. A graduate nurse education (GNE) program is one that educates nurse practitioners, nurse midwives, nurse anesthetists, or clinical nurse specialists. These APNs are prepared as expert clinicians to deliver primary care and services supportive to primary care. They also manage chronic medical conditions and other concerns typical of Medicare beneficiaries. GNE programs are post - baccalaureate, advanced practice nursing programs accredited by a national accrediting body and linked by a written agreement to an academic institution that is accredited by a national, state and/or regional accrediting body, and award a graduate degree.

In order to educate adequate numbers of skilled APNs who provide high quality and cost-effective services to Medicare recipients and others, there must be a reliable revenue stream that is not subject to the uncertainties of the annual appropriations process. Medicare monies support provider operated nursing and allied health programs. AACN urges that these nursing education monies be redirected to educate APNs.

We suggest the following Medicare changes regarding support for professional education at Medicare facilities:

1. Changing eligibility to include jointly operated graduate programs.

Medicare reimburses hospitals for a portion of the costs of eligible hospital-owned or operated nurse education programs. In fiscal 1991, hospital operated undergraduate programs received \$174 million from Medicare, according to Health Care Financing Administration data. Since the inception of Medicare, nursing education has shifted almost entirely to community colleges, senior colleges, and universities. Most APNs represent categories of providers not in existence when Medicare educational payment policies were designed; educational cost of these new providers are, with one exception (nurse anesthetists), not covered by Medicare. **Consequently, eligibility requirements should be changed to those "jointly-operated" (provider-academic) programs incurring costs for support of APN education.** Providers eligible to receive reimbursement would have to meet all of the following criteria: must be eligible to receive Medicare Part A, incur clinical costs for the support of graduate nurse education programs, and have a written contractual agreement with the program's academic institution. Cost allocations for determination of Medicare's share of reimbursement would include student stipends, costs of nursing clinical faculty and supervision at the clinical site, and program expenses, all limited to that portion of the education taking place at the Medicare provider facility. Determination of the specific cost of education would be based on an appropriate ratio of faculty to students, and faculty and supervisory salaries.

2. Clarifying of "provider" definition to include out - patient facilities.

Medicare defines "provider" as "hospitals, skilled nursing facilities, home health agencies, and other facilities." With health care delivery evolving beyond acute care to community based sites, ambulatory care facilities as well as tertiary care sites, should be reimbursed for costs incurred for clinical training of APNs. It is critical to support these settings, because students must be exposed to a variety of places where people are getting care. **The Medicare definition of "other facilities" should be clarified to include those facilities that provide health care to Medicare recipients, with or without links to acute care settings, including, but not limited to, nurse managed centers,**

ambulatory care facilities, health maintenance organizations, and public health departments. A broad definition of eligible training facilities is necessary to facilitate clinical training of the largest number of APNs in those sites serving Medicare patients that have the greatest need for these practitioners.

Most nursing programs pay their own clinical training faculty or make arrangements with preceptors at clinical sites to provide clinical training at patient care sites outside the schools' academic facilities. The cost of faculty at the clinical site and cost of preceptorships for advanced nursing students, however, are part of the cost of providing patient care because patients receive the benefit of the care delivered by graduate students and their faculty. The cost of nursing education is that of any student receiving a master's degree. The average debt burden is low because most graduate nursing students work full time, go to school part time on the "pay as you go" plan, and do not accumulate large debts.

A brief description of the APN student follows: She (most are female) goes to graduate nursing school part-time for an average of 3.9 years and is a primary earner for the family. She goes to school to become an expert practitioner and a stable health care resource to the community. Stipend support from Medicare funds would provide opportunities for the APN student to attend school full-time, reduce the need to work while going to school, and allow the completion of a graduate degree more quickly.

Under this proposal, all entities that incur clinical costs for support of APN education would have access to GNE funding for the portion of the cost attributable to the Medicare patient population. GNE funding would allow the allocation of resources for added clinical faculty to expand the number of APNs in training. This would help eliminate the waiting lists which all graduate nursing programs are experiencing. Support of preceptors in the clinical sites would allow them to provide teaching and direct clinical supervision to the APN students as a planned component of their job responsibilities, rather than as an additional responsibility to their current workload. GNE support would also provide incentives to the practice sites to agree to take on students for clinical training. It would allow the clinical site to focus on training activities while having a positive impact on patient care. It would also provide reimbursement to the sites for a portion of training costs.

Due to limited resources in many of these settings where patients are receiving care, most can only take on one or two APN students at any one time. This forces programs of nursing to contract with numerous sites in order to provide clinical training for students. In addition, reimbursing clinical sites for training APN students recognizes the value of their services to patient care. With the number of specialty resident physicians likely to be reduced, these APNs will be delivering many of the services and care formerly performed by resident physicians. Acute care nurse practitioners who have graduated from programs such as these, are already assuming roles in a number of clinical sites.

APNs are precisely the type of health professional the Medicare populations will need for primary care, management of chronic medical conditions affecting older people, and patient education to help this population avoid injury and expensive hospitalization or nursing home care. The APN can be a vital component in increasing access to quality health care services for Medicare patients in a rapidly changing health care environment.

At present, Medicare reimbursement for nursing education programs is limited by the "provider - operated rule," which directs most of the funding to diploma programs that produce entry level nurses. There are data indicating that the number of entry level nurses is adequate. There is a large gap, however, in the supply of advanced practice nurses. There have been five demonstration projects funded by Medicare to educate various types of advanced practice nurses. These projects ended in July 1994 and a report on the demonstration projects will be sent soon to Congress. These projects show that Medicare dollars increased the recruitment and retention of advanced practice nurses at the facilities running the programs, and improved the provision of nursing care. One project created a skilled nursing facility, and another implemented a management teaching/counseling program for cardiac rehabilitation. These programs suggest that more Medicare support

for advanced practice nurses will greatly benefit the Medicare population and could help reduce Medicare costs through replacement of more costly professionals.

This is the time to shift Medicare funding toward the recognized great need for advanced practice nurses. Redirection of the current Medicare monies for nursing education to APN education will increase the numbers of APNs and will ensure that Medicare patients will have the benefit of their skills in the future. Though the redirection of these funds for support to APN education requires no new Medicare expenditures, it is imperative that funding levels should not be reduced for those APN programs currently receiving Medicare support. Redirection of funds would focus Medicare support on the preparation of the nurse in great demand by the Medicare beneficiary population, and help meet the needs of the changing health care workforce.

COSTS FOR USE OF MEDICARE SUPPORT FOR NURSING EDUCATION

Initial estimates indicate that a proposal which reimburses for the clinical training of advanced practice nurses would cost Medicare no more than \$66 million, as opposed to HCFA's estimate of \$248 million for nursing education (which reimburses hospitals for the costs of educating mostly diploma nurses) in 1994.

1994 total number of full time APN students (AACN and AANA enrollment data)	8461
1994 Average cost per APN student (Division of Nursing data)	x <u>\$15,591</u>
Total cost of educating full time APN students in 1994	\$131,915,451
50% of the total reflects that 50% of education is spent in clinical training	x <u>50%</u>
Total cost of clinical training of full time APNs	\$65,957,725 million
**(reduced by the percentage of Medicare patient load, which varies by institution patient profile)	
1994 Estimated Medicare nursing expenditure	\$248 million
Total Projected Savings	\$182 million or more

** Example: If costs reported for nursing education at one hospital are \$200,000 and the Medicare patient load was 20%, Medicare reimbursement to the institution for nursing education would equal \$40,000.



AMERICAN ASSOCIATION OF PPOs

601 13th Street, N.W. * Suite 370 South * Washington, D.C. * (202) 347-7600 * FAX (202) 347-7601

September 21, 1995

The Honorable Bill Archer
 Chairman
 Committee on Ways and Means
 U.S. House of Representatives
 Washington, DC 20515

Dear Mr. Chairman:

The American Association of Preferred Provider Organizations (AAPPO) has enthusiastically supported the development of much-needed legislation to restructure Medicare, rescue it from looming bankruptcy, and bring to it the managed-care successes that have been so notable in the privately-insured health care market. To this end, we have been pleased to work with members of this Committee and to offer our vision of the role that PPOs can play in accomplishing your goals. We are gratified to hear that PPOs will be included as one option in an expanded menu of plan choices, and we hope that you will make the best use of PPOs' unique abilities to control cost and preserve choice.

AAPPO understands the Committee's enthusiasm for a 21st-century Medicare program that promotes risk-bearing private health plans. Naturally, cost predictability as well as containment is of critical importance in the budget process. However, some seniors may opt for one form of managed care over another, and there is general agreement that they cannot all be channeled into the most restricting forms of managed care (e.g., staff-model HMOs). AAPPO is concerned that Medicare legislation not attempt this indirectly by making all managed care plans behave like HMOs.

Most PPOs operate in a **managed fee-for-service** environment. They are not set up to accept risk, i.e., capitation. Yet non-risk PPOs are able to return eight to ten times their administrative fees in savings to payors through utilization management and negotiated fee schedules. PPOs are more geographically dispersed than other managed care networks, giving them a greater capacity to respond to beneficiary enrollment. They offer provider selection and credentialing, quality as well as utilization management -- and beneficiary satisfaction rooted in the ability to choose, each time service is needed, whether to see a network doctor or to consult one outside the network.

Preserving a degree of flexibility is an important part of encouraging beneficiaries to make the transition to managed care. PPOs are well equipped to provide this comfort level in addition to providing quality care and cost savings. But this can only happen if PPOs are not themselves forced into a too-precipitate transition. If required to bear full risk, the majority of PPOs will step out of Medicare. Others will say, accurately, that they cannot bear responsibility for services performed out of network; being charged with full responsibility will mean a sharp reduction in choice.

AAPPO asks you to look at a range of risk options that will maximize PPO effectiveness in Medicare. A summary of the association's proposal for risk and non-risk contracting is attached. If you or your staff have questions, or if AAPPO can provide additional information, please call me or Director of Legislative Affairs Lisa Sprague. Thank you for your attention to our concerns.

Sincerely,

Gordon B. Wheeler
 President and Chief Operating Officer



AMERICAN ASSOCIATION OF PPOs

601 13th Street, N.W. * Suite 370 South * Washington, D.C. * (202) 347-7600 * FAX (202) 347-7601

PPOs IN MEDICARE: RISK AND NON-RISK OPTIONS

The American Association of Preferred Provider Organizations (AAPPO) agrees with legislators that Medicare choices should be expanded, giving beneficiaries the same options available to those insured in the private market. We are concerned by proposals that would limit those choices to state-licensed, risk-bearing entities.

Most PPOs are not licensed as insurers or HMOs, and do not bear insurance risk. To require them to do so is to bar most PPOs from Medicare participation, thereby barring beneficiaries from an option that would offer both cost savings and provider choice.

AAPPO believes strongly that Medicare must build on the successes of the private sector, including PPOs. PPOs have charted impressive growth and popularity not by trying to replicate HMOs' structure, but by applying utilization and quality management to a fee-for-service base. In essence, PPOs represent *managed fee-for-service*. Given that 90% of Medicare beneficiaries currently are enrolled in a fee-for-service arrangement, it clearly would be advantageous to encourage this population to move into a more efficient and cost-effective variation. PPOs have the capacity to enroll large numbers of beneficiaries quickly -- but not if they must first undergo the laborious process of obtaining state insurance licensure.

AAPPO by no means suggests that PPOs seek to escape oversight and accountability. Indeed, we have proposed the development and implementation of federal-level standards to demonstrate PPOs' ability to deliver high-quality care and to protect beneficiary interests. Under the current scenario, we are prepared to work with Congress and the Health Care Financing Administration to develop standards appropriate to PPOs' unique structure; however, we would also suggest that private accrediting organizations could fulfill the role of arbiter.

PPOs seek direct contractor status under the Medicare program. As we envision the process, an interested PPO would first demonstrate its qualification by complying with formal standards. It then would contract with Medicare just as it now does with a self-insured employer, i.e., the employer bears the insurance risk, and compensates the PPO via an administrative fee for network access, provider credentialing, quality and utilization management, etc. AAPPO has suggested that negotiated performance targets could form part of this contract, and that non-risk PPOs put their administrative fees at risk as a form of performance assurance. In addition, PPOs would retain the option to participate as full-risk contractors by obtaining the necessary license or in partnership with a licensed carrier.

September 18, 1995



AMERICAN COLLEGE OF RHEUMATOLOGY
SPECIALISTS IN ARTHRITIS CARE & RESEARCH

Testimony before the Ways and Means Committee

on the Republican 1995 Budget Reconciliation proposal

by the American College of Rheumatology

September 22, 1995

INTRODUCTION

1 The ACR is the professional organization of rheumatologists. It includes practicing physicians,
2 research scientists, nurses, physical and occupational therapists, and other associated health
3 professionals who are dedicated who are dedicated to preventing disability, healing and
4 eventually curing more than 100 types of arthritis and related disabling and sometimes fatal
5 disorders of the joints, muscles, and bones.

6 As Congress and the public make increased demands for deficit reduction and a concomitant
7 reduction in expenditures on federal entitlements, the proposal submitted to the Committee for
8 consideration today provides an excellent guideline for discussion with other congressional
9 leaders and health policy makers on how best to reform Medicare. The proposal includes several
10 provisions long supported by the ACR. ACR strongly supports the plan's clarification of the self-
11 referral law to allow physicians to share facilities and be in compliance with the Stark II law. ACR
12 also strongly supports the CLIA provisions found in the plan. ACR appreciates the proposals'
13 provision on medical liability. ACR is pleased to see the proposal also provides language
14 mandating the use of a single conversion factor within the Medicare Fee Schedule. The
15 leadership's provision regarding Physician Sponsored Networks will provide increased
16 competition for health plans for beneficiaries business.

17 There are, of course, some provisions in the Republican proposal which give us cause for
18 concern. We are concerned over how the "Look Back" mechanism could arbitrarily reduce
19 physicians fees. ACR believes that a Point-of-Service rider should be mandated to ensure patient
20 choice of physician is provided. Additionally, ACR is concerned that there is no provision which
21 calls for a risk-based methodology when calculating the federal contribution to private health
22 plans for those seniors who choose them. We will elaborate on these issues below.

23 The ACR would like to thank the Ways and Means Committee for this opportunity to provide
24 written testimony. We offer the following comments on the Republican proposal and hope that
25 you will keep our views in mind as the budget reconciliation process goes through the inevitable
26 refinement process.

27 Risk-Based Methodology for Calculating the Defined Contribution

28 As you are well aware, Congress and health policy makers are coming to the conclusion that the
29 existing Medicare structure must be transformed from a defined benefit program to a defined
30 contribution program. Several policy makers have espoused the concept of providing "vouchers"
31 to Medicare beneficiaries and allowing them to purchase their own health insurance with these
32 vouchers. Although the Republican proposal does not advocate the use of vouchers per se,
33 beneficiaries could elect to participate in MedicarePlus plans, which would be paid through a
34 defined federal monetary benefit.

35 If such a system is to be a part of a long-term restructuring of Medicare, the ACR believes it is
36 imperative that a proper risk-based methodology be used to calculate the voucher amount. As
37 you know, the average expenditure per Medicare beneficiary in 1993 was \$4020. However, for
38 ten percent of beneficiaries, the average cost for care was \$28,120 and for the remaining ninety
39 percent the average expenditure was \$1,340. The ACR is concerned that patients with chronic
40 conditions, such as arthritis and related arthritic diseases, whose health expenditures exceed the
41 value of the voucher may be "left behind" as insurance companies look to enroll healthier
42 beneficiaries. In addition, because of the high costs of providing care to these patients, their out-
43 of-pocket costs may be so high that they could be forced into purchasing the lowest-cost health
44 plan available. Such plans will likely restrict them from accessing the physician best trained to
45 treat their chronic condition.

46 The ACR believes that a proper risk-based methodology will help alleviate these problems. The
47 methodology should be based on known variables established by medical literature accounting

for the co-morbid conditions affecting patient survival and quality of life. Prior patient utilization of health care services, though complex to administer, could be used to calculate a correct voucher value. In addition, it is clear that a detailed monitoring system would be necessary to ensure that providers and health plans did not adversely select against certain patients (ie. those with chronic, expensive conditions) and did not under-utilize resources associated with the improvement of morbidity and mortality of these patients. This monitoring system should not be used to alter diagnostic and procedural-related services; rather it should be focused on whether patients are receiving services when medically appropriate. ACR also believes that health plans should be required to include co-morbid and severity of disease data in their patient acceptance rates. This will ensure that health plans are appropriately spreading medical risk to all potential enrollees.

The "Look Back" Mechanism

ACR urges you not to arbitrarily subject the Medicare program to a "look back sequester" if spending under the program exceed estimated budget targets. Budget targets may be exceeded for various reasons such as the availability of new expensive technologies, increased use of services by beneficiaries, and if initially, insufficient numbers of beneficiaries enroll in the program. Indiscriminately cutting reimbursement rates to providers are likely to result in access problems for beneficiaries as physicians find it financially impossible to participate in health plans accepting Medicare vouchers. ACR recommends that if spending is higher than projected because of new useful technologies or increased patient utilization of services deemed medically necessary, Congress provide the funds necessary to reimburse for these services.

Mandatory Point-of-Service

The ACR notes that the Republican proposal did not contain a mandatory Point-of-Service provision. ACR has long advocated for this provision and we hope Congress will agree to mandate a POS in all Medicare managed health plans. Unlike more restrictive plans, the POS option allows enrollees who pay somewhat more the option of receiving services outside of the plan's network, thus broadening patients' freedom of choice in provider selection.

Under a POS, a health plan could charge an additional premium and higher coinsurance for services provided outside the plans' provider networks. Plans would be prohibited from reducing benefits or imposing excessive coinsurance on individuals who elect this option. The POS mandate strikes a balance between creating incentives to obtain services within a provider network and allowing people to go outside the network without prohibitive financial penalties.

A voluntary approach would not prevent health plans from imposing restrictions on choice. The sad truth is that many of the POS option arrangements now offered on a voluntary basis offer choice in name only. By imposing high cost-sharing when such services are provided outside the plan's provider network, they typically permit choice only for well off Americans for specialty services. For middle income Americans who wish to select a rheumatologist not on the plan's list, this is no choice at all.

Since some health policy makers have stated their concern that seniors may not be well suited to receive services in a capitated setting, it is extremely important that people be guaranteed the right to choose their own doctor. Medicare reform will not be credible if it promises choice, but then allows health plans to impose unacceptable restrictions on choice. ACR urges you to support enactment of a POS mandate in the budget reconciliation bill.

Fee Schedule Improvements

ACR is very pleased that the proposal includes a budget neutral single conversion factor for the Medicare Fee Schedule and replacement of the current volume performance standard with growth targets based on the gross domestic products plus two percent. As the Committee knows, the MVPS and separate conversion factors for surgery, primary care and non-surgery have served to distort the original intention of resource-based relative value system. We note however, that the proposal does not specify an implementation date for this change and makes reference only to upper and lower limits being placed on annual adjustments to "ensure reasonable updates and to reduce volatility." ACR urges the Committee to clarify that the implementation date for the single conversion factor will be January 1, 1996 and also to specify a lower limit on annual updates to the conversion factor to assure that the updates remain reasonable.

ACR also expresses its support for the replacement of the VPS with updates based on GDP plus two percentage points. This move has been endorsed by the Physician Payment Review Commission.

**Physician Self-Referral and Ownership
Shared In-office Ancillary Services Facilities Exception**

ACR appreciates the Republican proposal's improvement of the federal law on physician self-referral. As the Committee knows, the current self-referral law includes an exception that allows solo practitioners and group practices to provide in-office testing services (e.g., clinical labs and x-ray services). However, it does not provide an exception from the ban for in-office testing services provided by an in-office facility shared by two or more physicians located in the same building but who are not in practice together. The absence of a "shared" in-office ancillary service exception has been a problem since the original 1989 law was enacted.

Shared arrangements are a cost-effective and practical way for physicians in solo or small group practices to provide in-office ancillary services to their own patients, without unnecessarily duplicating facilities in the same office building. For example, it is practical for physicians who are already sharing office space to share a single in-office laboratory between them rather than setting up two laboratories. Shared arrangements are especially common among the primary care specialties. In most cases, it is not a viable alternative for physicians in shared arrangements to become a group practice. Becoming a group practice involves much more than sharing the cost of providing in-office testing services, e.g., sharing legal and financial liability. Physicians involved in the shared arrangement may have nothing in common other than the fact that they share office space with each other. Understandably, they may not want to become a group just so they can provide in-office testing services to their patients. That leaves them with two options; set up two laboratories in the same office or stop providing in-office testing services. ACR thanks the leadership for eliminating this major problem.

Clinical Laboratory Improvement Amendments of 1988 Relief

ACR appreciates the inclusion of CLIA relief in the Republican Medicare proposal. The ACR has been concerned by the large number of physicians' practices that have sharply limited or discontinued essential patient testing because of burdensome CLIA requirements. As a result, patients are referred to outside laboratories for routine patient testing which could be done during the office visit for far less cost and would enable the physician to treat the patient immediately. ACR believes it is critical that the regulatory burdens imposed on physicians and other health care providers by CLIA be eased so they can return to providing routine laboratory tests they are trained to perform as a part of their clinical examination. These tests are the basic tools used by the physician for immediate evaluation and diagnosis of a patient's medical condition. CLIA has unintentionally caused many physicians and other health care providers to stop offering the routine laboratory tests they need to provide patients with high quality care in an efficient and cost-effective manner.

CLIA has a direct effect on a rheumatologist's practice. During the course of a patient examination on a labile specimen, Rheumatologists conduct a synovial fluid analysis. Direct examination of synovial fluid is a simple one-step test similar to qualitative semen analysis in complexity. For the direct examination of synovial fluid, a sample of joint fluid is drawn and placed on a slide. It is then viewed under a microscope. The presence of bacteria indicates a bacterial infection that should be treated with antibiotics. The presence of crystals indicates gout. This simple exam, typically performed during the physical exam, allows for immediate treatment of patients who can be in a great deal of pain. The difference between bacteria and crystals is readily apparent. The identification of the crystals themselves, which requires a higher level of skill, is not necessary to make the distinction between bacteria and crystals and to begin appropriate treatment.

However, because synovial fluid analysis is classified as a highly complex test, it comes under the CLIA regulations. This results in significantly higher costs for the rheumatologist yet providing no improvement in patient care at all. The government concluded that CLIA will add approximately \$1.3 billion annually to the cost of health care.

The provision included in the Republican proposal will provide much needed relief for rheumatologists and other physicians who want to offer their patients routine laboratory testing in a timely and cost-conscious manner.

Medical Liability

The ACR is very pleased to see the inclusion of health care liability reform in the Republican proposal. As the Committee is well aware, our tort system is laded with excessive attorney costs, potentially huge punitive damage costs, and increased filing of non-meritorious claims against physicians. Further, the current tort system inadequately compensates deserving plaintiffs and

imposes unnecessarily high litigation costs on all parties. The cost of these judgments are then passed onto the consumer in the form of increased prices and decreased productivity of the work force. Fear of suits has led many physicians to practice "defensive medicine" adding between \$20 to \$25 billion dollars per year to the health care system. Physicians pay an estimated \$10 billion in malpractice premiums per year. By reforming the medical malpractice laws, with limits on how much juries can award for non-economic damages and providing guarantees that most of the monetary awards will go to patients rather than their trial attorneys, the Republican proposal offers real liability relief to the medical community. Such relief will result in more efficient and less costly care.

Conclusion

The ACR commends the leadership for drafting their proposal on transforming Medicare. The document contains many provisions which ACR has long supported and we applaud your goal of *preserving and strengthening Medicare for present and future beneficiaries*. We are aware that this year's budget process is just underway, however, we look forward to working with Congress on this crucial issue as the debate over Medicare continues.

STATEMENT OF AMERICAN LUNG ASSOCIATION AND THE AMERICAN THORACIC SOCIETY

These comments are submitted on behalf of the American Lung Association and its medical section, the American Thoracic Society.

Founded in 1904 to fight tuberculosis, the American Lung Association is the oldest nationwide voluntary health agency in the United States. Along with its medical section, the American Thoracic Society -- a 12,500 member professional organization of physicians, scientists, and other health professionals specializing in pulmonary medicine and lung research -- the American Lung Association provides programs of education, community services, advocacy and research to fight lung disease and promote lung health.

The ALA/ATS would like to take this opportunity to bring to the attention of the Committee its concerns regarding access to specialty care for the chronic lung disease patient. Under the proposed Medicare reform plan, which focusses principally on enrolling Medicare recipients into managed care plans, the access to specialty care question is paramount for our constituents who suffer from lung disease. In addition to including access to specialty care in Medicare reform, we would also like to see included a provision to end restrictive insurance industry policies that limit Medicare patients' access to the latest pharmaceutical products and medical devices. Furthermore, lifetime monetary caps on prescription drugs and medical devices should be eliminated.

LUNG DISEASE AMONG THE MEDICARE POPULATION

The prevalence of chronic lung disease varies with age, but for most categories chronic lung disease hits hardest in individuals 65 years of age and older. For instance, the prevalence of chronic bronchitis is the highest in those over 65, where 61.7 persons per 1,000 are affected. The prevalence of emphysema increases steeply with age, affecting 15.6 people per 1,000 in the 45-to 64-year-old group and nearly doubling to 29.8 per 1,000 after age 65. In addition, those over age 65 experience the second highest prevalence of asthma -- 48.2 per 1,000.

With these statistics in mind, it is only natural that the ALA/ATS be concerned with how Medicare recipients with chronic lung disease are treated under Medicare reform. If current proposals prevail, there will be an increasing number of Medicare recipients enrolled in managed care. The ALA/ATS wants to make sure that those with chronic lung disease will receive the same quality care and access to specialty care they receive under the present Medicare system.

THE NEED FOR ACCESS TO SPECIALTY CARE

In order to maintain optimal functioning in the face of a disabling condition such as chronic lung disease, patients require a wide range of health-related services. Medical treatment is, of course, primary. In terms of physician care, the patient's family physician usually makes a tentative diagnosis of chronic lung disease. In most instances, a consultation with a pulmonary specialist is suggested. In some cases, because of the extent of the patient's disease, referral to a pulmonary specialist is necessary.

Specialists serve a dual role in clinical practice: as a primary physician for a person with chronic disease and as a consultant for acute illness where the patient has been referred to the specialist. A gatekeeper system that too strictly requires permission or referral for every visit to a specialist would be a large detractor to access for people with chronic lung problems. Appropriate management of moderate to severe asthma by a specialist, for example, is more likely to result in fewer costly hospitalizations than care of those same cases by a general internist or family practitioner who does not have the extensive training to work with asthma. Further, pulmonary physicians are generally able to assume full care for the patient whose primary problem is lung related and more often do so at the patient's request.

Just as there is a need to include specialty care access in Medicare reform, there also remains the need to train specialists to perform those services. The ALA/ATS is concerned that every effort be made to continue funding of Graduate Medical Education (GME) through a Medicare set-aside. Although the trend of the medical profession is to produce more primary care physicians, the fact remains that with a growing elderly population, the need for specialized services, such as critical care/pulmonology, will continue to grow well into the next century.

The American Lung Association and the American Thoracic Society are dedicated to ensuring that

lung disease patients on Medicare have access to the appropriate specialty care. Unless there is specific language in the Medicare reform bill mandating an out-of-service option for managed health care plans, access to providers who are specialists for individuals with chronic diseases (e.g. a specialist acting in the primary care provider role) may be denied, or severely restricted in the interest of cost savings. Financial disincentives for specialty referral also must be eliminated. Referrals always must be based on the best interest of the patient, not the financial interests of the health plan.

MEDICARE RECIPIENT ACCESS TO LATEST PRESCRIPTION DRUGS AND DEVICES

A variety of oral, parenteral and aerosolized medications are required to treat chronic pulmonary disease. In addition, some patients require oxygen and durable medical equipment, such as nebulizers, humidifiers, suctioning equipment and mechanical ventilators. New drugs and devices that can better control and add improve the quality of life for lung disease patients are being made available daily. Unfortunately, Medicare recipients cannot receive the latest/experimental drugs or devices because of restrictive Medicare payment policies. As a result, these patients, who are often in most need of advanced drugs and devices, are being denied access to a series of new products and therapies.

Compounding this already stifling situation are lifetime caps on prescription drugs and medical devices. The cost of treating chronic diseases is very expensive. Lifetime monetary caps on these therapies cruelly postpone the inevitable for those with chronic conditions. For patients who have exceeded their lifetime cap, finding other cost-effective health insurance to help pay for their ongoing medical costs is a nightmare, if not impossible.

Studies have been conducted indicating that the eradication of lifetime caps would result in minimal increases in insurance premiums. Insurance companies can effectively spread their risk of having patients with catastrophic illnesses through reinsurance. From an actuarial view, there is a trivial increase in premium costs from raising the lifetime cap from half a million or a million dollars to six million dollars or eliminating it altogether -- the difference for the patient who has a chronic and costly disease, however, is tremendous.

CONCLUSION

With the ever increasing number of Medicare recipients enrolling in managed care plans and considering proposed legislative plans to encourage this trend, Congress should make sure that the issues of access to specialty care, the ending of restrictive Medicare drug and medical device policies, and the elimination of lifetime caps on prescription drugs and medical devices are thoroughly reviewed.

Continued access to specialty care, prescription drugs, medical devices and the elimination of lifetime monetary caps are of extreme importance to those with chronic diseases, especially chronic lung disease. It is the hope of the American Lung Association and the American Thoracic Society that the committee will seriously and carefully consider these options when formalizing its final plan for Medicare reform.

**American Nurses Association
Statement on
The Medicare Preservation Act of 1995
Presented to the House Ways and Means Committee**

September 26, 1995

The American Nurses Association (ANA) is the only full-service professional organization representing the nation's 2.2 million registered nurses, including staff nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives, nurse educators, nurse managers and certified registered nurse anesthetists, through its 53 state and territorial nurse associations. We appreciate this opportunity to present our views and recommendations on the Medicare Preservation Act of 1995.

Since this legislation has not yet been finalized, our comments are based on the descriptive material released by the Committee on September 20, 1995. As more detailed specifications and legislative language becomes available we would expect to have additional comments and recommendations.

Overview

ANA recognizes that very significant changes in the health care delivery system are underway across the country. These changes -- driven in part by purchaser demands for more efficient and affordable health care services and in part by reduced payments by publicly financed health coverage programs -- are responsible for consolidation and restructuring in the health care sector. ANA recognizes that the concerns of private purchasers of health benefits and taxpayers must be addressed in order to sustain the U.S. health care system, but we strongly insist that the quality and accessibility of care are not ignored.

In the public sector, the rate of growth of expenditures for Medicare must be reduced to ensure the solvency of Medicare's Part A Trust Fund. We strongly support the continuation of assurances that Medicare beneficiaries retain their entitlement to the traditional Medicare fee-for-service program in addition to other approved options. We agree with the need to offer Medicare beneficiaries access to a broader array of alternative delivery models that meet appropriate quality standards and provide for consumer protections. We know that some beneficiaries are currently enrolled in managed care organizations that render high quality services and result in high levels of patient satisfaction. Making such arrangements available to a larger number of Medicare beneficiaries is certainly an appropriate policy goal.

However, we are strongly opposed to both the magnitude and pace of the reforms proposed in the "Medicare Preservation Act of 1995." Reducing the growth in Medicare expenditures by \$270 billion over the next seven years is not only unnecessary but dangerous. The Committee's own document states that "This bill is designed to address the need to modernize the Medicare program and to assure the short-term solvency of the Program." We believe that the program savings are significantly in excess of what is required to stabilize the Part A Trust Fund over the next ten years while the long-term financing challenges of the "baby boom" generation are addressed separately.

The proposal presents a clear danger to the current 37 million, projected to be 41.5 million by the year 2002, aged and disabled beneficiaries who depend on the Medicare program for access to care, economic security and their very lives. According to the Congressional Budget Office (CBO), Medicare spending over the next seven years -- assuming savings of \$270 billion -- would rise at an annual average rate of 4.9 percent. In contrast, CBO estimates the annual average rise in private health benefit expenditures at 7.1 percent. When one considers the health care needs of the elderly and disabled compared to those covered under private plans, this disparity in growth rates is even more alarming. In short, it simply is not possible to constrain the growth in Medicare outlays to rates significantly lower than the growth rate for private benefits without

diminishing both the quality and accessibility of care for those who depend on Medicare.

In addition, more modest savings in Medicare expenditures – somewhere in the range of \$90 to \$110 billion over seven years – would be sufficient to prevent insolvency in the Part A Trust Fund for at least 10 years. These amounts – while not insignificant by any measure – would provide the “breathing room” needed to undertake a more thorough study of how to prepare Medicare for the challenge of covering the large number of “baby boomer” retirees starting in 2010. While such an approach would require Congress to revise its Budget Resolution, we think such a step is warranted to avert what in our judgment would be real harm to beneficiaries and to many of the health care facilities on which they depend.

ANA Specific Concerns

ANA approaches an analysis of the “Medicare Preservation Act of 1995” by attempting to assess its impact on four critical aspects of the program:

- the quality, accessibility and appropriateness of covered benefits;
- the affordability of coverage to beneficiaries and taxpayers;
- the utilization of an appropriate workforce; and
- the promotion of primary and preventive care and community-based care.

As noted earlier, the ANA supports the intent of this legislation to expand the health plan choices available to Medicare beneficiaries. Many of our members work in managed care plans and receive their health benefits from such plans. However, it is essential that any expansion in the eligibility of health plans to enroll Medicare beneficiaries must be accompanied by measurable and reportable standards and by the capacity to monitor and enforce those standards.

Quality and Accessibility of Covered Benefits

While more widespread utilization of managed care systems shows some promise in predicting and controlling health care costs for the Medicare population, merely expanding managed care to include more enrollees has not in and of itself shown a strong relationship to improved health status or outcomes. Past efforts to rapidly expand the infrastructure for managed care by waiving plan standards or greatly relaxing them suggest a predictable result: poor performing plans, financial failures, and egregious fraud. In addition, managed care does not assure increased health status or increased health outcomes. ANA strongly recommends that health plan standards take steps to assure the accountability of any entity that assumes financial risk for the care of Medicare beneficiaries. As the standard bearer for expectations of nursing care at the national level, the ANA has expanded this effort to the managed care arena. ANA’s Task Force on the Regulations and Accreditation of Managed Care is currently working to identify nursing’s recommendations for the essential elements of managed care regulations.

We are especially concerned about the potential for managed care plans to engage in inappropriate limitations on access to specialty care, selective marketing strategies, and targeted efforts to encourage the disenrollment of beneficiaries with expensive or chronic conditions. Standards are, of course, only as good as the capacity to enforce them. The resources currently available to the Medicare program to qualify and monitor plans are stretched to the limit. A substantial increase in the number of plans applying for participation in Medicare and greatly expanded oversight responsibilities will require significant additions to Health Care Financing Administration (HCFA) resources.

All of these concerns have obvious implications for the quality and accessibility of services to Medicare patients. In addition, when the impact of provider payment cuts and potential of deeper cuts from the “fail safe adjustment” included in the

Committee's proposal, are taken into consideration, we believe that even the traditional Medicare program is at risk for declines in the quality and accessibility of care. When hospitals and other providers do not have sufficient resources to maintain adequate staffing and other resources, care is delayed, quality is compromised, and costs are increased.

Managed care plans claim to be able to save money without sacrificing quality by keeping their enrollees healthy. Certainly, there are credible managed care plans that have emphasized primary and preventive care and health education classes for enrollees. Many of these plans have recognized the value of professional nursing in delivering these services.

However, many managed care plans have also tried to minimize their costs by limiting expensive services for people with serious illnesses. They have done this both by shortening the time patients spend in the hospital, for example, and also by discouraging people who are likely to use expensive care from enrolling in their plans. As for-profit health plans begin to dominate the field, for many providers, paying dividends to stockholders is prioritized over the responsibility to patient care. Nurses and patients themselves report many instances of patients being underserved. Staff nurses and advanced practice nurses find they are being capriciously replaced by unlicensed personnel in the health care facilities.

In some areas nursing leaders and others have led the way in establishing high quality service delivery systems within managed care plans. Nurses can help to motivate industry leaders to concentrate on quality. The Minnesota Nurses Association reports that hospitals affiliated with managed care organizations have responded to internal pressure by staff nurses, combined with publicity campaigns, by reversing staffing cuts.

One area of measuring quality health care services to which ANA has devoted substantial resources is the development of health care quality assessment reports (report cards). Report cards are intended for use by consumers and payers of health care to facilitate their selection and evaluation of care provided in a health care plan by specific providers and facilities. Report cards also are intended to help practitioners identify patterns of care that promote or inhibit the delivery of quality health care.

ANA commissioned Lewin-VHI, Inc. to begin the development of the **Nursing Report Card For Acute Care Settings** in order to explore the nature and strength of the linkages between nursing care and patient outcomes by identifying nursing quality indicators. The report provides a framework for educating nurses, consumers and policymakers about nursing's contribution to inpatient hospital care. Seven quality indicators were identified as "measurements of quality" of nursing care in acute care settings. These indicators are:

- . **Patient satisfaction**
- . **Pain management**
- . **Skin integrity**
- . **Total nursing care hours/patient (case and acuity adjusted)**
- . **Nosocomial infections, specifically UTI and pneumonia rates**
- . **Patient injury rate**
- . **Assessment and implementation of patient care requirements**

Although this nursing report card is aimed at all acute care settings, it is essential in assessing the utilization of acute care by beneficiaries in managed care plans.

In recent months, we have seen the first public outcry against decreased services and poor quality of care by managed care organizations. In state legislatures, as well as the U.S. Congress, legislation has been introduced to mandate minimum hospital stays for vaginal and cesarian births. Although ANA does not believe it is the role of policy makers to legislate minimum standards of care for every specific health condition, we do believe that this legislative trend is indicative of the public demand and expectation that

the government will assure minimum levels of quality patient care.

We acknowledge that fee-for-service medical care has had drawbacks for nurses and other professionals and for consumers. It emphasizes providing the most expensive care, such as institutional hospital care; and unfortunately, that is where the highest fees are found for physicians, hospitals, and insurance companies alike. While there is no one standard for medically necessary care, many observers agree that under fee-for-service, more tests and procedures are performed than necessary, at times to the detriment of the quality of patient care. Without any significant external oversight of their services or their charges, physicians have been able to dominate the health care system in their own interests and block many legislative reforms including the oversight of quality and appropriateness, and to keep out competing professions such as advanced practice nurses.

However, fee-for-service offers health professionals a great deal of autonomy in deciding what care is appropriate and offers consumers wide choices about which health professional to visit and a degree of control over which service to accept or reject. Yet, within the traditional Medicare fee-for-service program, we are disappointed that the "Medicare Preservation Act of 1995" does not include expanded recognition of non-physician practitioners as alternative providers of health care. The ability of nurses to provide health care services has been continually hampered by a number of artificial barriers that serve to cut the consumer off from access to services provided by these qualified health providers. These barriers include restrictive reimbursement policies by Federal and state programs. Current laws regarding reimbursement for advanced practice nurses are complicated and convoluted as to which categories of advanced practice nurses may be reimbursed, in what geographic areas, who may be paid and whether or not collaboration with other health providers is required. These laws are so confusing and complex for carriers, providers and consumers that they have become a barrier to access to these services in and of themselves.

We must guarantee that barriers the services of advanced practice nurses for the nation's elderly are removed. ANA was pleased to have the opportunity to work closely with Members of this Committee, as well as Members of the House Commerce and Senate Finance Committees, to achieve enactment of the "Rural Nursing Incentive Act". That provision, which was included in the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508), allows nurse practitioners and clinical nurse specialists who practice in rural areas to receive direct reimbursement under Medicare.

Every American must have access to and coverage for high-quality preventive, primary and community-care services. As cost-effective sources of quality care, advanced practice nurses can enhance patients' access to vital care. Nurse practitioners and clinical nurses specialists have demonstrated their value in the provision of care to Medicare beneficiaries in rural areas, and that provision of the Medicare law now needs to be expanded to cover the services of all nurse practitioners and clinical nurse specialists, regardless of geographic location and practice setting. If nurse practitioners and clinical nurse specialists are qualified to provide services in rural areas, they are equally qualified to provide these services in all other settings. Advanced practice nurses make health care affordable, available, acceptable and accountable. This expansion of coverage does not provide for reimbursement of new services, but rather provides for reimbursement for existing services by these advanced practice nurses. This action would enable nurse practitioners and clinical nurse specialists to provide essential services to help to meet the health care needs of older Americans. We strongly recommend that the legislation currently under consideration include provisions making available the services of nurse practitioners and clinical nurse specialists in all settings.

Affordability of Care

ANA understands that increases in the Medicare program must be brought more in line with growth in the overall Federal budget and that the Part A Trust Fund must be protected from bankruptcy. This can be accomplished with a reduced level of savings from Medicare and with modest increases in beneficiary participation in qualified managed care plans.

With respect to increases in the financial responsibility of Medicare beneficiaries, we want to caution against imposing new burdens on those with modest and low incomes. Low-income beneficiaries, including those with current eligibility for Medicaid and those who are qualified Medicare beneficiaries, should continue to enjoy special protections under the program. We are concerned that changes in the Medicaid program being considered elsewhere in Congress will expose these beneficiaries to the premium and cost-sharing increases that are called for in the Committee's bill. This would be a tragic reversal of a set of protections designed to recognize the special needs of those beneficiaries who may be largely or wholly dependent on very modest Social Security benefits. The ANA strongly recommends that any increases in premiums and cost-sharing for currently protected low income beneficiaries remain the responsibility of Medicaid or be waived for these individuals.

Two other issues related to beneficiary financial liability that are not explicitly addressed in the Committee's proposal must be raised. First, it is not clear to us whether the payment by Medicare to qualified private plans is anticipated to cover all of the costs of these plans or will be a fixed amount determined in a manner similar to the current methodology for calculation of the average adjusted per capita cost (AAPCC) with the beneficiary responsible for any difference between the cost of a private plan and the Medicare contribution. Assuming that beneficiaries pay the difference between the premium for a private plan and the Medicare contribution, we would hope that Medicare would seek to negotiate the most favorable rates for beneficiaries in a manner similar to the role played by many large employers on behalf of their workers and families.

In the absence of effective negotiations on premiums by HCFA, individual beneficiaries would be at a substantial disadvantage in obtaining favorable rates. Moreover, if most private plans require significant additional premium payments by beneficiaries it could serve as a means to assure the enrollment of only wealthy beneficiaries who in turn would likely be the most healthy. The resulting fragmentation of the Medicare risk pool would likely mean those with lower incomes and poor health status remaining in the traditional program driving up the costs in the fee-for-service sector more rapidly. This division of the Medicare population along income and health status lines would over time undermine the stability of the program.

Second, we are equally concerned about the prospect of a relaxation of the current balance billing rules in Medicare -- either in the traditional program or inside a qualified private plan. In the latter case, we are referring to the possibility of allowing physicians in HMOs and other private plans to charge beneficiaries amounts in excess of plan rates and above the maximum 120 percent limit in current Medicare. Loss of this important patient protection would, in our view, be a major retreat from a longstanding commitment to vulnerable beneficiaries -- most of whom live on annual incomes of less than \$25,000. ANA urges the Committee to extend the balance billing protections in current law to private plans that desire to participate in the program.

Maintaining the Workforce

ANA believes that one of the most critical components of the delivery system consists of the health professionals responsible for the delivery of care. Without the proper number and mix of the professional skills, the quality of care for all Americans will be in jeopardy. There is considerable evidence that some segments of the restructuring and consolidation of the delivery system seen today is resulting in inappropriate staffing

reductions and an alarming decline in the skill mix in health facilities. To save money, many hospitals are replacing registered nurses with less trained and unlicensed assistive personnel, nurses aides or patient care assistants. In addition, some of these actions have been taken without adequate notice or efforts to assist dislocated staff, risking the health and safety of patients and the security of practitioners and their families.

The hospital industry is in a state of massive restructuring wherein hospitals are changing the way they operate, the way care is delivered, and the way their employees are utilized because many managed care systems are forcing them to focus exclusively on the "bottom line." To maximize profits, hospitals are reducing nurse staffing by increasing nurses' workloads and replacing them with unskilled workers. The utilization of these unskilled workers to do nursing jeopardizes the safety and quality of patient care in hospitals. ANA has proposed legislative language that would provide information to the health care consumer on the "quality" of nursing care in all health care institutions. Specifically, ANA would propose that any Medicare restructuring proposal include a requirement that:

- ♦ all hospitals be required to report their RN staffing and patient outcomes data to the general public and that those institutions and agencies create quality report cards for hospitals and other health care systems for consumers to include data on RN staffing, mortality rates, infection rates, lengths of stay, readmissions, malpractice, and other safety and quality issues.

In addition, the nursing staffs of hospitals are bearing a large share of the professional and financial pain of adjustments in inpatient capacity. Nurses who remain in the inpatient setting are expected to assume larger patient loads and additional duties. Those who are dismissed often receive no assistance or counseling in continuing their professional careers. ANA believes that all payers -- including Medicare -- should share in the costs of providing for changes in the workforce. Such assistance should include costs associated with clinical training in ambulatory sites for advanced nurse practitioners and in re-training of nursing professionals to meet other workforce needs.

While we note the inclusion of additional workforce funds for graduate medical education, ANA strongly recommends that clinical programs for the education of advanced practice nurses be eligible for such support. This will ensure that we can establish and maintain clinical education programs in settings where primary and preventive care is delivered. In addition, there is a need for funds to support re-training health professionals for careers where there are documented workforce shortages.

Promoting Primary Care, Preventive Care, and Community-Based Care

ANA has long been committed to the value of primary and preventive care. We believe there is now clear and convincing evidence of the cost-effectiveness of such care. Certainly, increasing the role of managed care in the Medicare program has the potential for expanding access to these services. However, we assume that very large numbers of beneficiaries are likely to remain in the traditional Medicare program. Current Medicare benefits related to primary and preventive care are limited to a few limited services -- for example, mammograms; pap smears; and pneumonia and influenza vaccinations.

One of our primary concerns with all of the Medicare restructuring proposals currently being discussed is that they all perpetuate what is wrong with the medical model. Although Medicare has contributed to a dramatic decline in poverty and an improvement in health status among the nation's elderly, further steps could be taken to reduce costs in the Medicare program by re-orienting from the illness model of Medicare to a wellness model of health care. Health care should be focused on a broad scope of quality health services, not just the treatment of disease. Community-based clinics, health education, home-based care, and public health initiatives are important steps

toward addressing the growing need for better and more accessible health care services over the long-term. By including services that are geared toward preventing and minimizing disease, and coordinating the appropriate level of care indicated and existing services within our nation's communities, health care plans can save immense amounts of money as well as ensure a healthier population. One of the clearest examples of preventive care saving long term costs in the health care system is the early intervention and identification of decubitus ulcers (bedsores). Numerous studies have shown that a perceptive nursing assessment and early identification of individuals at risk to develop serious bedsores can prevent grave and even life-threatening consequences. Similar studies can demonstrate cost savings of preventive care for other conditions common in the elderly population.

We would like to draw your attention to a Medicare demonstration project currently funded by the Health Care Financing Administration. The Community Nursing Organization (CNO) is a three-year national demonstration, enacted as part of the Omnibus Budget Reconciliation Act of 1987 and first funded in the 1992-1993 Federal budget. Four sites were selected and are functioning today: Carle Clinic in Urbana, Illinois; Carondelet Health Care in Tucson, Arizona; the Visiting Nurse Service in Long Island City, New York; and the Block Nurse Program in St. Paul, Minnesota. The demonstration, a capitated model of nurse-managed health care, provides community-based health services to the elderly at a predictable, and controlled rate by utilizing registered nurses as health educators and care coordinators.

Patients and families enrolled in CNOs fall into two categories:

- (1) well-elderly persons who wish to maintain health and reduce risk; and
- (2) persons likely to be frequent users of hospital and ambulatory services or who are at risk of poor quality outcomes.

By combining the financing and delivery of health care services to the elderly in one package, the CNOs provide mechanisms for addressing patients needs in an environment of shrinking resources. To date, the CNOs have demonstrated that they provide:

- ♦ extremely high enrollee satisfaction
- ♦ overall lower costs than initially projected
- ♦ decreased traditional Medicare home care costs
- ♦ more cost-effective mix of services
- ♦ shorter duration of traditional Medicare home care
- ♦ utilization of less expensive equipment

The CNOs are one example of how a wellness model and nursing management of care can be incorporated into the Medicare health care delivery system to save money, to provide quality care, and to prevent illness among our nation's elderly.

ANA urges the Committee to consider expanding the current benefit package to include coverage for other preventive benefits with documented cost-effectiveness. While there would be some initial costs associated with these services, the long-term benefits to individuals and the program would offset these and provide a real return on the investment in terms of better patient outcomes and lower health care costs.

Conclusion

Mr. Chairman, the American Nurses Association recognizes the enormous challenges you and your Committee face in assuring the future of Medicare and protecting the interests of the 37 million beneficiaries who rely on it for access to care and their economic security. We believe a more modest package of program reforms is called for to meet the short-term threats to the solvency of the Part A Trust Fund and to bring Medicare spending more in line with growth in the Federal budget. We are anxious to work with the Committee to achieve these goals in a manner that assures the quality and

During its June 1995 meeting, ANA's House of Delegates adopted a resolution to guide the maintenance of a working Medicare system for the health of the entire nation. That resolution provides that:

- ♦ ANA will continue to advocate for a more cost-efficient Medicare program that stresses prevention and early intervention and Medicare must provide access to a full range of quality health care providers, including RNs, and services must be available in community settings. Redirection of Medicare funds must include funding for graduate nursing education;
- ♦ ANA will continue to advocate that Medicare include and incent advanced practice nurses as autonomous independent providers;
- ♦ Any savings realized from restructuring Medicare must be reinvested in expansion of coverage and benefits package for uninsured populations;
- ♦ ANA's legislative language for public disclosure of staffing and quality data must be utilized as a method of insuring that quality care is delivered when federal dollars are used and when appropriate included in any conditions of participation;
- ♦ Medicare must remain an affordable, accessible social program. ANA opposes the use of vouchers or Medical Savings Accounts as alternatives to providing increased access or a standard benefits program under Medicare; and
- ♦ Medicare must maintain at least the basic set of benefits now available and ANA will oppose any large scale cuts in Medicare, particularly in the absence of adequate quality enforcement mechanisms.

Thank you for this opportunity to present our concerns and recommendations on the "Medicare Preservation Act of 1995". The American Nurses Association looks forward to having the opportunity to work with the Committee as this proposal continues to be developed.

STATEMENT OF AMERICAN SOCIETY OF INTERNAL MEDICINE

1 The American Society of Internal Medicine, representing this nation's largest medical specialty,
2 appreciates this opportunity to share with the committee its views on the Medicare Preservation Act
3 (MPA). Doctors of internal medicine care for the largest proportion of Medicare beneficiaries and,
4 thus, our members are deeply concerned about any changes to this program that may affect our
5 patients' access to high quality health care.

6
7 Expanding Choices and Competition

8
9 The fundamental approach outlined in the summary document distributed last week, which is to offer
10 Medicare beneficiaries a wider range of competing health plans, is consistent with ASIM's own
11 proposals for keeping Medicare affordable. In particular, ASIM commends the leadership for
12 including provisions that would make it easier for physician-sponsored health plans to contract
13 directly with the Medicare program without an insurance intermediary and that provide for standards
14 recognizing the important differences between provider-directed plans and insurance companies.
15 ASIM also supports the proposed changes in the antitrust law, including replacement of the "per se"
16 rule on price discussions with a "rule of reason" standard.

17
18 In its own proposal for Medicare restructuring, ASIM made a number of recommendations for
19 improvements that can be made immediately in Medicare's risk contracting program. Those changes
20 in the Medicare Preservation Act with which ASIM agrees include the adoption of an open enrollment
21 period for health plans, improvements in the risk contract plan payment methodology, preservation
22 of the current Medicare benefits package and maintenance of standards governing guaranteed
23 acceptance, appeal rights and other consumer protections. ASIM also applauds the expansion of
24 these standards to require HHS to provide information to beneficiaries that will enable them to make
25 informed choices in selecting a health plan and that provide a certain level of due process for
26 physicians terminated from a health plan. ASIM believes that changes such as these will foster
27 competition based not on risk selection but on quality of care delivered and will make Medicare more
28 accurately reflect the health delivery system environment in which most Americans participate today.

29
30 Fee Schedule Improvements

31
32 ASIM particularly wants to commend the committee for including in its plan a budget neutral single
33 conversion factor for the Medicare fee schedule and replacement of the current volume performance
34 standard with growth targets based on gross domestic product plus two percent. We urge that this
35 budget neutral conversion factor be retained during the markup. As the committee knows, the MVPS
36 and separate conversion factors for surgery, primary care and non-surgery have served to distort the
37 original intention of physician payment reform and have actually worked to the detriment of primary
38 care, the very services payment reform was meant to assist in order to preserve patients' access to
39 these vital services. Indeed, each year, the updates resulting from the separate conversion factors
40 and MVPS have only amplified the inequity in payments between primary care and other services.
41 The summary of the Medicare Preservation Act which ASIM has reviewed does not specify an
42 implementation date for this change and makes reference only to upper and lower limits being placed
43 on annual adjustments to "ensure reasonable updates and to reduce volatility." ASIM urges the
44 committee to clarify in the legislative language that the implementation date for the single conversion
45 factor will be January 1, 1996, and to specify a lower limit on annual updates to the conversion factor
46 to assure that the updates remain reasonable.

47
48 ASIM also wishes to express its support for the MPA's replacement of the volume performance
49 standard with updates based on gross domestic product (GDP) plus two percentage points. This
50 move has been endorsed by the Physician Payment Review Commission and ASIM believes it is a
51 sound one.

52
53 Improvements in Physicians' Practice Environment

54
55 ASIM is pleased that the Medicare Preservation Act includes several provisions that will make
56 important modifications to the environment in which most physicians practice medicine. For example,
57 the medical liability changes will provide much needed reforms in the tort system without depriving
58 victims of malpractice their just compensation. Among the most important of these liability reforms
59 is the cap on noneconomic damages, which has proven to be successful in reducing health care
60 system costs in states adopting such limits.

61
62 In addition, ASIM congratulates the committee for including significant regulatory relief in the form of
63 changes to the Clinical Laboratory Improvement Act and self-referral laws. We agree with the
64 committee's assessment that CLIA has become "overly regulatory, burdensome, and costly" and that
65 the burden on physician office clinical labs should be lifted. Obviously, the manner in which that
66 burden is lifted is extremely important to physicians and we urge the committee to clarify this further
67 in the legislative language to encompass a complete exemption of physician office laboratories from

1 CLIA requirements.

2
3 Elimination of the Stark II group compensation requirements, streamlining of the designated health
4 services list, as defined in Stark II, and placement of a moratorium on enforcement of Stark II until
5 HHS issues its final regulations take giant strides toward removing some of Medicare's most
6 frustrating rules for physicians. ASIM especially wishes to commend the committee for its modification
7 of the in-office ancillary services exception as defined by HCFA in the Stark I final rule by repealing
8 the "directly supervised" terminology. This means physicians will not have to be present in their labs
9 while all testing done for Medicare patients is being performed. By repealing the site of service
10 requirement, this will allow physicians to provide services at satellite locations convenient to their
11 patients. Finally, ASIM is grateful for the committee's inclusion of a shared facility exemption to the
12 self-referral statute. This necessary exemption has been recognized by Congress on both sides of
13 the aisle for many years and it is unfortunate that its passage has heretofore been delayed due to
14 circumstances unrelated to the merits of these provisions.

15 "Fail Safe" Provisions

16
17
18 While ASIM finds much to commend in the Medicare Preservation Act, there are a number of aspects
19 to this plan about which we would like to raise some cautionary flags. Predicting increases in health
20 spending has never been an exact science. Numerous factors over the years – from advancements
21 in valuable new technologies, to increases in utilization of services for medically necessary reasons,
22 to sudden outbreaks of serious illnesses – have confounded accurate projections of health care
23 spending in this nation.

24
25 ASIM is concerned that creation of predetermined budget targets that will drive automatic reductions
26 in a particular "sector" of Medicare provider payments may have adverse consequences for patient
27 care. As ASIM understands it, the Medicare Preservation Act contains formulae for establishing
28 budget allotments for the fee-for-service side of Medicare and divides those allotments among sectors
29 equal to various types of provider services. If spending in the fee-for-service sector exceeds the total
30 amount budgeted for a year, proportionate reductions will be made the following year in each sector
31 whose spending contributed to the cost overrun. Alternatively, if a particular sector's spending falls
32 below its baseline allotment, its unspent balance will be reallocated among the other sectors.

33
34 Making growth rates category-specific under the fee-for-service side of Medicare, as would be done
35 under the Medicare Preservation Act, should help avoid circumstances in which a sector in which
36 costs are being controlled is placed at risk for overspending in another sector over which it has no
37 or little control. At the same time, ASIM questions the equity in dividing up among the other sectors
38 the unspent balance in a sector that comes in under its budget projection. This provides almost a
39 perverse incentive for a sector to spend as close as possible to its target. Alternatively, allowing
40 some (or all) of the surplus to be returned to that sector for improvements in payments would be a
41 better way to reward those providers at risk for cost efficient delivery of care.

42
43 It is not clear from the conceptual document how the "fail safe" target for the physician sector interacts
44 with the separate recommendation to replace the current VPS formula with a "sustainable rate of
45 growth" based on per capita GDP plus two percentage points, as recommended by the Physician
46 Payment Review Commission (PPRC). This change by itself is projected to hold annual growth in
47 Medicare spending for physicians' services to between 6 and 7 percent per year, according to the
48 PPRC. It is not clear why expenditures on physician services would also need to be subjected to a
49 fail-safe provision. ASIM agrees with the PPRC's concern that this [fail safe] provision may conflict
50 with the mechanism for constraining growth in physician spending. As the policy is further
51 developed, it is important to consider the interaction between the fail safe and the mechanism for
52 constraining growth in spending on physicians' services."

53
54 Although there were few specifics provided in the summary, constraints on spending under Medicare
55 Plus would appear to be in the form of the government contributions, or premium payments to plans,
56 being tied to the growth rates set out for Medicare through 2002. The government contributions,
57 though, are tied in turn to spending under the fee-for-service side of Medicare in that total allotments
58 provided for fee-for-service Medicare in a given year will equal the overall Medicare budget less
59 payments the Secretary estimates will be made under Medicare Plus. These calculations depend to
60 a great extent not only on the accuracy of estimating how many beneficiaries will join Medicare Plus
61 plans and how many will choose to remain in the fee-for-service side of Medicare but the kinds of
62 beneficiaries who opt for one type of Medicare over another. Recent statistics compiled by HCFA
63 indicate that, although the average per beneficiary expenditure under Medicare is approximately
64 \$4000, for ten percent of beneficiaries the average expenditure is somewhat over \$28,000. If most
65 of the latter group of beneficiaries choose to remain in Medicare fee-for-service while healthier
66 beneficiaries join Medicare Plus plans, this could have a significant impact on the actual spending
67 experience of the two sides of Medicare. As the chair of the Physician Payment Review Commission,

1 Gail Wilensky, noted in her testimony to this committee last week, adverse risk selection between the
2 fee-for-service side of Medicare and Medicare Plus could activate the fail safe mechanism leading to
3 cuts in provider payments and possible reductions in beneficiaries' access to services.
4

5 ASIM recognizes the need for controlling costs in the growth of Medicare. As the foregoing examples
6 demonstrate, however, setting budget targets so that spending in two vastly different types of
7 Medicare programs meets predetermined limits may have unintended consequences for the system.
8 If spending continually exceeds targets set, despite efforts to root out fraud, waste and abuse and
9 to improve the efficiency of the system, it may be useful not only to identify additional areas where
10 cost savings can be found but also to examine whether the targets were in fact realistic. Rather than
11 giving the federal bureaucracy considerable authority to effect automatic reductions in provider
12 payments, as the Medicare Preservation Act does, ASIM recommends that a commission,
13 independent of the executive branch, evaluate a variety of options for bringing spending in line. If
14 it is the intent of Congress to include some type of "lookback" mechanism that triggers automatic
15 spending cuts in Medicare, ASIM intends to analyze the specific legislative language and offer
16 additional recommendations in the future to make sure that the reductions anticipated are not so great
17 that they make it impossible for physicians to care for Medicare patients and still cover their overhead.
18

19 Conclusion

20
21 Again, we appreciate this opportunity to comment on the Medicare Preservation Act. ASIM will be
22 reviewing all Medicare reform proposals offered by the Congressional leadership to evaluate their
23 consistency with our policy. Our policy promotes widening health plan choices for beneficiaries—
24 including point-of-service plans and physician-sponsored networks (PSNs); reforming antitrust laws
25 to facilitate creation of PSNs; enhancing competition through uniform standards and rules by which
26 plans must abide; removing excessive lab regulations from the practice environment; and providing
27 for a single conversion factor and update formula based on GDP plus two percent.
28

29 ASIM applauds the committee for devising a plan that seeks to involve all stakeholder's in Medicare
30 in resolving the program's financial and operational weaknesses. We offer our commitment to work
31 with Congress to enact reforms in Medicare that will not compromise access to care and will ensure
32 that the program, and the peace of mind it has given the elderly for thirty years, will continue
33 successfully well into the twenty-first century.

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

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Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,



John Champlin, M.D.
154 Panoramic Way
Berkeley, CA 94704

RONALD D. COLEMAN
18TH DISTRICT, TEXAS

COMMITTEE ON APPROPRIATIONS
THE RANKING MEMBER,
SUBCOMMITTEE ON TRANSPORTATION

PERMANENT SELECT COMMITTEE
ON INTELLIGENCE

THE RANKING MEMBER,
SUBCOMMITTEE ON HUMAN INTELLIGENCE,
ANALYSIS, AND COUNTERINTELLIGENCE



Congress of the United States
House of Representatives
Washington, DC 20515

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HEARING IMPAIRED
TTY (202) 225-1804
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STATEMENT OF U.S. REPRESENTATIVE RONALD D. COLEMAN (TX-16)
COMMITTEE ON WAYS AND MEANS
September 22, 1995

I appreciate the opportunity to testify before this Committee on the proposed plan to reform Medicare. I am privileged to represent El Paso, Texas, a community of approximately 600,000 people. Of this amount, almost 60,000 people receive Medicare. In other words, 10% of El Paso's population is on Medicare. That is a significant number. These are significant cuts.

I regret that the Majority has not scheduled more time for hearings nor the ability to review the plan. The Democratic leadership has scheduled additional days of hearings on the only space provided to us, the lawn of the Capitol, so that the American people can have a chance to participate in the process that will affect 37 million of them.

I have had over 500 constituents writing or calling to urge me to oppose these cuts. One constituent writes:

"My wish is that the Democratic Party would hammer on the fact that President Clinton wanted health care reform 2 years ago. . . . The Republican Party bombarded the air waves stating that if it was not broken, don't fix it. It's ironic that the moment the Republicans came into office, health [care] had deteriorated so quickly, that now, the Republicans are the only solution to Medicare."

I could not agree more. Not only has the Republican party opposed the original drafting of this legislation, but they have continued to be antagonistic towards its existence for years. Now after providing only an outline, we are supposed to realistically debate the Republican effort "save" Medicare in one day? I have the same trouble believing this as my constituent does.

However, I will limit my comments to the minor details I am aware of regarding this plan.

Part B Premiums

First and foremost is my problem with the increase in Part B premiums. The plan calls for a continuation of the 31% premium instead of dropping the level to 25% as current law now dictates. This allows for an increase of almost \$700 a year by 2002.

Not one penny of this increase will go towards the Part A trust fund. This increase will only go towards the general fund and can be used to balance the budget while giving a \$245 billion tax cut to the wealthy.

Choice

The outline states that it offers a choice to seniors in the type of health care organization they would like to become a part of without limiting their ability to stay in the traditional Medicare program.

However, the different choices available to seniors have not been subjected to a test to determine if they will save any money. And plans such as Medical Savings Accounts and HMO's are only viable options for wealthy and relatively healthy senior citizens. Therefore, these "options" are only available to the few seniors who fit that description.

Waste, Fraud, and Abuse

Waste, fraud and abuse is the single biggest concern of my constituency regarding Medicare. I have spoken to many El Pasoans and, by far, the largest complaint regarding Medicare I have heard is "Stop the waste and fraud and you will find the money to support Medicare."

The Republican plan offers only 3 minor initiatives, a "hotline", making nursing facilities provide cost estimates, and stiffer penalties for those found guilty of fraud.

Again, there is no estimate on how much these programs will actually save and these measures are not comprehensive enough to deal with the entrenched problem of fraud and abuse throughout the system.

Effect on Hospitals and Providers

The plan also contains significant changes in assistance to health care providers. I had previously sent a letter to El Paso hospitals outlining the possible changes that might occur under this plan and asked them to illustrate how these changes might effect the day to day functioning of their hospitals. I would like to illustrate the destructive change this plan would have by reading one of those letters:

"Expected Effects to ... as a Result of Medicare and Medicaid Reductions:

Staffing:

If funding is not available, ... would face the very real possibility of staff reduction by as much as 992 positions during the 7 year period. We would lose \$31,982,080 over the next 7-year period for the El Paso economy.

Clinics:

Our clinics currently operate five days a week. The reductions would force a 50% cutback in operations to 2.5

days a week.

Reduction in Services:

The hospital district's mandate is to care for indigent patients and we do not believe that we could eliminate basic services. A reduction in both Medicare and Medicaid dollars would lead to a rationing of resources that would be manifested in a number of ways:

1. Eliminate Level One Trauma Services;
2. Reduction of Pharmacy, Physical Therapy and all other outpatient services;
3. Frequent delays in all inpatient services throughout every area of care.
4. Elimination of elective cases in the operating room and reserving the operating room for emergencies only. This would lead to less funding support to the rest of the hospital and create a greater need for tax payor [sic] support.
5. Our current funding for Physician Service totaling \$5,000,000 could be reduced by as much as 50% causing us to care for mainly indigent care patients.
6. Residency Programs: Our current funding of 148 residents would be reduced by as much as 60% or to only 59 residents. This sets the pattern for future physician shortages.

The above possibilities could eliminate all funded patients, putting greater risk on the tax base. All planned admissions could be delayed and the hospital could become one giant emergency room and triage hospital."

This is just one example of the type of destructive impact this plan would have on our community. I have received similar letters from all the other hospitals in El Paso.

Means Testing

The plan also proposes to charge seniors with incomes over \$75,000 for individuals and \$150,000 for couples higher premiums. Again, these premiums will not put one penny in the Part A trust fund. However, this revenue will go directly into the general fund. Means testing in this form is unnecessary.

Fail Safe Provision

The entire Republican budget plan rests on their ability to provide \$270 billion in savings from the Medicare program. However, the plan falls short of these savings by \$90 billion. Yesterday, Newt Gingrich said he was afraid that his own CBO would "substantially underscore" the savings he believed could be accomplished by using HMO's and other provider plans.

If the CBO cannot come up with the magic numbers Speaker Gingrich wants, where do you think they will come from? From the 37 million beneficiaries that Medicare now serves!

Aware that this plan may not total the \$270 billion, it includes a "fail safe" provision that will allow future bureaucrats to

make additional cuts.

This hidden provision subjects beneficiaries to unknown future liability. If future decisions expose health care providers to additional cuts, they may pass the cost directly to the beneficiary or drop out of the program altogether. This would mean that even after paying more money for less services this year, seniors would be asked to do the sacrifice again, sometime in the next seven years, to achieve the same savings the original plan proposed and have a choice of much fewer providers.

This plan is the wrong way to achieve the savings that Medicare needs. This plan allows the Republicans to attempt to balance the budget while giving a huge tax break to the most wealthy Americans on the backs of senior citizens and the disabled. It is wrong.

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

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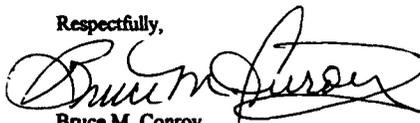
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I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,



Bruce M. Conroy
565 Bernice Ln.
Martinez, CA 94553.

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Respectfully,



Cesar B. Court, MFCC
4309 Foothill Way
Pittsburg, CA 94565

TESTIMONY
 THE HONORABLE ROSA L. DELAURO
 BEFORE THE COMMITTEE ON WAYS AND MEANS
 SEPTEMBER 22, 1995

THANK YOU CHAIRMAN ARCHER AND RANKING MEMBER GIBBONS FOR PROVIDING ME WITH THIS OPPORTUNITY TO TESTIFY TODAY. I AM GRATEFUL TO THE COMMITTEE FOR REVERSING ITS EARLIER DECISION REJECTING MY REQUEST TO TESTIFY. I WAS DELIGHTED TO GET YOUR INVITATION LAST NIGHT.

1. INADEQUATE AMOUNT OF HEARINGS

AT THE OUTSET, I NEED TO RESPECTFULLY EXPRESS MY DISAGREEMENT WITH THE COMMITTEE'S PROCESS.

MEDICARE IS A LIFELINE FOR OUR NATION'S SENIORS. THE CHANGES BEING PROPOSED ARE -- WITHOUT QUESTION -- THE MOST SIGNIFICANT IN THE 30 YEAR HISTORY OF THE PROGRAM. THE AMERICAN PEOPLE DESERVE A FULL DISCUSSION OF THE VAST AND DEVASTATING CUTS PROPOSED IN THIS BILL BECAUSE THEY WOULD MAKE SUCH A TREMENDOUS IMPACT ON THE LIVES OF OUR NATION'S SENIOR CITIZENS.

YET THE COMMITTEE IS CHOOSING TO HOLD ONLY ONE DAY OF HEARINGS ON THIS PLAN WHICH WILL DRAMATICALLY CHANGE THE LIVES OF AMERICA'S ELDERLY.

IT IS INSTRUCTIVE TO NOTE, BY COMPARISON, THAT BACK IN 1965 THERE WERE FOUR WEEKS OF HEARINGS ON THE BILL ESTABLISHING THE MEDICARE PROGRAM.

IN THIS CONGRESS, THERE HAVE BEEN 28 DAYS OF HEARINGS ON WHITEWATER. TEN DAYS OF HEARINGS ON WACO. AND TWO WEEKS OF HEARINGS ON RUBY RIDGE -- WITH MORE TO COME. DOES THE COMMITTEE BELIEVE THAT THESE MATTERS ARE MORE CONSEQUENTIAL TO THE AMERICAN PEOPLE THAN SLASHING \$270 BILLION FROM MEDICARE?

ALONG WITH 201 OTHER MEMBERS OF THE HOUSE, I AM A COSPONSOR OF THE RESOLUTION OFFERED BY DEMOCRATIC LEADER RICHARD GEPHARDT AND CHAIRMAN JOHN DINGELL CALLING FOR FOUR WEEKS OF PUBLIC HEARINGS ON THE REPUBLICAN MEDICARE PLAN.

SO ALTHOUGH I AM GRATEFUL FOR THE OPPORTUNITY TO TESTIFY HERE TODAY, I DO NOT WANT MY PRESENCE HERE SEEN IN ANY WAY AS CONDONING THE RAILROADING OF MEDICARE CUTS THROUGH THE CONGRESS.

2. LEGISLATION STILL HAS NOT BEEN PRODUCED

EVEN IF A SINGLE DAY OF HEARINGS ON THIS MATTER WAS ADEQUATE FOR A FULL PUBLIC DEBATE, I WOULD STILL BE CONCERNED THAT RAMMING THESE DRAMATIC MEDICARE CUTS THROUGH THE PROCESS IN THE DEAD OF NIGHT IS A DISSERVICE TO THE AMERICAN PEOPLE.

BECAUSE EVEN TODAY, WE DO NOT HAVE LEGISLATION. THE OUTLINE RELEASED IS ONLY THAT: A VAGUE OUTLINE WITH MOST OF THE IMPORTANT DETAILS UNDEFINED.

WE HAVE NO TABLE OR PRELIMINARY ESTIMATE FROM THE CONGRESSIONAL BUDGET OFFICE.

THE PART B PREMIUM IS NOT SPECIFIED.

THE ALLOCATION OF THE "FAIL SAFE" SPENDING LIMIT IS NOT DEFINED, THUS MAKING IT IMPOSSIBLE TO ANALYZE THE IMPACT ON DIFFERENT TYPES OF PROVIDERS.

3. \$270 BILLION IN CUTS UNNECESSARY TO FIX MEDICARE

NOT ONLY IS THE PLAN BEFORE US INCOMPLETE, ITS UNDERLYING PREMISE IS WRONG.

ALTHOUGH MY REPUBLICAN COLLEAGUES CLAIM MEDICARE FACES SOME SUDDEN AND UNPRECEDENTED CRISIS, THE CUTS THEY PROPOSE ARE FAR IN

EXCESS OF WHAT IS NECESSARY TO ENSURE THE MEDICARE TRUST FUND'S SOLVENCY.

ALLOW ME TO QUOTE FROM A LETTER DATED YESTERDAY, SEPTEMBER 21, FROM TREASURY SECRETARY ROBERT RUBIN WHO ALSO SERVES AS MANAGING TRUSTEE OF THE MEDICARE HOSPITAL INSURANCE TRUST FUND. MR. RUBIN SAYS,

"NO MEMBER OF CONGRESS SHOULD VOTE FOR \$270 BILLION IN MEDICARE CUTS BELIEVING THAT REDUCTIONS OF THIS SIZE HAVE BEEN RECOMMENDED BY THE MEDICARE TRUSTEES OR THAT SUCH REDUCTIONS ARE NEEDED NOW TO PREVENT AN IMMINENT FUNDING CRISIS. THAT WOULD BE FACTUALLY INCORRECT."

ADDITIONALLY, NOT ONE DIME OF THE PROPOSED INCREASE IN MONTHLY MEDICARE PREMIUMS WILL GO INTO EXTENDING THE LIFE OF THE TRUST FUND. AS YOU KNOW, IT IS ONLY THE MEDICARE PART A TRUST FUND THAT FACES INSOLVENCY. INCREASING PART B PREMIUMS DO NOT CONTRIBUTE TO THE SOLVENCY OF THE PART A TRUST FUND. THEREFORE, I MUST ASSUME THAT BILLIONS IN MEDICARE CUTS ARE BEING USED FOR SOME OTHER PURPOSE WHICH TAKES ME TO MY FINAL POINT.

4. MEDICARE CUTS SHOULD NOT PAY FOR TAX CUTS
IN THE JULY 28TH WALL STREET JOURNAL, THE SENATE FINANCE COMMITTEE CHAIRMAN SAID THAT FAILURE TO AGREE ON MEDICARE CUTS ENDANGERED THE TAX CUTS PROPOSED BY REPUBLICANS IN CONGRESS.

THE FINANCE COMMITTEE CHAIRMAN CANDIDLY LINKED THE MEDICARE CUTS TO THEIR TRUE PURPOSE: PAYING FOR A HUGE TAX BREAK FOR PEOPLE WHO NEED THEM THE LEAST. WITHOUT THESE DRASTIC CUTS IN MEDICARE, REPUBLICANS SIMPLY WOULD NOT HAVE THE MONEY TO PAY FOR \$245 BILLION PACKAGE OF TAX GIVE-AWAYS TO THE WEALTHIEST PEOPLE IN THIS COUNTRY.

IT IS WRONG TO DEMAND THAT MEDICARE BENEFICIARIES PICK UP THE TAB FOR TAX BREAKS TO THE MOST PRIVILEGED PEOPLE IN OUR SOCIETY.

IN CLOSING MR. CHAIRMAN I URGE THAT THE COMMITTEE HOLD ADDITIONAL HEARINGS ON THE LEGISLATION AFTER IT HAS BEEN WRITTEN. FAILING THAT I URGE THE REJECTION OF THIS BILL WHICH RAIDS THE MEDICARE TRUST FUND -- NOT TO FIX IT -- BUT TO PROVIDE A TAX BREAK FOR THE PRIVILEGED FEW.

THANK YOU.

STATEMENT OF STANLEY B. BENJAMIN, M.D.
PRESIDENT, DIGESTIVE DISEASE NATIONAL COALITION

Mr. Chairman and members of the committee, thank you for the opportunity to present the views of the Digestive Disease National Coalition (DDNC) regarding Medicare reform, specifically, Medicare coverage of colorectal cancer screening.

The DDNC is comprised of 23 national voluntary and professional organizations concerned with a broad range of digestive diseases. The Coalition has as its goal a desire to improve the health care of millions of Americans who suffer from one of the many conditions, both acute and chronic, which effect the digestive tract.

One of the most common, and fatal, digestive disorders is colorectal cancer. Colorectal cancer is the second leading cause of cancer death in the United States with 155,000 new cases reported each year. The death rate from a diagnosis of colorectal cancer approaches 60%. Colorectal cancer accounts for over half (1/2) of the 80,000 ostomy operations (a surgical procedure leaving the a patient with an appliance to collect body wastes) performed each year, resulting in an annual expenditure of \$1 billion. Anyone can get colorectal cancer, it is more common than either breast or prostate and cancer, and strikes men and women in almost equal numbers.

Despite these staggering statistics, colorectal cancer screening is not currently reimbursable for Medicare patients, even though advanced detection and prevention strategies have rendered colorectal cancers almost entirely preventable. Mr. Chairman, we know that early detection saves lives and saves health care resources. Diagnosis of colorectal cancer in an early localized stage translates into a 5 year survival rate of 93% for colon cancer and 87% percent for rectal cancer. Early detection not only improves the quality of life for patients but is much more cost effective than providing complex, expensive medical care to individuals in the later stages of the disease.

Every major Federal employee health plan recognizes the importance of colorectal screening procedures and provides coverage for these treatments. However, although the average age at the time of diagnosis is 71, Medicare still does not cover colorectal screening and prevention services.

Mr. Chairman, the DDNC supports HR 922, " The Colon Cancer Screening and Prevention Act", introduced on a bipartisan basis by Congressman Cardin. This important legislation addresses the problem of Medicare reimbursement for colorectal preventive services by extending Medicare coverage to include two colorectal screening tests at annual intervals.

Specifically, HR 922 would enable early detection of colorectal cancers by providing for an annual fecal occult blood test (FOBT). This is a non-invasive procedure, with an average cost of only \$5, that helps reduce the risk of death from colorectal cancer by between 33 and 43%. Second, Congressman Cardin's bill includes benefit coverage of a flexible sigmoidoscopy examination, which enables a doctor to inspect the lower part of the colon where 50 to 60% of polyps and cancers occur. Finally, this legislation permits individuals at high risk to receive a screening colonoscopy exam no more than once every two years. This procedure allows examination of the entire colon and, if necessary, biopsy and removal of suspicious polyps, which are the precursors to almost all colon cancers.

The DDNC, in collaboration with the American Cancer Society, the American Nurses Association, the American Medical Association, and several other health care advocacy organizations enthusiastically support Congressman Cardin's bill. I strongly encourage all members of this distinguished committee to incorporate the Medicare screening provisions of HR 922 in your comprehensive Medicare reform legislation. In addition, because the methods utilized for periodic screening and diagnosis vary, depending upon determination of the patient's risk category and current medical knowledge, the DDNC recommends that federal policy be flexible enough to allow the discretion of the health care professional, in consultation with the patient, to make the final decision on the screening technique to be employed. Coverage should reflect that discretion, and should allow for the most appropriate screening method.

Mr. Chairman, I believe it is apparent that providing Medicare coverage for colorectal cancer screening is consistent with this committee's goal of slowing the growth of Medicare spending. By extending Medicare coverage to include testing procedures, the federal government will give America's seniors (the most at-risk segment of the population) a financial incentive to be tested, and in the long run, save Medicare dollars.

Once again, Mr. Chairman, thank you for the opportunity to present the Digestive Disease National Coalition's views on Medicare coverage for colorectal cancer screening. It is our sincere hope that this committee recognizes the medical and economic advantages of colorectal cancer screening and extends Medicare coverage to include these vital procedures. To do less would deprive those who run the greatest risk of developing colorectal cancer the same opportunity to live a disease-free life as any other American.

September 19, 1995

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Respectfully,



Jayne Elliott
2500 Alhambra Ave.
Martinez, CA 94553

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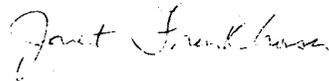
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Janet Frankhouser, RN
118 Silvey Acres Dr.
Vacaville, CA 95688

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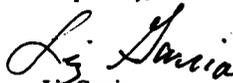
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Liz Garcia
2228 Colonial Ct.
Walnut Creek, CA 94598

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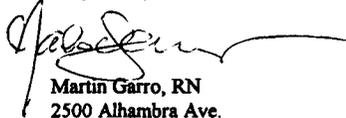
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Respectfully,

A handwritten signature in black ink, appearing to read "Martin Garro", with a long horizontal flourish extending to the right.

Martin Garro, RN
2500 Alhambra Ave.
Martinez, CA 94553

529 Walden Circle # 104
Boulder, CO 80303
Sept. 22, 1995

Mr. Phillip Mosley
Chief of Staff
Committee Ways & Means
1102 Longworth Bldg.
Washington, D.C. 20515

Dear Mr. Mosley,

Formulating a program to control costs and growth of Medicare costs is a very difficult undertaking. As a U.S. citizen who is on Medicare, I would like to express my opinion with the following suggestions:

- 1) Medicare should be means tested - change according to ability to pay, with Medicaid reserved for people of very low ~~or~~ no income.
- 2) Supplemental Medi-Gap insurance should also be paid for on a sliding scale.
- 3) Ho thousands of dollars spent in the last weeks of a terminally ill patient's life- have Hospice provide comfort and pain control.
- 4) Naturopaths and homeopaths should be included in the Medicare system, since many patients prefer to go to these types of practitioners with good results and emphasis on preventive care.
- 5) More home care instead of nursing home care when appropriate.
- 6) Studies made to determine whether current treatments and medications actually do what they claim.
- 7) Control fraud, simplify paperwork.
- 8) More choice for people- managed care is the opposite of free choice.

Thank you for your attention. I hope Congress will come up with Medicare reform that will not hurt the elderly.

Yours truly,

Mrs. Dorothy Goldfarb
Mrs. Dorothy Goldfarb

**Medicare Hearing
Testimony of Mr. Bob Rug, Milford CT
September 22, 1995**

Thank you Congressmen and Congresswomen.

I am here today to protest the cuts to Medicare. This is a very important issue affecting senior citizens all over our country. I have spoken to many senior citizens in my town and surrounding areas. They are all very concerned.

Some are living just above the poverty level.

They have high prescription drug costs, that are not covered by Medicare.

Their Cost of Living Adjustment (COLA) increase last year was 2.6% which was offset by increased Medicare premiums.

This 2.6% COLA increase is figured on the Consumer Price Index, and now Congress wants to refigure that, which means COLAs for seniors will be less.

Is this the way we should be treating our senior citizens? Who paid their taxes all their lives, and who fought wars for this country? So you and I can live in freedom?

I don't think so.

It is not fair to balance the budget on the backs of our senior citizens. I am sure there are other ways to balance the budget.

I want to give you a general overall view of my yearly income and expenses, so you will know what I am talking about.

I am a retired tax accountant. My wife and I receive social security. To supplement my income, I do some tax work for four months out of the year. My total annual income for my wife and I to live on is \$27,500. After we pay for our "essential expenses" like food, shelter, health care and prescription drug costs, amounting to nearly \$20,000 per year, we have less than \$7,000 left. We need the \$7,000 to pay for vital costs like clothing, car repairs and other incidental costs.

If the Republican Medicare plan passes and we are forced to pay twice as much for Medicare premiums, I don't know how we are going to afford it.

I sincerely think if you have to increase Medicare premiums, without adding any additional benefits then there should be a cut off. It should be increased on those who can afford it.

There should be an exemption for seniors, like myself, who are on a fixed income and cannot afford a doubling of our premiums.

In other words, I think, it should be increased on a single person earning over \$25,000 per year or a couple earning \$32,000 per year. Just like our tax laws are set up regarding taxes on social security.

Members of Congress, I hope you give this a lot of consideration when you cast your vote. The Medicare program serves 41 million Americans. Let me leave you with one thought. What happened to the government that was by the people and for the people?

I want to thank you very much for allowing me to come here today and voice my views to you.

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Archer:

As a health provider in the Contra Costa County health delivery system, and as a California tax payer, I am highly concerned about the proposed cuts in Medicare and Medicaid Programs.

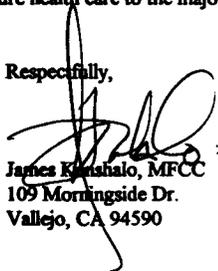
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Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,



James K. Kishalo, MFCC
109 Morningside Dr.
Vallejo, CA 94590

September 19, 1995

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Respectfully,


Linda Kirkhorn, L.C.S.W.
2335 Corona Ct.
Berkeley, CA 94708

Lake Geneva Financial Services Corp.

910 N. Elm Grove Road, Suite 26 • 414-796-0101
P. O. Box 671, Elm Grove, WI 53122-0671 • 800-236-1101

September 21, 1985

Mr. Philip Mosley
Committee on Ways and Means
U. S. House of Representatives
1102 Longworth Building
Washington, DC 20515

Re: Medicare

Congressmen:

As a result of my extensive experience in the Medicare Supplement Insurance business, both with our clients and the clients of the agencies we service, I am convinced that one of the single major problems with Medicare is the administrative cost plus the cost it imposes upon the insurance carriers who supplement Medicare.

All Medicare claims must be processed twice, both by Medicare and the insurance carrier.

When we consider that the cost to the carrier to issue a check is in the \$25 to \$50 range, and the government's cost is probably in the same range; the cost to process many claims is many times the actual claim cost.

One way to avoid this administrative duplication, would be to turn the entire system over to the private carriers.

I know that sometimes the large carriers suffer the same bureaucratic problems as those plaguing the government. However, they would be forced to "keep their house in order" by the competition factor.

If someone does not like their supplement carrier, there are 6 to 12 others available. If the individual has a problem with Medicare, there is no place else to go.

Enclosed are several samples of these very small claims processed by both Medicare and the carrier.

Sincerely,

LAKE GENEVA FINANCIAL SERVICES CORP.


C. A. Roloff
President

CONTINENTAL GENERAL INSURANCE COMPANY * PHONE (402)397-3200
 8901 INDIAN HILLS DRIVE * P O BOX 247007 OMAHA, NEBRASKA 68124-7007 A

INSURED NAME PIERCE, ELIZABETH I PATIENT NAME ELIZABETH
 POLICY NUMBER 350-2411549 CLAIM NUMBER 427718

BENEFIT DRAFT WAS MAILED DIRECTLY TO: MILW RADIO LTD SC
 FDR \$1.91 DRAFT#8182650

MR CHARLES A ROLOFF
 PO BOX 671
 ELM GROVE WI 53122-0671

PROVIDER / SERVICE DATES	BILLED AMOUNT	ALLOWED CHARGES	MEDICARE PAID	PAY AT 100 %	PAY AT 100 %	SEE COMMENTS	NON COVERED
MILW RADIO LT 6/24/95 -	22.75	9.54	7.63	0.00	1.91A	13.21B	0.00

TOTAL.....	22.75	9.54	7.63	0.00	1.91	13.21	0.00
PAYABLE AT.....				100 %	100 %		
AMOUNT PAYABLE.....				0.00	1.91		
TOTAL PAYMENT.....						1.91	

- * COMMENTS *
- (*) STOP THE PAPERWORK! YOUR PART B CLAIMS ARE RECEIVED ELECTRONICALLY FROM MEDICARE. YOU NO LONGER NEED TO SUBMIT PART B PAPER CLAIMS.
 - (A) OUR PAYMENT, COMBINED WITH MEDICARE'S, PAYS THIS BILL IN FULL.
 - (B) PROVIDER WRITEOFF - YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT.

PATIENT ID# 200519
 1 AUDITED BY: EDI/NRX 8/11/95

CONTINENTAL GENERAL INSURANCE COMPANY * PHONE (402)397-3200
 8901 INDIAN HILLS DRIVE * P O BOX 247007 OMAHA, NEBRASKA 68124-7007 A

INSURED NAME PIERCE, ELIZABETH I PATIENT NAME ELIZABETH
 POLICY NUMBER 350-2411549 CLAIM NUMBER 427718

BENEFIT DRAFT WAS MAILED DIRECTLY TO: FAMILY MEDICINE ASSOC
 FOR \$10.79 DRAFT#8182654

MR CHARLES A ROLOFF
 PO BOX 671
 ELM GROVE WI 53122-0671

PROVIDER / SERVICE DATES	BILLED AMOUNT	ALLOWED CHARGES	MEDICARE PAID	PAY AT 100 %	PAY AT 100 %	SEE COMMENTS	NON COVERED
FAMILY MEDICI 7/14/95 -	71.00	53.97	43.18	0.00	10.79A	17.03B	0.00

TOTAL.....	71.00	53.97	43.18	0.00	10.79	17.03	0.00
PAYABLE AT.....				100 %	100 %		
AMOUNT PAYABLE.....				0.00	10.79		
TOTAL PAYMENT.....					10.79		

- * COMMENTS *
- (*) STOP THE PAPERWORK! YOUR PART B CLAIMS ARE RECEIVED ELECTRONICALLY FROM MEDICARE. YOU NO LONGER NEED TO SUBMIT PART B PAPER CLAIMS.
 - (A) OUR PAYMENT, COMBINED WITH MEDICARE'S, PAYS THIS BILL IN FULL.
 - (B) PROVIDER WRITEOFF - YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT.

PATIENT ID# 87112
 5 AUDITED BY: EDI/NRX 8/11/95

CONTINENTAL GENERAL INSURANCE COMPANY * PHONE (402)397-3200
 8901 INDIAN HILLS DRIVE * P O BOX 247007 OMAHA, NEBRASKA 68124-7007 A

 INSURED NAME MADL, J RICHARD PATIENT NAME J RICHARD
 POLICY NUMBER 350-2223948 CLAIM NUMBER 427640

BENEFIT DRAFT WAS MAILED DIRECTLY TO: CRESTVIEW MEDICAL CLINIC PA
 FOR \$6.62 DRAFT#8177455

MR CHARLES A ROLOFF
 PO BOX 671
 ELM GROVE WI 53122-0671

PROVIDER / SERVICE DATES	BILLED AMOUNT	ALLOWED CHARGES	MEDICARE PAID	PAY AT 0 %	PAY AT 100 %	SEE COMMENTS	NON COVERED
CRESTVIEW MED 7/14/95 -	50.00	33.08	26.46	0.00	6.62A	16.92B	0.00

TOTAL.....	50.00	33.08	26.46	0.00	6.62	16.92	0.00
PAYABLE AT.....				0 %	100 %		
AMOUNT PAYABLE.....				0.00	6.62		
TOTAL PAYMENT.....					6.62		

- * COMMENTS *
- (*) STOP THE PAPERWORK! YOUR PART B CLAIMS ARE RECEIVED ELECTRONICALLY FROM MEDICARE. YOU NO LONGER NEED TO SUBMIT PART B PAPER CLAIMS.
 - (A) OUR PAYMENT, COMBINED WITH MEDICARE'S, PAYS THIS BILL IN FULL.
 - (B) PROVIDER WRITEOFF - YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT.

PATIENT ID# 01624561 J M
 I AUDITED BY: EDI/AAX 8/08/95

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Archer:

As a health provider in the Contra Costa County health delivery system, and as a California tax payer, I am highly concerned about the proposed cuts in Medicare and Medicaid Programs.

It is well known that 8.5 million California residents already are without health care, that there are, in addition, 4 million residents on Medi-Cal, and the population over age 65 is the fastest growing segment of the population.

Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,



Deborah Ledesma
2500 Alhambra Ave.
Martinez, CA 94553

September 19, 1995

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House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

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Respectfully,



Gerald Lutovich, M.D.
579 Sausalito Blvd.
Sausalito, CA 94965

September 19, 1995

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House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

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Respectfully,

A handwritten signature in black ink, appearing to read "Patricia Marlow". The signature is fluid and cursive, with a large loop at the end.

Patricia Marlow, L.C.S.W.
415 Bay St.
Crockett, CA 94525

Orwellian Doublespeak: A Citizen's Guide to the Current Medicare Debate

Jerry L. Mashaw & Theodore R. Marmor

Most of the public discussion of Medicare 'reform', dominated by the peculiar political craziness of deficit reduction and presidential politics, has been about as thoughtful as a food fight. The Republicans, who introduced their plan this week as "The Medicare Preservation Act of 1995, " claim they want to "preserve, protect and strengthen Medicare" by radically changing the program. The language is truly Orwellian: saving by transforming, preserving by transforming beyond recognition. The Democratic response has been partisan fury. They charge that Republican "preservation" of Medicare means nothing less than the lingering death of the program "as we know it." Surely, most citizens are perplexed; the elderly and disabled are understandably frightened. To try to put this overblown partisan rhetoric into some perspective, consider the following views [thoughts] on Medicare's real needs for reform and the directions that such reforms should take.

First, Medicare does need adjustment. A ten percent annual growth rate in the costs of care, which is what the Congressional Budget Office has projected, is simply not sustainable in the long run. Moreover, changes in longevity, medical technology, cultural conceptions of adequate medical care, national fiscal capacity and a host of other factors demand that any long-term program of medical insurance accept periodic adjustments. Rigid defense of the status quo is silly, but so is the demand for complete overhaul even when labelled 'preservation.'. Medicare has brought considerable security to the aged and disabled.

Reformers should attend to the many small things that can be changed a little. They should not search for some (unknown) one big thing that will "fix" the system for all time.

Second, the projected "bankruptcy" of the "trust fund" is a particularly misleading way to think about Medicare's cost problems. The trust fund is an accounting convention signaling that Medicare's hospital insurance (Part A) is financed by earmarked taxes. If time is needed to make necessary gradual adjustments in Medicare, the "fund" for Part A can be increased by new taxes or by temporary transfers from the surpluses in the Social Security retirement accounts. In any event, no one is going to wake up some Saturday morning to find that their hospital coverage has suddenly ceased because Medicare is "broke". Reformers must ask and answer hard questions about the likely success of particular cost control measures, what the savings will be, and how to manage the system in the face of the inevitability that these projections will not be entirely accurate. Discussion of changes in the size, sources of revenue and responsibilities of the "trust fund" is a sensible, necessary part of this process. Talk of 'bankruptcy' is not.

Third, costs are not the only problem. Medicare coverage is seriously underinclusive. It excludes payment, for example, for most pharmaceutical therapies and for long term care, both major elements in the treatment of chronic disease. These gaps not only ensure that Medicare fails to meet important needs of the elderly and the disabled, but also promote costly gaming of the system. To get Medicare payments for nursing home care, patients must be cycled through hospital stays, whether needed or not. Personal assistance must be provided by highly-paid nurses, even if the "medical" content of the care is minimal. Meanwhile mountains of paper are shuffled to try to prevent these "abuses." Reform should concentrate

on helping Medicare meet genuine needs and avoid artificial boundaries that cannot, in any event, be policed effectively. Broadened coverage need not necessarily be the enemy of cost control and, in some instances, will be its ally.

Fourth, lest this proposal for expanded coverage suggest we have lost touch with fiscal reality, we must emphasize that the costs of care may be cut in many ways. Less expensive forms of care can substitute for more heroic interventions. Unnecessary and marginally necessary care can be reduced. The amounts paid for particular interventions can be restrained. All of these approaches, and more, will surely be necessary. But reformers should remember that Medicare administrators have been quite successful at constraining costs when given the tools and political support to do so. They can be even more effective in the current context where private insurers are doing similar things. Providers now have nowhere to hide from system-wide demands for cost control. Prices and unnecessary utilization can be reduced while expanding coverage without providers abandoning Medicare patients or effectively shifting costs to private insurers.

Fifth, taxes can be raised. So can charges. Anyone who thinks that an earmarked tax for a popular program cannot be increased marginally in the current political climate simply has not been paying attention to what we have been doing over the past decade -- or to what opinion polls say Americans will support. Moreover, there is no reason that a program originally designed to prevent financial catastrophe for the elderly and disabled should use general revenues to subsidize eighty percent of all their expenditures for physician services (Part B). Part of these costs can and should be distributed differently. In other words, reform should (and almost surely will) require some adjustments in current payment arrangements --

who pays, how much and through what types of levies, charges or deductibles. But the modifications likely to be needed, given sensible cost controls, are really quite modest. Only politicians' refusal to utter the "T" word makes the situation look as if some massive fiscal reordering is in the offing, or that everything can be done without anyone paying any more for anything

Finally, those who are old or disabled -- and also sick -- deserve a more consumer-friendly system of health insurance. Offering them a smorgasbord of private insurance alternatives by converting Medicare's entitlement into an insurance "voucher," for example, may appeal to the Health Insurance Association of America and to those for whom "privatization" is the presumptive answer to all questions of public policy. The political and economic realities, however, are very different. This type of "freedom of choice" would drive most of the old and the sick to distraction and enormously increase the administrative costs and complexity of Medicare. How it would save federal dollars remains a mystery. Moreover, responsible "voucherization" would entail the politically unpalatable necessity of massive federal regulation of the insurance industry to try to prevent "cherry picking" of the better risks and cost-shifting between Medicare and non-Medicare patients by insurers covering both.

At the other end of the choice spectrum, a program of mandatory HMOs for all has already met stiff political resistance -- and for good reason. Most HMOs have catered to a quite different and much healthier slice of the population. Whether HMOs can serve the elderly and disabled well, and at reduced costs, is unknown. Reform in the organization of either insurance markets or medical service delivery must be understood to be experimental. Only careful trial will separate panaceas from placebos. Celebrating health maintenance

organizations, the current Republican position, is both premature and an enormous flip-flop from the party's criticism of President Clinton reliance on 'managed care.'

The loud partisanship of the current political rhetoric signals a recognition that reforming Medicare will be neither simple nor painless. But solutions will not get any easier with doublespeak or namecalling, political processes that distort the real issues and the real alternatives. There are both more problems to be solved, and more ways to solve them, than the current Medicare debate has begun to suggest.

September 19, 1995

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1102 Longworth Building
Washington, D.C. 20515

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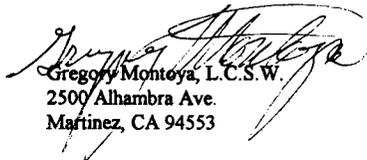
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Gregory Montoya, L.C.S.W.
2500 Alhambra Ave.
Martinez, CA 94553

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Respectfully,



Dorothy Murr
2229 Belle Ct.
Antioch, CA 94509



**National
Association of Health
Underwriters**

NAHU is an association of health and disability insurance professionals serving the needs of over 119 million Americans.

**Statement
on
The Medicare Preservation Act**

**Submitted to
The House Committee on Ways and Means
September 22, 1995**

**By
Donna Carnall
President
National Association of Health Underwriters**

I appreciate having this opportunity to present the ideas and recommendations of the National Association of Health Underwriters on Medicare reform and their relation to The Medicare Preservation Act.

NAHU believes that America's senior citizens have a right to good quality health care under a system that is both financially sound and provides them with a range of health insurance choices.

The present Medicare program is becoming more and more financially unsound and is projected to run short of funds by the year 2002. Medicare also represents a government-run single-payor system that limits senior choices to the plan prescribed by the government and denies seniors the opportunity to participate in the range of insurance options available to other Americans.

Medicare reform is thus essential if seniors are to enjoy the security of assured health care in the years ahead. Such reforms can either be undertaken in a strictly negative manner that cuts benefits and increases costs, or in a manner that revitalizes the system and allows seniors greater choices, more flexibility, and the opportunity to obtain a wider range of benefits to better meet their own personal needs. NAHU believes the latter route is the only way to go, and our recommendations for reform reflect that belief.

Our Real Choice Medicare Reform proposal contains 15 specific recommendations for reform. I am including the list of these reforms at the end of my written statement.

The general direction of The Medicare Preservation Act tracks quite closely with what we are proposing. In particular, we agree with the idea that Medicare should be opened up to allow seniors the choice of private sector options, thus having available to them the same range of benefit plans available to other Americans.

In undertaking such an innovative approach, it is important that Congress take advantage of the knowledge and expertise which professional health insurance agents can provide. No one knows more about the contents of an insurance policy and its applicability to the personal needs of a beneficiary than does an insurance agent. An agent's career success depends on such knowledge and understanding. An agent must have this knowledge base in order to successfully go through the state licensing process.

Senior citizens are going to need help in understanding the maze of different and competing private sector plans which will be made available under a Medicare private sector program. They are certainly not going to get that help from a government bureaucrat. Nor are they going to receive unbiased advice from company employees (this includes the AARP, which is in the business of marketing its own insurance policies). Only the professional insurance agent is going to be able to meet with seniors in the privacy of their own homes and help them pick and choose from among a range of options the plan which would best meet their needs.

If seniors are forced to rely only on printed materials received from the government or a company, they are likely to feel overwhelmed and thus inclined to stick with the familiar, i.e. the current Medicare program. Seniors often have a familiar insurance agent they have used and relied on over the years, and thus have more confidence in advice from such an individual than from a stranger such as a government bureaucrat or company employee. Personal assistance from their own agent will make them more comfortable in trying something new.

Health insurance agents will also, as part of their service, act as intermediaries between the beneficiary and the plan, assisting seniors with problems involving claim denial, billing questions, etc. This service will be particularly beneficial to senior citizens, who may not have anyone else to turn to for help in receiving proper payment for their medical needs.

Finally, it should be kept in mind that a new Medicare program is much more likely to succeed if professional insurance agents are out in the marketplace talking about the positives of private sector plans than if the promotional effort is left to the bureaucracy.

With the ability of agents to provide these services, it would seem to be almost a foregone conclusion that their participation in the new program would be encouraged. It appears, however, that the Medicare Preservation Act, as it currently stands, would actually discourage and prevent agent participation through establishment of a government-run enrollment process. Hopefully this is unintentional, but by providing enrollment solely through a system where the beneficiary checks off a box on an enrollment brochure and sends it back to the government, as the legislation apparently does, will effectively exclude agent participation. An agent is not able to receive a commission except by being able to enroll a citizen in a plan, and that would apparently be precluded.

It is important, therefore, that the legislation include language which provides specifically for the participation of licensed health insurance agents in the program.

If this cannot be accomplished by limiting enrollment strictly to the private sector, then there should at least be a provision allowing agents to be one of the sources for enrollment.

Senator Judd Gregg, in S. 1238, has included language which we feel would accomplish this goal, and we urge that it be incorporated into The Medical Preservation Act. It reads:

“USE OF AGENTS.—The Secretary, in consultation with the Trustees, shall implement the enrollment process in a manner that ensures that eligible individuals may utilize the services of, and enroll in the selected choice care plan through, independent insurance agents. Any plan salesperson or agent, whether independent or employed by a plan, that meets personally and directly with one or more eligible individuals to assist in their choice and enrollment in a plan, shall be required to be accredited and licensed in the State in which they operate.”

This language is needed not only to allow a role for agents, but also to prevent the bureaucracy from actively precluding a role. At present in the Medicare HMO program, the Health Care Financing Administration has issued instructions which “strongly discourage” the use of independent agents to market HMO policies. HCFA took advantage of the absence of any legislative language to the contrary to issue this directive. This must not be allowed to happen in the new Medicare-plus program.

It is also important that all those who are involved in the marketing and sale of the private sector Medicare policies be licensed, in the state in which they do business. Presently, independent agents must go through a licensing process at the state level, but many states do not provide for licensing for employees of insurance companies or managed care plans. The result is an unlevel playing field in which employees with little insurance knowledge may give misleading or faulty information. It is important for the sake of our seniors as well as the success of the program that this not be allowed to happen. The Gregg language provides the proper requirement in this regard.

As I indicated at the outset, NAHU supports the general direction and conceptual framework of the Medicare Preservation Act. We would like to be able to support the legislation, but to do so, our 12,000-plus members, those who are best able to make the program work out in the field, must be assured that they will be included in, not excluded from, the program and its implementation.

Thank you for your consideration.



1312 Tenth Street, Northwest
Washington, D.C. 20001-1492
Tel: 202-517-1895 FAX: (202) 812-3293

WRITTEN STATEMENT OF

Yvonnecris Smith Veal, M.D., President, National Medical Association

on

SAVING MEDICARE

Committee on Ways and Means

September 21, 1995

The National Medical Association, the oldest national group of African American physicians, is currently celebrating its centennial year. The NMA represents over 20,000 African American physicians and we have a rich history of advocacy for the poor and medically under served patients in America. We were the only national medical group to support the original Medicare and Medicaid legislation of 1965. Our primary concern is patient care. Medicare has been essential in the U.S. success in its citizens enjoying greater longevity and a more productive life.

Medicare not only serves as the safety net for the disabled, retired and elderly poor but Medicare is the country's fulfillment of its promise to its citizens. Another important benefit is that Medicare has provided a needed support system to help young and growing families maintain their economic stability while providing care, love and nurturing for their elderly

Excellence in Medicine: 100 Years of Caring

parents and relatives.

The Health Care Finance Administration reports that 3.36 million African Americans are Medicare beneficiaries. The concerns of the NMA in terms of Medicare financing are significant because the impact of changes in the Medicare entitlement programs may potentially create more barriers to health care access for our community where 23 percent of African Americans are already uninsured.

The current majority congressional proposal reduces Medicare costs by 270 billion dollars over seven years. A reduction of 124 billion dollars in Medicare spending over this same period is proposed by the Clinton administration. The important question is whether these proposed cost cutting measures will maintain access to affordable quality care for our most vulnerable patients. Any reduction in the current Medicare program must guarantee the preservation of funding of medically necessary services.

Proposals directed toward an unrealistic increase in out-of-pocket expenses for the burgeoning number of Medicare beneficiaries, as the baby boomers age, may result in a decrease in health care access. The impact of an increase in co-payments by Medicare beneficiaries requires further studies. It is unclear under the House majority proposals how quality care will be ensured. Future options for Medicare beneficiaries must clearly show maintenance of oversight for quality care.

The concept of Medical Savings Accounts needs further study to determine the impact it may have on the traditional Medicare program. If beneficiaries are allowed to move back and forth from M.S.A.'s to traditional Medicare, less money will be available in their M.S.A. for the treatment of any catastrophic illness.

We strongly purpose that changes in Medicare should not be made without more rational study and an opportunity for the majority of Americans affected to have a voice through public hearings.

WRITTEN STATEMENT OF PAUL HOUGHLAND, JR., CAE, EXECUTIVE DIRECTOR,
OPTICIANS ASSOCIATION OF AMERICA, ON THE HOUSE REPUBLICAN MEDICARE
REFORM PROPOSAL

SUBMITTED TO THE COMMITTEE ON WAYS AND MEANS, SEPTEMBER 26, 1995

The Opticians Association of America is pleased to have an opportunity to present its views on the House Leadership's Medicare Reform Proposal released on September 21, 1995 to the members of the House Ways and Means Committee.

The OAA represents approximately 40,000 dispensing opticians throughout the United States. Our membership consists of both individual and firm members. Individual members may work for another optician, an ophthalmologist, an optometrist or one of the large optical chain stores which dispenses eyewear. Firm members are small businessmen or businesswomen who own their own independent optical firms and compete with medical doctors (ophthalmologists), optometrists, and the chain stores in dispensing eyewear, both spectacles and contact lenses. The major issues examined in this statement reflect the concerns of the small, independent firm owner, the heart and soul of our association.

Opticians' interest in the current Medicare program is focused primarily on the Part B provision which provides reimbursement to providers who dispense eyeglasses following cataract surgery. The Health Care Financing Administration does recognize opticians as providers for the purposes of Medicare reimbursement.

As you know, under current law eyeglasses are not a reimbursable item under Medicare Part B except for those who have had cataract surgery. The issue of Medicare reimbursement has been a hotly debated topic within our association. In June, 1993 the OAA passed a resolution recommending "that Medicare discontinue the discriminatory practice of reimbursing for post-cataract surgery eyeglasses."

The Medicare Select program, which was extended and expanded earlier this year in Public Law 104-18, has allowed managed care entities in specified areas to provide additional benefits including eyeglasses to Medicare beneficiaries as an inducement to get them to enroll in their program. Under this program 23 percent of managed care companies offer eyeglasses as an added benefit.

As you might expect, in those areas where the Health Care Financing Administration has authorized managed care alternatives to provide eyewear for Medicare beneficiaries, at reduced cost or without cost, independent opticians and optometrists have lost business. Small businesses have lost customers to managed care entities supported by government tax dollars. Protests to HCFA have been routinely answered by letters explaining current law.

Now, in the name of Medicare reform, the House Leadership suggests creating private sector options in a Medicare Plus plan. One alternative would be a "Coordinated Care" choice in which a beneficiary might agree to a limited selection of physicians or other providers under a managed care option. Added benefits might be offered under this plan including EYEGASSES. In fact, Speaker Gingrich in his press conference of September 21, 1995, referred to the great success of Medicare managed care options in Arizona which did in fact offer eyeglasses as an added inducement to get Medicare beneficiaries to join their plan.

Opticians expected better treatment from a Congress we thought supported independent businesses. Approval of the additional benefit of eyeglasses could transfer up to \$3.1 billion per year from the independent optical sector to the managed care area. This would amount to the destruction of autonomous businesses, not only among opticians, but also among optometrists and ophthalmologists who also dispense eyewear. You have the potential of destroying

thousands of jobs in the small self-reliant business sector. Surely this is not the intent of Congress. We urge you to reject the added benefit of eyeglasses in the coordinated care option. This proposal amounts to nothing short of government aid to the large, well-financed HMO and managed care industry and their allies in the insurance profession.

While it is impossible to predict how many Medicare beneficiaries will elect managed care options under Medicare Plus, independent eyewear providers could lose up to 22 percent of their business to managed care. A conservative estimate of the present eyewear market shows that independent opticians stand to lose up to \$530 million dollars a years in sales to the managed care industry under this House leadership option.

Even if one out of four persons selects this Medicare Plus managed care option, all independent eyewear providers (ophthalmologists, optometrists, and opticians) would lose 5.5 percent of their business. What small business can afford to take this kind of a loss without disastrous consequences? This plan could put every independent optician in the United States out of business within a few years.

The OAA strongly supports the Medisave option which would combine a high-deductible insurance policy with a designated Medicare medical savings account (MSA). The OAA agrees that Medisave will allow Medicare beneficiaries to "gain direct, personal control over how part of their Medicare benefit is provided, and what it can be used for." Funds deposited in the MSAs could be used to purchase eyewear from an independent provider of choice. It would allow consumers maximum freedom of choice.

Provider-sponsored networks (PSNs) could be a useful reform in the OAA's judgment. However, there is no mention of nonphysician providers in the discussion of this alternative in the September 21 document. Is this an oversight or is it a deliberate omission? The OAA strongly believes that PSNs should include nonphysician providers and will support amendments which will achieve that purpose.

One portion of the PSN provision --- alteration of antitrust rules -- is deeply troubling, however. The arguments presented in the September 21 document are not compelling and do not establish sound reasons why the Department of Justice and the Federal Trade Commission should be required to promulgate guidelines within 180 days for those who form PSNs. The antitrust preferences suggested in this document would limit competition, choice, and innovation in the health care market. OAA will oppose any alteration of antitrust laws with respect to PSNs.

Because opticians do business in a highly-competitive marketplace the OAA strongly supports any and all measures that will insure a level playing field. It is for this reason that opticians have strongly supported the amendments to the Omnibus Budget Reconciliation Act of 1993 usually referred to as Stark II. The September 21 proposal suggests dismantling Stark II in ways that would hurt opticians, but more importantly, would damage the interests of consumers. Strong anti-referral language is the best way to assure the preservation of competition which will lead to the lowest cost for eyewear for consumers. The OAA strongly opposes the physician self-referral amendments suggested on pages 23 to 30. If you are serious about controlling fraud and abuse, retain the provisions of OBRA 1993.

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Archer:

As a health provider in the Contra Costa County health delivery system, and as a California tax payer, I am highly concerned about the proposed cuts in Medicare and Medicaid Programs.

It is well known that 8.5 million California residents already are without health care, that there are, in addition, 4 million residents on Medi-Cal, and the population over age 65 is the fastest growing segment of the population.

Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,



Angelique Parker
2500 Alhambra Ave.
Martinez, CA 94553

GERALD S. PARKER
11 SHORE ACRE DRIVE
OLD GREENWICH, CT 068780

September 21, 1995

Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

Attention: Mr. Phillip D. Moseley, Chief of Staff

Subject: Saving Medicare

The person submitting this statement is an individual (named above) speaking for himself. He retired thirty years after organizing, and, all but three or four, running the individual health insurance operations of The Guardian life Insurance Company of America. He designed the first Medicare supplement policy offered to the public. It went on sale on July 1, 1966, the day Medicare took effect.

The plan being reported in the media has great promise. However, it will create problems of its own which should be addressed. Some complain that the savings will not go to the trust fund. But the trust fund is really a fiction. It's invested in government bonds, and when the time comes to draw it down, we'll have to borrow again to make the payments.

The most serious problem is the reported degree to which cost savings are expected to be achieved by cutting the rate of increase in reimbursement to providers. The providers have already been squeezed considerably.

Physicians in this area are already required to accept fees anywhere from 20% to 50% below their normal charges to younger patients. Only a minority are willing to be "participating providers" who accept assignment. A few already refuse to accept new Medicare patients.

Every hospital sees an increasing proportion of its patients on Medicare, and it loses money on every one of them. Just this night as I write, a TV program on NBC reported "enormous bills being paid by Medicare for hospital supplies." Items such as bandages that wholesale for nineteen cents were being billed by hospitals and paid by Medicare for twice to eight or nine times their cost to the hospitals.

I strongly suspect that hospitals, forced to accept Medicare patients at grossly inadequate inpatient daily rates, try to cope as best they can by loading up the charges for medications, dressings, and other hospital supplies and services.

To further squeeze the providers is not going to be a solution that will last. What is needed is to accept the necessity for all of us to pay more of our share of the cost, both we beneficiaries and the younger workers.

Raising the deductible to \$140 is not enough. It ought to go to \$200 now and be indexed henceforth. We should raise the hospital deductible more and increase the Medicare tax on workers. Ask us who are retired to contribute too. There has been talk of some means testing, and clearly this should be done. Low and moderate income people should be subsidized, and the affluent should carry more of their load.

Incentives for people to elect HMOs is probably a sound idea. I think the idea of multiple choices for individual beneficiaries is a no-brainer. There is no way insurance companies can offer equivalent coverage on an individual basis for less than the Medicare premiums. Groups, yes, because they'll do it with HMOs or other managed care plans.


GERALD S. PARKER

PATIENT ACCESS TO SPECIALTY CARE COALITION

*317 Massachusetts Avenue, N.E. 1st Floor Washington, D.C. 20002
(202) 546-4732 FAX (202) 546-5051*

Statement of the PATIENT ACCESS TO SPECIALTY CARE COALITION

Committee on Ways and Means
September 22, 1995

Mr. Chairman, the Patient Access to Specialty Care Coalition appreciates the opportunity to express its views on the House Medicare plan unveiled yesterday. The Coalition is comprised of one hundred patient, senior and health professional groups united in their common belief that patients and the quality of their medical care are the most important components of the health care delivery system. Of primary concern to the Coalition is that all health plans allow patients the ability to seek medically necessary out-of-network treatment and services, and retain choice of health provider.

First and foremost, the Coalition applauds the House Republican leadership for recognizing that patient protection is essential to making the new Medicare system work for beneficiaries. Not only has the leadership included existing protective measures, it has gone beyond current law to incorporate additional provisions to help ensure that patients' best interests rise above all others.

The Coalition was particularly encouraged by the plan's inclusion of the following protective measures:

- Limits placed on physician incentive plans in HMOs
- Timely decisions on authorization of non-emergency care
- Expedited appeals process in life-threatening situations
- Access to all medically necessary services
- Disclosure of important information beneficiaries need in order to make educated decisions when selecting health plans

Along with these provisions, the Coalition wholeheartedly supports a beneficiary's ability to disenroll from a managed care plan if dissatisfied with the quality of care provided. However, we feel disenrollment should not be a patient's only choice when facing a problem with a health plan. Patients should have the freedom to see health providers outside the managed care network when they feel it necessary without having to completely disenroll from one plan and join another.

For example, in many situations patients do not have the luxury of waiting to disenroll from a plan. Consider a patient who suffers a heart attack and requires immediate treatment. However, his HMO won't approve the particular cardiologist with whom the patient has formed a long-standing relationship. Is this patient made to wait 30 or even 90 days in order to have the necessary medical care?

The leadership was accurate in articulating the need for a safety valve in the system. However, the Coalition believes a simpler approach to the same concern exists -- a point-of-service option

(POS). A POS option would enable patients to see physicians and specialists inside and outside the managed care network when they felt it necessary. In this way, beneficiaries would not be required to disenroll in order to receive the kind of care to which they are entitled. The concerns of beneficiaries, recognized by the leadership, can be simply and promptly addressed by a POS option in all health plans.

Quality of care requires this kind of freedom of choice. If seniors are satisfied with the care they receive inside their Medicare managed care network, they won't choose to access doctors and specialists outside the group. But without this freedom, seniors are locked into a rigid system, which may or may not give them the kind of care they need and deserve.

Most importantly, we *can* afford to give beneficiaries choice of doctors. The Congressional Budget Office is on record stating that with a reasonable co-payment, preserving the patient's right-to-choose need not negatively impact the federal Medicare budget.

Seniors should have the option of entering into managed care. However, in a recent survey conducted by ICR Research on behalf of the Coalition, 76 percent of Americans over 50 said they would be unwilling to join a Medicare managed care plan if it denied them the freedom to choose their own physicians, whether it be a specialist or a family doctor.

While the Coalition is encouraged by the emphasis the leadership clearly has placed on patients, we must, as patient advocates, urge the House to go a step further in adopting a point of service option into its Medicare plan. We ask the leadership to do this by incorporating Rep. Tom Coburn's bill, the "Medicare Patient Choice and Access Act" (HR 2350). This bill preserves a freedom that every American senior citizen enjoys today -- the freedom to see their own doctor and to have access to a specialist when they need one.

Meaningful Medicare reform must provide beneficiaries both with choice of plans *and* with choice of doctors. This kind of freedom of choice is the ultimate patient safety net and guard against inadequate care. It also assures that the nation's commitment to the health care needs of its seniors will be met fairly and economically.

Organizations Supporting

PATIENT ACCESS TO SPECIALIZED MEDICAL SERVICES UNDER HEALTH CARE REFORM

Allergy and Asthma Network/Mothers of Asthmatics, Inc.
 American Academy of Allergy and Immunology
 American Academy of Child and Adolescent Psychiatry
 American Academy of Dermatology
 American Academy of Facial Plastic and Reconstructive Surgery
 American Academy of Neurology
 American Academy of Ophthalmology
 American Academy of Orthopaedic Surgeons
 American Academy of Otolaryngology - Head and Neck Surgery
 American Academy of Pain Medicine
 American Academy of Physical Medicine & Rehabilitation
 American Association for Hand Surgery
 American Association for the Study of Headache
 American Association of Clinical Endocrinologists
 American Association of Clinical Urologists
 American Association of Hip and Knee Surgeons
 American Association of Neurological Surgeons
 American College of Cardiology
 American College of Foot and Ankle Surgeons
 American College of Gastroenterology
 American College of Nuclear Physicians
 American College of Obstetricians & Gynecologists
 American College of Osteopathic Surgeons
 American College of Radiation Oncology
 American College of Radiology
 American College of Rheumatology
 American Diabetes Association
 American EEG Society
 American Gastroenterological Association
 American Lung Association
 American Orthopaedic Society for Sports Medicine
 American Pain Society
 American Podiatric Medical Association
 American Psychiatric Association
 American Sleep Disorders Association
 American Society for Dermatologic Surgery
 American Society for Gastrointestinal Endoscopy
 American Society for Surgery of the Hand
 American Society of Anesthesiologists
 American Society of Cataract and Refractive Surgery
 American Society of Clinical Pathologists
 American Society of Dermatology
 American Society of Echocardiography
 American Society of General Surgeons
 American Society of Hematology
 American Society of Nephrology
 American Society of Pediatric Nephrology
 American Society of Plastic and Reconstructive Surgeons, Inc.
 American Society of Transplant Physicians
 American Thoracic Society
 American Urological Association
 Amputee Coalition of America
 Arthritis Foundation
 Arthroscopy Association of North America
 Association of Subspecialty Professors
 Asthma & Allergy Foundation of America
 California Access to Specialty Care Coalition
 California Congress of Dermatological Societies
 Congress of Neurological Surgeons
 Cooley's Anemia Foundation
 Cystic Fibrosis Foundation
 Eye Bank Association of America
 Federated Ambulatory Surgery Association
 Joint Council of Allergy and Immunology
 Lupus Foundation of America, Inc.
 National Association for the Advancement of Orthotics and Prosthetics
 National Association of Epilepsy Centers
 National Association of Medical Directors of Respiratory Care
 National Foundation for Ectodermal Dysplasias
 National Hemophilia Foundation
 National Kidney Foundation
 National Multiple Sclerosis Society
 National Osteoporosis Foundation
 National Psoriasis Foundation
 Orthopaedic Trauma Association
 Pediatric Orthopaedic Society of North America
 Pediatric Medical Group: Neonatology and Pediatric Intensive Care Specialists
 Renal Physicians Association
 Scoliosis Research Society
 Society for Vascular Surgery
 Society of Cardiovascular & Interventional Radiology
 Society of Gynecologic Oncologists
 Society of Nuclear Medicine
 Society of Thoracic Surgeons
 The Alexander Graham Bell Association for the Deaf, Inc.
 The American Society of Dermatopathology
 The Endocrine Society
 The Paget Foundation For Paget's Disease of Bone and Related Disorders
 The TMJ Association, Ltd.
 National Committee to Preserve Social Security and Medicare

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Archer:

As a health provider in the Contra Costa County health delivery system, and as a California tax payer, I am highly concerned about the proposed cuts in Medicare and Medicaid Programs.

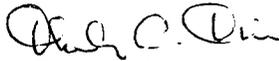
It is well known that 8.5 million California residents already are without health care, that there are, in addition, 4 million residents on Medi-Cal, and the population over age 65 is the fastest growing segment of the population.

Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,



Philip S. Piro, Clinical Psychologist
883 Redwood Dr.
Danville, CA 94526

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

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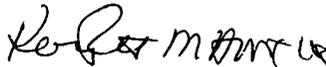
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Respectfully,



Karen Pratt, MFCC
535 Talbart
Martinez, CA 94553

STATEMENT OF PRIVATE CARE ASSOCIATION, INC.

The Private Care Association, Inc. (the "PCA") is a national association representing hundreds of independently owned, private referral services that specialize in home care services for children, the elderly, and the long-term infirmed. PCA members are dedicated to providing low cost, high quality medical care and, therefore, support modifications to Medicare that would provide greater access and superior medical treatment for all Americans.

I. The Sad Predicament of Medicare Home Health Care

It is no secret that the costs of Medicare are spiraling upwards. Home health care, as a component of Medicare, represents the fastest growing expense of the program. The Prospective Payment Commission recently reported that during the period 1991 through 1993, while overall Medicare costs grew 11.8 percent, the cost of providing home care grew by a whopping 38.1 percent. In real terms, the Department of Health and Human Services predicts that Medicare home health expenditures, which were \$3.3 billion in 1990, will increase to \$14.4 billion (estimate) in 1995.

Although the skyrocketing escalation of Medicare home care costs could be tolerated if the program operated efficiently and fraud free, that is not the case. As Sarah F. Jaggard, Director of Health Financing and Public Health Issues for the General Accounting Office, concluded in her July 1995 report to the Senate Finance Committee:

- Medicare pays more than the market price for medical services and supplies;
- Medicare has scant ability to screen claims for overcharging or over utilization; and
- Medicare does little to scrutinize the legitimacy of providers billing the program.

In short, the existing Medicare system of home health care is *not* a low cost, high quality provider, but an excessively expensive, over utilized program that is dangerously vulnerable to exploitation and graft. Why has home health care, as provided by Medicare, come to this predicament? The answer is clear:

- Home health agencies have a monopoly on the Medicare market for home care services;
- Home health agencies operate under a financial conflict of interest. A home health agency both (1) determines the amount of home care a beneficiary needs, and (2) performs the care that it determined is needed. The resulting incentive is for the home health agency to "over utilize" Medicare services, maximizing the amount of care that can be justified under the Medicare guidelines and realizing the increased revenue that over utilization produces; and
- Home health agencies have an incentive to consistently increase their costs each year and thereby increase their Medicare "reimbursement rate."

II. The Solution for Medicare Home Health Care

PCA offers a proposal that would reduce the escalating costs of home health care while maintaining — if not improving — the quality and quantity of care. Equally important, the PCA proposal would expand individual choice.

The PCA proposal involves only three slight structural modifications of the Medicare system:

- Convert existing home health agencies into "Case Management Agencies" ("CMA"), whose *sole* function in the area of home health care would be managing cases, not providing care;
- Replace the cost reimbursement system with a system under which contracts to perform home care services are awarded on a competitive bid, fixed fee or hourly fee basis; and

- Open the Medicare market for home care to all private sector providers that satisfy applicable state licensing requirements.

A. Case Management Agencies Instead of Home Health Agencies

Medicare is cost-inefficient because the entity that significantly influences the determination of the amount of home care provided, the home health agency, also provides the care. Although the rules require that any program of home care services be approved by a physician, customary practices have evolved to where the physician's approval is given perfunctorily. As a consequence, home health agencies are able to significantly influence the formulation of a plan of care.

Home health agencies also are responsible for documenting the care provided and the patients' response to such care. Since that information is highly relevant for determining the type and quantity of *additional* care that will be required, a home health agency remains involved in each incremental determination of the care needed.

The conflicting roles performed by a home health agency — of determining the need for care and performing the services necessary to satisfy the "need" — create for the home health agency an incentive to determine a "need" for as much care as Medicare guidelines permit, inasmuch as the greater the need for care, the more services its employees will perform. The over utilization of services that currently plagues the Medicare home care program is attributable in large part to the over utilization of services that occurs as a consequence of the conflicting roles performed by a home health agency.

PCA proposes to alleviate this conflict of interest, and thereby eliminate the resulting over utilization of services, by separating the care provider and care decider functions. Under the PCA proposal, a CMA would be barred from providing care, and prohibited from owning an economic interest in or receiving gifts from a care providing entity. The CMA would serve as an objective actor, determining the plan of care that is truly appropriate for a patient, and awarding contracts to perform the needed care based on quality and price.

The shift to a CMA would not represent a radical departure from present practice. While the existing Medicare program requires a home health agency to provide at least one line of service with its own employees (typically nursing and companion care), the program allows home health agencies to contract-out other services, such as physical therapy, occupational therapy and speech therapy. Under the PCA proposal, the CMA would simply contract-out *all* home care services. This way, the CMA maintains impartiality.

B. Repeal the Medicare Cost Reimbursement System and Allow Competitive Bidding

Medicare's current cost reimbursement system provides yet another incentive for home health agencies to drive up costs. Home health agencies are compensated based on a reimbursement system under which the amount of costs incurred during one year will determine a "reimbursement rate" for the services performed in a subsequent year. The incentive created under this system is for a home health agency to continuously increase the amount of costs it incurs each year so as to ensure annual escalation in the Medicare reimbursement rate for the services it provides. Thus, unlike competitive bidding, which drives costs down, the reimbursement system pushes costs skyward.

Opponents of the PCA proposal argue that "the rise of home health care should be seen as an encouraging sign because it provides better quality of care and quality of life." It is submitted, however, that taxpayers may celebrate the rise in demand for home health care without the precipitous increase in home care costs that has occurred under the current system.

A strict cost comparison of similar services provided by the private sector and under the current Medicare program make the case for competitive bidding. For example, in Dade and Broward counties, Florida, the average reimbursement for a skilled Medicare visit as opposed to a private sector visit were as follows:

DADE (per visit)

	MEDICARE	PRIVATE SECTOR
Skilled Nursing -	\$95.95	\$55.00 - \$70.00
Physical Therapy -	\$99.08	\$60.00 - \$70.00
Speech Therapy -	\$100.44	\$60.00 - \$70.00
Occupational Therapy -	\$98.60	\$60.00 - \$70.00
Home Health Aide -	\$48.20	\$17.00 - \$38.00

BROWARD (per visit)

	MEDICARE	PRIVATE SECTOR
Skilled Nursing -	\$97.26	\$55.00 - \$70.00
Physical Therapy -	\$143.00	\$60.00 - \$70.00
Speech Therapy -	\$101.81	\$60.00 - \$70.00
Occupational Therapy -	\$99.94	\$60.00 - \$70.00
Home Health Aide -	\$48.86	\$17.00 - \$38.00

Dade County is currently producing a significant savings for Florida taxpayers by using nurse registries under a Florida Medicaid waiver that applies to a narrow slice of the state's Medicaid program. (Except for the segment of the Medicaid market for home care that is affected by the Medicaid waiver, home care referral agencies are barred from that market also.) Catalano's Nurses Registry, Inc. has been servicing clients in District 11 (Dade County) under the Medicaid waiver since April 1995. During that time, while providing a total of only 5,242 hours of personal care services, the registry has produced a savings to the state of \$14,576. Based on Department of Health and Human Services estimates of the projected Medicare costs for 1995, Medicare would have saved over \$3.3 billion in 1995 had the Florida waiver concept been applied on a national basis to Medicare.

Looking at cost per hour, registry services are being provided at an average cost of \$8.80. Case managers in District 11 validate that the *best* hourly rate from a home health agency prior to using the registry was \$12. Further, there have been no complaints of poor quality or red tape. Data from the Medicaid waiver clearly show that private sector competition works. It drives down costs while producing equal or better quality than now realized.

Opponents of PCA's competitive bidding proposal charge that competitive bidding will lead to a decline in quality of service. This reasoning is obviously specious. All private contractors eligible to bid under the PCA proposal would be required to comply with all applicable state licensing requirements for home services. Further, as the practice of bidding for private sector nurses in Dade County Florida has shown, if anything, home care clients are well satisfied with the quality of care they receive from private sector providers.

C. Create a Competitive Market for Home Care of Providers Who Satisfy Applicable State Licensing Requirements

A related problem that has stifled competition within the home care market is the certificate of need ("CON") requirement that some states impose as a condition for eligibility to participate in the state's health care market. In some states, a CON is available only to home health agencies, thereby locking out home care referral agencies. Although the National Health Care Planning and Development Act of 1974 required states to establish CON programs, the federal mandate was repealed in 1987. Many states have repealed their CON laws, but in other states the CONs remain.

CONs are inimical to competition. They artificially freeze the "supply" side of a market, thereby artificially inflating the cost of services. In several states, such as Georgia, the number of home care providers that have been granted a CON has dwindled to two or three dominant agencies. Concentrating such market power into two or three competitors will lead to significant increases in the cost of home care. PCA supports fair competition, which the private sector provides. Consequently, PCA supports a federal prohibition against a state's use of the coercive CON system to lock out market competitors.

III. CONCLUSION — CUT COSTS AND INCREASE QUALITY

The home care industry is set to flourish in this country. Releasing the shackles of the existing home health agency system for a leaner, higher quality market-driven system will not only save taxpayers' money, but will allow a greater number of the more than 12 million Americans who need assistance with everyday activities to experience a higher quality of life.

The equation for cutting costs while maintaining or increasing quality in Medicare home care is clear: create competitiveness among providers by opening the market to the private sector. Competitive bidding through an objective, disinterested CMA will not only realize a decrease in basic costs of home care, but will unburden the system of opportunistic home health agencies that have spawned an egregious over utilization of the services made available under Medicare.

PCA is dedicated to this proposal and solicits your support in achieving enactment. We look forward to working with you to improve Medicare by providing less expensive, higher quality home care for all Americans.

Respectfully submitted,

Marc Catalano, RN, BSN
President
Private Care Association, Inc.
321 St. Charles Ave., Ste. 610
New Orleans, LA 70130
(504) 529-8800

To: Philip Moseley, Chief of Staff
 House Ways and Means Committee
 From: F.M.Rand, "senior citizen"
 Re: Medicare

There she was on TV, hobbling with a cane. "I've had 3 hip replacements already and soon I'll have to have a fourth. Who's going to pay for it?" My retort to her is, "I've helped pay for 3; why should I be required to pay for any more!"

I went to my doctor for a pap smear, but he tried to force me to take a lung pressure test to pad his bill. I refused outright. On the bill paid by Medicare was a charge of about \$50 for that test, which I deem 1. useless and 2. expensive. I phoned Medicare but was told that it was "too small" to pursue a refund. That's my money they gave away! When Medicare was set up, don't tell me pros didn't anticipate frauds, large and small; why was no crew put in place to review, investigate, prevent, and pursue frauds, small as well as large?

A man on vacation came down with a medical problem but, since he was outside his HMO area, he couldn't get Florida Medicare to pay the \$50 or so to cover him; he entered a hospital and Medicare paid the \$450 he incurred. I, too, know that if I want my medical care covered 100%; I must enter a hospital; otherwise, I'm lucky to get 30%.

I urge Congress to enable me to set up a Medical Savings Account. If the deductible is \$10,000., it would be hard but could be managed. I am worried about long-time care insurance above all. I tried a "fine" HMO for a year and want no part of that clinical medicine; I had enough of that from the Navy in WW II. Not only am I weary of helping pay for hypochondriacs or lonely elders who love visiting their doctors, but I am outraged to pay for self-abusers: alcoholics, druggies, AIDS "victims" (victims, my foot!), and felons. At the least they should be required to pay some fee for help. And I fume at families given cash if kids act up to get psycho-certification.

Finally, I firmly urge the committee to put no means cap on benefits. Although I understand my income is too small to affect my benefits, I insist that, if a man pays into Medicare, he must be given the same treatment on the same basis as any other payor. Don't retain the Democrat's "affirmative action", "progressive" discrimination on income-level basis. Whether he earns \$500 or \$5million, he must stand equal before the law: Equal justice for all, not class envy, rich vs. poor, ~~means~~ tests-- Democrat traps.



**Testimony before the Ways and Means Committee
on the Republican 1995 Budget Reconciliation proposal
by the Renal Physicians Association**

September 22, 1995

INTRODUCTION

1 The Renal Physicians Association (RPA) is a professional organization of nephrologists whose
2 goals are: to insure the optimal care under the highest standards of medical practice of patients
3 with renal disease and related disorders; to act as a national representative for physicians
4 engaged in the study and management of patients with renal disease and related disorders; and
5 to serve as a major resource for the development of the national health policy concerning renal
6 disease.

7 As Congress and the public make increased demands for deficit reduction and a concomitant
8 reduction in expenditures on federal entitlements, the proposal submitted to the Committee for
9 consideration today provides an excellent guideline for discussion with other congressional
10 leaders and health policy makers on how best to reform Medicare. The proposal includes several
11 provisions long supported by the RPA. RPA strongly supports the plans clarification of the self-
12 referral law which is necessary to allow nephrologists to contract with hospitals for outpatient
13 services. RPA supports the CLIA provisions found in the plan. RPA also advocated for the use of
14 a single conversion factor within the Medicare Fee Schedule. Further, RPA thanks the leadership
15 for their work on CLIA reform as well as providing increased opportunities for physicians to initiate
16 Physicians Sponsored Networks (PSN). RPA supports other provisions included in the plan.
17 There are, of course, some provisions in the Republican proposal which give us cause for
18 concern, especially over how the "Look Back" mechanism could arbitrarily reduce physicians fees.
19 We will elaborate on these issues below.

20 The RPA would like to thank the Ways and Means Committee for this opportunity to provide
21 written testimony. We offer the following comments on the Republican proposal and hope that
22 you will keep our views in mind as the budget reconciliation process goes through the inevitable
23 refinement process.

24 **PHYSICIAN OWNERSHIP/SELF-REFERRAL**

25 RPA is very pleased that the Republican proposal eliminates "inpatient and outpatient hospital
26 services" as a designated health service in the Stark II law. Elimination of this language will allow
27 nephrologists to contract with hospitals to provide inpatient dialysis services. As brief
28 background, the Omnibus Reconciliation Act of 1993 (OBRA 93) contained language expanding
29 the original self-referral prohibition to certain other designated health services. Among these
30 designated health services was the listing "inpatient and outpatient hospital services". This
31 language would prohibit situations where a nephrologist contracts with a hospital to provide its
32 inpatient or outpatient dialysis services if the nephrologist (or group of nephrologists) had a
33 financial interest in the dialysis service. This prohibition effectively hampers the continuum of care
34 that nephrologists provide to their dialysis patients and it may have an adverse affect on a
35 patient's access to inpatient dialysis. We ask that you work to fix this problem to ensure that
36 dialysis care is not impeded.

37 The principal concerns underlying the self-referral prohibition language of OBRA 93, inflated
38 charges and unnecessary utilization of services, do not apply to inpatient dialysis services. Most
39 inpatient dialysis services are furnished to End Stage Renal Disease (ESRD) patients who are
40 Medicare beneficiaries and are therefore covered by Medicare through the Prospective Payment
41 System (PPS). Under this system, the hospital receives a fixed amount of reimbursement to cover
42 all services furnished to an inpatient. Thus, opportunities for increased costs to governmental
43 payors as a result of inpatient dialysis contracts involving nephrologists are virtually non-existent.

44 Similarly, over-utilization is not an issue. Again, most patients requiring inpatient dialysis have
45 ESRD. Dialysis is a treatment that is prescribed for those with irreversible kidney failure who must
46 receive regular dialysis to live. Dialysis is not an elective procedure for ESRD patients and its
47 medical necessity cannot be questioned. Once diagnosed, most ESRD patients require dialysis

1 several times a week, for two to four hours per session, for the remainder of their lives. Dialysis is
2 always therapeutic and never diagnostic.

3 In addition, unlike situations where, for example, a referring physician has an ownership interest in
4 an MRI facility, nephrologists are directly involved in the supervision and care to their patients
5 receiving inpatient dialysis. Indeed, this provision of dialysis services is simply an extension of
6 the nephrologist's practice.

7 Prohibiting large numbers of inpatient dialysis contracts involving nephrologists will have
8 untoward, adverse patient care consequences: Given the fact that inpatient dialysis contracts are
9 very common in the industry, the question will become: who will assume the responsibility of
10 providing these services? Many hospitals do not provide inpatient dialysis and often lack the
11 expertise and desire to do so. Non-nephrologist entities could assume a greater responsibility for
12 providing this service. However, it is questionable whether these entities could assimilate all, or
13 even a significant part of, the potential new arrangements. More importantly, it is undesirable
14 from a patient perspective to bifurcate the responsibility of professional inpatient nephrological
15 care and the technical components of inpatient dialysis, placing the latter in the hands of non-
16 physician controlled entities.

17 Finally, it should be recognized that the training and support for the conduct of home dialysis is
18 often integrated with inpatient services. Therefore, prohibitions on inpatient dialysis contracts are
19 likely to have a broader negative impact extending to patients' access to dialysis in the home.

20 Congress agreed with RPA's views on this issue and drafted legislative language exempting
21 nephrologists when they refer patients for any dialysis related services. This language was
22 included in all the major health care reform bills originating in the House, including the Ways and
23 Means bill, the Gephardt bill, and the Rowland-Bilirakis Bi-partisan bill.

24 RPA is strongly supports the elimination of the inpatient/outpatient hospitals services" language
25 which would have caused a massive disruption in delivering dialysis care.

26 **FEE SCHEDULE IMPROVEMENTS**

27 RPA is very pleased that the proposal includes a budget neutral single conversion factor for the
28 Medicare Fee Schedule and replacement of the current volume performance standard with growth
29 targets based on the gross domestic products plus two percent. As the Committee knows, the
30 MVPS and separate conversion factors for surgery, primary care and non-surgery have served to
31 distort the original intention of resource-based relative value system. We note however, that the
32 proposal does not specify an implementation date for this change and makes reference only to
33 upper and lower limits being placed on annual adjustments to "ensure reasonable updates and to
34 reduce volatility." RPA urges the Committee to clarify that the implementation date for the single
35 conversion factor will be January 1, 1996 and also to specify a lower limit on annual updates to
36 the conversion factor to assure that the updates remain reasonable.

37 RPA also expresses its support for the replacement of the VPS with updates based on GDP plus
38 two percentage points. This move has been endorsed by the Physician Payment Review
39 Commission.

40 41 **MEDICARE SECONDARY PAYOR PROVISION FOR ESRD**

42 The Republican proposal contains language which would extend the Medicare Secondary Payor
43 provision for ESRD services to twenty-four months. Currently, Medicare is the secondary payor
44 for ESRD services for eighteen months. Although the RPA believes that the 18 month MSP period
45 is adequate, we realize the need to produce savings within the ESRD program and RPA supports
46 this provision. However, RPA believes that extensions beyond the already envisioned 24 months
47 would have a detrimental effect on dialysis patients.

48 An extension beyond 24 months could lead to higher insurance costs to ESRD patients as
49 insurance companies try to offset the price affects of the extension. Large price increases could
50 lead to patients dropping their coverage altogether. Some health plans could drop their ESRD
51 coverage completely. RPA is also concerned that such an extension would cause health plans to
52 continue to lower the ESRD reimbursement rates. In addition, an extension beyond twenty-four
53 months could provide employers with a disincentive for hiring ESRD patients or even those
54 predisposed to ESRD, such as individuals with hypertension or diabetes. Insurance reform which
55 guarantees issue of coverage, provides for portability of coverage and prohibits pre-existing

1 condition clauses would also go along way to protecting patients with chronic conditions like
2 ESRD.

3 **ERYTHROPOIETIN**

4 RPA was pleased to see that the Republican proposal did not include language which would
5 bundle reimbursement for Erythropoietin (EPO) should into the Medicare ESRD composite rate. It
6 is RPA's belief that there is no clinical or quality-assurance reason to bundle EPO payments into
7 the composite rate.

8 EPO is a hormone produced by the kidney which is necessary for the body's production of red
9 blood cells. Patients with kidney failure produce an inadequate level of EPO which results in
10 anemia. Epotin, a bioengineered form of EPO, is administered to these patients in order to
11 maintain the proper level of red blood cells. The EPO drug is currently reimbursed by Medicare at
12 a rate of \$10 per 1,000 units. This reimbursement policy is the most rational method available
13 and the safest for the patient because it allows the nephrologist to prescribe EPO solely on the
14 basis of the patient's need.

15 We believe that a primary motivation behind the proposal to bundle EPO into the composite rate
16 is financial. Large volume providers of the drug can purchase EPO from the manufacturer at a
17 discount. If EPO is bundled into the composite rate, large volume providers will be able to
18 increase their financial return because of their buying power, thereby creating a disparity in
19 financial returns between large and small distributors.

20 It is also our understanding that there is an interest in bundling EPO reimbursement into the
21 composite rate in order to provide an economic disincentive against over-prescribing the drug.
22 The perception that EPO is being over-prescribed is based on HCFA data which demonstrates
23 that EPO dosing has continuously increased per patient while the average hemocrit (a marker of
24 the degree of anemia) has remained flat. If this is the case, then the question of why patients are
25 becoming resistant to the effects of EPO should be addressed by quality assessment and quality
26 improvement methodologies, not economic disincentives.

27 Similarly, RPA is aware that anecdotal evidence exists regarding overdosing of EPO. However, a
28 policy decision on bundling EPO into the composite rate should not be based on such assertions,
29 rather, should be made after data has been collected and a scientifically accurate solution
30 developed. The RPA is currently exploring different statistical models and other data driven
31 studies regarding bundling and capitation of dialysis services, including EPO dosing, in order for
32 the renal community and policy makers to come to such a solution. Additionally, the Health
33 Services Quality Bureau and the renal Networks are planning a study on the quality and cost
34 effectiveness of EPO. Therefore, RPA believes that a decision to bundle EPO into the composite
35 rate would be pre-mature at best until proper data has been collated and analyzed. Once this
36 has occurred, a scientifically accurate policy decision can be made.

37 RPA is pleased that the Republican proposal did not include a provision to bundle EPO into the
38 Composite Rate.

39 **PHYSICIAN SPONSORED NETWORKS**

40 RPA believes that the Provider-Sponsored Networks (PSN) provision could provide the Medicare
41 program with a new way of delivering medical care. We support the concepts behind the
42 encouragement of these PSNs, namely, the increased competition PSNs will offer traditional health
43 plans as well as the recognition that the physician-patient relationship is the overriding theme to
44 physician sponsored care. RPA is currently working on adopting policy on this issue. We note
45 that PSN's dovetail nicely with the Disease Maintenance Organization (DMO) concept that many
46 physician groups that treat chronic condition patients are now considering. Further,
47 Congressional attention to this concept comes at an opportune time as the Health Care Financing
48 Administration (HCFA) is expected to begin their ESRD capitation project in the next several
49 months. This study will hopefully allow nephrologists to more accurately calculate a capitated
50 payment for total ESRD care. By examining the experience nephrologists have in a global
51 capitated world, renal physicians may be able to drastically alter the way ESRD care is delivered
52 and reimbursed.

1

MEDICAL LIABILITY

2

The RPA is very pleased to see the inclusion of health care liability reform in the Republican proposal. As the Committee is well aware, our tort system is laded with excessive attorney costs, potentially huge punitive damage costs, and increased filing of non-meritorious claims against physicians. Further, the current tort system inadequately compensates deserving plaintiffs and imposes unnecessarily high litigation costs on all parties. The cost of these judgements are then passed onto the consumer in the form of increased prices and decreased productivity of the work force. Fear of suits has lead many physicians to practice "defensive medicine" adding between \$20 to \$25 billion dollars per year to the health care system. Physicians pay an estimated \$10 billion in malpractice premiums per year. By reforming the medical malpractice laws, with limits on how much juries can award for non-economic damages and providing guarantees that most of the monetary awards will go to patients rather than their trial attorneys, the Republican proposal offers real liability relief to the medical community. Such relief will result in more efficient and less costly care.

15

CLINICAL LABORATORY IMPROVEMENT AMENDMENT OF 1988 RELIEF

16

RPA applauds the inclusion of CLIA relief in the Republican Medicare proposal. The RPA has been concerned by the large number of physicians' practices that have sharply limited or discontinued essential patient testing because of burdensome CLIA requirements. As a result, patients are referred to outside laboratories for routine patient testing which could be done during the office visit for far less cost and would enable the physician to treat the patient immediately. RPA believes it is critical that the regulatory burdens imposed on physicians and other health care providers by CLIA be eased so they can return to providing routine laboratory tests they are trained to perform as a part of their clinical examination. These tests are the basic tools used by the physician for immediate evaluation and diagnosis of a patient's medical condition. CLIA has unintentionally caused many physicians and other health care providers to stop offering the routine laboratory tests they need to provide patients with high quality care in an efficient and cost-effective manner.

28

CLIA has resulted in significantly higher costs for those physicians operating physician office laboratories. The government concluded that CLIA will add approximately \$1.3 billion annually to the cost of health care. Despite this cost of complying with CLIA, there is little, if any, documentation that CLIA has resulted in improved patient care. The provision included in the Republican proposal will provide much needed relief for physicians who want to offer their patients routine laboratory testing in a timely and cost-conscious manner.

34

THE "LOOK BACK" MECHANISM

35

RPA urges you not to arbitrarily subject the Medicare program to a "look back sequester" if spending under the program exceed estimated budget targets. Budget targets may be exceeded for various reasons such as the availability of new expensive technologies, increased use of services by beneficiaries, and if initially, insufficient numbers of beneficiaries enroll in the program. Indiscriminately cutting reimbursement rates to providers are likely to result in access problems for beneficiaries as physicians find it financially impossible to participate in health plans accepting Medicare vouchers. RPA recommends that if spending is higher than projected because of new useful technologies or increased patient utilization of services deemed medically necessary, Congress should provide the funds necessary to reimburse for these services.

44

CONCLUSION

45

The RPA commends the leadership for drafting their proposal on transforming Medicare. The document contains many provisions which RPA has long supported and we applaud your goal of preserving and strengthening Medicare for present and future beneficiaries. We are aware that this year's budget process is just underway and refinements of this proposal are inevitable. The RPA looks forward to working with Congress on this crucial issue as the debate over Medicare continues.

51

832 N.E. Laurelhurst Place
 Portland, OR 97232
 September 20, 1995

U.S. House Ways and Means Committee
 1102 Longworth
 Washington, D.C. 20515

Attn: Executive Director

Re: Medicare Hearings

Health care reform should occur before any structural changes in Medicare (Medicaid, too). Until this takes place, changes can't be made prudently.

There are factors causing health care costs generally to take too much of U.S. GDP. Several examples are cited. They are not necessarily listed in order of significance, nor do they exclude other factors that need to be addressed.

- Excess hospital capacity.
- Luxury features in hospital construction that do not affect the delivery of services.
- Fraud.
- Billing systems that are wasteful and that allow overcharges to go undetected.
- Unjustified malpractice awards.
- The need for more full-time emergency clinics to take care of people with minor illnesses and injuries who now are treated in more expensive hospital emergency rooms.
- The protection given to incompetent and impaired health care providers by review boards.

Sincerely,

Charles L. Sauvie
 Charles L. Sauvie

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Archer:

As a health provider in the Contra Costa County health delivery system, and as a California tax payer, I am highly concerned about the proposed cuts in Medicare and Medicaid Programs.

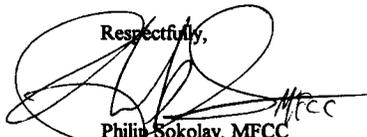
It is well known that 8.5 million California residents already are without health care, that there are, in addition, 4 million residents on Medi-Cal, and the population over age 65 is the fastest growing segment of the population.

Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,



Philip Sokolay, MFCC
2500 Alhambra Ave.
Martinez, CA 94553

**STATEMENT OF CHARLES R. MODICA, J.D., CHANCELLOR
ST. GEORGE'S UNIVERSITY SCHOOL OF MEDICINE
GRENADA, WEST INDIES**

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present the views of St. George's University School of Medicine on budget reconciliation and Medicare issues.

Since its founding in 1976, over 2000 students have graduated from St. George's with degrees in medicine. Many of these students are U.S. citizens who come from tax-paying families. Because of the quality of education received by students at St. George's, fully one-third of our students complete their second year, and transfer to a U.S. medical school.

Graduates of St. George's University School of Medicine enter primary care specialties at a rate of 76% -- a percentage for any U.S. Medical School to admire. The default rate on student loans for U.S. graduates of St. George's is less than 1%, also an enviable number.

At St. George's, we are very proud of our achievements and academic record. The states of California, New York, and New Jersey have recognized this track record, and have approved St. George's students for clinical clerkships in their respective states. The approval process utilized by New York is based on LCME accreditation guidelines and is identical in many ways.

Mr. Chairman, I bring this information to your attention because it is important that this committee not paint every graduate of a non-U.S. medical school with the same broad brush and because it is important for this committee to recognize that not every non- U.S. medical school is the same.

Council on Graduate Medical Education Recommendations

The prepublication recommendations of the seventh report of the Council on Graduate Medical Education that were transmitted recently to Congress by COGME are arbitrary in nature as they relate to International Medical Graduates, and are also directly contradictory to recommendations made in its first report related to International Medical Graduates.

Seventh Annual Report

COGME's Seventh Annual Report identifies the following commendable goals:

- 1) Decrease the number of specialists trained.
- 2) Increase the number of generalist physicians and improve primary care teaching.
- 3) Increase minority representation in medicine.
- 4) Improve physician geographic distribution.
- 5) Train more physicians in ambulatory and managed care settings.

COGME's Seventh Annual Report also makes the following recommendations related to IMGs:

- 1) Continued medicare GME funding for U.S. Medical School graduate residents at current level but reduce payments for International Medical Graduate residents.
- 2) Transition programs to assist IMG resident-dependent institutions.

Mr. Chairman, neither of these two recommendations will help to achieve the 5

stated goals. In fact, one could make a persuasive argument that implementation of these recommendations would make it more difficult to achieve the 5 stated national goals. Graduates of St. George's University School of Medicine, and International Medical Graduates in general are:

- 1) More likely to enter primary care specialties.
- 2) Certainly much more likely to be an ethnic minority.
- 3) Much more likely to enter a residency program in a setting that treats disadvantaged populations and perform these services in an ambulatory setting.

Furthermore, Mr. Chairman, the Seventh Report of COGME directly contradicts COGME's landmark first report which had the mandate to carefully review issues related to International Medical Graduates, which states that:

- 1) Selection into GME programs should be based on the relative qualifications of the individual applicant, not on group or institutional associations; and
- 2) For the purpose of limiting access to GME, the federal government should not establish policies which would discriminate against medical school graduates on the basis of citizenship, immigration status, or medical school location.

Mr. Chairman, and members of the subcommittee, St. George's recognizes that this committee has been given reconciliation instructions to achieve savings in the medicare program. We propose that if savings must be achieved in Graduate Medical Education, that they be done across the board and not be arbitrarily targeted at U.S. students who receive their medical education abroad.

I would also question the value of the Council on Graduate Medical Education and the motives of its members when recommendations such as theirs are made that do nothing to achieve the stated goals, but go a long way to protect the status quo for the U.S. medical establishment.

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Archer:

As a health provider in the Contra Costa County health delivery system, and as a California tax payer, I am highly concerned about the proposed cuts in Medicare and Medicaid Programs.

It is well known that 8.5 million California residents already are without health care, that there are, in addition, 4 million residents on Medi-Cal, and the population over age 65 is the fastest growing segment of the population.

Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,

A handwritten signature in cursive script that reads "Stella Stark".

Stella Stark
2500 Alhambra Ave.
Martinez, CA 94553

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Archer:

As a health provider in the Contra Costa County health delivery system, and as a California tax payer, I am highly concerned about the proposed cuts in Medicare and Medicaid Programs.

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Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,



Janiece J. Sydow
2500 Alhambra Ave.
Martinez, CA 94553

STATEMENT
on
MEDICARE REFORM
before the
HOUSE COMMITTEE ON WAYS AND MEANS
for the
U.S. CHAMBER OF COMMERCE
by
R. Bruce Josten
September 22, 1995

Mr. Chairman and members of the Committee, my name is Bruce Josten and I am the Senior Vice President for Membership Policy for the U.S. Chamber of Commerce. We appreciate the opportunity to submit this statement for the hearing record.

Medicare is indisputably in a state of crisis. Over the past five years, the program has grown at a staggering average annual rate of 10½%. Immediately ahead of us is a seismic demographic shift: the ratio of taxpayers to Medicare beneficiaries is declining rapidly – from about four to one today, to only two to one in the next fifty years. The program as currently structured simply cannot survive.

These considerations led the Medicare Trustees¹ to call for “prompt, effective and decisive action” in their 1995 Annual Report. The plan put forward by the majority meets this objective for the foreseeable future, assuring quality health care for Medicare beneficiaries and removing a substantial threat to our nation’s future financial health. The Chamber supports your efforts.

We believe the long-term solution to slowing the increase in Medicare spending is to increase competition. Encouraging seniors to evaluate and choose between competing health plans (including existing Medicare fee-for-service benefits) will lead to competition on the basis of quality and innovation. This competition will help bring prices down and will likely lead to expanded benefit options for seniors. We commend your focus on market forces rather than on government bureaucracies and mandates in your reform plan.

Clearly, the crisis facing the Medicare program requires fundamental change, rather than patchwork reforms. Past approaches to Medicare reform have failed to slow Medicare’s growth. Worse, these approaches have increased the burden on businesses and their employees through higher payroll taxes and more expensive health insurance.

Although no one as yet has explicitly called for a hike in Medicare tax rates as a solution, it remains the hidden alternative, and is the implicit policy of those who decry the proposed slowdown in Medicare spending growth. As we can see from the 1990 and 1993 Medicare tax increases, the so-called tax solution is no solution at all. Instead, the boost in tax rates have increased the tax burden on individuals and businesses while curtailing economic performance.

The Chamber recently released a study of the effects on individuals, business and the economy of raising taxes to save Medicare. Our conclusion – based on an optimistic evaluation, not a worst-case scenario – is that increasing taxes rather than reforming the Medicare system will bring the economy to the brink of recession. A copy of our study appears at the conclusion of these remarks.

The Chamber’s study reflects the recent report by the bipartisan Medicare Board of Trustees, which warned that Medicare trust fund reserves will be exhausted in seven years. The Trustees calculated that to balance the Medicare trust fund for the next 75 years – the usual period for long-term fiscal solvency – the Medicare payroll tax must

¹ The Secretary of the Treasury, the Secretary of Labor, the Secretary of Health and Human Services, the Commissioner of Social Security, and two members appointed by the President and confirmed by the Senate to represent the public. The Board is required by law to report to Congress each year on the operation of the trust fund during the preceding years and the projected financial status for future years.

immediately be increased from the current level of 2.90% to 6.42%. Delays in levying the new rate or phasing in the increase over time would result in an even higher ultimate Medicare payroll tax rate.

While the tax increase may seem to amount to only a few percentage points, it amounts to hundreds of dollars to the typical worker, thousands of dollars to the average small business, and billions of dollars for the economy. When aggregated across the entire economy, the effect would be to lower real GDP by \$179.4 billion within two years and hold GDP about \$95 billion lower 10 years later. This amounts to a 3.1% decline in GDP in the short run, and with economic growth projected to average less than 3% over the next five years, this decline could easily result in a recession. Over the long term, employment levels would be cut by 1.5%.

For a typical worker earning \$30,000 a year, this increase would raise annual Medicare payroll taxes to \$1,926 from the current \$870, and a small business employing 25 such workers would be liable for an additional \$13,200 tax payment per year. Because the Medicare payroll tax is levied on employment levels, not income, the tax due remains the same through both good and bad economic times, accentuating the pain of a downturn on employers who need to pay the tax regardless of profitability.

Our conclusion from this analysis is clear: higher taxes will rob working individuals of their hard-earned dollars, significantly increase costs on small and large businesses alike and bring the economy to the brink of recession. The tax "solution" to Medicare is tantamount to causing a recession. It is no solution at all.

The Chamber is convinced that the market approach to Medicare reform is the best and only appropriate means of solving the Medicare crisis. As reflected in the outline released yesterday, the Medicare Preservation Act is a long overdue solution that will provide solid and effective market-based reform that will secure Medicare's future over the long term. Important elements include:

- **Increased choices for Medicare beneficiaries through the MedicarePlus program.** The private sector has demonstrated that competition can bring both innovation and cost reductions. Medicare beneficiaries will benefit from these increased choices between coverage options, which would include the option of remaining in the existing Medicare program.
- **Restrained growth in Medicare spending.** Increases in Medicare spending are inevitable, even desirable. However, controlling the rate at which Medicare spending increases is as important to our nation's future financial health as Medicare itself is to seniors' health care.
- **Beneficiary incentives to report fraud and abuse.** Medicare beneficiaries should be natural allies in eliminating waste or fraud in the Medicare program, but have been underutilized in the past. Under the Medicare Preservation Act, beneficiaries will be given incentives to identify waste or fraud, or suggest means of increasing program efficiencies.

These and other elements of the Medicare Preservation Act will be explored in depth in the coming days. We look forward to working with you as this important proposal develops.

Thank you.

The Medicare Crisis: The "Tax Solution" Is No Solution

Martin A. Regalia • Vice President and Chief Economist

Robert D. Barr • Deputy Chief Economist

U.S. Chamber of Commerce • Washington, D.C.

The only solution detailed by the Medicare Board of Trustees for achieving financial balance in Medicare Part A is to raise taxes. Unfortunately, this is no solution at all. Higher taxes will rob working individuals of their hard-won dollars, significantly increase costs on small and large businesses alike and bring the economy to the brink of recession.

The Trustees calculate that balancing the Medicare trust fund for the next 75 years requires us to immediately hike the Medicare payroll tax from 2.90% to 6.42%. While the tax increase may seem to amount to only a few percentage points, it amounts to hundreds of dollars to the typical worker, thousands of dollars to the small business, and billions of dollars for the economy. Analysis by the Economic Policy Division of the U.S. Chamber of Commerce suggests the following impacts on individuals, businesses and the economy:

For a worker making \$30,000 a year, total Medicare payroll taxes paid would jump to \$1,926 from the current \$870.

A small business employing 25 such workers would be liable for an additional \$13,200 tax payment per year.

When aggregated across the entire economy, the effect would be to lower real GDP by \$179.4 billion within two years and hold GDP about \$95 billion lower 10 years later. This amounts to a 3.1% decline in GDP in the short run. With economic growth projected to average less than 3% over the next five years, this decline could easily result in a recession.

These results are even more startling when you consider that they represent an optimistic evaluation, not a worst-case scenario.

Overview of Medicare: Why Reform Is Necessary

Medicare is a nationwide health insurance program for older Americans and certain disabled persons. It is composed of two parts: Part A, the hospital insurance (HI) program, and Part B, the supplementary medical insurance (SMI) program.

Part A covers expenses for the first sixty days of inpatient care less a deductible (\$716 in 1995) for those age 65 and older and for the long-term disabled. It also covers skilled nursing care, home health care and hospice care. The HI program is financed primarily by payroll taxes. Employees and employers each pay 1.45% of taxable earnings, while self-employed persons pay 2.90%. In 1994, the HI earnings caps were eliminated, meaning that the HI tax applies to all payroll earnings.

Part B is a voluntary program which pays for physicians' services, outpatient hospital services, and other medical expenses for persons aged 65 and over and for the long-term disabled. It generally pays 80% of the approved amount for covered services in excess of an annual deductible (\$100). About a quarter of the funding comes from monthly premiums (\$46.10 in 1995); the remainder comes from general tax revenues and interest.

Medicare is not a means-tested program. That is, income is not a factor in determining an individual's eligibility or, for Part B, premium levels. Age is the primary eligibility criteria, with the program also extending to qualified disabled individuals younger than 65.

Over the years, tax revenues for Medicare Part A have exceeded disbursements, and so the remaining revenues have been credited to the Medicare HI Trust Fund. At the end of 1994, the trust fund held \$132.8 billion.

Conclusions of the Trustees

Each year, trustees of Medicare's Hospital Insurance Trust Fund analyze the current status and the long-term outlook for the trust fund, and their findings are published in an annual report. The 1995 edition, issued in April, demonstrated that the Medicare system is in serious financial trouble. The program's six trustees -- four of whom are Clinton appointees (cabinet secretaries Robert Rubin, Robert Reich and Donna Shalala, and commissioner of Social Security, Shirley Chater) -- reported the following conclusions:

Based on the financial projections developed for this report, the Trustees apply an explicit test of short-range financial adequacy. The HI trust fund fails this test by a wide margin. In particular, the trust fund is projected to become insolvent within the next 6 to 11 years. . . (HI Annual Report, pg. 2)

Under the Trustees' intermediate assumptions, the present financing schedule for the HI program is sufficient to ensure the payment of benefits only over the next 7 years. (pg. 3)

The program is severely out of financial balance and substantial measures will be required to increase revenues and/or reduce expenditures. (pg. 18)

...the HI program is severely out of financial balance and the Trustees believe that the Congress must take timely action to establish long-term financial stability for the program. (pg. 28)

The Trustees believe that prompt, effective and decisive action is necessary. (pg. 28)

The same set of Trustees also oversees the Medicare Part B program. In their 1995 Annual Report, they write:

Although the SMI program (Medicare Part B) is currently actuarially sound, the Trustees note with great concern the past and projected rapid growth in the cost of the program. . . Growth rates have been so rapid that outlays of the program have increased 53% in the aggregate and 40% per enrollee in the last 5 years. (SMI Annual Report, pg. 3)

The Trustees believe that prompt, effective and decisive action is necessary. (pg. 3)

Obviously, the Trustees believe that the Medicare program deserves our careful, immediate attention. The following pages present the figures that led the Trustees to their conclusions.

Where Medicare Stands Today

Medicare is a huge federal program. In 1994:

Medicare expenditures reached \$160 billion, just over half the size of Social Security

Expenditures grew 11.4% from 1993

Eleven cents of every dollar spent by the federal government went to Medicare

Medicare represented one-fifth of total entitlement spending

Between 1990 and 1994, Medicare grew at a 10.4% average annual rate, almost three times the 3.6% average inflation rate over the same period and twice the 5.1% average annual growth of the economy as a whole.

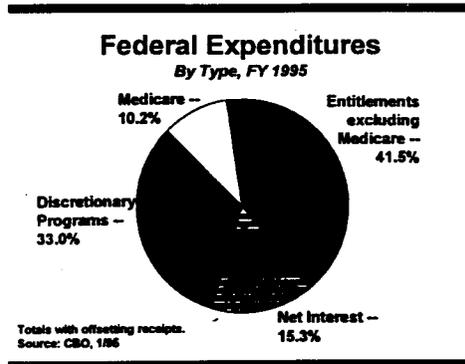
Medicare and the Federal Budget

Medicare spending must be addressed as part of the solution to balancing the federal budget.

That's because spending on federal entitlements -- such as Medicare, Medicaid and Social Security -- soared 8.4% annually on average between 1990 and 1994. Spending on

discretionary, annually appropriated programs -- such as defense, education and infrastructure -- increased 2.2%, which is less than the rate of inflation. Coming decades will see even more pressure for entitlement growth, as the leading edge of the Baby Boom generation reaches 65 in 2011.

Chart 1



Entitlements are not only the fastest growing portion of the federal budget, they're already its largest component, as shown in the accompanying chart. Just over half of all federal expenditures is spent on entitlements; only a third go to discretionary programs. *If we are going to balance the federal budget -- and keep it in balance over the long term -- entitlement reform must be part of the solution.*

Where Medicare Is Headed If We Do Nothing

Under current law, Medicare is projected by the Congressional Budget Office to grow at a 10.4% average annual rate over the next seven years. In 2002, the CBO projects Medicare spending will reach \$344 billion, claiming almost 16 cents of every dollar spent by the federal government.

Moreover, beginning next year, Medicare HI expenditures will exceed the program's revenues. The HI Trust Fund, which at year-end 1994 held \$132.8 billion, will have to be tapped to cover the projected \$867 million difference.

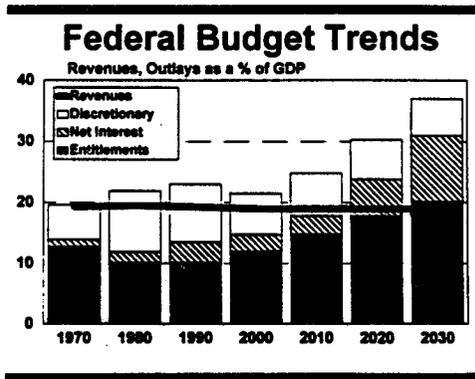
However, according to the Trustees' Annual Report, this shortfall isn't temporary. Instead, it

will balloon to be about seven times larger in 1997, which is just the following year, and more than twenty times larger by 1999. Under assumptions reflecting the most likely demographic and economic trends, 1996 will be the first year of a hemorrhage that will deplete the entire trust fund by 2002 -- just seven years away. The optimistic set of assumptions buys us only a little time, with trust fund depletion projected in 2006. Under the pessimistic scenario, the fund is exhausted as early as 2001. *In other words, within the next 6 to 11 years, it's virtually certain that Medicare will be insolvent -- unless we take action.*

The danger of inaction was made clear last winter when the President's Bipartisan Commission on Entitlement and Tax Reform, chaired by Sen. Bob Kerrey and then-Sen. John Danforth, issued its final report. The focus of the report was to look not years ahead, but decades ahead to assess the impact of federal budget trends. The report is sobering: Under current trends, virtually all federal government revenues are absorbed by entitlement spending and net interest by 2010, as shown in Chart 2. Deficit-financing will be required to cover almost all of the discretionary programs, including defense, health research, the FBI, support for education, and the federal judicial system.

Ten years later, the situation is worse. Growth in entitlements is so explosive that not only would the government have to borrow to pay for discretionary expenses, it would have to borrow funds to pay the lion's share of interest payments on the national debt.

Chart 2



Medicare's Impact on the Pay Stub

In addition to detailing the projected dissipation of the Trust Fund under current law, the Trustees' Report also describes the measures that would be necessary to shore up the trust fund over the next 25, 50 and 75 years. If the expenditure formulas are not altered, then preserving the trust fund can only be done through increases in the payroll tax or additional subsidies from general revenues. Table 1 illustrates the payroll tax increases that would be necessary to balance the trust fund.

Current Law

Currently, the combined (employee and employer) Medicare tax rate is 2.90%, applied to all payroll earnings. A worker earning \$30,000 a year in salary or wages, for instance, is directly taxed 1.45%, or \$435 annually, for Medicare Part A, the hospital insurance program. Employers then match that payment with another \$435, resulting in \$870 of tax revenue earmarked for the Medicare HI trust fund generated by having that worker on the payroll.

The Medicare contributions from both the worker and firm don't stop there, however. Because two-thirds of Medicare Part B (SMI) is financed through general revenues (the other third coming from Medicare premiums and interest), a portion of the worker's and the firm's general income taxes are also financing Medicare. The Trustees reported that \$36.2 billion of general funds were used to pay Medicare Part B claims in 1994.

Table 1
Medicare Hospital Insurance Payroll Taxes

	Current Law Employee + Employer	To Balance the HI Trust Fund Over the Next:					
		25 Years		50 Years		75 Years	
		Additional Tax	Total HI Tax	Additional Tax	Total HI Tax	Additional Tax	Total HI Tax
Tax Rates	2.90%	1.33%	4.23%	2.68%	5.58%	3.52%	6.42%
Percent increase over current law			45.8%		92.4%		121.4%
Payroll Earnings							
\$10,000	\$290	\$133	\$423	\$268	\$568	\$352	\$642
20,000	580	266	846	536	1,116	704	1,284
30,000	870	399	1,269	804	1,674	1,056	1,926
40,000	1,160	532	1,692	1,072	2,232	1,408	2,568
50,000	1,450	665	2,115	1,340	2,790	1,780	3,210
60,000	1,740	798	2,538	1,608	3,348	2,112	3,832
70,000	2,030	931	2,961	1,876	3,906	2,464	4,494
80,000	2,320	1,064	3,384	2,144	4,464	2,816	5,136
90,000	2,610	1,197	3,807	2,412	5,022	3,168	5,778
100,000	2,900	1,330	4,230	2,680	5,580	3,520	6,420

Source (for all tables): 1995 Annual Report of the Board of Trustees, Medicare Hospital Insurance Trust Fund, Table 1.D3, page 22
Calculations and macroeconomic simulations by the U.S. Chamber of Commerce

To Balance the Medicare HI Trust Fund for the Next 25 Years (through 2019):

According to the Trustees' analysis, the hospital insurance payroll tax would have to rise from 2.90% to 4.23% (a 46% increase) to keep the HI trust fund in balance for the next 25 years. Further, the increase would have to be made immediately and maintained through the entire 25-year period.

For our \$30,000/year worker for whom \$870 is currently provided to Medicare HI, this increase means an additional tax of \$399, bringing total annual hospital insurance payroll taxes to \$1,269. And that's before any other federal and state payroll taxes (such as unemployment insurance and Social Security) or federal and state income taxes.

However, even this increase in payroll taxes still leaves the trust fund exhausted in 2019, with the oldest of the baby boomers just shy of reaching their life expectancy. Because of this demographic bulge, balancing the HI trust fund over a longer period would require even higher payroll taxes.

To Balance the Medicare Trust Fund for the Next 50 Years (through 2044):

Balancing the trust fund over the next fifty years -- a span long enough to see most of the Baby Boomers through their lifetimes -- would require virtually doubling the hospital insurance payroll tax from 2.90% to 5.58%. The increase would have to be made immediately and remain permanent through the entire 50-year period. Again, for the worker earning \$30,000 a year, the total HI payroll tax rises from \$870 to \$1,674, an increase of 92.4%.

To Balance the Medicare Trust Fund for the Next 75 Years (through 2069):

Balancing the trust fund over the next seventy-five years -- roughly through the life expectancy of an individual born this year, and the usual period for long-term fiscal solvency -- would require an immediate boost in the Medicare tax rate of 121.4%, from 2.90% to 6.42%. Total HI payroll taxes for a worker earning \$30,000 a year would rise from \$870 to \$1,926.

Medicare's Impact on Business

Because it's levied on employment levels, not income, the payroll tax due remains the same through both good and bad economic times. This feature accentuates the pain of a downturn on employers, who need to pay the tax regardless of profitability. Consequently, relative to the income tax, a payroll tax can be particularly punishing to start-up firms or companies trying to weather a drop in business.

Table 2 shows the liability for Medicare HI payroll taxes that would be faced by firms of various sizes. Total liability is shown under current law and under the three tax rates computed by the Trustees to bring the HI trust fund in balance over periods of 25, 50 and 75 years.

For instance, a 25-person firm where the average worker earns \$20,000 per year is currently liable for a \$7,250 tax payment for the Medicare HI program (for their contribution, the workers themselves would be taxed an identical amount). To balance the trust fund over the next 25

Table 2
Medicare Hospital Insurance Payroll Tax
Annual Employer Tax Liability

		Average Salary: \$20,000						
		Number of Employees						
		5	10	25	50	100	500	1,000
Current Law		\$1,450	\$2,900	\$7,250	\$14,500	\$29,000	\$145,000	\$280,000
To Balance Medicare HI Over the Next:								
25 Years		2,115	4,230	10,575	21,150	42,300	211,500	423,000
50 Years		2,790	5,580	13,950	27,900	55,800	279,000	558,000
75 Years		3,210	6,420	16,050	32,100	64,200	321,000	642,000

		Average Salary: \$30,000						
		Number of Employees						
		5	10	25	50	100	500	1,000
Current Law		\$2,175	\$4,350	\$10,875	\$21,750	\$43,500	\$217,500	\$435,000
To Balance Medicare HI Over the Next:								
25 Years		3,173	6,345	15,862	31,725	63,450	317,250	634,500
50 Years		4,185	8,370	20,925	41,850	83,700	418,500	837,000
75 Years		4,815	9,630	24,075	48,150	96,300	481,500	963,000

years, the combined employee and employer tax rate would have to rise from the current 2.90% to 4.23%. Assuming that the liability continues to be evenly split between the employee and employer, the firm will face an HI payroll tax of about 2.11% per worker. For our 25-person firm, the total HI payroll tax would rise from \$7,250 to \$10,575 per year.

Medicare's Impact on the Economy

Raising payroll taxes to keep the Medicare Hospital Insurance trust fund afloat imposes substantial burdens on both workers and firms. To measure what that means for the economy as a whole, we conducted several policy simulations using the highly respected Washington University Macro Model from Laurence H. Meyer & Associates of St. Louis, MO.

The results are striking: The economy would suffer through sharply slower economic growth and higher unemployment in the near term. Over a longer period, the economy is saddled with a permanent loss of production and employment. As shown in Tables 3 and 4, the degree of severity for GDP and employment depends upon the increase in Medicare taxes enacted.

The tables compare each of three alternative tax simulations specified in the Trustees' Annual Report to LHM&A's June 1995 baseline forecast. To demonstrate the policy change working its way through the economy, we display the results for three of the ten years of our simulation: 1997, 2000 and 2004. This gives us snapshots of the short-term, intermediate-term and long-term impacts on economic output and employment. In each case, the imposition of the Medicare payroll tax increase takes place in the fourth quarter of 1995.

Table 3
Impact on Gross Domestic Product
Balancing the HI Trust Fund Through Raising Payroll Tax Rates

Years to Balance HI Trust Fund	Required Medicare Tax Rate	Difference from Baseline in Given Year, Billions of 1987 Dollars			Percent Difference from Baseline in Given Year		
		1997	2000	2004	1997	2000	2004
25 Years	4.23%	-\$68.4	-\$30.1	-\$36.1	-1.2%	-0.5%	-0.5%
50 Years	5.58%	-137.1	-60.5	-72.7	-2.4	-1.0	-1.1
75 Years	6.42%	-179.4	-79.4	-95.6	-3.1	-1.3	-1.4

As shown in Table 3, if the government imposed the most modest payroll tax increase — enough to keep the Medicare trust fund in balance for the next 25 years — production in the economy would be 1.2%, or almost \$70 billion, lower in 1997 than it would have been otherwise. By 2000, the percentage-point gap between the alternative closes to within 0.5% of the baseline level of production, but that distance is maintained even ten years after the tax increase took effect.

The short-term loss in output translates into 1.2 million fewer jobs relative to what we would have had otherwise, as shown in Table 4. While this decline, amounting to about 1% of the economy's jobs, moderates over time, the economy appears to have lost over 0.5% of its jobs permanently.

Of course, all of this economic turbulence puts the Medicare HI trust fund in actuarial balance for only the next 25 years. To generate long-term actuarial balance for the full 75-year period, the Medicare payroll tax rate would have to jump from 2.90% to 6.42%, triggering even stronger economic impacts than those described above. Production in the economy would be about 3% lower in 1997 than it would have been otherwise, with the long-term loss in output projected at 1.5%. Over 3 million jobs would be eliminated in 1997 relative to the baseline, with a projected permanent loss of about 1.5% of total employment over the long term.

Table 4
Impact on Employment
Balancing the HI Trust Fund Through Raising Payroll Tax Rates

Years to Balance HI Trust Fund	Required Medicare Tax Rate	Difference from Baseline in Given Year, Millions of Jobs			Percent Difference from Baseline in Given Year		
		1997	2000	2004	1997	2000	2004
25 Years	4.23%	-1.2	-0.6	-0.8	-0.9%	-0.4%	-0.6%
50 Years	5.58%	-2.4	-1.2	-1.6	-1.9	-0.9	-1.2
75 Years	6.42%	-3.2	-1.5	-2.2	-2.5	-1.2	-1.5

As dramatic as these figures are, there's good reason to believe that they are optimistic estimates. Because the macro model used in these simulations treats the Medicare payroll tax like the Social Security payroll tax, the increases in the tax rates apply only to the first \$61,200 earned (in 1995, and rising afterwards). That is, the model is not picking up the economic impact of applying the higher tax rates to incomes over the taxable base. Thus, these results should be considered a *minimum measure of the economic impact of raising Medicare payroll taxes*. Attempts to account for this problem yield significantly greater job loss and lower GDP. These results are available from the Economic Policy Division of the U.S. Chamber of Commerce.

It is important to note that, even with the set of numbers presented here with its inherent bias toward underestimating the economic impact, we can see that using payroll taxes to balance the Medicare trust fund imposes severe costs on the U.S. economy. These results clearly indicate that the Medicare problem must be solved by fundamental program reform, not tax increases.

September 19, 1995

Honorable Bill Archer, Chairman
House Ways and Means Committee
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Archer:

As a health provider in the Contra Costa County health delivery system, and as a California tax payer, I am highly concerned about the proposed cuts in Medicare and Medicaid Programs.

It is well known that 8.5 million California residents already are without health care, that there are, in addition, 4 million residents on Medi-Cal, and the population over age 65 is the fastest growing segment of the population.

Loss of a Federal mandate to cover vulnerable populations, with states regulating funds, will obviously result in decreased care.

Cuts in the Medicare budget of the magnitude being considered will devastate the Medicare Program, with the savings mainly to benefit those who do not require and depend on these resources.

I sincerely hope that your committee not be so short-sighted as to decimate a system that has provided and should continue to provide secure health care to the majority of us.

Respectfully,



Charles Windham, M.D.
2500 Alhambra Ave.
Martinez, CA 94553

