ADMINISTRATION'S MEDICARE CHOICES AND COMPETITIVE PRICING DEMONSTRATION PROJECTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

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ADMINISTRATION'S MEDICARE CHOICES AND COMPETITIVE PRICING DEMONSTRATION PROJECTS

FRIDAY, JULY 12, 1996

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

The Subcommittee met, pursuant to notice, at 11:17 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisories announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 2, 1996
No. HL-20

CONTACT: (202) 225-3943

Thomas Announces Hearing on the Administration's Medicare Choices and Competitive Pricing Demonstration Projects

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on the Health Care Financing Administration's (HCFA) demonstrations regarding Medicare health plan choices and competitive pricing. **The hearing will take place on Friday, July 12, 1996, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

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

BACKGROUND:

Currently, Medicare beneficiaries are provided health insurance coverage principally through a Federally administered, public fee-for-service program. However, beneficiaries are also able to receive their Medicare benefit through enrollment in private health maintenance organizations and other plans that contract with HCFA. At present, over 4 million Medicare beneficiaries, out of a total of 37 million, have chosen to receive their Medicare benefit through enrollment in privately administered health plans. These privately administered plans frequently offer advantages to Medicare beneficiaries in the form of reduced financial liability for cost-sharing with respect to deductibles and copayments, or in the form of enhanced benefits relative to the basic Medicare benefit package offered through the public program.

Comprehensive legislation to further the objectives of expanding the availability of privately administered plan offerings to Medicare beneficiaries, and making available to Medicare beneficiaries the latest innovations in benefit design that are enjoyed by workers in employer-sponsored health plans and through the purchase of private health insurance, were a major part of the Medicare provisions in the Balanced Budget Act of 1995, which was vetoed by the President.

Last year the Administration announced that it would conduct a "Medicare Choices" demonstration designed to explore ways to expand the availability of managed-care plans for Medicare beneficiaries and to test new ways for the Federal Government to pay private health plan contractors for the provision of health insurance coverage to Medicare beneficiaries.

In announcing the hearing, Chairman Thomas stated: "Expanding the range of choices in health plan designs available to Medicare beneficiaries continues to be an essential objective of this Congress. I am extremely interested to see that the Administration is now pursuing proposals advanced in the Congress last year and look forward to exploring in some depth the Administration's design and conduct of the Medicare Choices demonstration."

WAYS AND MEANS SUBCOMMITTEE ON HEALTH
PAGE TWO

FOCUS OF THE HEARING:

The hearing will focus on the key aspects of the design of the Medicare Choices demonstration, including selection criteria for health plans, designation of test markets, and review of the Government's testing of new methods for paying participating health plans, such as competitive bidding for the offering of Medicare coverage by private health plans.

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, Friday, July 26, 1996, 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 wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 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 including attachments.

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

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

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

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

Note: All Committee advisories and news releases are now available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS_MEANS/ or over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

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NOTICE -- CHANGE IN TIME

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 11, 1996
No. HL-20-Revised

CONTACT: (202) 225-3943

Change in Time for Subcommittee Hearing on the Administration's Medicare Choices and Competitive Pricing Demonstration Projects

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on the Administration's Medicare Choices and Competitive Pricing Demonstration Projects scheduled for Friday, July 12, 1996, at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building, **will begin instead at 11:00 a.m.**

All other details for the hearing remain the same. (See Subcommittee press release No. HL-20, dated July 2, 1996.)

Chairman THOMAS. The Subcommittee will come to order. Today the Health Subcommittee will examine the Clinton administration's managed care demonstration initiatives for Medicare. After almost 4 years in office, it is noteworthy that the administration has recognized that the Medicare Program must be modernized.

Medicare has much to learn from developments in the private sector, obviously. These demonstration initiatives indicate a new willingness on the part of the administration to borrow from the successes of the private health care market and provide Medicare beneficiaries additional high quality, less expensive health care choices. In light of Medicare's fiscal crisis, it is not coincidental that the administration is now adopting an agenda for Medicare which offers beneficiaries the types of choices that were included in the bill this Congress passed in its efforts to save Medicare. It is just too bad the President chose to play politics with Medicare and veto that bill last year.

It should also be mentioned that concerns have been raised about specific aspects of these demonstration initiatives. Personally, I am reserving judgment about these initiatives and I look forward to learning more about the details of the demonstration program from the administration as well as hearing the views of interested parties from the health care insurance fields.

It is my expectation, however, as the demonstration program is developed it will be designed to bring private innovations and resources to bear for Medicare beneficiaries in a real market setting rather than simply extending the long arm of government into private health care delivery. Additionally, we do not want Medicare as it evolves beyond simple old-fashioned fee-for-service insurance to cause unneeded distortions or dislocations in health care delivery by the manner in which the government provides for private sector coverage of Medicare beneficiaries.

The demonstration initiatives, I think, reflect a significant step forward by this administration. Nevertheless, I would hope the administration will pay close attention to today's discussions and at least be receptive to making any midcourse corrections which might be indicated by information generated by this hearing.

I recognize my colleague from California, the Ranking Member, Mr. Stark, for any opening remarks he might make.

Mr. STARK. Thank you, Mr. Chairman, for holding this hearing on the various Medicare managed care demonstration projects. I agree the administration is to be congratulated for pursuing projects to test ways to improve Medicare. I am not sure that the criticism of the administration at this point is warranted.

These demonstration projects simply attempt to test the kinds of ideas that were in the House-passed budget bill, with the all-important difference that the administration's proposals include some consumer and quality protections against massive balance billing. Unlike our House plan, the administration does not lock seniors into plans for 1 year at a time and cut traditional Medicare so that providers will end up forcing people into these untested plans.

There is a right way and a wrong way to make change, and I think the direction in which the administration is moving is going in the right way. I look forward to hearing from both the adminis-

tration witnesses and those providers who will have their own critical comments, I am sure, concerning which way these programs move.

Thank you.

Chairman THOMAS. Thank you. As usual, any Members who have additional written statements will be a made a part of the record, without objection.

Our first witness is Hon. Bruce Vladeck, Administrator of the Health Care Financing Administration. Bruce, welcome. Your written testimony will be made a part of the record and we can begin the proceeding in any way you see fit.

STATEMENT OF HON. BRUCE VLADECK, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you very much, Mr. Chairman. I will just give a very brief oral statement summarizing some of the points in my written statement. I do appreciate the opportunity to appear before you today, focusing on two programs that are central to our agenda of expanding the managed care choices available to Medicare beneficiaries while maintaining the existing structure of protections on quality and consumer choice.

Without inserting myself into the dialog between the Chairman and the Ranking Member, I would add that the administration believes there is considerable common ground between the Medicare reform proposals supported by the Majority in this Congress last year and those proposed by the President and supported by essentially all of the Democrats. We would hope that even as the legislative clock continues to tick forward that there would be an opportunity to rebegin the discussions to identify those areas of common ground so that we can move more quickly to address some of the longer term problems of the Medicare Program.

Having said that, let me get to the more specific subjects at hand. Permit me to begin by noting that HCFA's use of its demonstration authorities has had a profound effect on the evolution and success of the program for many years. Medicare's hospital prospective payment program, its hospice benefit, its other preventive benefits, and the Medicaid home and community-based waiver program all began as demonstrations. Of course, our current managed care programs are very much rooted in a series of demonstrations that began in 1980.

Since 1985, when we moved from the demonstration mode to the operational mode for managed care, we have experienced more than a tenfold increase in the number of Medicare beneficiaries enrolling in risk plans, and a sevenfold increase in the number of plans with which we have contracts. Nonetheless, I think there is a common ground and considerable consensus that the Medicare managed care program has not kept pace with some of the changes that have occurred in the private sector.

There are three areas of particular focus. First, there is wide belief that the types of managed care choices available to Medicare beneficiaries should be expanded. Second, there seems to be general consensus that beneficiaries need reliable, comparative information to assist them in making informed decisions about their choices. And third, there does seem to be almost universal consen-

sus that our payment methodology, the so-called AAPCC which bases payment on our experience in the fee-for-service population, needs to be delinked from fee-for-service costs in a particular community.

Changes along these lines were incorporated, again, in all of the Medicare reform proposals which were considered by the Congress last year. In the absence of signed legislation, our broad demonstration authority allows us to test potential improvements in all of these areas. I will focus today on two demonstrations, our so-called Medicare Choices Program and the competitive pricing demonstration.

First, on Medicare Choices. The goal of Medicare Choices is to provide beneficiaries with additional delivery system choices, and especially to address the problem of the unavailability for most beneficiaries of Medicare managed care choices in rural areas. We are using the Choices demonstration to pilot test new options which will give us experience and expertise in a wide variety of implementation issues, if and when appropriate changes in the program are enacted.

After a process that began with 372 expressions of interest, we now have 25 award candidates: 9 provider service organizations, 8 provider-owned HMOs, and 8 other managed care organizations, including 5 in rural areas. They represent a range of alternative payment options, including risk corridors, partial capitation, and blended payments. We expect all 25 of these plans to be certified and ready to enroll beneficiaries by the beginning of next year; some, we hope, will be ready well before then.

Should we be authorized in the future to contract on a permanent basis with PPOs or with PSOs directly, the lessons learned from Medicare Choices will significantly facilitate implementation.

Second, on competitive pricing, for years health care financing experts, including many in the HMO industry, have encouraged us to move from our current payment system to a more market-based rate. However, it is not at all obvious how to set market-based prices for Medicare managed care. There is a complex series of questions, and the best methodologies are not immediately obvious.

Recognizing the need to seriously examine this approach and how complicated it is, we have invested significant resources in developing a demonstration project. We worked with a number of outside contractors; we consulted with experts both from the academic sphere and from the industry. We conducted a number of surveys and focus groups on issues of consumer information and plan enrollment in order to design this demonstration.

It has three essential interrelated components: Beneficiary education, third party enrollment and counseling, and market-based rate setting.

In beneficiary education, we will contract with an independent third party to prepare and distribute educational materials to all Medicare beneficiaries in a specific market. These materials will explain the features in both Medicare fee-for-service and managed care and will provide comparative information on managed care plans as well as on Medigap options. They will not advocate managed care or fee-for-service Medicare, and certainly not any particular plan in comparison to others. They will also clearly state that

beneficiaries do not need to take any action to continue their current coverage and that the materials are there for information purposes.

The second component is third party enrollment and counseling. The independent third party contractor doing beneficiary education will also conduct all HMO enrollment and disenrollment activities and staff a toll-free counseling call center through which it will provide information to beneficiaries. This component of the demonstration reflects the trend among many private and public payers and responds to feedback we have received from beneficiaries indicating they would prefer having access to a third party when learning about or making managed care choices.

The third component is market-based rate setting. Under this demonstration, Medicare's payment rate will be based on bids submitted by all Medicare managed care plans in the demonstration site. Plans will bid on a standardized benefit package representing the most common denominator plan offered in the area. The rate derived from these bids will replace the current AAPCC. We have reserved the right to set the rate at a level that will assure that beneficiaries have access to more than one plan at the current community level of premiums.

In determining potential demonstration sites, we targeted those markets with relatively high AAPCC rates, relatively low Medicare managed care penetration, relatively healthy private sector managed care penetration, and enough Medicare HMOs to make competition feasible. In this process, however, we made one important mistake. After we identified Baltimore as the most appropriate initial site, we did not adequately consult with interested parties at the local level.

Fortunately for us, Mr. Cardin has shown some exceptional leadership in calling together for a series of meetings, which he has chaired with others from the congressional delegation, representatives of State government, representatives of Baltimore's managed care and other health care providers and the business community, as well as beneficiary groups to help us work through the issues raised by the demonstration. These meetings provide a level of reassurance that we will not proceed until we have convinced most of the affected parties that what we are doing makes sense and has addressed their needs and concerns.

In conclusion, Mr. Chairman, you and I and many witnesses before this Subcommittee over the years have expressed the belief that Medicare needs to learn from the private sector by expanding choices, helping beneficiaries to make informed choices, and reforming our managed care payment methodology. Each of these is a complex task with no obvious solutions. We are fortunate that our demonstration authorities allow us to test a variety of ways of making these important changes as we move Medicare into the 21st century.

Of course, I am happy to answer any questions you might have. Again, I appreciate the opportunity to appear before you today.

[The prepared statement follows:]

STATEMENT OF BRUCE C. VLADECK
ADMINISTRATOR
HEALTH CARE FININCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

INTRODUCTION

Good morning. I am pleased to be back to testify before this subcommittee. As was the case last time I appeared before you, my subject today involves demonstration projects of the Health Care Financing Administration (HCFA). Last time, the subject was long-term care. Today, my testimony will focus on two projects -- the Medicare Choices demonstration and the Competitive Pricing demonstration -- central to our agenda of expanding managed care choices available to Medicare beneficiaries while improving our payment methodologies.

BACKGROUND

Over the past three decades, HCFA's use of its demonstration authorities has had a profound impact on the evolution and success of the Medicare and Medicaid programs. Through support, development and testing of innovations in payment, delivery, access and quality, HCFA has contributed significantly to major program reforms and improvements. Let me just mention a few examples.

As the result of a program of research and demonstrations begun in 1976, Medicare moved in 1983 from cost-based reimbursement for hospital care to a prospectively determined per case payment based on diagnosis. The prospective payment system saves billions of Medicare dollars annually while the Diagnostic Related Group (DRG) classification system on which it is based is used today by half of the State Medicaid programs, CHAMPUS, and many private insurers, managed care plans, and other countries.

When the hospice movement was still in its infancy, HCFA initiated a Medicare and Medicaid demonstration to determine whether hospice could maximize patient autonomy during the last weeks of life and allow terminally ill patients to die with as much dignity as possible and relatively free of pain. Largely as a result of this successful demonstration effort, legislation established hospices as authorized Medicare providers. In 1994, about 270,000 Medicare beneficiaries used hospice care.

Beginning in the mid-1970s, HCFA sponsored a series of innovative Medicare and Medicaid demonstrations throughout the country to test the use of community-based services as substitutes for more costly institutional long-term care. These demonstrations served as the framework for the legislation authorizing the Medicaid waiver program under Section 1915(c) of the Social Security Act, under which home and community-based services may be covered.

HCFA's managed care programs were also rooted in extensive demonstration efforts. Beginning in 1980, HCFA tested the use of capitation payments for HMOs participating in Medicare. This pioneering effort demonstrated to plans, Congress, and the executive branch that HMO participation in Medicare on a capitated basis made sense for both beneficiaries and the program. Since HCFA implemented the Medicare managed care program in 1985, both the number of beneficiaries enrolling in risk plans and number of risk plans contracting with Medicare have

increased steadily. In 1985, only 309,000 beneficiaries were enrolled in risk plans whereas today over 3.6 million are enrolled in these plans, an increase of over ten-fold. Similarly, in 1985, only 32 risk plans contracted with Medicare. Today, 218 risk plans contract with Medicare.

There is general consensus among this Administration, the Congress, managed care plans, beneficiary advocates, and other providers that the Medicare managed care program should keep pace with private sector innovations while still ensuring that beneficiaries receive high quality care. For our purposes today, let me cite three areas that receive frequent mention. First, many believe that the types of managed care choices available to beneficiaries should be expanded to provide as many options as the commercial sector does. Within our current statutory authority, HCFA has recently expanded beneficiaries' managed care options to include a point-of-service option HMO. However, making additional choices such as provider sponsored organizations (PSOs) or preferred provider organizations (PPOs) widely available to Medicare beneficiaries is not possible under current law. Both the Administration and the Congress' balanced budget proposals include provisions which would allow Medicare to contract with these managed care organizations on a permanent basis.

Second, there is agreement that beneficiaries need reliable, comparative information on the managed care plans available in their local market areas in order to make informed decisions regarding enrollment. Again, there is common ground in the Administration and Congressional proposals. Both plans would require the Secretary of Health and Human Services to disseminate comparative information on managed care options at initial Medicare eligibility and during annual open enrollment periods. The Administration's bill also requires that information on Medigap plans be included in the comparative materials.

And third, most observers believe that the current payment methodology for managed care plans is flawed and should be improved. Under current law, the payment methodology is based on the Adjusted Average Per Capita Cost (AAPCC), generally referred to as "the AAPCC". Under the AAPCC methodology, payment levels for HMOs are derived from the utilization and cost experience in Medicare's fee-for-service population. There is general agreement that Medicare's payments to managed care plans should be "delinked" from fee-for-service costs in particular localities. In addition, recent research by HCFA confirms previous research findings that, because the current payment methodology does not adequately take into account the better health status of beneficiaries enrolled in Medicare HMOs, the Medicare program pays more for these beneficiaries than it would if they had remained in fee-for-service Medicare.

Congress has given HCFA broad demonstration authority to test potential improvements with which to address concerns like these. My testimony today will focus on two such demonstrations: Medicare Choices and the Competitive Pricing demonstration.

MEDICARE CHOICES

The purpose of Medicare Choices is to test the receptivity of Medicare beneficiaries to a broad range of managed care delivery system options and to evaluate the suitability of these options for the Medicare program. Our goal is to provide beneficiaries with additional delivery system choices and to increase options available to beneficiaries in rural areas. In addition, the Medicare Choices demonstration will help to develop approaches to a wide range of implementation issues-- including payment methods, certification requirements and quality monitoring systems--which would be associated with some of the new Medicare managed care choices piloted in this demonstration. In developing the design specifications for Medicare Choices, HCFA and its contractor consulted extensively with interested parties including managed care plans.

In order to minimize unnecessary investment of resources by applicants, HCFA used a two-step application process to select the managed care plans participating in the Medicare Choices demonstration. HCFA first asked plans to submit a pre-application statement of interest and a brief project description. After reviewing the pre-applications, HCFA then requested selected organizations to submit more detailed proposals.

During the pre-application process, HCFA encouraged a broad range of managed care organizations, including PPOs, PSOs and HMOs, to submit innovative managed care proposals, such as point-of-service and primary care case management systems. We also encouraged applicants to propose alternative payment methodologies such as risk corridors and blended capitation payments and to indicate a willingness to test risk adjustment methods.

HCFA targeted nine cities as well as rural areas. The nine target cities were Hartford, CT; Sacramento, CA; Jacksonville, FL; Atlanta, GA; New Orleans, LA; Columbus, OH, Philadelphia, PA; Louisville, KY; and Houston, TX. These sites represent areas with high managed care penetration in the commercial sector but low Medicare HMO penetration. We also accepted innovative pre-applications from interested organizations outside these target areas. We received 372 pre-applications, representing nearly every State in the nation.

From these 372 pre-applications, HCFA selected 52 managed care plans for further consideration; we requested these plans to submit final applications to HCFA by December 15, 1995. Plans invited to submit final applications offered a wide range of managed care delivery models and proposed a variety of payment methodologies.

We selected "award candidates" based on geographic factors, innovation of design, and ability to meet eligibility requirements. We selected 25 award candidates for final consideration -- nine PSOs, eight provider-owned HMOs or providers with HMO partners, eight HMOs or other managed care organizations.

The 25 award candidates submitted a variety of payment proposals -- thirteen requested 95% of the AAPCC, five requested risk corridors around the AAPCC, seven requested other payment

models such as partial capitation, blended payments, or capped fee-for-service payments. Sixteen of the 25 indicated an interest in testing a risk adjustment method. Five of the 25 award candidates are located in rural areas.

Award candidates are currently in the final steps of the Medicare Choices demonstration award process, which includes negotiations regarding payment methodology. Once these remaining details are worked out, HCFA will review plans to determine whether they meet standards regarding access, beneficiary protections, financial solvency, and quality assurance. While generally expecting plans to meet current law standards for Medicare HMOs, HCFA will evaluate plans participating in the Medicare Choices demonstration on a case-by-case basis.

HCFA expects plans to be certified and ready to enroll beneficiaries in 1997, but some may be ready to enroll beneficiaries sooner.

Both the Administration and the Congress support expanding Medicare managed care choices to include PPOs and PSOs and support similar provisions regarding PSO State licensing , solvency, and quality requirements. In the past, demonstrations have provided valuable information on implementing such program expansions. If HCFA is authorized in the future to contract with PPOs and PSOs on a permanent basis, the lessons learned from the Medicare Choices demonstration will significantly facilitate and accelerate implementation.

COMPETITIVE PRICING DEMONSTRATION

As I mentioned earlier, the current payment methodology for managed care plans is flawed and should be improved. For years, health care financing experts encouraged Medicare to move from our fee-for-service based method to one that relies more on a "market-based" payment rate. The managed care industry appeared to agree as well. The Group Health Association of America (now the American Association of Health Plans) testified before this Subcommittee in February 1995 that "payment rates are tied to the Medicare fee-for-service costs in a given area, and do not give the Medicare program the benefits of market dynamics present in the private sector." GHAA further stated that "Medicare payments to health plans should eventually be 'market-based'." In its 1995 Annual Report to Congress, the Physician Payment Review Commission (PPRC) recommended that "payment rates for Medicare health maintenance organizations established through competitive bidding ultimately should replace payment rates based on adjusted average per capita costs in markets with a sufficient number of HMOs bidding to achieve price competition."

However, developing a market-based rate is a complex endeavor and the best methodologies are not immediately obvious. Recognizing both the need to seriously examine market-based rate setting and the intricacy of the task, about two years ago HCFA began to invest significant resources in developing a demonstration which we refer to as "competitive pricing."

HCFA conferred with many experts when designing the demonstration's bidding process, including consultants at Abt Associates, a firm with a long history in health care financing policy; academics recognized as authorities on competitive pricing at the University of Minnesota; additional consultants with expertise in managed care; and other technical experts, including representatives of the managed care industry and the beneficiary population.

In developing the education and enrollment aspects of the demonstration, we worked with BENOVA (formerly knows as "Health Choice"), a contractor specializing in marketing and consumer education in the private and public sectors. We also convened two expert panels specifically to help develop the education and enrollment design specifications, one comprised of managed care plans and the other of beneficiary-oriented representatives. In addition, another contractor, Research Triangle Institute, conducted numerous focus groups in several states to determine beneficiaries' preferred methods of receiving information on health insurance options and their response to prototype educational materials. We also conducted 35 individual interviews with Medicare beneficiaries in four locations to more carefully examine their reactions to the prototype educational materials and to determine whether beneficiaries understood the most important elements included in these materials.

Components of the Demonstration

The competitive pricing demonstration focuses on two of the three concerns outlined in my introduction: altering the payment methodology for Medicare managed care plans and improving the ability of beneficiaries to make informed choices about their Medicare options. The demonstration has three essential and interrelated components: beneficiary education, third party enrollment and counseling, and market-based rate setting.

Beneficiary Education. HCFA will contract with an independent third party to prepare and distribute a comprehensive set of brochures to all Medicare beneficiaries in a specific market explaining the features of Medicare fee-for-service and managed care programs. The printed materials will highlight issues to consider when choosing between these two delivery systems. The materials will also include a chart comparing the benefit packages and premiums for all Medicare managed care plans in the beneficiaries' local market area in addition to comparisons of Medigap options. It will also include a list of HCFA-sponsored education seminars and informational videos and the number of a toll free counseling call center. The materials will not advocate managed care or fee-for-service Medicare. The materials will clearly state that the beneficiary does not need to take any action and are intended only to provide information.

Third Party Enrollment and Counseling. The independent third party contractor will also conduct all HMO enrollment and disenrollment activities and staff the toll free counseling call center. This neutral third party will provide objective information to Medicare beneficiaries who call seeking more information on their Medicare choices, as well as enroll beneficiaries who want to choose a managed care plan by mail or by telephone. In the competitive environment of this demonstration, managed care enrollment through a neutral third-party will help to ensure that

plans do not encourage healthier beneficiaries to enroll and discourage sicker beneficiaries from enrolling in their plan. In addition, while we believe that favorable selection into Medicare HMOs results in part from beneficiary self-selection, we are interested in learning if using a neutral third party has an effect on favorable selection into Medicare HMOs.

Another reason third party enrollment is an important part of this project is that HCFA's recent focus groups have found that Medicare beneficiaries would prefer having access to a third party (as opposed to a plan trying to "sell them something") when learning about and/or making managed care choices.

Several years ago, HCFA successfully piloted a beneficiary education and third party enrollment program in Portland, Oregon. In fact, some of the Oregon plans continued to contract with this third party after the demonstration ended. Third party enrollment is a mechanism used by many public and private sector purchasers, such as 22 State Medicaid programs, the CALPERS program, which covers over 1 million California state and local government employees, and many large employers.

Market-Based Rate Setting. Under this demonstration, Medicare's payment rate will be based on bids submitted by all Medicare managed care plans in the demonstration site. Plans would bid on a "community standard" benefit package, representing the most common plan offered in the area. The rate derived from bids will replace the current AAPCC rate. The same demographic factors now applied to the AAPCC (age, sex, Medicaid, and institutional status) will be applied to this market-based rate to adjust payment to establish the payment rate for individual beneficiaries in the first year of the demonstration. HCFA plans to apply new risk adjustment methodologies after the first year.

We have not determined yet precisely how we will set the Medicare payment based on submitted bids. We are committed to assuring that beneficiaries have access to more than one plan at the current premium level. For example, if most or all of the plans in the demonstration site are currently offering a "zero" premium option, we would set the Medicare payment rate so that several plans could continue to offer such an option.

Site Selection

In determining potential demonstration sites, we targeted those areas with a relatively high AAPCC rate, relatively low Medicare managed care penetration, and enough Medicare HMOs to make competition feasible. We are confident that we have been thorough and careful in gathering together the resources appropriate to design the demonstration. However, we also realize that we made a important mistake after we identified Baltimore as the most appropriate initial site for this demonstration. We did not adequately consult with interested parties at the local level.

Under Mr. Cardin's leadership, HCFA is now in the midst of a series of meetings, chaired by the Congressman, with others from the Maryland Congressional delegation, Baltimore managed care

plans, beneficiary representatives, Baltimore business representatives, and representatives of the State government. The purpose of these meetings is to discuss the issues and concerns raised by these parties, something we should have done earlier, but are glad to be doing now.

I'd like to take this opportunity to thank Mr. Cardin for his positive and constructive action after Baltimore was announced as the first potential demonstration site and to reiterate Secretary Shalala's commitment that we will not proceed with the demonstration until members of the Maryland delegation are comfortable with the demonstration's design and timetable.

Clarification of Demonstration's Parameters

The design and implementation of this demonstration is a complex undertaking and, hence, there are many areas where misunderstandings can occur. While it would not be possible to cover all areas, I would like clarify some of the demonstration's parameters.

First, no plan would be excluded on the basis of its submitted bid. The purpose of the bidding process is simply to set the Medicare payment amount on the basis of the managed care marketplace, rather than using the AAPCC rate. Indeed, the use of the phrase "competitive pricing" in lieu of "competitive bidding" is intended to convey that we are only setting the price, not using the bidding process to exclude any interested parties.

Second, beneficiaries will have the option of remaining in fee-for-service Medicare or enrolling in a managed care plan. No action on the beneficiary's part is required to stay in fee-for-service Medicare. The beneficiary's enrollment in a managed care plan will be completely voluntary. The contractor conducting third party enrollment will not be rated or compensated based on the number of beneficiaries enrolling in a managed care plan. The purpose of the education and information is to assure that beneficiaries understand all their options.

Third, managed care plans will be able to market to potential enrollees as they do today through mailings and radio, newspaper, and television advertisements. Their ability to deliver their message to potential enrollees will not be hampered. This demonstration simply provides comparative information on plan choices so that beneficiaries will be able to make informed choices and conducts enrollment and disenrollment through a neutral party, instead of through the plans.

Finally, the managed care industry has for many years expressed an interest in experimenting with a metropolitan statistical area (MSA) wide rate, and we had indicated that we would consider using one MSA-wide payment rate. However, concerns have been raised that this could discourage plans from providing services to individuals in Baltimore City, which has the highest county-specific rate in the region. We have indicated that we are flexible on whether to use one rate for the Baltimore MSA or to adjust the bid for county differences.

CONCLUSION

Mr. Chairman, you and I and many witnesses before your Subcommittee have expressed our belief that Medicare needs to learn from the private sector by expanding the range of managed care choices available to our beneficiaries, giving beneficiaries the information they need to make informed choices, and reforming how Medicare determines its payment rate to managed care plans to incorporate local market forces. But these are complex problems and no one knows the right solutions at this time. Fortunately, our demonstration authorities allow us to test how to make these important and needed changes. We believe we have worked responsibly with experts and affected parties to craft demonstrations that will allow us to move Medicare into the 21st century.

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

Chairman THOMAS. Thank you very much, Bruce.

Ordinarily, we operate by a fairly strict 5-minute rule as we go through this. But I think there is probably less partisan concern on this issue than anything we have discussed. So I am going to try to maintain as flexible a structure as I can so that we can get the information on the record that will be helpful to us in understanding some of the rationale behind the choices that HCFA made and, in fact, beginning at the beginning, the statutory authority that HCFA has.

The reason I would start off questioning that way is because in January of this year, you were quoted in a BNA article that you thought you needed additional authority to carry out the kind of demonstration that you are interested in. In the President's fiscal year 1997 budget package, there was a request to amend the existing statutory demonstration authority to specifically permit waiver of section 1876.

Let me say at the beginning, I personally believe that, given the broad demonstration authority that is on the books, you have the ability to do it, but obviously since the statement was made and the President's budget asked for specific authority, I think it is worthwhile for you to explain why that occurred.

Mr. VLADECK. I appreciate the opportunity to do that, Mr. Chairman.

Let me first say that we have been advised by our Office of General Counsel that section 402(A)(1)(a) of the 1967 amendments to the Social Security Act provides, in their view, a more than adequate authority to proceed with demonstrations of this sort. Nonetheless, there are at least three reasons why we sought specific legislative authorization for such a demonstration.

The first is, as you might note from the design of the Medicare competitive pricing demonstration, in the President's bill both this year and last year, we argued very strongly that in order to get a fully functioning, level playingfield, fair market for Medicare beneficiaries, we had to include Medigap or Medicare supplemental policies under the same set of rules as capitated plans. It is clear that the existing authority does not extend to Medigap where our regulatory oversight authority is very limited. A statutory authorization might permit their inclusion in such a demonstration.

Second, it has been our experience relatively routinely in the past, that as we sought to proceed with a demonstration, one or more affected parties sought to intervene through the judicial system to prevent it. While we think we would ultimately prevail under existing law, we believe that a much more explicit, specific recent congressional authorization would place us in a stronger position and save us steps in the event of litigation.

Third, frankly, we are just always more comfortable when we have a specific congressional expression of interest in moving in a particular direction than when we do not. Since all of these issues were very much addressed in the proposed legislation, we thought we should not try to hide from the Members of Congress or anyone else our intention to proceed in this direction.

Chairman THOMAS. And obviously, with the degree of change in this kind of a demonstration project, especially in the competitive pricing one rather than in the Choices one, although to a certain

extent it applies there, as well, you are going to be setting up a situation in which existing contractors may choose not to participate and you will be creating new ones that currently could not exist without the agreement in the demonstration project.

I am interested less right now in your entrance structure—we will talk about that in 1 minute—than I am in your exit structure, if people choose to leave. I did not see this in your testimony and I assume you have contemplated the downside. Obviously, in markets such as the Baltimore area, you have such a small number of folks that you are dealing with, you may have problems down the road, 3 to 5 years, in a market expected to expand significantly of its own accord that probably does not need the full structure of a demonstration project.

But have you sat down with the folks who modeled this to figure out what happens with the confusion and disruption for the beneficiaries if somebody pulls out?

Mr. VLADECK. We have talked about that and we have given it a lot of thought. To take an example, it contributes to our selection of Baltimore as a desirable initial site. In Baltimore, we have seven HMOs with either existing or pending contracts with the Medicare Program. At the moment, they serve a total of slightly fewer than 13,000 Medicare beneficiaries. So it is our feeling that if, as a result of the prices established in a competitive process, several of them withdrew from the market, there would still be available to beneficiaries a broad range of choices among competing plans.

Now, there is a risk, obviously, that some number of beneficiaries would not be able to stay in the same plan if a particular HMO chose not to renew its contract because of the new price. But again, there are a small enough number of folks involved so that we believe we have done what we can to minimize the risk.

Obviously, anytime we seek to reduce prices in any service Medicare pays for, there is always the risk that certain providers will drop out of the program.

Chairman THOMAS. I guess, Bruce, I am less concerned about that. If it is truly competitive and they cannot compete, I have no problem with that. That is what we are looking for.

My concern is that you have set up an artificial structure in order to run a demonstration in which someone complies with all of the rules but cannot compete, given the way in which you have artificially changed the market, and who then feels they must leave and understands, then, there is no ability to come back in within, what is it, a 5-year period? How do you justify refusing a contract to someone who, except for the demonstration project that you have imposed on the area, would otherwise meet the criteria and could compete?

Mr. VLADECK. The only basis that I could see, Mr. Chairman, for a plan that otherwise would seek a contract refusing to participate is that they thought the price was too low.

Chairman THOMAS. We will get into that as we talk about specifics, because I do not think it is just price that concerns a number of people about the way in which you may wind up modeling it.

For example, as you set up what you believe to be the competitive bid in the competitive pricing demonstration, you then lock in not just—and correct me anywhere if I am wrong in my under-

standing of the methodology—you do not just lock in the price, you lock in, in essence, the package.

Mr. VLADECK. The base package, sir.

Chairman THOMAS. The base package that was out there constructed in the competitive way. If they are above the price in terms of the competitive package, which, I believe, all of them waive any of the costs, which is an attractive way to get people into the program. But do they also add additional benefits, drugs and perhaps vision? That if they are above that competitive price, the only area you let them make adjustments in is requiring the beneficiaries to pay the difference.

You do not allow the plans to make adjustments in the package during the demonstration period, and it just seems to me, of what value is a demonstration of a competitive pricing package if the only variable is to add cost to the beneficiary without allowing the plan to mix and match those bonus benefits that they thought were attractive at one time but which obviously could be adjusted to keep them attractive, notwithstanding the higher price.

I understand the need to control the parameter of a test, but what you have done is basically thrown out, to me, the key ingredient of the HMO model for competitive price testing, and on that basis one would say, Look, I am above the number. You will not let me adjust the benefit package. It is dollars only. I am a loser. I am out of the game.

I do not know how you do not wind up dwindling to the one who either knew how to play the game or wound up lucking out. It is like ten little Indians. You will start off with a number of programs, but because you do not let them do what inherently they need to do to be competitive in the marketplace, the only adjustment being price, I do not see how you wind up with a significant study on competitive pricing.

Mr. VLADECK. Let me make two responses to that, if I may, Mr. Chairman.

Chairman THOMAS. Yes.

Mr. VLADECK. The first is, all of the experts and others we have talked to about this issue in preparation for this——

Chairman THOMAS. Let me say at the outset, as we get into these, the reason I am doing all this is that I am criticizing the fact that you do not have a perfect plan.

Mr. VLADECK. Yes.

Chairman THOMAS. Everybody needs to understand that.

Mr. VLADECK. And I hope you will understand that I am not suggesting that we do have a perfect plan yet.

If you are going to establish a competitive price, one of the critical issues is that it be for a standard product, that you are not comparing prices between apples and oranges, to use the conventional metaphor. If consumers are to make choices among different plans, then you have to separate out the question of what the price is for something that is standardized versus the prices for additional things which could still be offered in the marketplace at additional cost.

Second, I think it is a little bit oversimple to suggest that a plan can respond only by reducing its benefits package if it has an existing cost structure that at a given level of benefits is in excess of

the price that would be set competitively. Presumably, one of the other ways it could respond, since the competitive price is supported by at least one competitor in the same market, is to become more efficient in its operations or to reduce its overhead.

Chairman THOMAS. Or to put it in a slightly different way, become more attractive by becoming more standardized.

Mr. VLADECK. No, sir. I think——

Chairman THOMAS. I think that would be attendant.

Mr. VLADECK. I think the competitive advantage will be for the plan that at the government rate can further expand its benefit package at zero premium or the market-level premium. The plans that can do that will be the plans that produce the standard package most efficiently.

Mr. CARDIN. Would the Chairman yield on that?

Competitive pricing presents a challenge to the managed care community because there are no plans that operate in Baltimore today that offer a sole option which charges a fee to the beneficiary. That has not been successful competitively.

I think what the Chairman is raising is a concern that has been mentioned frequently by the managed care operators and that is if they come in with a bid that is higher than the competitive price that is selected by HCFA, that operator is going to have an extremely difficult time operating in the Baltimore market because their only option under the original configured pilot program is to charge a fee to the beneficiary. It is at least perceived by the managed care operators as unlikely that they could be competitive in the Baltimore market if they have to charge a fee for the basic program. Some operators are willing to charge a fee for a supplemental benefit, but for the basic benefit, they do not believe they can be competitive.

You can look at it two ways. One, it may cause the managed care operators to be very careful in the bids that they submit and to submit the lowest possible bid. However, as the Chairman has mentioned, the risk here is that there will be a significant number of managed care operators that may be effectively unable to compete in the Baltimore marketplace, giving a limited number of choices to our seniors, and I think that is the tradeoff that we are facing.

Mr. VLADECK. Let me say two things about that, if I may, Mr. Cardin.

First, that concern is, in large part, why we explicitly rejected the notion of setting the price at the lowest bid or even at some mathematically determined function of the bids that are submitted. It is our intention, and this is one of the things we are testing, to try to set a price at such a level that there will still be significant competition among enough plans that can maintain a zero premium for the standard benefit package. This is one of the things we are testing. If none of the bids permit us to do that, then we may not be able to proceed with competitive pricing. If all of the bids come in at the same level, we may have a different kind of legal problem, but that is one of the things we are trying to find out.

Second, one of the reasons we picked Baltimore is because of the average difference between the 95 percent of AAPCC that we are

paying the plans and their costs of producing the basic Medicare benefit package—not the community standard package, but the benefit package with deductibles and without the additional benefits. We estimate that there is a difference of almost $75 a month at the current time between what we are paying for the standard package and what it is costing the average plan in the Baltimore market to produce that.

We think that $900 a year, depending on where we set the price, ought to offer a considerable opportunity for plans which may have initially bid above the price to still provide the community benefit package at a lower rate and at zero premium.

Chairman THOMAS. But, Bruce, you introduced the Baltimore question, and it seems to me that you can find that kind of pricing differential in a number of communities.

Mr. VLADECK. Yes, sir.

Chairman THOMAS. So that cannot be the primary reason you chose Baltimore. My problem is that if, in fact, the way you are setting up your structure, and I agree you have to pare away reality to get some comparisons, it sounds to me like efficiency and cost cutting are two of those that you are focusing on as key factors. Why in the world would you choose the largest population community in a State which denies those plans one of the most effective and primary cost cutting tools, which would be hospital rates, given the uniqueness, as the gentleman from Maryland reminds me almost on a daily basis, of the single-payer system in Maryland?

I guess if we are looking for a place to test this business of cost cutting and efficiency, you have tied not one but almost both hands behind these organizations' backs, given the uniqueness of the location. So there has to be a reason why you chose Baltimore, and do not tell me it is because that is where your headquarters is.

Mr. VLADECK. We thought about that, because this is a very staff-intensive process, and we do not have a lot of——

Chairman THOMAS. You mean that is the reason?

Mr. VLADECK. No, it is not the reason.

Chairman THOMAS. All right.

Mr. VLADECK. But it was a consideration. This is a very staff-intensive process, as some of the Members know, and we do not have any travel money this year. But the issue of the rate setting is, as you know, and as I am reminded every day in this job, every community is unique on some dimension or another. No two are exactly alike.

We think in some ways, again, from the point of treating something as an experiment, that the hospital rate setting program in Maryland clearly has not in any way deterred or delayed the development and expansion of managed care in the private sector in the State of Maryland. It certainly is not an obstacle to the State's moving ahead with a very ambitious Medicaid managed care program. It certainly has not, under the current rules, discouraged HMOs from seeking to enter the Medicare business in Maryland.

We have formal communication as well as informal communication from the folks at the rate setting commission, who are very comfortable with this demonstration. Now, it is true, we have picked a site in which the HMOs have one less tool with which to lower their costs than they do in some other communities, although

I think the Maryland folks would tell you that is because the rate setting commission process in Maryland has already gotten savings as substantial as any the plans could achieve on their own.

Mr. McDERMOTT. Mr. Chairman?

Chairman THOMAS. I am less concerned about the difficulties of doing it in Maryland, and I know the gentleman from Maryland has had some great concerns not only in the way it was set up and who was involved but what may occur within the State. That is not my concern.

My concern is that if this is a test and we are only going to have three of these locations, the primary one you have chosen, the initial one, the one that is going to be focused on a lot, has a structure so different than anywhere else that I am trying to determine how much value for purposes of comparison with other areas in the country choosing Baltimore in Maryland with the all-payer rate on the hospital structure will help us in terms of the value of this demonstration across the United States. That is my concern. I will leave the difficulty in Maryland to the gentleman from Maryland. I am concerned about the universal value of the demonstration project because of that.

Mr. McDERMOTT. Go ahead.

Mr. VLADECK. Do you want to add to this, because I could respond to Mr. Thomas.

Mr. McDERMOTT. I do not understand what the argument here is, why that makes it more difficult in Baltimore. In an HMO, you have physicians' services and you have nursing services and you have in-home health services along with a variety of other things and you have hospital services. This is one setup in which the hospital services are factored out of the equation, so you can see whether the cuts can be made in the provider services, whereas in San Francisco or in some other place, there is no fix, so maybe the costs can be cut in hospitals.

I think Baltimore is a good place to have an experiment because it is the only place in the country where you have the hospitals factored out. That is not an issue in their ability to cut costs. I might be mistaken in my understanding, but——

Mr. VLADECK. Let me, if I just might——

Mr. CARDIN. Before you respond, if I might, I want to disagree with the premise by both the Chairman and Dr. McDermott in that it seems to me that managed care companies advertise that they save money by managing care, not by discounting. I just take exception to the fact that discounting saves money. I think it just shifts the costs of the services in the country and a good managed care company will save money by managing care and utilization and not by seeking to get a discounted service.

I would hope that, particularly when we look at the way the Federal Government buys services, that we would be as competitive as anyone else in what we pay.

Mr. VLADECK. Thank you. If I may just add a point, we spent a lot of time on this issue. There are no three metropolitan areas in the United States which one could claim in this instance, or probably most others, were representative of the circumstances in the Medicare Program throughout the country.

For a variety of reasons, it is probably not appropriate to go through the entire process of naming names of all the other metropolitan areas we looked at, but there are certain characteristics that Maryland does not have or Baltimore does not have. Just for example, we have a metropolitan area that is all within one State in Baltimore. Lots of the bigger metropolitan areas are not.

We have a metropolitan area where, compared to others, the variation in costs between inner city and the immediate suburbs is not as great as they are in some of the Northeastern cities. The Baltimore MSA does include some more outlying areas, which is a problem we are trying to address.

We could go on and on with the list, and I would be happy to go through City *x* has all these characteristics, but on the other hand, it does not have these characteristics.

Mrs. JOHNSON. Mr. Vladeck, if I may, I am looking at a letter from the Health Services Cost Review Commission in Maryland in which they say a more salient question is whether the results from a demonstration in an area with hospital rate regulation will be generalizable to areas without hospital rate regulation. Managed care organizations in other States have one cost reduction strategy unavailable to Maryland plans, the ability to negotiate hospital discounts.

Barbara Kennelly and I have a very nice urban/suburban area that did not get the right to go ahead with this kind of a demonstration, so there are succinct urban areas available that do have this.

Negotiating discounts is not just a matter of cost shifting. It is a matter of incentivizing institutional settings to learn from the private sector many of the cost control mechanisms that, frankly, have not been common in nonprofit hospitals and now are being adapted.

Furthermore, many of the cost control mechanisms that can be best used in hospitals are dependent upon having a far better and more integrated care system for postacute care. So if you are going to look at managed care network development, I honestly do not see how you can do that well excluding hospitals, not only from the point of view of costs but from the point of view of integrated care and continuity of care and varied settings of care.

So I am very concerned about that, and I am apparently not the only one. Apparently the Baltimore rate commission was also concerned about the applicability of the results you are going to get from Baltimore to other systems across the Nation. They say that specifically in this letter to you.

Mr. VLADECK. Again, Mrs. Johnson, every area has unique characteristics and there is no single site or even a small number of sites from which one could safely generalize everywhere in the country.

Mrs. JOHNSON. I understand that. It is just that Maryland is the only State left in the Nation that does rate regulation. Connecticut went through it for many, many years. We felt very strongly that we had overwhelming evidence of its downside. It did not work for us. It cost money, it did not save money.

So it is concerning to me that with so few demonstrations you would pick a site that is so different from the way the rest of Amer-

ica runs their health system, and maybe because of Maryland's unique geography and the structure of their health care industry. I do not know that, but I am concerned about your decision here.

Mr. McDERMOTT. It would seem to me what I am hearing, Mr. Vladeck, is that you have picked the wrong site, and the reason given for that is that Baltimore is not like anyplace else in the United States. It has a hospital rate setting mechanism. I would——

Chairman THOMAS. I would tell the gentleman that is not the only reason, but that is one reason.

Mr. McDERMOTT. A major reason, and that is the reason submitted in the letter from the local area. You cannot generalize off of us because we are different.

Chairman THOMAS. Right.

Mr. McDERMOTT. I suspect that you are going to run into the same buzz saw any place that you select as long as you have a provision that after HCFA selects the rate, anybody who is above the rate has to charge a premium. I think that is the real reason the Maryland HMOs do not want to get in and compete. They do not want the market to set rates. The HMO people, I think, will resist being put into a competitive position where they have to submit a bid and then if they are too high, they have to charge their customers a premium. I think you just have to face that fact right now, that no matter where you go in the country, you are going to run into the same buzz saw from the HMO operators.

Mr. VLADECK. If I may, Mr. McDermott, let me just say that I think every community is unique in one dimension or another. The marketing companies spent a lot of time trying to find a demographically typical census tract so they could test Olestra. We went through a somewhat analogous process at the much larger unit of analysis of the metropolitan area, which is the market for HMOs. There is not a representative community for the Medicare Program for these purposes, so that is true.

If I may just comment on your other observation, this is not an issue we have encountered solely in the case of HMOs. It is true that in many aspects of the Medicare Program, folks endorse in principle the concept of greater marketplace competition or more market-based pricing. Yet when we have tried to introduce competitive pricing for durable medical equipment items, for example, or clinical laboratory services, which were much more homogeneous than HMOs, the existing providers opposed it. Across a wide range of the sorts of things that Medicare purchases, in every instance, the existing providers have opposed market-based pricing.

So we are very much cognizant of this opposition in the provider community.

Chairman THOMAS. I stand in awe at my friend from Washington's ability to divert just enough off of the target to miss it. I do not disagree with anything that has been said in terms of people trying to compete in the marketplace, but again, the concern is the uniqueness of the packages that the HMOs offer, and they are shaping those packages based upon their belief of where they want to be able to outdo one another in a competitive structure. What you are doing is creating a demonstration which homogenizes them to a very great extent, to the point——

Mr. McDERMOTT. In——

Chairman THOMAS. Just 1 minute. To the point that above the competitive bid, not below, above the competitive bid, the only option is the price change, except for what you call the internal efficiencies and the rest.

We are going to hear testimony, for example, from the Memorial Sisters of Charity Health Plans. They, in their testimony, outline their HMO program. They are very proud of the fact that they eliminate the Medicare deductibles and coinsurance. They have nominal copayments specific to certain services, removal of Medicare's limits on numbers of covered hospital and skilled nursing facility days, enhanced benefits with a preventive wellness emphasis and an outpatient prescription drug benefit, and an annual vision and hearing exam with benefits for eyeglasses and hearing aids.

That is the package they have shaped that they think is a good market package. If they wound up in your study above that competitive bid, do you not think, to get a true feeling for a competitive structure for HMOs, they ought to be able, if they are above the competitive bid, to adjust that package?

Mr. VLADECK. Mr. Thomas, the package that we have defined for the Baltimore demonstration is the package that all the plans are offering in the existing market.

Chairman THOMAS. I understand that.

Mr. VLADECK. The market has produced convergence of benefit packages. That is what the existing market does, it drives the plans toward convergence of packages. All we are saying is, we want to set a price based on the standard package in the existing market.

Chairman THOMAS. But what you are doing is taking an existing market, determining what you believe to be the competitive price, whatever formula you use, and then telling people, the next year, that is the competitive price. And your mix of last year, if it does not bring you to that competitive price, cannot be changed if you are above it except to add dollars.

Mr. VLADECK. During this period.

Chairman THOMAS. If I knew that that was what was going to occur, the whole essence of the HMO operation is I will make an adjustment on the vision or the hearing. I will change it because the market has now changed. You are changing the market by virtue of coming in, arbitrarily setting a "competitive price" based upon last year's model and telling everybody this is now the model. You keep saying "we," government is going to come in and freeze the market. It may have been a competitive market at one time, but you do not allow the competition to see where the shifts will occur if you are above the competitive price except in the dollar game, which to me is not worth much of a study.

Mr. STARK. Mr. Chairman.

Chairman THOMAS. Certainly, the gentleman from California.

Mr. STARK. Bruce, let me just come back to see whether I think we may be getting a little off the issue here. The demonstration, as I thought I understood it, has two principles. One is to figure out a way for the government, HCFA, to pay a managed care plan for the basic plan. Now, there may be some reasons you have to pay for more, but for the basic plan. And two, to cover issues of

quality and consumer protection, and we will not hear any of that from the HMOs testifying today.

The bells and whistles that they add to these packages I will not say are of no concern to HCFA or to us, but that is not what you pay for. You have something in there that says if they are over, they have to offer extra benefits, but the fact is that, in law, we are charged with providing a basic package of benefits. So if HMO A wants to offer eyeglasses and whatever else, that really is not our issue. They are marketing gimmicks, for the most part. They use these additional frills to attract beneficiaries. As you indicated, in some markets, those have become almost standardized additions, but you still are not required to pay for them, as I understand the law.

So what you want to accomplish, and this is a rhetorical question, is to find a way for you to price that basic package, be it in San Francisco or Baltimore or Wapakoneta, Ohio, so that you have a way to, either through bidding or through some other calculation, price the basic package. The quality and consumer protection issues probably are mostly to protect the consumers from unscrupulous insurance peddlers, and perhaps some physicians, I do not know, but that is an issue that ought to apply evenly in whatever market you are in.

So the idea of whether or not plans have to charge extra or cut benefits, it really does not make any difference to what you are trying to do in the experiment, unless I am missing something. I think there is pretty universal agreement, we are paying too much under the AAPCC. We are too high. You are looking, I think, for a logical and empirical way to get that lower. How low, you do not know, I suppose. Am I missing something here?

Mr. VLADECK. No. In fact, I think that is very helpful, Mr. Stark, in helping to explain this issue a little bit further, or to try to explain it, because all this stuff is very complicated. But there are two problems going on that are interrelated and, I think, that are involved in this conversation.

In theory, the AAPCC payment to an HMO is supposed to cover the basic Medicare benefit package. In fact, because we are paying too much in most of the markets in which we have Medicare HMOs, beneficiaries, for no additional premium, are receiving additional benefits.

Mr. STARK. Right.

Mr. VLADECK. The question is, and this is a question we all talked about last year, how do you get from here to there since there are several million Medicare beneficiaries out there at the moment who, by opting into HMOs, have gotten additional benefits at no cost to themselves because we are overpaying the HMOs. The fact is that if you had a more efficient and equitable mechanism for pricing HMOs, those beneficiaries would not be getting as generous a set of benefits at the price they are now paying.

At some point, it is likely that, as a matter of policy, we are going to have to address this question. It is not a decision we are going to make, and it is not a decision we are going to make using our demonstration authority. That is a decision that Congress and the executive branch are going to have to make together: What to

do with those 3 million folks who are now getting additional benefits.

For purposes of this demonstration we are going to take the market's benefit package at the current market price, which is our AAPCC, and see, if we lower that price, how many plans are able to stay in that market at that package. That is exactly correct.

Mr. STARK. Thank you.

Chairman THOMAS. The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman, and thank you, Mr. Vladeck.

I want to commend the administration for at least attempting to broaden their horizons with respect to Medicare and the delivery of health care to senior citizens in this country. But this whole discussion reminds me of a discussion of industrial policy, where the government attempts to guess what the market is and what the market demands and create policy to make it happen.

I am just wondering how much we will learn from these demonstrations and if we will learn the right things, because you do seem to be, with all of your parameters and your guidelines, locking in a market situation. And as you know, the market seldom locks itself into anything. It is fluid. It changes from day to day, much less year to year, and you have, I think, a 3-year demonstration project where you are going to lock in a market circumstance that happens to be in place now.

I just want to urge you to reassess the flexibility that you allow those players in the marketplace during this demonstration. I am afraid if we lock in what we perceive to be the market for 3 years, we may not learn the right things. We may, in fact, think we learn that this does not work and the market cannot work when, in fact, we have not allowed the market a chance to work.

Under our plan, of course, we had a lot more flexibility. The market was pretty wide open, as a matter of fact, and I think we would have learned more under our proposal than we will under yours. But admittedly, I do not know enough about yours to say that to a certainty, so I am willing to listen some more and I do commend you for your efforts to try to learn how to open up Medicare.

But those are my concerns and I just wonder if you have any thoughts about those.

Mr. VLADECK. I appreciate that, sir. Let me just say, we are not seeking to lock anything in for 3 years. What we do is we absolutely reserve the right to redefine the benefit package or the price from year to year as the bidding process evolves.

The trick about the standard package really has to do with how to get the right kind of bidding process going. If people who bid too high can play games with their product after the price is established, then that is like saying that when HCFA goes to buy computers and specifies Pentium PCs with 20 megabytes of RAM, a producer who came in with a bid over our price could say, Let us just give you one with 16 megabytes and we will meet your price. In any bidding process, you have to define the standardized product of what the bid is for.

But it is a 1 year at a time situation, absolutely. In competitive pricing you want competitors in the marketplace to look at what the others are doing. You do not want them to collude, but you

want them to bid based on their expectation of what all their competitors are going to do. And the best way to learn about that is to look at what they did last year. So it has to be a very dynamic process.

Mr. MCCRERY. Why would you not, though, just establish as the basic plan the Medicare benefits that are specified in law today and then allow the plans to offer whatever over and above that they wish?

Mr. VLADECK. Because that would run a significant risk of leaving a large fraction of those 12,000 beneficiaries who are now in Medicare HMOs in the Baltimore area, worse off.

Mr. MCCRERY. What do you mean——

Mr. VLADECK. One reason we are not just turning it over to the market is because real markets have downsides, and we are not prepared to put beneficiaries significantly at risk for purposes of testing a new approach.

Mr. MCCRERY. Why would they be worse off? Just explain that.

Mr. VLADECK. Because now, beneficiaries are getting about 70 dollars' a month worth of additional benefits over and above the Medicare standard benefit package because of the way we set our prices at the moment. If we get bids for a price of the basic benefit package, the plans that had the greatest need to stay in the market would bid most of that $72 away and any beneficiary, to keep what they now have, would have to pay a premium.

Mr. MCCRERY. Why could they not switch plans?

Mr. VLADECK. Because there would not be any plans in the market at that point that could do it at zero premium.

Mr. MCCRERY. Why is that?

Mr. VLADECK. Because, as far as we know from the ACR, adjusted community rate, calculations and so forth, the supplemental package is worth something like $70 a month and there are plans that are currently providing the existing Medicare benefit package for $70 a month less than where we would expect the bid price to come out.

Mr. MCCRERY. Essentially, though, I think what you are saying is you do not trust the market to work, so you want to build in governmental parameters to make it work the way you think it should, and——

Mr. VLADECK. No, we think every market works in a way——

Mr. MCCRERY. That is a legitimate approach. I disagree with it, but I think that is what you are saying. I just fail to see how you can conclude that if you allow flexibility above the basic benefit package of Medicare benefits that are required under law today, you will not have a marketplace that responds to demands, and if you already have in place seven plans that offer a benefit package that is, in fact, above the required Medicare benefits today, I would be very surprised if the market were to all of a sudden in toto drop all of those extra benefits. Somebody is going to try to attract more people by offering those benefits and then somebody else will have to and somebody else will have to. That is how the market works.

Maybe I am missing something, but it seems to me that you are concluding that the market will work in a way that I am not familiar with.

Mr. VLADECK. Let me just try this one more time. We are now paying a certain amount of money per month in Baltimore which the plans see as an attractive price because they are still entering, and they are providing the basic benefit package plus about 70 dollars' a month worth of extra services.

We believe that if we set the price at the current cost of providing Medicare benefits, then a plan would need either to reduce its expenses by $72 a month per member or reduce the package of what it is providing or increase its premiums. We believe—and it is one of the reasons why we are not prepared to just dump this all in the market—that the way most markets would work is that those plans that had a strong base of existing members who were tied to physicians and health systems they like would transfer those costs to the beneficiaries and the others would reduce benefits, because that is what is happening in the private market.

If we were going into an area in which anything above the basic Medicare benefit package was already being paid for by requiring a premium from beneficiaries, then people would not be worse off as a result, and that would be fine. But in the majority of markets where the existing prices have led to additional benefits and no premiums, it is very hard to do this and not leave beneficiaries worse off.

Mr. MCCRERY. This whole thing is hard, and again, I commend you for trying to swim through all this and reach some logical conclusion, and I will cease after this——

Mr. VLADECK. One of the things I think we have made clear all along is that if we live long enough to get an initial site up and running, we do intend to test competitive pricing in several sites. We have always reserved the right to fine tune and alter and change the model as we develop experience moving from site to site, and we will certainly take very much to heart all the issues that you have raised as we think about how a second generation or second model might be constructed.

Again, this is hard, and I think those are all very real kinds of concerns and questions. I hope circumstances permit us to test a variety of different approaches over a relatively short period of time.

Chairman THOMAS. We have a number of——

Mr. MCCRERY. One closing comment. It seems to me that if we could somehow wave a wand and figure out what the true value in price terms of the current fee-for-service Medicare package is, then we ought to just say to the market, we are going to pay this much per person and let the market respond as to the benefit package over and above the basic package that we all think should be required. That is, to me, the best way to see how the market is going to work, and if you can get efficiencies, which we are all looking for, the market will provide those, not the government. So, to me, that is—and maybe that is what you are trying to get out of all of this, but it just seems to me to be rather a convoluted way to do it.

Mr. VLADECK. Mr. McCrery, I think that is what Congress thought it was doing when it set the AAPCC at 95 percent of the community fee-for-service price. I think they either had an exaggerated perception of our ability to adequately adjust for risk or just

overshot the mark by a little bit in their desire to encourage entry of managed care plans.

Chairman THOMAS. It was an attempt to figure out where we are supposed to be. We did that with a number of standards in the environment and the rest, and then as you get closer to it, you take a look at how realistic you are and you try to adjust, and that is what you are doing.

Obviously, we still want to talk about the Medicare Choices demonstration. The study structure there, frankly, is a whole lot easier and, I think, better, and we will get to that.

I want to introduce one additional complication as we go along, because no one has mentioned the third party broker structure rather than the plans themselves enrolling, and, of course, I think the plans sometimes think that rather than just a pure sales job, there is an educational job about the new culture in which someone is about to enter and they believe that is an important aspect of getting people off on the right foot. The third party broker may or may not provide that beyond the pure education.

So at some point, we want to spend just a little bit of time talking about that, what experiences we have had, if there have been adjustments in this third party broker structure as opposed to other models that you have seen. But other Members want some comments about the competitive bidding and I believe the gentleman from Georgia, Mr. Lewis, wanted to get in for 1 minute.

Mr. LEWIS. Thank you very much, Mr. Chairman, and Mr. Chairman, I will be very brief.

Mr. Administrator, first of all, let me congratulate you for trying to be creative. I think you are taking the right approach. It is good to try new ideas, but they must be tried first on a small group with a lot of flexibility so that our seniors will not be harmed. I think well-thought-out demonstration projects are good and necessary first steps. I would especially like to compliment you on your efforts to develop a way to provide seniors with impartial information about the health plans that are available.

It is my understanding that some of these demonstration projects will focus on improving monitoring the quality of care provided. Could you discuss some of these ideas?

Mr. VLADECK. The monitoring of the quality of care, sir, is that the question?

Mr. LEWIS. Yes, sir.

Mr. VLADECK. There are several dimensions to that. As part of our evaluation of the Choices demonstration projects, we have been working with the RAND Corporation to develop new technologies or processes by which, from a standardized information set collected at each encounter between a patient and the health care system, we could develop sort of a computerized early warning and monitoring system. We hope to have that system ready to test at about the same time that the first of the Choices sites begin operation.

That will be in addition to, not to the exclusion of, our existing quality assurance techniques. Our existing techniques take essentially two forms. First, we have very detailed requirements for the internal quality assurance processes that the plans themselves maintain; and we monitor their operation of those quality assur-

ance processes very intensively. Second, the PROs, the peer review organizations, for years have had responsibility for monitoring the quality of care in Medicare HMOs. It is only within the last few years that they have begun to recognize the special characteristics of HMO care and have begun to develop the tools and techniques that are necessary to look at quality in an HMO setting, and that will continue.

We will also continue some of the other monitoring we do of disenrollments, of changes in patterns of enrollment, and of the grievances and appeals of beneficiaries. That provides something of an early warning system for us about quality.

So I guess that is a long answer when the correct short answer is, we will keep in place our existing mechanisms while conducting the Choices demonstration and the competitive pricing demonstration, and we will test new techniques based on expanded information provided us by the plans and some research on quality measurement we have been doing with the RAND Corporation, UCLA, and folks elsewhere around the country.

Mr. LEWIS. I know the Chairman will want to move to the whole area of Choices, but it is my understanding that you will be working with one of the Medicare Choices projects in Atlanta.

Mr. VLADECK. Yes, sir.

Mr. LEWIS. I would be very much interested in learning more about what is going on there.

Mr. VLADECK. Perhaps, in addition to a very short answer, we can arrange a separate briefing, if you would like, to go into substantially greater detail. But so far we have had very limited Medicare managed care activity in Atlanta. Atlanta, like much of the Southeast, has been relatively late to large-scale commercial enrollment.

Perhaps because of that, a number of HMOs, insurers and provider-based organizations in Atlanta, saw the Choices demonstration as a way to get into managed care while, at the same time, addressing some of the concerns they have about payment mechanisms, or risk, or the nature of the insurance market or other matters concerning which the existing laws seem to create problems for them.

We still have a concern, I have to tell you, with some issues having to do with the relationship between our program and the policies of the State Department of Insurance and the Insurance Commissioner, and we are working very intensively with them to try to——

Mr. LEWIS. What you have in Atlanta, is this considered a modified provider service network, or——

Mr. VLADECK. We actually have a sort of an array of participants in Atlanta. Some of them are insurance-based organizations. Some of them are provider-based organizations. We have some existing HMOs that are seeking to change the way they do business for Medicare. We have the organization based at St. Joseph's Hospital, which is very much a provider-based system, although they are in partnership with an insurance company. We have the Georgia Baptist Health Care System, which is almost purely a provider-based system.

One of the nice things about the way this program is evolving in Atlanta is that we have different kinds of organizations, all of which have been involved in health care in the Atlanta area over the last several years. Some are from the provider side, some from the insurance side, and all of them are seeking to provide a comprehensive range of choices in that market. We are kind of excited by the prospect.

Mr. LEWIS. I must tell you that St. Joseph's and Georgia Baptist are two great providers and institutions in the heart of the city.

Mr. VLADECK. We are very pleased by the kind of response we got from Atlanta and we are looking forward to being very actively involved there.

Mr. LEWIS. We have something coming up in Atlanta in the next few days.

Chairman THOMAS. You do?

Mr. LEWIS. It is a little game going to be getting underway a week from today, you know.

Chairman THOMAS. It is kind of exciting.

Mr. LEWIS. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

The gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you, and thank you, Mr. Vladeck, for your patience and perseverance through all of this. Having worked through some of this in our work on the Medicare Preservation Act, I know that it is almost hopeless for those of us who have to spend only periodic times dealing with this, and yet it is extremely important that we figure out how to do it.

I am concerned about this aspect of your competitive pricing demonstration project. I hear what you are saying about not wanting to go into the market with a premium that is lower than you are already paying people in that market for a zero premium risk contract which provides actually more than Medicare benefits. You seem to have a good grasp of how much of the money you are paying those HMO risk contracts goes for the basic benefit plan under Medicare and how much goes for additional benefits.

Under that 95 percent of AAPCC reimbursement rate for the HMO risk contract, you are able already to factor out what is the basic benefit plan cost and what is the additional cost. Why do you not just go into the market at that level and let people see how much more they could provide? Then you really get a sense of competitive pricing. Why would you limit those who provide additional benefits to only dollar issues rather than benefit issues?

Mr. VLADECK. Mrs. Johnson, I mean this as a compliment and I hope you will understand it as such. That is exactly the question the Office of Management and Budget raised with us as we worked on designing this demonstration.

I think we are giving serious thought to the idea of actually asking for two bids from each plan, one for the existing market-level benefit package and one for the standard Medicare benefit package. The concern is that we do not want to leave current enrollees worse off, so we want to set a price that will buy, at least from some of the plans, the current benefit package, not just the basic benefit package.

And frankly, we and others are concerned that if we are too explicit about that difference, then the pressures on us will be overwhelming to move immediately toward that price on the basic benefit package. This is true not only in Baltimore, where there are only 12,000 folks affected, but in southern California and south Florida where there are hundreds of thousands of beneficiaries affected. And as I said, at some point, we are all collectively going to have to address what to do about the beneficiaries who are now receiving more than the basic benefits at zero premium.

Mrs. JOHNSON. Yes, I appreciate that.

Mr. VLADECK But we do not intend to do that as part of this demonstration.

Mrs. JOHNSON. But if you did—originally, I was sitting here thinking, why do you not do that? Why do you not ask for the competition at that level? I guess I do not clearly understand the relationship between the reimbursement rates that we have established and a demonstration project. If you asked for competitive bids at that level, that does not prevent you from continuing to reimburse the HMO risk contracts at the higher level for the higher benefit package, but it might incentivize them to offer something at the lower benefit package. Then the question is, what do you do with the rest of the money? You could give beneficiaries the choice of a rebate or of access to long-term care insurance or something like that.

I understand that that is difficult. That is why I at least wanted to know, why will you not let, then, plans offer more benefits for the current price than an HMO does if they can? Why are you going to anchor them to dollars when you do not anchor the HMO risk contract with a dollar anchor?

Mr. VLADECK. If I understand correctly, and I have to ask the experts, under the tentative rules we have talked about for the first competitive pricing site, once we establish the community standard benefit package and once we establish the government price, we are saying to plans whose bid price was higher than the price we set that they have to make up the difference in a premium. However, if a plan bid below the price we set, then they can pocket the difference or they can invest that into further benefits, and——

Mrs. JOHNSON. But, you see, I think since the project for us all is only to slow the rate of growth of Medicare premiums, I do not think the issue should be, how do we take back. The issue should be, how do we clearly get the value for our dollar. If you go to the market with the lower benefit package, too, retaining the current reimbursement rate, then the problem you have is how do you require those plans to provide value for the dollars above the benefit plan. If they do not want to provide value for that, then there are some other options there. You could string them out.

But it seems to me that to go into the market with a competitive pricing demonstration project that does not hit this pretty squarely is going to leave us with a notch problem. It is better to address that in the demonstration project now, knowing that we do not need to cut the 95-percent rate. In fact, one of the things we did in the Medicare Preservation Act was to beef up, perhaps irrationally—those of us from some parts of the country think it was done irrationally—the rural AAPCC so that we do buy a good benefit

package, and then slow the rate of growth in that benefit package so you put pressure on that benefit package that is offering more than Medicare benefits, which is why people will crosswalk into it.

So I do not want to cut those benefits; that is our current reimbursement rate. But I do not see your demonstration plan structure giving us the information we need about what the competition would be if we reimburse for the benefit structure, knowing that we also are capable of reimbursing for more than the benefit structure. So I just leave you with those thoughts. I know you hear what I am concerned about.

Then let me ask you one other question about the Georgia market. In many parts of the United States, because this is true of Connecticut and not true of Boston. I do hope one of your demonstrations will be in Boston. I do not know whether it is. I know Hartford did not get one.

Mr. VLADECK. No.

Mrs. JOHNSON. That is really unfortunate, because they went from one to four zero premium plans in 3 years and they have the long experience of the Harvard HMO and that is too bad. That would have been useful, because the Northeast is a different kind of environment.

But in the underdeveloped managed care plan areas, could you not start there with the basic benefit plan premium, so you do not have the two-tiered system? Do you have any HMO risk contracts in Atlanta?

Mr. VLADECK. We do have some existing ones. In some of the low-rate areas where we have been in the Medicare HMO business for a while, like the Pacific Northwest or the Twin Cities, we have publicly supported legislation to raise their payment rates on the theory that the way the current system was working was perhaps inequitable to them. So to go into those markets in the first round and to say, We want to drive down the price by the use of the marketplace, did not strike us as a particularly wise strategy.

Mrs. JOHNSON. No, but it does make it even more important in terms of the usefulness of these results that in that market, you have a price that is only package oriented, but that you have in other markets, like in the Northeast, you have a way of making comparability. So you have to do something about having a price that is package oriented, that is current Medicare benefit oriented or you will not have comparability. How you deal with the disparity, I think, is a better problem to try to resolve temporarily than not to have the competition or the competitive experience of the Medicare basket rate.

Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from Washington, I think, wanted to inquire.

Mr. MCDERMOTT. Listening to Mr. McCrery and Mrs. Johnson and myself and all the rest of us, I would like to ask a couple of definitional questions, because I have a little problem here. A senior citizen today, if they get Medicare, they receive the services under that plan, and then they can buy a supplemental policy. This supplemental policy can be a cheap one or a fancy one, depending on how much money they have or what they think their health needs are going to be. So I think of the Medicare package that we

have today as the basic package and the supplemental being the additional services that are bought beyond that.

What I do not understand is you are talking about a basic package and additional benefits. Are these "additional benefits" the same as the supplemental package that seniors buy from AARP or somebody else?

Mr. VLADECK. Let me try to explain, Dr. McDermott. Some of this really is a regional difference.

Chairman THOMAS. Bruce, as you answer that question, though, would you put some percentages on it, because I know it is not 100 percent that purchase some kind of additional coverage. If you could go through if you are able, the percentage of beneficiaries that purchase Medigap policies and the percentage eligible for additional cost-sharing or premium contributions because of Medicaid eligibility, so we have an idea of the universe.

Mr. MCDERMOTT. He wants to make it more complicated.

Mr. VLADECK. Let me start with the following and I hope these folks here will hit me or something if I get any of these numbers badly wrong.

Chairman THOMAS. I apologize for trying to make it more realistic rather than complicated.

Mr. MCDERMOTT. Complete.

Mr. VLADECK. The issue is as follows. If you take the benefits to which Medicare beneficiaries are entitled under the law with the existing very significant copayments and deductibles and caps on how many hospital days can be covered and so forth, that is what we refer to as the basic Medicare benefit package.

All but about 12 percent of Medicare beneficiaries purchase or have purchased for them some additional coverage. About 10 percent of beneficiaries receive additional benefits through HMOs, which is where most of this last discussion focused.

About three-quarters of Medicare beneficiaries purchase or have purchased for them supplemental insurance policies, Medigap policies with the ten varieties, all of which pay most of the coinsurance and deductibles for covered services and relieve some of the limitations on the utilization. Variations in policies largely have to do with additional benefits of which prescription drugs are the most important and the most expensive, rather than reduced out-of-pocket expenses.

About 12 to 15 percent of Medicare beneficiaries have very extensive coverage of their copayments and of additional benefits by virtue of their eligibility for Medicaid, and then about 10 percent——

Mr. MCDERMOTT. So their Medigap policy is essentially Medicaid?

Mr. VLADECK. Medicaid, that is correct.

Mr. MCDERMOTT. Yes.

Mr. VLADECK. And then about 10 or 12 percent of beneficiaries have no additional coverage at all.

Mr. MCDERMOTT. So they are simply bad debt to the system in whatever place.

Mr. VLADECK. Or they are paying out of pocket. They tend to be very much concentrated in the income band immediately above Medicaid eligibility. These are primarily folks who cannot afford supplemental insurance policies.

In the HMO side of Medicare, the rules for the risk contracts do not allow plans that provide the basic benefit package for a cost less than we pay them to pocket that difference. They are required to use that difference either to provide additional benefits at no additional charge or to buy down the part B premium, which is an out-of-pocket expense for beneficiaries that has not been part of this discussion, or some combination of both. About 60 percent of the Medicare HMOs provide the standard Medigap policy plus some additional benefits without any additional premium to beneficiaries because they are filling that gap between what they are being paid and their costs of producing the basic package.

Mr. MCDERMOTT. So they produce the basic Medicare package and then they buy—essentially, they are buying a Medigap policy. I mean, that is what that money is. The "additional benefits" are a Medigap policy for 60 percent of the people.

Mr. VLADECK. For 60 percent of the plans.

Mr. MCDERMOTT. The plans.

Mr. VLADECK. Sixty percent of the plans with which we have contracts is actually a higher proportion of beneficiaries, because, obviously, the so-called zero premium plans are the most attractive. But this is almost purely a regional phenomenon. In those parts of the country where the AAPCC, our basic price, is high by whatever measure, most of the HMOs are providing additional benefits at zero premium. That includes southern California, most of Florida, and many of the Northeastern cities. In those areas——

Chairman THOMAS. So another way of saying it, though, so people can come through the back door, is that at the 95 percent of AAPCC, the HMO can give you all of the basic benefits, we can throw in a Medigap policy, and we do not charge you any premium and maybe put drugs in, as well.

Mr. VLADECK. That is correct.

Chairman THOMAS. That is the other way of looking at it.

Mr. VLADECK. That is correct. And in the Twin Cities——

Mr. MCDERMOTT. And Seattle.

Mr. VLADECK [continuing]. And in Seattle and in Portland and in those few rural communities that have Medicare HMOs, in order to get the basic Medicare benefit package through an HMO, a beneficiary has to pay a significant premium or the HMOs do not want to have risk contracts with us at all and exercise the option they still have under the law to be reimbursed on a cost basis. This is increasingly the case in the Twin Cities.

So that is why there are about three separate layers of complication associated with this question, because in the high AAPCC areas, like Baltimore or like southern California, we have three sets of issues. One is that beneficiaries currently get expanded benefits at no additional cost to themselves if they enroll in an HMO. Second, we think that occurs in part because we are paying too much in our rate in those communities. But third, one of the arguments for why we are paying too much is the argument we hear from people from Seattle or Minneapolis, that we are paying too little in those communities. Yet we also tend to believe, and I think the savings taken in legislation suggests that we are, on average, overpaying at 95 percent of AAPCC.

Mr. McDERMOTT. But it is nationwide. Nationwide, you are overpaying.

Mr. VLADECK. The average payment is too high, but clearly, it is too low in some communities and higher than too high in other communities.

Chairman THOMAS. But you also have to say, rather than say the Baltimore experience, the Maryland metropolitan area experience gives you a swing of almost $200 between the highest and the lowest AAPCC within that demonstration area, so the margin that an HMO has to work with given the very short geographic differences between that $200 difference means you really have a tough time in certain areas offering anything that is reasonable and in other areas you have enormous windfall.

Mr. VLADECK. As I think we have pointed out, in other instances, the pricing differences within the Baltimore MSA are less than average for MSAs around the United States. In fact, one of the other criteria we looked at and one of the other reasons we gravitated toward Baltimore was because, as compared to the Los Angeles-Riverside County market area or the metropolitan New York market area, that $200 a month difference is less than it is in many larger markets.

Chairman THOMAS. It just occurred to me, and I apologize, I did not pick up on the subtleties, we will reexamine the HCFA travel budget. [Laughter.]

Mr. VLADECK. I appreciate that——

Chairman THOMAS. I did not realize that was where you were headed at the beginning.

Mr. VLADECK [continuing]. Your assertion of jurisdiction in that regard, but I am not sure everyone feels that way.

Chairman THOMAS. I do learn, though.

Quickly, on the third party broker, what you learned, why you are doing it, if you have changed it at all from past experience.

Mr. VLADECK. Let me just say that we first got into the question of third party brokers in our meetings with private employers, particularly those who had sought to undertake relatively large scale or rapid conversion of their retirees to managed care plans. We clearly still have significant selection problems in the Medicare HMO program. There are lots of reasons for it and I do not want to imply motivation at all.

To some extent, perhaps entirely, that is a function of the characteristics of beneficiaries in terms of who was interested in managed care and who was not. But to some extent, I would assume that if HMOs were rational and if those that were publicly owned were protecting the interest of their stockholders, they would also shape their marketing and enrollment activities in a way that is more likely to attract better risks.

Particularly when you introduce the kind of dynamic to the marketplace that a lower price does, we are concerned about the extent to which one of the responses to this change in price would be selective marketing or selective enrollment. We have had a lot of experience with this issue on the Medicaid side, where almost half of the States with Medicaid managed care programs are now using third party brokers, and so we thought it was appropriate to test it at this point.

Chairman THOMAS. Prior to turning it over to the gentleman from Maryland, you have two additional competitive bid pricing sites. We were listening to some of your criteria. My friend and colleague from California indicated that he was still in the running, based upon the criteria that you announced. Have you, in fact, settled on the two additional sites?

Mr. VLADECK. No, we have not. We have a list. We have learned from our experience in Baltimore. Once we identified potential sites, we went to the industry at the national level and asked if we could identify such a community, either from our list or theirs, in which all of the plans would be willing to volunteer to participate in such an experiment, since that would have been our preference. We were unable to identify a city where that was the case. We then——

Chairman THOMAS. Did you spend a lot of time on that search?

Mr. VLADECK. I do not know how energetically they acted, but we waited a number of weeks for the response. We have several other sites in mind, but we have learned from Baltimore that before saying anything in public, it is probably prudent and wise to consult extensively with folks from that community. We have not yet begun those consultation processes in any other community.

Chairman THOMAS. As you sharpen your model from the Baltimore experience, I would urge you to touch bases with us as you move forward to suggest areas that you might be looking at for modification so we can follow the progress, as well.

Mr. VLADECK. We would appreciate that very much, sir.

Chairman THOMAS. Thank you.

The gentleman from Maryland.

Mr. CARDIN. Thank you, Mr. Chairman.

It might be useful, since Baltimore has been mentioned quite frequently, to just share with the Subcommittee some of the conversations that have taken place in Baltimore. It is true that we were not involved in the initial decision to select Baltimore and we have raised significant objection to that process, but I want to compliment HCFA in meeting with us and working with us since the initial release of Baltimore being selected as the initial site.

I think it is clear from the testimony today that the current pricing mechanism for the managed care plans needs to be changed, that using 95 percent of an average rate that varies so greatly among even small areas is not the best way to compensate for bringing managed care to our Medicare beneficiaries. So we welcome looking at a new pricing mechanism.

Members of the Subcommittee have pointed out why Baltimore would be good or bad. Many of the issues that have been raised will be present regardless of what site is selected, and I think that is clear. But there are two unique aspects to Baltimore that we want to make sure are discussed before moving forward in Baltimore, and one has already been mentioned. That is the all-payer rate structure and whether the all-payer rate structure is the right location for the first initial program.

The second is timing, and it has not been brought out yet, Mr. Chairman, and I think it is important to point out that the Maryland Legislature approved a plan that will bring all Medicaid eligibles into HMOs and enrollment will start in January of this year.

We are using a third party contractor to bring in the Medicaid population, so there will be a significant change in the Maryland HMO community. There is a great deal of concern by our State as to whether they can have a successful integration of the Medicaid population into HMOs at the same time that there is a Medicare pilot program moving forward. That issue is being presently addressed by HCFA and the State of Maryland.

I might tell you, it is anticipated that the legislature in January will be considering expanding that program to include also long-term care, so it is a significant change taking place in Maryland. There is concern as to the capacity of the State and the managed care operators to handle a pilot program all at once and we need to keep this Subcommittee informed as to how those discussions are progressing.

The other issues that have been brought up, I think, are very important. We have talked about the competition and competitive pricing. That is going to be true wherever this type of a pilot program is started and we need to make sure that, in fact, we will have competition and a significant number of plans offered to our seniors.

The AAPCC rate differential in Baltimore concerns me because it would be very easy to go and try to enroll a person, an elderly person who lives right across the Bay Bridge, where the AAPCC rate is so low, where you are going to be now using an average rate which would reward significantly a plan that enrolls individuals in that area. This is true in Baltimore, but I believe is true in many other areas.

The consumer protection issues, the use of third party brokers, these are all matters that need to be fully addressed before moving forward with a pilot program regardless of where that pilot program takes place.

The integration of our seniors who currently have multiple options available and the confusion that will just normally be associated with any new program need to be addressed. In Baltimore, we are one of the sites that have a waiver, where our seniors currently are receiving more benefits than just the normal Medicare benefits under a cost program. That is present in five locations in the country. We want to make sure the seniors that are enrolled in that program are not confused with this new effort.

So there are a lot of problems that have been raised that will occur regardless of what site a pilot program moves forward with that need to be addressed before we move forward.

So, Mr. Chairman, I appreciate your giving me, at least, this opportunity to explain to the Subcommittee. I want to thank HCFA for the close working relationship that we have now established. It seems to me that if we proceed in Baltimore, there will be some modifications to what has been already advertised. It is extremely important that this Subcommittee be kept informed of what is happening in Baltimore, or other sites, because I do think an awful lot depends on this program being done in a successful manner if we are going to be able to move forward in giving more options to our seniors in managed care. Thank you.

Chairman THOMAS. I thank the gentleman for his comments.

I think HCFA understands now that perhaps what they thought was a typical kind of a project, although innovative and novel, has, in fact, generated a great deal of interest. These folks are not trying to make sure it fails, but, in fact, to try to make sure that it succeeds, because decisions that are partially overdue need to be made, and frankly, as we were going through our look at changes in the program, we were desperately searching for the kinds of tools that you will be looking for in these demonstration programs. Had we had them available, a risk adjustment mechanism, an ability to compare and contrast in a way that would allow us a dollar profile, we all believe we could have done a much better job in trying to restructure. So we are very interested in a positive way in what you are doing.

Do you want to go into the competitive bidding, because we are going to go to Choices right now.

Mr. McDERMOTT. Could I just ask one thing on this?

Chairman THOMAS. Yes. Go ahead.

Mr. McDERMOTT. Mr. McCrery asked a question about why you did not go into the market, and Mr. Cardin just said something which triggered a thought in my own mind. My father is 91, went to church and came back with an envelope from an HMO that had been handed to him by one of the other people there. And my father said, "She said to me, 'Ask your son if this is good for me to get into.'"

One of the things that I would like to hear you talk about is what the downsides of competitiveness are and what consumer protections exist for Medicare beneficiaries enrolled in HMOs. Mr. McCrery was suggesting maybe we should just let the market be a little freer. It is sort of managed competition, if you will, and you did it for consumer protection reasons, I suppose. I do not know.

Mr. VLADECK. Let me, if I may——

Mr. McDERMOTT. Because people 91 years old may have a hard time deciding on which HMO to join.

Mr. VLADECK. Let me respond, not exactly to your question but to the illustration, in a sense. We find, through formal opinion research as well as just through people we talk to less formally, an enormous desire on the part of beneficiaries in those communities where there is a lot of managed care marketing going on for help in figuring this out. That is where the third party information is needed—not just the videos or the brochures that are done by a third party, but the counseling, the 1–800 number, the neutral party who will tell people, if you want to do *x*, here is what you want to do. Here is the upside and the downside of each of these choices.

In terms of the risks, there are three, I think, and Mr. Lewis got to some of them. Obviously, we want to have an absolute floor that we are continually raising in terms of the benefits and the quality of service and protection of beneficiaries. We believe in continuous improvement, not only on our own part, but on the part of the people from whom we buy services. We think one of the dynamics of better quality measurement, which is certainly true in the most successful private sector firms, is that once you think you can measure your quality performance, you keep raising the bar all the time. Those are sort of preconditions.

The third thing, and the hard thing, has been that as you put economic pressure on the system, how do you structure the market in such a way that providers' responses have to be in the direction of getting more efficient or getting better, rather than in the direction of reducing what they are providing for that price or finding a way to shift it to someone else, either in out-of-pocket costs or in noneconomic costs, such as waiting times, difficulties getting through on the phone, whatever, to the beneficiary.

That is the hard part, and if you put the question at that level, it is one that every large purchaser has all the time and one that we have lived with not only in the managed care setting, but in the other areas of Medicare where we have tried to reform payment.

One of the issues on prospective payment for hospitals was, if you lower the price, what is going to happen? The answer appeared to be, to a considerable extent, hospitals raise their prices to folks who are not constrained, and when they ran out of those folks, hospitals began increasing their productivity, which was what we had hoped to get 10 years ago.

So the issue is when you reduce the price you pay to someone, there are a lot of different ways he can respond. How do you channel circumstances so the response is in the direction of greater efficiency or a better product rather than in the direction of a reduction in the quality or the diversity or the characteristics of what is being provided? One way you do that is by putting a floor on what is provided in qualitative terms as well as in benefit package terms, but the other way has to do with the way in which you structure the bidding process. That is what we have been trying to figure out.

Mr. McDERMOTT. Thank you.

Chairman THOMAS. Let me explain part of my problem with that, using DRGs as an example. Clearly, on diagnostically related groups, you have a narrow band, but you basically put a dollar amount on it and then let them figure out how to accomplish what was required within that dollar amount.

To me, a better analogy to the HMO market would be to say, This is what we have to spend. What can you do for us? Understanding the basic package is a given, what can you do for us at that price, and let then the HMO figure out how they make the efficiencies or offer various products.

By your predetermining that efficiency is the goal that you are shooting for, and locking all of the other variables into place, I do not know that since we are now outside of a narrow, defined group to the larger picture that all we get are people dropping out of the marketplace. Because the only way I can make an adjustment under that model is to add dollars, and dollars is the most important motivator. That is back to my original concern about that model that you structured, and I understand the difficulties.

Mr. VLADECK. I would argue that the model you are suggesting, where we say, Here is our price, is very close to what we have been doing over the last 10 years. When we tell HMOs, You must provide the basic benefit at that price and provide whatever else you want; that is what we have been doing under the AAPCC.

Chairman THOMAS. I understand, but the dart you threw landed at 95 percent and you built in the problem of the difficulty of the

AAPCC to begin with as the base from which you took the 95 percent. So you created a uniform charge off of an inequitable base, and I do not know that that gave us a whole lot to deal with in that.

For example, I would much rather you went in and you said, all right, here are your options. You are going to get 95 percent, 94, 93, 92, 91, or 90, we do not know which yet. What can you give us for those prices, and then pick one kind of an approach. There are a number of ways to deal with this. But my concern is, above the average or the competitive bid structure, you can only play with dollars, and that is a basic difference.

Now, let us move to the Medicare Choices demonstration, because I think from a model point of view, one, it is easier to deal with. Two, it is also kind of exciting because you have a couple of dozen areas that you are dealing with which will give us faster a better understanding of the diversity that is out there.

Where are you in terms of the kind of different delivery models and the risk payment adjustment models that we are playing with here, or what do you hope to get out of the Choices demonstration study?

Mr. VLADECK. Of the 25 sites or organizations of providers with whom we are hoping to consummate Choices demonstrations, I am trying, of course, to——

Chairman THOMAS. On those 25, if you simply threw them up on a map of the United States, are there any obvious holes?

Mr. VLADECK. The answer is yes, I think, as Mrs. Johnson suggested.

Chairman THOMAS. The Northeast?

Mr. VLADECK. The Northeast is underrepresented. I am trying to visualize this. Philadelphia is more mid-Atlantic. There is nothing north of Philadelphia except a rural provider in New York State that is a very interesting model. So we have upstate New York filled in there on the map.

Chairman THOMAS. OK.

Mr. VLADECK. I think we did pretty well in that regard. I believe of the 25, only 2 are proposing to use the existing payment methodology without some modification.

Now, there is a whole variety of sorts of modification. Some of them want the existing payment methodology with just more sophisticated risk adjustors, and this will be our first empirical test of the risk adjustors on which we have been working. Some of them want to talk about a more shared risk kind of arrangement. Some of them want to talk about a partial capitation or a partial risk model, at least in the startup years. So we do——

Chairman THOMAS. And you are calling those risk corridors?

Mr. VLADECK. Risk corridors is what I would call shared risk.

Chairman THOMAS. Yes.

Mr. VLADECK. In other words, somewhere between cost and full risk would be shared risk between the buyer and the seller. So pretty much the full range of noncompetitively bid pricing suggestions that have been analyzed seriously for Medicare capitated plans are being tested in one or another of these sites.

Chairman THOMAS. On the side of structure, you obviously want to get as much innovation as possible so you are providing for a number of waivers for groups that might come in.

Mr. VLADECK. Actually, the waivers are primarily of two kinds, relative to our existing rules.

Chairman THOMAS. Obviously, 50–50.

Mr. VLADECK. They are of two kinds. The 50–50 rule and the 5,000 minimum commercial enrollment rule are the only major categories I can think of. There will be some——

Chairman THOMAS. One of the things we ran into as we were looking at the Choices structure was the fact that you have existing State licensing structure that may or may not allow for some degree of diversity. My assumption is you are going to allow for models that would not otherwise be real world if they had to go through the licensing.

Mr. VLADECK. That is correct, although we are actually finding, at least in some of the States, that the perceived rigidities of the State licensure process are not as great as had been perceived. In other words, we have reserved the right to contract with an entity that does not have a separate State license as an entity. On the other hand, everybody is better off if the entity is appropriately licensed in the State, and as I suggested in my colloquy with Mr. Lewis, in Georgia and in Pennsylvania and in several of the other States, our involvement has caused the State insurance commission or the State insurance department to respond more flexibly than the providers initially perceived they might.

Chairman THOMAS. So we have a group of folks who may or may not conform to certain rules but clearly probably get certain rules, like the 50–50, and they are moving into the two dozen markets and they are going to obviously be in competition with folks who have met all those other standards. Some of them will already be entities that are dealing with risk contractors under the other rules. Where are you going to deal with, for want of a better term, cannibalism, piracy, their structure taking from an existing structure that they service beneficiaries, because they know about them and can almost do a fairly decent selection if they have a hospital profile on them.

Mr. VLADECK. Real markets—I do not mean to sound sort of silly about this—but real markets are messy. What we are seeing, for example——

Chairman THOMAS. But we are creating an advantage for this entity by waiving the rules. It is not a real market.

Mr. VLADECK. Except the alternative way of saying that is we are reducing barriers to entry that are created by our existing rules and thereby not acting in a protectionist fashion toward existing participants in the market. As a transitional——

Chairman THOMAS. I accept that. It is going to be messy and there are going to be some painful areas and some people are going to complain.

Mr. VLADECK. Yes.

Chairman THOMAS. I have a bigger question, and that is, what is it, a 5-year study?

Mr. VLADECK. Choices, I think the contracts, which are annually renewable, are three to five, depending on the market.

Chairman THOMAS. Three to five? My biggest fear is you are wildly successful. We have created all of these incubator models. We have nursed them through early infancy and childhood. Are we going to require them somewhere along the way to mature into a structure that would meet the standards if it were not for the test?

I mean, if we are successful in some markets and then walk away, you have a model that could not exist in the real world that has thousands of beneficiaries plugged into it. What is your exit strategy, I guess is what I am saying.

Mr. VLADECK. That is an issue we always have with demonstration programs.

Chairman THOMAS. Yes, but this one may be——

Mr. VLADECK. And I think the answer is, if we have not 3 to 5 years from now managed to change the law on Medicare managed care, the exit strategy for these projects will be, in some ways, the least of our problems.

We have had a lot of experience working with this Subcommittee and with other parts of the Congress. In fact, this type of situation came up the last time I was before this Subcommittee. We have undertaken demonstration projects because there was an apparent consensus of a broad direction in which public policy ought to move, but a lack of certainty about the details; and so we set out to test something. For whatever reason, the public policy process did not move as quickly or in the direction, and we so have, for example, four social health maintenance organizations which everybody likes, which have enrollees who are very happy and well served, for whom we have to keep extending the demonstration authority. That is a risk inherent in this process.

Chairman THOMAS. Or waivers, as we have discussed.

Mr. VLADECK. Or waivers. That is a risk that is inherent in the demonstration process.

Chairman THOMAS. And then the problem of the inevitable failures of those models that are not as successful as we would like. Since they came into existence by virtue of the incubation structure anyway, are you planning on requiring those who are otherwise real world to absorb the expense of bringing those beneficiaries back into the structure, or is Medicare going to assist in dealing with those failures so that there is no financial risk for people who are otherwise doing what you have told them to do in the real world?

Mr. VLADECK. No. I think it is fair to say, although maybe it is not a fair policy, that all of the organizations that are participating in the Choices demonstration are at full risk for the basic failure or success of the program. For example, they are at risk to the extent that they may invest substantial resources in developing a new payment method, or substantial resources in enrolling a lot of folks in a PPO which does not then become permanent, or in a risk adjustor which is then discarded. We have never promised and are not in a position ever to compensate them for any of the losses associated with that.

Chairman THOMAS. In attempting to look at these new models, have you had any discussion with any groups or entities about difficulties with other aspects of the law, antitrust or other areas, that you can begin to build some understanding of perhaps some adjust-

ments that need to be made in other areas of the law to better allow these folks to do what they believe and you believe that they would like to do?

Mr. VLADECK. Yes. One of the things we have not perhaps adequately conveyed and that is relevant to both these demonstrations but it is particularly relevant to part of the Choices demonstration is how much learning about the implications of applying a theoretical concept in the real world occurs and how important that is both to the provider community and to ourselves.

For example, all of us have spent an enormous amount of time over the last year and a half in thinking about the implications for policies, for laws, of provider-sponsored organizations and networks, their antitrust implications, their payments, and so on and so forth, all of it around a set of hypotheticals.

Chairman THOMAS. And the risk, where does it fall and on who.

Mr. VLADECK. We hope that if we have half a dozen functioning Medicare contracts with functioning provider service networks, that the next time we are looking at broad policy, we will have somewhat more experience on which to base those discussions. Many of those discussions will be around problems or issues or questions that we do not anticipate at all at the moment, I would expect.

Chairman THOMAS. That, to me, will be the most successful aspect of it, that we find out what it is we did not expect to find out.

The gentleman from California.

Mr. STARK. Bruce, I just wanted to get on the record a clarification. There was a story in the New York Times on Monday dealing with the issue of HMO financial incentives to doctors to not order tests or refer patients to specialists. I think that the headline was inaccurate. So the question I pose to you is to ask, is it not correct that you have not shelved the proposed rules but you intend to put them into effect?

Mr. VLADECK. I believe there was a double negative in the question, so let me just try to answer not with a yes or no.

Mr. STARK. Please.

Mr. VLADECK. On March 28, we published a final rule with comment having to do with physician incentive arrangements in managed care plans, and there were a variety of effective dates associated with those requirements. For the provision of stop-loss insurance for physicians capitated under certain kinds of arrangements, we have agreed that it is a better reading of the law that the effective date of implementation should be January 1, 1997, rather than May 28, 1996. Other than that, we have changed none of the policies or specifics or decisions that are contained in that final rule of March 28.

Mr. STARK. So those regulations will go into effect?

Mr. VLADECK. They will go into effect on a rolling basis, depending on the various effective dates of the various provisions.

Mr. STARK. As was published——

Mr. VLADECK. As was published on March 28.

Mr. STARK. And you will enforce them vigorously?

Mr. VLADECK. Vigorously.

Mr. STARK. Like a Doberman pinscher?

Mr. VLADECK. I am not sure that is the analogy I would particularly propose.

Chairman THOMAS. I was going to say a Saint Bernard, but that is OK. [Laughter.]

Mr. STARK. Thank you very much for that clarification.

Mr. VLADECK. Thank you, sir.

Mr. STARK. I thank the Chairman.

Chairman THOMAS. I think the gentleman from Washington has a parochial question.

Mr. MCDERMOTT. We will not get into which dogs we look like, right? [Laughter.]

You are preparing to do a demonstration project in Seattle, which I am eager to see the results of, but it roughly looks to me that the purpose of this project is to develop a better set of risk adjustors. Is it possible to do that? What I do know is that you are having some difficulty in getting enough participants to actually have a study. You had four HMOs that said they would come in and then one dropped out and so now you are down to three. If anybody else drops out, it is not a good demonstration. Is that a fair assessment of what is happening?

Mr. VLADECK. I think that is entirely true and it gets back to the question of keeping volunteers in these programs. It is both true and ironic that in those communities in the United States that were the earliest to experience widespread managed care penetration, both in the private sector and Medicare, many of the best established plans have the most difficulty coming up with new data systems and new informational processes that have to be part of any kind of demonstration.

Mr. MCDERMOTT. Are you saying because they are so lean and mean that they do not have the money to give you the kind of encounter data you want, or are you implying something else?

Mr. VLADECK. No. I am really implying that the older group model plans traditionally did not maintain encounter data, in part Because they were not in the fee-for-service business, whereas the newer IPA kinds of plans or some of the insurance-based plans that came out of a different world were much more likely to have encounter-specific data from the outset. That has been part of the issue.

Mr. MCDERMOTT. Does that suggest, then, that the design of your model is one that will exclude all the not-for-profits that started a long time ago and really will only be accessible by those new HMOs that have come on in the last 6 or 7 years?

Mr. VLADECK. No. With the help of the largest, oldest, most sophisticated nonprofit plan in the Seattle area, we had hoped to test various ways of getting at encounter-level information to permit us to test that whole idea and find out whether we really needed to have it, whether there are other ways to get that information, how standardized we need it, and so forth.

But I think it is safe to say that we cannot envision a fair test of any change in the market in the greater Seattle area without Group Health, to be specific, because they are so significant a provider to our beneficiaries. We have been working very closely to try to develop a demonstration that makes sense for all the plans and still meets some of our needs for information and still keeps the plans interested.

Mr. McDERMOTT. Just so I can understand why you selected Seattle, was it the long history?

Mr. VLADECK. No. I believe this was largely a self-selected——

Mr. McDERMOTT. They came forward and said——

Mr. VLADECK. Again, 3 years ago, we went to what was then the Group Health Association and said, we share your discomfort with the AAPCC. We are interested in testing changes to it and basically said, we will approve any budget-neutral demonstration that protects beneficiaries and tests any other payment method. The Seattle project was the most developed and sophisticated one we got, and even that is barely budget neutral.

Mr. McDERMOTT. So they described the——

Mr. VLADECK. This was something that was initiated by the plans in Washington State themselves.

Mr. McDERMOTT. They put it together and brought it to you and you approved it, and then the people sort of figured out that they did not have the capacity to produce the data that they had promised.

Mr. VLADECK. I do not want to jump to that conclusion. We are still working on that.

Mr. McDERMOTT. All right. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. If there are no other questions, I want to thank you very much, Bruce.

We have a series of votes on the floor and I think the most efficient way to deal with this will be to recess the Subcommittee until 2 p.m. Those who need lunch or want lunch can get it at that time, and if there are any inconveniences by virtue of moving the rest of the panels back, please let me know and we will try to accommodate you. Otherwise, the Subcommittee stands in recess.

[Recess.]

Chairman THOMAS. The hour of 2 having arrived, the Subcommittee will reconvene.

The first panel, Mr. Agar, Mr. Ryan, Dr. Braden, Mr. Womer, thank you. I apologize. Sometimes control of the time is not our own.

I would tell all of you that any written testimony that you may have submitted will be made a part of the record and you may begin to inform the Subcommittee in any way you see fit for the 5 minutes that you have available. We will begin with Mr. Agar and then move across the panel.

STATEMENT OF J.H. MICHAEL AGAR, PRESIDENT, HEALTH PLANS OF PENNSYLVANIA, INC.; AND VICE PRESIDENT, MANAGED CARE, CROZER-KEYSTONE HEALTH SYSTEM, MEDIA, PENNSYLVANIA

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

Chairman Thomas and Members of the Subcommittee, my name is Michael Agar. I am vice president for managed care for the Crozer-Keystone Health System and president of its wholly owned subsidiary, Health Plans of Pennsylvania. Crozer-Keystone is a finalist in HCFA's Medicare Choices demonstration program and we are very proud to have been selected and are working hard to make it a success.

Crozer-Keystone is a not-for-profit integrated delivery system that provides a broad continuum of care to the 550,000 residents of Delaware County and surrounding communities. Health Plans of Pennsylvania is the system's managed care arm. It currently manages full risk patients from other payers and is in the process of being licensed as a risk-bearing entity by the Pennsylvania Department of Insurance.

The elderly are the largest users of our medical, rehabilitative, and social services. We have 95,000 Medicare beneficiaries in our immediate area and we have made significant investments in ensuring that Medicare recipients have access to those services. We have created the Crozer-Keystone Institute for Senior Health, the Silberman Center, and the Institute's ElderMed Program serves 40,000 members who are provided with health education, wellness, and outreach programs.

This rich array of services for the elderly, when combined with Crozer-Keystone's complete continuum of care, is why we know our facilities, doctors, and hospitals can do the best job of integrating and coordinating the care of our patients and of managing their care to ensure quality while using the techniques of managed care to increase efficiency and cut costs.

Our goal is to demonstrate that we can build on the existing relationship with our senior community to overcome their concerns about managed care and to focus on keeping them healthy while providing superior service when they get sick. We are known in our communities, we belong to our communities, and we are trusted by our communities.

Crozer-Keystone's Medicare Choices demonstration project is designed to be another innovative and creative service to offer to our senior community. It features zero premium. It has a point-of-service option. Ours will be one of the first products available in our area. We will also offer members a number of health education opportunities with rewards to encourage healthy behavior.

We will do an annual health risk assessment on every member. If the assessment shows that a member has diabetes, for example, we will schedule the member for the system's diabetes education class. Upon successful completion of the class, the member will be rewarded with enhanced benefits, such as eyeglasses, hearing aid, or exercise program membership.

I want to point out that it would be extremely difficult for Crozer-Keystone to offer a Medicare product in our market without the HCFA designation. Currently, an insurance license is required in Pennsylvania and in other States in order to offer a risk product. However, we are not an insurance company. We are a provider-sponsored organization. The HCFA designation has given us top priority with the Commonwealth's Departments of Insurance and Health. It is making it possible for us to receive the necessary certificates of authority to launch our Medicare Choices Program within HCFA's desired timeframes. Without this designation, this process would have taken years, not months.

The ability of Crozer-Keystone to directly contract with government programs is critical to our continued ability to provide high-quality and innovative care to our communities. As you continue your efforts to balance the Federal budget, it is clear that the rate

of annual increases for Medicare will be reduced. Combine these reductions with new insurance, entrance into the field of government-sponsored health care, businesses taking anywhere from 15 to 30 percent of the premium for their own use, and you have a situation that could dictate reductions in service to patients.

And there is no guarantee that these entities, once in the Medicare business, will stay in. For example, several HMOs in the Philadelphia area have recently said they are going to go out of the Medicaid business because the rates are getting too low. These are our patients in our communities. We are not going to go anywhere. We have to take care of them and we want to do it with the best resources available and with the most efficient use of these resources possible in this era of fiscal constraint.

In conclusion, we at Crozer-Keystone feel fortunate to be chosen as part of this program. We are committed to making it work because we believe that direct contracting is the key to the future successful health care delivery for many local health care providers. We commend the Subcommittee for passing legislation last year that would have allowed that to happen and look forward to working with you to bring the benefits of PSOs to more Americans by passing similar legislation at the earliest possible time.

Thank you very much. I would be happy to answer any questions.

[The prepared statement follows:]

STATEMENT OF
CROZER-KEYSTONE HEALTH SYSTEM
BEFORE
THE COMMITTEE ON WAYS AND MEANS
HEALTH SUBCOMMITTEE
Presented by
J. H. Michael Agar
Vice President, Managed Care, Crozer-Keystone Health System
and
President, Health Plans of Pennsylvania, Inc.

Chairman Thomas and members of the subcommittee, my name is J. H. Michael Agar. I am vice president for managed care for the Crozer-Keystone Health System and president of its wholly owned subsidiary, Health Plans of Pennsylvania, Inc. (HPP). Crozer-Keystone is a finalist (one of nine integrated delivery systems nationally) in the Health Care Financing Administration's (HCFA's) Medicare Choices demonstration program. We are extremely proud to have been selected for this program and are working hard to make it a success.

BACKGROUND ON CROZER-KEYSTONE HEALTH SYSTEM

Crozer-Keystone Health System is a not-for-profit, integrated health system that provides a broad continuum of care to 550,000 people in Delaware County and surrounding communities. Our system includes 100 employed primary care physicians, three community hospitals, one tertiary medical center and four long-term care facilities.

Health Plans of Pennsylvania is the system's managed care arm. It currently manages full-risk patients from other payers and performs the tasks of premium sufficiency analysis, network development and maintenance, customer services, provider training and relations and utilization management. HPP is in the process of being licensed as a risk-bearing entity by the Pennsylvania Department of Insurance.

As the elderly are the largest users of our medical, rehabilitative and social services, Crozer-Keystone has made significant investments in ensuring that Medicare recipients have access to those services. With the creation of the Crozer-Keystone Institute for Senior Health, our programs and services take every aspect of the senior citizen's physical, mental and emotional well-being into account. Our Silberman Center provides a variety of senior services including adult day care, geriatric assessment, outpatient mental health services and physical therapy. The Institute's ElderMed Program provides health education, wellness and outreach programs to more than 40,000 members. Our $40 million, 180,000-square-foot Healthplex is a 21st Century wellness, health and prevention center. Opening in September of this year, it will serve as the focus of our wellness efforts.

This rich array of services for the elderly, when combined with Crozer-Keystone's complete continuum of care, is why we know our facilities, doctors and hospitals can do the best job of integrating and coordinating the care of our patients, and of managing their care to ensure quality while using the techniques of managed care to increase efficiency and cut costs.

HCFA's designation of us as a Medicare Choices finalist, coupled with the national publicity surrounding the awards, gives the program an imprimatur that engenders a spirit of enthusiasm and cooperation both within and outside of Crozer-Keystone.

Our goal is to demonstrate that we can build on our existing relationship with our senior community to overcome their concerns about managed care, and to focus on keeping them healthy while providing superior service when they get sick. We are known in our communities. We belong to our communities. We are trusted by our communities.

MEDICARE CHOICES PROGRAM

Crozer-Keystone's Medicare Choices demonstration product is designed to be another innovative and creative service offered to our senior community. There are 95,000 Medicare beneficiaries in our immediate market and more than 650,000 in the greater Philadelphia region. Under the Medicare Choices program, our Medicare plan will offer three special features:

1) **Zero premium.** The beneficiary who enrolls in our plan will pay no additional premium to the Medicare program.

2) **Point-of-service option.** Ours will be one of the first point of service products available in our area. It's a flexible benefit plan that allows beneficiaries to choose from an extensive number of in-network physicians, with an option to use any physician of their choice with a modest co-payment. Market research indicates that this will be an attractive benefit.

3) **Rewards for healthy behavior.** We will also offer members a number of health education opportunities with rewards to encourage healthy behavior. For example, we will do an annual health risk assessment on every member. If the assessment shows that a member has diabetes, we will schedule the member for the systems diabetes education class. Upon successful completion of the class, the member will be rewarded with enhanced benefits such as eyeglasses, a hearing aid or exercise program membership.

It would be extremely difficult for Crozer-Keystone to offer a Medicare product in our market without the HCFA designation. Currently, an insurance license is required in Pennsylvania and other states in order to offer a risk product. However, we are not an insurance company. We are a provider-sponsored organization (PSO) -- a group of local health care providers joined together to deliver high-quality health care in our community.

While we should be subject to stringent requirements and standards, we -- and many other delivery organizations that want to develop PSOs to serve seniors -- must be able to offer a risk product without doing the administrative and regulatory contortions necessary to fit into a regulatory system that recognizes only insurance companies as managed care providers.

The HCFA designation has given us a top priority with the Commonwealth's Departments of Insurance and Health; it is making it possible for us to receive the necessary certificates of authority to launch our Medicare Choices program within HCFA's desired time frames. Without this designation, this process would have taken years, not months.

The Medicare Choices program is demonstrating that PSOs can offer seniors the care they need in an efficient and cost-effective manner.

ABILITY TO CONTRACT WITH THE GOVERNMENT IS CRITICAL

The ability of Crozer-Keystone to directly contract with government programs is critical to our continued ability to provide high quality and innovative care to our communities. As you continue your efforts to balance the federal budget, it is clear that the rate of annual increases Medicare will be reduced. Combine these reductions with new insurance entrants into the field of government-sponsored health care -- businesses taking anywhere from 15 percent to 30 percent off the top -- and you have a situation that could dictate reductions in service to patients.

And there is no guarantee that these entities, once in the Medicare business, will stay in. Several HMOs in the Philadelphia area have recently said they are going to get out of the Medicaid business because rates are getting too low. These are our patients in our communities. We aren't going anywhere; we have to take care of them, and we want to do it with the best and most efficient resources available in this era of fiscal constraint.

Many of the features of a PSO such as ours are being looked at in the Medicare Choices program. In essence, PSOs can help reduce federal expenditures for Medicare by eliminating the insurance middleman -- that 15-30 percent taken off the top by many managed care organizations, for example. More importantly for patients and providers, PSOs are provider-run -- clinical decisions are made by providers and their patients, not by a faceless numbers cruncher at the end of an 800 number.

CONCLUSION

Mr. Chairman, to balance the federal budget and tame the federal deficit, you must reduce the growing cost of entitlement programs. Motivating Medicare beneficiaries to receive their care in a provider-sponsored, managed care environment will cost Medicare less, improve the health of beneficiaries, and build on long traditions of community-based health care delivery.

It will ensure that the dollars Congress allocates to support our seniors through Medicare is spent on their care, and not on insurers' profits. We hope the Crozer-Keystone Medicare Choices program and the other provider-sponsored organization programs provide you with solid evidence that this approach meets the dual objectives of higher quality and lower cost.

We at Crozer-Keystone feel fortunate to be chosen as part of this program. We are committed to make it a success, because we believe that direct contracting is key to the future of health care for many local health care providers. We commend this subcommittee for passing legislation last year that would have allowed that to happen, and look forward to working with you to bring the benefits of PSOs to more Americans by passing similar legislation at the earliest possible time.

Chairman THOMAS. Thank you very much, Mr. Agar.
Mr. Ryan, et al.

STATEMENT OF TIMOTHY J. RYAN, VICE PRESIDENT AND CHIEF FINANCIAL OFFICER, MEMORIAL SISTERS OF CHARITY HEALTH PLANS, HOUSTON, TEXAS; ACCOMPANIED BY ALBERT BRADEN, III, M.D., REGIONAL MEDICAL DIRECTOR, UNIFORMED SERVICES FAMILY HEALTH PLAN, SISTERS OF CHARITY OF THE INCARNATE WORD HEALTH CARE SYSTEM, HOUSTON, TEXAS; AND DOUGLAS X. WOMER, JR., VICE PRESIDENT, MANAGED CARE AND BUSINESS DEVELOPMENT, SOUTHEAST TEXAS REGION, SISTERS OF CHARITY OF THE INCARNATE WORD HEALTH CARE SYSTEM, HOUSTON, TEXAS

Mr. RYAN. Thank you. Chairman Thomas, I am Timothy J. Ryan. I am the chief financial officer of the Memorial Sisters of Charity HMO in Houston, Texas. I would also like to introduce Dr. Al Braden, a health plan participating physician, and Doug Womer, the regional vice president for the Sisters of Charity of the Incarnate Word of Houston, Texas, who have accompanied me here today.

We at Memorial Sisters of Charity have worked hard to develop a strong program and I appreciate the opportunity to speak to you this morning about our commitment to the Medicare Choices demonstration project.

Memorial Sisters of Charity HMO is a provider-owned health plan and that is part of an integrated health care delivery system and that system is sponsored by two of the strongest nonprofit integrated health systems in southeast Texas, Memorial Health Care System and the Sisters of Charity of the Incarnate Word Health Care System.

Both Memorial and Sisters of Charity have a long history of providing innovative and quality health care to special populations, including Medicare and Medicaid. We have a commitment to community service, and this shows in that 45 percent of our admissions in Memorial and 41 percent of the admissions in Sisters are for Medicare or Medicaid beneficiaries. Indeed, our organizations, our parent organizations, as we refer to them, have been around in the region, Memorial for 95 years, and Sisters of Charity of the Incarnate Word, 130 years.

Both of our parents organized the HMO and organized what we refer to as the health plans, which includes an HMO, where we obtained the license in December 1995 and an insurance company, where we obtained the license in May 1996, and a management company so that they could pursue their mission to provide quality health care to the residents of southeast Texas.

The MSCH health plans filed as an integrated delivery network in our application for HCFA for the demonstration project submitted in August 1995. This filing was really a representation of who we are and what we are. We are primarily deliverers of health care. We have organized ourselves in such a way to be able to pursue our mission to deliver health care and to be able to engage in the business of delivering health care.

Our mission is to minimize administrative overhead and maximize the dollars available for the delivery of health care. We do not have stockholders. We do not have to send dividends or report our earnings off to people outside of our community. Our mission and our goal is to provide the quality care and provide the tools available for our providers to deliver quality care to our members.

On project management, the MSCH HMO will administer the Medicare Choices demonstration project. This gives us flexibility regardless of the regulatory rules. The use of the HMO entity ensures HCFA that the assumption of risk under the demonstration program complies with all Federal and State laws.

In delivering the health care services, the MSCH HMO benefits from broad geographic coverage of its extensive hospital and provider network. Our parents' hospitals and physicians are very experienced in the delivery of very high quality care. MSCH HMO has established the infrastructure to manage the risk that the physicians and hospitals and other providers are undertaking.

The HMO will have to support the providers in managing this risk, and we have four major ways that we do that. We obtain reinsurance protection so that for catastrophic cases, we will have other entities with very substantial resources there to provide help.

We have an installation of a multimillion dollar information system to provide data on the delivery and assessment of care. This, we feel, is a very integral part of our ability to be able to manage the risk. It can identify those individuals who need special care. My predecessor on the panel mentioned diabetes and our information system will be able to identify from claims those individuals who have diabetes and send out reminder notices to notify the providers that we need to make appointments and we need to get those people in to be able to deliver special care to them.

We were chosen by HCFA because we met the criteria that was requested. We have developed an urban and a rural delivery component. We will cover 15 counties in southeast Texas, 14 which are considerably rural. We will participate in the test phase and implement an alternate reimbursement mechanism. We have been notified that MSCH was selected for the award and are currently awaiting a confirming site visit, and that is our current status.

MSCH HMO is truly excited about being involved in the Medicare Choices demonstration project. We spent a great deal of time and money in preparing for this project and have established a positive working relationship with HCFA. This project allows MSCH to shorten the length of time that it would have taken us to get our goal, and our goal is to provide the care, and it is the common goal of providing senior citizens with quality health care.

With our rural service areas, MSCH HMO will provide the benefits of Medicare managed care to beneficiaries who have historically been excluded from membership by current HMOs operating in the Houston area because of residencies outside of the HMO's marketing service areas. Earlier in the day, Mr. Vladeck spoke of the discrepancies between the AAPCC in urban and rural areas.

Some of our attractive features, I think you went ahead and mentioned those earlier, so I will skip over that.

Also included as part of our MSCH standard Choice 65 health plan is a self-referral option, which allows members limited access

to providers other than their selected primary care physician for consultive services and diagnostic testing. In addition to PCP access, the self-referral option offers an attractive element of physician choice and we believe that it allows our members a little peace of mind, that they are not trapped inside an HMO.

During the first year of the demonstration project, we will shadow price the Johns Hopkins University/Lewin Group risk adjustor mechanisms. We will be paid from the AAPCC in the same manner as any risk contracting HMO or competitive medical plan. Memorial Sisters of Charity HMO will work with HCFA to gather data at no cost to the government and test the risk adjustor system to ensure that it works. In the second year, upon review, MSCH HMO will activate the risk adjustor mechanism and the resulting capitation payment.

We are not seeking reinsurance from HCFA, nor will we be asking for a risk sharing arrangement or a partial fee-for-service payment. We believe that our proposed plan is a straightforward pricing approach which will allow HCFA to engage in a very clean test of the risk adjustor mechanism over a diverse service area.

We are ready to launch the demonstration project. I would like to thank you, Chairman Thomas, and the Subcommittee for the invitation to speak. I would like to thank Congressman Archer and his staff for their hospitality and support. Memorial Health Care System and Sisters of Charity of the Incarnate Word Health Care System have committed the resources necessary to launch the Medicare demonstration project immediately and remain committed to offering managed care choices to the senior residents of southeast Texas while supporting HCFA's endeavors to control medical costs for the Medicare-eligible population.

Thank you again. I would be happy to answer any questions you may have.

[The prepared statement follows:]

STATEMENT OF
MEMORIAL♥SISTERS OF CHARITY HMO
BEFORE
THE COMMITTEE ON WAYS AND MEANS
HEALTH SUBCOMMITTEE

Presented by
Timothy J. Ryan, CPA
Chief Financial Officer
Memorial♥Sisters of Charity HMO

Mr. Chairman and members of the Subcommittee, my name is Timothy J. Ryan and I am Chief Financial Officer of Memorial♥Sisters of Charity HMO. I also would like to introduce Dr. Albert Braden, a health plan participating physician and Douglas X. Womer, Regional Vice President of Sisters of Charity of the Incarnate Word, who have accompanied me here today. We at Memorial♥Sisters of Charity HMO have worked hard to develop a strong program, and I appreciate having the opportunity to speak to you this morning about our commitment to the Medicare Choices Demonstration.

Memorial♥Sisters of Charity HMO
Memorial♥Sisters of Charity HMO *(MSCH HMO)* is a provider-owned health plan and part of an integrated health care delivery system jointly sponsored by two of the strongest, non-profit integrated health systems in Southeast Texas: Memorial Healthcare System *(MHS)* and the Sisters of Charity of the Incarnate Word Health Care System *(SCH)*, Houston, Texas.

Both MHS and SCH have a long history of providing innovative and quality health care to special populations, including Medicare, Medicaid, the under served, and residents of rural areas. In fact, forty-five percent *(45%)* of admissions in MHS and forty-one percent *(41%)* of admissions in SCH are Medicare and/or Medicaid beneficiaries. MHS and SCH have served the region for more than 95 and 130 years, respectively.

MHS and SCH formed MSCH HMO with a significant start-up capital commitment to advance their strategies for developing a truly integrated health care financing and delivery network. On December 15, 1995, the Texas Department of Insurance granted MSCH HMO a license to operate as an HMO. Subsequently, Memorial♥Sisters of Charity Insurance Company was granted its insurance license on May 8, 1996.

MSCH Health Plans filed as an Integrated Delivery Network *(IDN)* in our original application to HCFA for the Demonstration Project, submitted August 11, 1995. This IDN filing represented the healthcare delivery organization and was appropriate due to the timing of the RFP and the post application awarding of our HMO license by the State of Texas. Today MSCH HMO is operational and functional as an HMO with substantial reserves in excess of Texas Department of Insurance requirements. Although MSCH HMO is structured as a *"For Profit"* Limited Liability Corporation *(LLC)*, our mission is to minimize administrative overhead and maximize the dollars available for the delivery of care to the residents of Southeast Texas. We have worked closely with our physician and hospital partners to develop a benefit plan and delivery system focused on the full continuum of health care services including wellness/prevention programs to ensure timely and appropriate access to care.

Although we just received our HMO license this past December we are ahead of our commercial enrollment projections submitted in the Medicare Choices Demonstration application.

Project Management
MSCH HMO will administer the Medicare Choices Demonstration project. The use of the HMO entity ensures HCFA that the assumption of risk under the demonstration program complies with all Federal and State laws.

In delivering health care services, MSCH HMO benefits from the broad geographic coverage of its extensive hospital and provider network. MSCH HMO has established an infrastructure to manage the *"risk"* physicians and hospitals are undertaking through: (1) obtaining reinsurance protection (2) the installation of a multi-million dollar information system to provide data on the delivery and assessment of care (3) physician participation as members of the HMO Board of Directors and (4) a physician directed medical management process. MSCH HMO is a network model primarily contracting for physician services through a number of Physician Organizations *(PO)*. The physician-governed POs reflect the established patterns of treatment in the communities served by MHS, SCH and affiliated hospitals. This network includes 27 hospitals and more than 1,200 physicians to potentially serve a Medicare population estimated at 432,000.

Chosen By HCFA

MSCH HMO was selected as a final Medicare Choices candidate because it met the criteria requested in the Department of Health and Human Services' Request for Proposal. In addition, MSCH HMO agreed to the following:

- Develop an urban/rural delivery component;
- Offer a Self-Referral Option allowing out of network benefits when members choose to see physicians other than their selected Primary Care Physician; and
- Participate in the test phase of alternative reimbursement mechanisms.

MSCH HMO was notified on April 15, 1996 of its selection by the Health Care financing Administration *(HCFA)* for a site visit for the Medicare Choices Demonstration Project. MSCH HMO is the only HMO selected by HCFA to serve Harris County, Texas *(Houston)* which includes more than 256,000 Medicare beneficiaries. In addition to Harris County, MSCH HMO will provide health care coverage in fourteen other Southeast Texas counties.

MSCH HMO is truly excited about being involved in the Medicare Choices Demonstration Project. We have spent a great deal of time and resources in preparing for this project and have established a positive working relationship with HCFA. This is an excellent example of the federal government working with private industry for one common goal -- providing senior citizens with quality health care in a cost-efficient manner.

MSCH HMO will provide the benefits of Medicare managed care to beneficiaries who have historically been excluded from membership by current HMOs operating in the Houston area because of residencies outside of the HMOs marketing service area.

MSCH HMO's proposed benefit structure will incorporate several features to make its Choice 65 plan appealing to Medicare beneficiaries:

- elimination of Medicare deductibles and coinsurance;
- nominal copayments specific to certain services;
- removal of Medicare's limits on numbers of covered hospital and skilled nursing facility days;
- enhanced benefits with a preventive/wellness emphasis and an outpatient prescription drug benefit; and
- annual vision and hearing exams with benefits for eyeglasses and hearing aids.

Also included as part of MSCH HMO's standard Choice 65 plan is a Self-Referral Option which allows members limited access to providers other than their selected Primary Care Physician *(PCP)* for consultative services and diagnostic testing. In addition to PCP access, the Self-Referral Option offers an attractive element of physician choice.

All of these standard benefits come at no additional cost to Choice 65 members beyond their Medicare Part B monthly payment.

Alternative Forms of Reimbursement
MSCH HMO has agreed to utilize the Johns Hopkins University/The Lewin Group *(formerly Lewin-VHI)* ACG/PACS risk adjustor mechanisms. During the first year of the demonstration, MSCH HMO will accept risk payment derived from the AAPCC in the same manner as any risk contracting HMO or Competitive Medical Plan. MSCH HMO will work with HCFA to gather data and test the risk adjustor system. In the second year, upon review, MSCH HMO will activate the risk adjustor mechanism and the resulting capitation payment.

MSCH HMO is not seeking reinsurance from HCFA, nor will it be asking for a risk-sharing arrangement or partial fee-for-service payment. MSCH HMO believes its proposed straightforward pricing approach will allow HCFA to engage in a very clean test of the risk adjustor mechanism over a diverse service area.

MSCH HMO Is Ready To Launch The Demonstration
We would like to recognize the help of U.S. Senator Kay Bailey Hutchinson and her staff to get a HCFA site visit review as soon as possible due to our state of readiness. We are disappointed that we have not been able to confirm an actual date for a visit. Memorial Healthcare System and Sisters of Charity of the Incarnate Word Health Care System have committed the resources necessary to launch the Medicare Demonstration Project immediately and remain committed to offering managed care choices to the senior residents of Southeast Texas while supporting HCFA endeavors to control medical costs for the Medicare eligible population.

Again, thanks for the opportunity to discuss this important project with you. I will be happy to answer any questions that you may have.

Chairman THOMAS. Thank you very much, Mr. Ryan.

Both of you were here when we talked to Bruce earlier.

Mr. AGAR. Yes.

Chairman THOMAS. So you got the drift of the group's focus. I think you appreciate that we were looking at it obviously as practitioners rather than any kind of a partisan structure. So the questions that I would ask I think any of the Members would be interested in. Just because there is one of us, do not think that you are going to be slighted on the questions. I guess if I had to choose one to be here, I would probably choose me.

Mr. Agar, you talked about the benefit of being in the demonstration program because it allows you to, in essence, short circuit the procedures in the State of Pennsylvania for getting licensed. Both of you really are PSOs, right, in terms of structure, although you call yourself an HMO from a delivery service. Mr. Ryan, are you basically a PSO?

Mr. RYAN. Yes. Our organization is primarily interested in the delivery of health care services.

Chairman THOMAS. Right. You may or may not know, we wrestled with this whole business of how to take this new entity in a different world under our legislation and deal with insurance commissioners, given the broad range of experience and interest and, frankly, sophistication, to a certain degree, of all of the States' insurance commissioners. We came to the conclusion that really, to make these work, if you created them, you were going to have to have some kind of a Federal role—these were Republicans who came up with the idea that you had to have a Federal role in terms of approval.

Mr. Agar, you said it was months rather than years. What was the kind of working relationship with the Pennsylvania Commission? Was it, we have to do it because HCFA said we did, so you could be in the demonstration project but do not come back here in the real world and expect to get what you are getting, or was it a kind of a learning curve, where you were talking about what you were trying to do, they were interested and wanted to try to work with you?

Mr. AGAR. Basically, the only thing that is short circuited is time in this process. We are going through all the steps anyone else would have to go through. But being a demonstration program that HCFA had a timetable for, they were willing to work with us to do this in time to——

Chairman THOMAS. And I am looking more to the attitude of the people you were working with at the State level. They were supportive——

Mr. AGAR. Yes. They were very supportive and had worked very hard to do this.

Chairman THOMAS. And the kind of questions they asked were reasonable and appropriate, not——

Mr. AGAR. They were all the questions they ask of an insurance company.

Chairman THOMAS. Right.

Mr. AGAR. For example, we have——

Chairman THOMAS. Did you find some of the questions were not as responsive as you had hoped they would have been to what you are trying to do?

Mr. AGAR. Fundamentally, I think that we know we have to be held to the exact same standards as any other group going into this business. I think the point where things turn is on how you define statutory net equity.

For example, we have assets of about $380 million. Not one penny of that is counted in our statutory net equity of our wholly owned subsidiary and I think that is the area that needs work, because I do not think that is necessarily correct because we are providers of care. We are not intermediaries between the patient and the providers of care.

Chairman THOMAS. One of the ongoing debates, and that is why I am asking you the question, and Mr. Ryan, I will ask you in terms of the Texas experience, is that I think it is very much an open debate as to whether provider-sponsored organizations are a distinction without a real difference or if, in fact, people who have the professional skills are part of the structure and, in essence, have a professional sweat equity commitment so that you do not need the kind of financial profile that you would if you had to purchase all of those services as an insurance company or another structure. So we are trying to figure out if this is simply a different folk running the show or if it is a different show.

You are telling me, Mr. Agar, that the tests that Pennsylvania put you through were basically a test that an insurance company would go through. Did they talk about the belief that since you have a different makeup with the professionals as part of that risk obligation structure that perhaps their financial profile analysis was somewhat archaic or that they would have to rethink it?

Mr. AGAR. At the very senior level of the department, that type of thinking, along with the Governor, is taking place. But at the operational level where people have to execute, they have to follow the rules that are in place.

Chairman THOMAS. We are looking for sympathy and understanding. That is what we are looking for. We are not looking for any bent rules.

Mr. AGAR. At the bureaucratic level, not much. They understand cash very well.

Chairman THOMAS. Yes. Old dogs, new tricks.

Mr. Ryan, do you have knowledge, or do any of the gentlemen with you have knowledge? You already have a State licensure?

Mr. RYAN. Yes, sir. We have an HMO license and a separate insurance company license.

Chairman THOMAS. So you have all these different entities. You fit in a little better.

Back to structure. Mr. Agar, are you going to, in the package that you envision—I think I just have a little more of a working knowledge of Mr. Ryan's package because he laid it out and I used it as an example—are you going to have beneficiaries have any out-of-pocket expense contemplated?

Mr. AGAR. In the two major areas, let me give you a clear example for physician visits and hospital visits. For physician visits in-network, there is a $5 copay. For hospital, there is no charge. If

they decide to go out of—they can self-refer out-of-network for physicians. They have to pay $35 a visit. They can go to any hospital they want if it is precertified based on medical necessity and the charge there will be $375.

Chairman THOMAS. Per——

Mr. AGAR. Per stay.

Chairman THOMAS. Per stay?

Mr. AGAR. Per stay.

Chairman THOMAS. As an out-of-service——

Mr. AGAR. Out-of-network.

Chairman THOMAS. I am asking you this question, Mr. Ryan, because you exhibit a profile of a more generalized question that I asked Mr. Vladeck on a demonstration project and it should not, obviously, carry any implication that I believe it may occur, but it nevertheless is part of the problem of trying to set up a demonstration project. You folks already are risk contractors, is that correct?

Mr. RYAN. Yes, sir.

Chairman THOMAS. And you are proposing to go into a demonstration program by changing in any degree the structure that you now have as a risk contractor?

Mr. RYAN. No. I do not think we are going to change any of our structure, per se. The demonstration Choices project offers us the opportunity to achieve our goal or achieve our mission in a way—because our goals are similar. HCFA wants to——

Chairman THOMAS. No. I understand. What I want to find out is that if you have a beneficiary who is already under a risk contract arrangement——

Mr. RYAN. I am sorry. I misled you. We do not have a Medicare risk contract. We have the HMO license and the insurance company. We are out marketing to commercial enrollees, and if the Medicare Choices project had not come along, we would have pursued a CMP.

Chairman THOMAS. OK. And you are getting a 50–50 waiver?

Mr. RYAN. We have included a 50–50 waiver in our application.

Chairman THOMAS. But if you were to create some kind of a joint structure or if HCFA were to look at your overall operation as you move into the Medicare area, could you meet a 50–50 requirement if they looked at your overall business practice as you moved into the Medicare, and why are you seeking a 50–50 waiver given the business profile you already have?

Mr. RYAN. When we filed our application for the Medicare Choices demonstration, it was August 1995. We did not have the HMO license or the insurance company at the time. I believe that if we started today, we would meet the 50–50 waiver. But the rule that the 50–50 waiver is intended—the object of that rule is really to make sure that you do not have the creation of a separate substandard health delivery——

Chairman THOMAS. No. I understand the history of it, and it may have been needed at one time, but a lot of us think it is an anachronism, which is interesting, because every time we try to do a demonstration project, we waive the 50–50 rule and then we require it out in the real world when probably it is an anachronism.

You folks obviously talk to other people in your marketplace and they are becoming aware that the demonstration project will be

moving into both the Pennsylvania and the Houston area. Have you had any feedback from any of your "competitors" or other folks in the area about the fact that you do not have to comply with ordinary rules, or "How did you get in? Can I get in?" Has there been any discussion among folks in terms of this particular program?

Mr. AGAR. I am not aware of any. No, sir.

Mr. RYAN. We have not had any discussions. I do think that there is a quid pro quo. We are providing a lot of data. We are providing ourselves as a guinea pig to use the risk adjustor payment mechanism and that does entail a bit of risk that the payments will be less and that we will end up with less funds and less resources to provide that care.

Chairman THOMAS. How are you structuring yourself to deal with that financial risk? Are you using any of your other entities as a support or a fallback?

Mr. RYAN. What we refer to as our parent——

Chairman THOMAS. You are going to assume, and I agree with you, a relatively large financial risk on the Medicare enrollment. How are you dealing with that?

Mr. RYAN. We are sharing the risk with our providers. We have organized physician groups and the hospitals have organized. In Texas, you must separate those in risk sharing arrangements.

Chairman THOMAS. Right.

Mr. RYAN. Those providers will be sharing the risk. We will be providing a tremendous amount of information that will allow them to be effective in sharing that risk.

Chairman THOMAS. Can you spend a minute or two talking about how you determined the shared allocation on the risk basis in terms of the providers? Is there a set percentage? Is there a responsibility? Is there a specialty area? How do you deal with assigning risk?

Mr. RYAN. We did go through a responsibility grid that is about 26 pages long. We had the actuaries involved to determine what the traditional fee-for-service payment structure would look like and how services, how they have traditionally been delivered and how that allocation of resources traditionally——

Chairman THOMAS. I assume there was a discussion about how that really is not real world, and if we are going to look at it, we should look at it differently?

Mr. RYAN. We instructed our actuaries not to use the pie in the sky method but to actually get down and look at who is giving the care.

Mr. WOMER. There is a further test on that, because when the health plan then sends the contracts down to the hospital providers and the physicians, we then send that same data out to then another set of actuaries, independent of the health plans, and they come back, because we have to justify to the physicians that there is an equitable distribution of risk and capitation following that risk. So there are a couple of checks on that methodology.

Chairman THOMAS. Did you learn anything from this process that you did not know that may or may not be applicable to your other activities in terms of the relationship of providers in the structure?

Mr. RYAN. I think we are learning a great deal all the time as we go along, and it has been a very interesting process to get a large number of people, from the Sisters of Charity organization, from the Memorial Health Care Organization, from physician groups, together and talk about the common problems, because, essentially, these people have delivered health care in a microcosm or kind of separately.

The patient walks into their office. They do everything they can, and then they send the patient on. What we are trying to do is make sure the people have information as to what has happened to that patient before, what does that patient need now, and what is the result that we want.

Chairman THOMAS. Mr. Agar, any similar or dissimilar experiences on the risk? How are you dealing with the risk question?

Mr. AGAR. In a very similar manner, through actuaries based on what has actually been spent in the past and what we think we can do through utilization management. We have several years of experience with full risk Medicare contracts with other payers, where they pass the risk down to us and then we manage it. That gave us the insight and the experience to go forward with this process.

Chairman THOMAS. I would be interested in comparing the two profiles that you come up with.

Mr. WOMER. Mr. Thomas, this is not our first endeavor into risk. We have many contracts with the insurance companies for both commercial and Medicare risk, so our position——

Chairman THOMAS. I understand that, but the way you spin it off is slightly different, is it not?

Mr. WOMER. No——

Chairman THOMAS. It really is not?

Mr. WOMER. No.

Chairman THOMAS. Good.

Mr. WOMER. The models are consistent. The models are consistent by what primary care physicians take as the risk, what the specialists do, what the hospitals do. They are very consistent because what you are looking for when you are dealing in risk is to aggregate lives to offset adverse selection. So you want to keep your models as consistent as possible and that way all the providers in the community know exactly what the routine of care should be.

Chairman THOMAS. Some of our discussion in dealing with provider-sponsored organizations was that in the assignment of risk, if it was something that was slightly different and the focus has been shifted, that you would have either some new concerns or a desire to redistribute the traditional structure. But you feel that basically there was nothing new there.

Mr. WOMER. Yes, sir.

Chairman THOMAS. It was just a mechanical, in essence, arrangement and the signoff is that everybody agrees that what you are doing is appropriate with a third party check that, in fact, you are OK?

Mr. WOMER. That is correct. And Sisters of Charity, as an organization, has been dealing with a government at-risk program, the Uniformed Services Treatment Facilities. That program has been

around since 1981 and has been fully at risk under the Uniformed Services Family Health Plan. So this is more of the same business for us.

Chairman THOMAS. Thank you.

The gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Mr. Agar, I notice that in your testimony, you mention that if you had not had the HCFA designation, you really could not have gotten into serving Medicare beneficiaries because you could not have gone through the contortions necessary to deal with the State regulatory system. I thought that was really interesting. Why is that?

Mr. AGAR. It is not so much the contortions. It is just that, like many State insurance departments, they are overwhelmed with applications and this was a way to get their attention and focus and cooperation so we could move through the exact same process they put the insurance companies through but do it in a reasonable amount of time.

Mrs. JOHNSON. So it is not that you do not have to go through the State process, but the State process is geared to insurance companies and managed care plans and you did not fit?

Mr. AGAR. No. It is just that——

Mrs. JOHNSON. Would it have been harder for you to go through?

Mr. AGAR. It is just that you cannot necessarily get their attention. There is a fair amount of feeling that the insurance companies do not want to see providers getting in this business. There may be some pressures there.

Chairman THOMAS. I would tell the gentlelady, we talked about this briefly and one of the points that Mr. Agar made—he is afraid, not to tell you what he told me, because he does not want to repeat himself, but you need to know it, because she has been involved and she missed your testimony—that in dealing with the Pennsylvania Insurance Commission, the top people and the Governor were understanding of the slight differences. The bureaucrats down who check the boxes wanted to check the insurance company boxes. We do not care what you call yourself. Meet these requirements. The folks up top were more understanding, so that there was a willingness to facilitate.

Mrs. JOHNSON. Thank you. That was interesting and I enjoyed your discussion. Thank you for being here today.

Chairman THOMAS. Thank you very much.

Do any of you have any final comments?

Mr. AGAR. Thank you very much.

Mr. RYAN. Thank you.

Chairman THOMAS. Good luck to you.

The second panel is Christine Boesz, the vice president for government programs, NYLCare Health Plans, and Janet Newport, vice president of government programs of FHP. I want to thank both of you for coming and your patience.

Any written testimony that you have will be made a part of the record and you may now inform us in any way you see fit in the time you have.

Ms. Boesz.

STATEMENT OF CHRISTINE C. BOESZ, VICE PRESIDENT, GOVERNMENT PROGRAMS, NYLCARE HEALTH PLANS, INC.

Ms. BOESZ. Thank you, Mr. Chairman and Members of the Subcommittee. My name is Christine Boesz and I am the vice president of government programs for NYLCare Health Plans. NYLCare is a wholly owned subsidiary of the New York Life Insurance Co. and we currently have 5 Medicare risk contracts serving over 65,000 Medicare beneficiaries in approximately 6 States.

I want to thank you for the opportunity to appear to discuss with you the Medicare demonstration programs that are currently under development. We are involved in both of them. We believe that one is well designed and collaborative and that one has some serious flaws and is a mandatory program. I want to contrast these two.

NYLCare is completely supportive of finding ways to improve Medicare through these demonstration projects. While we are proud of the health care that we provide to Medicare beneficiaries, we are acutely aware of the deficiencies in the present system of providing coverage to America's elderly. We see the problems as highly complex and the solutions as equally complex, but we do believe that carefully targeted demonstration projects are ways, and perhaps the only ways, to test emerging new ideas. We are also acutely aware of the difficulties that are faced by the Federal Government in determining a fair price to pay for the health care services.

NYLCare is not just theoretical in its support. As I mentioned, we have been selected both in Houston and in Atlanta to try two of the Choices. We have also been selected in Baltimore through the competitive prices, so we will talk a little bit about that.

First, I want to turn to the Baltimore situation. There, we believe that the HMOs are being forced on a mandatory basis to get engaged in a project that is seriously flawed. We believe that this has come about because the project was developed without participation of the affected people. HCFA has only just begun to meet with HMO representatives, and that has been due in great part to the efforts of Congressman Cardin and the Maryland congressional delegation, and we certainly thank them for their efforts.

One of the problems that we see, very briefly—they were discussed at length this morning, so I will be brief, is that only approximately 3 to 5 percent of the Medicare beneficiaries are currently involved. We are actually excluding 97 percent of the Medicare market in terms of how the pricing is established.

We certainly believe that the third party enrollment broker is very problematic in that the involvement of a broker interrupts the critical bond that an HMO must establish with their members during the enrollment process. We believe that if HCFA goes ahead with the pricing demonstration, it should be pricing only, that it should leave the enrollment to the HMOs, who, over the years, have actually worked with HCFA to develop procedures and training programs that guide us in this effort.

In fact, HCFA has extensive guidelines advising HMOs on how to market, how to protect the beneficiaries, and they actually monitor these processes on a very regular basis. The value added by an independent government contractor that has no accountability to

the HMOs, who serve the Medicare enrollees, only adds an intrusive layer of government bureaucracy that seniors must go through.

We are also concerned that the pricing is based on a single areawide rate and that it very possibly could be skewed because of the current range of the AAPCC. We are willing to work with HCFA on finding a way to handle this problem, but the way that it is designed right now does not give us any securities in that area.

We also want to point out that in the third party broker arena, it is very problematic in that employers have collective bargaining agreements and other employment contract areas that this will interfere with.

You talked extensively this morning why Baltimore is a poor selection. We believe that because of the hospital rate setting system, there is no generalizability to other States. Hospital costs represent approximately 56 to 57 percent of our costs, and so, therefore, we are limiting what we are actually competing on with respect to price.

The data reporting elements are cumbersome and we believe that HCFA does not have the systems necessary to handle the various types of data that they are asking us to submit.

Given all of these concerns, the implementation deadline is simply unreasonable. We are concerned that the project, as proposed, will affect the Medicare beneficiaries most of all. It has the potential to reduce choice, raise cost, and limit access. We are asking that you ask HCFA to stop the process and to work with us, as we will work with you, in designing a better competitive bidding project.

Very quickly, let me turn, if I may, to the Choices to point out some of the differences that we believe exist. Choices is also a competitive product. It is a competitive demonstration that involves new payment models. The difference is that the framework is voluntary. It is a cooperative, collaborative effort between us, provider-sponsored networks, and HCFA. The Choices demonstration stimulates entry of new plans into the marketplace, unlike the competitive pricing demonstration, which we are afraid will raise barriers and may even support the exit of some of the players.

We think that an important element of the Choices demonstration is that it focuses on new relationships between the various parties that need to be involved. We think that these relationships will offer new products to Medicare beneficiaries and new opportunities for providers to participate in new products.

The major difference, in summary, that I want to point out between the two programs is the position of the beneficiary versus HCFA, and that is the principal difference. In Choices, the beneficiary is at the center and the beneficiary's interests are being served. In the competitive pricing project, HCFA itself is at the center and the balance seems to swing over to HCFA's interest to just save dollars without sufficient concern for the beneficiary. I want to point out that Choices is not a cookie-cutter approach and it certainly shows the willingness of HCFA to work with the industry and vice versa in a very collaborative effort.

In conclusion, I would like to say, as more seniors move into the Medicare health care networks and as we continue to age as a Na-

tion, more alternatives to the present system are needed. We believe that the Choices demonstration is an excellent beginning. It has the support of private health care networks in seeking solutions to very vexing problems. The Choices demonstration is well positioned to contribute new approaches. In sharp contrast, the competitive pricing demonstration, as presently constructed, will not contribute to the solutions and, in fact, could do harm. I thank you very much.

[The prepared statement follows:]

STATEMENT OF CHRISTINE C. BOESZ
VICE PRESIDENT FOR GOVERNMENT PROGRAMS
NYLCARE HEALTH PLANS, INC.

Mr. Chairman, members of the Subcommittee, my name is Christine Boesz, and I am the Vice President for Government Programs for NYLCare Health Plans. NYLCare is a wholly-owned subsidiary of New York Life Insurance Company. New York Life is one of the country's five largest life insurers with policyholders from every state and with over $74 billion in assets. NYLCare is a national health care company providing health care coverage to 3.5 million Americans in every state. These health coverages are provided through health maintenance organizations (HMOs), preferred provider organizations (PPOs), and indemnity insurance. NYLCare's HMOs currently provide benefits under Medicare risk contracts to more than 65,000 senior citizens across the nation, a number that has doubled in the last year.

Thank you for the opportunity to appear before this subcommittee to discuss two Medicare demonstration programs under development by the Health Care Financing Administration (HCFA), the "Competitive Pricing" and "Medicare Choices" projects. These two demonstrations offer a contrast in two approaches -- one well designed and collaborative and one with flaws and mandatory. I will discuss the contrasts between the two.

NYLCare is completely supportive of finding ways to improve Medicare through demonstration projects. While we are proud of the health coverage we provide to Medicare beneficiaries, we are acutely aware of the deficiencies in the present system of providing coverage to America's elderly. We see the problems as highly complex, and the solutions as equally complex. Carefully targeted demonstration projects designed to explore new ways of providing health coverage to senior citizens are a sound way -- perhaps the only way -- to test emerging ideas. We also are acutely aware of the difficulties faced by the federal government in determining a fair price to pay for health services needed by the elderly.

NYLCare's support of Medicare demonstration projects is not merely theoretical. We have been selected to participate as a finalist in two of HCFA's "Choices" programs, a selection we consider an honor. The first is our plan in Houston, and the second is a teaming arrangement with the Morgan Health Group in Atlanta. I am excited about the possibilities presented by these programs, which I will address in greater detail later in this testimony.

However, we have grave concerns about HCFA's proposed competitive pricing program scheduled to begin in the Baltimore, Maryland area on January 1, 1997. We believe that the proposed project will hurt Medicare beneficiaries and will limit the expansion of Medicare health care network options in Baltimore and the surrounding areas.

I will first discuss our concerns about the Competitive Pricing Pilot program, and will then address the "Choices" program.

Competitive Pricing Pilot Demonstration Project

HCFA has proposed a competitive pricing pilot project that would force HMOs to obtain Medicare business based on a mandatory competitive bidding process. Under this process, HCFA would determine the price Medicare will pay HMOs for serving its beneficiaries. The goal of the demonstration is to test methods to replace Medicare's often criticized HMO payment system -- known as the adjusted average per capita cost (AAPCC) -- with a system that more fairly reimburses HMOs for services provided Medicare beneficiaries. The first site chosen for this project is Baltimore.

Project developed without participation of affected people

We believe the design process for that program has substantial flaws. This problem results from a process of developing the demonstration project that included no input from the effected parties, namely seniors, businesses, health plans, and physicians. All of these affected parties learned about this project just two months ago, in the beginning of May. HCFA has only just begun meeting with HMO representatives, due in

great part to the efforts of Congressman Cardin and the Maryland congressional delegation.

Project excludes Medigap fee-for-service carriers from pricing formula

The project mandates that all Medicare-participating HMOs participate, yet it excludes Medigap fee-for-service carriers from the actual pricing formula. Because only 9,000 of the 325,000 Medicare beneficiaries in the Baltimore area are enrolled in HMOs, the project effectively addresses only the payers that serve less than 3% of the population. A true competitive pricing formula would include the other 97% as well.

Third-party enrollment broker is problematic

HCFA plans to contract with a third party enrollment broker to enroll and disenroll beneficiaries. Health plans will not be permitted to enroll or disenroll beneficiaries directly. Forcing enrollment through a third party enrollment broker is not only unnecessary; it is fraught with logistical and operational problems that could lead to confused Medicare beneficiaries and to added Medicare program costs. The third party, which will have caused the problems, will remain unaccountable. The involvement of a broker interrupts critical bond that HMOs establish with their members during the enrollment process. HCFA should limit its pricing demonstration project to pricing only -- and leave enrollment to the HMOs, who over the years have worked with HCFA to develop procedures and training programs that help the HMOs' staffs handle the operational details of enrollment and disenrollment. In fact, HCFA has extensive guidelines advising on acceptable procedures and outcome-monitoring of our operations in these areas.

We all have learned that the education of a Medicare enrollee is crucial to a satisfactory relationship in a health care network environment. Specifically important is information on how to access services, when and where services are available, and how to seek assistance if there are any problems whatsoever.

The issue is accountability. I believe that the HMO has responsibility for explaining its benefits, its delivery system, any limitations, and how its services can best be used by the individual beneficiary. The value-added by an independent government contractor that has no accountability to the HMOs is not clear. At the same time, it adds an intrusive layer of government bureaucracy that seniors must go through. If the purpose is general education, that is a function different from sales, enrollment, service, and accountability for this continuum.

Pricing based on single, area-wide rate would skew bidding process

The program would establish a single payment rate for a seven county area whose current AAPCCs range from a low of $407 to a high of $614. HMOs which serve predominantly those counties in the low end of the range could submit winning bids that are higher than their current program payments. Conversely, those which serve predominantly counties at the high end of the range will be forced to bid at rates substantially, and unfairly, below the current payment levels of their counties. This could lead to marketplace distortion that could unfairly force HMOs to leave the Medicare market entirely, limiting choice for the beneficiaries.

Retirement plans threatened

This enrollment process also will have a major impact on employers and the relationship they have with their retirees. Applying this demonstration to beneficiaries in employment-based groups is unworkable and again shows the lack of understanding and analysis by HCFA of this important segment of the Medicare market. Many employers negotiate customized benefit packages under collective bargaining agreements or other employer-specific criteria. Furthermore, employers who operate nationwide usually offer the same benefits company-wide. This project jeopardizes this relationship. Many

employers use their own administrator to inform and assist retirees about the benefits afforded by the company. Adding another layer of government bureaucracy will only add to the confusion and possible distribution of misleading misinformation.

HCFA may require that HMOs in the demonstration suspend or waive their current arrangements with employer groups who have retirees living in the service area. The HMOs could not offer additional benefits to beneficiaries under any current arrangements they may have with the beneficiaries' employers. Employer groups, often through collectively bargained union contracts, require that health insurers customize benefits to a very high degree. Employers, and therefore employees, will lose choice. By forcing employer groups into a single set of benefits, this demonstration project would create an entirely impractical, unworkable situation. One of the largest employers in the Baltimore area is the federal government, which has developed a very different pricing formula, and is unlikely to allow any change for its Medicare eligible retirees.

A practicable approach to competitive pricing would be to waive employer groups from the process, so that it would address only the individual market.

Baltimore is a very poor selection

HCFA has outlined, very generally, criteria it used in selecting Baltimore. I would argue that, even if this were a well designed project, other sites around the country would be more appropriate and that Maryland has "special circumstances" which HCFA did not fully study or understand.

HCFA has said that the pilot should be conducted at a site at which the average AAPCC is higher than the national average. Yet, Baltimore's average AAPCC is $487.59, only $46.00 higher than the national average of $441.00. Several other sites have much higher average costs and would therefore be more appropriate selections.

HCFA has said that it wishes to have a site that has a reasonably-sized Medicare population. Baltimore's Medicare risk population is between 3 percent and 5 percent of the total Medicare eligible population. Other sites around the country have higher concentrations of Medicare beneficiaries than Baltimore, and should be far more likely candidates under this criterion.

Perhaps the most important reason why Baltimore is not an appropriate site for this project is that Maryland is the only state in the nation that has an all-payor system for hospital rates. HCFA has contended that the Maryland Commission in charge of the rate setting system has said that the demonstration project will have no effect on the system. This is not entirely true. The Commission has taken no position on the project. It does say in its June 26 letter to Congressman Cardin that ". . . the presence of hospital rate regulation would have to be considered when analyzing results from Maryland. . . ." We have the same questions about the generalizability of a Baltimore project. To our knowledge, HCFA has not performed any analysis to show that the results from a rate-setting state can be used to model potential results to a state without a rate-setting system to the 49 states that do not have such a rate-setting system.

The Baltimore area is the first of three areas chosen to take part in the project. Under the three-year pilot, expected to begin in early 1997, HMOs in the Baltimore area will only be able to compete for Medicare business through this mandatory competitive bidding process. Interested HMOs will submit bids to HCFA on a standard benefit package they wish to market to Medicare beneficiaries. If, in addition, they wish to market a more comprehensive benefit package, they also must submit a bid for that package to HCFA. It is not clear why or what relevance this has to the Medicare payment.

Up to half of HMOs will be forced to charge higher premiums

Under the design, "losing" HMOs, those with bids above the HCFA payment, would be forced to charge the Medicare recipient the difference. As a result, some, and perhaps many, seniors will pay higher out-of-pocket costs. Today, seniors in most

Medicare HMOs pay little or no premiums. Next year, under this project, more than 50% of the HMOs operating in Baltimore would be required to charge their senior members a premium. Under the proposed plan, the senior citizen in a "losing" plan may face a premium increase, experience unwelcome benefit reductions, and disrupt their continuity of care by having to switch to another HMO. The "losing" HMOs should have the choice of waiving that difference, particularly if the difference were so small that it would not be cost-effective to charge and collect it, and would only be a nuisance to the Medicare recipient.

Ultimately, the competitive pricing project would almost certainly have a perverse long term effect of reducing both competition and patient satisfaction in Maryland because it would impair the ability of HMOs to become economically viable in the market place.

Data reporting requirements are cumbersome

HMOs would be required to submit individually identifiable encounter data to HCFA on an ongoing basis. It is unclear if HCFA systems will be in place to receive this data. Serious problems currently exist with submission of data on the working aged enrolled under Medicare risk contracts and HCFA resources are heavily committed to preparing for implementation of the Medicare Transaction System (MTS). Systems for receipt of encounter data will need to be carefully structured, and testing of the transmission process will be essential. Additionally, we would question whether HCFA considered, in its criteria, that the State of Maryland will require HMOs to submit encounter data to the State. This raises questions of compatibility, redundancy, and purpose. HMOs face the burden of keeping different sets of data for different members.

It also is not clear why this data is needed in a real time experiment. We could submit encounter data in demonstration models to test bidding that simulates behavior and costs, a much less disruptive approach.

Implementation deadline is unreasonable

Implementation is scheduled to begin in early 1997. The proposed schedule for this demonstration exacerbates the problems above, leaving no time for participation of many parties in their resolution. The period is so compressed that it may lead to rushed implementation of the program before the HMOs can develop new benefit packages, adapt to a new enrollment process, and install the new systems needed to comply with the demonstration requirements. HCFA also needs time to develop many of these same systems. Successful implementation of this competitive pricing project, wherever it is conducted, will require the focused attention and commitment of all parties involved. The time table outlined by HCFA will not make that possible for the project scheduled for Baltimore. We are concerned that the project as proposed will affect Medicare beneficiaries most of all -- it has the potential to reduce choice, raise costs, and limit access to options that are being promoted in other parts of the nation. We ask that this Congress direct HCFA to stop this poorly designed project in its tracks and require HCFA to start over and work with all the stakeholders in designing a project that will work for senior citizens.

Choices Demonstration Project

The Medicare Choices Demonstration project is another matter. HCFA solicited applications from a wide variety of health care networks to test alternative payment methods and to provide Medicare beneficiaries with more delivery system choices. The objective of this demonstration is to evaluate the receptivity of Medicare beneficiaries to a range of health care network models and to determine the long term viability of these models. In this project HCFA asked for voluntary participation and selected participants who were willing to try innovative approaches in risk sharing, certification requirements, and quality monitoring systems. HCFA has indicated that, while Medicare money may not be saved initially, the development of this framework that would cut costs over time. The goal is to modernize Medicare and to offer more beneficiaries more choice.

Competition is clearly a goal of this Demonstration project. HCFA is negotiating payment models that include partial capitation, capped fee-for-service payments, and rates that blend payments between urban and rural areas so that Medicare beneficiaries living in rural areas have more options. NYLCare's HMO in Houston is looking into a blended rating methodology.

Framework of Voluntary, Cooperative Innovation

The Choices Demonstration is clearly built on a collaborative approach. Participation is voluntary. The parameters of competition are not dictated by HCFA, they are market driven. Choices health plan participants can compete on benefits and price. They are not limited in how they can compete with Medigap insurers. These are the attributes that should be included in all HCFA demonstrations.

The Choices Demonstration stimulates entry of new health plans into the marketplace. This is in contrast to the Competitive Pricing Demonstration, which seems destined to raise barriers, and may even support the exit of current Medicare risk contractors.

An important element of the Choices Demonstration that we support is the focus on new organizational relationships. Specifically, we believe that partnerships between provider sponsored organizations and health insurance companies may be able to offer new products to Medicare beneficiaries and new opportunities for providers to participate in Medicare health care network programs. NYLCare's teaming with the Morgan Health Group in Atlanta is evidence of our interest in exploring with HCFA the advantages and disadvantages of alternative models.

Beneficiary versus HCFA

The principle difference between the two demonstration projects is the focal point of competition. In Choices, the beneficiary is at the center and the beneficiaries' interests are being served. In the competitive pricing project, Medicare itself and its interests are at the center. In Choices, HCFA is willing to move incrementally, with reasoned caution about serving beneficiaries and saving Medicare dollars and working with the private sector. With Competitive Pricing, the balance seems to swing in HCFA's interest to save dollars without sufficient concern for the beneficiary and without an understanding of how Medicare managed care works.

Choices- Not a "cookie cutter" approach

HCFA is to be complimented on its vision in the design of the Choices Demonstration. The 25 selected health care network plans are evidence of HCFA's understanding of the importance of diversity and innovation as proposed by the organizations. Of the 25 plans, 16 have proposed testing health risk adjustment methods as a part of their payment approach, and 12 have proposed testing economic risk sharing with HCFA. While there is still much work to do to bring these proposals into operational status, they are a clear indication of willingness by the plans to work with HCFA. In turn, HCFA's willingness to work with a wide variety of organizations on complex delivery and financing issues shows a commitment to innovation that is crucial for finding solutions to the problems that confront the Medicare program.

Conclusion

As more seniors move into Medicare health care networks, and as we continue to age as a nation, more alternatives to the present system are needed. We believe that the Choices Demonstration is an excellent beginning that has the support of private health care networks in seeking solutions to very vexing problems. The Choices Demonstration is well positioned to contribute new approaches. In sharp contrast, the Competitive Pricing Demonstration, as presently constructed, will not contribute to solutions, and could, in fact, do harm.

Chairman THOMAS. Thank you very much, Ms. Boesz.

Ms. Newport.

STATEMENT OF JANET NEWPORT, VICE PRESIDENT, GOVERNMENT PROGRAMS, FHP, INC., COSTA MESA, CALIFORNIA; ON BEHALF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS

Ms. NEWPORT. Good afternoon, Mr. Chairman and Members of the Subcommittee. Thank you for the opportunity to come here from California to testify at your hearing.

FHP is a multistate Medicare risk plan. We have almost 400,000 members in 8 States. We have been a longstanding Medicare participant in the Medicare risk program.

Today, I am testifying on behalf of the American Association of Health Plans and my testimony focuses on the Medicare Choices demonstration. Before I delve into my comments on the Choices demonstration, I would like to make a general observation.

We believe that managed care must be a part of the long-term solution of the Medicare financing issues that we all face, just as managed care has been an extremely important and effective part of the quality improvement and cost containment achieved in the private sector. Competition among health plans and providers has been and will continue to be a key part of this. As long as the Medicare system developed to achieve competition establishes level playingfields for health care competition, then managed care can be an active part of the solutions we all seek.

In testimony before this Subcommittee nearly 1 year ago, AAHP stated that, "Medicare can best be strengthened by giving beneficiaries the same kinds of choices that are already available to millions of working Americans, including Federal employees and Members of Congress." We believe that the Choices demonstration, if carefully structured, can be the first step in the process of updating the Medicare Program to offer these choices.

In that same testimony, however, we urged Congress to hold all Medicare health plan options to strong and comparable standards, not just to ensure fairness and a level playingfield for competitive plans but also to ensure that all beneficiaries can be assured that regardless of the option or the type of benefit they choose, their health plan has complied with a set of requirements which have been structured to ensure that their health care needs and interests are protected.

While we understand that demonstrations are designed to test various theories, and in this case new choices, the potential changes in some of the rules and procedures need to be carefully evaluated. The underlying purpose of a particular requirement should be carefully considered before waiving it in a particular case. HCFA should ask whether alternative safeguards are in place and whether beneficiaries will enjoy the same level of protection under a waived regulation as they do under current policy.

As AAHP warned in last year's debate, the greatest risks to Medicare reform lie in its initial stages. It will not take many failures to discredit new initiatives in the eyes of the public. We believe that this is also true for reforms implemented through demonstration projects.

In our view, the purpose of a demonstration is to identify a basic set of regulatory requirements that can then be applied to all plans serving Medicare beneficiaries and not to develop a series of carve-outs or special rules that deal with a particular organization's idiosyncrasies. Unless this is understood at the outset, HCFA will run the risk of creating demonstrations that demonstrate little except the advantages and failures of special treatment, potentially at the expense of existing choices in the market.

For example, some States have found that waiving of solvency standards for health plans participating in the Medicaid Program allowed a market instability and some plans have gone bankrupt, leaving Medicaid recipients without the appropriate health services.

In deciding which applications to approve and which waivers to grant, HCFA should take into account the impact that its decisions may have on the competitive environment in specific markets. In Houston, for example, one of the final candidates, as you have just heard from, is a provider-based organization with whom my plan contracts to provide services to a majority of our Medicare enrollees in that market. If, for example, the 50–50 rule is waived for this group, it would be allowed to enroll Medicare beneficiaries immediately, giving the plan every incentive to market itself to the beneficiaries it is already serving under contract with FHP.

It is important to note that rule changes in this case mean no real change necessarily in the facilities that are available to serve the Medicare population and will have marginal impact on the percentage of Medicare beneficiaries who may enroll in private plans. This needs to be evaluated, obviously.

AAHP and FHP appreciates the opportunity to present our views on this and I will be happy to answer any questions you have.

[The prepared statement follows:]

STATEMENT OF JANET NEWPORT
AMERICAN ASSOCIATION OF HEALTH PLANS

Mr. Chairman, I am Janet Newport, Vice President of Government Affairs of FHP, Inc., testifying today on behalf of the American Association of Health Plans (AAHP). AAHP (formerly GHAA/AMCRA) represents more than 1000 HMOs, PPOs, and similar health plans. Its member companies are dedicated to a philosophy of health care that puts the patient first by providing coordinated, comprehensive health care. Together they care for more than 100 million Americans. FHP has a long history of serving Medicare beneficiaries under the Medicare risk contracting program. Today, we serve 391,000 beneficiaries in eight states.

We very much appreciate the opportunity to participate in today's hearing and to share our views on the Medicare Choices Demonstration currently under development by the Health Care Financing Administration (HCFA).

During last year's debate over Medicare reform, the Association took the position that the program must be modernized to reflect the dramatic developments that have occurred in the private sector since Medicare was enacted over 30 years ago. In 1995, fee-for-service is no longer the predominant approach to coverage in the private sector. More than 60 percent of all working Americans with private health plan coverage now receive their care through HMOs and other organized systems of care. By contrast, only about 11 percent of today's Medicare beneficiaries are in HMOs.

In testimony before this subcommittee nearly a year ago, AAHP stated that "Medicare can best be strengthened by giving beneficiaries the same kinds of choices that are already available to millions of working Americans, including federal employees and members of Congress." We believed it then, we believe it now, and we believe that the Medicare Choices Demonstration, if carefully structured, can be the first step in the process of updating the program.

In that same testimony, however, the Association also urged the Congress to hold all Medicare health plan options to strong and comparable standards -- not just to ensure fairness and a "level playing field" for competing plans, but also to ensure that all beneficiaries can have the same confidence in their health plan regardless of the option they choose.

The current Medicare standards for risk contractors are designed to ensure that organizations entering the Medicare program have the organizational structure and operational capacity to provide health care to Medicare beneficiaries -- over the long haul, not for a year or two. While we understand that demonstrations, by their very nature, involve temporary changes at least to some rules and procedures, the underlying purpose of a particular requirement should be carefully considered before waiving it in a particular case. Current standards include requirements on:

- **Financial resources** -- Solvency and capitalization standards are designed to ensure that Medicare contractors have the financial strength and stability to provide care to the Medicare beneficiaries they enroll. Capitalization standards are particularly important for new plans, because it is common for new organizations that provide as well as pay for health care services to sustain losses in their early years of operation. This is due in part to the fact that they must absorb the start-up costs of creating a delivery system and the infrastructure that supports it. In addition, adequate solvency standards are particularly critical under the Medicare program because Medicare beneficiaries use services more frequently and intensively than younger populations.

- **State licensure** -- In addition to meeting federal Medicare program requirements, plans must be licensed in States in which they operate. This adds a level of local accountability to the federal regulatory safeguards that apply.

- **Quality improvement systems** -- Plans must have systems to monitor and assess quality of care and must provide mechanisms for a plan's providers to work together to address areas in need of improvement. Such systems include utilization review to ensure the appropriateness of services provided to beneficiaries. Clinical decision making is the

responsibility of the plan's health care providers, and it is through their efforts that quality is evaluated and sustained.

- **Delivery system** -- Plans must demonstrate that they have provider networks in place that will afford access to needed services for all enrolled beneficiaries.

- **Marketing** -- Plans must comply with fair marketing practices to ensure that beneficiaries have the opportunity to make informed choices among the options available to them.

- **Management systems** -- Administrators must be prepared to operate in many arenas -- member services, provider relations, enrollment and disenrollment procedures, coverage decisions, premium development, regulatory compliance, and other basic functions that support a delivery system.

- **Information systems** -- Plans must have data systems to carry out enrollments and disenrollments and to provide information on beneficiary satisfaction, the utilization of services, and other aspects of plan performance.

- **Enrollment composition (50/50 rule)** -- While the 50/50 rule, which requires plans to have a minimum commercial enrollment, is not a particularly good proxy for quality, it has assured some equivalence between plans available to Medicare beneficiaries and those available to the rest of the population.

After considering the underlying purpose of these requirements, HCFA should ask whether alternative safeguards are in place and whether beneficiaries will enjoy the same level of protection under the waiver as they do under current policy. As we warned during last year's debate, the greatest risks to Medicare reform lie in its initial stages, and it will not take many failures to discredit new initiatives in the eyes of the public. We believe that this is as true for reforms implemented through demonstration projects as it is for legislative initiatives.

In deciding whether to waive a particular requirement, agency officials should also ask themselves whether they would be prepared to extend the same treatment to other Medicare contractors if the demonstration is ultimately judged a success. In our view, the purpose of a demonstration is to identify a basic set of regulatory requirements that can then be applied to all plans serving Medicare beneficiaries -- not to develop a series of "carve outs" or special rules that deal with a particular organization's idiosyncracies. Unless this is understood at the outset, inappropriate waivers may be granted, and HCFA will run the risk of creating demonstrations that "demonstrate" little except the advantages and failures of special treatment. For example, in some instances states have applied lower solvency standards to Medicaid plans than to plans serving commercial members. The resulting financial instability of some of these plans has jeopardized health care services for Medicaid beneficiaries.

Finally, in negotiating contracts with demonstration participants and deciding which waivers to grant, HCFA should take into account the impact that its decisions may have on the competitive environment in specific markets. Even if the geographic areas selected by the agency had relatively low Medicare HMO enrollment, this would not necessarily mean little disruption would occur if a Choices Demonstration entered one of these areas.

In Houston, for example, one of the final candidates is a provider-based organization with whom my plan -- FHP -- contracts to provide services to our members. If the 50/50 rule is waived in order to permit this group to enroll Medicare beneficiaries immediately, it will have every incentive to market itself to the beneficiaries it is already serving under contract with FHP, rather than to seek out new enrollees. And if greater flexibility on benefits and favorable financial terms are added to the built-in advantage provider-based groups have because of their existing relationships with Medicare beneficiaries, it may well succeed. The result will be a shift of enrollment from FHP, which has invested substantial resources to enter the Medicare market in Houston, to a newly recognized organization -- but with no real change in the facilities that are

available to serve the Medicare population and little impact on the percentage of Medicare beneficiaries who enroll with private plans.

AAHP appreciates the opportunity to present our views about the Medicare Choices Demonstration. If it is crafted with care, we believe that this initiative can be a positive first step in the process of updating the Medicare program and expanding the options available to Medicare beneficiaries. We look forward to working with all concerned to assure its success, and I would be pleased to answer any questions you may have. Thank you.

Chairman THOMAS. Thank you both very much.

You were here earlier, I assume, while we were talking to Mr. Vladeck. So I hope some of your concerns were expressed by our questions, because, obviously, we have the same concerns. If you are going to take the time and the enormous energy to set up demonstration projects, you would hope that you would have the ability to get some results that you had, one, a level of confidence in, and two, you could replicate in other areas.

If you will indulge me for just 1 minute. I represent a very rural area, high desert, and the Bureau of Land Management wanted to run a test in the desert because in the spring, there is some green grass that grows briefly and then various sheepmen petition to be able to run their sheep on the desert where the grass is. There was some concern about the damage that may be done to the desert tortoise, and we believe the crows coming in from the population intrusion do far more damage. But the test that BLM wanted to run was that they created a number of styrofoam shells that looked like tortoises and they wanted to set the styrofoam tortoises out and then have the sheep go out into the desert and eat the grass to see what reaction sheep would have to tortoises.

Most of us know that tortoises, not being warmblooded, when the sun comes up, go hide under rocks and in their burrows and come out and move around. So I met with the sheepmen and we had a discussion about the conditions under which we would allow this experiment to occur and the first condition that the BLM would have to agree to would be that we would allow them to put the styrofoam tortoises out if they would allow us to put styrofoam sheep out, and then we could run a test that we thought was equitable and reasonable as to what was going on.

I think, in part, that is what you are saying. The concern that I had, especially in this larger demonstration model, is that if we are waiving all of these rules and some of these programs are successful, the only answer I got from Dr. Vladeck was that we hope within 3 to 5 years we have changed the rules so that these people who got the advantage under the rule would be, in fact, conforming with the rule at that time. That is probably not the best answer that he gave me from the number of answers that he gave me, some of which were very good.

So I, too, have a very real concern about the usefulness, and the point that I am going to continue to make to HCFA is that if every time you run one of these programs you waive the 50–50 rule, maybe it is time to waive the 50–50 rule. Get rid of it. We did that in the legislation that we offered because we thought maybe it was a rough model for quality at one time, but it is clearly an impediment.

Perhaps, Ms. Newport, you can give us an example, if you have any, of real world problems, if you are not going to get a waiver on the 50–50 rule, of decisions you have to make in the real world to live with the 50–50 rule as you try to run your business versus not having to worry about the 50–50 rule.

Ms. NEWPORT. Thank you. I really appreciate the opportunity. We have been a longstanding opponent of waiving the 50–50 rule or getting rid of it. We obviously have had more of a welcome reception on that position in recent years than we had before that.

For example, FHP is in an ongoing effort to expand our risk contracting program. When we do go into a new market, the requirement that we have to have a base commercial enrollment, notwithstanding years and years and years of experience and a good track record in running the risk contract benefit program for our members, forces us to start all over again. It does artificially limit the choices to beneficiaries that otherwise could be made available in a market much more quickly.

We do have systems in place to assure quality. We do have systems in place to inform beneficiaries fully of the choices and options that we provide within our program, which is not just one-stop shopping. We have several types of benefit programs we can offer. So I think it just is an artificial barrier to choice in markets.

Also, for example, if we have participation in Medicaid Programs in some areas, that works against expanding our choice into Medicare because both of those count against you, if you will, if you wanted to open up a different product line, if you want to call Medicare risk a product line. So I think it—the 50–50 rule—is just an artificial barrier to choice.

Chairman THOMAS. Ms. Boesz, do you have any comments at all?

Ms. BOESZ. I would agree with Ms. Newport in the sense that we have a number of new starts, particularly in States like Maine and in North Carolina, where we are in a joint venture with Duke University where we are being called upon to do Medicaid. It limits our ability to get into the Medicare risk contracting because of the Medicaid constraint. So it is a barrier.

Chairman THOMAS. Of the waivers that were discussed, obviously, the 50–50 rule, the 5,000 minimum, and the State licensure, what we heard from Mr. Vladeck that it was not as difficult as they might have thought initially in terms of the State license aspect and that what we got was basically bumping the queue to allow them to be processed sooner. Our discussions when we were contemplating moving into the Federal level was a degree of opposition from insurance commissioners or the appropriate agency in the State to some of these newer structured entities.

If you had to create a hierarchy of waivers between, say, the 50–50, 5,000, or the jumping the queue on the State licensure, could you give me which one is the most valuable, maybe, from a business point of view that you do not have to meet?

Ms. NEWPORT. I think having a 50–50 waiver would be the most valuable.

Chairman THOMAS. The 50–50 would be one?

Ms. NEWPORT. Yes. I think that we go into States all the time and just as part of doing business, some States have larger standards, if you will, in terms of the breadth and depth of the application you have to send in. Some are less so. Licensure requirements differ all over the board, but more States are becoming more sophisticated about that. But that is not something that is not duplicated in the HCFA application process.

Chairman THOMAS. Ms. Boesz, I am having some difficulty understanding how HCFA, in its former multiple locations in the Baltimore area now and its very nice—I am trying not to call it a Taj Mahal—in its very nice new building in Baltimore, and the reason they were interested in part, I guess, in Baltimore, is that they are

there, so that they do not have to spend money, but how could you then have people who are in the State, in the community, in the metropolitan statistical area planning a model for that area and not factor in the concerns that you have and the amazing statement to me from the gentleman from Maryland that the State was planning on moving its entire senior structure into a market which admittedly was just relatively few thousands out of a multihundred thousand senior market? How does that happen?

Ms. BOESZ. I am sorry, Mr. Thomas. I cannot explain what HCFA's thinking was on that. Mr. Cardin's point was that the State is moving the Medicaid Program, not the seniors.

Chairman THOMAS. But some of them are seniors.

Ms. BOESZ. Some of them are seniors, yes, that is true.

Chairman THOMAS. And you do not have as mature an HMO market for Medicare or the seniors, and the sheer impact, either freezing it under that demonstration program or, in fact, folks electing not to be in the market, has got to have an impact on the State's ability to move into that area.

Ms. BOESZ. And it will. It absolutely will have an impact, and that concerns us.

Chairman THOMAS. I think the reason I asked the question was that staff told me that you may have had some experience with HCFA in your professional career in the past?

Ms. BOESZ. Sir, I have. Yes. I did have some experience, but I still cannot explain this particular phenomena.

Chairman THOMAS. Could you give, just for the record, the basis of your experience? If it was a brief few months, then obviously you do not have the ability to understand HCFA.

Ms. BOESZ. My experience with the Agency was over the last 10 years. I was in the managed care program and I was the Director of the office that handled the managed care risk contracts.

Chairman THOMAS. How long have you been away from HCFA?

Ms. BOESZ. One year.

Chairman THOMAS. It is amazing, what happens in 1 year sometimes.

Ms. BOESZ. Yes.

Chairman THOMAS. I want to thank both of you. Obviously, this Subcommittee, clearly on a bipartisan basis, is concerned. We want these demonstration programs to be a success. Frankly, I think the Choices one, notwithstanding the concerns about the waivers, because that is going to give us at least an opportunity to see the pluses and minuses of the waivers in removing or not removing, but the study model for the Choices is far superior to the competitive pricing, which, to me, is another one of those gigantic misnomers which attempts to create a competitive pricing model by freezing at one time a model that may or may not have been competitive and then not allowing the participants to adjust to the new competition.

We are hopeful that we can work with HCFA in improving that model, not for the other two sites but before they impose it in the Maryland area. I guess my confidence is that in Dr. Vladeck's testimony, he indicated that Mr. Cardin had final say and that no other demonstration programs would go forward until Mr. Cardin OK'd the Baltimore area program. I guess I am jealous, but I think that

Mr. Cardin has waived that power so that Dr. Vladeck does not have to get his approval. I have told him to retain it for a while so we will be able to work with those interested parties who, I believe, have very real concerns, because all of us want a successful program.

This sounds to me like not only will we not be able to use the data as extensively as we would like, but the location of the demonstration may, in fact, leave a toxic waste site in terms of health care delivery that we would not want to participate in.

I want to thank you both very much.

Ms. NEWPORT. Thank you.

Ms. BOESZ. Thank you, Mr. Thomas.

Chairman THOMAS. The Subcommittee stands adjourned.

[Whereupon, at 3:25 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF CHIEF MASTER SERGEANT JAMES D. STATON, USAF (RET.)
EXECUTIVE DIRECTOR
AIR FORCE SERGEANTS ASSOCIATION

Mr. Chairman and distinguished committee members, thank you for this opportunity to participate in your deliberations on expanding managed-care options for Medicare beneficiaries. Although your focus is primarily on private-sector options, there is a demonstration program that you could support that would affect hundreds of thousands of Medicare-eligible military retirees. I am speaking of Medicare subvention.

Under current law, military retirees are thrown out of TRICARE, DOD's health care program, upon reaching age 65. Although AFSA is unhappy about important aspects of the program, it still represents a less expensive alternative when compared with other health care options. Unfortunately, the only other option available to over-64 military retirees is Medicare. *Military retirees are the only federal retirees who lose their health insurance at age 65.* Some retirees may still use Military Treatment Facilities on a "space-available" basis, but with the downsizing of the military infrastructure, even the Department of Defense (DOD) admits that all of that care will eventually be eliminated.

These changes are in stark contrast to the fact that all retirees were promised, in exchange for a lifetime of service, they would receive free, lifetime health care in the military health system. However, even the replacement of that promise, TRICARE, with its cost-shares and enrollment fees, pushes them out at a certain age. That is discriminatory and morally wrong.

The most widely accepted alternative is Medicare subvention. With subvention, over-64 retirees could use Medicare to cover the cost of participating in TRICARE Prime, an HMO program. However, because of budget-scoring technicalities, it has been difficult to obtain even a demonstration program of subvention. While there is some agreement within the administration that statutory language is not needed, it would simplify matters to have that language.

There are two bills, H.R. 3142 and H.R. 3151, that would authorize subvention demonstration programs. Even as these bills languish, DOD and the Health Care Financing Administration (HCFA) are in negotiations to work out the details of a subvention demonstration. *Any subvention authorization language must come out of the Ways and Means Committee. I urge this subcommittee to approve a demonstration project and push for its approval in the full committee.*

With subvention, DOD would charge HCFA 93 percent of the average cost of care for Medicare patients in a given region. That is *after* DOD covers the $1.2 billion worth of health care for Medicare-eligibles that it now covers annually. This is a complete winner for DOD, HCFA, the beneficiaries and the taxpayers. *Mr. Chairman, quite frankly, there is no good reason for subvention not to happen.*

Mr. Chairman, AFSA believes that the time to act is very, very soon. With Congress planning to adjourn in early October, it is imperative that you and others on the committee work for approval of legislative language that would allow DOD and HCFA to go forward with a subvention demonstration. Military retirees deserve far more than they have received, and no less than this.

TESTIMONY OF
LISA ADATTO, VICE PRESIDENT, PRINCIPAL
BENOVA, INC.

FOR THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
JULY 12, 1996

Mr. Chairman and Members of the Subcommittee:

I am pleased to submit this testimony for today's hearing record on behalf of Benova, Inc., the nation's oldest and most experienced firm serving as enrollment brokers for health plans for Medicaid and Medicare programs. I am vice president and a founding principal of the company.

In this testimony, I will explain why Benova urges this committee to support the demonstration project proposed by the Health Care Financing Administration (HCFA), as a result of our considerable experience with unbiased, third-party educational and enrollment programs. We believe these programs can help meet our nation's health care objectives, including better control of health care costs.

Benova, Inc. is a corporation founded in 1982 and based in Portland, Oregon. We have approximately 225 employees and offices in Oregon, Connecticut, Oklahoma, California, Ohio and Virginia. We are an enrollment contractor who has worked extensively with state Medicaid programs, employers and HCFA to provide unbiased third party education and enrollment services, and consulting services in designing prototype education and enrollment programs.

As noted, we support the HCFA demonstration projects, and believe that a model program incorporating unbiased information and enrollment is highly worth testing. We are convinced a third party enrollment program is technically feasible, cost effective, and provides a better level of service to beneficiaries. In addition, we believe that use of a third party will assist in meeting national health care objectives both by driving competition and by reducing biased selection into managed health care plans. Our belief is that third party enrollment contractors can work effectively with the HMO industry and assist HMOs in meeting their enrollment objectives.

We believe that the reason that managed care has been so successful in reducing health care costs in market sectors other than Medicare is that the marketplace has created conditions for effective competition. Highly sophisticated purchasers, such as employers and state governments, drive competition through a bidding process. Consumers, such as employees, are given comparative information and are thus well informed about available options which further drives competition. On both the demand and supply sides, competition works.

In the Medicare program, competitive forces are not working as effectively and costs remain high. On the supply side, health plans do not need to bid for services; instead they are paid automatically, based upon historical data driven by fee-for-service payments. On the demand side are uninformed consumers who don't know which options are available. With the growing number of options and complexity of the Medicare program it is very difficult to make comparisons or even understand the competitive advantages of one option versus another.

The proposed HCFA demonstration will test new methodologies for driving competition. Given the urgency of national budget issues, we recommend that the demonstration go forward with the support of this committee.

Enrollment Broker Benefits for the Medicare Consumer

Service improvements occur in two ways. By providing "one stop shopping" an enrollment contractor is allowing beneficiaries a rational method of learning about which health plan options are available, how the programs work, and how they differ. In addition, an unbiased third party is able to prevent fraud and abuse by offering straightforward information without pressure or inaccurate claims.

There is much evidence that prospective Medicare beneficiaries have a difficult time understanding the Medicare program, how fee-for-service and managed care programs work, and how the health plans offered in any area differ. Consequences of the confusion are low HMO enrollment, misunderstandings about how to use health insurance, and irrational purchasing. Almost all studies of the Medicare program indicate that HCFA should provide more information to beneficiaries and promote an informed choice.

At this time twenty-two states have purchased enrollment contractor services or are in the bidding process to acquire these services for their Medicaid programs. States have found that use of the broker is a cost-effective and efficient method of educating recipients about the health plan choices available to them. Without a broker, states have found, even when managed health plan choice is mandatory, up to 50% of enrollees into state Medicaid programs do not make a choice at all and must be assigned to a health plan. Benova's experience is that with information 90% of state recipients make an informed choice. Enrollment contractors can be equally effective in a voluntary environment where beneficiaries choose between fee-for-service and managed health care. In fact, because without information many beneficiaries are likely to do nothing, the provision of information through a contractor can increase enrollment in managed care just by raising its visibility.

Description of Enrollment Contractor Services

Enrollment contractors operate as many other brokers (travel agents for example) or retail establishments do. They pull together a set of competing products (health plans in this case) into a convenient venue for choice, and they offer a single point of purchase to the consumer.

Typical services include mailing written materials such as brochures, booklets and comparison charts, call centers offering live operators trained to answer questions and walk consumers through the choice process, seminars, one-on-one "choice counseling" and enrollment processing. In many cases, the enrollment contractor can replace services provided by individual health plans and reduce expenditures spent on education and enrollment.

Technical Feasibility/Industry Experience

The enrollment contractor industry is working effectively with private and public employers, with health care purchasing alliances, and is especially well established with state Medicaid programs. At this time, 22 states have purchased enrollment contractor services or are in the bidding process to acquire the services.

There are numerous firms providing enrollment contractor services. With experience in six states, and a 12 year history, Benova is one of the most experienced enrollment contractors. However, several companies offer services to multiple states; a recent bid by Pennsylvania for enrollment contracting attracted bids from eight different firms.

Successful enrollment contractors are technically sophisticated and experienced in both communications and processing of enrollment transactions. They are well equipped to handle enrollment data from multiple plans and transmit the data to the sponsor be it a private employer or a public agency. Enrollment contractors are able to adapt their systems, to the varying demands of each region, and mix of health plans.

Elimination of Biased Selection

One of the key concerns about the managed care program for the Medicare population is that it doesn't appear to save money. This contrasts with the private sector and the Medicaid programs which have seen significant savings through managed care. There is some evidence that a biased (or healthy) population joins managed care plans, while sicker beneficiaries stay in fee-for-service. This can happen naturally, as beneficiaries with extensive provider networks choose to maximize their flexibility by staying in fee-for-service. It is also possible that health plan marketing practices encourage biased selection by targeting the most healthy segment of the population. This targeting could occur by the subtle messages portrayed by the pictures on health plan brochures, by highlighting benefits that attract the most healthy, and by overt sales practices.

Enrollment contractors will have no incentive or interest in biasing selection to or away from managed care. It is a key hypothesis to be tested that the use of a third party can reduce biased selection, and contribute to the use of managed care plans to reduce Medicare health care expenditures.

Cost Effectiveness of Third Party

It is extremely expensive for the insurance and HMO industry to educate and enroll Medicare beneficiaries into their programs. HMO executives tell us that it can cost up to $700.00 per member to enroll a new member. Much of the effort is duplicative as health plans spend millions to take enrollment from one plan to another. Medicare anticipates spending around $10.00 per beneficiary on the enrollment contracting service. This is consistent with enrollment contracting services in the Medicaid program.

One of the key hypothesis to be tested by a demonstration is whether a third party can provide administrative efficiencies. However, some efficiencies are apparent. For example, prudent use of the Medicare beneficiary list will eliminate the need to recreate the list for marketing purposes. Giving the Medicare beneficiary basic information about how the program works will eliminate the need for this to be done by each health plan and sales agent. Third party enrollment can eliminate the duplication of these processes. And beneficiaries who have made an informed choice are more likely to remain with their chosen health plan which will reduce the number of times that beneficiaries will need to be reeducated about their options and, from the perspective of the health plans, this lengthens the revenue stream associated with a new sale.

Working Effectively with the Health Plan Industry

Benova's experience is that an enrollment contractor can work very effectively with participating health plans and assist health plans to meet their goals. A third party can assist health plans by saving them money, by enrolling informed beneficiaries who are more likely to stay in their chosen health plan longer, and by heightening awareness of the managed care industry, increasing HMO enrollment.

Before a demonstration, it is typical for the enrollment contractor and the sponsoring agency to engage in a planning process to work out operational details, and create the type of partnerships needed. Our experience is that these relationships are successful.

Conclusion

The concept of operating an open enrollment with the opportunity for consumers to receive comprehensive and unbiased information is found in many studies outlining how to improve the Medicare program, and in many of the proposed pieces of Medicare legislation. We are pleased to have this opportunity testify to our support for this concept.

Statement of the National Association of Health Underwriters
by
David K. Kehl
Senior Director of Government Affairs

I appreciate having this opportunity to present the views of the National Association of Health Underwriters regarding the Medicare Demonstration Projects.

NAHU represents nearly 13,000 health insurance agents and brokers, serving the insurance needs of over 100 million Americans.

Many of our members handle Medicare supplement policies, and have established a good working relationship with their senior clients. Unfortunately, because of what appears to be an anti-agent bias in the Health Care Financing Administration, the services of agents are not available to seniors under the Medicare HMO program.

We have two concerns which we hope can be addressed as part of the effort to expand the availability of choices and options to our senior citizens.

First, in the implementing instructions governing the current Medicare HMO program, contained in the HMO Manual for the Medicare Select program, **"HCFA strongly discourages the use of Medicare marketing representatives who are not employees of your health plan."** In essence, HCFA is telling the plans that they should not use independent agents.

Last year, in recognition of the important services independent agents can provide to seniors, the Ways and Means Committee included language in the committee report for the Medicare Preservation Act which would basically have overridden the HCFA directive. The language stated:

> "With respect to marketing and enrollment, it is the Committee's intent to allow independent agents acting on behalf of MedicarePlus organizations to explain the plan's benefits and limitations and to accept enrollment forms from individuals electing the product."

Since this legislation never became law, the existing HCFA directive still governs, and in the absence of any directive to the contrary, will evidently be applicable to the Medicare Choice demonstrations. We strongly urge that the directive be lifted overall, and certainly with respect to these demonstrations, so that the plan participants will not be intimidated from utilizing the services of independent agents.

Secondly, HCFA's plan to use third party contractors to conduct all enrollment activities in the competitive pricing demonstration project will effectively preclude a role for agents.

NAHU is strongly opposed to this approach, and urges that enrollment be the responsibility of the plan itself and its representatives, as is currently the case with respect to the Medicare HMO program and the choices demonstration project.

HCFA appears to be concerned that seniors will receive biased information and that only the healthier risks will be recruited if enrollment remains with the plan. This concern can be alleviated by allowing independent agents to participate. Independent agents provide information on the alternatives available. They utilize their hands-on experience to walk customers through the different options available and go over what might be best suited to the customer's own personal needs. They can answer questions based on real world knowledge, not on the basis of an instruction manual, as would likely be the case for employees of third party contractors. Third party employees would not be able to help steer seniors to a particular plan which might best meet the seniors' needs, because these employees are instructed to be "neutral". If they do steer seniors to a particular plan, they could be accused of taking sides, and rightly so.

With regard to risk selection, independent agents do not have any incentive to risk-select. They will receive a commission regardless of whether they sign-up healthy or sickly persons.

We believe it would be extremely shortsighted for the Medicare program not to 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.

As we move in the direction of providing seniors with more options under the Medicare program, they are going to need help in understanding the different plans. Simply receiving a batch of printed materials is not going to do the job. They are likely to feel overwhelmed. 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. Seniors often have a familiar agent they have used and relied on over the years, and thus have more confidence in advice from such an individual than from strangers, such as government or company employees.

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 remembered, from a consumer protection standpoint, that agents must be licensed by the state. They are currently tested by each state for competency, undergo a criminal background check and a fiscal responsibility check, and must take education and continuing education courses prior to becoming licensed or having a license renewed. Will these standards be applied to third party contractors or HMO employees? Many states currently do not require 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.

In conclusion, we believe that independent, licensed, professional insurance agents are best equipped to bridge the gap between Medicare beneficiaries and new Medicare choices. When it comes down to relying on unlicensed company employees or unlicensed employees of government-financed third party contractors, versus licensed, experienced professional agents free of charge to the government, why not allow agents the opportunity to show how they can make the programs work for our senior citizens?

PREMIER

July 26, 1996

Chairman Bill Thomas
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
1136 Longworth HOB
Washington, D.C. 20515

Dear Chairman Thomas:

I am writing today in strong support of HCFA's planned competitive pricing demonstration for Medicare risk contracts. The demographic realities that the aging of the Baby Boom generation will ultimately force on the Medicare program demand all reasonable alternatives to reduce expenditures and improve program efficiency be seriously considered. Using competitive pricing, or competitive bidding, to determine Medicare payment rates for capitated contracts, laboratory services, durable medical equipment, and even selected high cost and high volume surgical procedures is a promising cost containment approach that deserves testing and evaluation.

There are many design issues involved in any complex demonstration. HCFA should work cooperatively with existing health plans and emerging provider sponsored networks in resolving specific demonstration design questions as they might arise. Holding hearings on the demonstrations allows for open review of HCFA's procedures. HCFA should carefully review and respond to all concerns raised by the providers before proceeding with the demonstration. But, we should not let the special interests use this process to deter the need to move forward with this demonstration.

Mr. Chairman, my statement of support for the competitive pricing demonstration is made knowing full well how painful a truly competitive health care market place will be. There is enormous excess capacity in all elements of the current health care delivery and financing systems. Although competition, based on price and quality, is the best mechanism to squeeze out this excess it will be painful. The Medicare program provides a statutory entitlement for beneficiaries, not for providers or plans. That fact is too often ignored in policy debates.

Sincerely,

James L. Scott

James L. Scott
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Washington, DC

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