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HEARINGS BEFORE THE

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(Volume 1 of 6)

104th Congress
1995-1996

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LONG-TERM CARE TAX PROVISIONS IN THE CONTRACT WITH AMERICA

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

JANUARY 20, 1995

Serial 104–1

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

89–248 CC WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-047065-X

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LONG-TERM CARE TAX PROVISIONS IN THE CONTRACT WITH AMERICA

FRIDAY, JANUARY 20, 1995

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

The subcommittee met, pursuant to other business, at 11:40 a.m., in room 1310, Longworth House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
January 11, 1995
No. HL-1

CONTACT: (202) 225-3943

THOMAS ANNOUNCES *CONTRACT WITH AMERICA* HEARING ON LONG-TERM CARE TAX CLARIFICATION

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the subcommittee will conduct a hearing on tax incentives for long-term care insurance as part of the Senior Citizens' Equity Act (H.R. 8) that is a portion of the Contract with America, the series of 10 bills offered by the Republicans as a national legislative agenda. **The hearing will begin at 11:30 a.m. on Friday, January 20, 1995, in 1310 Longworth House Office Building. An organizational meeting of the subcommittee will precede the hearing and will begin at 11:00 a.m.**

This hearing will feature invited witnesses only. In view of the limited time available to hear witnesses, the Subcommittee will not be able to accommodate requests to be heard other than from those who are invited. Those persons and organizations not scheduled for an oral appearance are encouraged to submit written statements for the record of the hearing.

BACKGROUND:

The costs associated with long-term care are of increasing concern for America's senior citizens and their families. Currently about 7.1 million elderly individuals need long-term care services, and estimates indicate that as many as 13.8 million Americans will need long-term care services by the year 2030. Currently, care is typically paid out-of-pocket by private individuals and by the Medicaid program. Most Americans do not take long-term care needs into consideration as a part of personal financial planning during their working years or when planning for retirement. The financial resources required to meet an individual's long-term care needs are difficult to predict. For most Americans, saving the tens of thousands of dollars necessary to finance a potential extended nursing home stay is impractical and financially impossible. Traditional health care coverage, including Medicare, does not cover most services associated with long-term care. The portion of the Medicaid program devoted to long-term care is designed to care for the nation's poor who require such services. To qualify for Medicaid assistance for long-term care, individuals must first "spend down" a significant portion of their savings and other assets. In addition the disastrous financial impact on families struggling with the costs of long-term care, federal and state governments are finding it increasingly difficult to pay their portion of long-term care costs under the Medicaid program.

Unlike traditional health care insurance, long-term care insurance does not currently enjoy tax favored status. The Senior Citizens' Equity Act of the *Contract With America* clarifies the tax treatment of long-term care insurance policies by treating long-term care insurance in a manner similar to accident and health insurance as a way to encourage individuals to actively plan for their long-term care needs.

FOCUS OF THE HEARING:

The hearing will focus on the provisions in the Senior Citizens' Equity Act of the *Contract With America* -- providing tax favored treatment for long-term care insurance.

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 by the close of business, Tuesday, February 7, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements 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, 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.

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

3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.

4. A 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.

* * * * *

Chairman THOMAS. This is the opening meeting of the Subcommittee on Health, in regard to the Contract provisions with America in terms of long-term care provisions.

Today's hearing will reveal several of the Contract With America provisions within the subcommittee's jurisdiction. It, obviously, reflects a hope to hold a series throughout the course of the year, focusing on new and novel approaches, issues facing not only the delivery of health care, but clearly, the financing as well.

The defeat of health care reform last year means many of the challenges which faced the last Congress remain unresolved. Fortunately, while we failed here at the Federal level in Congress to form a consensus on even limited reforms, the private sector has continued, as it must, to move forward with many innovative approaches to provide high-quality, cost-effective health care coverage.

It is my intent to use this hearing process as a means of highlighting these innovations for use in dragging the Federal Government into the 21st century. In addition, rather than struggling to find problems with the current system, and attempting to add layer on layer of new regulations on the existing system, I hope that out of the hearings, we can focus on what the marketplace is doing today and how the Federal Government can learn from the private sector and, indeed, the States, in modernizing some of our more antiquated programs and blending the structure into a positive one.

The hearing will review the desirability of clarifying the tax treatment of long-term care policies as a means of encouraging the purchase of such policies and the evolution of the private market. The scope of the hearing is limited to the tax clarifications for long-term care policies, including H.R. 8, the Seniors' Equity Act.

Today's hearing, hopefully, will show us that in fact there are solutions that are real and achievable to the long-term care problems plaguing many of our citizens. We will hear, hopefully, from a broad spectrum of individuals and groups that will provide us with the insight we need to make responsible program decisions rather than focus on the high cost of entitlement strategy favored by the previous majority, as the solution to all our difficulties. The panelists we will hear from today, will show us that there is much to be gained from providing the right incentives and empowering individuals and their employers to make better plans for their own particular needs.

Mr. STARK. Mr. Chairman, thank you.

Today, we begin the subcommittee's work in the 104th Congress, and we find that health care costs continue to rise at an unacceptable rate of more than twice the general inflation rate; 40 million Americans remain without health insurance at any one point in time. I suppose under dynamic scoring, that number would approach 60 million.

We weren't successful in the last Congress in confronting these issues. That was certainly not the fault of this committee. This committee took the lead, reported a bill that was fully financed and worked; every American would have had guaranteed health insurance. Although I suspect that a comprehensive reform bill will not be on this subcommittee's or perhaps anybody else's agenda this

year, I do believe that the need for the results of that bill are a high priority among the American people.

There may be some attempts to do a wink and a promise and call some minor tinkering reform, and I believe it is our responsibility to point out to the public the difference between that type of a bill and what real reform would be.

Second, if I can mention the Speaker's name under our rules, when he addressed our full committee the other day, he misspoke. He hammered on Medicare pretty hard, and I think this committee has a long history of great pride in how we have both added oversight and legislation to keep the Medicare system the finest health insurance system in the United States, if not the world.

One of the things the Speaker was sadly misinformed on, is that HMO managed care plans according to GAO and Mathematica, cost us anywhere from 6 to 28 percent more than the current indemnity plan for Medicare. That is not opinion. Those are, in fact, the numbers. And we have to resist on this committee running off on some of these ideas where we hear what might save money, because we have the luxury of astoundingly accurate projections.

Whether we have been under Republican or Democrat administrations, the predictions of HCFA for what will be spent in the years ahead, have been amazingly accurate when you compare it to other government estimating. I think it would auger well for us to continue to support Medicare, indeed, improve it where we can.

It has the lowest overhead of any insurance plan in this country, returns a higher percentage of premium to the beneficiaries than any insurance company in the country, if not the world, and has less than 4,500 bureaucrats serving 35 million people. There is not an insurance company in the world that can come close to matching that, and the Chairman and I would spot our salaries and staff in there.

Admittedly, we have certain advantages, such as mandatory enrollment. We do have 99-plus percent of all the people over the age of 65, which perhaps Prudential could use and lower their overhead if they had that luxury, not having to have the sales cost. But the fact is we don't serve our 35 million constituents who enjoy Medicare well to unnecessarily trash it.

There is a lot of work to do in this committee, and this committee has a long history, and I am confident that the Chairman will continue that in a balanced fashion trying to improve Medicare, to crack down on fraud, to do away with unnecessary procedures, to cut down on overpayment to providers where it is not necessary, and indeed, to provide additional benefits to the beneficiaries where we are able. And I look forward to working with the Chair to continue that.

We in this committee will not deal with the tax reduction or the repeal of the Social Security tax from 85 to 50 percent. It is important for us to remember that those funds were dedicated to the Medicare Hospital Insurance Trust Fund. So if, in fact, we reduce the Social Security tax, we are taking money out of the Medicare Trust Fund.

We could fix that, for those of you who insist on voting to reduce the Social Security tax, by requiring that we hold harmless the Medicare Trust Fund, and I would like to remind you that we have

those responsibilities, not to destroy Medicare because it is a program that has worked for so long. Now, I have to give credit where credit is due. The Insurance Association of America was the leading factor in destroying health reform last year, and it is only fitting that the first order of business of this committee would be to pay them back by rewarding them with the lead spot on our agenda. And the bill really before us is for the rich.

Tax breaks don't very well favor the 85 percent of Social Security beneficiaries who earn below $34,000 a year in income. And we failed to deal with the abusive practices of companies and the bill does nothing do curb those unfair practices in selling coverage without nonforfeiture benefits or without inflation protection.

So I hope that we can, as we pay off the insurance industry, keep in mind that we must protect the public from unnecessary and often unconscionably inadequate and unfair products.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman for his conclusion.

Now we will begin the process with the first panel. Mark Meiners, who is the associate director, University of Maryland Center on Aging; Stanley Wallack, who is the cochairman of the Coalition on Long-Term Care Financing; and Joshua M. Wiener, who is the senior fellow at the Brookings Institution.

From my right it is Wiener, Wallack and Meiners. Your written testimony will be made a part of the record and you will have 5 minutes to proceed in any manner you choose.

STATEMENT OF MARK R. MEINERS, PH.D., ASSOCIATE DIRECTOR, UNIVERSITY OF MARYLAND CENTER ON AGING, AND NATIONAL PROGRAM DIRECTOR, ROBERT WOOD JOHNSON FOUNDATION PARTNERSHIP FOR LONG-TERM CARE

Mr. MEINERS. Thank you.

Mr. Chairman, and members of the committee, I am Mark Meiners, the associate director of the University of Maryland Center on Aging, and I also serve as the national program director for the Robert Wood Johnson Foundation Partnership for Long-Term Care. The partnership for long-term care is a multi-State, public-private long-term care insurance program that is successfully operating in California, Connecticut, Indiana and New York. The program is designed to encourage the sale of high-quality affordable long-term care insurance by offering special protection for Medicaid's resource limits.

I am pleased to have the opportunity to meet with your committee today to discuss the long-term care insurance provisions in H.R. 8, the Senior Citizens' Equity Act. The provisions supporting the long-term care insurance market development will help keep long-term care from continuing to be the forgotten stepchild in the health care forum debate.

I would like to have this opportunity, also, to thank Congresswoman Nancy Johnson, and Barbara Kennelly for the long support that they have given to the partnership program. We very much appreciate it.

The goals of the partnership are compatible with the long-term care provisions in H.R. 8. After careful consideration of the financing dilemma of long-term care, the partnership States have con-

cluded that support for private insurance is needed to balance Medicaid's role as the payer of last resort. The long-term care insurance market needs a boost.

We as a nation have not yet accepted that the blessing of a longer life carries with it the curse of catastrophic long-term care costs for some of us. Willard Scott's visits to the ever growing population of centenarians are all nice but they don't pay the nursing home bills when it comes to long-term care. Denial is rampant.

This is where the tax features in H.R. 8 can help. At least tax-favored treatment lends a much needed assist with the education of consumers about long-term care insurance as a good way to take personal responsibility in preparing for this risk.

Combined with product standards like those which the partnership States have negotiated, the tax breaks will help us achieve good value for consumers. But the effect will be greater than just education. By treating long-term care insurance like other health insurance, we mainstream chronic care as a real problem that deserves our attention and our dollars. It places long-term care insurance on an even footing with other employee benefits that are considered during financial planning.

Tax-free withdrawals from IRAs and other retirement accounts to purchase long-term care insurance serves to both encourage savings and to even the playingfield for those who haven't benefited from the chance to buy long-term care insurance on a pretax basis.

The impoverishment protection offered by the RWJ partnership States is an important additional incentive that should be encouraged. We would like to see the removal of the language in the 1993 Omnibus Budget Reconciliation Act that has held back the growth of partnership States. The partnership program is designed to help the market while, at the same time, serving as an alternative to transfer of assets. Without the partnership, only inflation-protected lifetime coverage gives complete assurance that a person will not be impoverished by long-term care expenses. With the partnership, high-quality protection can be obtained for more limited, less expensive coverage.

Without the partnership approach, important options such as inflation protection and home health benefits may not get consideration because they add to premium costs. With the partnership, shorter coverage can be viewed as a better alternative to giving up quality features such as these.

In summary, the long-term care provisions of H.R. 8, along with the partnership program can work together to broaden the improved market for long-term care insurance as an important piece of a long-term care financing puzzle.

I thank you for the opportunity to share with you my views on long-term care insurance, and I would be very happy to answer any questions. My written testimony elaborates a bit more on the points and the benefits of the Robert Wood Johnson Foundation Partnership for Long-Term Care.

Thank you.

[The prepared statement follows:]

TESTIMONY OF MARK R. MEINERS, PH.D., ASSOCIATE DIRECTOR
UNIVERSITY OF MARYLAND CENTER ON AGING

Mr. Chairman. Members of the Committee. I am Dr. Mark Meiners, Associate Director of the University of Maryland Center on Aging, and the National Program Director of the Robert Wood Johnson Foundation (RWJ) Partnership for Long-Term Care.

The Partnership for Long-Term Care is a multi-state public-private long-term care insurance program successfully operating in California, Connecticut, Indiana, and New York. The program is designed to encourage the sale of high quality, affordable, long-term care insurance by offering special protection from Medicaid's resource limits.

I am pleased to have the opportunity to meet with your committee today to discuss the long-term care insurance provisions in H.R. 8 - "The Senior Citizens Equity Act." It is my strong sense that the provisions supporting long-term care insurance market development will help keep long-term care from continuing to be the forgotten step-child in health care reform.

I would like to take this opportunity to thank Congresswomen Nancy Johnson and Barbara Kennelly for their long standing help in getting the RWJ Partnership for Long-Term Care implemented.

The Partnership program is grounded in the recognition that neither the public nor the private sector could, or indeed should, shoulder the financing burden of long-term care by itself. Yet the way we currently share the burden is a vicious cycle of out-of-pocket spend-down until impoverishment, at which point Medicaid will help. That is, unless you are well-to-do and savvy enough to get yourself a good lawyer to hide your resources. Typically it is the middle class that finds itself most on its own in dealing with long-term care costs. After careful consideration of this financing dilemma the Partnership states have concluded that support for private insurance is needed to balance Medicaid's role as the payer of last resort.

Simply stated, the long-term care insurance market needs a boost. We as a nation have not yet accepted that the blessing of a longer life carries with it the curse of catastrophic long-term care costs for some of us. Willard Scott's visits to the ever growing population of centurgenarians are nice but they don't pay the nursing home bills. When it comes to long-term care, denial is rampant.

This is where the tax features in HR 8 can help. At the very least tax favored treatment lends a much needed assist with the education of consumers about long-term care insurance as an way to take personal responsibility in preparing for this risk. This fact was recognized as far back as 1986 when former Health and Human Services Secretary Bowen's report on catastrophic illness called for a $100 tax credit targeted to the elderly. Though modest in size, the tax credit was included in the recommendations primarily for the education effect it could have on the market.

But the effect will be greater than just eduction. By treating long-term care insurance like other health insurance we mainstream chronic care as a real problem that deserves our attention and our dollars. Allowing long-term care insurance to be purchased on a pre-tax basis will encourage more employers to include this coverage in

their fringe benefit options. It places long-term care insurance on an even footing with other employee benefits that are considered during financial planning. Also, the earlier the purchase the more likely a person is insurable and able to adequately prepare for this risk by prefunding their premiums.

Tax-free withdrawals from IRAs and other retirement accounts to purchase long-term care insurance serves both to encourage saving and to even the playing field for those who hadn't benefited from the chance to buy long-term care insurance on a pre-tax basis. Tax deductions for long-term care insurance is another approach to encourage saving for chronic care needs.

The impoverishment protection incentive offered by the RWJ Partnership States is an important additional incentive that should be encouraged. We would like to see the removal of the language in the1993 Omnibus Reconciliation Act that has held back the growth of Partnership states. The RWJ Partnership strategy for encouraging the market is an excellent compliment to the long-term care insurance tax benefits outlined in HR 8 and states should be allowed to implement the Partnership Program if they so choose.

The Partnership Program is designed to help the market by improving the quality and affordability of long-term care insurance while at the same time serving as an alternative to asset transfers. Without the Partnership, only inflation protected lifetime coverage can give complete assurance that a person will not be impoverished by long-term care expenses. With the Partnership this same assurance can be obtained from more limited, less expensive coverage.

Long-term care insurers are faced with the difficult dilemma of trying to improve products while keeping them affordable. States are additionally interested in making sure that the market includes the many middle income purchasers who might not consider buying long-term care insurance because they had limited resources to protect and could not comfortably spend enough on insurance to get meaningful lifetime protection from impoverishment. Yet they are most at risk of spending down to Medicaid eligibility levels when they need long-term care which also makes them likely candidates for divestiture.

Without the Partnership approach it is likely that the market will go more in the direction of an up-scale sale; the type that would not likely be of much concern to long-term care policy makers except to the extent it could serve as an alternative to divestiture. Important options such as inflation protection and home care benefits would not get appropriate consideration because they add premium costs. With the Partnership, shorter coverage can be viewed as a better alternative to giving up these features.

The Partnership helps make long-term care more affordable and more valuable and therefore more attractive than the benefits of insurance alone. The Partnership States selected the strategy of linking the purchase of long-term care insurance to Medicaid eligibility after considering a number of alternative options. They see it as a way to target their support for the private market directly

to those areas of greatest public interest. The strategy is fiscally conservative, helps middle income people avoid impoverishment, serves as an alternative to divestiture, promotes better quality insurance products, builds consumer protection, and helps maintain support for Medicaid.

The Partnership provides a fiscally conservative form of premium subsidy. Only those who buy a policy and use the benefits get the special protection. Program related expenditures would be well after the program had begun and savings would be occurring to cover those costs. In contrast, traditional premium subsidies (including tax breaks) entail public expenditures at the time of purchase for all purchasers. Our estimates suggest that the Partnership strategy is at least budget neutral with some potential for Medicaid savings.

The Partnership gives middle income people a way to get help with catastrophic long-term care expenses without becoming impoverished. Under special arrangements with the state, insurance companies that specialize in long-term care can assure their policy holders they no longer have to go broke to qualify for Medicaid. The assets protected under the Partnership can mean the difference between autonomy and dependence if a policy holder exhausts their insurance and still needs assistance.

Buyers also don't have to resort to legal maneuvering to hold onto their savings. The Partnership policies are an alternative to transferring assets to relatives or friends to avoid spending hard-earned savings on long-term care. Participants can control their funds instead of worrying about how someone else might be handling their money. They also don't have to worry about current government efforts to stop Medicaid gaming. The States, on the other hand, can now pursue such efforts with less controversy, knowing people are being given a reasonable alternative.

The Partnerships bring the states into a close working relationship with insurers, providing both the means and the incentive to monitor insurer performance. Partnership policies are subject to a rigorous review and carry a stamp of approval from the states indicating they have meet rigid state certification requirements. As part of the program, educational campaigns are increasing awareness about the lack of protection and their financial options.

Finally, the Partnership Program can help mitigate concerns about means-testing; that programs for the poor are poor programs because they lack broad-based political support. By linking the Partnership incentive to Medicaid the constituency for the means-tested program can be enhanced rather than eroded. This is an important consideration as we contemplate health care reform. If a comprehensive long-term care program is neither fiscally or politically feasible, as was indicated by the details of the Clinton Plan, then incremental improvements to Medicaid may be the best bet for positive future developments. However, Medicaid's long-term care benefits cannot be sustained, much less improved, unless affordable and appealing private market financing options can serve to encourage people to plan for their own long-term care needs as much as possible.

In summary, the long-term care provisions of HR 8 along with the Partnership Program can work together to broaden and improve the market for long-term care insurance as an important piece of the long-term care financing puzzle.

Thank you for this opportunity to share with you my views on long-term care insurance market development. I will be happy to answer questions you may have.

Chairman THOMAS. Thank you.
Mr. Wallack.

STATEMENT OF STANLEY WALLACK, CHAIRMAN, COALITION ON LONG-TERM CARE FINANCING; AND DIRECTOR, INSTITUTE FOR HEALTH POLICY, BRANDEIS UNIVERSITY, FACULTY MEMBER, HELLER GRADUATE SCHOOL AT BRANDEIS

Mr. WALLACK. Thank you.

I am here representing a coalition that is involved with long-term care reform. The coalition is made up of people from the research community, insurance companies and providers. I appreciate the opportunity today to discuss the Senior Citizens' Equity Act. Because the coalition agrees with many of the specifics in the act, I really want to spend most of my time discussing the importance of the policy.

This committee knows all too well the problems you face in dealing with the Federal budgets over the next few years and the growth of entitlement programs, and I think you will have to be looking for both solutions in the short run and in the long run. And clearly, for the long-run solutions, you need to think about innovative ways that the Federal Government can solve social problems.

The Federal Government needs to solve social problems not just by taking over the financing of them. I think one of the first tests of this new thinking is with regard to long-term care, and this committee has the opportunity to deal with that.

After looking at this problem, I personally took a leave from Brandeis University in 1987 to get involved with the long-term care insurance development of the marketplace to see if the private sector can help solve this problem. And I think we can solve it with a limited amount of government funds. But I don't think we can solve it without the government getting involved. And I think that one of the big lessons I learned in the last few years is that to solve a social problem we have to have the government involved in a partnership with the private sector.

Now, I think the private sector, as you will learn today, is growing and is trying to solve part of the problem. There are over 100 companies involved in selling long-term care insurance. Over 3 million policies have been sold. But what is most interesting is that the product has really improved over the last 10 years. The benefits are much more comprehensive. Benefits are being triggered when someone hits a disability level.

What is most interesting and most important is that the value of these products has improved over the years. The typical purchaser of a long-term care insurance product is 65 to 70 years of age today. They get between 4 and 5 years' worth of coverage and pay about $100 a month in premiums. Now, if they were to go into care right away, 85 to 90 percent of their expenses would be covered. Less of it is covered depending on when they go in, depending on the rate of increases in inflation.

It is very important to point out that even with this growth, relatively few people have bought long-term care insurance; 4 to 5 percent of the elderly population have bought it. And I think one of the reasons for that is the biggest competitor against the private

market is the Federal Government and the government programs. People look to the Federal Government to deal with social welfare problems, particularly older people. And the government needs to do a number of things to get the population to take over this responsibility for themselves.

Certainly, you have to educate. And we need Federal standards for long-term care insurance. I think we have to rethink the public financing programs and how they fit with the private financing programs. A positive thing to do is tax clarification. I think that the value of this could be very significant.

First of all, long-term care is an ideal event to be insured for. A relatively small percentage of the people have large expenses, therefore insurance makes a great deal of sense. To appreciate the potential of tax clarification, I think the best example is to look at the fifties and the growth of acute care health insurance when we had tax clarification. It is, in fact, when the market developed.

Now, if we have tax clarification, it would be better for the consumer. The price will fall. But what I think is more important is that the attitudes of the consumer will change with regard to their view of insurance. And this, I think will cause the biggest change. A change in attitude about people taking on responsibility.

The likely impact, I think, could be very significant. When LifePlans did a survey of people who were not purchasing long-term care insurance, what we found is that 80 percent of them would reconsider if in fact there was tax clarification. The other savings, and I think Mark will talk about it more, is that Medicaid could save significantly if people buy long-term care insurance. It will stop people from spending down.

LifePlans has estimated in a published study that for each policy that is bought by individuals, Medicaid could save around $2,000.

Let me turn briefly to the specifics of this bill. With much of it, we are in agreement. We certainly believe some technical improvements can still be made. One thing that I find troublesome is with regard to who is qualified to get home care benefits. The way the current bill reads, is that to be qualified for home care, one has to be really needing to go into an institution. That really was not the intention of a lot of long-term care insurance products.

You, in fact, want people to be able to get care in their home. That is why people are buying this product. And we think it would make more sense to have the benefits geared with the level of disability.

Another one, which I don't have time to talk about, is the importance of coordination with private and public programs. And here I think there is a very big issue with regard to Medicare and home health care, which I hope this committee will address, and the growth in Medicare toward becoming a chronic care program.

This rapid growth, I believe, is related to the fact that Medicare is now serving the chronically ill people, as opposed to the acutely ill people. This committee needs to make some policy decisions on that.

I do think that the potential of long-term care is very exceptional in helping individuals have independence and having individual choice. I think that it would take an awful lot of fiscal pressure off of the Federal Government, both Medicare and Medicaid. And I think this committee should look at tax clarification as an investment in the future, because if you don't encourage people to buy private long-term care insurance and take care of their own costs, it is going to lead to more pressure on Medicare and Medicaid.

Thank you.

[The prepared statement follows:]

TESTIMONY OF STANLEY WALLACK
COALITION FOR LONG TERM CARE FINANCING

Good morning, Mr. Chairman and Members of the Subcommittee on Health. My name is Stanley Wallack and I am Chairman of the Coalition on Long-Term Care Financing. I also am the Director of the Institute for Health Policy at Brandeis University and a faculty member of the Heller Graduate School at Brandeis. In 1987, I founded LifePlans, a long-term care managed care company.

I am here today on behalf of the Coalition on Long-Term Care Financing which represents a diverse group of researchers, leading insurance companies offering long-term care insurance coverage and providers of long-term care services. Coalition members are united by a common commitment to the establishment of a strong partnership between the public and private sectors in financing long-term care services.

The Coalition appreciates the opportunity to testify on a matter of critical importance to consumers, providers and insurers of LTC services: to identify the most appropriate and fiscally responsible roles for the public and private sectors in financing LTC services and creating the incentives necessary to promote these roles and responsibilities. To this end, we very much appreciate the leadership demonstrated by sponsors of the Senior Citizens' Equity Act by including tax clarification of LTC insurance products in this bill. We believe that such an action will significantly enhance the marketability of LTC insurance policies by: (1) creating financial incentives to purchase LTC policies; and (2) sending a strong signal to the marketplace that the government considers this a legitimate approach to financing LTC services.

Mr. Chairman, my written testimony addresses several critical issues related to the establishment of a solid public-private partnership in LTC financing. These include:

* clarifying the tax status of LTC policies and other instruments for financing LTC services such as medical savings accounts;

* enacting federal standards governing private LTC insurance policies to assure consumers value in such policies;

* clarifying the role of the federal government in covering home health care services under the Medicare program to eliminate the confusion about Medicare home care coverage and the ambiguity about public and private sector roles in financing these services; and

* identifying more rationale alternatives for government involvement in the financing of LTC services than that represented by current Medicaid programs.

At your request, I will limit the bulk of my oral statement to the tax clarification provisions in the Senior Citizens' Equity Act. However, I ask your indulgence in allowing me briefly to address a related matter that has great fiscal significance to the Federal government and important implications for the development of a growing and innovative private market.

I. BACKGROUND

A. The Problem and Need for Federal Involvement

I want to begin my testimony by emphasizing the importance of a meaningful public/private sector approach in the financing of LTC. This debate is not occurring in a vacuum. Great strides already are being made with respect to innovations in the private market. Little more than ten years ago, many LTC insurance policies were limited primarily to skilled nursing facility services following a hospital stay. In response to consumers' demands for broader coverage of a variety of benefits, however, today's products provide comprehensive coverage of the full range of LTC benefits from home and community-based services through institutional care. Further, virtually all products offered by leading carriers have eliminated provisions limiting access to coverage, such as prior hospitalization and level of care requirements.

All too often, those supporting a public/private partnership are only providing lip service to this idea. We are not far from 2010, when the baby boom generation will reach retirement age and

the number of disabled accelerates rapidly. LTC expenditures will increase exponentially when this happens. Without addressing the issue of public and private sector roles today, there will be pressure for more government assistance in the future.

In 1993, national LTC expenditures totalled $108 billion. About 65% was paid by the Federal and state governments and about 35%, out-of-pocket. If current LTC spending patterns persist, LTC expenditures will more than double in the next 25 years. The Medicare and Medicaid programs represent the two fastest growing entitlement programs. Federal spending for Medicare in 1992 was $119 billion. It is projected to reach $189 Billion by 1995 and $310 billion by 2000. Medicaid spending reached almost $125 billion in 1993 and is projected to reach $360 billion by the year 2000.

Although the elderly accounted for only 11.5 percent of the Medicaid case load in 1993, expenditures for this group totalled 28.4 percent of spending. Likewise, while the disabled accounted for 15.5% of Medicaid beneficiaries, close to 40% of Medicaid dollars were spent on their care. The disproportionate share of Medicaid dollars spent on the elderly and disabled will only continue to increase as the elderly population grows. Between 1992 and 1993, the number of Medicaid beneficiaries grew by 8.8%, but two-thirds of the increase in Medicaid spending during this period was attributed to the growth in enrollment. Per capita spending grew only 2%.

Currently, the fastest rising budget expenditure for both Medicare and Medicaid is for home care. In the next six years, expenditures on home care are expected to double, even in the absence of any major programmatic changes. This growth reflects an increasing need for services as well as an inability to manage acute and chronic populations and to accurately define service norms. If the record growth in Medicare home health care expenditures were to continue, they could exceed Medicare physician payments in the next ten to fifteen years.

For these and other reasons, the Coalition believes that the Federal government must be clear about the services it will and will not pay for and what it expects of individuals in terms of personal and private responsibilities. We should not overlook the opportunity and importance of encouraging private sector involvement in the financing and managing of LTC services.

The history of social welfare programs in this country, as well as the particular interests of the private and public sector strongly suggest that, over time, LTC services will be financed by a mix of public and private programs. To assess what mix would work best, it is important to determine what each sector can do as well as to evaluate what each sector should do. Private LTC policies have evolved over the past decade. Market forces have been effective in shaping policy configurations as well as their cost. In general, policies today are more far more comprehensive than first generation policies. Consumers also receive more value per dollar of premium than in the past. However, the number of policies sold continues to be low in comparison with the proportion of elderly who could afford to buy them. This will remain the case until the Federal government clearly and unequivocally defines its own role in this area.

Older people look to the Federal government for signals on financing LTC needs. At no time was this more evident than in 1993 and 1994 when Congress was debating health care reform. Members considered a series of options for LTC from a non-means tested home care program for the severely disabled to a public insurance program for nursing home services. During this time, interest in LTC insurance dropped noticeably. Insurance company members of the Coalition experienced fewer responses to invitations to discuss LTC insurance products as well as a reduction in actual sales. Following the end of the formal debate in 1994, interest in exploring product options and sales began to rise again. Only if the Federal government is supportive and sends the proper signals will the private market approach its full potential. It must take the lead in recognizing the viability of private LTC insurance and establish incentives that will promote the evolution of this market such as tax clarification and federal standards for policies.

B. Private Market Potential

The private market consistently has spearheaded efforts to enhance financial protection against LTC risk in the past decade. Data collected by the Health Insurance Association of America for policies sold in 1992 reflects the growth in the private market place. Currently, 135 companies offer LTC insurance coverage. Since 1987, the number of policies sold has increased from 815,000 to almost 3 million at the end of 1992. The number of policies sold has grown an average of almost 30 percent annually. The majority of LTC insurance policies, about 82 percent, have been sold to individuals or through group associations.

Sales through the employer market and life insurance market, while a smaller percentage of total sales, also have increased dramatically. In the past five years, the number of policies sold in the employer market has grown from 20,000 in 1988 to over 350,000 in 1992. This represents an average annual growth of over 100 percent. Employer policies comprised over 12 percent of the market at the end of 1992. During the same period, the number of life riders sold has increased to over 157,00 policies, representing an average annual growth of over 300 percent. Life riders now represent over 5 percent of the LTC insurance market.

Coalition members believe that these markets hold great promise for the future expansion of private LTC insurance coverage since the average age of purchasers is much lower than in the individual market and premiums are much lower as a result of younger aged purchasers. While the average age of buyers in the individual market was 68 in 1992, the average age of purchasers in the employer and life insurance markets was 42 and 38, respectively.

LTC insurance coverage has continued to expand in response to consumer demand. HIAA analyzed policies of the top fifteen LTC writers representing 80 percent of the market of all individual and group association policies sold in 1992. All products analyzed offered coverage for skilled, intermediate and custodial nursing home care, home health care and adult day care services, and inflation and nonforfeiture protection. In addition, 80 percent of the policies covered alternate care services and 93 percent covered respite care. Daily benefit offers ranged from $40 to $200 per day for nursing home care and $20 to $100 per day for home care services.

II. COALITION POSITION

A. In General

The Coalition supports four key strategies for promoting public-private partnerships in LTC financing:

* aggressive strategies to educate consumers about LTC risk and options for financial protection;

* tax clarification of LTC insurance policies to provide incentives for consumers to plan for their LTC needs in advance through the purchase of private coverage;

* federal consumer protection standards to ensure that policies provide value to consumers and that this value is maintained over time; and

* public assistance programs for those who cannot afford to protect themselves against LTC risk through private means.

Based on our principles regarding LTC financing reform, Coalition members are pleased to note that the Contract with America includes provisions to clarify the tax status of LTC insurance products. This suggests that Members of Congress recognize the market potential for private LTC insurance. This recognition clearly is warranted by the growth of this market in recent years and the continued refinement of products with a view toward meeting the diverse needs of consumers.

B. Tax Clarification

1. Why Tax Clarification?

The Internal Revenue Service has yet to rule on the treatment of premiums paid for LTC insurance policies and benefits paid out by such policies. The Coalition believes that clarification of the tax status of LTC insurance would significantly enhance the LTC market and is important for the following reasons:

* **Enhance Product Legitimacy:** It would enhance product legitimacy by treating this benefit the same as all accident and health insurance coverage. From a consumer's perspective, if LTC insurance is as important as other insurance coverages such and health, life and disability products, why hasn't the government ruled on its tax status?

* **Expanded Market Penetration:** It would increase consumer interest in purchasing products and employer interest in offering coverage.

* **Reduce Public Spending:** It would reduce the drain on public sector programs, most notably Medicaid and Medicare, through enhanced private sector coverage.

* **Catastrophic Coverage:** LTC is a catastrophic event; those who need LTC services for an extended period of time incur enormous financial expenses. While the government has a responsibility to help consumers determine how to protect themselves against this risk, this does not mean that the government actually has to pay for this risk. Instead, the public sector can encourage individuals to self-finance this risk through insurance mechanisms by providing a financial incentive in the form of a tax benefit.

* **Reduce Costs to Consumers:** Tax clarification of LTC policies will reduce the effective cost of policies to consumers by allowing them to deduct premium expenses as legitimate medical expenses.

We believe the impact on consumer interest would be particularly significant in the group market since most consumers are used to purchasing health insurance benefits through their employer. Based on surveys conducted by the Washington Business Group on Health, the Health Insurance Association of American and others, we believe that tax clarification would increase employer interest in offering LTC coverage and, in some cases, making a premium contribution to this coverage. Employees also would be more likely to purchase policies if their premium contributions were tax free.

2. Potential Impact on Consumer Behavior

During World War II, many employers began offering group health insurance as an employee benefit as a "substitute" for higher wages since there was a wage freeze. Market penetration increased even more dramatically when health insurance coverage was granted favorable tax treatment. By the end of 1991, fully 85 percent of the civilian noninstitutionalized population was covered under a plan. The Coalition believes tax clarification would have a similar impact on the LTC market. The studies identified below provide evidence supporting this belief.

Washington Business Group on Health

The Washington Business Group on Health conducted a survey during the summer of 1991 to determine employer views toward private LTC insurance as a potential employee benefit. Responses were collected from Fortune 500 companies and members of the National Business Coalition Forum on Health, a membership of state, local and regional business coalitions. The two main reasons for offering private LTC insurance cited by survey respondents included: (1) protecting employee/retiree financial security and (2) encouraging greater employee responsibility for benefit planning.

Among the barriers to sponsoring a LTC insurance plan cited by potential plan sponsors were the following:

* Unfavorable tax treatment

* Fear of government mandates for employer contributions

* Feeling that LTC would be added to Medicare or other government programs.

The survey also asked employers about appropriate roles for the Federal government relative to LTC financing. Survey results indicate far more support for Federal roles which promote private sector coverage and individual responsibility than for the expansion of public benefits:

ROLE	PERCENT FAVORING
Tax incentives for personal savings for LTC	86%
Qualification of LTC for flexible benefits plan	70%
Treatment of LTC on same tax basis as medical care	59%
Tax incentives for employer financing of LTC	44%
LTC coverage through Medicare or federal program	23%
LTC coverage through Medicaid	12%

Conference Board

According to a study on employer offerings of LTC insurance protection by the Conference Board in 1991, most sponsors and carriers believe that the provision of a tax credit or deduction to plan participants and/or sponsors will increase both the number of plans offered and participation rates by employees and their families. Employers indicated that the lack of tax clarification "continues to impede their decision making on the best methods to design, administer and upgrade their plans."

Sponsors recommended several approaches for tax clarification of LTC policies:

* Allow employees to pay for all or part of their premiums on a pre-tax basis;

* Develop LTC Income Retirement Accounts and 401(k) plans;

* Provide tax deductions to employers who contribute to LTC benefits.

Employers interviewed for the Conference Board study also stressed two other important roles for the Federal government. First, they felt that the Federal government has a responsibility to increase public awareness about LTC risk and the need to protect themselves. Employers indicated that this would lead to higher participation in employer LTC benefit plans and a consequent reduction in public spending for LTC through Medicaid. Second, employers felt it was critical for the government to define its position on LTC solutions. For example, sponsors suggested that the government focus on the long-term costs of not taking actions to increase private coverage instead of the short-term revenue loss associated with the granting of tax deductions. Sponsors also warned against government responses to LTC financing that would penalize employers who have had the foresight to offer this coverage, such as new entitlement programs.

Buyer-Non Buyer Survey

LifePlans conducted a study on behalf of the Health Insurance Association of America in 1990 to determine who purchases LTC insurance policies, what motivates them to buy such policies and what kind of policies they purchase. LifePlans simultaneously collected data from a group of individuals who elected not to purchase coverage to identify similarities and differences between the purchasers and nonpurchasers.

Respondents who elected not to purchase private coverage were likely to reject coverage based on cost (too expensive), their inability or unwillingness to spend more money on additional insurance coverages or the belief that policies needed to be improved. Further, nonpurchasers were far more likely than purchasers to believe that the federal government should provide universal coverage of LTC benefits.

These findings underscore the critical importance of the government's role in public education about LTC insurance products for several reasons. First, research conducted by LifePlans indicates that about 30 to 40 percent of those 65 and above could afford a private LTC policy that would cover the majority of their expected lifetime expenditures on LTC services. The typical policy purchased by the over 65 population in 1991 provided over five years of nursing home care with benefits of $70 per day and one third of purchasers selected inflation protection. This typical policy cost about $100 per month. The benefits provided under this policy would cover the entire duration of service utilization for 85-90% of those purchasing coverage.

Almost 70 percent of Medicare beneficiaries 65 and older purchase Medigap coverage which costs roughly the same price as an average LTC policy. The affordability of this coverage is even more dramatic for the under 65 population, particularly employees who have the added benefit of receiving a group discount. Therefore, we strongly believe that the affordability issue so often raised is really a matter willingness to pay for LTC coverage, not financial ability to purchase such coverage.

Second, consumers might be more willing to purchase private LTC coverage if they understood the risk they face without insurance. With the tremendous amount of press this issue has received in recent years, it is difficult to conceive of the number of consumers who still believe that their LTC needs will be met by Medicare, private health insurance or other government programs. Public education about this risk is essential to dispelling these misconceptions.

Third, consumers need better information about how to evaluate the quality of products. As mentioned above, products have improved light years since the first generation policies were released. Because the market has received such negative press from advocates of government-sponsored insurance programs, however, consumers are often distrustful of these products. In this regard, the Coalition acknowledges that the insurance industry has to do a better job of promoting the value of these products as well. In addition, we believe that federal product standards would enhance consumer confidence in LTC policies.

Non purchasers indicated that the following government actions would make them more likely to purchase coverage:

	ACTION	PERCENT FAVORING
*	If the government would give them a tax break for purchasing a policy.	80%
*	If the government would give a seal of approval to certain products.	64%
*	If the government provided information on how to choose an insurance policy.	59%

Consistent with the WBGH and Conference Board surveys, the LifePlans study demonstrated that tax clarification of LTC products would increase consumers' interest in purchasing policies. The study also underscores the importance of a "government seal of approval" vis-a-via product standards and a role in public education about LTC risk.

3. Specific Recommendations for Tax Clarification

The Coalition supports most of the provisions in the Senior Citizens' Equity Act with respect to tax clarification. Benefits to the individual up to the maximum limit would be tax-free,

employer contributions toward premiums would be a tax-free fringe benefit, and LTC expenses would be treated as other medical expenses. We also appreciate some of the changes made to the legislation prior to introduction such as modifications made to the treatment of tax reserves and the inclusion of transition rules which would prevent current policy holders from being penalized.

Below is a brief summary of our position on the tax clarification provisions in the Senior Citizens' Equity Act. We believe that several technical changes may be necessary to ensure that the intent of Congress is carried out. The Coalition would like to go on record as supporting the following provisions:

Tax Reserves: The Coalition appreciates the inclusion of a provision to conform the tax treatment of LTC reserves with the statutory reserving requirements. All other insurance lines are permitted to take a deduction for reserves when they are established. Currently, the federal tax code in unclear as to when companies are allowed the deduction for LTC insurance. Consequently, in second year the policy is inforce, the company pays approximately 70% of premium income is taxed. This clarification is of critical importance to the growth of this market.

Effective Date: We support the effective date provisions for newly issued and existing policies. This provision would allow current policy holders to be eligible for tax-favored treatment if their policy met the state requirements at the time it was issued. This provision will prevent individuals who had the foresight to plan in advance prior to the enactment of this law from being penalized and effectively will reward them for planning for their LTC needs.

Maximum Benefits: The Coalition appreciates the inclusion of a maximum daily benefit of $200 since it recognizes the high cost of LTC in certain parts of the country. Previous legislation set this limit much lower and would have penalized those who live in high cost areas. We also appreciate the provision which would tax as income only those benefits that exceed the limit. Prior legislation would have disqualified all benefits under a policy that exceeded the daily limit.

The Coalition requests several additional revisions to the Senior Citizens' Equity Act which are described in more detail in HIAA's testimony. These include the following:

Treatment as Accident and Health: We request that LTC benefits be treated as accident and health insurance for policyholders and insurers. In addition, we request that LTC insurance benefits be treated as payments for the loss of bodily function under Sec. 105(c) of the I.R.S. Code. This clarification would conform to the eligibility criteria employed by most LTC insurance policies today; i.e., benefit eligibility based on the inability to perform a specified number of activities of daily living such as eating, dressing, bathing, etc.

Per Diem Policies: Per diem policies pay a fixed amount when the beneficiary meets the eligibility requirements. These policies should be treated as qualified LTC contracts with respect to coordination with Medicare.

Employer Deduction for LTC Premiums: The legislation should clearly specify that LTC insurance policies are not treated as deferred compensation plans. This will assure employers' ability to deduct contributions to these policies as a legitimate business expense.

LTC Premiums: We request that the current limitation on qualified premium levels be eliminated. This provision is unnecessary since the 7.5 percent AGI floor already limits significantly the amount of premiums individuals would be allowed to deduct. No other health insurance policies limit the amount an individual can deduct. Furthermore, we believe that the implied concern that individuals will "over-insure" or use per diem policies as an annuity benefit is unfounded. Experience to date demonstrates that, if anything, individuals are likely to underinsure for LTC risk. It also is important to note that while the average age of purchase in the individual market is about 68, 10-15 percent of purchasers are 75 and above. These individuals will have higher than average premiums by virtue of their age and should not be penalized by excluding part of their premiums from the tax deduction.

Chronically Ill Individual: The definition of chronically ill individual needs to be clarified. Paragraph (B)(iii) pertaining to Activities of Daily Living should be clarified in two ways. First, (B)(iii)(I) lumps toileting and continence into one single ADL. This is not a clinically accurate definition. The major ADL scales such as Katz separate toileting and continence into 2 different ADLs since they involve disabilities in two different bodily functions -- one voluntary (toileting) and the other involuntary (continence). Second, the legislation should clarify that bathing is also a separate ADL, i.e., not related to toileting or continence. We also request that mobility be dropped from the list of ADLs since it is not commonly used by carriers as an ADL.

These changes would result in the following six clinically accepted measures: bathing, dressing, transferring, toileting, continence and eating. We support setting the eligibility standard at 2 out of 5 ADLs, but recommend that companies be allowed to choose any five out of the six designated ADLs. We believe that it is too early in the product's development cycle to standardize this feature.

Qualified Facility: The bill defines "qualified facility" as an individual's home <u>if a licensed health care practitioner certifies that without home care the individual would have to be cared for in a hospital, skilled or intermediate care or similar facility.</u> This language requires that an individual be nursing home certifiable in order to qualify for tax benefits under a LTC insurance plan. This requirement is completely inconsistent with the intent of private LTC insurance policies which are designed to provide as broad a range of coverage across the continuum of care possible. Such policy design specifically responds to consumers' desire for choice of the type of services and settings they can use to meet their LTC needs. Further, it effectively makes the eligibility criteria much more stringent than the criteria described in Sec. 818A(c)(2)-Chronically Ill Individual. We believe that this discrepancy would be confusing and misleading to consumers. The Coalition requests that this language be modified as follows: "if a licensed health care practitioner certifies that the individual meets the eligibility criteria described in Section 818A(c)(2).

Cafeteria Plans: The legislation should clarify that LTC insurance can be offered through a cafeteria plan as a strategy for increasing employer-based coverage.

Parents and Grandparents: The bill should provide that policies covering parents and grandparents are treated like policies covering dependents.

4. Medicare Duplication

The Coalition supports Sec. 818A(a)(10)(B) which requires coordination between LTC insurance policies and Medicare. Many LTC policies currently include this coordination function. Coordination of Medicare and LTC policies has the following advantages:

* results in lower premiums, since the LTC policy would pay only for excess coverage (and effectively prevents consumers from "overinsuring" by virtue of duplication);

* extends the life of the policy since the lifetime benefits are only reduced by the amount paid for LTC services in excess of other (i.e., Medicare) coverage;

* reduces health care inflation by not requiring multiple payments from different policies for the same services;

* demonstrates consistency with health care reform goals related to integration and coordination of acute and LTC services.

This provision clarifies an amendment to the Social Security Act enacted as part of HR 5252 which would have had the effect of prohibiting coordination of benefits between Medicare and LTC policies for two reasons. First, HR 5252 makes it illegal to sell to Medicare beneficiaries a health insurance policy that duplicates any benefits to which the individual would otherwise be entitled (under Medicare, Medicaid or other private insurance) unless (1) the policy pays benefits without regard to other coverages. We find this provision extremely contradictory. It

essentially says that policies are prohibited from duplicating coverage, but they may duplicate coverage if both policies pay benefits without regard to each other.

The second requirement for "waiving" the prohibition against duplication is that the carrier must disclose the extent to which the LTC policy duplicates coverage with Medicare or other insurers. Currently, it would be impossible to determine where Medicare and LTC insurance policies coordinate because Medicare coverage decisions are not consistent. This is particularly true of coverage decisions regarding home health care benefits. To address this issue, we request further clarification of the amendment in HR 5252 by specifying that LTC policies that coordinate coverage with Medicare are not considered to duplicate Medicare coverage. Without this clarification, the amendment would have the effect of penalizing private insurance companies for the lack of clarity regarding Medicare coverage policies for home care benefits.

C. Medicare Home Care Coverage

The Coalition firmly believes that tax clarification of LTC products and the establishment of federal standards will significantly enhance the growth of this market. As I mentioned above, however, to realize the full potential of this market, it is critical that the Federal government clearly and unequivocally define its role in this market. Medicare coverage of home health care benefits provides a good example of why this is so important.

Medicare coverage of home health care benefits originally was conceived as a short-term benefit. To be eligible for coverage, an individual had to have been hospitalized prior to receiving home care and be in need of skilled nursing services. Had the Medicare program continued to operate under these rules, the consumer's responsibility for covering longer term services related to chronic conditions -- as opposed to short-term services of a recuperative nature -- would be fairly clear. Similarly, the type of coverage needed under private LTC insurance policies to pay for home health care services in excess of the Medicare benefit would be clear.

Throughout its history, however, the Medicare program has changed to incorporate medical services such as skilled nursing care and rehabilitative care and social services such as homemaker and chore services. Perhaps the most important change in the definition of the Medicare home care benefit occurred in August 1988. at that time, HCFA released the modified Health Insurance Manual known as HIM-11. Revised eligibility rules meant that clients with both acute and chronic care needs could receive supportive services and that a range of home care services could be provided to those with purely chronic care needs. The result of these modifications has been a rapid expansion in all facets of Medicare home care and a dramatic escalation in spending. Medicare home care spending grew from about $2.1 billion in 1988 to $7 billion in 1991 to $11.7 billion in 1993.

Below are examples of increases in the percentage rate of growth in Medicare home health care services by category:

CATEGORY	1987-1988 (Pre-HIM-11)	1988-1989	1989-1990
TOTAL VISIT CHARGES	11%	33%	56%
PERSONS SERVED	2.4%	7.7%	14%
AVERAGE CHARGE PER VISIT	6.4%	6.5%	4.9%
AVERAGE NUMBER OF VISITS PER PERSON	4.4%	12.5%	33.3%

The rapid growth in expenditures reflects both a changing profile of individuals receiving the benefits as well as a change in the mix of services needed to care for people. Whereas prior to implementation of the HIM-11 change, most individuals required primarily skilled services, after the change, many people with chronic needs appeared to be served by the program. This was reflected in both the client profile as well as service packages provided to clients. A preliminary study of a sample of beneficiaries conducted by Brandeis University showed that many have limitations in at least two activities of daily living, a common criteria for characterizing a chronic care population or those with cognitive impairments. While almost all receive at least one skilled service, many also received less-skilled services. And irrespective of diagnostic grouping, most individuals received multiple skilled and unskilled services.

A finding of concern from the preliminary study was that no clear pattern existed between the types of services received and their primary diagnosis. This suggests that there is a considerable amount of discretion available to home health care agencies and that factors other than primary diagnosis are likely play an important part in explaining the allocation of services to individuals. Similarly, it was difficult to discern clear norms of care for individuals of similar profiles and significant practice variations across geographic region and by provider type (nonprofit vs proprietary) were observed.

The development of an effective public/private partnership in the financing of home health care and related services will require a clear delineation of responsibilities between Medicare and private insurance or other private financing. The situation insurance carriers currently face with respect to the Medicare non-duplication issue is a case in point. Carriers will be hard pressed to develop "wrap-around" coverage as long as Medicare coverage determinations are determined in an arbitrary fashion, much less advise their clients about their coverage needs.

Equally important, if Congress is serious about getting federal spending under control, it needs to revisit the original intent of the Medicare program to determine if this program should continue to provide coverage for acute and recuperative services or if the program should be expanded to cover long-term chronic illness. This is a critical public policy decision since the latter decision would effectively result in federal LTC insurance for the elderly and disabled. The financial implications of creating a new Federal entitlement for LTC services are enormous and would require a significant shift in current spending priorities.

Coalition members believe that a more rationale policy would be to continue relying on Medicare for acute and recuperative stays of a short term nature and on private financing for longer term illness of a chronic nature. This will require clarifying existing coverage rules under Medicare and possibly reinstating a limit on the number of home care visits for which beneficiaries would be eligible. Program and implementation rules that must be considered include the following:

* **The lack of a clear definition of what constitutes home care:** Almost all services that can be provided in the home and are deemed by a physician to be "medically necessary" are now reimbursable under the program.

* **The lack of consistency across agencies:** The lack of clear benefit triggers leaves great discretion to the physician and agency regarding the type of services to be provided, and leaves significant leeway to agencies regarding the intensity of service delivery.

* **The lack of consistency in patterns of care:** There is little discernable relationship between an individual's primary diagnosis and the package of services she or he receives.

* **The lack of accountability in the role of the physician and home health care agencies** in determining eligibility for services and the nature of services.

Mr. Chairman, the Coalition will be conducting additional research regarding this issue and identifying more specific recommendations on how to solve these problems over the next six months. We will be happy to share these recommendations with you and other Members of

Congress. In fact, we believe this issue warrants further investigation by the committee through a separate hearing devoted to this topic.

D. Federal LTC Insurance Standards

The Coalition supports appropriate federal standards for consumer protection to ensure that LTC insurance policies have initial and continued value. To ensure access to affordable protection, however, any federal legislation must strike an appropriate balance between the extent of policy requirements and affordability. In addition, contrary to several bills introduced last year, states should not have the right to mandate additional measures as a requirement for sale in their state. The state's ability to preempt federal standards is inconsistent with the intent of federal standards which have been designed, in part, to create greater uniformity across products. While we support a state's right to require additional standards in order to receive state certification, carriers should not be prohibited from selling policies that meet federal standards.

We strongly urge the establishment of standards that, when combined with effective enforcement mechanisms, ensure that individuals know the value of what they are purchasing and ultimately receive that value. The Coalition believes that LTC insurance plans must be understandable, fairly and appropriately priced and clearly articulated. To assure that value is maintained over time, we support procedures for appropriate policy pricing, establishment of required reserves and disclosure of information concerning the financial strength of insurance companies -- areas over which the consumer has little or no control. Additionally, we support the establishment of standards at the outset to ensure that benefits will be paid as promised.

Coalition members support most of the provisions included in the 1993 version of the Model Act and Regulation adopted by the National Association of Insurance Commissioners. For example, we support the following consumer protection measures:

1. **Requirements:**
   * guaranteed renewability
   * coverage of Alzheimer's Disease
   * offer of inflation protection
   * offer of nonforfeiture benefits
   * 30 day free-look period
   * delivery of detailed outline of coverage and shopper's guide
   * provision of continuation or conversion coverage for group policyholders
   * auditable marketing standards to assure fair and accurate comparison across policies

2. **Prohibitions:**
   * post claims underwriting
   * prior-hospitalization requirements
   * preexisting conditions exclusions
   * marketing practices such as twisting and churning;

3. **Sanctions:**
   * civil monetary penalties for agents and insurers who violate regulations

The Coalition also supports numerous consumer protection provisions which exceed requirements in the current NAIC Model Act and Regulation such as:

* requiring insurers to establish: LTC education and training programs; procedures for monitoring sales practices of agents; meaningful update protection programs; a thorough claims process which includes a written explanation of filing procedures; clear and thorough written definitions of benefit eligibility criteria to be presented at the point of sale.

* mandating the use of benefit eligibility criteria using clinically-based empirical research in the area of disability and LTC;

* establishing minimum standards for LTC insurance reserves and criteria for evaluating insurer reporting data.

Conclusion

The Coalition believes that sponsors of the Senior Citizens' Equity Act have taken a very important first step toward promoting a public/private partnership in LTC financing by creating strong incentives for the purchase of private policies. We also believe that additional steps must be taken both to enhance consumer confidence in this market and to clarify consumers' understanding and expectations regarding the level of support and protection they can anticipate from the government versus the amount of coverage they will be responsible for themselves.

The Coalition believes that the most efficient way to divide public and private sector responsibilities and minimize confusion regarding coverage is to: (1) relate eligibility for public LTC benefits to financial need; and (2) provide strong incentives for those who can afford to self-insure to do so through savings, private insurance, medical IRAs, etc. Financial incentives will promote wider penetration of private insurance and savings vehicles for those with the financial ability to protect themselves.

Coalition members appreciate the opportunity to address these important issues. We stand ready to assist the Subcommittee in any way we can.

Chairman THOMAS. I thank the gentleman for his timing as well as his statement.

Mr. Wiener.

STATEMENT OF JOSHUA M. WIENER, SENIOR FELLOW, THE BROOKINGS INSTITUTION

Mr. WIENER. Thank you, Mr. Chairman.

The current system of long-term care financing is a mess. Catastrophic costs are routine, welfare dependence on Medicaid is routine. The system is biased toward institutional rather than home care services. To meet this need, a small but growing private long-term care insurance market has developed.

In my testimony, I make basically four points: One, while a lack of clarity about the tax status of private long-term care insurance is a barrier to its growth, the real barrier is the high cost of good-quality policies.

According to data from the Health Insurance Association of America, good-quality policies at age 65 cost $2,228 a year per person. If not bought until the age of 79, they cost $7,000 a year. There are a variety of studies that have found that only 10 to 20 percent of the elderly can afford private long-term care insurance.

Two, employer-sponsored policies are a way to solve the affordability problem. A tiny but growing market is developing. Lower premiums exist in the employer market because people have a chance to pay premiums for a longer period of time; thus, reserves can build and there are slightly lower administrative costs. But employers, even with tax clarification, are unlikely to contribute to the cost of private long-term care insurance.

The reason they will not contribute is that employers face between $187 and $400 billion in unfunded liabilities for retiree acute care health care benefits. What is happening is that they are cutting back on their retiree acute care health benefits; they are not looking for a new benefit to pay for.

I should also mention in terms of the employee-sponsored products, they are, in general, very good. But their inflation protection has been grossly inadequate and needs to be changed.

Three, in terms of recommendations, in principle, I do support tax clarifications. I do not, however, support aggressive tax subsidies to encourage purchase. Analyses that have been done at the Brookings Institution suggest that individual tax credits or deductions for purchase of private long-term care insurance don't do much to promote the market because the subsidy goes mostly to people who would have bought the policies anyway. They are costly in terms of lost revenue, which is not compensated by Medicaid savings, and the benefits flow mostly to upper-middle and upper-income elderly.

I do favor tax clarifications, because it is a precondition for private insurance playing a larger role in the market and it really is not a significant change in the operating assumptions of the current market. What I think is basically lacking in H.R. 8, is standards. If we are going to give large tax benefits to private insurers, there should be higher standards in terms of nonforfeiture benefits, inflation protection, and standards for home care benefits. There ought to be a quid pro quo for those tax clarifications.

Four, I think two questions of priorities must be asked: First, does it make sense to provide long-term care tax benefits for upper-middle and upper-income persons if they are to be financed through large cuts in programs for the poor, the Medicaid program; or for average elderly, the Medicare program? Obviously, no decisions have yet been made, but the press keeps reporting possible Medicare cuts of up to $500 billion over a 5-year period; that is big money, even here in Washington.

Second, given whatever amount of funds are available for new initiatives for the elderly—and there is perhaps $25 to $30 billion over a 5-year period—are tax expenditures for private long-term care insurance the most effective way to spend that money? I, for one, would rather take that money, and put it into a block grant for the States to provide home care for the severely disabled elderly and nonelderly.

In conclusion, we have a serious problem. And long-term care tax clarification can help private insurance play a more important role, but even with tax clarification, the role of private long-term care insurance is likely to remain small.

I disagree with Dr. Wallack about what the potential impact of these tax clarifications could be. And I would, in fact, prefer to spend this money in other ways, providing a block grant to the States to provide home care services for the severely disabled.

But one thing is sure, the elderly population is growing. The disabled population is growing and this problem will not go away.

Thank you.

[The prepared statement follows:]

TESTIMONY OF JOSHUA M. WIENER
THE BROOKINGS INSTITUTION

The current American system of financing and delivering long-term care for the elderly and the younger disabled population is badly broken. At present, the United States does not have, either in the private or the public sectors, satisfactory mechanisms for helping people anticipate and pay for long-term care. In particular, the disabled elderly and their families find, often to their astonishment, that the costs of nursing home and home care are not covered to any significant extent either by Medicare or their private insurance policies. Instead, the disabled elderly must rely on their own resources or, when those have been exhausted, turn to welfare in the form of Medicaid. Moreover, although the vast majority of disabled elderly live in the community, nearly two-thirds of public expenditures for long-term care for the elderly are for nursing home care (Wiener, Illston and Hanley, 1994).

The Growth of Private Insurance

To address these problems, a small, but growing private long-term care insurance market has developed over the last ten years. Although 97 percent of the elderly have Medicare coverage and almost two-thirds have medigap policies, insurance against the potentially devastating costs of long-term care is relatively rare (U.S. House of Representatives, Committee on Ways and Means, 1992). As of the end of 1993, approximately 2.1 million policies were in force, overwhelmingly sold to the elderly on an individual rather than group basis. Employer contributions toward the cost of long-term care insurance are virtually nonexistent.

Long-term care insurance is somewhat of a paradox. On the one hand, good quality long-term care insurance is too expensive to be affordable by all but a relatively few elderly; on the other, many more people can afford policies than currently purchase them. Because of its unique characteristics, long-term care insurance does not fit neatly into the existing tax models of health and accident, life, or disability insurance, pensions or private annuities. For example, it is not clear whether long-term care insurance benefits are excludable from income as are health insurance benefits or countable as income as are pensions. Employers have no guidance as to whether contributions toward the cost of long-term care insurance would be a tax deductible expense as is health insurance and most life insurance (up to a maximum). Moreover, private long-term care insurance relies on a large buildup of reserves, as does whole life or cash-value life insurance but not health insurance. Receipt of benefits depends on having an underlying medical problem, but the individual may not be "sick" as they must be to receive most health insurance benefits. In addition, long-term care benefits may cover not only health services such as skilled nursing care, but also unskilled care, such as homemaker services, which is intrinsically desirable, whether or not a person has a disability. Indeed, some new private long-term care insurance policies provide cash benefits to individuals who have a specified level of impairment, making these products resemble disability insurance rather than health insurance.

Although the uncertainty of the tax treatment of private long-term care insurance is a minor barrier to its expansion, by far the greatest impediment is the high cost of good quality policies. Despite the marked improvement in the financial position of the elderly over the past twenty years, long-term care insurance remains unaffordable for most elderly. The average annual premium for high quality-policies sold by the leading sellers in 1992 was $2,228 a year if purchased at age 65 and $7,202 a year if purchased at age 79 (Health Insurance Association of America, 1994).

The policies are expensive for two reasons: 9 out of 10 are sold individually and, therefore, carry high administrative costs; and, most policies are bought by older people whose risk of needing long-term care is great. Consequently, most studies estimate that only 10 to 20 percent of the elderly can afford good-quality private long-term care insurance (Wiener, Illston and Hanley, 1994; Crown, Capitman and Leutz, 1992; Friedland, 1990; Zedlewski and others, 1990; Rivlin and Wiener, with Hanley and Spence, 1988). Other research has found the percentage of the elderly who can afford private insurance to be higher, but these studies have done so by assuming purchase of policies with limited coverage, by assuming the elderly would use their assets as well as income to pay premiums, or by excluding a large proportion of the elderly from the pool of people considered

interested in purchasing insurance (Cohen, Wallack and Kumar, 1992; Hagen, 1990; and, Cohen, Tell, Greenberg, and Wallack, 1987).

Employer-Sponsored Long-Term Care Insurance

One option to address the affordability problem is to encourage the purchase of private long-term care insurance at younger ages, especially through employers. Since 1987, a tiny but expanding market of employer-sponsored insurance for long-term care has developed. As of the end of 1992, a total of 350,000 policies had been sold through 566 employers. In a key difference from acute care polices, where most employers pay a large proportion of the cost of insurance, virtually all employer-sponsored long-term care policies are offered on an employee-pay-all basis.

Employers are especially unlikely to contribute to the cost of group policies unless they are assured that their contributions are tax deductible, and that the tax consequences of receiving long-term care benefits can be clearly explained to their employees. Employer contributions could make long-term care insurance more affordable by reducing the amount that employees have to pay out-of-pocket and might give employees confidence in the product. Although clarifying the tax code so that employers may deduct the cost of helping their employees pay for private long-term care insurance is unlikely to significantly promote their contributions, it is virtually certain that they will not contribute without it.

The Advantages of the Employer-Sponsored Market

Theoretically, employer-sponsored plans offered to the nonelderly provide several advantages over those purchased individually. First, premiums for younger policyholders can be substantially lower than those for older policyholders because younger policyholders pay premiums over a longer period of time and because earnings on premium reserves have more time to build. For example, we estimate that the premiums for a 42-year-old will be approximately one-quarter to one-third of the premium for a 67-year-old (Wiener, Harris and Hanley, 1990).

Although lower premiums are tied to the age of the purchaser and not necessarily to the fact that policy is employer-sponsored, the nonelderly are easiest to reach through their place of employment. The workplace is where most health, life, and disability insurance is purchased and most retirement savings through pensions are established.

Lower administrative and marketing costs offer another potential source of savings over individual policies. Administrative and marketing costs are high in individual policies because sales have to be made one at a time. Group markets are able to achieve lower costs through economies of scale. Moreover, employers bear many of the costs of administering the policy, such as collecting premium payments through payroll deductions. Employers may also elect to assume part of the costs of marketing the plan to their employees. Informal discussions with insurance actuaries suggest that most assume only a ten percentage point difference in the anticipated loss ratio between individual and group plans.[1] Thus, although administrative savings are desirable and not trivial, they will not dramatically lower premiums.

Enrolling people at younger ages through the workplace also reduces the risk of adverse selection and therefore the need for medical underwriting. Disability is relatively rare at younger ages. The less frequent underwriting typical of employer-based policies is an improvement over the universally strict practices used for purchase of individual insurance policies. However, most disabled persons with significant disabilities are not in the work force and would not, therefore, be eligible for these policies.

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[1]The loss ratio is the percentage of the premium that is for benefits rather than administrative and other overhead. Many companies assume a loss ratio of 60 percent for individual policies and 70 percent for group policies.

Finally, advocates of employer-sponsored insurance argue that the quality of policies should improve through the involvement of company benefit managers. Large groups have more market power than individuals to negotiate with insurance carriers for less restrictive policies with richer benefits and lower prices. In general, the quality of policies in the employer market is quite good, especially in providing home care benefits. On the other hand, most employer-sponsored policies have grossly inadequate inflation protection. Under most policies, the insured must purchase additional coverage from time-to-time to compensate for inflation, but at the new older age and therefore at a substantially higher premium.[2]

Impediments to an Employer-Sponsored Strategy

Despite the potential advantages of selling to the nonelderly population through employer groups, the employer-sponsored market may not expand enough to play a significant role in financing long-term care. Employers are reluctant to offer the policies, and employees are not rushing to purchase them.

The uncertain tax status of long-term care insurance has no doubt prevented some employers from offering long-term care insurance policies to their employees. But tax factors are likely to be overwhelmed by the financial problems facing employer-sponsored acute health benefits for retired employees; these benefits supplement the acute care services of the Medicare program. Unlike pensions, virtually all corporations offering post-retirement health benefits have financed them on a pay-as-you-go basis rather than prefunding them. Prodded by accounting rules established by the Financial Accounting Standards Board that require companies to disclose their future financial liability for these benefits, corporations are now aware that, collectively, they have an estimated $187 billion to $400 billion in unfunded liabilities (U.S. GAO, 1993; U.S. GAO, 1989; EBRI, 1988; and, Warshawsky, 1992).

As a result, large numbers of employers, concerned about health care costs for both their active employees and retirees, are cutting back on retiree benefits or dropping that coverage altogether. For example, in 1991, 41 percent of the employees of medium and large firms with health benefits for retirees aged 65 and older paid none of the insurance costs, down from 55 percent in 1988 (U.S. Bureau of Labor Statistics, 1993; and, EBRI, 1992). In this environment, it seems unlikely that many additional employers will want to contribute to a new, potentially expensive insurance plan that will primarily benefit retirees twenty to thirty years after they have left the company.

To date, employee demand has not played a large role in the decision of companies to add long-term care insurance to their benefit package. The desire to maintain a company's image as a leader in employee benefits or a personal sensitivity to the problem by a senior officer or employee benefit manager have been larger factors. Nonetheless, surveys of large employers suggest the possibility of a large increase in the number of companies offering policies, if not paying for them.

Employees also have been reluctant to purchase insurance. The Health Insurance Association of America estimates that, depending on how the universe of eligibles is defined, only 5.3 percent to 8.8 percent of those offered employer-sponsored long-term care insurance have purchased policies (HIAA, 1991).

Several factors limit employee demand. First, although premiums for policies without inflation adjustment are quite low at younger ages, they cost more than many people are willing to pay voluntarily. Moreover, a high quality long-term care insurance policy with a level premium, inflation protection, and nonforfeiture benefits purchased at age 50 can cost

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[2]For example, if a person buys a policy at age 42 that pays $60 a day in nursing home benefits and if inflation is 33 percent during the next five years, then the insured can buy additional coverage of $20 a day to compensate for the inflation but at the price charged 47-year-olds, not 42-year-olds. We estimate that to retain purchasing power, the inflation-adjusted premium at age 82 would be approximately ten times what they were at age 42. This is because nursing home use is exponential by age.

more than $1,000 a year (Wiener, Harris and Hanley, 1990). In a survey of nonpurchasers of employer-sponsored policies offered by two major insurers, LifePlans, Inc., reported that 82 percent of respondents felt that the fact that "the policy costs too much" was either "very important" or "important" in their decision not to purchase a policy (LifePlans, 1992). Even though economists contend that increased employer contributions for fringe benefits are mostly offset by reduced wages, 90 percent of respondents in this survey said that they would be more willing to purchase a policy if their employer contributed to the cost.

In addition, middle-age workers usually must contend with other, more immediate expenses, such as child care, mortgage payments, and college education for their children. In the LifePlans, Inc., survey, 80 percent of nonpurchasers stated that they had "more important things to spend money on at this time" was either "very important" or "important" in their decision not to purchase a policy. The risk of needing long-term care is too distant to galvanize many people into buying insurance.

Finally, selling to the nonelderly population raises difficult considerations of pricing and product design. An actuary pricing a private long-term care insurance product for a 45-year-old must predict what is going to happen forty years into the future, when the insured is age 85. To say the least, this is difficult. Ironically, although one of the advantages commonly claimed for private insurance is its flexibility to respond to the needs and wants of consumers, policyholders who buy insurance at younger ages are locked into the existing model of service delivery decades before they use services. Who knows what the optimal delivery system will be a half century from now?

Recommendations

Private long-term care insurance is likely to grow, but products geared toward the elderly face critical affordability barriers. The emerging employer-sponsored private insurance market offers the promise of solving much of the affordability problem, but that market is likely to remain small because of the difficulties in persuading employers to offer policies and employees to purchase them. In particular, the major barrier to employer contributions to the cost of private long-term care insurance is the large unfunded liability that employers currently face for retiree acute care benefits. The ambiguity of the current tax code does not help, but employer contributions probably will not increase substantially even with changes in the tax code.

Although there are gray areas, a sharp distinction should be made between proposals to clarify the tax treatment of private long-term care insurance and proposals to actively promote its purchase. In principle, many of the tax clarification proposals are worthy of support; the proposals to actively promote private long-term care insurance are not.

Many proposals have been made to provide tax incentives to subsidize purchase of private insurance. As a rule, these proposals either primarily benefit upper-income people who can already afford to purchase insurance or provide too small a subsidy to make policies affordable for people of more modest means. Consequently, public subsidies are likely to have only small effects on long-term care financing in relation to the amount of federal revenue lost.

In particular, tax deductions or tax credits for the purchase of private long-term care insurance are ineffective ways to subsidize long-term care; at least in the range that has generally been discussed. Because only half the elderly pay any income tax at all, few low- or middle-income elderly would receive any benefit from a tax deduction or credit (Grist, 1992). Only about 30 percent of all tax returns include itemized deductions (Prizzi and Curry, 1992).

In an analysis of an earlier proposal put forth by then-Representative Willis Gradison (R-Ohio, now president of the Health Insurance Association of America), which is roughly similar to the tax incentive included in the "Contract with America," we found that the impact in 2018 to be small, especially compared to the tax loss (Wiener, Illston and Hanley, 1994).

First, the proportion of the elderly with private insurance would increase by only 8 percentage points; the vast majority of older persons would still not have private insurance. Second, because of the higher income of insurance purchasers, the increased number of people with private insurance would have virtually no effect on Medicaid for nursing home care. Third, the tax loss would be four times the Medicaid savings. Moreover, the tax loss per additional person insured would be high; approximately $1,700 per additional insured. Finally, most benefits would flow to the upper-income elderly population; approximately two-thirds of insurance nursing home benefits would be paid to elderly persons with incomes over $40,000 a year.

While tax incentives for the purchase of private long-term care insurance should not be enacted, favorable tax clarification of the status of long-term care insurance is desirable in principle. The rationale for reasonably favorable tax clarification is that it is a precondition to private insurance playing a larger role in the financing of long-term care and to a large extent is not a significant departure from the operating assumptions of the current market. In essence, the tax code should make it clear that private long-term care insurance can build up reserves on a tax-free basis and that the product should otherwise be treated like health insurance. For the insured, that means that any benefits paid from long-term care policies or from riders on life insurance policies should not be considered taxable income. Moreover, employer contributions for long-term care insurance should be a tax-deductible expense and should not be counted as taxable income for employees.

Supporters of private insurance who oppose increased direct federal spending for long-term care insurance face a dilemma regarding the revenue loss inherent in tax clarifications, especially regarding employer contributions. On the one hand, if advocates contend that the revenue loss will be small, they are implicitly admitting that the change will not encourage many employers to contribute. On the other hand, if they say that tax benefits will encourage a great many employers to contribute to the cost of insurance, the potential revenue loss could be large, partly defeating the purpose of relying on private rather than public spending.

While favorable tax clarification of private long-term care insurance is desirable, two questions of priorities must be asked. First, does it make sense to provide long-term care tax benefits for the upper-middle class, while financing these tax breaks in part by cutting Medicaid, which is targeted on lower-income persons and individuals who have incurred catastrophic out-of-pocket expenses? While only 27 percent of Medicaid beneficiaries in 1993 were elderly and disabled, two-thirds of Medicaid expenditures were for acute and long-term care services for this population (Rowland, 1994). Persons needing long-term care services will almost certainly be worse off if Medicaid is cut substantially. Similarly, drastically cutting Medicare to finance these tax incentives will leave the average beneficiary with less rather than more confidence that they will receive the services they need.

Second, would the money included in the "Contract with America" for favorable tax clarification of private long-term care insurance and services, tax incentives for purchase of private long-term care insurance, and tax credits for care of the disabled elderly be better spent some other way? I would much prefer spending this money on a new block grant to the states for the provision of home care for the severely disabled population. Such a program would help create a more balanced delivery system and could be a significant increase in public funding for home care. Versions of this type of program were included in many health reform proposals last year.

Changing demographics ensure that Congress will have to deal with long-term care well before the baby boom generation starts needing large amounts of long-term care. Rather, by the end of this decade, virtually all of the parents of the baby boom generation will be elderly; many of them will be very elderly and starting to use long-term care. The elderly will turn to their adult children for care and, in some cases, financial assistance. Long-term care will no longer be an academic issue, but an intensely personal one from which the baby boomers will not be able to escape. The question of "How are we going to take care of Mom?" will become a major concern for a substantial portion of a very large and influential generation. When that happens, long-term care will be an issue that neither Congress nor the president will be able to ignore.

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Chairman THOMAS. Thank you very much.

Mrs. Johnson.

Mrs. JOHNSON OF CONNECTICUT. Thank you, Mr. Chairman.

And I thank the panel for their testimony.

It certainly is true that tax-favored treatment of health insurance did lead to the explosion of the provision of health insurance by employers.

I am interested, Mr. Wiener, that you dicker with the panelists as to your evaluation of the impact of providing tax-favored treatment. I am particularly interested, because you believe that a better solution to long-term care would be government appropriations.

When you look at what long-term care costs are doing to State Medicaid budgets, and what they are doing to Federal Medicaid and Medicare budgets, I don't know where you think that money is going to come from. So I think this issue of, can we make the tax clarifications and other things induce participation so that people can begin preparing for their own future at age 20, with a 50-cent additional premium on an employer policy, is a similar, very critical issue. We could get people to insure for 2 years, and the vast majority of people are not in long-term care more than 2 years, and we let the government take it up after that. I think we have an insurable, affordable item there, and I see no other way than a partnership to bear the costs of long-term care.

So I would like to start by asking the first two speakers: What makes you believe that providing favorable tax treatment will increase the long-term care insurance market?

And, Mr. Meiners, particularly with the added inducement of asset protection, do you see any developments in that market that are different than the ordinary policy market that would lead us to believe that the more incentives we provide, the more likely we are to have solid participation, broad participation in this market?

Mr. MEINERS. Sure. One of the things we have done in the partnership program was to try to examine the various incentives, tax breaks being one, the asset protection being another. And we looked at the cost effectiveness of those. And since we were working with States, and working in an environment where we were trying to be budget neutral or produce savings, and States really can't offer as effective tax breaks, we really came upon this idea of taking the Medicaid program as it was, which was acting as a backup, and make it more of a certain part of the package that people who bought insurance would be getting. By doing that, we are able to offer the people the opportunity to buy a higher-quality product because we have been able to negotiate with the insurers for higher-quality standards as part of the deal. Also given consumers the certainty that if they buy this product, and use up those benefits, they can avoid impoverishment and gain access to public assistance.

Mrs. JOHNSON OF CONNECTICUT. So, effectively, your program, if every American participated in an asset protection long-term care policy, it would shift the cost of the first year or two, depending on how many years of asset protection they chose, to the private sector, and leave the public sector with the truly long-term care institutional costs. Isn't that, in effect, how it works, and at the same

time preserves the right of families to have some small measure of assets to pass on to their children?

Mr. MEINERS. That is right. It introduces an incentive to prepare on their own for this risk and makes explicit the idea that the public program is there to help. Medicaid is there to help for a lot of people. Unfortunately, it is only the people who are already poor or the people who are savvy enough or well-to-do enough to hire a good lawyer and to hide their assets that now benefit from Medicaid. The middle class is on its own. Rather than have that gaming go on, we try to create an incentive that serves as an alternative to that gaming of the system, but more importantly, helps make shorter-term, affordable high-quality coverage available to a broad spectrum of people. We feel it is a strategy that will really bring long-term care to people on a much wider basis.

Mr. WALLACK. Thank you.

One has to make their best guesstimate as to the likely impact of long-term care insurance tax clarification. However, there are, and I mention in my brief comments some surveys of nonpurchasers. In LifePlans' study we found that 80 percent of nonpurchasers would reconsider if there was tax clarification.

The Washington Business Group on Health did something comparable and asked the employer community: What do you think would be the most important step that the Federal Government could make? And they said, tax clarification. And so it would be an opportunity for employers to look at long-term care again. And I would think they have been innovators in solving other problems and we can't predict how that market is going to evolve if employers begin to engage and see the signal from the Federal Government that they want employers to help take this problem on.

If you just look at this as nothing more than a price reduction because we are giving people a tax break, then I think the effect would be rather limited; maybe a 20-percent increase, because you had a 28-percent tax break. But that is not all. It is the change in attitudes that you have to create and for this insurance makes sense. The attitude toward insurance is key. And that is why we had the tremendous growth in the fifties of health insurance. The idea that people should be taking care of themselves. And the potential there is very significant.

Mrs. JOHNSON OF CONNECTICUT. Thank you.

Mr. Wiener, would you like to comment?

Mr. WIENER. Yes, first of all, in terms of some of the tax clarifications, I think the market is already operating in that way. I think if you told people who bought private long-term care insurance that it wasn't clear that the benefits they received were excludable from income, they would be shocked. I don't believe anybody is reporting that as income now. So some of that is already operational.

In terms of employers, I think the bottom line is that they face huge, huge, unfunded liabilities for retiree acute care health benefits, $200, $400 million. And basically, retiree acute care health benefits are falling through the floor.

Employers are running away from retiree health benefits as fast as lawyers will let them do that. And so the last thing in the world that they are looking for is another large potentially expensive benefit to provide to their retirees. Some employers will contribute, but

I think it is just not realistic, given that unfunded liability, to think that large numbers of employers are going to move in that direction.

You asked the question about where is all this money going to come from? I am merely proposing that you take the money that is already in the Contract, that you have already budgeted in some shape, manner or form, and instead of spending it on tax clarification, instead of spending it on reducing the taxes on upper-income elderly, that you take that money and put it into a long-term care block grant. And, indeed, I think if you talked to the Republican Governors, they would love that additional money as a way to try to create a more balanced delivery system. It is something that they have been struggling to do.

Chairman THOMAS. Mr. Wiener, the gentlewoman's time has expired.

Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

Something tells me in my sixth sense that a bill similar to the one we are discussing might pass out of this subcommittee. And anticipating that, Mr. Wallack has identified my concerns in his testimony where he, I think, pretty generally follows the model act for regulation by the National Association of Insurance Commissioners.

And I would like to ask the other two witnesses if they agree with Mr. Wallack's suggestion, that in addition to making this more available, there should be some requirements, prohibitions and sanctions to protect the consumers generally along the lines as outlined in this testimony.

Would that be your feeling Mr. Meiners and Mr. Wiener?

Mr. MEINERS. Yes——

Mr. STARK. I mean, I don't want to go into them. There are a lot of them here, and some great group of insurance commissioners figured out what we ought to do, and I am sure we will get a lot of discussion about which are better than others, but I do feel it is important.

Let me then go to the basis for the questions that I would like to ask you further. In this committee in the past, I think we have accepted the idea that long-term care has very little to do with medical costs. It is a brand of happenstance, and generally a person who may need long-term care may not, because of that long-term care, need more pharmaceutical treatment and more doctors. In other words, some people need long-term care for a variety of reasons and some do not.

If you accept $36,000 a year, $30,000 a year, somewhere in that range is what it costs—$3,000 a month—for some kind of long-term care maintenance, and if you take the figures again that I think are uncontrovertible, that 13 percent or about 4 million of the 35 million seniors fit into the category where they have income of $34,000 or $44,000 for a family, arguably they could pay for it. They wouldn't have much left, but they could make it.

The remainder, 30 million-plus, are pretty low income, and to come up with a couple of thousand bucks is tough. Thus it is an income transfer problem. It doesn't have a whole lot to do with

stopping Alzheimer's or cutting back on AIDS. We have got about 30 million people who can't afford it, period.

And if you look at how they got to that income level at the age of 65, they probably didn't have a lot of extra discretionary money when they were working and younger. I doubt in the average coverage of life insurance is $10,000 or $15,000, and probably that costs less than this would cost. You have got to get to a substantial cash value. And that is pretty difficult.

So if this program costs $1 to $1½ billion—and it is my understanding there is no cost estimate yet? I would ask the gentlelady? Brookings and the Treasury have talked in the neighborhood of $1 to $1½ billion a year.

Chairman THOMAS. Will the gentleman yield on that point?

We do not have a cost estimate. And as has been the tradition in the committee and this subcommittee, we will not move product until we get a cost estimate.

Mr. STARK. If the witnesses will accept that as a reasonable range with some windage, we are talking about providing 600,000 people with a $2,500 premium, if you wish. And I heard the witnesses suggest that maybe there is a better way to go about this. That maybe we could spread the aid more fairly across the income spectrum, or take, as Mr. Wiener has suggested, the savings that would have to go to subsidize upper-income people who arguably have the money to make it. My time has expired with my question, but I would ask you if any of the witnesses find anything that they feel was incorrect or misleading in the numbers that I suggested and the outline of the problem?

Does that concur, Mr. Wiener, with how you see it, or Mr. Meiners? Are we talking about the right problem?

Mr. WALLACK. We certainly are talking about huge catastrophic expenses for people. And I think it is fair to say that a relatively small percentage of older people can afford that $35,000 or $50,000. Insurance, therefore, works. If you believe in insurance with regard to catastrophic coverage, it is when, in fact, there are relatively few going in, you spread that risk. And we have had this debate many times. This is really affordable for a large percentage of the population if they come on early enough. So the issue is spreading the risk.

Another thing you have to remember is that today about 50 percent of the costs or so, are being paid privately. So there are individuals, there are families taking this burden. And what we want to try to do is take the pressure off the population about this burden. An insurance mechanism is private, but it spreads that risk.

Mr. STARK. Don't you think it is a random risk for somebody under 65 years old? If you are going to start at the age of 45, the risk of being committed in your elderly years, it is my understanding, is pretty random, and if that is the case, you make a good case for social insurance. I don't think you can underwrite it with any accuracy.

Mr. WALLACK. The employers' policies do not use underwriting. You used the word "social" and I use the word "insurance." I think that is the real debate here. Do we want to socialize programs or do we want to use insurance?

And I think insurance is exactly the key concept. And that is why the employer comes in and takes everybody, that is a way to go about it. And as Mrs. Johnson was saying, with small payments, so we can go with insurance? Then we could have the debate, should it be social or private?

All I am suggesting is that to the extent we want private solutions to help with the Federal budget, this is an area where people are willing to do it and they have the wherewithal and we should be encouraging it.

Chairman THOMAS. The gentleman's time has expired.

The gentleman from Nebraska, Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

I guess a little bit of history about myself for I have personally experienced this problem that we are seeing. As an insurance agent with Connecticut Mutual Life Insurance Co., not only did I sell life insurance, but I sold health insurance, and I also attempted to sell long-term care insurance. And the word "attempt" is put there for a reason, because when my wife and I would be doing estate planning, we would say the second-to-die policy would take care of their needs and whatever else they needed. But when it came to taking care of long-term care needs and providing for the future, there was no need. They felt like the government would take care of them if there was ever a problem in the future. If they had a catastrophic problem, it would be handled.

I guess my question would be for Mr. Wallack, that when the Federal Government expanded the tax incentives for health care insurance, you saw a real boom in the market for health insurance and a lot of people went ahead and took advantage of that and purchased it. Would you see the same thing as far as long-term care insurance? And do you have any numbers to back up your thoughts on that?

Mr. WALLACK. I think we talked a little bit about that. I think there is potential. I really think that is the potential of this market.

I think the individuals that really want to protect themselves are older people, and I think you will see a growth in that market. Only 4 percent of the older people are protecting themselves now. It could be much higher than that. I think the key to this in the future is going to be the employer market and how employers look at this.

I think Josh made a good point; they have huge liabilities right now and they don't want to take out something that is undefined for the future. If employers do contribute, they can look at this as a defined contribution and limit their risk and still have a real opportunity to help. And they pay only a small percentage of the total premium. I think the key is the employer, and individuals wanting to take care of themselves. There are numerous different vehicles for the employer to use.

Mr. CHRISTENSEN. I can tell you that if there is an incentive there to purchase long-term care insurance, you are going to see a lot of things happen in this country as far as the purchase of long-term care, but you are going to see a residual effect of people not depending on the government. And it is going to be a cost shifting to the private sector which we are all trying to move toward.

Chairman THOMAS. The gentleman from Maryland, Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

First, let me say I think that we should have some tax clarification as relates to long-term care insurance and would hope that we could get more private insurance coverage, particularly with the employers. I have listened very carefully to the testimony of the witnesses, and I think that could be useful. It certainly won't solve the problem, but it could be useful.

Where I think we are at a disadvantage today, Mr. Chairman, is that we don't have the cost estimates from joint tax. It would be interesting to find out the answer to the point that Mr. Christensen made as to whether this particular proposal will produce savings.

To a certain degree, those people who do buy long-term care insurance and do not go on the Medicaid rolls, that clearly would be a savings to the public Treasury. But as Mr. Wiener pointed out, to the extent that we are just subsidizing people who currently have these policies, then it is a loss of revenue to the Federal Government, without improving the circumstances for long-term care.

I don't really have a good grip from the information we currently have. We have Treasury estimates that indicate this is going to be a $5.9 billion loss over a 5-year period. That concerns me.

The other point is that in addition to tax clarification, if I understand, the proposal before us also allows withdrawals from IRAs, tax free, to buy long-term care insurance. I am curious as to whether that may not lead to certain types of practices that are not what we would want to encourage.

So let me just pose a question to Mr. Wiener, because I do believe that Brookings has some figures on this. What type of savings can we anticipate from this type of proposal? Is it a good cost benefit proposal?

Mr. WIENER. First of all, let me clarify that we have no estimates specifically on this proposal. We have done other estimates of somewhat more aggressive tax credits for the purchase of private long-term care insurance that former Representative Gradison put forward.

Basically, we find negligible Medicaid savings even 25 years out into the future. We find that there is a 4 to 1 tax loss to Medicaid savings. So this is not a revenue-neutral proposal. I would also note that it is in the nature of tax subsidies for private long-term care insurance that you would take any tax loss early or up front, because the tax loss goes with the premiums. And any savings you would get would be further down the line as those people get older and start using long-term care services. So, you are guaranteed short-term tax losses even if you get benefits in the long run.

Mr. CARDIN. There are several provisions here, and I am curious as to whether your testimony applies to each of those provisions. One of the provisions here is to allow tax preference for employers who provide the benefits. Another is to treat these premiums similar to health costs as far as the deductibility by the individual. A third is to allow tax-free withdrawals from IRAs. Do your views apply to each of those different provisions or is there a difference on which approach we take?

Mr. WIENER. I am most enthusiastic about allowing employers to take that as a tax deduction. I agree with Stan that the future of

private long-term care insurance lies in the employer market. I think we probably disagree as to how far that would take us. Products sold to the elderly are simply too expensive. So I think that is where we need to go.

In terms of deductibility for the 7.5-percent cap, I am somewhat less enthusiastic about that. But I would be willing to go along with it. I favor these things in principle. I supported them as part of overall health care reform. But at that point, that was a small part of a much larger initiative. This is now the ball game. And I guess I would prefer to take that money and spend it elsewhere.

Mr. CARDIN. Do either of the other two witnesses want to comment quickly?

Mr. WALLACK. I would like to comment about the assumption that you are making about who is going to buy this policy. The long-term care financing problem is really catastrophic expenses for the middle class. And the people that really are going to take advantage of this, I believe are going to be people who in fact really need that insurance coverage.

Mr. CARDIN. Is that through the deductibility or is that through the employer-provided benefits or the IRAs?

Mr. WALLACK. I think it will be employer provided. And who really needs it——I think we need to look rationally at who needs insurance to cover those costs. It is the middle-income people. That is what our long-term care financing problem is about.

Mr. CARDIN. Which tool is going to be the most useful? If you had to pick one, which is the most important?

Mr. WALLACK. The provision? I think—that is a tougher one for me. I guess—I don't really want to say, because I don't know what the cost elements are. I think the employer one is important, but I think the individual deduction for premiums is very important, because I think most older people see the risk 5 or 10 years out and those are the people that really want to buy insurance. You have to see the risk to want to buy it, and I think there are good products that give good coverage for older people.

Mr. MEINERS. One of the things to keep in mind, there was an awful lot of talk in the Clinton plan of the integration of acute and long-term care. I think that long-term care needs to become more of the mainstream when we think of our health care reform package. And to have people when they are deciding about their health insurance face different tax structures for acute versus long-term care, it erodes the chances for integrated care.

Cost aside, we need to jump start the market and have people planning for their long-term care needs. And acute care is not long-term care. But it is an important expense that people need to plan for and that needs to happen. In that sense, we don't have an even playingfield.

Chairman THOMAS. The gentleman's time has expired.

Mr. Houghton.

Mr. HOUGHTON. I would like to ask Mr. Meiners a question.

I am from New York and I think that the Robert Wood Johnson Foundation had a big impact on many of the plans which are promoted in New York following the waiver that New York State got to mix the Medicaid and private long-term care insurance.

I wonder what the experience has been. I understand that the basis here is that it helps people with incomes above $20,000 and $50,000 in assets. And once that coverage is exhausted, maybe you can clarify this, the State is going to provide Medicaid coverage. That is the line policy in order for people to keep their assets. How has that worked? Because I think New York is a little different from some of the other States.

Mr. MEINERS. Basically, all States have made the link between the special asset protection and the purchase of a State-certified long-term care insurance policy. In the State of New York, they have gone in the direction of simplified approach. If you buy 3 years' worth of nursing home care or the equivalent of 6 years' worth of home and community care and exhaust that coverage, your total assets are protected.

In the other States, their model that is used is called the dollar-for-dollar approach. It allows for the purchase of different amounts of insurance. And if you use that up, you get asset protection equal to the amount the insurance has paid out.

The New York approach is very much an incentive to act as an alternative to divestiture and Medicaid gaming, which from reports and research that have been done, is apparently more rampant in New York than any other place in the country. That is one of the major differences. But both are designed to basically make quality insurance more affordable. In other words, rather than having to buy lifetime protection to avoid impoverishment, you can buy some lesser amount which is going to be more affordable.

Mr. HOUGHTON. Are there any contrary examples in any other State, or have they pretty much followed this pattern?

Mr. MEINERS. Well, I think in terms of comparing the market as it is today, what we are trying to do with this program is to really make long-term care insurance more affordable so that if, for example, in these States that are using the dollar-for-dollar approach, a person can only afford 1 years' worth of benefits, prior to this time, they might have looked at that option and said, gee, my risk in a nursing home is possibly 2.5 years. I am still going to be impoverished. Why bother?

Now we have created a vehicle where people can look at lesser amounts that are more compatible with the amounts of resources they have to spend and protect, and look at that decision and say it makes sense for me. I can afford to buy 1 or 2 or 3 years' worth of coverage, and if I use that up, I am not going to be impoverished.

That is a big difference and, from my point of view, makes the overture that you make to the consumer an easier overture, you can guarantee them they won't be impoverished because of the deal. And I think that is an important extra incentive.

Mr. WIENER. I think a key question in evaluating the partnership is whether having easier access to Medicaid is much of an incentive to buy private long-term care insurance. And while it is still relatively early in the process, I don't think we have seen the kind of jump starting of the market in the partnership States that I think some people had hoped we would get. We have had a couple thousand policies sold, and that is about it.

Mr. MEINERS. Well, that is not exactly our take on it.

Mr. HOUGHTON. If I might just interrupt?

It is relatively new, though, isn't it? Some of the States haven't got it. New York started in 1992, end of 1992. So it is really awfully hard to tell.

Mr. MEINERS. Right. And I would say a couple of things in response to that. First of all, insurance, the benefits of insurance are there right up front. Insurance is what pays the bills first. OK. So whatever you are getting from insurance, why people would be interested in long-term care insurance, is there. This is an extra benefit over and above that.

In essence, it is the State coming in and saying we are going to insure your assets or help insure you to help you avoid impoverishment. And in terms of policies sold, New York alone has sold 4,000 policies in about a year. And that is in an environment where we have been talking about health care reform and the possibility of a new national long-term care strategy. So the environment is now changing and we expect people to be more receptive.

The taxes, as I mentioned in my testimony, the tax clarification and some of the tax provisions can only help that knowledge and attention.

Mr. WALLACK. Can I make one footnote to that, please?

When you actually go out and look at what people are willing to pay for long-term care insurance, they may have the means to pay a lot, but basically when you look at the marketplace, most people who are buying it, at the ages of 65 to 70, are spending between $80 and $120 a month.

That effectively gives you about 3 to 5 years of coverage. And so that is what people want to do. People want to insure themselves. They don't necessarily want to go out and insure themselves for every single contingency. People should not overinsure. So the concept of a Federal reinsurance notion here, which is what is in the New York program, I think fits in well with how people are taking care of themselves.

Mr. HOUGHTON. Thank you very much.

Thank you, Mr. Chairman.

Chairman THOMAS. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Let me start by asking a quick question to Mr. Meiners. In your testimony, you indicated that it would be wise for us to repeal a portion of OBRA 1993, and I can't identify which portion, unless you were saying the entire OBRA.

Mr. MEINERS. No, it was specifically the provision that limited the growth of partnership States by basically saying that any new—the four States were grandfathered in, but any new States were required to do a State recovery on the protected assets. So, in essence, the person couldn't pass those assets on to someone else.

About that time, we had as many as 20 other States that had legislation of one sort or another interested in doing a partnership. That put a damper on that. Although some States have, nonetheless, gone forward and are doing a modified partnership, it is our sense that that limits both enthusiasm, frankly, for the States that are in the partnership and new States.

Mr. KLECZKA. Thank you.

Mr. Wallack, you indicated that if, in fact, this tax-free treatment were to be enacted, that the price of long-term care insurance would fall. Are you talking premiums or the actual cost to the consumer?

Mr. WALLACK. I am talking net cost to the consumer. I think premiums have pretty well settled down. They haven't come down, but people are getting more for what they are paying. You are seeing in the market $100 a month for a premium. So if they get a deduction, the net price to them would come down.

Mr. KLECZKA. What is the profitability experience in the industry out selling these policies? What is the loss ratio?

Does anyone know?

Mr. WALLACK. This legislation has requirements. I don't know if it is 65 or 70 percent.

Mr. KLECZKA. What is the actual?

Mr. WIENER. I don't think we know. And I don't think we will know for a very long period of time, because it is the nature of this product that you are selling policies to people who won't use the benefit for years in the future. So the yearly loss ratios are not useful. What you want is over the lifetime of the policy.

Mr. KLECZKA. Well, it has been mentioned here that it would be ideal if 20-year-olds would go into this type of insurance because of the relatively cheap cost. But we found last year that 20-year-olds don't buy health insurance today because they are healthy. Once they turn 42, they are not so healthy and then they start looking around for a policy.

And I can see the same thing happening with this type of insurance for a 50-year-old. All right?

I am quasi-healthy, but I am never going to need long-term care until I am 65 or 69, and then I will think about buying that policy. That is the way the public thinks on this. You can dispute that, but I think that is the way we are handling this today.

Mr. WIENER. I think that is absolutely right. The time when you can afford these policies is when you are young and when you think you are going to live forever and you will never need long-term care. It is when you are elderly and start thinking about your own mortality that this becomes more of an issue and, at that point, you can't afford good-quality policies. You may be able to afford a less good policy. But the policies with inflation protection and nonforfeiture benefits, according to HIAA, costs over $2,000 a year at age 65.

Mr. KLECZKA. Well, if this program hinges on employer participation, we found out in the health care debate last year many employers today don't offer health insurance. Mr. Houghton and I served on the Oversight Committee last year and spent a lot of time working on the PBGC and, as you said, Mr. Wiener, knowing the unfunded liability in that program, to think that an employer on his own motion would go into this type of a policy or coverage for the employee is just whistling Dixie.

Yes, there is a rationale for health insurance. Healthy employees are productive employees. But after that employee leaves your workplace and is now 70, whether that person needs long-term care or not, providing it is not to the employer's advantage. But if employers are going to take on a gigantic liability in this country,

knowing what is going on in the pension area, this is not going to happen to my friends in my lifetime, unless everyone was organized and this was the bottom line at the bargaining table, and that is naturally being reversed as we all know.

Mr. MEINERS. One of the things that struck me in terms of the various proposals on the table is it is unclear which ones might have the most effect. I think as I said before, I think leveling the playingfield is an important consideration. I think it is very possible that people at that financial planning stage, if they are given the chance to draw money out of their IRAs for long-term care insurance, that they are more likely to feel positively toward this important decision.

In a funny way—and the other consideration is that if they are not successful, it isn't going to cost much. It is not going to cost much in the sense that people won't take advantage of the tax break. And if they are successful, you have accomplished getting people more involved in preparing for long-term care.

Mr. KLECZKA. On the IRA withdrawal, pending before the Ways and Means Committee are several proposals dealing with IRAs. One that I have supported for years is a withdrawal from your IRA for a downpayment on a home. That is why a lot of young couples can't get in, because they can't afford the downpayment. It is not because they can't afford the monthly payments. So we are going to permit that. We are going to draw that down. And then when the kids get to college, you can draw down for that. And now we can draw down for the long-term care.

How much money do you think these people have in these IRAs?

Mr. WALLACK. People at different points in their life cycle need different things, and we are talking about choice.

Mr. KLECZKA. But one family unit is going to find out when they got to that IRA at age 65 for the long-term health care, very little is left.

Chairman THOMAS. The gentleman's time has expired.

Mr. Johnson.

Mr. JOHNSON OF TEXAS. Thank you, Mr. Chairman.

I just would like to ask Mr. Wallack, it appears to me that you believe in cutting out the States. And I would like for you to discuss why you think the Federal Government ought to make standards that eliminate the States from the process. Speak to that if you would.

Mr. WALLACK. OK. I am not sure I am saying cutting out the States. I think there is a lot of variation. And people buy these policies, they move to other States, and I think we would benefit by having good national standards at least as an option for selling this policy, so that people would have them.

If the States, in fact, want to go beyond that, they may go beyond that. But I believe policies should meet these Federal standards and insurers should be able to sell them in all States.

Mr. JOHNSON OF TEXAS. Do you disagree with Mr. Houghton's New York concept?

Mr. WALLACK. No, in fact, I think there is a real role here—that is one model. The government has to participate in the solution in some real ways. Without it, it just isn't going to happen. To say blindly that the private sector is going to solve this problem is im-

possible given how we develop social welfare solutions in this country. The government has got to participate at the State level and at the Federal level with these solutions. That is the only way the private sector is really going to be successful.

Mr. JOHNSON OF TEXAS. OK. It is a matter of degree.

Mr. WALLACK. Yes, it is.

Mr. JOHNSON OF TEXAS. Thank you, Mr. Chairman. I don't have any further questions.

Chairman THOMAS. I thank the gentleman.

And I recognize our friend and colleague, the gentleman from Georgia, who was not here during the initial introductions but is a returning member of the subcommittee, Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Mr. Wiener, I agree that we should look for both private and public solutions, but we must remember tax incentives cost money. They cost taxpayers money. Could you talk more about whether this is the best way to spend the taxpayers' money.

Mr. WIENER. Certainly. I think there are two questions, one of equity and one of efficiency. The analyses that we have done of private long-term care insurance, and especially of the tax credit that Representative Gradison put forward, suggested that the overwhelming majority of private long-term care insurance expenditures or benefits would go to upper-income elderly.

And so especially if we are talking about cutting the Medicaid program, which is our primary mechanism of financing long-term care, I think we have a real equity problem. Medicaid basically is targeted on poor people and people who have really impoverished themselves. I think it is unfair to take money from that program to give to upper-income persons.

Another question is one of efficiency. And I think our history of tax incentives has been that you largely end up subsidizing people who would otherwise have done what you are trying to get them to do. And so what we have found in our analysis is that you don't increase the number of people with private insurance under the Gradison proposal by very much, but you lose a fair amount of money.

And we estimate that the additional costs per additional person with insurance in the year 2018 would be about $2,000 a policy. So you are losing—your cost per additional person insured is almost as much as the cost of the policy. That is not a very efficient way of getting things done.

My own preference is to build on what we have in this country in terms of long-term care financing delivery and that is largely a State system. States are innovators in terms of home care and other things in long-term care. And I think it makes a lot of sense to give them a pot of money and be flexible with that and let them expand home care. We have a system right now that is very heavily geared toward institutional care, and I think we need to balance that.

Mr. LEWIS. Mr. Wiener, can you help me out for a moment here. Are you suggesting—or would it be fair to say that this proposal takes from the middle class and the poor to give to the wealthy?

Mr. WIENER. Well, I don't think in and of itself you can say that. The question is, where is the money going to be found to pay for

this? Many of the proposals, certainly the one cutting Medicaid, would take services from poor people.

The primary beneficiaries of tax clarification will clearly be upper-income people. You could finance that by raising other taxes on upper-income people. But that is not inherent in tax clarification.

Mr. LEWIS. What does this really mean for the poor elderly and the average working-class person?

Mr. WIENER. With good-quality policies costing over $2,500 a year, I don't think moderate and working-class elderly are going to purchase policies. They may buy policies and then find they can't afford it and then drop it.

Mr. LEWIS. Thank you very much.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

And once again, the gentleman who was not with us earlier because of his other subcommittee assignments, but a new member of the subcommittee is a new Member of Congress, the gentleman from Nevada, Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

Mr. Wallack, a tremendous amount of the money that is spent from the public sector toward long-term care is spent in what Mr. Wiener described as the public institutions, or in institutional long-term-care type care. Can you address how the private sector has encouraged more of the home care and how you think that this tax clarification would encourage, discourage, or otherwise, those reforms from increasing or decreasing?

Mr. WALLACK. Sure. One of the nice things about a private market is that it has to respond to consumers' interest and consumers have clearly said what they want to do is stay at home and have broad-based benefits. And, therefore, if you look at the change in this product over the last few years, it has, in fact, become extremely comprehensive in terms of home care, assisted living, all sorts of benefits. And what the products are now doing is giving people almost a pot of money and letting them have a lot of choice.

So the products have been very responsive to individuals, in terms of their wanting to stay independent and giving themselves choice. And one of the things that I was worried about with some of the things in this bill is that we don't want to restrict that. We want to, in fact, let people be able to stay at home. They want to stay home and that is why I think most people are buying long-term care insurance, not because of institutional care, but because it gives them choice and the ability to get services in other settings.

Mr. ENSIGN. Home care is less expensive than institutionalized care, obviously; right?

Mr. WALLACK. Well, it should be and could be. And I think the real issue for people is that by giving that option to people with regard to home care, you in fact don't force them into expensive institutions, and that is where people really do spend down.

You can make home care extremely expensive if people want to make a nursing home in their home, but that is not usually the case. Usually it is for people who are not quite as disabled and who, therefore, can be kept at a low level of care, so, therefore, it is less expensive.

Mr. ENSIGN. Mr. Wiener, let me follow that up with you, and that is if this is moving toward the trend in home care, especially in the private sector, you mentioned in the States as well, but if we can get that moving toward long-term home care, where it is more compassionate, where people want to be, wouldn't that also lower the cost and not hurt the lower-income people?

Mr. WIENER. I think you have to be very careful here. There is a large, rigorous research literature that suggests that total cost for long-term care with expanded home care is, in fact, higher than a long-term care system with relatively restricted home care services.

And the reason for that is given a choice between nursing home care and nothing, many people would choose nothing. But given a choice between nursing home, home care, and nothing, many people choose home care. And so what you get is large increases in home care use, which more than offset a relatively small reduction in nursing home use.

I am a strong supporter of home care. I think there is a place for institutional care as well, but I don't think you can make the argument for home care based on the idea that we are going to have a much cheaper, much more cost-effective system.

Mr. ENSIGN. But I think that sometimes you are looking at that as too much of an isolated case. You also have to consider the people that if they had help with long-term home care, could also remain productive. In other words, a lot of those people are staying home and taking care of somebody and they can't be in the workplace remaining productive and paying tax revenues into our system.

I think that overall the advantages clearly outweigh the disadvantages as far as encouraging home care. And I think in the long term, my personal opinion is long term, it is going to end up being less expensive when you take the whole picture into account.

Mr. WIENER. While there are certainly people who quit jobs or work less because of the caring for relatives, the available evidence suggests that those numbers are quite small. And remember, the children of 85-year-olds are in their late fifties and early sixties themselves, and are likely to be pulling out of the work force. So those are the children, and their workplace participation is not likely to be high.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman THOMAS. I want to thank the panel. Obviously it is difficult in making clearer decisions without cost estimates as we go forward, and this committee has always been uncomfortable without cost estimates and we will get those as I said.

In addition, this is the only item in front of us, so I think we are putting a bit of inordinate focus on it. If it were part of a more comprehensive reform plan, I think, as was clearly indicated, we would all agree it would be part of that program.

And finally let me just say that one of the things that we cannot predict now, but one of the reasons I think everyone is for this very modest adjustment is that the private sector would be afforded one more tool in its arsenal of innovation and coordination of various policies. You could create an insurance environment for an entire lifetime continuum that could be seamless and that investments in one type of insurance could then be moved into another, so that all

the predictions about the consumption of this product I think are in an atmosphere in which no one knows what the dynamic will be if we provided that full spectrum. And I think that is one of the things that we are hopeful in doing. This is a small part of it. But I thank the first panel for their focus and enlightenment that they provided us. Thank you very much.

The second panel is Barbara Fosberg, Bethesda, Md.; David Allen, executive officer, Professional Staff Congress—City University of New York Welfare Fund; David Guttchen, project director, Connecticut Partnership for Long-Term Care; Gail Holubinka, director, New York State Partnership for Long-Term Care; and Kevin Mahoney, project director, California Partnership for Long-Term Care.

I believe the lineup will be from my right to your left, from your left to my right. It will follow the introductions. Ms. Fosberg. All of the panelists' testimony will be made a part of the record without dissent, and you will have 5 minutes to expand on your interests however you choose.

STATEMENT OF BARBARA B. FOSBERG, BETHESDA, MD.

Ms. FOSBERG. Mr. Chairman, members of the subcommittee, good afternoon. My name is Barbara Fosberg. I am an attorney representing neglected and abused children in the D.C. Superior Court. My 35 little clients would not have my assistance and considerable attention were it not for the fact that I have a long-term care policy with the Travelers Insurance Co. which provides a trained home health aide to care for my husband who has Alzheimer's.

I would like to share with you the events leading up to the purchase of the policy and what it has meant to our family. My husband retired from the State Department Foreign Service after 32 years with the government. After his retirement and after our children were "grown and gone," I entered the American University's College of Law and I graduated at age 60.

Because I had had some health problems while in law school, I began to think about the possible eventual need for home health and nursing home care. A friend who had a policy with Travelers recommended them, but, in keeping with my methodical bent, I drew up a detailed chart of some dozen companies, listing premiums, coverage, and so forth, and interviewed representatives from each before deciding that Travelers offered our family the most comprehensive protection available. Little did I realize, when I was doing this in 1990, that in 1994 my husband would be diagnosed with Alzheimer's, the type with quick onset and rapid deterioration.

At that most difficult time, it was both helpful and reassuring to be assisted by our insurance agent, John Haslett, who facilitated an orderly and smooth transition through the approval of our claim process. The first step in seeking a care provider was a referral to a local hospital with a geriatric department that had trained care coordinators.

This home management team from Suburban Hospital evaluated our personal health care needs and found a highly qualified home health aide. These services, which include periodic visits by the

geriatric nurse and the socialworker, are covered by our Travelers policy.

For awhile, my husband was able to attend a senior day care center twice a week and to be cared for at home 3 days a week while I was in court. Not only is the home care covered by this policy, but the day care is also covered. Because his condition now precludes his attending day care, he is cared for 5 days a week by the excellent home health aide. I have recently contracted for additional help on weekends in order to make home visits to my young clients. And this extra help is also covered by the policy.

Because my husband is in the "sundowning" stage of Alzheimer's, meaning that he wanders throughout the house all night, I do not know how much longer I shall be able to keep him at home, perhaps for as long as I can subsist on 4 hours sleep a night.

I do, however, want to keep him in his own home for as long as he is able to recognize his surroundings and to recognize his loved ones. When the time comes that he can only be cared for in the nursing home, then our long-term care policy will also cover 100 percent of the expense up to $100 a day.

This long-term care policy has given me peace of mind knowing my husband is well cared for; moreover, it has given me the opportunity to continue my work with abused and neglected children.

I hope that your subcommittee can facilitate expanded coverage and tax incentives to more people who would otherwise not be able to continue their outside worthwhile endeavors.

Thank you.

Chairman THOMAS. Ms. Fosberg, thank you for your personal difficult testimony. We appreciate it.

Mr. Allen.

STATEMENT OF DAVID ALLEN, EXECUTIVE OFFICER, PROFESSOR, CITY UNIVERSITY OF NEW YORK WELFARE FUND

Mr. ALLEN. Good afternoon, Mr. Chairman and members of the subcommittee. My name is David Allen. I am a professor in the City University of New York. And I would like to thank you for the opportunity of appearing here this afternoon.

In addition to teaching economics, I am a trustee and executive officer of the Professional Staff Congress, City University of New York Welfare Fund, a program of fringe benefits for the faculty of the City University.

I am here today to personally attest to the valuable role long-term care coverage plays in our benefit plan and to urge your support of the private long-term care market through the tax clarifications provided in H.R. 8. And Mr. Chairman, I am very proud to say that our union was the first union in the United States to offer a group long-term care plan to its members and the City University was the first university in the United States to do that.

The impetus for our plan came in 1988 and it came neither from our own staff nor from an insurance company. Instead it came from our own members, our retirees. They are organized in a special retirees' chapter of the union and members of that chapter knew from firsthand experience the number of Americans in need of long-term care and the high cost of providing it.

Because long-term care insurance was a new concept and because of the complexity of evaluating different plans, they came to us and asked if our welfare fund would provide them with a good group plan that they could have confidence in. We solicited bids from a number of insurance carriers and we were successful in finding a large company, John Hancock, which was willing to offer a plan similar to what our members wanted.

Approximately 2,500 of our 13,000 members now purchase our group long-term care insurance and it has been very well received. Our members have had the confidence of knowing that even if they didn't read all the fine print in the policy, they knew somebody who did.

As I mentioned, about 20 percent of our members, including my wife and myself, purchase long-term care insurance. Judged by other group plans, we are considered very successful, but I believe we could do better. The 10,000 people in our group who have not yet purchased long-term care insurance have not been given divine assurance that they are never going to need the care nor are they independently wealthy.

What they need is a message from Congress encouraging them to take action now to provide themselves with protection from the high cost of long-term care. I believe H.R. 8 is a step in the right direction. The bill will provide official recognition of long-term care insurance and much needed clarification of its tax implications.

With regard to the City University, Mr. Chairman, there are two changes to H.R. 8 that I would like to suggest that would make it more beneficial to our members. First, I encourage the committee to clarify the eligibility of long-term care plans for inclusion in section 125 plans. The ability of employers to offer long-term care coverage in a section 125 cafeteria plan would be a very substantial encouragement to individuals to purchase group long-term care insurance.

Second, and more importantly, I encourage the committee to amend this legislation by adding 403(b) to the 401(k) provisions. Since 403(b) plans are to those of us in the educational community what 401(k) plans are to those in the private sector, I believe we should be given the same incentives as people with 401(k) plans.

The reality of the history of our country is that Congress has through the Tax Code provided people with incentives to do hundreds of things. When those incentives are carefully thought out, I believe they constitute good public policy. I believe that most members of this committee want to do something to ease the growing costs to Medicaid of providing long-term care.

If that is true, I encourage you to join me in supporting H.R. 8. I encourage you to add 403(b) to the bill's 401(k) provisions and to clarify that long-term care benefits can be offered through section 125 plans. If you do that, I believe you will see many more Americans choosing to protect themselves from future long-term care costs through the purchase of private insurance.

And, Mr. Chairman and members of the subcommittee, I just want to conclude by thanking you very much for giving me the opportunity to be here and let an ordinary American citizen come before this important subcommittee and express his point of view.

[The prepared statement follows:]

TESTIMONY OF DAVID ALLEN, EXECUTIVE OFFICER
CITY UNIVERSITY OF NEW YORK WELFARE FUND

Good afternoon. Mr. Chairman and Members of the Subcommittee, my name is David Allen. I am a professor in the City University of New York. I would like to thank you for the opportunity to appear before your subcommittee.

In addition to teaching economics at the University, I am a trustee and Executive Officer of the Professional Staff Congress - City University of New York Welfare Fund. The Welfare Fund is a program of fringe benefits for the professional staff of the City University of New York. In addition to policymaking responsibilities as a trustee of the Fund, as Executive Officer I have special responsibility for member relations. It falls to me to meet with our 13,000 active and retired members around the University, to listen to their complaints and suggestions and to explain to them the programs of the Fund.

I am a believer in private long term care insurance and I encourage you to provide incentives to Americans to purchase protection now against the future possibility of long term care costs. I am here today to personally attest to the valuable role long term care coverage plays in our benefit plan and to urge your support of the private long term care market through the tax clarifications provided in H.R. 8, the Senior Citizens' Equity Act.

The Professional Staff Congress, which is a local of the American Federation of Teachers, was the first union in the United States to sponsor a group long-term care insurance program and the City University of New York was the first university in the United States to offer its professional staff long-term care insurance.

The impetus for our plan came in 1988 and it came neither from our own staff nor from an insurance company anxious to sell its product. Instead, it came from our own retirees. They are organized in a special retirees' chapter of the union. Members of that chapter knew from first-hand experience the number of Americans in need of long term care and the high cost of providing it. Because long term care insurance was a new concept and because of the complexity of evaluating different plans, they came to us and asked that our Welfare Fund provide them with a good group plan that they could have confidence in. Group plans cannot meet the needs of 100% of the population. I do believe, however, that group plans have a special role to play in meeting the need for long term care insurance. Because long term care insurance is new and because of the variety of plans on the market, groups can do for members what they cannot do for themselves -- hire professionals to read the fine print, evaluate competing plans and select a plan that represents good value for the money, a plan designed to meet the specific needs of that particular group. In addition, group plans have the advantage of lower rates, thanks to group purchasing power and the ability to attract all age ranges.

We solicited bids from insurance carriers for a plan that met out needs. Although negotiations with carriers are always a process of give and take, we were successful in finding a large insurance carrier, John Hancock, willing to offer a plan similar to what our members wanted. Approximately 3,000 of our 13,000 members now purchase our group long-term care insurance and it has been very well received by our members from the beginning. Furthermore, the Fund through the years has been able to modify the plan and make it even more attractive to our members. Our members have had the confidence of knowing that even if they did not read all the fine print in the policy, they knew someone who did. And, of course, they have the security of knowing that their hard-earned assets are protected by the policy should they need long term care. Although our long term care coverage has not yet generated many claims, our employees' experience to date with the Welfare Fund's long term care benefit has been uniformly positive -- as reflected in our low lapse rate. And I really should be saying "we" instead of "they" because my wife and I were among the very first persons to enroll in our long term care plan.

As I mentioned, about 23% of our members chose long term care insurance. Judged by other group plans, we are considered very successful, but I believe we could do better. The 10,000 people in our group who have not yet purchased long-term care insurance have not been given divine assurance that they will never need this protection. Nor are they independently wealthy. What they need is a message from Congress encouraging them to take action now to provide themselves with protection from the high cost of long-term care. I believe that H.R. 8 is a step in the right direction. The bill will provide official recognition of long term care insurance and much-needed clarification of its tax implications, and thus additional incentives for its purchase.

With regard to the Welfare Fund, there are two changes to H.R. 8 I would like to suggest that would make it more beneficial to our members. First, I encourage the committee to clarify the eligibility of long term care plans for inclusion in Section 125 plans. The ability of employers to offer long term care coverage in a Section 125 "cafeteria" plan would be a very substantial encouragement to individuals to purchase group long term care insurance. Second, and most importantly, I encourage the Committee to amend this legislation by adding 403(b) to the 401(k) provisions. There is no rational public policy reason for offering an incentive to those covered by 401(k) plans but denying them to the millions of Americans employed in the educational community who are covered by 403(b).

One way or another, the cost of long term care is going to be paid, but Americans need and want an alternative to public programs for financing their long term care needs. We will always need Medicaid for those who never had the financial means to purchase private long term care insurance, for those whose expenses are so catastrophic that they exceed the parameters of a reasonable long term care plan, and for those who are already too old to buy long term care insurance. But for the majority of Americans, I believe private long term care plans are the best choice.

The reality of the history of our country is that Congress has, through the tax code, provided people with incentives to do hundreds of things. When those incentives are carefully thought out, I believe that they constitute good public policy. I believe that most members of this committee want to do something to ease the growing costs to Medicaid of providing long term care. If that is true, I encourage you to join me in supporting H.R. 8. I also encourage you to add 403(b) to the bill's 401(k) provisions and to clarify that long term care benefits can be offered through Section 125 plans. If you do that, I believe you will see many more Americans choosing to protect themselves from future long term care costs through the purchase of private insurance.

Thank you.

Chairman THOMAS. Thank you very much, Mr. Allen.
Mr. Guttchen.

STATEMENT OF DAVID J. GUTTCHEN, PROJECT DIRECTOR, CONNECTICUT PARTNERSHIP FOR LONG-TERM CARE, STATE OF CONNECTICUT OFFICE OF POLICY AND MANAGEMENT, HARTFORD, CONN.

Mr. GUTTCHEN. Thank you, Mr. Chairman. Mr. Chairman, members of the subcommittee, thank you for the opportunity to present testimony today regarding the long-term care insurance provisions found in H.R. 8. I am pleased to be here to discuss the long-term care financing issue from a State government perspective.

My name is David Guttchen. I am the project director for the Connecticut Partnership for Long-Term Care, and I work out of the State of Connecticut Office of Policy and Management which is our Governor's executive staff agency. The financing of long-term care is a serious concern for State governments because of the financial devastation our residents face and the increasing burden long-term care places on the Medicaid program.

As you know, Medicare and general health insurance do not cover most long-term care. And it is unlikely there will be new Federal benefits coming for long-term care in the near future. Medicaid has become by default the primary public payer for long-term care.

However, because poverty is a criteria for Medicaid eligibility, individuals and families are wiping out a lifetime of savings paying for their care. Representative Stark mentioned the cost of care is about $30,000 or $36,000. In the State of Connecticut, as in a State like New York, on average, a year in a nursing home will cost over $60,000. With these costs, it does not take long for individuals to wipe out their hard-earned savings.

Individuals are also resorting to transferring or sheltering their assets in order to become eligible for Medicaid. In either case, people are losing their financial independence and Medicaid long-term care costs are skyrocketing. In fact, in Connecticut this last fiscal year we spent over $850 million in our Medicaid program for long-term care. That is over 50 percent of our Medicaid budget and close to 10 percent of our total State budget. And it represents a 300-percent increase in long-term care Medicaid costs since 1987.

I am proud to say Connecticut has been a leader in addressing the long-term care financing dilemma that I believe all States are facing. Beginning in 1986, Connecticut has been working on innovative financing approaches for its citizens. One such program is the Connecticut Partnership for Long-Term Care, and while she is not in the room, I would like to thank Representative Johnson as well as Representative Kennelly for all their support over the years for the development of the partnership plan as well as the Robert Wood Johnson Foundation for their initial support and continued support for the partnership projects.

The Connecticut partnership launched in 1992 and the first program of its kind in the country, as Dr. Meiners earlier described, is a unique alliance between State government and private insurance companies that uses a combination of private long-term care insurance and coverage through the Medicaid program to provide Connecticut residents with long-term care protection without the

fear of impoverishment. As was noted, similar programs are up and running in New York and California as well as the State of Indiana and other programs are being launched in Illinois, Iowa, and Maryland.

The Connecticut partnership seeks to reduce the reliance on Medicaid as the primary public payer of long-term care as more individuals privately insure for their long-term care risks. The program offers through participating insurers specially certified, high-quality, affordable long-term care insurance that can protect the individuals' hard-earned resources and help them retain their financial independence and dignity.

A significant achievement for the partnership programs are the standards we have developed for insurance policies sold through our programs. These standards such as mandatory inflation protection and specialized agent training were developed to address consumer concerns about the adequacy of the coverage they were purchasing and assure that a meaningful benefit is provided.

These standards, while protecting consumers, also increase confidence in the insurance being purchased. The Connecticut partnership is targeted to and most advantageous for those with modest incomes and assets. These are the most likely candidates to spend down their resources and end up on Medicaid and the least likely to be able to afford adequate private insurance.

By offering back-end coverage through Medicaid without the requirement that one be impoverished, the Connecticut partnership makes the purchase of quality private insurance more affordable and accessible for the middle class.

The partnership was developed to provide an incentive for individuals to buy quality private long-term care insurance. The program has proven to be a win-win formula. Individual purchasers win as they take personal responsibility for their long-term care costs with the knowledge that if their needs exceed their insurance coverage, they can access Medicaid and not impoverish themselves.

Insurance companies win as the market for private long-term care insurance expands and State and Federal Governments win as the growth in Medicaid long-term care expenditures is constrained. The long-term care provisions found in H.R. 8 should prove to be an additional incentive for the purpose of long-term care insurance. As with the partnership projects, the provisions could create a win-win situation as long-term care insurance is made more affordable, sales increase, and the reliance on Medicaid is reduced.

I see my time is up. I just want to make one last technical point that Dr. Wallack mentioned earlier in terms of a concern with the bill. We certainly support the provision in H.R. 8 that requires long-term care policies to coordinate benefits with Medicare, but we also need to point out the contradiction with H.R. 5252, the Social Security Act Amendments of 1994 which was passed in October of last session which prohibits long-term care insurance policies from coordinating benefits, and we urge the subcommittee and full committee to look at amending the Social Security Act to remove this inherent contradiction between the two bills.

Thank you for the opportunity to testify today.

[The prepared statement follows:]

Testimony of
David J. Guttchen
Project Director
Connecticut Partnership for Long-Term Care
State of Connecticut Office of Policy and Management

Mr. Chairman. Members of the Subcommittee. Thank you for the opportunity to present testimony today regarding the long-term care insurance provisions found in H.R. 8 - "The Senior Citizens Equity Act". I am the Project Director for the Connecticut Partnership for Long-Term Care and work out of the State of Connecticut Office of Policy and Management, our Governor's executive staff agency. I am very grateful to be able to represent the views of the State of Connecticut on the important issue of how we as a society will pay for future nursing home and home care costs.

The financing of long-term care is a serious issue for state governments because of the financial devastation our residents face and the increasing burden long-term care puts on the Medicaid program. As you know, Medicare and general health insurance do not cover most long-term care. Medicaid has become, by default, the primary public payor for long-term care. However, because poverty is a criteria for Medicaid eligibility, individuals and families are either wiping out a lifetime of savings paying for their long-term care - which does not take long in Connecticut where the average cost for nursing home care is over $60,000 a year - or are resorting to transferring or sheltering their assets in order to appear poor and become eligible for Medicaid. In either case, people are losing their financial independence and Medicaid long-term care costs are skyrocketing. In fact, in fiscal year 1987, Connecticut's Medicaid program spent $275 million on long-term care - that figure has risen to over $850 million for fiscal year 1994, a total that represents 53% of our Medicaid budget and close to 10% of Connecticut's total state government budget. With people living longer and the large numbers of "Baby Boomers" turning 65 years of age in the next 20 to 30 years, the financial strain long-term care will put on Medicaid will be enormous.

Connecticut has been a leader in addressing the long-term care financing dilemma that, I believe, all states are facing. Dating back to a special commission developed in 1986 to look at the private and public responsibilities for financing long-term care, Connecticut has been working on innovative long-term care financing approaches for its citizens. One such program is the Connecticut Partnership for Long-Term Care.

The Connecticut Partnership, launched in April 1992 and the first program of its kind in the country, is a unique alliance between state government and private insurance companies that uses a combination of private long-term care insurance and coverage through the Medicaid program to provide Connecticut residents with long-term care protection without the fear of impoverishment. Similar programs are now operational in California, Indiana and New York and are being planned in Illinois, Iowa and Maryland.

The Connecticut Partnership seeks to reduce the reliance on Medicaid as the primary public payor of long-term care as more individuals privately insure for their long-term care risks. The program offers, through participating insurers, specially certified, high-quality, affordable long-term care insurance that can protect the individual's hard earned resources and help them retain their financial independence and dignity. A significant achievement for the Partnership programs are the standards developed for the insurance policies sold through the projects. These standards were developed to address consumer concerns about the adequacy of the coverage they were purchasing and assure that a meaningful benefit is provided to the policyholder. These standards, while protecting consumers, also increase confidence in the insurance being purchased.

The Connecticut Partnership is targeted to, and most advantageous for, those with modest incomes and assets. These are the most likely candidates to spend down their resources and end up on the Medicaid program and also the least likely to be able to afford adequate private insurance in the absence of our program. By offering back-end coverage through Medicaid, without the requirement that one be impoverished, the Connecticut Partnership makes the purchase of quality private insurance more affordable and accessible for the middle class.

The Connecticut Partnership was developed to provide an incentive for individuals, especially those with more modest incomes and assets, to buy private long-term care insurance. The program has proven to be a win-win formula. Individual purchasers win since they are able to take personal responsibility for their long-term care costs with the knowledge that if their needs exceed their insurance coverage they can access the Medicaid program and not impoverish themselves. Insurance companies win as the market for private long-term care insurance expands. And state and federal governments win as the growth in Medicaid long-term care expenditures is constrained. To date, close to 2,000 Connecticut residents have purchased a Connecticut Partnership policy and well over 16,000 individuals have been provided long-term care information through our program's consumer education campaign.

The long-term care provisions found in H.R. 8 should prove to be an additional incentive for the purchase of long-term care insurance. If these provisions help to make long-term care insurance more affordable and attractive they have the potential to positively impact consumers, insurers and state governments. As with the Connecticut Partnership, the long-term care provisions in H.R. 8 can create a win-win situation as long-term care insurance is made more affordable, sales increase and the reliance on Medicaid is reduced.

The long-term care provisions in H.R. 8 should work as a compliment to the efforts of the Connecticut Partnership and the other Partnership projects. Hopefully, the combination of these incentives will help to expand the market for quality long-term care insurance and make for a more equitable financing system that relies less on Medicaid.

There is, however, one technical point that is worth mentioning. While we fully support the section of H.R. 8 that requires long-term care policies to coordinate benefits with the Medicare program, it is important to note that H.R. 5252, the Social Security Amendments Act of 1994 (passed by Congress in October 1994) prohibits long-term care policies from coordinating benefits with Medicare creating an obvious conflict with H.R. 8. We strongly urge that the Social Security Act be amended to allow for long-term care policies to coordinate benefits thus removing the contradiction with H.R. 8.

In conclusion, while certainly private long-term care insurance is not appropriate for, or accessible to, everyone, a growing market will enable state governments, such as Connecticut, to utilize its scarce resources for those greatest in need. The tax provisions found in H.R. 8, and programs such as the Connecticut Partnership and Partnership programs in other states, can provide incentives to expand the private market and benefit both the private and public sectors.

Thank you again for the opportunity to provide this testimony regarding H.R. 8's long-term care provisions. Please contact my office if the State of Connecticut can be of further help as the subcommittee and full committee deliberates this matter.

Chairman THOMAS. Thank you very much.
Ms. Holubinka.

STATEMENT OF GAIL HOLUBINKA, DIRECTOR, NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE, ALBANY, N.Y.

Ms. HOLUBINKA. Good afternoon, Mr. Chairman, members of the committee. I am Gail Holubinka. I am director of the New York State Partnership for Long-Term Care, and I would like to thank you for the opportunity to speak before this committee on the important issue of offering tax incentives to purchasers of long-term care insurance.

As in most States, New York's Medicaid expenditures are escalating and as in most States, the fastest growing and most difficult area to control is long-term care. New York is justly proud of the extent and quality of the care that it provides to elderly Medicaid recipients, but with total Medicaid long-term care costs exceeding $7 billion, that is with a B, in 1994, the State believes that the current system of long-term care financing must change.

Medicaid was established to provide health care to the poor. However, poverty can be situational as well as historical. In the event of a financially catastrophic long-term care episode, those who have always lived comfortably could find themselves at risk of impoverishment.

For example, the average cost of a semiprivate nursing home for a year in New York would range from $62,000 to $75,000. Given an average stay of 2½ years, even New Yorkers with resources of $175,000 will wind up as Medicaid recipients. This is not the type of poverty the designers of the Medicaid program envisioned addressing.

However, this is a scenario that is a reality in New York. Compounding the problem is the fact that with such large amounts of life savings at stake, the incentive to take advantage of divestiture tactics to gain Medicaid's assistance is enormous. In either case, whether the impoverishment is actual or artificial, the result is the same. In New York State, Medicaid has become the safety net for the middle and even the upper middle class citizen when long-term care is needed. This is the reality in New York that we have faced and we have taken action.

In 1988, under a grant from the Robert Wood Johnson Foundation, New York accepted the challenge to create an alternative to the unpalatable choices of impoverishment or divestiture that would be attractive to its citizens and save Medicaid funds. The result of that effort is the New York State partnership.

In selecting a financing alternative that would be affordable to residents but would not require increased public expenditure, New York looked to the source of personal financial protection against most catastrophic events, private insurance, and combined it with a concept of shared risk between the individual citizen and the State.

Under the New York partnership, residents who purchase a time-limited amount of long-term care insurance from participating private insurers and who subsequently exhaust the benefits under such insurance are allowed to apply for Medicaid, contributing their income, but retaining all of their assets. The use of insurance

has also created the opportunity to improve and promulgate the relatively new long-term care insurance product in a way that will help all the State residents regardless of whether they participate in the partnership.

By establishing standards of quality for partnership policies, New York has created guidelines by which residents may judge all long-term care insurance. By embarking on extensive educational campaigns to inform the public of the risks, costs, and options of long-term care financing, the partnership has made residents aware of the problems they face.

Indeed, partnership activity has raised the issues of long-term care financing to an integral component of retirement planning. In New York, the strategy is paying off. The incentive and affordability offered by the partnership has stimulated the long-term care insurance market. Since the partnership became operational in 1993, the sale of long-term care insurance has increased by over 50 percent, with two-thirds of that increase being in the sale of nonpartnership policies.

Clearly New York's approach has struck a chord with its citizens. However, as impressive as that response has been and as vital as the partnership is, there is a long way to go before long-term care insurance becomes as accepted as private health insurance. And New York believes that the major factor that hinders its acceptance is the lack of clarification regarding the tax status of long-term care insurance.

New Yorkers who have heeded the call for the personal responsibility in terms of taking care of their own long-term care needs, need support and encouragement in their effort to pay their own way and so do the millions of others who are also going to care for themselves if given the opportunity to do so without negative tax implications.

There is a cost, but we believe that the cost can be overcome through the savings in other programs. Where the reliance on Medicaid can be delayed or avoided, savings will accrue to offset any investment.

We therefore ask you to support the clarification of the tax incentives for long-term care.

Thank you.

[The prepared statement follows:]

TESTIMONY OF GAIL HOLUBINKA
NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE

Good afternoon. Mr. Chairman. Members of the Committee. I am Gail Holubinka, Director of the New York State Partnership for Long Term Care. Thank you for the opportunity to speak before this committee on the important issue of offering tax incentives to purchasers of long term care insurance.

As in most states, New York's Medicaid expenditures are escalating. And, as in most states, the fastest growing and most difficult to control area of spending is long term care. New York is justly proud of the extent and quality of the care it provides to elder Medicaid recipients, but, with total Medicaid long term care costs exceeding $7 billion in 1994, the state believes that the current system of long term care financing must change.

Medicaid was established to provide health care to the poor. However, poverty can be situational as well as historical. In the event of a financially catastrophic long term care episode, those who have always lived comfortably could find themselves at risk of impoverishment. For example, the annual semi-private rate for nursing home care in New York ranges from $62,000 to $75,000. Given an average stay of two and one-half years, even New Yorkers with resources of $175,000 could become Medicaid recipients. This is not the type of poverty the designers of the Medicaid program envisioned addressing, but this scenario has become a reality in New York. Compounding the problem is the fact that with such large amounts of life savings at stake, the incentive to take advantage of divestiture techniques to gain Medicaid's assistance is enormous. In either case, whether the impoverishment is actual or artificial, the result is the same: in New York State, Medicaid has become the safety net for middle and even upper middle-class citizens when long term care is needed. This is a reality New York has faced and it has taken action.

In 1988, under a grant from the Robert Wood Johnson Foundation, New York accepted the challenge to create an alternative to the unpalatable choices of impoverishment or divestiture that would be attractive to its citizens and save Medicaid funds. The result of the effort is the New York State Partnership for Long Term Care.

In selecting a financing alternative that would be affordable to residents but not require increased public expenditure, New York looked to the source of personal financial protection against most catastrophic events, private insurance, and combined it with the concept of shared risk between the individual citizen and the state. Under the New York Partnership, residents who purchase a time-limited amount of long term care insurance from participating private insurers and who subsequently exhaust the benefits under such insurance are allowed to apply for Medicaid contributing their income but retaining all assets.

The use of insurance also created the opportunity to improve and promulgate the relatively new long term care insurance product in a way that would help all state residents regardless of whether they participate in the Partnership. By establishing standards of quality for Partnership policies, New York has created guidelines by which residents may judge all long term care insurance. By embarking on extensive educational campaigns to inform the public of the risks, costs, and options of long term care financing, the Partnership has made residents aware of the problems they may face. Indeed, Partnership activity has raised the issue of long term care financing as an integral component of retirement planning.

New York's strategy is paying off. The incentive and affordability offered by the Partnership has stimulated the long term care insurance market. Since the Partnership became operational in 1993, the sale of long term care insurance has increased by over 50 percent, with two thirds of that increase being in the sale of non-Partnership policies. Clearly, New York's approach has struck a chord with its citizens. However, as impressive as the response has been and as vital as the Partnership is in providing affordable coverage, there is a long

the major factors hindering this acceptance is the lack of clarification regarding the tax status of long term care insurance.

The New Yorkers who have heeded the call for personal responsibility need support and encouragement in their effort to pay their own way. So do the millions of other citizens who are willing to care for themselves if given the opportunity to do so without negative tax implications. There is a cost in tax clarification that would place long term care insurance on the same level as health insurance. However, where reliance on Medicaid can be delayed or avoided, savings will accrue to offset that investment. Specifically, New York has estimated that for each divestiture avoided, Medicaid could well save over $100,000 on an average stay; for each impoverishment avoided, Medicaid could save over $75,000. While potential savings in states with lower long term care costs might be less dramatic, the concept is sound. Replacing public dollars with private dollars makes sense.

Government must recognize the dilemma of long term care financing that the public faces and assist citizens in doing what they can to help themselves. The Partnership concept is definitely a part of the answer, but the first step should be for government to encourage and acknowledge the benefit of personal planning for possible long term care costs to both the citizen and society as a whole . By declaring that tax-wise, long term care insurance will be treated like health insurance and, therefore, be considered as desirable as health insurance, government will send its citizen's the clear message that must be heard if reasonable solutions to paying for the care of our elderly, now and in the future, are to be found.

Chairman THOMAS. Thank you very much.
Mr. Mahoney.

STATEMENT OF KEVIN J. MAHONEY, PH.D., PROJECT DIRECTOR, CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE, SACRAMENTO, CALIF.

Mr. MAHONEY. Thank you, Mr. Chairman. On July 29, 1994, Governor Pete Wilson launched California's Partnership for Long-Term Care program. This partnership between private insurers and Medicaid aims to provide individuals a way they can plan ahead to meet their needs for nursing home and community care without fear of impoverishment. At the same time, this program works to constrain the growth of the Medicaid program. Though our program is less than 6 months old, we are receiving about 1,000 inquiries a month at our toll-free telephone number.

Under current California law, individuals must spend down their assets to just $2,000 in order to qualify for MediCal benefits to pay for their long-term care needs. Under the partnership program, a person who buys a State-certified policy is entitled to keep additional assets equal to the amount his or her insurance has paid out and still receive Medicaid benefits. This dollar-for-dollar approach allows for a variety of product designs ranging from 1 to 5 years of coverage.

This program encourages individuals to plan for their long-term care needs by offering affordable quality protection to people with varying financial needs. As opposed to what you heard on the earlier panel, prices for a 65-year-old, even for these high-quality products, start from $65 to $85 a month.

This partnership is based on the premise that neither the public nor the private sector alone can solve the long-term care financing problem. There is an important role for private insurance. There is a key role for the public sector and they can work in concert. Title III of H.R. 8 builds on that same foundation. Clarifying the tax status of long-term care insurance will play a significant role in legitimizing the private market, and increasing the affordability and attractiveness of coverage.

But should we stop there? Here again, the experience of these successful State partnership programs may give some guidance. The goal of the California partnership is not merely to increase the sale of private long-term care insurance, rather it is to increase the number and proportion of middle- and modest-income individuals with long-term care protection. The well to do have a number of ways to pay for care. Medicaid can provide protection for the poor. The dollar-for-dollar partnership approach helps make coverage more affordable for those with modest means and it is our hope that the income tax deduction or credits contained in H.R. 8 will do the same.

Furthermore, whereas the sale of additional long-term care insurance is a prerequisite to meeting our goals, it is a means to an end. It is also important that the coverage be in place 20 or 30 years from now when people need the care and that that coverage really cover a substantial portion of the care that those people need.

The goals of the California Partnership for Long-Term Care include keeping the coverage in place and diminishing the number of people who spend down to Medicaid. In this respect, the standards the partnership policy must meet are key. As the recent study in this fall's issue of Health Affairs shows, unless policies provide adequate coverage and inflation protection, purchasers run a significant chance of still ending up on Medicaid.

The California Partnership for Long-Term Care created a consumer standards working group made up of consumers, providers, insurers, and State officials to develop standards that would give the public the necessary confidence in the private market.

Among the features we pioneered were a stepdown provision, which enabled people to lower their coverage if their economic situation worsened without losing all the reserves they had already built up. Tax clarification might be enhanced if it, too, included standards for the private policies, such as the consensus standards developed by the National Association of Insurance Commissioners. Certainly we in State Medicaid offices value attention to basic consumer standards ensuring the adequacy of the coverage.

I appreciate the chance to appear and speak on private long-term care insurance and the value of clarifying its tax status. I hope that the example of California's public, private partnership for long-term care can offer some useful insights, particularly in the areas of targeting benefits to the middle- and modest-income individuals who lack coverage and establishing basic insurance standards so that private coverage will increase, that coverage will persist, and the reliance on Medicaid will diminish.

Thank you.

[The prepared statement follows:]

TESTIMONY OF KEVIN J. MAHONEY, PH.D.
CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE

Mr. Chairman and Members of the Committee. I am Kevin J. Mahoney, Ph.D., Project Director for the State of California's Partnership for Long-Term Care.

On July 29, 1994 Governor Pete Wilson launched the California Partnership for Long-Term Care. This Partnership between private insurers and Medicaid aims to provide individuals a way to plan ahead to meet their needs for nursing home and community care without fear of impoverishment. At the same time, this program works to constrain the growth of the Medicaid program. Though this program is less than six months old, we are receiving about 1,000 inquiries a month at our toll-free telephone number.

Under current California law, individuals must "spend down" their assets to just $2,000 in order to qualify for Medi-Cal benefits to pay for their long-term care needs. Under the Partnership program, a person who buys a state-certified policy is entitled to keep additional assets, equal to the amount his or her insurance has paid out, and still receive Medi-Cal benefits. Individuals will still need to use their incomes to pay their share of the cost.

When a policyholder requires long-term care (whether in a nursing home or at home), he or she will first receive benefits under their certified private insurance policy. If the policyholder requires care above and beyond what the policy provides, the individual can apply for Medi-Cal without impoverishing himself or herself.

This dollar-for-dollar approach allows for a variety of product designs with benefits ranging from one year to five years of coverage. The program encourages individuals to plan for their long-term care needs by offering affordable, quality protection to people with varying financial means.

This Partnership is based on the premise that neither the public nor the private sector alone can solve the long-term care financing problem. There is an important role for private insurance. There is a key role for the public sector--and they can work in concert.

Title III of H.R. 8, "The Senior Citizens' Equity Act", builds on this same foundation. Clarifying the tax status of long-term care insurance will play a significant role in legitimizing the private market, and increasing the affordability and attractiveness of private coverage.

But should we stop there? Here again the experience of these successful state Partnership programs may give some guidance. The goal of the California Partnership for Long-Term Care is not merely to increase the sale of private long-term care insurance. Rather, it is to increase the number and proportion of middle and modest income individuals with long-term care protection. The well-to-do have a number of ways to pay for needed care. Medicaid offers protection to the poor. The dollar-for-dollar Partnership approach helps make coverage more affordable for those with modest means. It is our hope that the income tax deduction (or credits) contained in H.R. 8 will do the same.

Furthermore, whereas the sale of additional long-term care insurance is a prerequisite for meeting our goals, it is a means not an end. It is also important that coverage be in place twenty to thirty years from now when the individual needs care, and that the benefits cover a substantial portion of the costs of care. The goals of the California Partnership for Long-Term Care include keeping the coverage in place, and diminishing the number of people who spend-down to Medicaid. In this respect, the standards Partnership policies must meet are key. As the recent study by Cohen, Kumar and Wallack (published in the Fall, 1994 issue of Health Affairs) shows, unless policies provide adequate coverage and inflation protection, purchasers run a significant chance of still ending up on Medicaid. The California Partnership for Long-Term Care created a Consumer Standards Working Group (made up of consumers, providers, issuers and state officials) to develop the standards that would give the public the necessary confidence in

the private market. Among the features we pioneered were a step down provision which enabled people to lower their coverage if their economic situation worsened--without losing all of the reserves they had already built up. Tax clarification might be enhanced if it, too, included standards for the private policies--such as those developed by the National Association of Insurance Commissioners. Certainly, we in state Medicaid offices value attention to basic consumer standards assuring the adequacy of the coverage.

I appreciate the chance to appear before you today to speak on the importance of private long-term care insurance, and the value of clarifying its tax status. I hope that the example of California's Public/Private Partnership for Long-Term Care can offer some useful insights, particularly in the areas of targeting benefits to the middle and modest-income individuals who have lacked coverage, and establishing basic insurance standards so that private coverage will increase, that coverage will persist, and reliance on Medicaid will diminish.

We will be very happy to share our experience as you continue your deliberations.

Chairman THOMAS. I want to thank the panel. Ms. Fosberg, I want to thank you for your testimony because obviously if everyone approached their living conditions as precisely and succinctly as you did, we would have less reliance on folks having to spend their entire savings to achieve the level of concern and care that you have.

Mr. Allen, I appreciate your testimony, especially because it isn't just the tax incentive. Obviously you had a group who had felt a need and they approached you to try to resolve their problem. It just seems to me that if this is part of a package that is offered, more and more people, word of mouth or otherwise, will begin to focus on it. Agents will obviously begin to put this in their portfolio as they discuss with you what your options are.

And last, because I have to go to a vote, we will start the third panel when I come back. Could we have a relatively brief response if you have any data because what we are talking about is getting people to fall back on their own resources more through an intelligent way of relying on their own resources and not spending it down to qualify for a public program. It would have to work itself out over time, do we have any estimates at all of what creating an incentive for individuals to spend their own money through a private insurance program would save the public funds at all over any period of time?

Do any of you have any information in that regard?

Mr. MAHONEY. I could start to answer. In the projections that we did for the California partnership, simulations showed that in the early years the partnership was basically a break-even for the State. A good part of that was due to the help of the Robert Wood Johnson Foundation and the seed money they gave to develop and evaluate the partnership program.

Our projections show that, carried out into the next century, our partnerships will lead to savings ranging from 1 to 7 percent of the Medicaid long-term care budget; that is part of what these State demonstrations are intended to show.

Chairman THOMAS. Some of us were looking in the last Congress for methods to save in the 5- to 6-percent range in terms of Medicaid. It is interesting that if we simply set up a private option for individuals that that savings would be achieved. I want to thank the panel very much and we will begin the third panel as soon as we get back after the vote.

Thank you.

[Recess.]

Mr. CHRISTENSEN [presiding]. We are going to go ahead and call our hearing back into order. Could we get Mr. Garner and Mr. Chies and Mr. Hagen? The committee would be pleased to hear your testimony, and, Mr. Garner, why don't you start first?

STATEMENT OF RICHARD GARNER, VICE PRESIDENT, LONG-TERM CARE DIVISION, CNA INSURANCE COS., CHICAGO, ILL., ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA (HIAA)

Mr. GARNER. Good afternoon, Mr. Chairman, and members of the Ways and Means Subcommittee on Health. My name is Richard Garner and I am vice president, Long-Term Care Division, for the

CNA Insurance Cos. I am here today on behalf of the Health Insurance Association of America, which represents many of the Nation's leading commercial insurance companies. About 60 percent of the long-term care insurance policies sold have been issued by HIAA member companies.

We welcome the opportunity to testify today on the important issue of long-term care tax clarification. We strongly support the tax clarifications that are contained in the Senior Citizens' Equity Act. These provisions will directly benefit millions of consumers. Further, it demonstrates the cooperation between the public and private sectors that is essential for improving our system for financing long-term care.

Though much of the health care reform debate in the past has focused on acute medical care, millions of Americans of all ages, but especially the elderly, also face potentially catastrophic expenditures for long-term care services.

HIAA believes that our country's long-term care financing system can be improved by using the following three strategies:

One, emphasizing individual responsibility in financial planning for the exposure to long-term care risks; two, promoting the growth of the private long-term care insurance market by providing tax incentives for purchasing coverage; and three, expanding public assistance for those who are unable to finance their own long-term care expenses.

Insurers can foster individual responsibility by providing quality products which meet the needs of consumers. Insurers must also participate in educational efforts to increase the public's awareness of the potential financial burden of long-term care. For its part, Congress can help foster individual responsibility by dispelling the notion that a new government entitlement program is just around the corner.

Congress has an equally important role in encouraging the growth of the private long-term care market by enacting tax clarification. Tax clarification for long-term care insurance would reduce its costs for many Americans, increase its appeal for employers, and increase public confidence in this tremendously important private insurance coverage.

The Senior Citizens' Equity Act supports the strategies I outlined above. It demonstrates the government's commitment to the private long-term care insurance market. It reinforces individual responsibility, and it provides the necessary clarification to remove uncertainty the public now has about the tax treatment of long-term care.

HIAA believes that tax incentives will stimulate individuals to plan for their own financial security and will stimulate employers to sponsor group plans as employee benefits. In turn, this expansion of the private long-term care insurance market will have the effect of reducing future costs to the government by reducing Medicaid outlays.

Let me emphasize again that the tax clarification provisions will directly benefit consumers. In particular, policy benefits to the individual would be tax free up to the maximum limit. Employer contributions toward premiums would be a tax-free fringe benefit to

the employee and long-term care expenses would be deductible as medical expenses.

Some provisions in the proposed bill need reinforcement or technical corrections. In particular, employer deductibility of premiums should be added; long-term care should be included as a qualified benefit in a cafeteria plan; the effective date provisions should be adjusted to give sufficient time for newly issued policies to conform with the act; and the requirement that policies coordinate with Medicare to receive tax-favored treatment should be reconciled with the Health Care Financing Administration's apparent interpretation that such coordination is disallowed. HIAA will be pleased to assist the subcommittee in crafting these and other technical revisions.

Mr. Chairman, our written statement addresses these issues in greater detail and I would be pleased to answer questions. We appreciate the opportunity to participate on an ongoing basis as this legislation evolves.

Thank you.

[The prepared statement and attachments follow:]

TESTIMONY OF RICHARD GARNER
HEALTH INSURANCE ASSOCIATION OF AMERCA

Good morning Mr. Chairman and Members of the Ways and Means Subcommittee on Health. My name is Richard Garner and I am Vice President, Long Term Care Division, for the CNA Insurance Companies. I am here today on behalf of the Health Insurance Association of America (HIAA) which represents many of the nation's leading commercial insurance companies. About 60 percent of the long-term care insurance policies sold have been issued by HIAA's member companies.

HIAA welcomes the opportunity to testify today on the important issue of long-term care and, in particular, on the long-term care tax clarification provisions in the Senior Citizens' Equity Act. Mr. Chairman, we commend the Republican Leadership for coming forward with this ambitious legislative program for early consideration in the 104th Congress. Cooperation between the public and private sectors is essential for financing and delivering long-term care services, and tax clarification is a critical element of that cooperation.

Though much of the health care reform debate in the past has focused on acute medical care, millions of Americans of all ages, but especially the elderly, also face potentially catastrophic expenditures for long term care services.

HIAA believes that our country's long-term care financing system can be improved by using the three following strategies:

(1) emphasizing individual responsibility in financial planning for the exposure to long-term care risks;

(2) promoting the growth of the private long-term care insurance market by providing tax incentives for purchasing coverage; and

(3) expanding public assistance for those who are unable to finance their own long-term care expenses.

Both the private insurance industry and the government have roles to play in accomplishing these strategies.

Insurers can foster individual responsibility by providing quality products which meet the needs and expectations of consumers and by providing well-trained agents to sell them. Insurers must also participate in educational efforts to increase the public's awareness of the potential financial burden of long-term care. For its part, Congress can help foster individual responsibility by dispelling the notion that a government entitlement program is just around the corner.

Congress also has an important role in encouraging the growth of the private long-term care market by enacting tax clarification and reasonable federal standards for long-term care insurance. Tax clarification for these products would reduce the cost of long-term care insurance for many Americans, would increase their appeal to employers, and would increase public confidence in this relatively new private insurance coverage.

In conjunction with tax clarification, we would support establishing reasonable federal standards for long-term care insurance products that would serve as a "seal of approval," further building consumer confidence in private long-term care insurance products. However, such standards must not be so onerous that they prohibit all but "cadillac" policies from being sold. It is critical to ensure that consumers will have the opportunity to choose appropriate protection for their individual circumstances from a wide range of coverage options. Equally important, we propose that consumer access to products that meet federal standards be dramatically increased. This could be accomplished by requiring that only an insurer's state of domicile must certify that a new policy meets the federal standards in order to sell that policy in all states where the insurer is licensed.

Congress also has a role in expanding assistance to those in financial need. Such assistance could take the form of enhancements to the Medicaid program. HIAA believes it is far better to use limited tax dollars to target care to those unable to protect themselves, and to encourage those who can afford to do so, to purchase private protection.

Mr. Chairman, the testimony below will focus on HIAA's views on the importance of addressing long-term care financing issues and our recommendations on how long-term care financing improvements can best be accomplished. We appreciate the opportunity to present our views on the provisions in the Senior Citizens' Equity Act and hope the Subcommittee would be receptive to further comments from HIAA as the legislation evolves.

I. TAX CLARIFICATION

The focus of this hearing is on one of three strategies for improving our long-term care financing system, specifically, tax clarification of private long-term care insurance and services. HIAA applauds the sponsors of the Senior Citizens' Equity Act for including the long-term care tax clarification title. The current uncertain tax treatment of long-term care insurance is a hindrance to market acceptance. Clear tax rules will add confidence in, and further the establishment of, the private long-term care insurance market.

This legislation demonstrates the government's support for and its commitment to the private long-term care insurance market as the primary means of helping Americans to fund for future long-term care needs. It reinforces the message to the public about individual responsibility. This will lead to an increase in the portion of the population who seek to protect themselves against catastrophic long-term care expenses. Furthermore, the expansion of this market will have the parallel effect of reducing future costs to the government by reducing Medicaid outlays.

We also are very pleased that the Senior Citizens' Equity Act contains provisions which clarify the tax status of life insurance policies that accelerate benefits because of terminal illness or long-term care needs. Since accelerated benefit policies were introduced in the early 1980's, we have sought clarification of the federal tax issues surrounding these products. As a result of this clarification, policyholders will be able to utilize their life insurance policies to assist them in dealing with extraordinary medical expenses without adverse tax consequences.

Most of the tax clarification provisions directly benefit consumers. In particular, policy benefits to the individual up to the maximum limit would be tax-free, employer contributions toward premiums would be a tax-free fringe benefit, and long-term care expenses would be treated as other deductible medical expenses. HIAA believes that these tax incentives will stimulate individuals to plan for their own financial security and will stimulate employers to sponsor group plans as part of their employee benefit package. In addition, the social policy reasons that Congress has, for years, supported tax incentives for the purchase of accident and health insurance are equally applicable to support for tax incentives for the purchase of long-term care insurance.

HIAA supports the majority of the tax clarification provisions contained in the Senior Citizens' Equity Act. We believe that some of these important provisions need technical correction. We have identified these below and will be pleased to assist the Subcommittee in crafting these revisions.

Maximum Benefit/Treatment of Excess Benefits: HIAA supports the bill's provision giving tax favored treatment for a maximum daily benefit of $200, indexed for inflation. The bill treats as taxable income the aggregate amount of excess benefits received during the taxable year. HIAA supports this provision because disqualifying all benefits when a policyholder receives excess benefits is particularly unfair to individuals living in high cost areas where daily costs of institutional care already exceed the maximum benefit of $200. These individuals would be penalized twice -- having to pay higher daily costs and losing tax favored treatment of the first $200 in benefits. If the intent of the bill is to require aggregation of multiple policies, this provision may need to be clarified.

Effective Date/Transitions Rules: HIAA supports the effective date provisions for both newly issued and existing policies. Technical revisions may be necessary to ensure that policies issued after the date of enactment, but before the state approves new policies that conform to federal tax requirements, are granted favorable tax treatment. This is needed so there is no unintended effect of discouraging the market until new policies are approved.

Medicare Coordination: HIAA supports the requirement that a long-term care policy must coordinate with Medicare to be qualified for tax favored treatment. Long-term care carriers face a dilemma, however, resulting from indications from representatives of the Health Care Financing Administration (HCFA) with respect to its interpretation of the Medicare Technical Amendments (H.R. 5252) adopted at the end of the last session. We understand HCFA may interpret these amendments as prohibiting the sale of long-term care policies which coordinate with Medicare. We concur with Chairman Archer's view in his recent letter to the National Association of Insurance Commissioners (NAIC) that such interpretation does not reflect Congressional intent. (See attached letters.) This issue is discussed separately in Section II below.

Tax Reserves: HIAA supports the bill's provision which conforms the tax treatment of long-term care reserves with the statutory reserving requirements. This important provision updates the Internal Revenue Code to reflect recent changes by the National Association of Insurance Commissioners (NAIC) regarding long-term care reserve requirements. Treating tax reserves and statutory reserves consistently for the companies will result in lower long-term care premiums for consumers.

Treatment as Accident and Health: The bill intends to treat long-term care insurance as accident and health insurance for both policyholders and insurers. To accomplish this, we recommend a technical change to treat long-term care insurance as accident and health insurance for purposes of the entire income tax title. As currently drafted, the bill refers to the Internal Revenue Code part on company taxation and then has specific references to the I.R.C. sections 104 and 106, but not section 105, regarding individual taxation. Further, the bill should include language that long-term care insurance benefits are also qualified as payments to compensate for the loss of a function of the body under I.R.C. section 105(c). This criteria is closely related to the inability to perform activities of daily living and, therefore, is more consistent with the eligibility criteria used in most long-term care insurance products.

Long-Term Care Riders: HIAA supports the long-term care rider provisions included in the section pertaining to the tax treatment of accelerated death benefits under life insurance contracts. Many life insurance products include riders which accelerate benefits for long-term care needs in varied types of facilities, including

home care. The bill includes an important clarification of the tax treatment for accelerated death benefits paid under a life insurance contract for chronically ill individuals, ensuring the same treatment is available for individuals confined to all qualified facilities and not just nursing homes.

There are other provisions in the bill which HIAA believes need substantive changes in order to accomplish the objective of encouraging the development of the private long-term care market.

Activities of Daily Living: The bill uses activities of daily living (ADLs) as a benefit trigger, requiring the policyholder to be certified as unable to perform at least 2 out of the listed ADLs. It includes mobility, dressing, transfer, eating, and effectively treats bathing, toileting and continence as one ADL. This does not reflect the "Katz scale" of ADLs which have become standard practice in the industry. We recommend that the bill include the six activities of daily living that are most prevalent in the market (and reflect Katz' research) -- eating, dressing, transferring, bathing, toileting, and continence. HIAA will be pleased to work with the Subcommittee to craft an appropriate benefit trigger.

Per Diem Policies: The bill should ensure that a level playing field is created among different types of long-term care policies, including expense-reimbursement contracts and per diem contracts (which pay a fixed amount upon the determination of benefit eligibility). Per diem contracts should be treated as complying with the requirements of the definition of qualified long-term care contracts with respect to providing other coverage and coordination with Medicare, if they meet the other definitional requirements. Further, premiums paid for per diem contracts should be eligible for the individual tax deduction.

Long-Term Care Premiums: The bill allows individuals to deduct as medical expenses under I.R.C. section 213 the amount of long-term care insurance premiums, up to a specified limit based on age. The tax treatment for long-term care premiums should be consistent with the treatment for accident and health premiums in that the deduction should not be limited in amount (beyond the medical expense deduction floor). Individuals living in high cost areas who want to purchase adequate coverage should not be penalized by losing the deduction for the premiums, especially since benefits in excess of $200 (indexed) will be taxable income to them.

There are additional provisions that HIAA believes could stimulate the private market and should be included in the bill.

Employer Deduction for Long-Term Care Premiums: The bill should specifically permit employers to deduct, as a business expense, contributions to long-term care plans by including a provision that long-term care insurance does not have the effect of deferring compensation. Employers may not currently deduct any item which would otherwise qualify as an ordinary and necessary business expense but which has the effect of deferring compensation. Employer deduction is critical because the employer market is an effective way to expand the long-term care insurance coverage to the non-elderly population. Long-term care insurance is more affordable when purchased at a younger age and allowing employers to deduct contributions will encourage employers to offer, and possibly contribute toward, long-term care group plans.

Cafeteria Plans: The bill should specifically permit long-term care insurance to be offered through a cafeteria plan, including a provision that long-term care insurance does not have the effect of deferring compensation. This would provide an incentive for employers to offer long-term care insurance plans as a part of their benefits package. Because employees typically purchase group long-term care insurance at a earlier age, the cost is much lower, thereby encouraging more private protection.

Parents: Many companies now permit covered employees to enroll their parents in their employee benefit plan. To help encourage this trend, HIAA recommends that, for the purposes of determining the tax treatment for long-term care insurance, parents be treated as dependents of the covered employee, when the premium is paid by the employee.

II. MEDICARE DUPLICATION

In the final hours of the 103rd Congress, certain "technical amendments" to the Omnibus Reconciliation Act of 1990 (OBRA '90) were adopted. H.R. 5252 deals with the sale of health insurance that duplicates Medicare, Medicaid or other coverage. It was an attempt to clarify confusion that resulted from provisions in OBRA '90. Representatives of the Health Care Financing Administration (HCFA) recently indicated at public meetings that H.R. 5252 could be interpreted as prohibiting the sale of long-term care policies that coordinate benefits with Medicare. Under such interpretation, it would be a criminal offense to sell a long-term care policy that coordinates with Medicare after October 31, 1994. On the other hand, the Senior Citizens' Equity Act requires long-term care policies to coordinate with Medicare to be qualified long-term care contracts for tax purposes. This presents an irreconcilable difference for companies selling long-term care insurance. Clearly Congress would not in one bill prohibit the sale of long-term care policies which coordinate with Medicare and in another bill require long-term care policies to coordinate with Medicare.

In a recent letter to the NAIC, Ways and Means Chairman Archer and Senate Finance Chairman Packwood identified two areas of further confusion regarding what constitutes duplication within the meaning of H.R. 5252. With respect to the sale of long-term care policies that coordinate benefits with Medicare benefits, the Chairmen noted that requiring policies to pay directly regardless of Medicare payments would exhaust the policy benefits sooner or make it more expensive. The Chairmen further stated that this was not their intent. If an administrative resolution is not achieved, the Chairmen indicated their intent to seek clarifying legislation.

We believe that HCFA's interpretation of the duplication rules in H.R. 5252 is incorrect and concur with the Chairmen that it conflicts with Congressional intent. HIAA has also written to HCFA to express our views and to request further consideration of this issue so that it could be resolved administratively. The Senior Citizens' Equity Act presents the Committee with the opportunity to add language to clarify that H.R. 5252 does not prohibit the sale of long-term care insurance policies that coordinate with Medicare.

III. CONSUMER PROTECTION STANDARDS

A. HIAA Consumer Protection Standards

HIAA and its members agree with policy makers and consumers that strong consumer protection laws and their full enforcement are critical to the development and growth of the private long-term care insurance market. HIAA believes that the cumulative effect of government regulation should be to create an environment where the benefits of regulation outweigh their costs to consumers, the private sector and government. Regulations should aid, not hinder, the development of the private insurance market. There are multiple provisions in the current NAIC Model Act and Regulation which HIAA firmly supports as appropriate consumer protection. These include:

* Requirement that individual policies be guaranteed renewable.
* Required offer of inflation protection.
* Prohibition against post-claims underwriting.
* Requirement that insurers establish auditable marketing standards, for fair and accurate comparisons of policies, notification of limitations of coverage, and notification of senior counseling programs if one exists in the state.
* Prohibition against prior-hospitalization requirements.
* Required 30 day free-look period with full refund of paid premiums upon return of policy within this period.
* Penalties on agents and insurers for violations of sales and marketing laws equal to three times the commission rate, or $10,000, whichever is greater.
* Required delivery of detailed outline of coverage.
* Required coverage of Alzheimer's Disease.
* Prohibition of preexisting condition exclusion period of longer than six months.
* Minimum standards for home care, including prohibitions against tying benefits for home care to the need for skilled nursing care, covering only services by registered or licensed practical nurses, or limiting coverage to services provided by Medicare-certified agencies or providers.
* Prohibition against conditioning eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care.
* Requirement that group policies provide for continuation and conversion.
* Loss ratio requirements at least equal to 60 percent for individual and group policies.
* Prohibition against twisting, high pressure sales tactics and cold lead advertising.
* Requirement that agent determine appropriateness of a recommended purchase prior to sale.
* Required delivery of buyers' guide prior to sale.

In addition, there are several provisions which HIAA supports which go beyond the current NAIC Long-Term Care Model Act and Regulation. They include:

* Require that insurers establish and implement long-term care education and training programs and materials for their marketing representatives and appropriate home office staff.
* Require that insurers establish procedures for monitoring the sales practices of their agents. Measures of agent conduct include lapse rates, replacement rates, rescission rates, and application denial rates. Such agent specific data shall not be required until it reaches a credible level.
* If states have continuing education requirements, require agents licensed as accident and health agents to earn long-term care insurance credits.
* Require policies to waive premiums while the insured is receiving nursing home benefits.
* Require insurers to establish and maintain a meaningful update protection program that offers policyholders information on new policy forms, improvements and coverage currently marketed by the insurer.
* Require insurers to base benefit eligibility criteria upon clinically-based empirical research in the area of disability and long-term care which accounts for the inability of the insured to perform an appropriate number of activities of daily living; or a similar level of disability due to cognitive impairment.
* Require insurers to provide a clear and thorough written definition of the benefit eligibility criteria at the point of sale.
* Require insurers to inform an applicant about coverage decisions within 60 days after receiving a completed application and all necessary supporting documentation requested by the insurer.
* Require insurers to establish a thorough claims process which will be explained clearly in written form at the time a claim is filed.
* Require insurance departments and the NAIC to develop and specify minimum standards for establishing long-term care reserves. In addition, the NAIC should, working with insurers, develop criteria for evaluating insurer reporting data.
* Require states to report the finally adjudicated violations of a state's long-term care insurance laws or regulations.

B. Relation to State Law

HIAA's support for federal long-term care insurance standards is conditioned upon adoption of a "federal option." A federal option would allow an insurer to sell a policy that meets the federal standards, approved by its state of domicile, in any state in which the company is licensed to do business. HIAA believes that separate state requirements would limit consumers' access to a wide range of long-term care insurance products by stifling competition in the market.

Such a policy would benefit consumers by increasing the number of carriers selling long-term care insurance products, by expanding the type and number of products available to consumers, by reducing the time lag between product filings and product availability in the market place, and by lowering the costs of products. Furthermore, this would increase competition among insurance companies on the basis of quality products, competitive prices, and service to their customers.

CONCLUSIONS

HIAA believes that our current long-term care financing system can best be enhanced by implementing three strategies. First, individual responsibility in planning for long-term care risk must be promoted. Second, the development of a strong private long-term care insurance market must be facilitated through tax incentives that increase the affordabilty of long-term care products and lend credibility to this market. Federal standards, in conjunction with tax clarification, can further increase consumer confidence in long-term care products and spur market growth. Third, for those who are unable to finance their own long-term care services, a program of public assistance must be provided.

HIAA applauds the sponsors of the Senior Citizens' Equity Act for recognizing the need to address long-term care insurance reform through the establishment of incentives for the development of the private long-term care market. Only through a strong commitment of cooperation between the public and private sectors in long-term care financing will we be able to address the long-term care needs of our aging population. Clearly the magnitude of the financing dilemma suggests the need for such cooperation to ensure access to long-term care services for all Americans. Though HIAA supports adoption of reasonable federal standards, tax clarification of private long-term care insurance is so important that it should not be delayed while the Committee considers appropriate long-term care standards. In the event that future legislative proposals deal with standards for long-term care insurance, HIAA would appreciate the opportunity to provide additional specific comments.

The Health Insurance Association of America would like to serve as a resource to Members of Congress and the Administration in refining proposals to improve our country's system for financing long-term care services. We stand ready to assist the Subcommittee in this process in the coming months.

Health Insurance Association of America

Bill Gradison
President

January 3, 1995

Bruce C. Vladeck, Ph.D.
Administrator
Health Care Financing Administration
Room 314G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Bruce:

We at the Health Insurance Association of America (HIAA) are very concerned about the effects that an adverse interpretation of Public Law 103-432, the Social Security Amendments of 1994, may have on the availability and affordability of long-term care insurance. The problem relates to the interpretation of § 171(d) of P.L. 103-432 that amends § 1882 (d)(3) of the Social Security Act. That section deals with the sale of health insurance that duplicates Medicare, Medicaid or other coverage.

The law, as amended in 1994, provides that health insurance policies that duplicate Medicare may be sold to persons on Medicare and Medicaid only if two conditions are met. First, the insurance application form must be accompanied by a prominent disclosure stating the extent to which the policy's benefits duplicate Medicare. Second, the policy must pay all its benefits in full without regard to other health coverage the person may have. We have learned that the Health Care Financing Administration (HCFA) is considering interpreting the latter requirement to mean that it is now not permissible for a long-term care insurance policy sold to a person on Medicare to contain language that makes it secondary payer to Medicare benefits or to exclude charges where benefits are payable under Medicare. It is this interpretation that has triggered a crisis for many long-term care insurers.

HIAA believes that coordination with Medicare is consistent with an emerging national policy that duplicative coverages should be discouraged. You are probably aware that most of the health care reform bills that have addressed long-term care – including the President's proposed Health Security Act – would require that private policies coordinate with Medicare. In addition, almost all the Congressional proposals that would clarify the tax treatment of long-term care insurance have consistently required coordination with Medicare. For those reasons, many leading long-term care insurers have changed their products to include provisions that coordinate policy benefits with Medicare.

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If under the HCFA interpretation, coordination of benefits with Medicare can no longer be employed, long-term care policies sold in the future will have to duplicate Medicare payments. Ironically, the section of the 1994 legislation that creates this problem is labeled "Preventing Duplication." Such an interpretation would result in the following adverse effects:

- The greatest damage done will be inflicted upon Medicare beneficiaries. Their long-term care insurance premium dollars will be spent on duplicative coverage when they could be better spent on extending their private benefits beyond the limited protection afforded by Medicare.
- If insurers whose policies currently coordinate against Medicare have to delete that feature and obtain approval of their revised policies in all 50 states, then there would be substantial expenses and market disruption associated with such a revision to both insurers and state insurance departments. This price tag will then have to be passed on to the consumers in the form of higher insurance premiums.
- Such an interpretation will also impair the Public-Private Partnerships for Long-Term Care that have been implemented in four states and which several other states are interested in establishing. These programs enable purchasers of long-term care insurance to protect some of their assets for the purpose of Medicaid eligibility. A fundamental principle of the Partnership programs is that asset protection should not be granted for policies that make duplicative payments.

All of this disruption can be avoided by an interpretation of this legislation that more clearly matches its legislative intent and legislative history. **Of paramount importance is to recognize that long-term care insurance policies with Medicare coordination provisions by definition do not duplicate Medicare. Therefore, they should be subject to neither the disclosure requirements nor the requirement to pay in addition to Medicare.**

HIAA believes that these adverse effects are not the objectives of this legislation. There is also further evidence in the legislative history of P.L. 103-432 that Congress did not intend to prohibit long-term care insurance from coordinating with Medicare. When the 1994 amendments reached the floor of the Senate, a colloquy took place between Chairman Moynihan of the Finance Committee and Senator Dodd of Connecticut. Chairman Moynihan assured Senator Dodd that the Senate Finance Committee did not intend to prevent coordination of benefits by long-term care insurance policies and expressed the hope that the administration's regulations, applicable to all long-term care insurance, would address coordination, "... in a way that encourages cost-effective long-term care coverage..." (Congressional Record, October 8, 1994, page S15025.)

Clearly, for Medicare beneficiaries, lower premiums and extended coverage that coordination makes possible are in the public's best interest. HIAA, therefore recommends that HCFA clarify that long-term care insurance policies

that coordinate against Medicare are not prohibited. An interpretation of § 1882(d)(3) that permits coordination is based upon two elements:

1. Certainly no duplication in benefit payment exists when an expense-incurred long-term care insurance coordinates with Medicare. A Medicare beneficiary would not be reimbursed twice for the same service, either from Medicare or from a private long-term care insurance policy. Since policies that explicitly make their payments secondary to Medicare do not duplicate payments made by Medicare, HCFA can conclude that the requirement that duplicative policies pay their benefits without regard to other coverage is not applicable to them.

2. With respect to long-term care insurance policies that have the potential to duplicate Medicare benefits, because their benefits are payable on an indemnity basis or otherwise do not specifically coordinate with Medicare, it is appropriate for HCFA to conclude that the law requires disclosure of this potential and require payment of its benefits in full without regard to other coverage to which the insured may be entitled.

In the longer term, it may be appropriate for Congress to enact further amendments to § 1882(d)(3) to clarify exactly how it wishes long-term care insurance to be treated. However, given the fact that it took the Congress four years to enact technical amendments to its 1990 revision of that section, it is imperative that the Department of Health and Human Services act now to avoid repeating the type of confusion in the long-term care insurance market place and disservice to Medicare beneficiaries that resulted when OBRA '90 misstated Congressional intent with regard to "duplicative" health insurance. The action recommended above would serve as an interim measure until Congress does more to clearly express its intent.

Thank you for your prompt attention to this matter. I appreciate the opportunity to provide you with HIAA's views on this important subject. If you have any questions or need further information, please feel free to contact Alan Richards at (202) 223-7785 or Susan Coronel at (202) 223-7873.

Sincerely,

Bill Gradison

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

December 19, 1994

Mr. Lee Douglass
President
National Association of Insurance Commissioners
Hall of the States
444 N. Capitol St. NW, Suite 309
Washington, D.C. 20201-1512

Dear Mr. Douglass:

The Congress recently enacted H.R. 5252, The Social Security Act Amendments of 1994 (P.L. 103-432). One of the provisions in these technical amendments attempts to clarify confusion that resulted from provisions in the Omnibus Reconciliation Act of 1990 (OBRA 1990) regarding the sale of health insurance policies to Medicare beneficiaries that duplicate benefits to which they are already entitled.

The intent of the OBRA 1990 Medigap provision was to prohibit the sale to Medicare beneficiaries of policies that overlap and coordinate benefits. The specific wording of the provision led to confusion as to whether the sale of any health insurance product to a Medicare beneficiary was prohibited.

To clarify the issue, P.L. 103-432 states that the sale of health insurance policies that duplicate Medicare or Medicaid benefits is not prohibited if (1) the benefits are fully payable directly to the insured without regard to other health benefit coverage, and (2) a statement disclosing the extent of duplication is displayed prominently on the written statement.

The legislation provides the opportunity for the NAIC to develop the disclosure statements, subject to approval by the Secretary of Health and Human Services. We understand that the NAIC has begun the process of developing these statements.

Unfortunately, our attempt to clarify this issue has resulted in further confusion as to what constitutes duplication. We would like to call your attention to two areas where we feel confusion still exists.

First, there continues to be confusion over the definition of duplication. The primary intent of the duplication provisions in P.L. 103-432 was to make sure that Medicare beneficiaries

understood the health insurance coverage they were purchasing and how it related to other coverage that they now have. The statements mandated in the legislation are expected to be straightforward, simple, and recommended only for policies where there is unquestionable duplication.

Secondly, the wording of P.L. 103-432 appears to make illegal the sale of any long term care policies that coordinate benefits with Medicare benefits. Many long term care policies coordinated benefits so that the beneficiary is covered for a longer period of time. Requiring these policies to pay directly regardless of Medicare payment would exhaust the policy sooner or make it more expensive. This was certainly not our intent.

We would like this problem to be addressed administratively, and will work with the Administration to this end. However, if this cannot be resolved satisfactorily, we would like to alert you to our intent to seek legislation as soon as possible during the next Congress to clarify this exception.

We appreciate your continued cooperation on these Medigap insurance provisions.

Sincerely,

Bob Packwood
Committee on Finance

Bill Archer
Committee on Ways and Means

Mrs. JOHNSON OF CONNECTICUT [presiding]. We appreciate your testimony.

Mr. Hagen.

STATEMENT OF RON HAGEN, VICE PRESIDENT FOR PRODUCT DEVELOPMENT AND GOVERNMENT RELATIONS, AMEX LIFE ASSURANCE CO., SAN RAFAEL, CALIF.

Mr. HAGEN. Thank you, Madam Chair. AMEX Life is the largest and oldest writer of long-term care insurance in the country. We insure over a quarter of a million individuals against the catastrophic risk of nursing home as well as home and community-based care expense.

By way of background and since Congressman Stark mentioned our name earlier on, I would like to indicate to you also that our latest generation of product is an expense-incurred reimbursement policy covering nursing home as well as assisted living and other alternate care facilities, as well as a full range of home and community-based care expenses up to the daily benefit amount purchased by the insured.

The product is, as we euphemistically term it, a care-managed or managed-care product that provides very strong incentives to look at individuals' needs and match those up to the appropriate range of home and community-based services. The typical policy sold by AMEX Life provides a daily benefit of $100 a day for unlimited nursing facility expenses and/or institutional expenses with a 100-day elimination period, which acts like a deductible.

In addition, most individuals under the age of 70 choose to purchase inflation—automatic inflation protection so that a daily benefit amount keeps pace with inflation. The price varies with the age of the insured at the time of purchase, but once bought is level, like a whole life insurance policy. Typically, a 50-year-old individual in the marketplace here would pay about $450 a year for such coverage, while a 65-year-old will pay approximately $1,250 a year. This latter amount is about what many seniors spend annually on Medicare supplement insurance policies, and I just wanted to make that clear since there was a variety of different types of average premium numbers thrown around today in one of the earlier panels.

In order for the private long-term care insurance market to reach its full potential, private industry must offer the public high-value products, government must clarify that these products are treated like health insurance policies for tax purposes, and there must be a joint educational effort to inform the public of Medicare and Medicaid's limited long-term care benefits, the likelihood of needing long-term care services, and their catastrophic costs.

I would specifically like to thank Congresswomen Nancy Johnson and Barbara Kennelly for their leadership in the fight to establish just such a public-private partnership and the Republican leadership for including the necessary tax clarifications in the Contract With America.

The provisions contained in the Senior Citizens' Equity Act, H.R. 8, do a number of critically important things. First, the bill clarifies that qualified long-term care insurance policies are treated like other accident and health policies. This means that benefits paid

under a policy are excluded from the gross income of the insured, and any portion of the premium paid by the employer is excluded from the employee's income and deductible by the employer.

Second, H.R. 8 clarifies that insurance companies can deduct their reserves for these polices, when, in fact, States require reserves to be established or set aside. All other lines of insurance are permitted to take a deduction at the same time that the reserves are set up and long-term care should be treated equitably in this regard.

Third, the Senior Citizens' Equity Act "grandfathers" existing policies. Virtually no existing policy meets the definition of the qualified long-term care policy contained in H.R. 8. Consequently, it is extremely important not to penalize those people who have taken personal responsibility for themselves and purchased quality long-term care insurance coverage which met or exceeded existing State standards when purchased instead of relying on government for assistance.

AMEX Life fully agrees with the recommendations of the Health Insurance Association of America and the Coalition for Long-Term Care Financing. Specifically, I would like to emphasize several of these. The Contract With America, like most, if not all, long-term care bills introduced during the last Congress, requires policies to coordinate with Medicare.

Unfortunately, the Health Care Financing Administration seemingly is interpretating legislation passed last year, H.R. 5252, to prohibit the sale of such policies. I don't believe that Congress intended last year's Social Security amendments to have this effect, and I urge the committee to include technical and conforming amendments stating that long-term care insurance policies that coordinate with Medicare do not duplicate Medicare and therefore would not be prohibited from sale.

In addition, I encourage the subcommittee to reexamine the activities of the daily living provisions used to determine if an individual is in fact chronically ill and eligible for benefits. No carrier that I know uses the particular set of the ADLs, activities of daily living, listed in H.R. 8.

The ADLs in the Senior Citizens' Equity Act would cause several problems. First, mobility is not, according to most experts, even considered to be an ADL and is actually part of most other ADLs as typically defined. For example, if an individual is unable to move, they would fail bathing because they could not go to and from the bathroom. Second, H.R. 8 combines what are almost always—and what most experts consider three distinct functions—toileting, continence, and bathing—into a single ADL. These are in fact separate and distinct functions and should be treated as such.

Finally, there are six ADLs in widespread use in the industry today. We would suggest that since most companies select five of these six and pay benefits when an individual is unable to perform two of them, that a company be allowed to select the five of six standard ADLs they wish to use.

Finally, I think this will enable the market to continue to develop and grant consumers the greatest range of choice possible.

I thank the subcommittee for holding this hearing and considering this important piece of legislation. I would be happy to answer any questions the subcommittee may have.

Thank you.

[The prepared statement follows:]

TESTIMONY OF RON HAGEN
AMEX LIFE ASSURANCE CO.

Thank you Mr. Chairman. I am Ron Hagen, Vice President for Product Development and Government Relations at AMEX Life Assurance Company, a subsidiary of American Express. AMEX Life is the largest and oldest writer of long-term care insurance in the country. We insure over one-quarter of a million individuals against the catastrophic risk of nursing home and home care expenses.

Our latest generation product is an expense reimbursement policy covering nursing and assisted living facilities and a full range of home and community based care expenses up to the daily benefit amount purchased by the insured. The home and community based care coverage is a managed care arrangement where AMEX Life pays the full cost of these services if you use one of our recommended case managers or consultants, or 80 percent for aides and other personal care services in the home (up to the daily benefit limit) if you do not.

The typical policy sold by AMEX Life provides a daily benefit of $100 per day for unlimited nursing facility expenses with a 100 day elimination period during which the individual pays his own expenses. (This acts like a deductible.) In addition, most individuals under the age of 70 choose to purchase inflation protection so that their daily benefit amount keeps pace with inflation. The price varies with the age of the insured at the time of purchase, but once bought is level, like a whole life policy. Typically, a 50 year-old will pay $350 per year while a 65 year-old will pay $1,200. The latter is about what seniors annually spend on Medicare supplement insurance policies.

The need for long-term care insurance is large and will grow tremendously over the next few decades as the baby boom ages. Neither the public sector nor private individuals has the resources to solve our long-term care financing problem; it is just too expensive. We need to form a public/private partnership in which the government helps those who are unable to provide for themselves, while encouraging those that can to save for their own needs, either through the purchase of a private insurance policy or through a variety of savings instruments.

In order for the private long-term care insurance market to reach its full potential, private industry must offer the public high value products, government must clarify that these products are treated like health insurance policies for tax purposes, and there must be a joint educational effort to inform the public of Medicare and Medicaid's limited long-term care benefits, the likelihood of needing long-term care services and their catastrophic costs.

I would like to thank Congresswomen Nancy Johnson and Barbara Kennelly for their leadership in the fight to establish just such a public/private partnership and the Republican Leadership for including the necessary tax clarification in the "Contract with America".

The provisions contained in the Senior Citizens' Equity Act, HR 8, do a number of critically important things. First, the bill clarifies that qualified long-term care insurance policies are treated like other accident and health policies. This means that benefits paid under a policy are excluded from the gross income of the insured, and any portion of the premium paid by an employer is excluded from an employee's income and deductible for the employer.

Second, HR 8 clarifies that insurance companies can deduct their reserves for these policies when the reserves are established. Currently, the National Association of Insurance Commissioners and the states require companies to establish reserves under a one-year, full preliminary term reserve method. The Internal Revenue Code, however, requires companies to use a two-year method. This timing mismatch prevents companies from taking a deduction until one year after the reserves are actually established. All other lines of insurance are permitted to take a deduction at the same time the reserves are set up.

Third, the Senior Citizens' Equity Act grandfathers existing policies. Virtually no existing policy meets the definition of a qualified long-term care insurance policy

contained in HR 8. Consequently, it is extremely important not to penalize those people who took responsibility for themselves and purchased quality LTC insurance coverage which met or exceeded existing state standards when purchased instead of relying on the government for assistance.

AMEX Life fully agrees with the recommendations of the Health Insurance Association of America and the Coalition for Long-Term Care Financing. Nevertheless, I would like to emphasize a few of them. The "Contract with America", like most, if not all, long-term care bills introduced during the last Congress, requires policies to coordinate with Medicare. Unfortunately, the Health Care Financing Administration is interpreting legislation passed last year to prohibit the sale of such policies. I do not believe that Congress intended last year's Social Security Amendments to have this effect, and I urge the Committee to include a technical and conforming amendment stating that long-term care insurance policies that coordinate with Medicare do not duplicate Medicare and, therefore, would not be prohibited from sale.

In addition, I encourage the Committee to reexamine the activities of daily living (ADLs) used to determine if an individual is chronically ill. No carrier that I know of uses the particular set of ADLs listed in HR 8. The ADLs in the Senior Citizens' Equity Act would cause several problems. First, "mobility" is not considered by experts even to be an ADL, and is actually a part of most of the other ADLs. For example, if an individual is unable to move, he would fail bathing because he could not go to and from the bathroom. Second, HR 8 combines what are almost always three distinct functions – toileting, continence and bathing – into a single ADL. These are in fact three separate functions and should be treated as such.

There are six ADLs in widespread use in the industry today: bathing, dressing, toileting, transferring, eating and continence. Most companies select 5 of these 6, and pay benefits when and individual is unable to perform 2 or more of them. There is, however, little agreement on which 5 to use. I suggest that the Committee amend this section to allow companies the flexibility to choose which 5 of the 6 listed above to use in their policies. This will enable the market to continue to develop, and grant consumers the greatest range of choice.

Finally, I would like to point out that while the $200 per day benefit limit would allow most Americans to fully insure against their long-term care risks, it does not meet everyone's needs. In many Northeast urban areas, it is not unusual to find skilled nursing facilities that cost $250 per day. Consequently, persons living in high-cost areas would be prohibited from fully insuring on a tax favored basis like those living in low-cost areas.

I thank the Committee for holding this hearing and for considering this important piece of legislation. I am happy to answer any questions the Committee may have.

Mrs. JOHNSON OF CONNECTICUT. Thank you very much, Mr. Hagen.

Mr. Chies.

STATEMENT OF STEVEN E. CHIES, PRESIDENT, NORTH CITIES HEALTH CARE, INC., COON RAPIDS, MINN., AND CHAIRMAN, LEGISLATIVE COMMITTEE, AMERICAN HEALTH CARE ASSOCIATION

Mr. CHIES. Thank you, Madam Chair, members of the subcommittee. My name is Steve Chies. I am president of North Cities Health Care, a provider of long-term care services. I also serve as the chairman of the legislative committee for the American Health Care Association.

AHCA represents more than 11,000 long-term care facilities caring for over 1 million elderly, frail, and disabled individuals. On behalf of AHCA's membership and the individuals we care for, we thank you for the opportunity to speak at this very important hearing.

AHCA has long supported private long-term care insurance as a means to increase the proportion of nursing facility residents not dependent on Medicaid as a primary payment source. For the past several years we have worked with the Coalition of Long-Term Care Insurers and Providers to promote appropriate Federal standards for long-term care insurance, for legislation that would clarify the Federal tax status of private long-term care insurance, and for other appropriate steps to begin to shift the cost of long-term care from Medicaid to private insurance sources.

We support the provisions of the Senior Citizens' Equity Act that would help Americans plan and prepare to meet the costs of long-term care. We look forward to working with the members of the committee to improve the legislation and to secure enactment.

Madam Chair, as you and the members of the committee are well aware, caring for the elderly is costly both to the elderly and their families along with the Federal and State government. We heard a lot of testimony on that today.

The demographics of the aging population will only compound this problem as we go forward, and clearly overall costs of providing long-term care services will increase at alarming rates. We know the Federal budget is in fiscal crisis, and I am not aware of many States that will be able to address future budgetary needs of the elderly.

Long-term care insurance is important both to the Federal and State governments as it offers citizens the opportunity to plan for their own future health care needs and not to depend on government programs like Medicaid for their long-term care needs. Making medical assistance available for the truly needy will expand benefits for all Americans.

According to the 1993 Gallup survey 79 percent of Americans agree that private long-term care insurance should play a more active role in paying for nursing home bills for most Americans. They have recognized that long-term care insurance should play a significant role in the protection of the elderly and their families from the catastrophic cost of a long-term illness.

Having long-term care insurance policies that provide the elderly and their families choices and options for the amount of services is what the American public wants. Most elderly do want to be cared for in their own homes or communities, yet financial resources at times drive the decision to a different direction.

Long-term care insurance can address that need, and I think the testimony of the previous panel, from Ms. Fosberg, is indicative of the options and choices that people have when they do have adequate long-term care insurance. While a long-term care insurance policy is available and being marketed, only a couple million policies have been sold.

We think this legislation that you have proposed will remove some of the barriers for purchasing long-term care insurance, including the need for tax clarification of long-term care insurance. We support and applaud your efforts with this legislation.

Unfortunately, there are other barriers to the development of a strong long-term care insurance market. They include a need for Federal standards for long-term care insurance policies and basic consumer protections. To allow for the addition of new public, private partnerships to purchase long-term care insurance similar to the demonstration projects you heard testimony from Connecticut, New York, Indiana, and California.

Consumer education on the need for health care insurance is very important. As a provider of health care insurance, I can tell you that many elderly believe that Medicare will pay for the full cost of a nursing home stay or they will pay for unlimited home care visits, and that is just not the case. Medicare has a very limited amount they will pay and the elderly do not understand that.

Finally, we need to clarify the law to assure the coordination of Medicaid benefits with long-term care insurance policies. Clearly it will take a number of years before we will see significant numbers of long-term care insurance policies that will actually pay for long-term care services and will offset the cost of Medicaid and the Medicare programs. This will take a number of years.

However, it is imperative that Congress does take action in the very near future. Because of the built-in delay of purchasing policies and the long timeframe before people actually need long-term care services, it could take anywhere from 10, 15, or even 20 years before we would see the value in the Federal and State budgets.

We would urge the passage of this act and hope Congress will continue to respond to the desires of the population and remove other barriers for planning for our future health care cost needs.

Thank you.

[The prepared statement follows:]

TESTIMONY OF STEVEN E. CHIES
AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman, Members of the Subcommittee, I am Steve Chies, President of North Cities Health Care, Inc., a provider of long term care. I also serve as Chairman of the Legislative Committee of the American Health Care Association (AHCA). The more than 11,000 long term care facilities that make up the AHCA care for more than one million elderly, frail, and/or disabled residents. On behalf of AHCA's members, and the residents of our member facilities, thank you for the opportunity to speak at this important hearing.

AHCA has long supported private long term care insurance as a means to increase the proportion of nursing facility residents not dependent on Medicaid. For the past several years, AHCA has worked as part of a coalition of long term care insurers and providers, the Coalition for Long Term Care Financing, to promote appropriate federal standards for long term care insurance, for legislation that would clarify the federal tax status of private long term care insurance, and for other appropriate steps to begin to shift the long term care cost burden from Medicaid to private insurance.

AHCA supports the provisions of the Senior Citizens' Equity Act that would help Americans plan and prepare to meet the costs of long term care. We look forward to working with the Members of this Subcommittee to improve the bill and to secure its enactment.

My testimony will emphasize AHCA's position that:

- the private sector must play a much more significant role in supporting long term care;
- private long term care insurance can be the cornerstone of strong private/public partnership; and
- legislation to clarify the federal tax treatment of long term care insurance -- and other legislative steps -- will help establish a significant role for private long term care insurance in financing long term care.

THE NEED FOR CHANGE IN LONG TERM CARE FINANCING

Our society, individually and collectively, has not made adequate provision for financing the costs of long term care. Individuals and families are not saving for, or insuring themselves against, the costs of long term care. The federal/state Medicaid program is stretched to the breaking point. Families and governments are going broke.

Without action to address these problems, our growing elderly population will come to rely much more heavily on Medicaid to pay for long term care. In 1993 Medicaid accounted for approximately 52 percent of all long term care payment -- and about 69 percent of all nursing facility residents -- in the United States. If current trends continue unchecked, Medicaid will be burdened with an ever increasing share of the nation's long term care costs as the baby boomers reach retirement. But these current trends cannot continue. Federal and state budgets -- already strained badly by current Medicaid long term care obligations -- cannot bear such costs. Nor would the elderly be well served by an overwhelmed Medicaid program.

February 1993 Gallup Organization survey results indicated that 76 percent of Americans agree that "government should pay the cost of nursing home care only for those who cannot afford it." In order to meet the nation's growing long term care needs without both emptying the public purse and sacrificing quality of care, our society cannot afford to rely solely on government. Instead we must encourage and enforce an expectation of personal responsibility on the part of those with the means to plan for and pay for potential long term care costs. Government can -- and must -- help in this effort by working to see that individuals have the information and resources needed to accept responsibility for meeting their own long term care needs.

LONG TERM CARE COSTS ARE IMPOVERISHING SENIOR CITIZENS

Most elderly Americans are unaware of the magnitude of long term care costs and of the limits of government assistance. Most Americans do not foresee needing long term care. Most probably do not realize how costly months or years of long term care can be. Many Americans wrongly assume that government programs or their general health insurance will cover the costs of any long term care services they might need. For all these reasons, individuals and families face long term care costs for which they have not planned and which they cannot afford.

The cost of long term care can quickly wipe out the assets even of those who have worked and saved for a lifetime. The cost of one year of nursing home care is more than triple the average annual income for an elderly American. But the nation's current long term care policy does not promote personal planning, saving, or the purchase of insurance against the financial risk of long term care costs. Nor does our nation provide comprehensive social insurance against the financial catastrophe of long term care costs. Only after a long term care recipient has been impoverished does government assistance become available through Medicaid -- a "welfare" program.

MEDICAID IS IMPOVERISHING THE FEDERAL AND STATE GOVERNMENTS

According to the Health Care Financing Administration (HCFA), total Medicaid payments (state and federal) have nearly doubled over recent years -- from $54.5 billion in FY 1989 to $101.7 billion in fiscal year 1993. The countless court battles over Medicaid reimbursement, and the protracted battle over "provider specific taxes" well illustrate the strain that Medicaid is putting on state and federal resources. This strain jeopardizes the availability and quality of both acute and long term care for those who must depend on Medicaid. Clearly, if current long term care needs have stretched federal and state budgets to their limits, the future needs of a burgeoning population of elderly will overwhelm our current arrangements for long term care financing. Therefore, the nation must look to sources other than government for additional resources to meet the future long term care needs.

We believe that long term care reform should have the following goals:

- providing appropriate access to the full continuum of long term care services;
- ensuring that all Americans have the means to meet the cost of long term care;
- moving individuals and families away from dependence on government welfare programs for long term care financing; and
- addressing the nation's long term care needs in a fiscally responsible way.

Fostering a robust long term care insurance market is key to meeting these long term care reform goals.

THE ROLE OF PRIVATE LONG TERM CARE INSURANCE

Results from a March 1993 Gallup Organization survey indicate that 79 percent of Americans agree that "to keep government costs as low as possible, private insurance should play a more active role in paying for nursing home bills for most Americans."

Private insurance, so useful in protecting individuals and families from the financial risk of acute illness, has great potential also for marshaling private sector resources to meet long term care costs. Insurance offers a very good means to preserve an individual's choice from among various long term care arrangements and competing providers. Its expanded use would make an appropriate private/public long term care partnership viable. It has great potential for lessening the long term care cost burden that the graying of America will otherwise put on the American taxpayer.

To date, private insurance accounts for less than two percent of all payments for long term care services. AHCA is confident, however, that with appropriate changes in federal policies private long term care insurance can and will take on a larger role in meeting long term care costs. AHCA is looking 15 to 20 years into the future to a time when private long term care insurance will represent 15% or more of payments for long term care services. In order to reach such a future, however, we must take steps now.

AHCA's members feel strongly that, with the right federal policies, private long term care insurance can become the centerpiece of a private/public long term care partnership that would help families, states, and the federal government meet the costs of long term care. Therefore, we strongly support the provisions of the Senior Citizens' Equity Act that would foster the development of the private long term care insurance market and increase private sector resources available to meet the costs of long term care. Specifically, AHCA supports the provisions of the Senior Citizens' Equity Act that would:

- make it clear that private long term care insurance enjoys the same federal tax treatment as accident and health insurance;
- clarify that benefits provided under long term care insurance are excluded from income;
- clarify that employer-provided long term care coverage is excluded from income;
- treat qualified long term care services as medical care;
- clarify that taxpayers can include long term care premiums in calculations of deductions for medical expenses;
- exclude from taxation IRA withdrawals used to pay long term care expenses or insurance premiums; and
- exclude from taxable income accelerated death benefits.

In addition, AHCA members believe that Congress must consider seriously tax incentives for the purchase of long term care insurance that are stronger than those already contained in the Senior Citizens' Equity Act. Demographic trends guarantee that the current level of public resources will fall far short of future long term care needs. Although the Congress may be reluctant to provide for tax expenditures greater than those currently before this subcommittee, short-run tax expenditures that build a long term care insurance market will pay great dividends in the long-run. Therefore, AHCA suggests that the Congress consider such measures as a targeted tax credit for the purchase of long term care insurance.

Furthermore, in order to improve the Senior Citizens' Equity Act, AHCA would like to suggest that the Subcommittee amend the legislation to address the following specific points:

- Federal standards and consumer protections for long term care insurance would help ensure that policies offer value to consumers and that policies would pay appropriately and adequately for quality long term care when needed. AHCA supports standards as written in the "Quality Care for Life Act" (S. 2205) as introduced in the 103d Congress by Senator Hatch.
- We urge the repeal of provisions of the Omnibus Budget Reconciliation Act (OBRA '93) that discourage states from establishing private/public long term care partnerships along the lines of those already in place in Connecticut, New York, Indiana, and California. The provisions in question undercut partnership incentives to purchase private long term care insurance through raising the level of asset protection under Medicaid.
- We hope the Congress will take steps this year to promote awareness on the part of senior citizens and their families of the potential costs of long term care, the limits of

current public long term care assistance, long term care insurance options, and of information necessary to be a smart long term care insurance consumer.

- We hope that you will be able to include in the Senior Citizens' Equity Act provisions to make clear that long term care insurance policies are not prohibited because of "Medicare duplication."

FEDERAL STANDARDS AND CONSUMER PROTECTIONS

Appropriate federal standards and consumer protections for long term care insurance would inspire consumer confidence; foster the growth of the private long term care insurance market; and ensure that elderly consumers are spared the problems that once plagued the "Medigap" insurance business. As long term care providers, AHCA's members do not benefit from private insurance policies that provide inadequate coverage. Nor do providers do not benefit from sales practices that lead individuals to purchase inappropriate policies or policies that they cannot afford to pay for. Accordingly, AHCA supports federal standards to ensure appropriate policy design and sales practices.

At the same time, providers cannot benefit from private insurance policies priced out of the reach of consumers by federal regulation that is too heavy-handed. Therefore, AHCA recommends that proposed federal standards be balanced by considerations of affordability. Congress needs to consider carefully the trade-off between the value of a policy feature and the cost to consumers of mandating that feature.

PRIVATE/PUBLIC PARTNERSHIPS FOR LONG TERM CARE

Working with the Robert Wood Johnson Foundation, Connecticut, New York, Indiana, and California have established private/public long term care partnerships that encourage the purchase of approved long term care insurance policies by offering purchasers enhanced asset protection under the Medicaid program. Generally, under such a partnership program, if a long term care insurance purchaser requires long term care and eventually exhausts his or her insurance benefits, the state will raise the Medicaid asset eligibility threshold by the amount of the long term care coverage purchased.

In a number of states -- including, I understand the Chairman's state -- there is considerable interest in establishing private/public partnerships along the lines of those already underway in Connecticut, New York, Indiana, and California. However, the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) included provisions [Section 13612 (a) (C)] that discourage states from implementing such partnerships. Specifically, these provisions require states to make recovery from the estates of those who had enjoyed enhanced Medicaid asset protection. That is, these provisions make a partnership's asset protection only temporary.

Many states are interested in encouraging residents to purchase private long term care insurance because they see an opportunity to slow the growth of their Medicaid spending by shifting a significant share of long term care costs to private insurance. We are now beginning to see evidence that this opportunity is real. Publishing in Health Affairs in the Fall of 1994, Marc Cohen, Nanda Kumar, and Stanley Wallack estimated that having a long term care insurance policy reduces the probability of spending down to Medicaid eligibility levels by some 39 percent. The authors estimate that, in the aggregate, Medicaid expenditures would be reduced by $7,945 to $15,519 for every nursing home entrant who had a long term care insurance policy. According to the analysis of Cohen, Kumar, and Wallack, this translates into cutting what Medicaid pays per nursing home entrant in half for long term care purchasers.

AHCA hopes that the Congress will remove the obstacle that Section 13612 (a) (C) of OBRA '93 presents to states that would like to pursue a private/public long term care partnership. Indeed, we hope that following the enactment of the long term care insurance provisions of the Senior Citizens' Equity Act, the Congress will give serious consideration to measures that will encourage all states to establish long term care partnerships.

LONG TERM CARE CONSUMER EDUCATION

A public opinion survey conducted for the Employee Benefit Research Institute in the summer of 1994 found that 45 percent of respondents believe that Medicare pays for long term care. This means that even after nearly 30 years of Medicare, many beneficiaries are in for a rude awakening should they need long term care coverage.

We hope the Congress will take steps this year to promote awareness on the part of senior citizens and their families of the potential costs of long term care, the limits of current public long term care assistance, long term care insurance options, and of information necessary to be a smart long term care insurance consumer. To this end AHCA suggests that the Ways and Means Committee might specify that Internal Revenue Service tax forms and reference material explicity address long term care insurance tax treatment once it is clarified. In addition, the federal government's Medicare and Social Security beneficiary information mailings could include long term care insurance consumer information. At the least, the use of Social Security and Medicare beneficiary information could provide the public service of correcting the widespread belief that Medicare covers long term care.

MEDICARE DUPLICATION

The long term care private/public partnerships underway in Connecticut, Indiana, New York, and California (and others under development in Maryland, Iowa, and Illinois) promote the sale of long term care insurance policies that "coordinate" with the Medicare program. That is, such insurance policies are designed to combine with Medicare coverage to pay benefits that cover the costs of long term care services, but not more than 100 percent of the cost of services. This coordination feature helps to keep the cost of the private insurance policies down and, hence, affordable to a greater number of purchasers.

Shortly before adjournment, the 103d Congress adopted a Medicare technical amendments bill, H.R. 5252. A provision of this legislation prohibits the sale to Medicare beneficiaries a health insurance policy that duplicates any benefits to which the beneficiary would be entitled under Medicare, Medicaid, or other private insurance unless:

1. the policy pays benefits without regard to other coverage and

2. the carrier discloses "the extent to which the policy duplicates" other coverage.

The practical effect of this provision is to outlaw the sale of long term care insurance policies that coordinate benefits with Medicare. The Health Care Financing Administration has put long term care insurers on notice that this is indeed their interpretation of the provisions in question. We believe, however, that this interpretation in inconsistent with Congressional intent. In any case, such an interpretation contradicts the Senior Citizens' Equity Act. Therefore, AHCA hopes that the Ways and Means Committee will amend the Senior Citizens' Equity Act to clarify that the sale of long term care insurance policies that coordinate with Medicare coverage is permitted.

CONCLUSION

Fiscal necessity and pragmatism clearly show that government cannot continue to bear an increasing financial burden of long term care. Private sector ways and means must be harnessed in partnership with public programs and resources. In order to form the required partnership, Congress should seek to maximize the role of private long term care insurance through:

- long term care insurance federal standards and consumer protections:
- tax clarification for long term care insurance products; and
- public education.

AHCA is pleased that the Congress is discussing long term care in the context of the "Contract with America" – and we are pleased to have been included in that conversation. We commend you for holding this hearing.

Thank you for your attention and your consideration.

Mrs. JOHNSON OF CONNECTICUT. Thank you very much for your testimony.

I agree that it will be some number of years before the purchase of long-term care policies will affect public costs, but it was only about 5 short years ago that we sat here talking about what managed care was accomplishing in the private sector in terms of cost reduction and had much testimony from companies saying if more people would do this, you would see. And more people are doing it and we are seeing.

So what is so important about this initiative is it is going to start the process that in the long run is going to be very fruitful, and it is one that both Barbara Kennelly and I and people from both sides of the aisle have worked hard to try to initiate for 3 or 4 years and so we consider it not only important, but long overdue.

There are two questions that I wanted to ask the panel and I regret I had to miss the preceding panel. First of all, is the ADL structure in our bill too rigid to serve the home care needs of our seniors? Are any policies offering home care outside of that structure? What thoughts would you have on that aspect of the long-term care policies?

Mr. GARNER. I can take that question. I believe that the language in the bill is too restrictive. If we look at the products that are available today in the marketplace, a more typical definition is one that just requires substantial assistance or supervision, and I think that is more typical of what we are seeing in the marketplace, and I also think it better fits consumers' ideas of what is a reasonable benefit trigger.

Mrs. JOHNSON OF CONNECTICUT. Thank you very much. Would you care to comment?

Mr. HAGEN. Yes, I would. I agree with Dick. We certainly see in the marketplace now language in contracts that would allow for supervisory or standby assistance and that is all that is necessary sometimes. It is very difficult to predetermine whether the person will actually need hands-on care every time they perform the function.

The other thing that is important to recognize, whether we are talking institutional or home care benefits, is that there needs to be separate pathways to benefits for people that are cognitively impaired, have Alzheimer's, senile dementia, things of that nature. A number of chronically ill individuals, as much as 15 to 20 percent, do not have any ADL limitations at all yet due to dementia need care.

I would also suggest again that there is a standard list of six ADLs, as I mentioned in our testimony, which we probably would be wise to go back and take a look at. Typically, "mobility" is defined as a part of defining those ADLs and traditionally we don't see that as a standard ADL.

Mrs. JOHNSON OF CONNECTICUT. One of my concerns is that government will define this too narrowly and the market will not be able to serve the growing needs of seniors. I have been through this with my own mother over the last 10 years, and the need is certainly much greater than the ADL need and if there are policies already out there, we don't want to restrict it.

That leads me to my next question. In my original legislation, there was a long section on standards. You heard from one of my colleagues on the other side of the aisle how concerned he would be with standards. That is why all that stuff was in there.

On the other hand, in the new environment, I would have to say I have a lot of concern about putting the standards language that parallels the NAIC standards in Federal statutes. Again, it will retard the flexibility and the development of the product.

Is there anything else we could turn to, any simpler index of standards or any governing language that would be preferable to delegating it to the NAIC? We are thinking about those kinds of things because there is such a serious problem with enormous detail in Federal law, setting standards for private sector products.

Mr. GARNER. Yes, the Health Insurance Association of America has looked very carefully at a set of standards and I have included some of those in my written testimony. In some places, those standards are more stringent than what the NAIC would require. In other areas, they do not impose certain minimum benefit standards on the individuals as the NAIC proposal has done. I would recommend that we look at the Health Insurance Association of America's consumer protection paper as an outline for standards.

Mr. HAGEN. I agree with that, Congresswoman Johnson. The Coalition for Long-Term Care Financing, which I cochair along with Stan Wallack, who testified earlier, also has a very similar package of standards that we would recommend looking at.

Again, as Dick said, some of which exceed the NAIC Act and Regulation, some of which really focuses much more on providing options and choices for people on things like nonforfeiture as opposed to mandating the benefit because we believe, and frankly the marketplace tells us this right now today, that people make reasonable choices when given those choices, and that mandating inflation or mandating nonforfeiture benefits for everyone may not be a rational choice, but that we have standards or guidelines that are in place to dictate, if you will, so as to assure that these benefits, should they be purchased, provide real value to the consumer.

Mrs. JOHNSON OF CONNECTICUT. Thank you. I would ask you to look back at your proposal. I talked to Mr. Wallack about this on my way to vote last time, and tried to cut them down, because if we have standards not all States are complying with them. I think probably the most important issue is making sure consumers understand clearly what they are getting, what they are told, and what would commonly be understood by the language is in fact what you get. So some aspects of the standards are more important.

Last, let me just ask you to enlarge briefly on the H.R. 5252 coordinating problem, if you would. I guess it was Mr. Hagen who spoke about that, or anyone who wants to.

Mr. HAGEN. Yes. We really do believe that the intent here—at least we hope the intent here in providing a technical correction under H.R. 5252 to this duplication or Medicare nonduplication issue was to not prohibit long-term care insurers from coordinating with Medicare as most carriers do on most of the products that are out there now.

Our reimbursement products do coordinate with Medicare. That is the most fail-safe way of making sure that there is no significant duplication and, for the most part, the duplication that exists between long-term care policies and Medicare is rather insignificant and at the margin.

The best way we found of doing that while making sure that the person who has a real need gets compensation for that need but doesn't get paid two or three times for that need is in fact to coordinate and require coordination in all cases and most of the bills that have been introduced into Congress—the standards bill, the tax bills—have all required coordination with Medicare as a way to make sure there is no duplication, and we think that makes a lot of sense, and we hope that that in fact was—believe that that in fact was the intent of the Congress.

Mrs. JOHNSON OF CONNECTICUT. Thank you. I believe that was the intent of Congress, too. And so I wanted to get clearly on the record that there is that problem and we will do our best to fix it.

Mr. Christensen, would you like to go on?

Mr. CHRISTENSEN. Sure.

I wanted to say to Mr. Garner, since my colleague, Mr. Stark, earlier gave you credit for stopping last year's health care proposal, I wanted to add my two cents and say thank you, too. I don't know if you should get full credit, but I do want to thank everybody for stopping what I thought was a bad bill and would have really caused this country to go in the wrong direction, and I do like what we are doing now, more private type of corrections, and I think that Madam Chairman is definitely leading the charge in the right direction.

I wanted to ask the question to Chies, Chies, Chies?

Mr. CHIES. Chies, that is correct.

Mr. CHRISTENSEN. What kind of long-term care business do you see down the road, 15 years from now? Thirty years? When do you see the private sector and if we can get this implemented and taken in effect? When do you see the real impact and the pluses for us moving to this more of a private way of doing business? If Mr. Hagen has a viewpoint on that, I would be open.

Mr. CHIES. If you start today by passing this legislation, you will not see the impact next year. Clearly, I would say you are looking at 15 years before you feel the full impact. At that point, hopefully, the funding sources for long-term care will be balanced out. Right now it is so skewed to either private resources or medical assistance, a more balanced approach to where a third and a third and a third perhaps in 15 years.

Mr. HAGEN. I really don't disagree with that. I think the important thing here is doing the kind of tax clarification that we are talking about. And putting the long-term care insurance market on a level playingfield with other types of accident and health insurance, we will give credibility and send a message to the people out there who have maybe been delaying the purchase of good, quality coverage that is available with the anticipation that the government may step into the breach if they don't believe that government already is there, that we will create some significant incentive to get back to the kinds of growth rates in the private marketplace that we saw before the most recent round of the health care

reform debate which I think added to some considerable extent to the confusion about whether government was going to pay for long-term care in the future.

We saw 45- and 50-percent growth rates over the period 1988 to 1992. Since then and since the debate went on for health care reform with the potential for home care being part of a government program, we saw those growth rates coming down to the 20- to 30-percent range.

There is no reason based on a good effort to educate the public about what is real and not real about what they can expect from the government on long-term care that we can't see growth rates in excess of 45 or 50 percent.

People need to understand what the choices are, and we need to make sure that there are good-quality products, and we need to make sure that they provide value, and we need to work in partnership with government, both State and Federal, to that end.

Mr. CHRISTENSEN. Do you think if we implement this with the effective day of January 1, 1996, is that going to give you enough leadtime to get your products on the market?

Mr. HAGEN. This is an excellent point. We are in the process of introducing a new portfolio of products and we anticipate, if the last time around is any guide, that that takes fully a year to achieve the necessary individual State approvals. In other words, if you have a January 1, 1996, effective date, we would have to start right now and we would have to know right now what those standards are. The ADLs we talked about before, for example.

We are going to be in a difficult position, each hopefully being on bended knee to the States and asking them to speed the process along. A number of States, a number of very large States take a considerable period of time in reviewing these policies and the rates that we charge for the policies.

Mr. CHRISTENSEN. And then to get your brokers and your agents also up to speed. That is where I come in and where I understand that there is a lag period there and it takes a while.

Mr. HAGEN. Right.

Mr. CHRISTENSEN. So your opinion is, it is probably going to be tough to get it done by then?

Mr. HAGEN. Yes, I think it will be.

Mr. CHRISTENSEN. Thank you, Madam Chairman.

Mrs. JOHNSON OF CONNECTICUT. Mr. Ensign will inquire.

Mr. ENSIGN. Thank you, Madam Chairman. I just want some general comments, anyone who chooses to respond. I recently visited a rehabilitation type hospital fairly new—I am from Las Vegas—fairly new to the Las Vegas area. Actually, the reason I was invited there—it wasn't by the company; it was one of my supporters in the campaign; her father was being treated at this as a day patient. He had been institutionalized. He suffered from a stroke and no place had been able to help him.

But being able to be home and then going as a day patient through all the rehabilitation is sort of a free market reform that is coming about through insurance. And I think that what Madam Chairman addressed about the flexibility that the marketplace can have is important and I too share the concerns that we will tie the hands too much by language that is too stringent.

Mr. GARNER. I would agree with that. Insurance companies today just aren't able to foresee all of the provider delivery mechanisms that will exist for long-term care over the next 15 or 20 years, and that is the time over which we will be paying the benefits on many of the policies that are being purchased today.

So I agree completely with you that we need to have some sort of flexibility in the language that we use to develop products that do qualify for favorable treatment.

Mr. HAGEN. I would just add to that that what we are all about here is providing meaningful catastrophic protection for people against the risk of long-term custodial or personal care services, whether that be in a home or institutional setting. And what we have seen is that nursing facilities are changing and they are not necessarily the only place where institutional services of that nature are being provided. We are looking at assisted living facilities and a broadening out of the definition of what an institution is that provides those types of services as well as a whole range of community care providers.

I think that gets back to the point we made earlier about the importance of the eligibility criteria for the benefit here. The ADLs, if you will, and cognitive impairment, as a separate pathway to benefits, because increasingly we are having difficulty with different States defining providers differently. We see a whole new range of providers coming on the horizon.

We want to cover the need here, which is for custodial or personal care services that can cost $50,000 or $60,000 a year, if it is institution based. But we also have to understand that we are not clairvoyant here. We are broadening our definitions and we are providing a continuum of services in these policies now that, frankly, didn't exist 4 or 5 years ago. And in many cases government doesn't even provide that range of services in the public programs or social insurance programs that we have.

But I say all that to get back to the point that it is very, very important, as we move toward a disability model in these products, that the ADLs and the eligibility criteria for the benefits are absolutely critical that we get it right.

Mr. CHIES. As a provider, I would agree with both the gentlemen. The only caveat I would give you is that you need to be careful about allowing the insurance companies to become too specific in their policies. We have situations where only the benefit can be used if it is in a licensed nursing home. There are other types of facilities out there. There are other opportunities for people, including assisted living day care, home care, et cetera. And I would be real concerned if we are only talking about nursing home coverage here.

Second, we can't predict the future. We can't predict what is going to happen 15 years from now. And as much flexibility as Congress can afford would be of assistance in selling the policies and then people purchasing the policies and actually using them.

Mr. ENSIGN. Thank you.

Mrs. JOHNSON OF CONNECTICUT. Thank you, very much. And your description, Mr. Hagen, of how the services are developing, and each of you during the course of your testimony, is a clear indi-

cation of how important it is that we not limit the growth of services in this area.

On the other hand, it is also true that the consumer information requirements cannot allow companies to use words like "licensed" that the public doesn't understand the implications of in terms of their restrictions.

So, recognizing those two problems, we have to be sure to write this correctly and we look forward to your continued input. Thank you. I thank this panel and call up the next panel.

Robert Shreve, chairman of the board of the American Association of Retired Persons; Max Richtman, executive vice president of the National Committee to Preserve Social Security and Medicare; and Jake Hansen, director of government affairs, The Seniors Coalition.

I thank this panel for being with us. You have long followed and been helpful in guiding policy for seniors in America and we welcome your testimony today. I will have to leave at about 27 after, so if we could move right into the statements, I would appreciate that. And I will have worthy colleagues who will succeed me in the chair.

We will start with Mr. Shreve.

STATEMENT OF ROBERT SHREVE, CHAIRMAN OF THE BOARD, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. SHREVE. Thank you, Madam Chair. My name is Robert Shreve. I am chairman of the board of directors of AARP. We appreciate this opportunity to present our views on long-term care tax treatment in the Contract With America.

We are pleased that the Contract includes provisions that attempt to address long-term care because this is an issue that strikes at the heart and the economic security of many millions of families across America.

Tax treatment of long-term care insurance should be clarified. New expansions of such tax incentives in isolation from broader reforms, however, raise some concerns. Unfortunately, most older persons would derive relatively little benefit from these tax preferences, including the close to one-half of older Americans with insufficient income to even owe taxes.

Before changes are enacted, it will be important to understand how much they would cost and who would benefit. Such tax breaks are not our priority for spending limited new dollars on long-term care. Of greater priority would be to help make home and community-based care more available to middle-class families in the form of grants to States.

Absent a new public program, the needs that cause financial chaos for many families will continue unabated. If the proposed tax clarifications are enacted, strong consumer protection standards, at least as strong as those developed by the NAIC, must be included as a condition for receiving favorable tax treatment. Federal dollars should not be used to encourage the purchase of policies that fail to provide meaningful coverage.

With regard to specific long-term care proposals in the Senior Citizens' Equity Act, the provision to treat qualified long-term care services as medical care could be the most significant for consum-

ers because it will help families deal with catastrophic out-of-pocket expenses and is not limited to those who purchase long-term care insurance.

Allowing employers to provide tax-free long-term care insurance and permitting exclusions for insurance benefits could promote the growth of the group market. And such incentives should be extended to include employees' parents. Under the proposal to allow tax-free exchanges of life insurance for long-term care policies, certain beneficiaries of life insurance, particularly spouses, should be required to consent.

And permitting tax-free distributions of IRA and 401(k) plans to purchase long-term care insurance would only help the higher-income individuals.

To improve the market for consumers, major limitations still must be addressed, particularly exclusions for preexisting conditions, lack of affordability, and poor coverage of home care.

For example, first, preexisting condition exclusions must be prohibited or minimized, as most agree must be done for medical insurance. Government reinsurance should be made available to companies that meet strong underwriting standards which reduce discrimination.

Second, incentives should be created for companies to offer several standard policies among others offered. Consumers could more easily compare benefits, price competition would increase, and premiums may be reduced.

Third, we should create strong national standards to stabilize premiums. While initial premiums are lower for younger purchasers, the key to affordability is affordability over time. Absent premium stability requirements, premiums may increase so much over 30 or 40 years that many could not afford to continue paying.

Fourth, companies should be encouraged to offer paid up policies so that after a period of time payments are no longer needed to receive full benefits as is often the case in the life insurance market.

Fifth, strong standards should be created for covering home and community-based care.

Let me close with a critical consideration for us about how tax breaks proposed here and elsewhere will be financed. AARP urges that the Medicare program not be singled out as a financing source. Medicare has been cut by nearly $200 billion since 1980. Beneficiaries are only starting to feel the impact of the 1993 reductions of $56 billion. Medicare cannot sustain the level of cuts required to pay for the lion's share of a balanced budget and other provisions in the Contract.

AARP stands ready and willing to work with this subcommittee to develop effective responses to the long-term care crisis whether the proposals are in the public or private sectors. Thank you.

[The prepared statement follows:]

TESTIMONY OF ROBERT SHREVE
AMERICAN ASSOCIATION OF RETIRED PERSONS

The American Association of Retired Persons (AARP) appreciates this opportunity to present its view on the provisions of the Contract with America relating to tax clarifications for long-term care included in the Senior Citizens' Equity Act. The Association has a deep, long-standing interest in long-term care and looks forward to working with the members of this Subcommittee to address not only this but other facets of this important issue. Not only has AARP been very active on the long-term care legislative and regulatory fronts, we also offer a long-term care insurance product as a service to our members through the Prudential Insurance company. We appreciate the fact that the Contract with America includes provisions that attempt to ease the substantial financial burden many families face when the need for long-term care arises.

THE NEED FOR LONG-TERM CARE REFORM

Critical to the economic security and peace of mind of America's families is protection and coverage for long-term care. For the millions of families with a loved one suffering from a chronic disability, the long-term care issue strikes at the core of their economic, physical and emotional well-being. While struggling with the trauma of doing everything in their power to avoid placing family members in an institution for the rest of their lives, Americans are faced with the daunting task of finding the resources and assistance to keep loved ones at home where they belong. Not only are the costs to families' budgets potentially enormous, but the emotional and physical toll on family caregivers -- typically women in their 50's -- is often debilitating. Caregivers continue to risk jobs, future pension and Social Security benefits, while placing their own health in serious jeopardy.

Long-term care is an intergenerational issue in which family members of all ages are vulnerable, particularly middle-class families. Approximately one-third of those who need home and community-based long-term care are under 65 years of age, whether they are children born with a disability or parents paralyzed in an accident. Surveys over the years have consistently shown very strong support for a program to address the problem among the young and old. For example, in a survey conducted last June, 94% of respondents agreed that it was important to include a new home and community-based coverage in a health care reform proposal.

Long-term care has also traditionally received strong bipartisan support in the Congress. Members of this Committee spoke out strongly last year favoring the inclusion of a long-term care benefit in health care reform legislation. And in the Senate Finance Committee, when Senator Pryor offered an amendment last July to include coverage for home and community-based long-term care, a majority of both Republicans and Democrats on the Committee voted in favor of the amendment.

Our nation's current long-term care system suffers from serious fragmentation, an institutional bias, and lack of decent coverage in both the public and private sectors. For the most part, our system requires families to deplete their life savings until they are bankrupt and eligible for Medicaid, a means-tested welfare program. With nursing home stays, on average, costing about $37,000 per year (much more in some geographic areas), and home health visits, on average, costing almost $85 per day (much more if complex services are needed), spending-down to impoverishment can happen quickly. A recent study reported in the Journal of the American Medical Association found that, of a sample of seriously ill adults discharged home from the hospital, loss of most or all of the family savings was reported by 31% of the families surveyed.[1] In addition, since very few states have good Medicaid home care programs, too many disabled persons are forced into institutional settings prematurely, ultimately costing the state and federal governments even more. As a nation, we cannot be proud of such a "non-system." Japan, Israel, Canada and most European nations have devised far more compassionate, rational approaches for their elderly and disabled citizens in need of long-term care. America can do better.

[1] Covinsky, K.E. et al, "The Impact of Serious Illness on Patients' Families," Journal of the American Medical Association, Vol. 272, No. 23 (pp. 1839-1844).

LONG-TERM CARE TAX CLARIFICATION

In general, AARP agrees that clarifications of how long-term care insurance should be treated under the tax code, such as treatment similar to accident and health insurance, are important. New expansions of such tax incentives in isolation from broader reforms, however, raise some concerns. Of particular concern is the fact that the majority of older persons would benefit little or not at all from these tax preferences. Indeed, close to one-half of older Americans have insufficient incomes to owe taxes and would receive no relief from these proposals. Distributional analyses and resolution of apparent discrepancies between Joint Tax Committee and Treasury Department revenue estimates on these provisions would be welcome. Such tax breaks are not the Association's highest priority for spending limited additional dollars on long-term care. Before these changes are enacted, it would be very useful to understand more clearly how much they would cost and who would benefit.

Of greater priority to the Association would be for the federal government to help make home and community-based care more available to middle class families. A program in the form of a grant to states in which they could participate at their option could be effective. Federal contributions could be capped so that no new entitlement would be created. With some criteria set by the federal government, the public sector would provide a foundation for support and the private sector would play an important supplemental role. This is not unlike our nation's income security program for older Americans, where Social Security provides the foundation, supplemented by private pensions and savings. While Social Security helps to provide some peace of mind for millions of retirees, it does not address their needs when a long-term disability strikes, nor does Medicare. If a public home and community-based program were put into place for severely disabled individuals of all ages and incomes, the proposed new tax incentives, if accompanied by consumer protection standards, would be an appropriate complement.

Absent a new public program, the chronic care needs that cause spenddown and financial chaos for many middle-class families will continue unabated. Medicaid generally is available only to those with low incomes and tax breaks and private insurance largely benefit only higher income persons. Of the over 3 million Americans with severe disabilities living in the community, approximately **one-half** have incomes between 100% and 400% of the federal poverty line ($9,500 to $38,000 for couples and $7,400 to $29,600 for singles). Something must be done to address their very serious needs.

THE NEED FOR CONSUMER PROTECTION STANDARDS

If a decision is made to move forward on the proposed tax incentives, we strongly urge that federal consumer protection standards be included as a condition for policies receiving favorable tax treatment. These standards should be at least as strong as those included in the most recent version of the Model Law and Regulation passed by the National Association of Insurance Commissioners (NAIC).

Unfortunately, despite recent improvements, the long-term care insurance market continues to be one in which the large print giveth and the small print taketh away. Too many consumers continue to spend significant sums of money on policies providing largely illusory benefits. Although states have had the option to adopt the standards drafted by the NAIC, constructed with great deliberation over the past eight years by expert state Insurance Commissioners, along with industry and consumer representatives, many have not yet adopted a number of the most important provisions in the models. Consensus among consumer and industry groups exists that we need nationwide, uniform standards for these products. Such standards would accrue to the benefit not only of consumers but to the many responsible companies offering decent policies who desire stability and are being placed at a disadvantage for lack of a level playing field vis-à-vis industry members offering substandard policies.

National standards are particularly important as a condition for granting favorable tax status. Federal tax expenditure dollars should not be used to encourage the purchase of

long-term care insurance policies that fail to provide meaningful coverage. Almost all of the legislative proposals on long-term care insurance tax incentives introduced over the years by members of both parties have included consumer protection standards. We understand that this subcommittee intends to examine appropriate standards for long-term care insurance policies in the near future and look forward to working with subcommittee members to construct strong standards for qualifying policies, based on the work already accomplished by the NAIC. In our view, the market improvements recommended below also should be tied directly to eligibility for proposed tax breaks. It will also be important to ensure that the proposed definition of "chronically ill individual" in the legislation does not leave out important populations needing long-term care.

LONG-TERM CARE PROPOSALS IN THE SENIOR CITIZENS' EQUITY ACT

Treatment of long-term care services and insurance premiums as medical care -- Section 303(a) of the Act would treat qualified long-term care services as medical care for purposes of the medical expense deduction allowed individuals under Section 213 of the Internal Revenue Code when such expenses are in excess of 7.5% of adjusted gross income. Because its benefits are not limited only to those who purchase a private long-term care insurance policy and because it will help families burdened with catastrophic out-of-pocket expenses, we believe this proposal could be the most significant for consumers under this Title of the Act. For some, the proposal could delay nursing home placement and spenddown to Medicaid eligibility. Treating long-term care insurance premium payments as medical care in the same way would have a much more limited impact.

Treatment of employer-provided long-term care insurance and long-term care insurance benefits -- The proposals under Section 302 to allow employers to provide employees with tax-free long-term care insurance and to permit exclusions for benefits provided under long-term care insurance, in theory, could help to promote the growth of the group market for younger purchasers. As we explain later in our testimony, such growth is one way to make long-term care insurance more affordable. Many employers, however, are already having difficulty funding health benefits for current workers and retirees and would likely be reluctant to take on new liabilities. Of the relatively small but growing number of companies that offer long-term care benefits to their employees (approximately 360 companies in 1992), virtually all only serve as sponsors and do not contribute to premium payments. To the extent that this proposed tax incentive might motivate some employers to consider making even a small contribution toward the premium, or help to get the issue on the collective bargaining table, this could be a positive step for future generations of retirees. To have a noticeable, immediate impact, however, such tax incentives would have to be extended to long-term care insurance for the parents of employees.

Exchanges of life insurance for long-term care insurance -- Section 304 would allow individuals to make tax-free exchanges of their life insurance policies for long-term care policies. The Association believes that certain beneficiaries of the life insurance policies -- spouses in particular -- should have their interests protected by requiring their consent to such an exchange. This would recognize both the economic partnership and the need to ensure a sound understanding by the spouse of the implications of an exchange decision.

Distributions from IRAs and 401(k) plans -- The Association has concerns with Section 305, which would permit tax-free distributions from IRAs and Section 401(k) plans to purchase long-term care insurance. In all likelihood, only a small percentage of better-off individuals would take advantage of this option, further limited to those who have qualified retirement plan funds. The proposal would create horizontal inequities in the tax code because benefits would vary with income.

LIMITATIONS OF PRIVATE LONG-TERM CARE INSURANCE AND RECOMMENDATIONS FOR IMPROVING THE MARKET FOR CONSUMERS

Even if strong federal standards to improve the quality of private long-term care insurance products were enacted, there still are three major limitations in the private market that need to be addressed for a private sector solution to be viable for the vast majority of middle income American families: (1) exclusions based on pre-existing conditions; (2) lack of affordability; and (3) poor coverage of home and community-based services. These problems can be traced largely to fundamental ground rules which govern all kinds of private insurance, namely: (1) insure only manageable risks; (2) avoid ambiguous risks; and (3) control induced demand.[2] These factors also explain why the Association believes that a public sector program, with private insurance playing a significant supplemental role, is the only solution that could address effectively the long-term care needs of **all** Americans, including the middle class and persons with disabilities. In addition, a public program would more efficiently distribute benefits, since it would not be subject to the types of marketing and administrative costs that can absorb up to 40% of private long-term care insurance premiums.

A fundamental problem with private long-term care insurance is that it discriminates against millions of Americans with pre-existing conditions. Private long-term care insurance companies only sell policies to healthy persons because of their desire to minimize the risk of someone using long-term care services. To illustrate our concern, we have attached a long-term care insurance application form which makes it clear in the "insurability profile" section that anyone at risk of needing long-term care should not apply. We do not mean to be critical of this particular product (the company offers one of the better policies on the market); similar forms are used by virtually every company selling long-term care insurance in order to weed out bad and ambiguous risks. By enrolling only healthy people, companies exclude millions of Americans who may now need or will soon need long-term care, including persons over 80 or 85 years of age. A recent study conducted for AARP by Coopers & Lybrand and William M. Mercer estimated that **approximately 23% of persons over age 65 are uninsurable and cannot purchase a long-term care insurance policy** for these reasons.[3]

In order for a private sector solution to be a serious option for those in need, pre-existing condition exclusions would have to be prohibited or minimized, as most members of Congress agree must be done for private medical insurance policies. The concern, of course, is that if companies are not able to underwrite their products, adverse selection will take place and premiums will escalate dramatically. There are at least two ways this could be addressed. First, efforts need to focus on expanding the **group market**. The larger the group, the more risk sharing among purchasers can take place. This is why Medicare, which has a very large risk pool, can accept older Americans regardless of pre-existing conditions, at a relatively low per-enrollee cost. Most long-term care insurance policies, however, are now sold on an individual basis. While risk pooling is relatively easier in this market for employer groups, in order to have much usefulness for those who currently purchase this insurance -- older retired persons -- creative ideas for developing risk pooling will be essential.

A second response to the problem of insurance exclusions based on pre-existing conditions is to examine how companies underwrite their products and develop standards to reduce these discriminatory practices. Incentives, such as the proposed tax breaks, should be created to significantly reduce exclusions by making government **reinsurance** available to companies that meet the standards or substantially improve their underwriting policies. Limiting some of the risk for companies selling these products has the potential for creating incentives for them to accept more ambiguous

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[2] Ball, Robert, Because We're All in This Together, Part 5 (1989).
[3] Munson, Bart et al, Affordability of Private Long-Term Care Insurance -- New Perspectives, July 1994 (Table 6).

risks than they have been willing to historically. Reinsurance might be financed, in part, by premium taxes, consistent with some current state practices.

Another fundamental problem with private long-term care insurance is that these products, if they provide meaningful protection, are simply too expensive for most older Americans. According to the aforementioned Coopers & Lybrand and William M. Mercer study, annual premiums for the average age purchaser (approximately 70 years), for a policy that provides good protection, are approximately $3,500, or almost $300 per month. Very few older Americans, most of whom are on fixed incomes, can afford these premiums. Roughly half of all elderly couples are living on less than $25,000 per year. The study found that **fewer than 10% of persons over age 65 can afford a good policy**, assuming they would be willing to spend up to 7% of their income and 25% of their annuitized assets on premiums. A Long-Term Care Insurance Personal Worksheet recently developed by the NAIC, for example, advises that it may not be a good idea to buy a long-term care insurance policy if the premiums will be more than 7% of prospective purchasers' incomes and if they have assets of less than $30,000 (excluding their home). Absent substantial government-sponsored premium subsidies, it is difficult to see how meaningful private insurance protection could be made affordable to most older Americans.

There are methods, however, to help make policies somewhat more affordable, in addition to the tax breaks discussed earlier. One important improvement, for example, would be to create an environment in which greater **price competition** existed for a limited number of standard policies. AARP has resisted the temptation to suggest moving the long-term care insurance industry in the same direction as Medicare Supplemental policies by mandating standard packages, because we do not want to stifle innovation in a relatively new market where some progressive companies are offering bold, innovative products to consumers. However, if incentives, such as the proposed tax breaks, were created for companies to offer, for example, four standard policies, without limiting their ability to offer other products, consumers could more easily compare benefits (an extremely complex task in the current market), companies would compete primarily on the basis of price, and this increased competition could reduce premiums.

Without question, the affordability issue could be addressed, in part, if younger adults could be persuaded to purchase private long-term care insurance. The younger the purchaser, the less expensive the product (even though good inflation protection is critical for younger purchasers and can increase premiums significantly). However, most younger adults have other pressing financial priorities, such as home mortgages and paying for education expenses. General denial about the probability of needing long-term care any time in the foreseeable future also has kept younger persons from purchasing such insurance. One response to this problem is public education. Another response, as discussed above, is to provide incentives for employers to offer this coverage to employees (and their parents).

While the **initial** premium for a long-term care insurance policy will be lower for younger purchasers, the key concern is affordability **over time**. Most policyholders probably will not need to use long-term care benefits until they are in their 70's or 80's. We are concerned that over the life of a 30-40 year old policy, the premiums may increase so much that many policyholders, by the time they reach age 75 or 80, could not afford to continue paying premiums. These policyholders would be forced to drop the policy after paying many thousands of dollars in premiums, but before benefits are actually needed or used. This is particularly the case with a large number of products in which premiums are designed to increase along with inflation protection. For younger purchasers, if a policy does not have inflation protection it will be almost worthless by the time they need long-term care. The primary issue, therefore, is **premium stability** (and providing incentives to offer level premium products that include inflation protection). Unlike typical medical insurance, most long-term care insurance policies pay a fixed indemnity amount and, therefore, cannot justify premium increases on the basis of the rising cost of care. Although there have not been

widespread premium increases in this market to date, this is a relatively young product (only a few companies sold long-term care insurance prior to the late 1980's) and most policyholders will not need benefits for 10 to 20 years after they have bought a policy. Therefore, we still do not know how many purchasers will ultimately use their insurance coverage (whether companies' actuaries accurately estimated utilization) and whether the policies are properly priced.

Unfortunately, accurately pricing long-term care insurance policies is not easy, particularly for younger purchasers. Even the most experienced actuaries have a difficult time. This is illustrated by a NAIC report in which the best actuaries in the industry attempted to price various policies. Alarming variation existed even for the base policy (without inflation or nonforfeiture protection), where price for the **same product** for a 40-year old purchaser **varied by over 300%** ($248 vs. $793). For an 85-year old purchaser, prices varied by over $3,500 ($7,506 vs. $11,035).[4]

Without question, if long-term care insurance is to be available in a meaningful way to younger purchasers, strong national standards on premium stability must be established. The NAIC recently passed standards to promote long-term care insurance premium stability. While the standards do not go as far as we would ideally like, they are the result of much deliberation and give and take on both sides and should be included as part of a broader set of national long-term care insurance standards.

To bolster the market for younger purchasers, incentives should also be created to encourage companies to develop and offer **paid-up policies**. Under such policies, after premiums have been paid for a certain period of time (e.g. 10, 20 or 30 years), no additional payments are needed to receive full benefits. These could, for example, be designed to be paid-up just prior to retirement. A few creative companies are just starting to offer paid-up policies.

Finally, private long-term care insurance needs to do a much better job **covering home and community-based care**. Like Medicare and Medicaid, private products suffer from a clear institutional bias. Unlike nursing home care, where no one wants to have to use these benefits, insurance companies are uncertain about future home care utilization and cost patterns and are concerned about the potential for induced demand. Thus, some companies limit home care coverage by requiring prior nursing home care, paying only a small fraction of the nursing home benefit, covering only medically necessary services, and/or excluding coverage for homemaker services. This can be addressed, in part, by developing stronger home care coverage standards for policies to meet, and by making the aforementioned reinsurance program available for companies willing to take on these more ambiguous risks.

FINANCING LONG-TERM CARE TAX CLARIFICATIONS

The Association has serious concerns about how tax breaks proposed here and elsewhere in the Contract with America will be financed. AARP urges that the Medicare program not be singled out as a financing source. Medicare has been cut substantially over the last several years -- by nearly $200 billion since 1980. Moreover, the program and its beneficiaries are only now beginning to feel the impact of the $56 billion in reductions recently made as part of OBRA' 93. Without question, Medicare could not sustain the level of cuts required to pay the lion's share of a balanced budget and for the other provisions in the Contract.

While it has been said that cuts in Medicare spending would simply be reductions in the program's rate of growth, increases of the magnitude needed to finance the Contract, including the Balanced Budget Amendment, would translate into real and substantial out-of-pocket costs for 36 million disabled and aged beneficiaries who depend on Medicare as their primary source of health insurance. Older Americans already have the highest out-

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[4] Final Report from the NAIC Long-Term Care Insurance Nonforfeiture Benefits Ad Hoc Actuarial Group, June 2, 1992 (p. 9).

of-pocket expenditures for health care than any other age group. Health care expenses already account for 23 percent of the average older person's household income as compared with 8 percent for the non-elderly. Cuts in Medicare of the magnitude required to pay for the provisions of the Contract would create a barrier to care for many beneficiaries, or would limit their choices of health plans, providers and coverage.

Deep cuts in Medicare are also fiscally short-sighted. Cutting Medicare means that costs will simply be shifted to businesses and individuals -- driving up the costs of private health insurance. For businesses, this added expense means that employers will scale back coverage, require workers to pay more or eliminate health insurance coverage for their workers all together.

By making deep cuts in Medicare as a way to pay for the Contract, Congress will be turning its back on the commitment it made to Americans: pay into the Medicare system during your working years and you will have protection against health care costs when you need it most.

CONCLUSION

AARP believes that a variety of methods exist to improve the market for private long-term care insurance. Tax incentives would make these policies more attractive to prospective purchasers, assuming favorable treatment is conditioned on meeting strong consumer protection standards as well as on key market reforms. The proposal to treat qualified long-term care services as medical care for purposes of the medical expense deduction may be of even greater importance to consumers.

Additional recommendations to improve the private market for consumers include: (1) extension of tax-free employer provided long-term care insurance to the parents of employees; (2) the availability of government reinsurance in exchange for accepting ambiguous risks and meeting certain underwriting standards; (3) strong standards on premium stability; (4) incentives for companies to offer a limited number of standardized benefit packages to promote price competition; (5) incentives for companies to develop paid-up policies; and (6) strong standards on home care coverage.

Unfortunately, all of these proposals would still fail to address the needs of most middle-income families in need of long-term care. The proposed tax incentives would favor higher income individuals. Exclusions on the basis of pre-existing conditions and problems of affordability and institutional bias persuade us that a public program, emphasizing home and community-based care and supplemented by private insurance, is the most logical way to solve our nation's long-term care crisis.

AARP stands willing to work with this subcommittee and other interested Members of Congress to develop effective responses to the long-term care crisis facing America, whether the proposals are primarily in the public or private sectors.

Chairman THOMAS [presiding]. Is it Mr. Richtman? I don't see your name up there, but I thought it was you. Go ahead.

STATEMENT OF MAX RICHTMAN, EXECUTIVE VICE PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. RICHTMAN. Thank you, Mr. Chairman.

I am Max Richtman, executive vice president of the National Committee to Preserve Social Security and Medicare. The national committee supports the tax incentives for long-term care private insurance included in the Contract With America.

The national committee agrees about the need to clarify these areas in the Tax Code. While we support a long-term care public program, especially for home and community-based long-term care, private insurance is an important part of the long-term care solution.

The number of people willing and able to purchase long-term care policies, while still relatively small, is likely to increase as the baby boom generation matures. By passing these tax incentives, the government would, in effect, be endorsing private long-term care insurance. This is a relatively low-cost initiative.

The national committee believes it is equally important to link these tax incentives with the kinds of standards proposed in H.R. 3651, by Congresswoman Johnson, in the last Congress and supported by you, Mr. Chairman. We believe a bipartisan consensus will exist—we hope it will—for standards for private long-term care insurance.

Currently, the Tax Code makes no reference to long-term care insurance. As long as health insurance is taxed favored, we believe long-term care insurance should be treated similarly. The need for long-term care most often is related to chronic illness and the financial risk is substantial. But the cost of policies is significant and the potential need uncertain and far into the future. Purchasing long-term care insurance requires foresight and planning. Individuals would have to buy even more insurance if benefits would be taxable. Taxing contributions or benefits would simply stack the deck against private long-term care insurance.

The Contract With America would provide an exclusion for employer-provided coverage. While some employers have arranged for group coverage, few employers contribute toward the cost. Employer contributions, we believe, would make a big difference in the affordability and availability of private long-term care insurance.

While it would be unreasonable to expect many employers in the near future to enter into a new commitment to pay for long-term care insurance, some employers undoubtedly would be willing to make it part of a flexible benefit plan. But if the tax laws are not changed and clarified, it is unlikely that employers will ever pay for long-term care insurance.

Employers whose employees are relatively young and healthy might even desire to provide this insurance. Premiums are much more affordable, as you know, for younger Americans, but younger Americans need more incentive to begin to plan for their long-term care. This incentive could be provided by employer-provided coverage.

Tax equity would require full deductibility we think for premiums, including long-term care insurance premiums. There is no reason that insurance paid by an employer should be tax free but premiums paid by individuals should be nondeductible.

Given the favorable experience with the 1990 Medigap reforms and concerns about poor quality of long-term care policies, the national committee hopes this subcommittee will also pass long-term care insurance standards. The NAIC, with the participation of the insurance industry, continues to work on standards which could be the basis for national standards. These standards should include inflation protection, nonforfeiture protection, State approval of premium increases, standardized language, a 6-month limit on the use of preexisting condition limits, and limitations on agents' sales practices. Without adequate standards, we think many people will end up with a false sense of security if they buy long-term care insurance.

In conclusion, the national committee strongly supports the initiative of the House Republicans in the area of senior benefits. These initiatives have been given a significant boost by the new majority. Long-term care tax incentives are an important beginning to what we hope will be an ongoing process in providing all Americans with greater access to quality, affordable health care. Thank you very much.

Chairman THOMAS. Thank you, Mr. Richtman.

[The prepared statement follows:]

TESTIMONY OF MAX RICHTMAN
NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

I am Max Richtman, Executive Vice President of the National Committee to Preserve Social Security and Medicare, a grassroots, education and advocacy organization representing millions of senior Americans. The National Committee supports the tax incentives for long-term care private insurance included in the Contract with America.

The National Committee agrees about the need to clarify these gray areas in the tax code. While the National Committee supports a long-term care public program, especially for home and community-based long-term care, private insurance is an important piece to the long-term care solution. The number of people willing and able to purchase long-term care policies, while still relatively small, is likely to increase as the baby boom generation matures. By passing these tax incentives, the government would in effect be "endorsing" private long-term care insurance. This is a relatively low cost initiative costing only $1.3 billion over five years.

The National Committee believes it is equally important to link these tax incentives with the kinds of standards proposed in H.R. 3651 by Congresswoman Nancy Johnson in the last Congress and supported by you, Mr. Chairman. We believe that a bipartisan consensus exists for standards for private long-term care insurance similar to the 1990 medigap insurance reforms.

Currently the tax code makes no reference to long-term care insurance. As long as health insurance is tax favored, so also should long-term care insurance. The need for long-term care most often is related to chronic illness and the financial risk is substantial. But the cost of policies is also significant and the potential need uncertain and far into the future. Purchasing long-term care insurance requires foresight and planning. Individuals would have to buy even more insurance if benefits would be taxable. Taxing contributions or benefits would stack the deck against private long-term care insurance.

The Contract with America would provide an exclusion for employer provided coverage. While some employers have arranged for group coverage, few employers contribute toward the cost. Employer contributions would make a big difference in the affordability and availability of private long-term care insurance. Considering the burden on employers for health insurance for current employees and retirees, it would be unreasonable to expect many employers in the near future to enter into a new commitment to pay for long-term care insurance. Some employers, however, undoubtedly would be willing to make it part of a flexible benefit plan. But if the tax laws are not changed, it is unlikely that employers will ever pay for long-term care insurance.

The exclusion of employer provided coverage is also key to encouraging younger Americans to purchase insurance. Employers whose employees are relatively young and healthy might even desire to provide this insurance. Premiums are much more affordable for younger Americans, but younger Americans need more incentive to begin to plan for their long-term care needs. This incentive could be provided by employers.

Another provision would allow premiums for long-term care insurance to be deductible under current law as a medical expense. Unfortunately medical expenses are only deductible to the extent that total medical expenses exceed 7.5 percent of Adjusted Gross Income (AGI). This provision will help seniors more than younger Americans. Long-term care premiums are higher for seniors who already tend to have higher medical expenses relative to their total income.

Tax equity, however, would require full deductibility for premiums, including long-term care insurance premiums. There is no reason that insurance paid by an employer should be tax free but premiums paid by individuals should be non-deductible.

Tax incentives for long-term care insurance and long-term care insurance standards were part of most major health care reform bills in the last Congress, including the Bipartisan Bill sponsored by former Congressman Roy Rowland and Congressman Michael Bilirakis and the Dole/Packwood bill in the Senate. It was not part of the Republican leadership bill in the House, however, which probably explains why it has not been included in the Contract with America even though standards are supported by most of the House Republican health care leaders.

Given the favorable experience with the 1990 medigap reforms and concerns about poor quality long-term care policies, the National Committee hopes that this Subcommittee will also pass long-term care insurance standards. The NAIC, with the participation of the insurance industry, continues to work on standards which could be the basis for national standards. These standards should include inflation protection , non-forfeiture protection, State approval of premium increases, standardized language, a six-month limit on the use of preexisting condition limits and limitations on agent sales practices. Without adequate standards, many will end up with a false sense of security if they buy long-term care insurance.

In conclusion, the National Committee strongly supports the initiative of House Republicans in the area of senior benefits. Initiatives, which languished in the previous Congresses, have been given a significant boost by the new majority. Long-term care tax incentives are an important beginning to what we hope will be an ongoing process in providing all Americans with greater access to quality, affordable health care.

Chairman THOMAS. Mr. Hansen.

STATEMENT OF JAKE HANSEN, DIRECTOR OF GOVERNMENT AFFAIRS, THE SENIORS COALITION

Mr. HANSEN. Thank you, Mr. Chairman. I represent the 1 million members of The Seniors Coalition. Our members believe that free individuals working together——

Chairman THOMAS. Excuse me, Mr. Hansen, would you take the mike.

Mr. HANSEN. I am sorry about that.

Our members believe that free individuals working together in free markets can find solutions to most of the problems facing older Americans. They believe there is already too much bureaucratic regulation and redtape in our society, and they believe we should turn to the Federal Government for help only if solutions cannot be found at the level of the State, the city or the county, the neighborhood, the family, or the individual.

The Seniors Coalition is pleased that Congress is addressing the problem of long-term care. Too many senior citizens are forced to spend down the accumulated resources of a lifetime because of serious illness that requires nursing home care. Among millions of older Americans, there is a constant fear that at any time they might lose most of what they own.

Because of changes in our country's population, the problem of paying for long-term care will probably get worse. The oldest segment of our population, those over age 85, will grow the fastest. It is estimated that by the year 2050 nearly a quarter of all people over 65 will be 85 years of age or older. By 1990, people age 65 or older face a 43-percent lifetime risk of entering a nursing home. About 1 in every 5 seniors face a nursing home stay of over 1 year and about 1 in 10 would be in a facility for 5 years or longer.

The cost of such care can be astronomical. The cost of care in a nursing home in 1992 was about $28,500 a year for unskilled care and about $32,000 a year for skilled care. Private insurance policies account for only 1 percent of long-term care. Medicaid paid the vast majority.

According to HCFA, under current law, Medicaid by the year 2025, will pay for two-thirds of all long-term care. Congress is now facing the tough choices that will be necessary to balance the budget, but if we do not make reforms in long-term care, those choices will be even tougher.

In recent years, there has been significant progress in the development of private insurance for long-term care. The public is beginning to understand the magnitude of the problem of paying for long-term care. People are beginning to realize the importance of taking steps now to alleviate hardship later in life.

In 1993, a poll by the Employee Benefit Research Institute showed that, by a ratio of 2 to 1, people expected to use private means to pay for long-term care rather than depending on the government. After survey participants were given more information about long-term care, nearly two-thirds said they would be interested in purchasing a long-term care policy directly from an insurance company or through an employer. So we see that while many of today's seniors are forced to bankrupt themselves to qualify for

Medicaid, most of tomorrow's seniors look for ways to avoid that indignity.

The question is, how do we build a system that makes private long-term care insurance attractive and affordable to consumers of all ages? The Seniors Coalition believes that the Senior Citizens' Equity Act in the Contract With America is a big step toward that goal.

Some say that changing the Tax Code is no way to provide long-term care to America's seniors, but I believe they are wrong for three reasons. First, last year's health care debate, as well as changes in the insurance industry, have heightened people's awareness of long-term care, its cost and its methods. They recognize that there are alternatives to a government-run system.

Second, they recognize that the government's programs don't always live up to their promise. Today's seniors want options that will let them provide for themselves and determine their own fates.

Third, the fact is, taxpayers change their habits in response to changes in the tax system. If long-term care insurance is affordable and accessible, people will take advantage of this opportunity. The opportunity is before us to dramatically change the way Americans view their long-term health care. Medical technology is extending the length and improving the quality of life in ways that no one imagined. We must build a system that places primary responsibility on individuals and families with the government stepping in only when absolutely necessary.

We believe long-term care provisions of the Contract With America will take us in the direction we need to go. The Seniors Coalition will assist you in any way possible to assure the passage of these provisions.

Chairman THOMAS. Thank you, Mr. Hansen, for your testimony.

[The prepared statement follows:]

THE SENIORS COALITION
11166 MAIN STREET, STE. 302 ♦ FAIRFAX, VA 22030 ♦ (703)591-0663

STATEMENT OF JAKE HANSEN
DIRECTOR OF GOVERNMENT AFFAIRS
THE SENIORS COALITION

PRESENTED TO THE
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

FRIDAY, JANUARY 20, 1995

Mr. Chairman, thank you for inviting me to address the committee on the Long Term Care Provisions that are part of the Contract With America.

I represent the one million members of The Seniors Coalition. Our members believe that free individuals, working together in free markets, can find solutions to most of the problems facing older Americans. They believe there is already too much bureaucratic regulation and red tape in our society. And they believe we should turn to the federal government for help only if solutions cannot be found at the level of the state, the city or county, the neighborhood, the family, or the individual.

The Seniors Coalition is pleased that Congress is addressing the problem of Long Term Care. Too many senior citizens are forced to "spend down" the accumulated resources of a lifetime because of a serious illness that requires nursing home care. Among millions of older Americans, there is a constant fear that, at any time, they might lose everything they own.

Because of changes in our country's population, the Long Term Care problem will probably get worse. Life expectancy has steadily increased in the United States, with almost all of the increase since 1970 being attributable to decreasing death rates for those over 65 years of age. According to U.S. Census Bureau figures, the oldest segment of the population, those over age 85, will grow the fastest. It is estimated that by the year 2050, nearly a quarter of all people over 65 will be 85 years of age or older.

By 1990, people age 65 or older faced a 43% lifetime risk of entering a nursing home. About one of every five seniors faced a nursing home stay over one year, and about one in ten would be in a facility for five years or longer. The cost of such care can be astronomical. The cost of care in a nursing home in 1992 was about $28,500 a year for unskilled care and about $32,000 a year for skilled care.

Private insurance policies account for only one percent of Long Term Care. Medicaid pays the vast majority. According to the Health Care Financing Administration, under current law Medicaid, by the year 2025, will pay for two-thirds of all Long Term Care.

Congress is now facing the tough choices that will be necessary to balance the budget. But if we do not make reforms in Long Term Care, those choices will be even tougher.

In recent years, there has been significant progress in the development of private insurance for Long Term Care. The public is beginning to understand the magnitude of the problem of paying for Long Term Care. People are beginning to realize the importance of taking steps now to alleviate hardship later on in life.

Consider the results of a 1993 poll by the Employee Benefit Research Institute. Asked how they expect to pay for Long Term Care, 18% of respondents said they expected to use personal savings; 42% said they expected to use private Long Term Care insurance; and only 28% expected the government to pay for it. In other words, by two to one, people expected to use private means to pay for Long Term Care rather than depending on the government. After participants in the survey were given some information about Long Term Care, about two-thirds said they would be interested in purchasing a Long Term Care policy directly from an insurance company or through an employer.

Thus, we see that, while many of today's seniors are forced to bankrupt themselves to qualify for Medicaid coverage, most of tomorrow's seniors look for ways to avoid that indignity.

The question is, how do we build a system that makes private long term health care insurance attractive and affordable to consumers of all ages?

The Seniors Coalition believes that the Senior Citizens Equity Act in the Contract with America is a big step toward that goal.

No longer should America's seniors be forced into bankruptcy to pay for health care services. Likewise, the federal government should not be expected to continue picking up the tab through Medicaid; most Americans are ready and willing to pay for private Long Term Care insurance. As the figures I quoted earlier aptly illustrate, with the aging trend we're facing, Long Term Care will bankrupt the government. The provisions in HR 8 provide the avenue for shared responsibility between the government, the consumer, and the insurance industry.

Promoting the private market will undoubtedly lead to reduced public financing of Long Term Care. Long Term Care insurance policies have expanded greatly over the past few years and now offer a wide variety of benefit options and more flexible eligibility criteria. As these reforms are passed, I believe we will see a dramatic growth in the employer-sponsored market. If we can make it possible and realistic for working-age people to provide for their long term health care needs now, we can eventually reduce public financing to a bare minimum.

To successfully shepherd this transition, Congress should be careful to set standards and guidelines to ensure consistency between Long Term Care policies. Now this does not mean that we should establish a government-run health care system. But it does mean that there are some inequities between competing plans and carriers that must be addressed to guarantee that consumers are given the best options from which to select a policy.

I would also suggest that Congress take this opportunity to evaluate the role of private Long Term Care insurance in overall Medicaid reforms. It is vital that regulations governing this system be uniform, that they provide adequate reimbursement to care providers. We also must end the bias toward institutionalized care. Not only have Medicaid and Medicare regulations pushed people toward institutionalized care, but the absence of market-driven private policies have made non-institutionalized care too expensive for the vast majority of people. These reforms will end the cycle that encourages the elderly to intentionally divest themselves to qualify for Medicaid coverage.

Some say that changing the tax code is no way to provide Long Term Care to America's seniors, but I believe they are wrong for three reasons.

First, last year's health care debate, as well as changes in the insurance industry, have heightened people's awareness of Long Term Care, its costs and its methods. Just as they

rejected the notion of a government run health care system, seniors are rejecting the notion that the only way to provide for their Long Term Care needs is through a government-run, taxpayer-financed bureaucracy.

Second, there is a growing realization among America's seniors that one federal program after another has, in the name of helping seniors, hurt them. Many of these programs have weakened the economy, raided the Treasury, sent taxes skyrocketing, created rivers of red tape and has taken away peoples' freedom and self-sufficiency. Today's seniors are dismayed that time and time again they are expected to quietly become wards of the welfare state in exchange for their contributions throughout their working years. Today's seniors want options that will let them provide for themselves and determine their own fates.

Third, the fact is that taxpayers change their habits in response to changes in the tax system. For example, if Congress imposes a hefty gas tax, people tend to vacation closer to home, thereby reducing the expected revenues from increasing the tax. If Long Term Care insurance is affordable and accessible, people will take advantage of this opportunity.

The Long Term Care problem is too big and too serious for the solution to come directly from a federal government that can't even balance its own books. Any proposed solution that relies mostly on the federal government is a dead end. The responsibility to finance Long Term Care must be a shared one. The vast majority of people can provide for themselves, and should be expected to. The federal government can help those who, through no fault of their own, cannot provide for themselves.

The opportunity is before us to dramatically change the way American's view their long term health care. Medical technology is extending the length and improving the quality of life in ways that no one imagined. Our nation's policy on Long Term Care will fail if it is based on outmoded and failed notions of centralized government control. Instead, we must build a system that places primary responsibility on individuals and families, with the government stepping in only when absolutely necessary.

We believe the Long Term Care provisions of the Contract With America will take us in the direction we need to go. The Seniors Coalition will assist you in any way possible to ensure the passage of these provisions.

Chairman THOMAS. If my colleagues will allow me, Mr. Richtman, your statement, I think is entirely accurate that the gentlewoman from Connecticut and I sponsored very similar legislation. We had some minimum standards in it.

In his opening statement, you may or may not have been here, but the ranking member of the committee has become much more prescient in recent days. He predicted the vote on this measure when we get to a markup on it, and I believe his prediction is going to be correct.

He also in some initial testimony ferreted out the standards of the National Association of Insurance Commissioners and pressed others to support them. So I am pleased to see that he has not only discovered prescience, but some new found wisdom in the National Association of Insurance Commissioners, which I hadn't heard him express in the past.

We will be looking at a number of options. This is just a particular piece of the Contract With America. There will be a number of other issues coming before us. My hope, of course, is that it amalgams into a larger reform package that will move forward. This will either stand alone or will be blended.

There are a number of issues that we will be looking at that hopefully will be pulled together in a way in which—that which was wise in the previous Congress will not only be carried forward but will become law in this Congress.

So we are very—I am sure the gentlewoman from Connecticut would tell you if she were here, we are cognizant of the legislation that we have sponsored in the past and we are anxious to continue forward in the direction that we enunciated, but as a minority we were unable to deliver on and which we hope we will be able to as a majority.

Mr. RICHTMAN. Mr. Chairman, in response to that, there is of course a lot of room for debate and different kinds of standards. And even in the bills that you sponsored, cosponsored, the Rowland-Bilirakis bill, as you know, the standards involved in that bill especially as to nonforfeiture, that was something companies had to offer, but were not required to offer.

Some of the other legislation sponsored by members of this subcommittee required that it be in the policy. So there is room there and we hope we can work with you in deciding the best course of action.

Chairman THOMAS. You certainly can work with us. And I anticipate working with the minority as we have in other areas where there is agreement. This is the only piece in front of us, so we are looking at it in more detail than we would if it were part of a larger package. It is needed. The final details will be worked out as we move forward.

Mr. Shreve, is it my understanding that AARP in terms of various services that it offers to seniors has a long-term care insurance component in terms of the panoply of products you offer?

Mr. SHREVE. Yes, sir, we have a number of years ago, began to offer long-term care insurance programs that are available to members of the association.

Chairman THOMAS. But how long ago, just ballpark?

Mr. SHREVE. Maybe 5 years ago.

Chairman THOMAS. A felt need of the members in terms of questionnaires or leadership thinking, this was an appropriate way to go?

Mr. SHREVE. In any effort to produce a new program, we have tried to determine what the members' needs are by sampling the membership.

Chairman THOMAS. And was this one of the areas that the membership said they wanted to go?

Mr. SHREVE. Yes, there was a need for that or a demand for that on the part of a number, a substantial number of members.

Chairman THOMAS. In terms of coverage—primarily nursing home? Home-based health care? Over the 5 years, have you shifted the policy in terms of emphasis?

Mr. SHREVE. We have made two or three changes. I think we are offering four different programs now that have different components so that people can determine themselves. We are also in favor of nonforfeiture and inflation protection in programs and we offer that to members that want them.

Chairman THOMAS. Now, in offering an expanded product in this area, has this, once again, been in response to the members desiring a different-looking product?

Mr. SHREVE. Exactly.

Chairman THOMAS. And my assumption is that there has been a growing demand for this product?

Mr. SHREVE. Yes, there has.

Chairman THOMAS. Have you done any projecting forward in terms of increased growth or can you give me some idea of the growth over the 5 years that the program has been in effect?

Mr. SHREVE. I think there are between—and I apologize that I didn't come prepared to answer that specifically, but we are——

Chairman THOMAS. And you certainly can for the record correct any answer that you give. I am not trying to put you on the spot.

Mr. SHREVE. I appreciate that. And we will provide you with the numbers.

[The following was subsequently received:]

Long-Term Care Insurance Sales—AARP/Prudential

1986	1,121
1987	29,244
1988	34,102
1989	5,985
1990	7,028
1991	9,731
1992	10,751
1993	7,935
1994	4,728
Total	110,625

These figures do not include the number of policies that have lapsed.

Off the top of my head, I am thinking in terms of 40,000 to 50,000 policyholders.

Chairman THOMAS. From obviously an initial offering which was some small thousands and then it has grown to that?

Mr. SHREVE. Yes.

Chairman THOMAS. And response back to you indicate, obviously because it is growing, that this seems to be something that they are satisfied with?

Mr. SHREVE. Yes, so far. Of course, there again you never know as an individual until you need to use the policy yourself. And there are people that have bought the policy and are, you know, keeping it in force. And if they need those benefits some day, they will be available to them.

Chairman THOMAS. And your magazine, which has stories, useful stories, helpful hints and other things, along with I don't want to say advertisements but boxes for choices that you can make in some of the offerings, I would be anxious—and I know you didn't come prepared for this, but I would be interested in knowing if you have run some articles focusing on long-term care in the last year or two and has there been any increased response from the educational arrangement of talking about the need for it and on the next page having a form that the seniors could fill out and send in for that insurance?

Mr. SHREVE. I think that—we will provide that information to you.

Chairman THOMAS. If, in fact, that has been done. My guess is that maybe would be something useful to look at in terms of growth.

Mr. SHREVE. We will provide that information to you.

Chairman THOMAS. Again, since it is new and novel and since the opportunity from a previous panel for a real full understanding of the number of people who would respond to a program being cut off by government policy of the former majority not allowing this to expand, I am looking for whatever models we can find to begin to get a feel on the growth of long-term care insurance coverage. And anything you can serve us from the thousands of folks that utilize your structure would be very much appreciated.

Mr. SHREVE. We will get it to you.

[The following was subsequently received:]

Bringing lifetimes of experience and leadership to serve all generations.

March 23, 1995

The Honorable William M. Thomas, Chairman
Subcommittee on Health
Committee on Ways and Means
1136 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

This letter is in response to your question to Robert Shreve, Chairman of AARP's Board of Directors, at the January 20 hearing before the Subcommittee on the subject of Long-Term Care Tax Clarification.

There are issues of our publications in which both educational articles on health or long-term care and advertising may appear. You raised an interesting question as to whether the inclusion of an article affects response to an ad in the same publication. But, since we do not coordinate publication of articles with advertising, we do not look for a correlation with response rates.

Enclosed are materials regarding the long-term care insurance policies that AARP makes available to our members through Prudential Insurance Company. Among the enclosures are:

- Advertisements printed in Modern Maturity or the AARP Bulletin;
- The reply card that appeared with the long-term care insurance ads;
- Informational articles appearing in the Bulletin or our Health Insurance News publication;
- Product information describing the current long-term care insurance plans; and
- A question and answer brochure included with the product descriptions.

I hope these materials are helpful. If you have any further questions or if we can be of any further assistance, please ask your staff to contact Howard Bedlin of our Federal Affairs staff at (202) 434-3781. I apologize for the delay in delivering these materials to you.

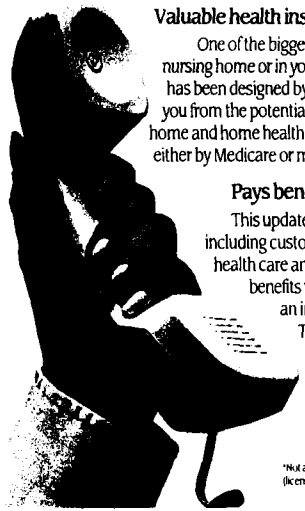
Sincerely,

Martin Corry, Director
Federal Affairs

Enclosures

cc: The Honorable Fortney "Pete" Stark

One quick call puts information about AARP's Long-Term Care Plan right in your hands.



Valuable health insurance coverage for long-term care.

One of the biggest worries about long-term care - either in a nursing home or in your home - is high costs. That's why this plan has been designed by AARP and The Prudential to help protect you from the potentially heavy expenses of long-term nursing home and home health care - expenses not likely to be covered either by Medicare or most private insurance policies.

Pays benefits for up to four years.

This updated plan will help pay for all levels of nursing home care, including custodial care for up to four years, as well as providing benefits for home health care and adult day care visits. And it's specially designed to help keep pace with inflation. Your benefits will increase by 5% *compounded* annually to help keep you covered when costs rise. Call now for an important information kit that includes details on plan benefits, costs, limitations and exclusions. This is a limited-time offer and is available in most states to AARP members aged 50-79 who meet certain eligibility requirements.* Your request must be received by **October 10, 1990.** (Ask for Operator 59.) **1-800-245-1212**

AARP Group Health Insurance Program

*Not available in Kansas. Group Policy Form No. GRP-79(71 A-101. The Prudential Insurance Company of America (licensed in all states), Fort Washington, PA 19034 NB224

The**Prudential**

AARP Bulletin
September, 1990
Job Number 0G5455021
1/2 page, 2 color
W.B. Doner and Company

Control

Lots Of Long-Term Care Insurance Plans Protect You Today. But What About Tomorrow.

The expense of long-term care can deplete a lifetime of savings. That's why AARP and The Prudential have worked together to develop AARP's Long-Term Care Plan. It's an insurance plan that helps protect you and your savings from nursing home, home health care, and adult day care expenses not likely to be covered by Medicare or your basic health insurance. Not just now, but in the future, too.

Unlike some other similar plans, AARP's Long-Term Care Plan helps protect you against inflation as well. Your benefits will increase by 5% *compounded* annually to help keep you covered when costs rise.

While not inexpensive, AARP's Long-Term Care Plan provides a range of benefits few other long-term care plans can match. And it's available to AARP members age 50-79 who meet certain eligibility requirements.

This is a limited-time offer and available in most states.* For more information on plan benefits, costs and limitations, call us no later than October 10, 1990.

(Ask for Operator 74.) 1-800-245-1212

AARP Group Health Insurance Program

*Not available in Kansas. Group Policy Form No. GRP-79171 A-101. The Prudential Insurance Company of America (licensed in all states). Fort Washington, PA 19034 NB228.

The**Prudential**

AARP Bulletin
September, 1990
Job Number 0G5455016
1/2 page, 2 color
W.B. Doner and Company

Test

Lots Of Long-Term Care Insurance Plans Protect You Today. But What About Tomorrow.

The expense of long-term care can deplete a lifetime of savings. And erase the careful plans you've made to ensure a comfortable retirement.

In response to members' requests, and to help you plan better for the future, AARP has worked with The Prudential to develop AARP's Long-Term Care Plan. It's an insurance plan that helps protect you and your savings from nursing home and home health care expenses not likely to be covered by Medicare or your basic health insurance.

Not just now. But in the future, too. Unlike some other long-term care plans, AARP's Long-Term Care Plan helps protect you against inflation as well. Your benefits will increase by 5% *compounded* annually to help keep you covered when costs rise.

While not inexpensive, AARP's Long-Term Care Plan provides a range of benefits few other plans can match. It helps cover all levels of nursing home care, including custodial care, as well as providing home health care benefits. And it's available to AARP members aged 50–79 who meet certain eligibility requirements. Perhaps most importantly, AARP's Long-Term Care Plan helps keep pace with inflation. AARP and The Prudential won't have it any other way.

For more information about AARP's Long-Term Care Plan, including plan benefits, costs and limitations, send in the attached card. This is a limited time offer and available in most states.* However, your request for information must be received by October 10, 1990. If you prefer, you can call toll-free Operator 31 1-800-245-1212

AARP Group Health Insurance Program

ThePrudential

*Not available in Kansas. Group Policy Form No. GRP-79171-A101. The Prudential Insurance Co. of America (licensed in all states). Fort Washington, PA 19034-3123

Long Term Care Insurance Covers Things You May Not Even Think Of As Long Term Care.

There's a lot more to long term care than nursing homes. Which is why our long term care insurance covers more than just nursing home care.

A long term care plan from the AARP Group Health Insurance Program, provided by The Prudential, can help cover the costs of recovering at home after an injury or illness. Or a visiting nurse or a qualified therapist if you need personalized care. And, of course, we can help cover the cost of nursing home care, which can exceed $30,000 a year*.

There is a waiting period before coverage takes effect. For complete information about our plans, including benefits, costs, eligibility, limitations and exclusions, just call us toll-free, or send in the attached card. We can also send you a free copy of AARP's *Before You Buy: A Guide to Long Term Care Insurance*.

Call today. Because there are some very good reasons to get long term care insurance — even if you never set foot in a nursing home.

NO ONE HAS MORE ANSWERS TO YOUR SUPPLEMENTAL HEALTH INSURANCE NEEDS. CALL US.

1-800-523-5800

OPERATOR # 16,

MON. - FRI. 9-5 ET.

Modern Maturity
July/August '94

AARP Group Health Insurance Program

ThePrudential

AS219 *American Hospital Association, "Economic Trends," Fall 1992, Vol. 8, No. 3, data through June 1992, based on a 3-year average. Group Policy Nos. G-36000-2-4-10. The Prudential Insurance Company of America (licensed in all states) Fort Washington, PA 19034. All plans may not be available in your state. AARP's Medicare Supplement Plans do not duplicate Medicare's benefits, and unless specifically stated, will only pay for benefits that are Medicare eligible expenses. All plans may not be available to persons eligible for Medicare by reason of disability. Not connected with or endorsed by the U.S. Government or the Federal Medicare Program. These Long Term Care plans are not available in California, Delaware, Kansas, Minnesota or New Hampshire, and are available only to AARP members age 50-79 who meet certain eligibility requirements. AARP's Hospital Advantage Plans are no-major medical plans, and are only available to AARP members age 50-64 who meet certain eligibility requirements.

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YOUR MONTHLY PAYMENT WILL BE LOWER IF YOU
APPLY FOR LONG TERM CARE INSURANCE NOW AND
ARE ACCEPTED BEFORE YOUR BIRTHDAY. CALL US
TODAY FOR COMPLETE DETAILS.
IF YOU WOULD LIKE THE FREE AARP BOOKLET,
CHECK HERE .

1) Please send me information on AARP's:
- ☐ Group Hospital Plans
- ☐ Medicare Supplement Plans
- ☐ Long Term Care Plans

2) AARP Membership number:

_____
(see mailing label for number)

3) My date of birth is: ____ / ____ / ____
Month Day Year

4) Name _____
(Mr., Miss, Mrs., Ms.) Please Print

Address _____

City _____

State _____ Zip _____

Phone(____) _____
Area Code

AARP Group Health Insurance Program

MS200

ThePrudential

Sample of card that goes with LTC ad in Modern Maturity

AARP offers care plan

Deadline for information requests Oct. 10

The Association's Nursing Home and Home Health Care Plan is now available for a limited time period in nearly every state. This plan is part of the AARP Group Health Insurance Program provided by the Prudential Insurance Co. of America.

The benefits of this plan are $50 per day in any state-licensed nursing home, with an option for a higher level of benefits; $35 per visit for physical therapy, occupational therapy and skilled nursing care received in the home; $30 per day for adult day care; and $25 per visit for personal care and home health-aide services.

Maximum allowable days of coverage are 1,095 days for nursing home stays and 730 visits for home health/adult day care visits.

Under the plan, benefits will increase 5 percent per year, beginning Jan. 1, 1991. As already indicated, plan participants will be offered a standard plan and an optional, higher benefit amount plan. The plan is "guaranteed renewable" to those insured under it.

The plan is open only to AARP members aged 50 through 79. There are certain other eligibility requirements, and thus members must complete a brief medical questionnaire. To receive benefits, the insured member must meet a 90-day deductible for nursing home stays and a 45-day deductible for home health/adult day care visits. Once in a nursing home for 90 days, the monthly premium is waived.

Premiums will be on a sliding scale based on age at purchase. The rates will be available in the information kit sent to those inquiring. Rates will not increase as an insured member ages. The only way the rates may increase is if they are changed for everyone in a member's class and state.

Although persons age 80 and over aren't eligible to enroll, those who are already in the plan may not be disenrolled on the basis of age, regardless of how old they are.

Requests for information must be received no later than Oct. 10, 1989. For information, call (800) 245-1212, Operator 94. The deadline for applications is Oct. 31.

1989 AARP Bulletin

AARP Forum

DO YOU KNOW WHAT YOU NEED TO KNOW ABOUT LONG-TERM CARE?

Many people don't find out until they – or loved ones – need care for a chronic illness.

QUIZ YOURSELF!

The Answers are on Page 8

1. Nursing home use is declining because todays elderly are healthier. ❑ True ❑ False
2. A 65-year-old man today has a one-in-three chance of spending time in a nursing home during his lifetime. ❑ True ❑ False
3. The number of workers who are responsible for the care of elderly relatives is expected to increase almost 10 percent in this decade. ❑ True ❑ False
4. More than one-third of those who need long-term care are under 65. ❑ True ❑ False
5. Generally, most people over 65 don't have to worry about long-term care expenses. Medicare pays most nursing home and home care costs. ❑ True ❑ False
6. Medicaid pays for home and community care as well as nursing homes. ❑ True ❑ False
7. The national long-term care system isn't perfect, but disabled people, who really need long-term care, can get it. ❑ True ❑ False

AARP Health Insurance News is a quarterly newsletter for AARP Members Insured by the AARP Group Health Insurance Program provided by The Prudential.

Address inquiries to the editors at:

AARP Health Insurance News,
P.O. Box 25601, Lehigh Valley, PA 18002-5601

Editors	AARP Editor	Graphic Design
Peter Boericke	Shirley Mercer	James B. Covelens, Jr.
Chris Joiner	AARP Group Health Insurance Program	Matthew Fine

ANSWERS: from page 3

1. **False.**
   The elderly may be getting healthier, but increasing numbers of people over 85 are driving up nursing home use. The nursing home population grew 24 percent in the 1980s, mostly among people over 85.* However, experts say this trend could change. Better home and community services could help healthier older Americans stay out of nursing homes.
2. **True.**
   One-third of men who became 65 in 1990 will need nursing home care during their lifetimes. Their wives have an even greater chance of entering a nursing home – more than one-half of women this age will need such care.**
3. **False.**
   The increase will be much higher, employers predict. In 1992, employers estimated that 20 percent of their workers were responsible for the care of elderly family members. They expected the percentage to double to 40 percent by 1997 as baby boomers' parents grow older.***
4. **True.**
   There are 3.5 million people under 65 who need long-term care. They include children and adults with severe mental retardation, cerebral palsy, multiple sclerosis, AIDS and other chronic diseases. Some were disabled in accidents causing head or spinal cord injuries.†
5. **False.**
   Most people don't realize that Medicare doesn't cover long-term care – just some short-term skilled nursing home and home care. Medicaid, the federal/state health program, does pay for long-term care. But it only pays when your income is low and most of your savings are used up.
6. **True.**
   But Medicaid is much more likely to pay for nursing home care. In 1990, Medicaid paid less than $5 billion for home and community care, compared with $24 billion for nursing homes.††
7. **False.**
   Almost a third of severely disabled persons who responded to a government survey said they did not receive any help at all.† ■

* 1990 United States Census
** United States Census Projections
*** "Families and Work Institute Surveys", Wall Street Journal.
† "A Call For Action," U.S. Bipartisan Commission on Comprehensive Health Care, (Pepper Commission), 1990.
†† Health Care Financing Administration

Published quarterly by The Prudential Insurance Company of America for members of the American Association of Retired Persons insured under the AARP Group Health Insurance Program. Address inquiries to AARP HEALTH INSURANCE NEWS, P.O. Box 25601, Lehigh Valley, PA 18002-5601

The AARP Group Health Insurance Program

HEALTH INSURANCE NEWS

ThePrudential

"Value, Service, Commitment"
1-800-523-5800

Summer 1992
Volume 9, No. 3

Fast Facts

- **PAYMENT OPTIONS:** Although your coupon payment book is set up for monthly payments, you may pay in advance for up to one year at a time. Simply send in one coupon and a check or money order for the total amount of any advance payments you are making. We will credit your AARP Group Health Insurance account.
- **FOR YOUR RECORDS I:** If you are using money orders to pay for your AARP Group Health Insurance coverage, be sure to keep the receipt portion for your records. Unlike personal checks, no record of payment is returned to you by the money order provider to indicate that your payment has been processed. It is a good practice to keep the receipt you receive at the time you purchase your money order.
- **FOR YOUR RECORDS II:** You have the legal right to obtain copies of anything you sign. If you are asked to sign any papers regarding medical treatment you are about to receive or regarding the manner in which your medical expenses will be handled, be sure to ask for a copy of the signed material. ■

AARP'S LONG TERM CARE PLANS: Important Benefits for All Levels of Care

The cost of long-term care (the care you need when you are unable to take care of yourself – due to either prolonged illness or disability) can be considerable. That's why choosing the right long-term care insurance plan is an important financial decision. An average year in a nursing home can cost $25,000.00 or more. And the cost of home health care (3 visits a week) averages $7,200.00 a year.*

AARP's Long Term Care Plans provide benefits not covered by most major medical plans, Medicare, or Medicare supplement plans, including AARP's Medicare Supplement Plans. They pay daily benefits for stays in a nursing home for up to four years. Benefits are also provided for visits from home health care professionals and visits to adult day care facilities. These are paid for a lifetime maximum of 730 visits.

These plans are designed to help AARP Members protect their savings, assets, and income from the high cost of extended long-term nursing home stays and home health care. Long-term care insurance is recommended for those who have substantial assets to protect ($30,000.00 excluding real estate) and who can afford to pay the premiums for a number of years.

Your age at the time you apply for a long-term care plan will affect the cost of your coverage. AARP's Long Term Care Plans allow you to obtain coverage at a rate based on your current age. For many AARP Members, this will help make your Long Term Care coverage more affordable. And your rate is guaranteed not to increase for at least five years. Only AARP Members ages 50 through 79 are eligible to apply for AARP's Long Term Care Plans. To keep rates as affordable for as many members as possible, there are certain eligibility requirements, including completion of a brief health questionnaire. Individuals who are eligible for Medicaid benefits should not apply for an AARP Long Term Care Plan.

...continued on page 3

AARP's Long Term Care *...continued from page 1*

Three Levels of Care

AARP's Long Term Care Plans offer benefits for all three levels of care:

Skilled nursing care is the highest level of treatment a nursing home resident can receive. It provides comprehensive, planned care, including rehabilitative or restorative therapy, medical or drug therapy, dietary supervision, and/or professional observation and judgement. These vital services are generally needed on a short term basis to enable a patient to recover initially from a serious accident or illness.

Intermediate nursing care is usually prescribed for patients who need medical attention on a 24-hour-a-day basis, but do not require constant skilled nursing care. Intermediate nursing care can be provided by a trained or certified aide or licensed professional.

"Long-term care is defined as the care you need when you are unable to take care of yourself—due to either prolonged illness or disability."

Custodial Care provides assistance in the activities of daily living, such as eating, bathing, and moving about. This type of care can be provided by an aide rather than a licensed professional.

For More Information . . .

If you'd like detailed information on plan benefits, limitations, exclusions, costs, and other terms of coverage for AARP's Long Term Care Plans, an information kit is available. **Just call toll free 1-800-245-1212 and ask for Operator 91.** ■

Plans available only to members ages 50-79 who meet certain eligibility requirements. All Plans may not be available in your state. Not available in Kansas. Group Policy Form G-36000-10. The Prudential Insurance Co. of America (licensed in all states). Ft. Washington, PA 19034.

*SOURCE: 1991 Consumer Guide to Long-Term Care Insurance, Health Insurance Association of America, February 1991.

6 TIPS FOR CHOOSING A GOOD LONG-TERM CARE INSURANCE POLICY

1. **Policy Provisions** – Make sure you know what the policy covers and what it doesn't. If you don't understand something, don't hesitate to contact the insurance company underwriting the coverage. Do not purchase any coverage unless you have a full understanding of the policy's benefits, provisions and limitations.
2. **Inflation Protection** – To help keep up with inflation, some policies increase your daily benefits by a certain percentage each year. Other plans may give you the opportunity to purchase increased daily benefit amounts after four or five years.
3. **Rate Guarantee** – Some long-term care policies guarantee that your rates will not increase for a certain number of years after your coverage becomes effective.
4. **Stability of Insurer** – Always check up on the financial health of the company underwriting the policy. Make sure you're confident that the company will be around when you need the benefits.
5. **Local Costs** – Before making a decision, check out the average cost for nursing homes, home health care and adult day care facilities in your area. Remember, inflation will increase the cost of care over time.
6. **Non-Forfeiture** – Some long-term care policies include a non-forfeiture feature. This feature guarantees that you will be covered to receive full benefit amounts, for covered visits and stays during a specified period of time, even if you cancel your coverage. This feature applies only if you have continuously paid the plan's premium for a pre-determined number of years. ■

AARP Group Health Insurance Program

Post Office Box 13999
Philadelphia, PA 19187

Underwritten by The Prudential

Dear Friend,

I am pleased you have requested the enclosed information on AARP's Long Term Care Insurance Plan. AARP has worked closely with The Prudential to develop this valuable insurance coverage. You must be a member of AARP to take advantage of this long term care protection and all the other membership benefits. The enclosed membership benefits sheet will tell you why I think AARP Membership is one of the best values in America today. Now, here's the information you requested.

The rising cost of long term care is a serious issue facing mature Americans. Currently, home health care can cost as much as $600.00 a month. For those who need nursing home care, the cost can be as high as $2,500.00 a month.* Medicare provides little coverage for these types of costs. The same is true of many major medical plans.

A New Plan with a Flexible Benefits Structure

One advantage of AARP's new Plan is that there are no preset limits on the total number of home health care visits, adult day care visits or nursing home days. This means that you can use your benefits for the covered service you need the most (up to the lifetime maximum) — whether it's strictly home health care and adult day care, solely nursing home care, or a combination of all three.

Up to $150,000.00 in Long Term Care Coverage

AARP's Long Term Care Plan (FO) provides a combined lifetime maximum of up to $150,000.00 to help pay for covered home health care visits, adult day care visits, nursing home stays and respite care.

The new Plan pays up to $50.00 to $70.00 per visit for home health care, up to $60.00 per visit for adult day care, and up to $100.00 a day for nursing home care. Daily and per visit benefits are paid up to the combined maximum dollar amount of $150,000.00.

There are many more reasons to apply for AARP's New Plan, including...

- **RESPITE CARE COVERAGE** ... The Plan provides benefits for covered short-term stays in a nursing home, or home health care or adult day care services. Benefits would be paid for actual costs up to $50.00 a day. Please see the enclosed brochure for more details about Respite Care Coverage.
- **EXTENDED PROTECTION** ... This valuable feature guarantees that you will receive continued coverage at FULL benefit amounts, for covered stays and visits during a specified time period, if you have to cancel your protection, for whatever reason. With Plan FO, as long as your coverage has been in effect for at least 10 continuous years, you will receive this Extended Protection. The lifetime maximum benefit of up to $150,000.00 still applies.
- **20% OFF MONTHLY RATES** ... Either you or your spouse (whoever is younger) will receive a 20% discount on monthly rates when both of you are covered under the Plan.
- **RATE GUARANTEE** ... Rates are guaranteed not to increase for at least 10 years for any reason under Plan FO.

- **INTERCHANGEABLE DEDUCTIBLES** ... Any covered Home Health Care or Adult Day Care visit that counts toward one of these treatment plan's deductibles may also be counted as a day in satisfying the nursing home deductible. Similarly, a covered Nursing Home Day that counts toward the nursing home deductible may be used to satisfy your Home Health Care or Adult Day Care deductible.
- **NO LENGTHY MEDICAL QUESTIONNAIRES** ... Unlike many similar policies on the market, this Plan has no lengthy medical questionnaires. AARP Members and their spouses age 50-79 who are in generally good health and are able to answer "no" to all the health statements on the Application will be accepted for coverage.

If you would like a Plan with the same broad spectrum of coverage as Plan FO, but with a lower monthly rate, apply for AARP's Optional Plan (FG). This Plan has a lower monthly rate because it does not offer Extended Protection. Complete details of AARP's Long Term Care Plan (FO) and Optional Plan (FG) are outlined in the enclosed brochure including the benefits, costs, limitations and exclusions. Please study it carefully.

How to Apply for This Valuable Coverage

To apply, you must first complete the enclosed Membership Acceptance Form. Then, complete all the appropriate areas on the enclosed Long Term Care Insurance Application. Return the Application along with your Membership Acceptance Form and payment in the envelope provided. **For the earliest Effective Date, your Application must be received and approved by the date at the top.**

I think you'll find this coverage to be among the very best values for your health insurance dollar. In fact, it's the only long term care insurance approved by AARP. Because of the high costs of home health care, adult day care and nursing home care, AARP believes the protection provided by AARP's Long Term Care Plan is very important. I hope you'll review this coverage in consideration of your future financial well-being.

Sincerely,

Allen M. Haight, CLU
Senior Vice President
Prudential/AARP Operations

P.S. The sooner your Form is received, the sooner it can be processed. Should you have any questions about this coverage, call toll-free 1-800-247-2335 weekdays from 9:00 a.m. to 5:00 p.m., Eastern Time. You can expect superior personal service from the Prudential Service Representatives.

* The 1991 Consumer Guide to Long Term Care Insurance, Health Insurance Association of America. The home health care figure is based on a national average of 3 visits per week. The nursing home figure is also based on a national average.

LA8240

AARP's Long Term Care Insurance Plan (FO)

Benefits Up to $150,000.00

Combined Lifetime Maximum Coverage For Home Health Care, Adult Day Care, Nursing Home and Respite Care Expenses.

This New Plan Features:

- No preset limit on the total **number of visits** for covered home health care and covered adult day care – benefits up to **$50.00 - $70.00 per visit.**
- No preset limit on the total **number of days** for covered nursing home stays – benefits up to **$100.00 per day**.
- **Respite Care benefits of up to $50.00 a day for 20 days per year.**
- 20% discount on monthly rates when both you and your spouse are accepted into the Plan.

PLUS:

- Extended Protection continues your coverage, for a specified period, should you have to cancel your Plan.
- Rates are guaranteed not to increase for at least 10 years for any reason.
- Opportunity to purchase increased daily and per visit benefit amounts at least once every 4 years.

AARP Group Health Insurance Program

ThePrudential

This New Plan is available exclusively to AARP Members and spouses.
See inside for details.
Please reply before the date on your Application.

The Benefits of the New AARP Long Term Care Plan (FO)

Home Health Care and Adult Day Care Visits

How much the Plan pays:

- **Actual charges up to $70.00** for each covered visit by a nurse (RN or LPN) or qualified therapist.
- **Actual charges up to $50.00** for each covered visit by a qualified home health aide.
- **Actual charges up to $60.00** for each covered adult day care visit.

Home Health Care and Adult Day Care Benefit Payments will begin with the 46th covered home health care or adult day care visit in any one benefit period. Any covered nursing home day that counts toward the nursing home deductible during a benefit period may also be counted as a visit towards satisfying the 45-visit home health care and adult day care deductible. (See **COVERAGE REQUIREMENTS** section of this brochure.) Benefits are paid for up to 7 visits per calendar week.

Nursing Home Care

How much the Plan pays:

- **Actual charges up to $100.00** for each covered day in a skilled nursing facility.
- **Actual charges up to $100.00** for each covered day in an intermediate care facility.
- **Actual charges up to $100.00** for each covered day in a custodial care facility.

Nursing Home Benefit Payments will begin with the 91st covered day of your confinement in an eligible nursing home in any one benefit period. Any covered home health care or adult day care visit that counts toward the home health care/adult day care deductible during a benefit period may also be counted as a day towards satisfying the 90-day nursing home deductible. (See **COVERAGE REQUIREMENTS** section of this brochure.)

Automatic Benefits Increase

The daily and per visit benefits stated above will increase 8% annually – with no corresponding rate increase to you – when you are in the same benefit period (receiving benefits for covered services or care) for one year. This increase will become effective one year after your home health care visits, adult day care visits or nursing home stay begins. When your benefit period ends, your benefit amounts return to the benefit amounts in effect before the increase(s).

PLAN OPTION: The New AARP Long Term Care Plan (FG)

If you would like a Plan with the same broad spectrum of coverage as the featured Plan FO, but without the Extended Protection feature, apply for the Optional AARP Long Term Care Plan, FG. Plan FG is also a new Plan and has the same **$150,000.00** combined lifetime maximum as Plan FO. The monthly rates of this Plan are lower than Plan FO.

The benefits for Optional Plan FG are as follows:

- **Actual charges up to $70.00** for each covered visit by a nurse (RN or LPN) or qualified therapist.
- **Actual charges up to $50.00** for each covered visit by a qualified home health aide.
- **Actual charges up to $60.00** for each covered visit to an adult day care facility.
- **Actual charges up to $100.00** per day for covered nursing home stays.

The rates for Plan FG are guaranteed for at least 5 years and are included in the MONTHLY INDIVIDUAL RATES chart. All other provisions, limitations and exclusions described in this Brochure apply to both the featured Plan FO and the Optional Plan FG.

Introducing the most flexible Plan in AARP's Long Term Care portfolio – with a lifetime maximum of up to $150,000.00 in benefits.

Up to $150,000.00 in Benefits

AARP's Long Term Care Plan can provide daily and per visit benefits up to **$150,000.00**. Benefits help pay for covered home health care visits, adult day care visits, nursing home stays and Respite Care. Plus, this new Plan also offers you several appealing advantages:

- ***Flexible Benefits***

  Many long term care plans have set limits for the total number of home health care and adult day care visits you will be paid for, as well as another set limit on the number of nursing home days you can receive.

  One advantage of the new AARP Plan is that there are no preset limits for the total number of home health care visits, adult day care visits or nursing home days. You can use part or all of your benefits for the covered service you need the most – whether it's strictly home health care and adult day care, solely nursing home care, or a combination of all three.

- ***Respite Care Benefits***

  Family members who provide care at home sometimes need to take time away from their care-giving responsibilities – due to business travel, family emergencies or just temporary relief. Respite Care benefits will provide benefits for covered short-term stays in a nursing home, or for home health care or adult day care services. **For example:**

  - A family member is providing care (at no cost) at home for a relative.
  - The family member needs to visit his or her grandchildren.
  - Respite Care would provide benefits for a home health aide to come in and help out until the family member returns.

  Informal care must be provided by an **informal caregiver** (a relative) in your home for at least six months beginning on or after the effective date of insurance. Services received under this Plan benefit are not subject to the deductible period. Respite Care benefits would be paid for actual costs up to $50.00 a day for covered services. The Plan provides respite coverage for up to 20 days per year and a lifetime maximum of 100 days. This benefit applies to both Plans FO and FG.

  Please note that the **Lifetime Maximum** under this Plan and the Group Policy for **Nursing Home Stays, Home Health Care Visits, Adult Day Care Visits,** and **Respite Care** combined is $150,000.00.

- ***You do not have a preset limit on the total number of visits for home health care and adult day care.***

  Unlike some other plans, the new AARP Long Term Care Plan does not limit you to a preset total number of visits for home health care and adult day care. Should you be able to recuperate at home from an illness or injury, you can use the Plan benefits to help pay for as many visits as you need – **up to the combined lifetime maximum of $150,000.00**. Your at-home care must be administered by a qualified nurse (RN or LPN), qualified therapist or qualified home health aide. Home health care and adult day care cannot exceed more than 7 visits per week. Benefits start after the deductible period.

  This new Plan will pay actual charges **up to $50.00 - $70.00 per visit** for covered home health care.

- ***You do not have a preset limit on the total number of days for nursing home stays.***

  Some Plans have a set limit on the number of days benefits are paid for nursing home stays. AARP's Plan does not limit you to a certain number of days for covered nursing home stays. If you need the special attention that only a nursing home can provide, the Plan will pay benefits for as long as you are confined – **up to the combined lifetime maximum of $150,000.00**. Nursing home care must be provided by an eligible facility. Benefits start after the deductible period.

  This new Plan will pay actual charges **up to $100.00 a day** for covered nursing home care.

HERE'S HOW EXTENDED PROTECTION WORKS

Continued Coverage at FULL Benefit Amounts If You Have To Cancel Plan FO

We're confident that, if accepted, you will be fully satisfied with the new AARP Long Term Care Plan (FO) and want to continue the coverage for as long as you can. However, should you have to cancel the Plan for whatever reason, FULL benefit amounts would still be payable for a specific period of time for covered home health care, adult day care, nursing home stays and respite care. The amount of time your coverage would continue is determined by your age at the time you are accepted into the Plan, as well as the length of time your premiums are paid. Under Plan FO, your coverage must be in effect for at least 10 continuous years to receive any Extended Protection. Further, you can not resume your payments once you have cancelled the Plan. At the end of the Extended Protection period, all benefits will cease.

The following are three examples of how Extended Protection works:

Age Accepted Into Plan FO	Age You Cancel Plan FO	Years of Coverage paid for	Years of Extended Protection After You Cancel Plan FO*
55	65	10	9 years, 5 months
55	70	15	8 years, 3 months
65	80	15	4 years

- **The lifetime maximum benefits of $150,000.00 still applies under Extended Protection. Extended Protection will not apply while your monthly payments have been waived under the Waiver of Premium Provision.**

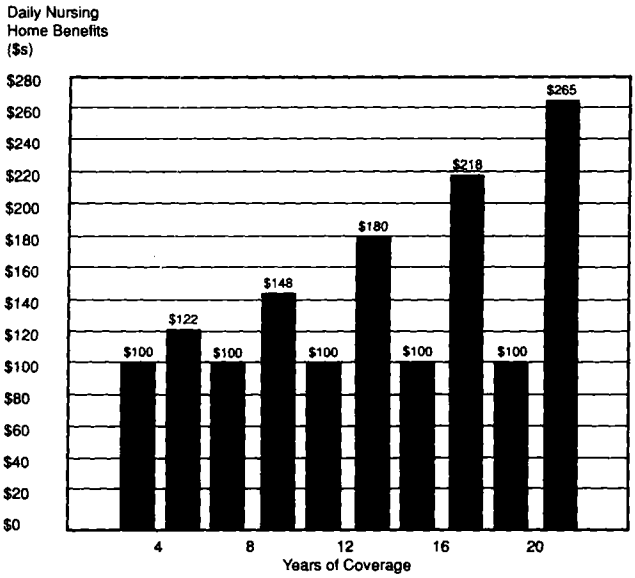
Save 20% on monthly rates

AARP's new Plan gives you and your spouse an outstanding opportunity to save money on your monthly rates. When you and your spouse are both accepted into the Plan, the younger person applying will receive a 20% discount on their monthly rate. This discount will remain in effect for as long as both you and your spouse are covered under the Plan. If one insured discontinues coverage, the continuing spouse would not receive a discounted monthly rate.

Further, rates for you and your spouse are guaranteed not to increase, for any reason, for at least 10 years under Plan FO. Plan FG rates are guaranteed for at least 5 years. Your effective date will be the first of the month following Prudential's receipt and approval of your Application.

Optional Inflation Protection

Under this Plan, you'll have the opportunity to purchase increased daily and per visit benefits at least once every four years. This feature was designed to help you prepare for the rising costs of home health care, adult day care, and nursing home stays. The chart below shows an example of how your benefits might increase over time if you purchase the optional inflation protection.



■ Benefits if you elect not to enroll in upgrade offers.

■ Benefits if you elect to enroll in ALL upgrade offers. (Based on 5% Compounded Annually)

NOTE: Actual Upgrade Increases May Vary

This Optional Inflation Protection will not be offered while your coverage is being continued under Extended Protection. Rates for the increased benefits are based on your age at the time you enroll for the increase.

ADDITIONAL PLAN FEATURES

20% DISCOUNT ON MONTHLY RATES

This feature allows you and your spouse to save money when both of you are accepted into the Plan. Upon acceptance, the younger person with this new coverage – either you or your spouse – will receive a 20% discount on monthly rates. It's an outstanding opportunity to lower the cost of long-term care insurance coverage. Discount rates will remain in effect only while both you and your spouse maintain coverage.

RATE GUARANTEE

You are guaranteed that the rates for Plan FO will not increase ... for any reason ... for at least 10 years. Plan FG rates are guaranteed for at least 5 years. After the guaranteed time periods, your rates can only change if changed for all members of the same class insured under this Plan who reside in your state. Additionally, all rate changes must first be approved by your Association.

WAIVER OF PREMIUM

If benefits for a nursing home stay have been payable for 90 nursing home days during a benefit period, The Prudential will waive your monthly payment for any month you receive benefits for the remainder of that benefit period.

CONTINUATION OF COVERAGE

You will not lose coverage unless you fail to make your payments when due or reach the Plan's maximum benefits, regardless of the number of claims you make (up to the maximum benefits). In the event that the Group Policy is terminated and not replaced by another insurance policy providing similar coverage and conditions within 31 days, Prudential will, at its option, provide you with a basis for either maintaining coverage under a group policy or conversion to an individual policy.

COVERAGE REQUIREMENTS

To be covered for Home Health Care, Adult Day Care, and/or Nursing Home Benefits, the visit or stay must meet the following requirements.

- A "Plan of Treatment" must be developed by your physician, must specify the type and frequency of treatment, and must be recertified within 60 days of the end of the deductible period and at least once every six months thereafter. A "Plan of Treatment" that includes home health care or adult day care must include a certification that you would require an inpatient stay in a nursing home if the home health care or adult day care were not provided. Or, it must certify that you are unable to perform, without direct human assistance, 2 or more of the Activities of Daily Living (bathing, dressing, toileting, transferring, and eating).
- You must receive services provided by an eligible Adult Day Care Facility or an eligible Home Health Care Agency or be confined in an eligible Nursing Home.
- You or your physician must notify The Prudential of your "Plan of Treatment" by phone or mail at least 7 days before the end of the deductible period.
- The home health care visit must be made by a nurse (RN or LPN), qualified therapist, or qualified home health aide provided by an eligible Home Health Care Agency, licensed referral agency, licensed nurse registry, or provided by an independent health care professional to you in your home on a visiting basis. A qualified home health aide visit must be of at least 2 hours duration. A qualified adult day care visit must be at least 3 hours in duration.

Respite Care for Nursing Home Stays, Home Health Care Visits, and **Adult Day Care Visits** are covered when:

- You have received informal care from an **Informal Caregiver** for at least six months beginning on or after the effective date of the Certificate. This benefit will not duplicate other benefits payable under the Plan.
- Respite Care benefits for nursing home care, home health care or adult day care are subject to the Coverage Requirements.

Note: A preceding hospital stay is not required for you to collect home health care, adult day care, or nursing home benefits. A preceding nursing home confinement is not necessary for you to collect home health care or adult day care benefits.

ELIGIBILITY FOR THE PLAN

Members age 50 through 79 who are able to answer "No" to each one of the Health Statements in Section B of the Application are eligible to apply for coverage under the AARP Long Term Care Plans. Spouses may also apply for protection, provided they meet the same requirements.

American Association of Retired Persons
601 E Street, N.W., Washington, DC 20049

Dear AARP Member,

I am pleased you have requested the enclosed information on AARP's Long Term Care Insurance Plan. Your Association has worked closely with The Prudential to develop this valuable insurance coverage.

A lot of people believe that Medicare, a major medical plan, or a Medicare Supplement Plan will cover the costs of home health care and adult day care, as well as extended nursing home care. The truth is Medicare and many types of private insurance provide little or no protection against these costs, which can easily reach as much as $600.00 a month for home health care ... and $2,500.00 a month for nursing home care.*

AARP's Long Term Care Plan (LL) offers many important benefits and features for AARP Members to help prevent the possible loss of savings, assets, and income to the potentially overwhelming expenses of long term care.

AARP's Long Term Care Insurance Plan (LL)

AARP's Long Term Care Plan (LL) was designed to provide a broad range of long term care benefits, including home health care, adult day care, and nursing home care. Of course, almost everyone would prefer to recuperate in the comfort and privacy of their own home as long as possible, so this Plan provides benefits for professional home health care services, as well as adult day care when you require care or assistance at home.

And when an extended nursing home stay is required, AARP's Long Term Care Plan provides valuable benefits for any level of nursing home care in any qualified state-licensed nursing home. **Plus, visits used toward satisfying the home health care and adult day care deductible can be used toward satisfying the 90-day nursing home deductible. And, nursing home deductible days can be used toward satisfying the 45-visit home health care and adult day care deductible.**

Plan Features That Make a Difference

If you are comparing AARP's Long Term Care Plan to any other policies, please consider the following features:

- **GUARANTEED BENEFIT INCREASE** ... The AARP Group Health Insurance Program guarantees to increase your AARP Long Term Care Plan benefits by 5%...compounded annually. There will be no corresponding rate increase as a result of this benefit increase, and it applies to home health care, adult day care and nursing home care benefits.
- **RATE GUARANTEE** ... Your affordable monthly rate is guaranteed not to increase for at least 5 years for any reason.

- NO LENGTHY MEDICAL QUESTIONNAIRES ... Unlike many similar policies on the market, this Plan has no lengthy medical questionnaires. AARP Members and Spouses age 50-79 who are in generally good health and are able to answer "no" to all of the health statements on the Application will be accepted for coverage.

Complete details of the Plans are outlined in the enclosed brochure including the benefits, costs, limitations and exclusions. Please study it carefully. Also, make note of Optional Plan LM, which offers higher benefits at a higher monthly rate.

How to Apply for This Valuable Coverage

To apply, complete all the appropriate areas on the enclosed Application and return it promptly with your first month's payment in the envelope provided. **For the earliest Effective Date, your Application must be received and approved by the date at the top of that form.**

Your Association understands that the high costs of home health care, adult day care, and nursing home care are of great concern to AARP Members. That's why the AARP Group Health Insurance Program developed this valuable coverage. Take advantage of this opportunity to apply for the only long term care insurance approved by your Association. Apply today – Give yourself the security of this important protection.

Sincerely,

Wayne F. Haefer
Director, Membership Division

P.S. Should you have any questions about this coverage, call toll-free 1-800-247-2335 weekdays from 9:00 a.m. to 5:00 p.m., Eastern Time. You can expect superior personal service from the Prudential Service Representatives.

* The 1991 Consumer Guide to Long Term Care Insurance, Health Insurance Association of America. The Home Health Care figure is based on 3 visits per week.

LA8237

AARP's Long Term Care Insurance Plan (Plan LL)

Helps Pay for Home Health Care, Adult Day Care, and Nursing Home Expenses Not Covered by Medicare and Private Insurance Plans.

- **$25.00 - $35.00 per visit** for Home Health Care and Adult Day Care – up to a lifetime maximum of 730 visits.
- **$50.00 per day** for Qualified Nursing Home Confinements – for up to a lifetime maximum of 4 years (1,460 days).
- **Pays for ALL LEVELS** of Nursing Home Care ... Skilled, Intermediate and Custodial.

PLUS These Additional Features

- **Rates are guaranteed** not to increase for at least 5 years for any reason.
- **Guaranteed Benefits Increase:** Per visit and daily benefits are compounded 5% annually – with no corresponding rate increase for this benefit increase.

Please reply before the date on your Application.

AARP Group Health Insurance Program

ThePrudential

The Benefits of the AARP Long Term Care Plan (Plan LL)

Home Health Care and Adult Day Care Visits

How much the Plan Pays the First Year of Coverage:

- **$35.00** for each covered visit by a nurse (RN or LPN) or qualified therapist.
- **$25.00** for each covered visit by a qualified home health aide.
- **$30.00** for each covered adult day care visit.

How Long Benefits Are Paid: Benefits are paid for up to 7 visits per week for a lifetime maximum of 730 visits.

Home Health Care and Adult Day Care Benefit Payments will begin with the 46th covered home health care or adult day care visit in any one benefit period. Any covered nursing home day that counts toward the nursing home deductible during a benefit period may also be counted as a visit toward the 45-visit home health care or adult day care deductible. (See **COVERAGE REQUIREMENTS** section of this brochure.)

Nursing Home Care

How much the Plan Pays the First Year of Coverage:

- **$50.00** for each covered day in a skilled nursing facility.
- **$50.00** for each covered day in an intermediate care facility.
- **$50.00** for each covered day in a custodial care facility.

How Long Benefits Are Paid: Benefits are paid up to 4 years for a lifetime maximum of 1,460 days.

Nursing Home Benefit Payments will begin with the 91st covered day of your confinement in an eligible nursing home in any one benefit period. Any covered home health care or adult day care visit that counts toward the home health care/adult day care deductible during a benefit period may also be counted as a day in satisfying the 90-day nursing home deductible. (See **COVERAGE REQUIREMENTS** section of this brochure.)

*The daily and per visit benefits stated above will increase 5% annually — with no corresponding rate increase to you. This **Guaranteed Benefits Increase** feature will begin one year from the effective date of this insurance.*

PLAN OPTION: AARP's Long Term Care Plan (LM)

If you would like a Plan with the same broad spectrum of coverage as the featured Plan LL, but at higher benefit amounts, you can apply for the Optional AARP Long Term Care Plan, LM. Plan LM pays benefits for the same number of visits and days as Plan LL and it includes the annual 5% Guaranteed Benefits Increase feature. The monthly rates of this Plan are higher than Plan LL.

The first year of coverage benefits for Optional Plan LM are as follows:

- **$50.00** for each covered visit by a nurse (RN or LPN) or qualified therapist.
- **$35.00** for each covered visit by a qualified home health aide.
- **$40.00** for each covered visit to an adult day care facility.
- **$75.00** per day for covered nursing home stays.

The rates for Plan LM are included in the MONTHLY INDIVIDUAL RATES chart. All other provisions, limitations and exclusions described in this Brochure apply to both the featured Plan LL and the Optional Plan LM.

Guaranteed Benefits Increase

Benefits Compounded Annually By 5% For As Long As Coverage Continues

To help offset the steady rise in home health care, adult day care, and nursing home costs, AARP's Long Term Care Plan (LL) contains a valuable feature that automatically increases all your benefits by 5% each year over the preceding year's benefits.

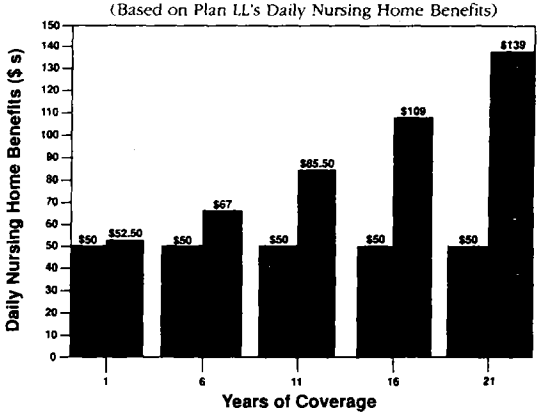
The graph to the right shows how the ***compounding*** *of benefits under Plan LL can result in significant increases over time.*

There is no corresponding increase in your monthly rate for this increase in benefits.

- **COMPOUNDED BENEFITS:** *5% increase over previous years' benefit.*
- **ORIGINAL BENEFIT:** *No inflation protection.*

A Plan for Now and for the Future

(Based on Plan LL's Daily Nursing Home Benefits)



Benefits will increase each year, beginning one year after the effective date of this insurance. Benefit increases will be paid for visits or days of stay that occur on or after the effective date of the increase.

Your Monthly Individual Age Rates (Guaranteed For Five Years)

The monthly rates for Plans LL and LM shown below are based on your individual age as of your insurance effective date. The rate for your spouse, if applying, is determined the same way. Your effective date will be the first of the month following Prudential's receipt and approval of your Application and first month's payment.

PLAN LL and PLAN LM

(Rates are for each person applying for coverage)

Age as of Effective Date	Monthly Rate*		Age as of Effective Date	Monthly Rate*		Age as of Effective Date	Monthly Rate*	
	Plan LL	Plan LM		Plan LL	Plan LM		Plan LL	Plan LM
50	$47	$71	60	$75	$113	70	$134	$201
51	$49	$74	61	$79	$119	71	$143	$215
52	$52	$78	62	$83	$125	72	$153	$230
53	$54	$81	63	$88	$132	73	$163	$245
54	$56	$84	64	$94	$141	74	$174	$261
55	$59	$89	65	$99	$149	75	$186	$279
56	$62	$93	66	$105	$158	76	$197	$296
57	$65	$98	67	$112	$168	77	$209	$314
58	$68	$102	68	$119	$179	78	$222	$333
59	$71	$107	69	$126	$189	79	$234	$351

* Rates for you and your spouse are guaranteed not to increase for at least 5 years for any reason.

Plan Features

Rate Guarantee

You are guaranteed that the rates for these Plans will not increase ... for any reason ... for at least 5 years. After 5 years, your rates can only change if changed for all members of the same class insured under this Plan who reside in your state. Additionally, all rate changes must be approved by AARP.

Benefits Are Paid Directly To You

These benefits will be paid to you regardless of any other insurance you may have. If you prefer, payments can be sent to your health care provider.

Waiver of Premium

If benefits for a nursing home stay had been payable for 90 nursing home days during a benefit period, The Prudential will waive your monthly payment for any month you receive benefits for the remainder of that benefit period.

Continuation Of Coverage

Unless you fail to make your payments when due or reach the Plan's lifetime maximum benefits, you will not lose coverage regardless of the number of claims you make (up to the lifetime maximum benefits). In the event that the Group Policy is terminated and not replaced by another insurance policy providing similar coverage and conditions within 31 days, Prudential, at its option, will provide you with a basis for either maintaining coverage under a group policy or conversion to an individual policy.

Coverage Requirements

To be covered for Home Health Care, Adult Day Care, and/or Nursing Home benefits, the visit or stay must meet the following requirements.

- A "Plan of Treatment" must be developed by your physician, must specify the type and frequency of treatment, and must be recertified at least once within 60 days of the deductible period, and at least once every six months thereafter. A "Plan of Treatment" that includes home health care or adult day care must include a certification that you would require an inpatient stay in a nursing home if the home health care or adult day care were not provided. Or, it must certify that you are unable to perform, without direct human assistance, 2 or more of the Activities of Daily Living (bathing, dressing, toileting, transferring, and eating).
- You must receive services provided by an eligible Adult Day Care Facility or an eligible Home Health Care Agency or be confined in an eligible Nursing Home.
- You or your physician must notify The Prudential of your "Plan of Treatment" by phone or mail at least 7 days before the end of the deductible period.
- The home health care visit must be made by a nurse (RN or LPN), qualified therapist, or qualified home health aide provided by an eligible Home Health Care Agency to you in your home on a visiting basis.
- A qualified home health aide visit or adult day care visit must be of at least 3 hours duration.

Note: A preceding hospital stay is not required for you to collect home health care, adult day care, or nursing home benefits. A preceding nursing home confinement is not necessary for you to collect home health care or adult day care benefits.

Eligibility For The Plan

Members age 50 through 79 who are able to answer "No" to each one of the Health Statements in Section B of the Application are eligible to apply for coverage under the AARP Long Term Care Plans. Spouses may also apply for protection, provided they meet the same requirements.

QUESTIONS & ANSWERS

Q. ***Who is eligible to apply for this new Plan?***

A. **AARP Members (and their spouses) age 50-79 residing in an eligible state** may apply for the new AARP Long Term Care Plan. However, in order to keep the monthly rate affordable for as many members as possible, only those who can answer "No" to each of the Health Statements on the Application form will be accepted under the Plan.

Q. ***Who should not consider the new AARP Long Term Care Plan?***

A. **Individuals who might qualify for state provided Medicaid or Medicaid-type benefits** do not need this Plan and should not apply. This is because the government will pay for most of the benefits provided by this Plan at little or no cost. In addition, individuals should base their ability to pay for the Plan on their projected retirement income. Because this Plan can help to protect your assets, participation in this Plan is recommended only for people with assets of $30,000.00 or more (excluding homes).

Under Federal Law, no new health insurance may be issued to you if it would duplicate any of your current health insurance benefits. To help prevent the possibility of members becoming over-insured, no member may be enrolled in more than one Plan of this type.

Q. ***If I ever do need long term care, it probably won't be for a long time. Why should I apply for this new coverage now?***

A. **Your monthly rates will be less expensive if you apply now,** because your monthly rate is determined by your age at the time your coverage becomes effective. This affordable monthly rate for Plan FO is guaranteed not to change for at least 10 years for any reason. Plan FG rates are guaranteed for at least 5 years. And your state of health at the time you apply will determine whether or not you are accepted. Only those who are in generally good health and can answer "No" to all of the Health Statements on the Application can be accepted. **If your health is good now, it makes sense to apply now.**

Q. ***What kind of coverage does this new Plan provide?***

A. AARP's Long Term Care Plan (FO) provides a total lifetime maximum benefit amount of up to **$150,000.00 in insurance coverage.** First, the Plan pays up to $50.00 to $70.00 for each covered **home visit by nurses, qualified therapists, and qualified home health aides.** Second, this Plan also pays up to $60.00 per visit for covered **care in an adult day care center.** Third, it pays up to $100.00 a day for covered **stays in a nursing home.**

Q. ***What makes this new coverage more flexible?***

A. The new AARP Long Term Care Plan does not have preset limits on the total number of home health care visits, adult day care visits or nursing home days. That means that **you can use part or all of your benefits for the covered service you need the most** – whether it's strictly home health care and adult day care, solely nursing home care, or a combination of all three.

Q. ***Will benefits be paid for a stay in any kind of nursing home?***

A. **Most state-licensed nursing facilities – including skilled nursing facilities, intermediate care facilities, and custodial care facilities – qualify under the Plan.** However, stays in nursing homes outside the United States, homes where there is no charge to you, or facilities that provide residential care or room and board accommodations only, are not covered. See the definitions and exclusions in the brochure for more details.

LL1113

Q. ***Is a nursing home confinement or preceding hospital stay necessary for home health care or adult day care benefits?***

A. **No.** Home health care or adult day care benefits are paid without a prior nursing home confinement or hospital stay. However, your doctor must certify that without home health care or adult day care, your condition would call for treatment in a nursing home. Or, your doctor must certify that you are unable to perform 2 or more Activities of Daily Living. See Coverage Requirements in the enclosed brochure for details.

Q. ***Is a hospital stay required before nursing home benefits are payable?***

A. **No.** A preceding hospital stay is not required. You're eligible for benefits whether you enter a nursing home from your home ... or you enter after a hospital stay. It doesn't matter.

Q. ***Is Alzheimer's disease covered?***

A. **Yes.** Visits or stays due to Alzheimer's disease and similar forms of senility are covered if the disease develops after your coverage effective date. Other mental, nervous, psychotic, or psychoneurotic disorders are not covered.

Q. ***What is Respite Care coverage?***

A. **Respite Care coverage helps pay for covered short-term stays in a nursing home, as well as home health care or adult day care services.** This type of coverage allows family members who provide care at home to take time away from their care-giving responsibilities. Under AARP's new Plan, there is no deductible period for coverage if informal care has been provided for at least 6 months beginning on or after the insurance effective date. Benefits are paid for actual costs up to $50.00 a day.

Q. ***Why are there deductible periods?***

A. **The deductible periods help keep the monthly cost of the Plan more affordable.** Most people can afford the expense of a relatively small number of home health care and adult day care visits or a short-term nursing home stay, but long-term care can lead to severe financial burdens. This Plan is designed to help protect you financially should you be in need of long-term care.

Q. ***Does the Plan offer any type of discount on monthly rates?***

A. **Yes.** You or your spouse will receive a 20% discount on monthly rates when both of you are covered under the new Plan. Upon acceptance, the younger person with coverage – either you or your spouse – will receive a 20% discount on monthly rates. It's an outstanding opportunity to save on your monthly rate.

— IMPORTANT —

If you have any questions about the enclosed Plan(s), please call your Prudential Service Representative toll-free at **1-800-247-2335, any weekday from 9:00 a.m. to 5:00 p.m., Eastern Time.**

For the earliest effective date, your Application must be received and approved by the date at the top of that form.

Chairman THOMAS. With no further questions from—the gentleman from Nevada, Mr. Ensign.

Mr. ENSIGN. Mr. Shreve, most of the members of AARP are lower income or middle income or what percentage thereof?

Mr. SHREVE. With 33 million members we have a pretty heterogeneous group. We have people that are rather affluent. We have people that are not and have to make a decision whether or not they are going to renew for an $8 fee. So we have a full range.

Mr. ENSIGN. Of the people that have bought the long-term care insurance, have you got a general feel on their income levels? Are they in the higher income levels?

Mr. SHREVE. Yes, there is no question about it. The people with higher income are the ones that can afford it. And at the same time they are trying to protect what assets they may have, and it is a calculated risk.

Mr. ENSIGN. Do you feel that these provisions in the tax clarification would benefit some of them in the middle class and not just the upper class because they are starting to do it earlier in their lives when it is a little more affordable?

Mr. SHREVE. Yes, I think it could. I would like to speak not only for our membership but for all older people, and when we talk about all older people, as I mentioned earlier, almost half of them do not have enough income to pay income taxes, therefore they are not going to get any break, regardless of what they do to provide for themselves.

Mr. ENSIGN. Sure. OK. Thank you, Mr. Chairman.

Chairman THOMAS. Mr. Christensen.

Mr. CHRISTENSEN. First, I want to thank the panel for staying here all day and being here for us. And I wanted to thank Mr. Hansen, too. And does The Seniors Coalition, do they sell any product or not? Are there any products that they sell?

Mr. HANSEN. No, we don't, not at this time. We are purely a lobbying organization.

Mr. CHRISTENSEN. Do you see in the future that you might get into that area?

Mr. HANSEN. Well, as a matter of fact after the health care debate, and of course we were opposed to the Clinton plan, we found a lot of people joining our organization and they were saying they wished that we were offering some benefits. So we will look at that.

We know that there is a need out there. And we know that not only are there many wealthy seniors who want this, but there are a number of, you know, middle—moderate meaned seniors who would rather not end up going on the public dole. And this is going to, in the long run, if we offer this type of insurance, and if the country makes it available, we will find many, many people taking advantage of it, I believe.

Mr. CHRISTENSEN. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you, Mr. Christensen.

Once again, I thank the panel very much for your willingness to abide until the end.

The first hearing of the Health Subcommittee of the Ways and Means Committee is adjourned.

[Whereupon, at 2:41 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

January 19, 1995

The Honorable Bill Thomas
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman,

I am writing to present the views of the Alzheimer's Association on provisions in the Senior Citizens' Equity Act related to long term care, and ask that this letter be made a part of the record of the Subcommittee's hearing on this issue scheduled for January 20.

The Alzheimer's Association is the national voluntary health agency organized specifically to represent the interests of the 4 million persons with Alzheimer's disease and their 19 million family members. We work through a network of over 200 local Chapters in the 50 states, several thousand support groups and more than 35,000 volunteers. There is no issue more important than long term care for families facing the emotional, financial, and physical devastation of Alzheimer's disease.

The Senior Citizens' Equity Act addresses this issue in two ways: it clarifies the tax code to treat qualified long term care expenses as medical expenses for personal income tax purposes, and it provides favorable tax treatment for long term care insurance.

Tax deductibility of qualified long term care expenses. This is an important clarification of current tax law which the Alzheimer's Association has long supported. Alzheimer's disease is one of the most costly illnesses a family can face. Even when most of the care is provided by the family, yearly out-of-pocket expenses average more than $12,000. If residential care is needed, annual costs easily exceed $30,000. And those costs can add up for 5 to 10 years, sometimes even longer. At best, the tax code is confusing as to whether these costs are deductible as medical expenses. Some taxpayers have claimed such expenses and have won their arguments with the Internal Revenue Service. Others have been discouraged from taking the deductions or have been overruled by the IRS.

The Senior Citizens' Equity Act makes very clear that these expenses are deductible. The language is written specifically to include persons with Alzheimer's disease and the type of care they need:

ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSOC. INC.

Washington Office: 1319 F St., NW, Suite 710 • Washington, DC 20004 • Phone: (202) 393-7737 • Fax: (202) 393-2109

- The definition of "chronically ill individual" specifies persons whose disability is due to cognitive impairment (which includes Alzheimer's disease and related dementias).

- "Qualified long term care services" are defined to include maintenance and personal care services as well as diagnostic, preventive, therapeutic, and rehabilitative services.

- "Qualified facility" is defined to include not just nursing homes but other settings that are often more appropriate for Alzheimer care and less costly for the taxpayer, such as assisted living facilities, adult day care, and the person's own home.

We urge enactment of this tax clarification provision as a matter of basic tax fairness. This provision is part of the Contract with America. It was also part of President Clinton's health care proposals last year. There should be no partisan disagreement on this issue.

Tax Treatment of Long Term Care Insurance. The Alzheimer's Association cannot offer the same enthusiastic support for these provisions of the bill before the Subcommittee, for two reasons:

> First, private long term care insurance is an option only for the most well-to-do and the healthiest, those least in need of help. It will do nothing for the millions of American families already shouldering the heavy burden of long term care expenses. Private insurance may have a role in a more comprehensive approach to long term care. But this is not where we should be spending the next tax dollars for long term care.
>
> Second, no tax dollars should be spent at any point to encourage sale or purchase of long term care insurance without strong national standards and enforcement mechanisms to assure that consumers are actually getting meaningful protection.

A good long term care insurance policy is simply not affordable for most people, especially older Americans and younger families with children. The best estimates are that 10% to 20% of older Americans can afford a policy. That would cover about 11% of long term care expenditures and save an estimated 2% of Medicaid nursing home costs. For people over the age of 65, a good policy will cost as much as $3500 to $4000 a year. But median income for insurable persons in this age group is only $12,230; even with assets (other than the house and car) included, average total wealth is only about $24,000. Older Americans already pay an average of 23% of their income for health care (for Medicare cost-sharing, premiums for Medigap policies, prescription drugs, etc.). They simply do not have the money to purchase a long term care insurance policy worth having.

Cost is not the only limiting factor. Regardless of how much money you have, if you have any condition that suggests you may eventually need long term care, you cannot buy a policy. Attached to this testimony is the first page of the application for one of the best long term care insurance policies now on the market. Its "insurability profile" effectively excludes every one of the 14 million Americans with disabilities or functional limitations --

the very people who need, or are most likely to need in the foreseeable future, long term care. (This is not a criticism of the insurance industry. It is the nature of insurance. In a voluntary market, this is the only way a responsible insurer can avoid adverse risk selection.)

Even the most enthusiastic supporters of long term care insurance, insurance companies themselves, concede that at best they may be able to insure 40% of the market. The majority of families will get no benefit from the insurance subsidies you are considering.

For these reasons, the Alzheimer's Association does not believe you should spend the next tax dollars for long term care to subsidize private insurance. But if you are going to do it, at least you must be sure that the policies are worth buying, by specifying uniform national standards for all such policies. The Association would not be enthusiastic about tax considerations for long term care insurance in any event, but we will actively oppose them if you do not include national standards. We would be happy to work with you in developing such standards.

A Typical Family Story. Just this week, we received a telephone call in the Washington office of the Alzheimer's Association from a man in Sun City West, Arizona, Mr. J.C. Whidmont. When we told him about the legislation before the Subcommittee, he encouraged us to share his story with you, to bring home the implications of your actions for real families who are dealing with Alzheimer's disease. Five years ago, Mr. Whidmont considered buying one of the best long term care insurance policies then on the market. The annual cost of the premiums would have been $4000 each for him and his wife. But because Mrs. Whidmont had a lung condition, the company would not issue her a policy. The lung problem has been cured, but in the meantime, Mrs. Whidmont has been diagnosed with Alzheimer's disease, so she is still uninsurable. Nothing you do about long term care insurance will help the Whidmonts.

Mr. Whidmont is now spending $17,000 a year for adult day care to provide therapeutic care for his wife and make it possible to keep her at home with him. None of that cost is deductible for income tax purposes, because Mrs. Whidmont happened to get the wrong disease. The legislation before the Subcommittee would make it possible for Mr. Whidmont to deduct his day care expenses. But Mr. Whidmont is more concerned about the future. He recognizes that, in spite of everything he does, the day may come when he can no longer care for his wife at home. He knows that the cost of good residential care will be at least $30,000 a year, possibly much more. That is when the tax deduction will make the critical difference in his ability to care for his wife.

A Concluding Comment. Tax clarification will help people like Mr. Whidmont who are struggling to pay large long term care bills. But Congress must understand that it is not really an adequate answer to the underlying problem. Even with favorable tax treatment, most families do not have enough income and assets to pay these high costs for any period of time without mortgaging their future and their children's future. Many will still spend their way into poverty and will have no option but to turn to Medicaid for assistance. That system is already under enormous strain and may not withstand the kind of budget cuts Congress is considering this year.

Congress cannot address the long term care problem piecemeal. In the end, you must confront the problem head on and fashion a comprehensive solution that spreads the risk among the entire population. We look forward to the time that we can resume that discussion with you.

Thank you for considering our comments on this legislation. We commend the Subcommittee for addressing the issue of long term care. The Alzheimer's Association is available to work with you to find real solutions for the millions of families who are looking to you for support.

Sincerely,

Stephen McConnell
Senior Vice President,
Public Policy

92001

PLEASE COMPLETE ALL SECTIONS BEFORE SUBMITTING APPLICATION

BENEFIT AMOUNT SELECTIONS			BENEFIT OPTIONS
Daily Maximum $ _____	Benefit Multiplier ☐ 730 ☐ 1460 ☐ 1095 ☐ 2190 ☐ Unlimited	Elimination Period ☐ 0 days ☐ 50 days ☐ 100 days	Inflation Protection ☐ Compound 5% ☐ Equal 5% ☐ None

Premium Payment Method:		Submitted Premium:	Agent Producer Code (Required):
☐ Check ☐ EFT* ☐ American Express® Card* Premium Payment Mode: ☐ Monthly (Check Method not available) ☐ Quarterly ☐ Semi-Annual ☐ Annual	*Be sure to complete the Authorization Form (note: some states restricted)	$ _____	006 _ _ _ _ _ _ _

AMEX *Life Assurance Company*
650 Los Gamos Drive, San Rafael, California 94903

Please Print Clearly

APPLICATION
For Group Insurance

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Name _____
As It Should Appear On Your Certificate

Street Address _____

City _____ State ____ Zip ____

Social Sec. No. ___-__-____

Married? ☐YES ☐NO • If YES, is spouse applying? ☐YES ☐NO

Birthdate _____ Age ____ Sex ☐M ☐F

( ) DAY TELEPHONE ( ) EVENING TELEPHONE

Weight: ____ lbs. Height: ____ ft. ____ in.

For more space, attach a signed and dated sheet with question number and details

YES NO **INSURABILITY PROFILE**

☐ ☐ 1. Are you covered by Medicaid (not Medicare)?

2. Have you had, do you currently have, or have you ever been medically diagnosed as having:

☐ ☐ A. Alzheimer's Disease; Organic Brain Syndrome; Dementia; Chronic Memory Loss; or Senility?

☐ ☐ B. Multiple Sclerosis (MS); Parkinson's Disease; More than One Stroke; Muscular Dystrophy; or ALS (Lou Gehrig's Disease)?

☐ ☐ C. Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or positive HIV test?

☐ ☐ D. Metastatic Cancer (spread from original site/location)?

☐ ☐ 3. Within the past 6 months, have you had: Open Heart Surgery; Back or Spine Surgery?

☐ ☐ 4. Within the past 12 months, have you had a: Stroke; or Transient Ischemic Attack (TIA)?

☐ ☐ 5. Within the past 48 months, have you had Cancer of the: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas, Stomach, or Testes?

☐ ☐ 6. A. Do you use a Walker or Wheelchair; Oxygen; Respirator; or Kidney Dialysis?

☐ ☐ B. Do you need the assistance of or supervision by another person in performing any of the following activities: Moving in/out of bed or chair; Bathing; Dressing; Eating; Toileting; Bowel/bladder control; Walking?

If you answered YES to any part of questions #1 through #6, DO NOT SUBMIT THIS APPLICATION. Otherwise, please continue.

☐ ☐ 7. A. Do you have any other accident and sickness or long term care insurance policy or certificate (including health care service contract, health maintenance organization contract) in force or applied for? If YES, give coverage details below.

Company _____ Coverage Type _____ Amount $ _____ per ____

Company _____ Coverage Type _____ Amount $ _____ per ____

B. If you have AMEX Life Nursing Home coverage, please list policy/certificate number(s): _____

☐ ☐ 8. Did you have another long term care insurance policy or certificate in force during the last twelve (12) months?
If so, with which company? _____ If that insurance lapsed, when did it lapse? _____

☐ ☐ 9. Do you intend to replace any of your long term care, medical, or health insurance coverage with this certificate?
If so, name of insurer being replaced: _____
(AGENT: If YES, be sure to fill out Replacement Notice. Leave one copy with applicant; send one copy with application.)

92001

AMERICAN ACADEMY of ACTUARIES

February 7, 1995

Dear: Members of the House Committee on Ways & Means Subcommittee on Health

RE: Analysis of Long-Term Care Provisions in H.R. 8.

The Academy's Long-Term Care Committee (the committee) is pleased that the Health Subcommittee has held a hearing on H.R. 8, which examines long-term care (LTC) financing. This is a timely debate.

Increasing longevity, coupled with relatively lower birth rates, results in an aging population—and a growing challenge for financing LTC. Not only will there be more elderly people utilizing more—and different—services in the future, but the cost burden of these services on each working individual will rise, as the ratio of people using the services to the working-age population increases.

In addition, recent medical breakthroughs have tended to focus on acute illnesses; these discoveries extend life expectancy, but they don't necessarily extend the period of time during which people can continue to live free of limitations on the most basic activities of daily living (ADLs). The result may be two-fold: more people living to reach ages wherein chronic ailments become prevalent, and then living more years with those chronic problems.

Besides demographics, other societal changes compel us to consider possible new approaches to finance LTC. The caregiver support structure in place earlier this century has been altered by higher divorce rates and the greater proportion of women in the paid labor force (who then, as now, provide most of the care for the elderly). Consequently, the people who used to have enough time to provide care for elderly relatives are increasingly unable to do so. In addition, our highly mobile society tends to disperse families geographically, leaving elderly parents far from the offspring who, in the past, may have provided care. The trend toward fewer children per family also reduces the number of offspring available to provide support to elderly parents.

These demographic trends and societal changes support an argument for programs that prefund the cost of LTC, to avoid mortgaging the futures of ensuing generations to support the swelling population of retirees at older ages who lack ready access to family members able to provide care over extended periods of time.

It is generally agreed that LTC is a rapidly growing problem and that it is important to educate the public about the potential magnitude of future costs of LTC to individuals, families, and society as a whole. Further, removing financing barriers, such as an unclear tax treatment, will

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empower individuals to make intelligent decisions to address the problem. Minor changes in tax law today could reduce the need for major policy shifts tomorrow.

Therefore, our committee supports the effort to clarify the tax treatment of private LTC policies. We note that adverse tax treatment is less of a barrier to the design and widespread marketing of LTC policies than is unclear tax treatment. This is true with respect to group policies (sold through employers), as well as individual policies.

Actuarial Implications of H.R. 8

Our committee is pleased to comment on the specifics of H.R. 8 that have actuarial implications, including ADL requirements, the deductibility of LTC insurance premiums based on insured age, the reserve method, the qualified location of care, the use of IRA and 401(k) withdrawals to finance LTC insurance, indexing the cost of living, and the $200 limit on daily benefits.

Activity of Daily Living Requirements

The requirement that individuals must be unable to perform at least two ADLs without substantial assistance from another individual may be too restrictive. Currently, about one-third of ADL-disabled elderly have only one ADL disability. Often what is needed is standby help, supervision, cueing, or other minor assistance. In other cases, the use of special equipment can obviate the need for any personal assistance. The current trend is a movement away from relying solely on personal assistance toward using special equipment, alone, or in combination with, personal assistance. The proposed legislation could inhibit this trend, thereby unintentionally introducing upward cost pressures on LTC.

The proposed legislation defines five categories of ADLs: 1) mobility, 2) dressing, 3) toileting (which includes incontinence) and bathing, 4) transfer, and 5) eating. However, toileting, continence, and bathing should be clearly identified as three distinct ADLs. In particular, toileting and continence should be clarified as two distinct ADLs, not treated as one. This would then yield a total of seven ADLs.

Deductibility of LTC Insurance Premiums Based on Insured Age

H.R. 8 states that the deductibility of "eligible long-term care premiums" will be based on the insured's age, with allowable premiums rising with age. These limitations are based on attained age, even though LTC premiums are generally based on issue age, with level or flat premiums for the life of the insured. This means that the increases in limits as the individual ages will make even very expensive policies fully deductible after less than 10 years, when the age for the next higher limit is attained, but may inhibit purchase of an appropriate benefit at younger ages.

Changing from attained age to issue age may be a problem for younger and older persons. For younger persons, the need for inflation protection and nonforfeiture benefits, with generous LTC benefits, will make the proposed limits too low. For older persons, the cost of LTC insurance will increase dramatically in the 75-to-85-year range. Currently, LTC policies are not issued to individuals above age 80. By setting the limit for those above age 70 to a level appropriate for age 70, the legislation may encourage this practice.

Reserve Method

H.R. 8 would eliminate the inconsistency and the financial difficulty created for LTC insurers by a National Association of Insurance Commissioners' (NAIC) Model Health Statutory Reserve requirement that states that insurers must hold, at a minimum, 1-year preliminary term reserves, while the Internal Revenue Service (IRS) code limits reserves that may be tax deductible by the insurer to those calculated according to the weaker 2-year full preliminary term reserve method.[1] Our committee views changes that will bring consistency between minimum required statutory reserves and reserves recognized by code for tax purposes as appropriate.

Location of Care

The proposed legislation defines qualified care as care received in a "qualified facility." It may be more appropriate to broaden that definition, to include care received in an individual's home if a licensed health care practitioner certifies that the individual meets the eligibility criteria described. One of the purposes of LTC insurance is to enlarge the range of options available to persons in need of LTC—not to restrict options such that they benefit only those who are nursing home certifiable.

IRA and 401(k) Withdrawals to Finance Long-Term Care Insurance

SEC.305(a) and IRC SEC.137 permits LTC premium payments to be made with pre-tax dollars from IRA accounts and 401(k) accounts. This will have the effect of providing a tax deduction up to the full premium amount for the 70% of tax filers who currently do not itemize their deductions. This should make it easier for the elderly and middle-aged to purchase LTC insurance, since the cash buildup inside an IRA or 401(k) should be comparable to that inside an LTC policy purchased at a young age. It is unclear whether this benefit would also apply to 403(b) plans. If it would not apply, it probably should, in order to maintain consistency.

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[1] The LTC Insurance Valuation Methods Task Force, which is a Society of Actuaries group, is currently researching this and other LTC valuation matters and anticipates releasing a report this Spring.

Cost of Living Indexing

The cost of living indexing reference (1)(F)(5) to the medical consumer price index (CPI) should be re-examined. LTC involves more than medical care; it also includes personal services and residential care, whose costs may not be linked to the rate of medical care increases. The Department of Labor publishes a nursing home index that might track LTC costs more closely. However, it would be preferable to create a new index based on a market basket of long-term care services, which would include a mix of medical, nursing, personal care, and residential elements.

$200 Daily Limit

The $200-per-day limit may not be adequate in some states. In Connecticut, parts of New York, northern New Jersey, and parts of Pennsylvania, $250 per day is more typical of the private-pay requirement for nursing home residents.

Conclusion

Our committee has commented on only a few areas. We are prepared to provide further analyses of LTC legislation and to provide some insights into premiums and related benefits. Please direct any questions you may have to Mike Anzick, a health policy analyst in the Academy's Government Information Department. He can be reached at (202) 223-8196.

Long-Term Care Committee
American Academy of Actuaries

STATEMENT OF
MICHAEL F. RODGERS
SENIOR VICE PRESIDENT,
AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING
HEALTH SUBCOMMITTEE

February 3, 1995

The American Association of Homes and Services for the Aging (AAHSA) is a national association representing not-for-profit nursing facilities, housing, assisted living, continuing care retirement communities, health related facilities and community service organizations for the elderly serving over one million elderly persons on a daily basis. Nearly seventy-five percent of AAHSA's 5,000 members are affiliated with religious organizations, while the remaining are sponsored by private foundations, fraternal organizations, government agencies, unions, and community groups. Since its founding in 1961, AAHSA has been a leader in the field of nonprofit care and services for the aging.

AAHSA has long supported a public and private partnership with a strong role for private insurance as the solution to long-term care coverage in America. AAHSA's position is based on the principle that individuals who can afford to protect themselves against risk of long-term care be given strong incentives to do so, while scarce public resources are preserved for those most in need. We applaud the initial efforts contained within HR 8 of the Contract with America to provide tax incentives for employers to offer and individuals to purchase long term care insurance.

Because of AAHSA's long history and strong commitment to serving the needs of the older population, our interest in long term care insurance products is extensive and long standing. While long term care insurance products have been on the market since 1985, the products that exist today are much more flexible in providing coverage for a range of long term care services in addition to institutional care. The evolution of the long term care insurance product is consistent with the evolution of long term care. At one time, nursing facilities and long term care were synonymous terms and the only environment to receive long term care was within a skilled nursing facility. However, we have moved away from the institutional bias for long term care and now emphasize limited risk, autonomy, and independence for older individuals. Consequently, insurance products have been modified to provide coverage and reimbursement for long term care services other than those provided within an institutional setting, such as home care and care provided by community based services.

We are pleased that the language within HR 8 addresses home care as a long term care option that may be offered by insurers. In addition, we support the use of ability to function based on activities of daily living (ADLs) as the trigger for accessing long term care services. However, AAHSA would like the legislation amended to incorporate the following recommendations:

1. The legislation defines a chronically ill individual as one who has been certified by a licensed health care practitioner as "being unable to perform...at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity,". AAHSA recommends amending this definition by changing the time frame for the inability to perform from 90 days to 60 days to comport more closely with current long term care policies.

2. Include in the "maintenance or personal care services" two additional and instrumental activities of daily living: 1) medication assistance and A) meal preparation. The legislation proposes that inability to perform activities of daily living necessary to live independently as the criteria for triggering coverage. Medication assistance and meal preparation are critical to independent living. While an individual may not require

institutional care for assistance with these activities, the activities are of the type that can and probably should be provided through home care or adult day care.

3. Separate bathing and toileting into separate ADL triggers. These activities should be considered independently because functional impairment in one is not necessarily related to the other.

4. The legislation defines a "qualified facility " as "a nursing, rehabilitative, hospice, or adult care facility (including a hospital, retirement home, nursing home, skilled nursing facility, intermediate care facility or similar institution...or an individual's home if a licensed health care practitioner certifies that without home care the individual would have to be cared for in a facility..." AAHSA recommends adding "assisted living provider" as a qualified facility. Including assisted living in long term care services would further increase the attractiveness of long term care insurance to both the insurance provider and the consumer. Assisted living is a rapidly growing ancillary to the long term care field. Consumers are attracted to assisted living because it permits a flexible lifestyle based upon individual needs and enhances independence and autonomy. Because assisted living programs are designed to meet the specific needs of each individual, it is also a cost effective alternative to home care or nursing facility care. In addition, most states currently regulate assisted living services in order to ensure that providers meet certain level of care standards, thereby guaranteeing a certain level of quality care.

5. Though the current Congress is emphasizing less Federal government and increased state and local control, we feel that minimum federal standards should be developed for long term care insurance. The rationale supporting this recommendation is standardization and consumer protection. Uniform standards could reduce administrative burdens and costs for insurance companies which currently are subject to fifty different sets of state regulations. In addition, uniform standards for long term care insurance products would enhance consumers' understanding of product options, their ability to make prudent purchasing decisions, and enhance consumers' confidence in the product. Finally, uniform regulations would "level the regulatory playing field" and ensure that consumers are protected by the same laws and regulations in every state. Currently tremendous variation exists among states. AAHSA opposes regulations that threaten the growth and evolution of this market either by severely restricting product development and flexibility or pricing products beyond the reach of the average consumer through requirements that constrict the market to unaffordable products.

6. AAHSA supports and encourages expanding the public-private partnerships similar to those currently funded by Robert Wood Johnson Foundation Partnership for Long Term Care. Mark Meiners, Ph.D., National Program Director for this program provided testimony at the Health Subcommittee's hearing on January 20, 1995 detailing the rationale for the program and its attractive features. Individuals need to feel that there is an asset protection advantage in purchasing long term care insurance in order to take advantage of incentives to purchase and feel assured that they will not be impoverished by long term care expenses that would encourage inappropriate transfer of assets to qualify for public long term care benefits. The Partnership for Long Term Care provides further incentive to purchase private long term care insurance and discourages accessing public benefits. Since private/public partnerships for long term care have been available in California, New York, Connecticut and Indiana, there has been a significant increase in the sale of long term care insurance policies. In New York, the State Partnership for Long Term Care has captured more than thirty percent of the long term care insurance market. Connecticut and Indiana have experienced sales trends that are consistent with New York. In Indiana, total sales of long term care policies increased by twenty seven percent within the first six months that the partnership was offered. AAHSA supports the position of the Robert Wood Johnson Foundation Partnership for Long Term Care encouraging the removal of language from the 1993 Omnibus Reconciliation Bill that has held back the growth of these partnerships that currently exist in four states, New York, California, Connecticut and Indiana. Three additional states, Iowa, Illinois and Maryland have launched partnership programs modeled after those of the original Robert Wood Johnson Foundation grantees. Iowa was able to obtain a state plan amendment to qualify for full asset protection as the partnership provides. However, the two other states were unable

to obtain a state plan amendment yet proceeded to implement the partnership plans incorporating the limitations specified in OBRA 1993. Removal of the limitations within OBRA 1993 would encourage further development of and access to partnership plans.

Thank you for the opportunity to present AAHSA's views regarding long term care insurance. Should additional hearings take place or additional information be required, AAHSA is happy to participate and assist the Health Subcommittee of the Ways and Means Committee.

TESTIMONY SUBMITTED FOR THE RECORD

TO THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

HEARING ON HR 8

THE SENIOR CITIZEN'S EQUITY ACT

JANUARY 20, 1995

On Behalf of the Listed Organizations
American Association of University Affiliated Programs
American Network of Community Options and Resources
American Parkinson's Disease Association
American Rehabilitation Association
American Speech-Language-Hearing Association
American Theraputic Recreation Association
National Multiple Sclerosis Society
The Arc
United Cerebral Palsy Associations

Mr. Chairman, we the undersigned organizations appreciate this opportunity to submit the following statement for the record of the hearings on HR 8, The Senior Citizen's Equity Act.

We applaud the committee for its efforts to bring much needed equity to senior citizens after a lifetime of contributing to society. It is appropriate to enable citizens to retire in dignity and comfort and to pursue activities delayed by the need to work and raise families. However, as most Americans, persons with disabilities desire to work and assume all the responsibilities and duties of citizenship in an opportunity society. In order to do so, persons with disabilities must be able to compete on a level playing field. The reality is that faced with the extraordinary cost of disability, persons with disabilities need financial relief from these extraordinary expenses to live independently and be self-sufficient. Therefore we recommend that this bill be renamed the "Senior and Disabled Citizens Equity Act" and the attached amendments be made to the proposed legislation.

A recent Harris poll showed that two-thirds of working age people with disabilities are unemployed. Of this number, 79% want to work. As you may know, individuals with disabilities face significant disincentives in attempting to enter and remain in the workforce. Social Security statistics show that the number of SSDI beneficiaries who successfully return to the workforce is less than one-half of one percent. People with disabilities of all types, including physical, sensory, cognitive, or mental impairments, can experience difficulty in entering or re-entering the work force and can experience substantial costs associated with their disability not encountered by those without disabilities.

We are concerned that HR 8, as it is currently written, relies too heavily on long term care insurance to meet this critical service need for elders and individuals with disabilities. While we do not believe that private insurance will be able to adequately meet the long-term service needs of persons with disabilities of all ages, we recognize that it may help to pay some of the long-term service costs of those persons with disabilities (generally older people) who can afford to purchase and maintain private coverage. Since numerous inadequacies and abuses, including discrimination against people with disabilities, in the long-term care insurance market have been well documented, we believe that private long-term care insurance should not be given preferential tax treatment unless adequate standards are in place to protect consumers from such practices and discrimination.

In order to promote the goal of employment and increased self sufficiency for individuals with disabilities, we recommend changes in Title III to address the cost of long-term services for working persons with disabilities. To do this, we propose a tax credit of one-half of all personal assistance services up to $15,000 for any individual with a disability who is working. We recommend the incorporation of the attached section 303 as part of the Senior and Disabled Citizens Equity Act.

The proposed tax credits and changes in medical care deductions for Personal Assistance will help to offset the extraordinary expenses of living with a disability and assist people with disabilities to enter the workforce by giving them a measure of economic equity with those wage earners amd tax payers who do not need to pay these extraordinary costs.

Personal assistance is defined as one or more persons or devices assisting a person with a disability with tasks which that individual would typically do if they did not have a disability. This includes assistance with such tasks as dressing, bathing, getting in and out of bed or one's wheelchair, toileting (including bowel, bladder and catheter assistance), eating (including feeding), cooking, cleaning house, and on-the-job support. It also includes assistance with cognitive tasks like handling money and planning one's day or fostering communication access through interpreting and reading services.

Individuals with disabilities incur substantial expenses in the conduct of their everyday lives as they try to learn, work, recreate, and live in the community. The cost of personal assistance to enable individuals with severe disabilities to work can be a barrier to employment, as individuals with disabilities often do not earn enough in wages to afford to pay for personal assistance in addition to a rent or mortgage, utilities, food, and related life expenses. Other examples of extraordinary expenses include the cost of accessibility modifications such as a wheelchair lift for a van or hand controls for a car; a wheelchair ramp or alternative signaling device for an accessible home; or medications and medical supplies. There are major expenses for assistive technology, including wheelchairs, hearing aids, guide dogs, computers, augmentative communications devices and the training and maintenance costs of the equipment. Not the least of these extraordinary expenses is for health specialists above and beyond the typical health expenses incurred by the average person. All of these expenses conspire to trap individuals with disabilities in a cycle of poverty and total governmwnt dependency from which most cannot escape without tax assistance to level the economic playing field.

We believe that the inclusion of these amendments would greatly enhance the ability of individuals with disabilities to become and remain contributing members of American society. Encouraging people with disabilities to become tax-payers rather than tax-takers would reduce the out-flows of the SSDI Trust Fund and increase the revenues to both the General Fund and the SSDI Trust Fund. It will also assist them to discharge fully their duties and responsibilities as citizens.

This testimony recommends that several minor enhancements be made to the provisions offering tax incentives for the purchase of long term care insurance. These include expanding the settings in which insurance funded services can be delivered, modifying the definition of chronically ill ill individual to include individuals with disabilities, and expanding the definition of the eating activity of daily living.

Thank you for this opportunity to present testimony for the record. If you have further questions, please contact Tony Young of the American Rehabilitation Association at 202-789-5700 or 1350 I Street, Northwest, Suite 670, Washington, DC 20005.

PROPOSED AMENDMENTS

The Senior Citizens' Equity Act

[recommended amendments are underlined]

1. Rename This The Senior and Disabled Citizens' Equity Act

SECTION 1. SHORT TITLE.
This Act may be cited as the "Senior And Disabled Citizens' Equity Act".

3. TITLE III -- TREATMENT OF LONG TERM CARE AND SERVICES

4. SEC. 301. TREATMENT OF LONG TERM CARE INSURANCE OR PLANS.

(a) General Rule. -- Subpart E of part I of subchapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 818 the following new section:
SEC. 818A. TREATMENT OF LONG TERM CARE INSURANCE OR PLANS.
(c) Qualified Long Term Care Services. -- For purposes of this section --
(1) In General. -- The term 'qualified long term care services' means necessary diagnostic, preventive, therapeutic, and rehabilitative services, and maintenance or personal care services, which --
(A) are required by an individual with a disability or chronic illness at home or in a qualified facility, and

5. AMEND SECTION 818A, (c)(2) to read:

(2) Individual with a Disability or Chronic Illness. --
(A) In General. -- The term 'individual with a disability or chronic illness' means any individual who has been certified by a licensed health care practitioner as --

6. AMEND SECTION 818A, (c) (2)(B)(v) to read:

(B) Activities of Daily Living. -- For purposes of subparagraph (A), each of the following is an activity of daily living:
(v) Eating. ---- The process of acquiring or preparing or getting food from a plate or its equivalent into the mouth.

7. AMEND SECTION 818A, (c)(3) to read:
(3) Qualified Facility. -- The term 'qualified facility' means --
(A) a nursing, rehabilitative, hospice, a comprehensive outpatient rehabilitation facility, or adult day care facility....
(B) an individual's home, including those of two or more individuals choosing to share quarters.

8. SEC. 303 (b) COST OF PERSONAL ASSISTANCE SERVICES REQUIRED BY EMPLOYED INDIVIDUALS.

``(a) Allowance of Credit.

``(1) In general.In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the applicable percentage of the personal assistance expenses paid or incurred by the taxpayer during such taxable year.

``(2) Applicable percentage. For purposes of paragraph (1), the term `applicable percentage' means 50 percent reduced (but not below zero) by 10 percentage points for each $5,000 by which the modified adjusted gross income (as defined in section 59B(d)(2)) of the taxpayer for the taxable year exceeds $45,000.

``(b) Limitation.The amount of personal assistance expenses incurred for the benefit of an individual which may be taken into account under subsection (a) for the taxable year shall not exceed the lesser of

``(1) $15,000, or

``(2) such individual's earned income (as defined in section 32(c)(2)of the Internal Revenue Code) for the taxable year. In the case of a joint return, the amount under the preceding sentence shall be determined separately for each spouse.

``(c) Eligible Individual. For purposes of this section, the term `eligible individual' means any individual (other than a nonresident alien) who, by reason of any medically determinable physical, mental, cognitive, or sensory impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, is unable to engage in any substantial gainful activity without personal assistance services appropriate to carry out activities of daily living in or outside of the home. An individual shall not be treated as an eligible individual unless such individual furnishes such proof thereof (in such form and manner, and at such times) as the Secretary may require.

``(d) Other Definitions. For purposes of this section:

``(1) Personal assistance expenses. The term `personal assistance expenses' means expenses for

``(A) personal assistance services appropriate to carry out activities of daily living in or outside the home,

``(B) homemaker/chore services incidental to the provision of such personal assistance services,

``(C) in the case of an individual with a cognitive impairment, assistance with life skills,

``(D) communication services, including, but not limited to, assistance with interpreting, reading, letter writing and the use of communication devices, augmentative communications devices and/or telecommunication devices,

``(E) work-related support services,including, but not limited to, ongoing services to assist an individual in performing work- related functions necessary to obtain and retain work in an integrated work setting, and to fulfill the functions of a job and personal services on the job;

"(F) mobility services in and out of home, including but not limited to, escort and driving,and/ or mobility assistance including on the use of public transportation,

``(G) coordination of services described in this paragraph,

``(H) assistive technology and devises, including assistance with evaluating the needs of an individual in his or her every day environment; purchasing, leasing or obtaining assistive technology devices for use by individuals with disabilities; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing such devices; coordinating and using other therapies, interventions or services with AT devices (e.g., those associated with existing education/rehabilitation plans or programs); training or technical assistance for an individual with disabilities or where appropriate, the family; and training or technical assistance for personal assistants; , and

``(I) modifications to the principal place of abode of the individual to the extent the expenses for such modifications would (but for subsection (e)(2)) be expenses for medical care (as defined by section 213 of the Internal Revenue Code) of such individual.

``(2) Activities of daily living. The term `activities of daily living' means the activities referred to in section 213(g)(3) of the Internal Revenue Code.

``(e) Special Rules.

``(1) Payments to related persons. Credit shall be allowed under this section for any amount paid by the taxpayer to any person who is related (within the meaning of section 267 or 707(b) of the Internal Revenue Code) to the taxpayer.

``(2) Coordination with medical expense deduction. Any amount taken into account in determining the credit under this section shall not be taken into account in determining the amount of the deduction under section 213 of the Internal Revenue Code.

``(3) Basis reduction. For purposes of this subtitle, if a credit is allowed under this section for any expense with respect to any property, the increase in the basis of such property which would (but for this paragraph) result from such expense shall be reduced by the amount of the credit so allowed.

``(f) Cost-of-Living Adjustment. In the case of any taxable year beginning after 1996, the

$45,000 amount in subsection (a)(2) and the $15,000 amount in subsection (b) shall be increased by an amount equal to

``(1) such dollar amount, multiplied by

``(2) the cost-of-living adjustment determined under section of the Internal Revenue Code for the calendar year in which the taxable year begins by substituting `calendar year 1995' for `calendar year 1992' in subparagraph (B) thereof. If any increase determined under the preceding sentence is not a multiple of $1,000, such increase shall be rounded to the nearest multiple of $1,000."

(b) Technical Amendment. Subsection (a) of section 1016 of the Internal Revenue Code is amended by striking ``and" at the end of paragraph (24), by striking the period at the end of paragraph (25) and inserting ``,and", and by adding at the end thereof the following new paragraph:

``(26) in the case of any property with respect to which a credit has been allowed under section 23 of the Internal Revenue Code, to the extent provided in section 23(e)(3)."

(c) Clerical Amendment.The table of sections for subpart A of part IV of subchapter A of chapter 1 is amended by inserting after the item relating to section 22 the following new item:

``Sec. 23. Cost of personal assistance services required by employed individuals."

(d) Effective Date.The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

TESTIMONY OF THE ASSOCIATION OF HEALTH INSURANCE AGENTS
A CONFERENCE OF
THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS

The Association of Health Insurance Agents (AHIA), a conference of The National Association of Life Underwriters (NALU), on behalf of itself and NALU, submits this statement in general support of the proposals relating to the tax treatment of long-term care (LTC) insurance contained in the Senior Citizens Fairness Act, one of the 10 bills that form the "Contract with America." AHIA and NALU believe that the LTC tax rules proposed in this legislation will encourage employers and individuals to purchase LTC coverage. An increase in the level of LTC coverage will in turn promote an increase in private sector responsibility for the care-taking required in extreme old age. It should in turn diminish the pressure on Medicaid and on private citizens to finance the costs of elder care, whether in a nursing home or in a community or private home setting.

AHIA, a conference of NALU, represents over 10,000 professional health insurance agents who specialize in helping individuals and businesses, especially small businesses, find and purchase affordable, adequate health insurance coverage. NALU, a federation of over 1,000 local and state life underwriter associations, represents some 138,000 professional life and health insurance agents all over the country.

Tax Incentives Will Encourage Individual/Employer Assumption of Responsibility for Risks Associated with Cost of Care during Extreme Old Age

Americans in all income classes and from all political persuasions share a concern about what will happen to their parents and/or to themselves if and when they get old enough that they can no longer care for themselves. The cost of nursing home care–or in-home custodial care–is extremely expensive. Estimates range from $24,000 to $36,000 and higher per year. The issues facing the "sandwich generation"–those middle-aged babyboomers facing the need to provide custodial care for both aging parents and very young children–are well-documented and at the front of the minds of most Americans. In fact, it is this very prevalence of concern that inspired the authors of the "Contract with America" to include proposed legislation that will help address these concerns. The tax incentives that will help make LTC more available because it will become more affordable are generally present in the "Senior Citizens Fairness Act." AHIA and NALU support this committee's efforts to enact these provisions.

Generally, the tax incentives contained in this legislation would treat LTC insurance as health and accident insurance. Among these provisions is one that includes LTC in the IRC Section 106 rule that premiums (or contributions to a separate fund) paid by employers are not included in the taxable incomes of the employees receiving the coverage. Presumably, the authors of this legislation also intended for employers who provide LTC coverage to their employees (for their own benefit or for the benefit of their parents) to also be able to deduct the cost of that coverage as an ordinary and usual business expense. However, this needs to be clarified in final legislative language because of the rule in the Internal Revenue Code that otherwise deductible business expenses that have the effect of deferring compensation are not currently deductible. Because LTC can arguably be characterized as a form of deferred compensation because it provides a future benefit (as opposed to protection against a current risk), there needs to be clarification that employer-paid LTC premiums are in fact deductible, regardless of LTC's characterization as a present or future benefit.

In addition, the legislation needs to be clarified to be sure that employers can provide LTC coverage that protects against the cost of parents' needing care, as well as spouses and children. The crux of the LTC issue is concern about aging parents, as well as about one's own personal old age. It is very important to allow employer-provided LTC coverage to include parents as well as selves and children in the group being protected.

The Senior Citizens Fairness Act also includes rules that allow individuals to deduct the cost of LTC coverage as a medical expense, within the rules of IRC Section 213 (i.e., medical expenses are deductible to the extent they exceed 7.5% of adjusted gross income). Another provision in the legislation would allow individuals to receive benefits payable under an LTC policy on a tax-free basis, at least to the extent that the benefits do not exceed $200/day. NALU and AHIA believe that these provisions are important considerations in

making the decision to purchase LTC coverage an affordable one. Tax-free benefits and the ability to deduct the cost of the coverage--at least to the extent that it exceeds 7.5% of AGI--will encourage people to assume their own individual responsibility to plan for the costs of their own extreme old age.

The combination of rules contained in this legislation--treatment of LTC as health and accident insurance for tax purposes; the excludability of the value of employer-provided LTC from employee taxable income; the tax-free treatment of benefits payable by LTC policies; and the deductibility by individuals of LTC premiums within the rules of Section 213--will, when combined with the needed clarification that employers can deduct the cost of their employees' LTC coverage and that employees can claim parents as dependents for purposes of employer-provided LTC, significantly enhance the overall level of LTC coverage. When LTC is treated as other employer-provided benefits, employers will look seriously at adding LTC coverage to their benefits packages. It is a benefit which addresses a real concern among many employees, and will be viewed by many employers as a cost-effective way to attract and retain quality workforces. However, parity in tax treatment of LTC as an employee benefit with other employee benefits (like health insurance, life insurance, retirement plans, etc.--all of which have similar tax rules) is crucial to acceptance of LTC as an employee benefit. And as with most, if not all, insurance benefits, coverage tends to be less expensive and broader in scope if it is group as opposed to individual, and if it's available at younger as opposed to older ages.

For those individuals whose employers do not choose to offer LTC coverage, the individual tax rules--tax-free benefits, deductibility of premiums within the rules of Section 213--will encourage them to purchase the needed coverage on their own. And for both employers and individuals, the addition of one more tax rule that is generally available to most employer-provided benefit choices would be to allow inclusion of LTC coverage in Section 125 cafeteria plans. Cafeteria plans are an increasingly popular mechanism among both employers and employees for tailoring the most cost-effective benefits package. Because cafeteria plans involve salary reduction, employers have much more flexibility in offering choices of available benefits for the same total amount of compensation (salary and cost of benefits). Because of the options, employees can choose to accept only those benefits they really want; they can have (taxable) cash compensation instead of benefits they don't select.

LTC, because it can be characterized as providing a future benefit as opposed to protecting against a current risk, has been argued as qualifying as deferred compensation. There is a rule against including deferred compensation in cafeteria plans. Thus, in order to include LTC coverage in a cafeteria plan, the law would have to be clarified to make it an allowable cafeteria plan benefit. NALU and AHIA urge you do this. Availability of LTC through a cafeteria plan will substantially increase availability of funding when and if prospective insureds need nursing home (or in-home) care. NALU and AHIA strongly urge that the LTC tax provisions be amended to include a provision that makes LTC an allowable cafeteria plan benefit.

"Contract" Legislation Is Largely Silent on Standards; That Is Appropriate Because the States and NAIC Are the Appropriate Forum for Development, Implementation of LTC Insurance Policy Standards

LTC is not a new issue confronting this committee, or Congress. LTC insurance has been the subject of Congressional attempts to write Federal underwriting and marketing standards as well as the subject of a debate over whether to grant it status, for tax purposes, as a benefit or as health and accident insurance. "Contract" legislation is largely silent as to LTC insurance standards. With one exception (a requirement that to qualify for tax advantages, the policy must pay no more than $200/day in benefits, indexed), there are no standards set out in this bill. NALU and AHIA believe that this approach is appropriate.

The associations do in fact support standards to be applied to LTC insurance. However, we believe that the States are the appropriate forum for development and

implementation of policy design and marketing requirements. The National Association of Insurance Commissioners (NAIC) has a long history of developing LTC policy standards (both as to product design and as to marketing practices). NAIC then makes available to the States its model laws and regulations. This process includes input from consumers, insurers, legislators and regulators. NALU and AHIA are active in the process. Where appropriate, we support the NAIC model laws and regulations and where appropriate we encourage NAIC and, if necessary, the individual states to make appropriate modifications. This is exactly the process in place for LTC standards. The associations are working closely with NAIC and the States to modify the existing package of LTC standards.

We believe that the long-term care needs of individuals are best served by the flexibility that is available by regulating LTC coverage at the State level. Costs of long-term care vary dramatically among the States. Options for long-term care, in terms of facilities and services, also vary dramatically. State-financed options vary. In short, there is so much variation in the factors that make up the package of LTC standards that it is appropriate that those standards be established at the State level. To the degree uniformity is needed or desirable, it generally develops because of uniform or near-uniform adoption of NAIC standards. But development of those standards at the NAIC level allows for variations among the several States as the circumstances in those States dictate.

Again, NALU and AHIA strongly support continuation of State regulation of all insurance, including long-term care insurance. And that means that standards--which are near-universally agreed to as necessary--should be developed by the NAIC and implemented by the individual States. Accordingly, we support the "Contract's" absence of a standards package in its provisions.

The one exception to this statement is the requirement that LTC policies pay no more than $200/day in order to qualify for the tax treatment set out in the legislation. Because the $200 is indexed, AHIA and NALU believe that it is a benefits level that is acceptable, albeit low enough that some policies currently on the market would exceed that ceiling. However, to the extent that benefits up to $200/day (indexed) remain tax-advantaged, the associations are prepared to support the provision. AHIA and NALU urge, however, that clarifying language be added to the legislation to make sure that only excess benefits become taxable, not the basic $200/day worth of benefits. This is particularly important for high-cost metropolitan areas where many LTC policies' limits are already higher than the $200/day base. To disqualify the entire policy would be most unfair; disqualification of excess benefits should suffice.

On a related subject, while the $200/day benefit limit is marginally acceptable as long as it's indexed and as long as only the excess benefits become subject to tax, it is also important to make clear that reimbursement policies as well as per diem policies qualify for the tax rules contained in the "Contract" legislation. The choice of reimbursement (the policy pays direct nursing home or in home custodial care costs) or per diem (the policy pays the beneficiary as result of the beneficiary incurring nursing home or in home custodial care costs) should be a matter of personal choice, not tax policy. Either policy form can be "right" for some prospective insureds and "wrong" for others. The tax code, so long as the value of the policies' benefits are treated equally, should not distinguish between the two policy forms.

Summary: AHIA and NALU Generally Support "Contract's" Proposed Tax Rules for LTC Insurance

In summary, AHIA and NALU generally support the "Contract's" LTC tax provisions. The associations believe that employers should be able to pay for and deduct the cost of LTC coverage for their employees. We believe that employees should be able to cover their parents as dependents for purposes of LTC coverage. We believe that LTC should be an allowable cafeteria plan benefit. We support making employer-provided LTC excludable from employees' taxable incomes. We support making individually-purchased LTC premiums deductible within the rules of IRC Section 213, and we support making LTC

benefits tax-free to beneficiaries. This package of tax rules will, we believe, encourage businesses and individuals to purchase LTC coverage. To the extent that the level of LTC coverage increases, the level of personal assumption of the responsibility to plan for one's old age will also increase. This in turn will reduce pressure on the Federal government and on the Federal budget to provide for citizens who need custodial nursing or in home care during those years when they become too old to care for themselves.

In short, AHIA and NALU believe that the package of LTC rules proposed in the "Senior Citizens Fairness Act"–as improved by the modifications proposed in the foregoing statement (clarification of employer deductibility, allowance of LTC as a cafeteria plan benefit, clarification that only excess benefits would be taxable, and clarification that per diem and reimbursement type policies will be treated equally)–is good tax policy and good social policy. We support the provisions, and your efforts to enact them into law.

Publisher of Consumer Reports

January 19, 1995

The Honorable Bill Archer
Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515-4307

Dear Chairman Archer:

The Ways and Means Committee is considering H.R. 8, a proposal to provide people age 59 1/2 or older with tax incentives to purchase private long-term care insurance. **We urge you to oppose H.R. 8 in its present form.** Even though it may sound appealing at first blush, it has two serious problems. First, it does not address the very serious deficiencies in these private policies. Second, it favors higher income consumers at the expense of middle-income consumers. Furthermore, the bill would cost American families over $1 billion during the first five years.

Consumers buy private long-term care insurance in order to provide their family with economic security against financial devastation that can result from costly long-term care bills. Tax incentives alone -- without increased consumer protections -- will result in many disappointed families who will not achieve this economic security because the policy sold to their loved one fails to provide the expected benefits. This is a very inefficient use of tax dollars.

The private long-term care insurance market is one in which the average consumer can not make informed, responsible choices for his or her family's economic security. In June 1991, Consumer Reports found widespread agent abuses and numerous loopholes that deny coverage to consumers when they really need it. Consumers need to be protected so they can more effectively make choices in this market. Numerous bills that would solve these problems were introduced in the 102nd and 103rd Congresses, often with bipartisan support.

We do not believe that providing tax incentives for the purchase of long-term care insurance is a responsible way to spend tax dollars. If you retain the tax incentives, we urge you to finance them through a tax that would be paid by high-income consumers, the principal beneficiaries. Otherwise, the tax burden falls on the middle class. We recommend that you consider a tax credit rather than a tax deduction, so that middle class taxpayers in lower tax brackets benefit as much as taxpayers in higher tax brackets.

Enclosed is a more detailed analysis of H.R. 8. Thank you for considering our views.

Sincerely,

Gail Shearer
Director, Health Policy Analysis
Washington Office

Washington Office
1666 Connecticut Avenue, Suite 310 • Washington, D.C. 20009-1039 • (202) 462-6262

ANALYSIS OF H.R. 8
CONSUMERS UNION

H.R. 8 has two serious problems. First, it does not address the very serious deficiencies in these private long-term care insurance policies. Second, it favors higher income consumers at the expense of middle-income consumers. The bill would cost American families over $1 billion during the first five years.

THE PRIVATE LONG-TERM CARE INSURANCE MARKET HARMS CONSUMERS.

Consumer Reports has issued several reports about the many flaws in the private long-term care insurance market. We believe that it would be extremely irresponsible for Congress to encourage consumers to buy a product that will fail to provide their family with economic security. Unless the legislation includes badly needed federal consumer protection standards, then the result is likely to be the purchase of defective policies by thousands -- possibly even millions -- of consumers.

Among the traps awaiting unwary consumers (as reported in **Consumer Reports**, June 1991) are:

Agent abuses. Not one of the 15 agents whose sales pitch our reporter monitored properly explained the policies' benefits, restrictions, and policy limitations. Some actually lied.

Large rate increases. Premiums are not guaranteed over the life of the policy. Consumers may face the possibility of stiff premium increases in the future.

Fine print and loopholes. Agents and companies' sales materials often fail to reveal policies' limitations and restrictions. Consumers may believe, for example, that any nursing home stay will be covered, when in fact the definition of "nursing home" limits the coverage to a fraction of nursing homes.

Impossibility of comparison shopping. Benefits, terminology and definitions vary so greatly from policy to policy that consumers cannot make informed purchasing decisions. The long-term care insurance market currently flunks the "kitchen table test": it is virtually impossible for a prospective purchaser to sit down at his or her kitchen table and make a rational comparison of policies. The choices and variations from policy-to-policy are too complicated.

Inadequate inflation coverage. Most policies lacked built-in coverage of inflation. Without inflation coverage, policies may be nearly worthless by the time they are needed.

Dropped coverage. What happens if you drop your policy? Few policies have so-called "nonforfeiture benefits" which return to policyholders some of their equity if they drop their coverage.

STRONG CONSUMER PROTECTION PROVISIONS ARE NEEDED.

We believe that this market can be made better for consumers.[1] Congress should follow the excellent model it developed (with strong bipartisan support) in 1990, when it enacted reform of the medigap market. This market shared many of the same imperfections as the long-term care insurance market. Some of the specific reforms that are needed include:

Built-in inflation coverage: Inflation protection should be built-in to all long-term care insurance policies. Without inflation protection, a long-term care policy provides only illusory coverage. Many consumers face a shock several years in the future, when they discover that their policy will pay only a small percentage of their long-term care costs.

Premium stability: We believe that long-term care premiums should be fixed, so that families know the future price at the time the purchase the policy. (In insurance parlance, policies would be "noncancelable.") Without fixed premiums, consumers are asked to purchase a policy without knowing its price. Consumers are better able to make a rational and efficient decision if they know up-front the price of the product. It is unfair to sell a consumer a policy and then later increase the price after the consumer is locked-in to the policy. Requiring all insurers to have fixed premiums will provide a "level-playing field" for all. The present system rewards companies who deceptively underprice their policies initially. It encourages companies to find ways to "game the system."

Simplifying shopping decisions. Policy terms (e.g., "skilled nursing facility," "licensed nursing facility," "custodial care," "home health care benefit," "inflation benefit," "nonforfeiture benefit," and other terms) should be the same from one policy to another. Regulators should work toward standardizing benefit packages -- modeled on the successful standardizing of the medigap market. Perhaps we should start with voluntary standard benefits.

Protections for consumers who drop their policy. All policies should be required to include a standard nonforfeiture benefit. This will help protect the 60 percent of policyholders that insurers expect to drop their policy within 10 years.

Protection against unscrupulous agents. The commission structure should be modified so that agents do not have a financial incentive to make a sale that does not meet the long-range needs of the purchasers. Senior health insurance counseling programs should be fully funded in all 50 states to provide consumers with an objective source of counsel about their long-term care insurance needs.

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[1]It is important to keep in mind, however, that the private market will never protect consumers who can not afford a policy or are too sick to qualify for a policy. Consumers Union supports financing long-term care through a largely public program. Until this is achieved, we support improved regulation of the private market.

IMPROVED OVERSIGHT OF PRIVATE LONG-TERM CARE INSURANCE HAS RECEIVED BIPARTISAN SUPPORT IN THE PAST AND SHOULD BE INCLUDED IN H.R.8.

Numerous bills that address consumers' needs for long-term care consumer protections were introduced in both the 102nd and 103rd Congress.[2] Congressman Wyden's bill H.R. 1916 (102nd Congress), which included comprehensive requirements, had bipartisan support. In 1992, Senators Kennedy and Hatch succeeded in reporting S.2131, "Long-Term Care Insurance Improvement and Accountability Act" out of the Labor and Human Resources Committee. S.2131 would have offered substantial protections to all purchasers of long-term care insurance.

Many health reform bills that were introduced in the 103rd Congress included strong provisions to improve the long-term care insurance market. For example, the Chafee/Thomas bills (S. 1770/H.R. 3704) would have linked beneficial tax treatment to meeting minimum consumer protection standards, incorporating many of the requirements that are in the National Association of Insurance Commissioner's long-term care insurance model. The Administration bill would have standardized policy format and terminology, prohibited false and misleading representations, regulated premium increases, and provided for an independent professional assessment of the need for long-term care.

THE PROPOSED TAX EXPENDITURE IS SUBSTANTIAL, INEFFICIENT AND WOULD PENALIZE THE MIDDLE CLASS.

Under H.R. 8, many purchasers of long-term care insurance would be eligible for a tax deduction or other tax incentives. In light of the country's limited health care resources, we do not believe that millions of new dollars should be spent each year on a tax incentive to encourage the purchase of long-term care insurance. Few low-income consumers can afford to buy a long-term care policy. We have several equity concerns about this proposed new tax expenditure which is estimated to result in over one billion dollars of lost revenues during the first five years. First, how would this new tax expenditure be financed? We believe that it would be inequitable to finance a new tax incentive that will be used predominantly by high-income consumers through increased taxes (or reduced benefits) for low- or moderate- income consumers. We urge you to explore revenue sources other than cuts in Medicare, cuts in

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[2]Bills introduced in the 102nd Congress include: S. 1693 (Senator Bentsen); S. 2141 (Senator Kennedy); S. 846 (Senator Pryor); H.R. 2378 (Cong. Bruce); H.R. 3830 (Cong. Stark); H.R. 1916 (Cong. Wyden). In 1992, Consumers Union issued a report (Analysis of Long-Term Care Insurance Proposals) that outlined consumer protections needed in long-term care insurance market, and compared the bills that had been introduced in the 102nd Congress. We would be happy to provide you with a copy of this report.

Medicaid, and general revenues. Ideally, the incidence for the increased taxes would fall on relatively high income consumers, since they are the beneficiaries of this policy. One possible source could be increased estate taxes.

A second equity concern is that the structure -- use of tax deductions instead of tax credits -- provides a larger benefit to high- income purchasers than to low-income purchasers. A 70- year-old purchaser of a $2,500 policy would get a $375 tax benefit if he or she is in the 15 percent tax bracket, while a 70-year-old purchaser in the 33 percent tax bracket would get a tax benefit of $825 for the purchase of the same policy.[3] Unfortunately, the this public policy approach will barely make a dent in solving the nation's long-term care crisis.[4]

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[3]This example applies to employer-paid policies. H.R. 8 provides a strong incentive for small "companies" to be established by people searching for a low-cost way of funding long-term care insurance.

[4]See, for example, Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance, by Joshua M. Wiener, Laurel Hixon Illston, and Raymond J. Hanley, The Brookings Institution, 1995.

TESTIMONY OF GREG SCANDLEN
COUNCIL FOR AFFORDABLE HEALTH INSURANCE

The Council for Affordable Health Insurance (CAHI) is pleased to submit written testimony on the tax incentives for long term care insurance contained in HR 8, The Senior Citizens' Equity Act. CAHI is an organization of insurance companies and individuals who are vitally involved with our health care financing system and its ability to serve all segments of our population.

We are convinced the best approach to the problems in our health care system is to maximize the individual's freedom of choice and to promote a robust competitive market. We support a program which uses the concepts which have always been the strength of our country -- individual freedom and responsibility; a free market for goods, services, and ideas; a robust competitive environment; and government involvement designed to protect those who are incapable of caring for their own needs.

We believe the best way for more Americans to finance their long term care needs is through the purchase of private long term care insurance, rather than through reliance upon government programs. In order to encourage individuals to plan for their retirement needs and purchase private long term care insurance, changes need to be made to our federal tax policy.

CAHI commends the House Ways and Means Subcommittee on Health for recognizing the importance of promoting private sector solutions in financing long term care. HR 8 is an important step in formulating appropriate tax policy in the treatment of long term care insurance. However, in order to reach the majority of American taxpayers, CAHI's proposal on the tax treatment of long term care differs in some respects with HR 8. Our specific recommendations follow.

The Need for Private Sector Solutions to Long Term Care Financing

The American population is aging, and especially as baby boomers reach retirement, the long term care needs of the nation will increase substantially. Currently, about 13 percent of the population is 65 and older. A recent Census Bureau report finds that more than 20 percent of the nation will be over age 65 in the year 2050.

However, individuals are not planning for their long term care needs. A 1994 Lou Harris and Associates poll asked adults aged 65 and over how they would pay for nursing home or home care. Almost half of those polled (48%) did not know how they would pay. Only 13% responded that insurance would pay, while 15% said they would rely on the government to pay the costs.

At present, Medicaid is the primary financing mechanism for nursing home care. In 1993, 74% of nursing home patient days were paid for by Medicaid. Medicaid recently edged out higher education to become the second largest program in states' budgets (following K-12 education).

This undue reliance on government programs is clearly not sustainable. Precious dollars that would otherwise finance health care for the poor are instead paying for the long term care expenses of people with the ability to purchase private long term care insurance. It is estimated that 20-25 percent of persons aged 65 or older who enter a nursing home as a private pay patient eventually "spend down" and are ultimately covered by Medicaid. All individuals who spend down to Medicaid, whether before they enter a nursing home or after, use about 50 percent of total Medicaid nursing home dollars.

Tax Clarification of Long Term Care Insurance

At present, under the current tax code, there is no clear statement as to the deductibility of long term care insurance premiums, whether paid by an individual or an employer. Nor is there a clear statement about how long term care benefits should be treated. This lack of clarity creates an impediment to the purchase of private long term care insurance and an undue reliance on government welfare and entitlement programs, such as Medicaid.

CAHI applauds the Senior Citizens' Equity Act for recognizing the need to clarify the tax treatment of long term care insurance. However, the goal of long term care tax policy should be to provide significant incentives for the purchase of long term care insurance to the broadest spectrum and largest number of Americans. We believe this necessitates treating long term care insurance differently than other forms of accident and health insurance. Merely treating long term care expenditures as a medical expense does not provide the appropriate incentive to the broad spectrum of individuals because it is limited to those who itemize and take advantage of medical expense deductions. In 1992, less than 5 percent of individuals filing tax returns itemized and claimed a medical expense deduction.

In contrast to HR 8, CAHI proposes that all taxpayers be able to deduct premiums for long term care insurance; the deduction should not be subject to a floor of 7.5% of adjusted gross income (AGI), nor limited to taxpayers who itemize.

In order to actualize real savings in the Medicaid program, the tax incentive must encourage individuals who would not otherwise purchase private long term care insurance to do so. It must not only be a benefit to those who would purchase it anyway. Crafting the tax treatment as CAHI proposes will achieve this end, and provide an appropriate tax incentive to individuals of all income levels.

Additionally, CAHI believes that benefits paid under a long term care policy should not be included as income to the recipient. HR 8 limits the amount of long term care benefits that can be excluded from gross income to $200 per day. We oppose setting such an artificial limit because it does not take into account the long term nature of when benefits are received under a long term care insurance policy, nor changes in the long term care delivery system. For example, the $200 per day limit may not be sufficient when individuals receive benefits under their long term care insurance policy 20 years hence.

Moreover, the $200 per day limitation guards against a problem with other health insurance -- over-insurance -- that does not exist in the long term care insurance market. The nature of long term care involves built-in barriers that discourage over-utilization. The reality of being in a nursing home, including the resultant loss of freedom, is an example. Indeed, moving into a nursing home is the choice of last resort for individuals and families.

In addition, long term care insurance is a "premium sensitive" product, with the average annual premium for 65 year olds commensurate with their premiums for a Medicare supplement policy. It is more common for purchasers to "underinsure" to save premium. This is accomplished through lower daily benefits or longer deductibles or elimination periods, or combinations of both, which subject consumers to out of pocket liability and therefore, personal responsibility for exposure to service costs.

As mentioned above, employer contributions for long term care insurance should be deductible as a business expense. It is important to encourage employers to offer group long term care insurance for several reasons. First, the long term care insurance would become effective earlier and at a younger age. This would result in prefunding the insurance risk, thus resulting in lower annual costs to the covered person. In addition, increased market penetration by all ages is needed to effectively reduce Medicaid outlays by protecting against asset spend down.

Additional Comments on HR 8

In addition to the tax treatment of long term care insurance premiums and benefits, CAHI would like to comment on the following aspects of The Senior Citizens' Equity Act.

Eligibility for Favorable Tax Treatment. Regulation of long term care insurance is under the purview of the states, and the existing framework of state regulation is working very well. The states have actively engaged in the oversight of the long term care insurance product, and have enacted ample and adequate consumer protections.

There is a movement to mandate extensive federal benefit standards for long term care policies in order for those policies to receive favorable tax treatment. CAHI believes that it is unnecessary -- indeed, inappropriate -- for the federal government to either usurp the states' ability to regulate insurance within their borders, or to add another layer of regulation on top of what is currently in place. Simply put, state regulation of long term care insurance is not "broken"; therefore, the process does not need to be fixed by the federal government.

Therefore, we consider it appropriate that HR 8 not contain benefit standards. The Subcommittee is right to leave this responsibility in the hands of the states, to be dealt with under their statutory and regulatory authority.

Insurance Company Reserves. HR 8 conforms the tax treatment of long term care reserves with the statutory reserving requirements. We enthusiastically support this provision, which CAHI believes will ultimately reduce the cost of long term care insurance.

Activities of Daily Living. HR 8 defines a chronically ill individual in terms of the inability to perform two of the specified activities of daily living (ADLs). In response, we restate our position on the regulation of long term care insurance: it is the purview of the states, not the federal government. The National Association of Insurance Commissioners (NAIC) is currently addressing this issue, and the states will have the opportunity to adopt those portions of the NAIC's model which they feel are appropriate. We maintain that it is unnecessary for HR 8 to address ADLs, and request that this provision be deleted from the bill.

IRA Withdrawals. CAHI agrees with the provision to allow tax free withdrawals from Individual Retirement Accounts for the purpose of purchasing long term care insurance. We would also note that Medical Savings Accounts, if enacted by the 104th Congress, would serve as an important financing vehicle for private long term care insurance premiums.

Grandfather Clause. We support the bill's provision to grandfather all existing policies which met the long term care insurance requirements of the state in which the policy was issued at the time the policy was issued. Without such a provision, there would be the potential for widespread dislocation in the long term care insurance market. Moreover, individuals who had taken the responsibility and purchased long term care insurance would be punished for their foresight, a result that should not occur.

Parents. There are many instances where children purchase a long term care insurance policy for their parent. In these cases, the family member that pays the premium should be given the tax deduction. HR 8 does not address this issue; we encourage the Subcommittee to add language in this regard.

Medicare Duplication

CAHI would also like to take this opportunity to ask the Subcommittee for further technical corrections to OBRA 1990. Since the passage of OBRA 1990, it has generally been a violation of Federal law to sell to a Medicare beneficiary:

1. a health insurance policy with the knowledge that the policy duplicates health benefits (Medicare, Medicaid or other health insurance coverage) to which the individual is otherwise entitled; or

2. a standardized Medigap plan to a person who already has a Medigap policy.

The 103rd Congress enacted HR 5252, which was signed into law October 31, 1994. HR 5252 retains the prohibition against selling a Medigap policy to a Medicaid recipient. Further, an exception was created for certain policies which duplicate Medicare or other health coverage. Such a policy MAY be sold if the policy pays its benefits without regard to other coverage the individual might have. Further, if Medicare is duplicated by the

policy, a disclosure of the extent to which the policy duplicates Medicare must be given to the consumer.

Under the terms of HR 5252, Congress gave the NAIC the opportunity to establish standards to be incorporated by reference as Federal requirements. The NAIC, in developing its standards, has defined the word "duplicates" in terms of the service received; if the individual receives a medical or hospital service, and that service is covered to any extent by both Medicare and private insurance, duplication exists. The fact that there may be no "duplication" at the benefit level does not change this fact.

This approach has led to a result which we believe was not intended by Congress; Home Health Care, Long Term Care and other health insurance policies which coordinate their benefits with Medicare (and therefore are less expensive to purchase and help to avoid overinsurance) may not be sold to a Medicare beneficiary. These policies meet the definition of a policy which "duplicates" but fall outside the statutory exception.

CAHI believes that this unintended result must be reversed by the 104th Congress. This could most easily be accomplished by enactment of a statutory definition of "duplication." Policies meeting the following would be considered as not duplicating Medicare: (1) health insurance policies (including long term care) that pay without regard to Medicare, or (2) health insurance policies (including long term care) that coordinate with Medicare.

Conclusion

America's increasing long term care needs necessitate immediate policy changes to encourage individuals and families to take personal responsibility to plan for future long term care needs. As a first step, the Council for Affordable Health Insurance believes the federal government should act quickly to clarify the tax treatment of long term care insurance premiums and benefits.

However tax clarification is only the beginning of the process. Even with an affordable long term care insurance product and favorable tax treatment, individuals will not purchase a private long term care insurance policy if they continue to believe that Medicare will pay for their long term care needs. An aggressive public education program to attack this misconception is essential. Government, both federal and state, must be responsible for accurately informing and educating the public regarding actual coverage available for long term care.

The Council for Affordable Health Insurance applauds the Subcommittee for promoting private sector solutions to long term care financing. We would be pleased to assist Members of Congress in crafting proposals to accomplish this goal. In particular, CAHI's Senior Issues Committee, composed of actuaries and insurance industry representatives who are experts in long term care financing, is available to aid the Subcommittee in developing the most appropriate tax policy for long term care. Thank you for the opportunity to provide our comments on HR 8.

TESTIMONY OF SARAH SNIDER
EMPLOYEE BENEFIT RESEARCH INSTITUTE

Introduction

The Employee Benefit Research Institute (EBRI) is pleased to submit for the committee record the enclosed statement regarding the long-term care insurance provisions contained in the Senior Citizens' Equity Act (H.R. 8). EBRI is a nonprofit, nonpartisan, public policy research organization based in Washington, DC.

EBRI has been committed, since its founding in 1978, to the accurate statistical analysis of economic security issues. Through our research we strive to contribute to the formulation of effective and responsible health and retirement policies. Consistent with our mission, we do not lobby or advocate specific policy solutions.

Among the general population, recognition that neither Medicare nor most private insurance plans cover long-term care has come slowly. Retirees and workers have only begun to understand their exposure to the risk of needing costly community or institutional long-term care, as an increasing number have faced the necessity of caring for a parent, spouse, or child needing chronic (and often increasing) personal care assistance.

Demographic trends ensure that the proportion of individuals requiring formal paid care will increase in years to come. Increased life expectancy, reduced fertility rates, and the aging of the baby boom generation mean that the proportion of people at greater risk of needing long-term care relative to the proportion who can provide physical and financial assistance will increase dramatically over the next several decades. In addition, more two worker families and single workers and increased mobility among family members mean that there will be fewer individuals available to provide care on an informal basis to friends and family.

Current Sources of Financing

Under the current system of financing long-term care, most financing for care comes from individual out-of-pocket expenditures or Medicaid, with Medicare and private insurance accounting for only a small proportion of total expenditures. Long-term care includes services provided by paid and nonpaid caregivers in institutional, home, and community settings. Because the majority of functionally dependent individuals receive long-term care on an informal basis from friends and family,[1] it is difficult to measure the total expenditures on this care. However, according to the U.S. Health Care Financing Administration (HCFA), nursing home expenditures totaled $69.6 billion in 1993, of which 33 percent was financed through consumer out-of-pocket payments. Most of the remainder was financed through the Medicaid program (52 percent), with Medicare accounting for 9 percent, other public and private programs accounting for 4 percent, and private insurance paying for 2 percent.

While private insurance now finances only a small portion of long-term care needs, as an increasing number of individuals recognize the possibility of needing long-term care and the costs associated with such care, private initiatives to provide for this need have grown, through both individually purchased and employment-based plans. By the end of 1992, a total of 2.9 million private-sector insurance policies had been sold, up from 815 thousand in 1987.[2] These policies included individual, group association, Continuing Care Retirement Communities (CCRC), employer-sponsored and accelerated death benefits specifically for long-term care. While the majority of these plans were sold to individuals or through group associations, employment-based plans accounted for a significant proportion of this growth (increasing from 20,000 policies sold and 2 employers offering long-term care insurance in 1987 to 350,000 policies sold and 506 employers offering long-

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[1]U.S. Bipartisan Commission on Comprehensive Health Care, *A Call for Action* (Washington DC: U.S. Government Printing Office, 1990).

[2]Susan Coronel, "Long-Term Care Insurance in 1992," *Policy and Research Findings* (Washington DC: Health Insurance Association of America, February 1994).

term care insurance in 1992). The average age of buyers of employer-sponsored plans in 1992 was 42, compared with 68 for purchasers of individual and group association policies. Furthermore, recognition that many states are currently suffering from serious budget deficits and have been forced to make changes to Medicaid that may threaten beneficiaries' access to quality care has led many leaders to regard long-term care insurance as a potential alternative to Medicaid.

The design of private insurance policies being sold has also changed dramatically in recent years. Long-term care insurance policies have become less restrictive as they have evolved, and many of today's policies have additional provisions that make them more valuable to individuals than earlier policies. For example, several insurers now offer policies that adjust the benefit for inflation. Many policies also now include a provision that allows policyholders to stop paying premiums after a specified number of days. One type of nonforfeiture provision continues coverage at a reduced benefit level if a minimum number of payments has been made. Another type allows partial recovery of premiums paid. While policyholders may value these provisions, policies with such features cost more. However, these and other innovations give an indication of how much the private long-term care insurance market has evolved since its emergence in the early 1980s.

ISSUES

Despite growth and significant changes with regard to private-sector long-term care insurance plans since the early and mid 1980s, no clear policy with regard to long-term care currently exists in the United States. While the private-sector market is likely to continue to grow and develop despite the ambiguities and obstacles that exist in the current system, it is unlikely that the goals of adequate coverage, universal access, affordability, and high quality care will be met without a more coherent strategy, including clarifications in policy objectives and in the regulatory environment, toward long-term care in the United States.

At present, long-term care needs are met through both public- and private-sector initiatives in the United States. Medicaid, Medicare, private-sector long-term care insurance, and private out-of-pocket payments (including reliance on family and friends) are all mechanisms used to meet individuals' long-term care needs. Recent proposals call for strengthening both public- and private-sector mechanisms through which individuals can gain access to the financing of long-term care. Some proposals advocate a public-sector solution, some a private-sector solution, and some advocate initiatives that would bolster the current public/private-sector mix. One such proposal is that contained in the Senior Citizens' Equity Act (H.R. 8) which would, among other things, encourage the growth of long-term care insurance contracts by stipulating that these contracts be treated as accident or health insurance contracts for tax purposes. The bill would also allow for the exclusion from gross income amounts withdrawn from individual retirement plans or 401(k) plans for the purchase of long-term care insurance.

The Taxation of Long-Term Care Insurance

Theoretically, long-term care insurance is an item for which individuals with assets to protect should be willing to pay. Furthermore, since people of any age may potentially need long-term care services, their assets could be at risk at any time. While the chances of having extended long-term care needs are small, the costs of such a need are extremely high. However, for a variety of reasons, only a small proportion of those who can afford long-term care insurance have actually purchased it. For those individuals who have no assets they wish to protect or who believe they will never require formal care (perhaps because they have a large family), long-term care insurance may never be worth the price. However, others may lack information on the probability of needing such care, may mistakenly believe that they are already

covered by Medicare or health insurance, or may be dissatisfied or mistrustful of policies that are currently available.

The tax code currently does not explicitly recognize long-term care. Therefore, the tax treatment of long-term care insurance premiums and benefits is ambiguous. Ambiguity surrounding long-term care insurance tax treatment might be an impediment to the market for long-term care insurance—particularly employer-based group insurance.

Proponents of changing the tax code argue that the ambiguity concerning long-term care leads to questions not only about how to treat long-term care expenses but also about the treatment of long-term care insurance. If long-term care were deemed to be medical, long-term care insurance premiums paid by an employer on behalf of an employee would be tax deductible to the employer and would not have to be included in the employee's gross income. In addition, the benefits received when a long-term care insurance claim is filed (whether under an individual or employer-sponsored policy) would not be included as taxable income to the beneficiary. However, since long-term care has not been thus defined, most employers have avoided the problem altogether either by not sponsoring a long-term care policy or by offering coverage on an employee-pay-all basis. Individuals purchasing long-term care insurance either on an individual basis or as part of an employer-based plan use after-tax dollars, which has been assumed to guarantee them tax-free claims payments consistent with general rules of insurance taxation. The assumption that long-term care premiums must be included in the taxable income of employees may impede the development of the group long-term care insurance market because employers may assume that other forms of compensation that are tax preferred (e.g., health insurance and pensions) will be more valuable to most employees. In addition, employers may refrain from offering long-term care insurance out of concern that their interpretation of the tax treatment will be contrary to an eventual ruling. A misinterpretation could require the payment of back taxes or result in uncertainty regarding the recovery of past surplus tax payments.

The provision in the Senior Citizens' Equity Act to treat long-term care insurance the same as accident and health insurance for purposes of taxation would mean that premiums paid by an employer on behalf of an employee would not have to be included in the employee's gross income and that benefits received when a long-term care insurance claim is filed would not be included as taxable income to the beneficiary.

If long-term care insurance were to receive the same tax treatment as accident and health insurance, employees receiving employer-sponsored long-term care insurance benefits would receive the same tax-exempt premium payments and nontaxation of interest on accumulating plan deposits that are characteristic of qualified pension plans. The benefits paid to them would also be tax exempt, similar to those paid by health plans. To date, the only other tax-preferred prefunding (prefunding without immediate taxation of interest) of health benefits is through a separate account in a tax-qualified pension plan (a 401(h) account). However, these accounts have not been widely used in the past because of various limitations.

Conclusion

Tax policy is often used to promote specific social and economic goals. The proposed policies for the tax treatment of long-term care can be evaluated in terms of their tax burden versus their social benefit (keeping in mind who bears the burden and who benefits). Tax policies can also be evaluated in terms of the public long-term care expenditures associated with the policy relative to the expenditures that would accrue without it. For example, a proposal to treat long-term care insurance the same as health insurance for tax purposes has an associated tax expenditure (and burden), and its adoption would subsidize those who purchase individual or receive employer-sponsored long-term care insurance. Furthermore, it might encourage the substitution of formal for informal or more efficient sources of care unless the policies pay benefits according to a disability model (i.e., disability triggers

payment as opposed to specific services). However, such a proposal may also further certain social and economic goals, including increased risk pooling, preservation of assets, and potential reduction in Medicaid expenditures for those who are not poor. Quantification and comparison of the costs versus the benefits of such a policy need to be carefully considered to develop appropriate public policy.

The committee faces a difficult challenge as they confront the complexities of this issue. EBRI stands ready to assist the committee in its efforts.

Equitable Life & Casualty
INSURANCE COMPANY
3 Triad Center, Suite 200
Salt Lake City, Utah 84180-1202

E. Rod Ross
President

TO: House Committee on Ways and Means
Subcommittee on Health

DATE: February 2, 1995

RE: Tax Treatment of Long Term Care Insurance under HR8, The Senior Citizens' Equity Act

Dear Mr. Chairman and Members of the Subcommittee on Health:

My name is Rod Ross and I am President of Equitable Life & Casualty Insurance Company.

Equitable Life & Casualty is a life, accident and health insurer domiciled in Salt Lake City, Utah. We are one of the oldest writers of Long Term Care (LTC) insurance in America.

We are especially pleased that the Senior Citizens' Equity Act, as part of the Republican leadership initiative under the Contract with America, is receiving attention this early in the 104th Congress. This proposal ends a long period of uncertainty regarding tax treatment of LTC insurance for insurers and consumers. Moreover, it establishes sound public policy in the face of a looming health care crisis.

The need to incorporate incentives for expanding private sector financing of long term care is well documented and has been presented to this Subcommittee through prior testimony. It need not be repeated by us.

We believe two questions need to be answered in formulating the most appropriate tax clarification for LTC insurance under HR8:

1. Should the tax clarification of LTC insurance apply to the broadest spectrum of taxpayers?

2. Does the federal government need to gain oversight over LTC insurance products?

The Need to Appeal to All Taxpayers

HR8 proposes to treat the deductibility of LTC insurance premiums as accident and health insurance, subject to the floor of 7.5% of adjusted gross income. We have seen other proposals identical to HR8 in this regard. We believe this "incentive" to be limited in application and value to the great majority of potential consumers.

Prior proposals which provided tax deductibility of LTC insurance as accident and health insurance were seen as benefiting only that small portion of the population who could afford it anyway without the deduction. This tax incentive should not be a vehicle only for the wealthy. Nor should it be limited to those taxpayers who itemize deductions.

The incentive to purchase private LTC insurance should appeal to taxpayers of all income levels. A straight line deduction accomplishes this result. It sends the right message--that personal responsibility for anticipating future contingencies is rewarded; that government should not be the financier of services for people capable of taking care of themselves. The proper incentive is a win/win proposition for individuals, for strained Medicaid budgets and a more significant private sector role in financing long term care.

The Recognition of State Authority

We have seen prior proposals which grant tax clarification of LTC insurance conditioned upon a base of federal minimum standards. We believe this linkage is unnecessary for several reasons:

a) The majority of states have existing standards defining LTC insurance, requiring prior approval of products;

b) States without specific LTC standards require prior approval of products under accident and health insurance standards; and

c) Insurance products marketed primarily to individuals age 65 and older receive more intensive scrutiny at the state level.

The federal tax treatment of accident and sickness and disability insurance is provided without mandating product design or specifications. Early on, the states deliberately considered specific minimum requirements for LTC insurance to ward off the occurrence of abuses and practices which regulators encountered in Medigap insurance.

We speak from firsthand experience when we tell you that the regulatory scrutiny of the states is alive and well in LTC insurance. Our latest product reimburses expenses incurred for home and community based services under a plan of care developed between the insured, the family and a care coordinator. The approval process for this product in the states was detailed; and the product was not approved in all states. Suffice it to say, state regulation over LTC insurance is more than adequate.

There is simply no need for an additional layer of federal oversight. Precedent in tax clarification of other health insurance exists to negate its necessity as well. At a point when the federal government has signaled strong support for the return of power to the states, to dictate standards to those now on the front line of regulatory oversight and consumer protection is a step backward.

Summary

In summary, we advocate a straight line deduction for taxpayers' premiums for LTC insurance. Additionally, we propose HR8 eliminate federal minimum standards and defer to the states in determining what is a LTC insurance contract.

We appreciate this opportunity to present our position regarding the tax treatment of LTC insurance under HR8, The Senior Citizens' Equity Act. Additionally, we offer our assistance in crafting acceptable proposals which promote a more active role in private sector financing of long term care.

Sincerely,

E. Rod Ross
President

STATEMENT OF LINCOLN NATIONAL CORPORATION, LINCOLN NATIONAL LIFE INSURANCE COMPANY, AND FIRST PENN-PACIFIC LIFE INSURANCE COMPANY ON THE SENIOR CITIZENS EQUITY ACT, H.R. 8

For hearings held before
The Subcommittee on Health of
The Committee on Ways and Means
on January 20, 1995

Lincoln National Corporation and Lincoln National Life Insurance Company, of Fort Wayne, Indiana, and First Penn-Pacific Life Insurance Company, of Oakbrook Terrace, Illinois (the "Lincoln National Companies") submit this statement for inclusion in the record of the hearings held by the Subcommittee on Health of the Committee on Ways and Means on January 20, 1995 concerning the Senior Citizens Equity Act, H.R. 8. The Lincoln National Companies are pleased to express their strong support for the provisions of the Senior Citizens Equity Act that provide clarifications for the tax treatment of accelerated death benefits and long-term care insurance.

We consider the Senior Citizens Equity Act well framed in providing tax clarifications for accelerated death benefits and long-term care insurance, and we compliment the drafters on both their willingness to step forward in this area and their foresight in so doing. H.R. 8 makes much-needed clarifications in the tax law, and is quite timely in view of the substantial and rising interest in "living benefits" provided through life insurance contracts. This fact, coupled with the importance of facilitating efficient funding for the often great costs of long-term care and terminal illness, make enactment of these tax clarifications both important and necessary.

There are two types of "living benefits" addressed by H.R. 8 that are increasingly offered in connection with life insurance contracts: (1) accelerated death benefits, usually provided by a rider on a life insurance contract which accelerates payment of the contract's death benefit when the insured becomes chronically ill (including the "long-term care acceleration rider") or when he or she becomes terminally ill (the "terminal illness rider"), and (2) so-called "non-acceleration" long-term care benefits, provided under a rider which pays long-term care benefits when the insured becomes chronically ill but which does not affect the values, including the death benefit, of a related life insurance contract (sometimes referred to as a "stand-alone" long-term care rider).

H.R. 8 addresses accelerated death benefits in section 306 of the bill, while non-acceleration long-term care benefits offered in connection with life insurance contracts are addressed in section 301 of the bill (specifically in proposed section 818A(d) of the Internal Revenue Code). H.R. 8 also addresses long-term care insurance offered independent of any life insurance contract in sections 301-303 of the bill. This statement focuses on the tax clarifications made for life insurance rider products, although we support the tax clarifications which H.R. 8 provides for long-term care insurance generally.

Accelerated Death Benefits

In General. Since the late-1980s, many life insurance companies have begun offering accelerated death benefits in connection with their life insurance contracts. The purpose of accelerated death benefits is to allow chronically and terminally ill policyholders to receive the full value of their contracts prior to death, not just their cash surrender values, to help them manage the added financial burdens occasioned by their illness.

People primarily purchase life insurance for income protection, to provide for a surviving spouse or children in the event of the insured's premature death. As individuals reach older ages, their need for income protection becomes less impor-

tant. But, at such times, the built-up value of the life insurance contract may be used to address other insurance needs that are then arising -- the risk that an illness will place substantial financial burdens on the family. Accelerated death benefit riders provide access to the "entire" value of a life insurance contract (including its pure insurance element) to pay long-term care or terminal illness costs. These riders thus substantially complement an individual's insurance protection after retirement, recognizing that one of the greatest risks, or emergencies, that individuals can face at this time is the financial crisis that arises upon an insured's chronic or final illness.

Accelerated death benefits constitute an important addition to the benefits offered under life insurance contracts. If they were not available, a chronically or terminally ill individual would likely be faced with poor financial options -- either avoiding life-time expenses to the extent possible or cashing in his or her life insurance contract to cover expenses. If forced to surrender the contract, the individual would lose the pure insurance element of the contract (the excess of the contract's death benefit over the cash surrender value). Under an accelerated death benefit rider, however, both the pure insurance element and the cash surrender value are available to provide benefits.

Long-Term Care Acceleration Riders. Under a long-term care acceleration rider, accelerated death benefits are paid to chronically ill individuals in the same circumstances as under stand-alone long-term care insurance contracts. When benefits are paid under the rider, however, there is a dollar-for-dollar reduction in the death benefit of the related life insurance contract -- the rider "accelerates" payment of the death benefit. Benefit payments under such a rider are made periodically, either in reimbursement of actual long-term care expenses incurred (subject to limits set forth in the rider) or as a stated percentage of the life insurance death benefit.

Terminal Illness Riders. Under a terminal illness accelerated death benefit rider, benefits are paid upon establishment of the insured's terminal illness (when the insured's life expectancy is 12 months or less). Most riders pay the benefits in a lump sum rather than on a periodic basis, although it is not uncommon for some portion of the life insurance death benefit to remain after the accelerated death benefit payment. For example, a rider might provide that 50 percent of the death benefit may be paid out as an accelerated death benefit, with the remainder to be paid out to the beneficiary when the insured dies.

Methods of Purchase for Long-Term Care Acceleration Riders and Terminal Illness Riders. There are several methods by which insurance companies are compensated in connection with accelerated death benefits, but, in all cases, the cost is only the time value of money cost associated with paying the death benefit prior to death. In the case of long-term care acceleration riders, the cost is typically assessed through stated charges imposed prior to the chronic illness, e.g., through a monthly rider charge. Therefore, in contrast with terminal illness riders, discussed next, the full undiscounted death benefit can be paid out as benefits under a long-term care acceleration rider.

In the case of accelerated death benefits payable under terminal illness riders, there are two mechanisms by which the cost is typically assessed: (1) through the so-called "lien method" or (2) in the form of a "back-end" discount. Under the lien method, the accelerated death benefit is paid out in the form of a loan: the loan is secured by a lien against the death benefit payable under the related life insurance contract, and interest accrues on this loan. Insurers generally require that some portion of the death benefit remain unencumbered by the lien after the accelerated death benefit payment is made, so that

interest can be offset against this amount upon death. When terminal illness accelerated death benefits are paid out through the discount method, the accelerated death benefit payment typically will represent 85 percent to 90 percent of the death benefit extinguished by the payment. The 10 percent to 15 percent difference represents the interest cost of paying the death benefit early.

As indicated above, for all accelerated death benefits, the insurance company need only charge for the time value of money cost associated with paying the death benefit prior to death. As a result, accelerated death benefits represent an inexpensive way for policyholders to acquire insurance protection against the costs associated with chronic or terminal illness. The low incremental cost of these benefits, together with the wide-spread current ownership of cash value life insurance, provides a large number of people with the ability to acquire these beneficial insurance coverages.

"Non-Acceleration" Long-Term Care Insurance Riders

We also strongly support the tax clarifications provided by the Senior Citizens Equity Act for "stand-alone" long-term care insurance. These tax clarifications are provided in sections 301-303 of the bill, and address both long-term care insurance benefits offered in connection with a life insurance contract and those offered independent of any life insurance contract. In the former case, it is our understanding that proposed section 818A(d), which addresses long-term care benefits offered under life insurance contracts, was included in the long-term care portion of H.R. 8 to address "non-acceleration" long-term care rider benefits, i.e., long-term care insurance riders which do not accelerate payment of the underlying life insurance contract's death benefit.

An example of a non-acceleration long-term care rider is the so-called "extension rider," which pays long-term care benefits only after a long-term care acceleration rider has paid out the entirety of the underlying life insurance contract's death benefit. Another example of a non-acceleration long-term care rider would be one similar to that described in IRS Private Letter Ruling 9106050 (November 16, 1990) which operated as an independent long-term care insurance contract attached to a life insurance contract.

The Proposed Legislation

We are very pleased that the Senior Citizens Equity Act contains provisions which clarify the tax treatment of accelerated death benefits and long-term care insurance. These clarifications are especially timely given that use of living benefits under life insurance contracts has flourished in recent years. With these clarifications, life insurance policyholders will be able to utilize their contracts in an efficient manner to assist them in dealing with the potentially devastating costs associated with chronic and terminal illness.

There are several minor technical changes, however, that we would recommend for improvement of the bill. We believe that the recommendations, set forth in the attached appendix, will help assure that the bill achieves its goals.

Conclusion

Accelerated death benefits and long-term care insurance provide an efficient and effective way for individuals to achieve some "piece of mind" in regards to the potentially devastating cost of chronic or terminal illness. Thus, it is entirely appropriate that favorable clarifications in the tax status of such benefits be provided at this time, to remove any unintended disincentive that may exist because of the current tax uncertainty.

APPENDIX

SUGGESTED TECHNICAL MODIFICATIONS TO THE ACCELERATED DEATH BENEFIT AND LONG-TERM CARE PROVISIONS OF H.R. 8

Matters Relating to the Section 7702 Definition of Life Insurance

Treatment of Rider Charges. When accelerated death benefit or long-term care rider charges are made against a life insurance contract's cash value to fund the rider, there may not be a corresponding reduction in "premiums paid" for the life insurance contract, within the meaning of section 7702(f)(1) of the Code, and this may prevent the life insurance contract from being able to mature on its promised benefits. This problem has been addressed in prior bills by providing for an increase in the guideline premium limitation under section 7702(c)(2) in any case where such charges do not reduce "premiums paid." (See proposed section 7702B(d)(3) in section 7402 of S. 2357, 103d Cong., 2d Sess.)

As an alternative to legislative language, we note that a specific grant of regulatory authority exists in section 7702(f)(1), under which "premiums paid" can be reduced by "amounts received with respect to [a life insurance contract] which are specified in regulations." If this approach is to be taken, it would be very helpful for this Committee's report to indicate that the Treasury Department should exercise its regulatory authority under section 7702(f)(1) in respect of accelerated death benefit and long-term care rider charges.

Application of the Section 7702(f)(7) Adjustment Rule. A related problem regarding "premiums paid" arises when payments of accelerated death benefits result in the application of the section 7702(f)(7) adjustment rule. Long-term care acceleration riders generally make periodic payments, so that the death benefit may be reduced by a relatively modest amount each month. In addition, while terminal illness riders can pay out all of the death benefit, many pay out only a portion of the death benefit, leaving some life insurance so that the beneficiary will receive a death benefit on the insured's death. Thus, under either type of rider, the life insurance contract, with a reduced death benefit, may remain after accelerated death benefits are paid, and this necessitates application of the section 7702(f)(7) adjustment rule under current law. This adjustment rule will often produce extremely harsh results in such circumstances -- adjustments may cause a life insurance contract to collapse either when or within a short time after accelerated death benefits commence. This is because the adjustment rule will reduce the guideline premium limitation, but the payment of accelerated death benefits (and any consequent reduction of the life insurance contract's cash value) apparently will not reduce "premiums paid."

We believe it would be appropriate to create a statutory rule to address how the section 7702(f)(7) adjustment rule should apply upon the payment of accelerated death benefits, and we would be pleased to provide any technical assistance that the Committee may require in this regard. Alternatively, this problem could be substantially ameliorated if the Treasury Department were to issue regulations indicating that "premiums paid" is reduced by any payments of accelerated death benefits, to the extent such payments reduce the cash value of the life insurance contract. If this approach is to be taken, it would be very helpful for this Committee's report to indicate that the Treasury Department should exercise its existing regulatory authority under section 7702(f)(1) to this effect.

Modification of "No Material Change" Transition Rule

The transition rule in section 307(d) of H.R. 8 is intended to prevent the addition of a long-term care or accelerated death benefit rider to a life insurance contract from constituting a modification or material change of the contract. Under this rule, adding such a rider would not disrupt any "grandfathering" that exists with respect to a life insurance contract, nor would it

subject the contract to a change in its limitations under the technical rules of sections 101(f)(2)(E), 7702(f)(7), and 7702A(c)(3). Thus, if a life insurance contract is currently governed by a set of rules under prior law, e.g., it is a section 101(f) flexible premium life insurance contract, the addition of a rider would not, in and of itself, cause the contract to become subject to a new set of rules. Further, if the contract is already governed by current law, e.g., section 7702A, the addition of a rider would not trigger a section 7702A(c)(3) material change.

As currently drafted, however, the rule does not appear to accomplish this purpose fully and unambiguously. We therefore recommend that the following changes be made:

- The rule currently appears to be limited to "determining whether section 7702 or section 7702A" of the Code "applies to any contract." This might be interpreted as limiting application of the rule to older, grandfathered contracts, denying its relief to recently or newly issued contracts. To clarify that this is not intended, the phrases "determining whether" and "applies to any contract" should be deleted.

- The rule currently has no application to terminal illness riders -- only long-term care riders are expressly covered -- and fails to mention section 101(f) contracts. The rule should be changed to cover the omitted riders and contracts.

- The rule currently appears only to address the addition of riders. The rule should be expanded to include the conformance of an existing rider to any of the Act's requirements, e.g., those of proposed section 818A(b) or (c).

Thus, we respectfully suggest that the transition rule be modified to read as follows (deleted language is stricken, new language is underscored):

> (d) Issuance of Certain Riders Permitted.-- For purposes of ~~determining whether~~ sections 101(f), 7702 or 7702A of the Internal Revenue Code of 1986~~ applies to any contract~~, the issuance, whether before, on, or after December 31, 1995, of a rider on a life insurance contract providing long-term care insurance or accelerated death benefit coverage, or the conformance of such a rider to the requirements of this Act, shall not be treated as a modification or material change of such contract.

Long-Term Care Acceleration and "Non-Acceleration" Riders

It is our understanding that the treatment of long-term care benefits under H.R. 8 has been bifurcated, so that benefits from "non-acceleration" long-term care riders are addressed in section 301 of the bill (in proposed section 818A(d) of the Code) and benefits from long-term care acceleration riders are addressed in section 306 of the bill (in proposed section 101(g)(1)(B) of the Code). We believe it is entirely appropriate to address these benefits in the manner done in H.R. 8, given the operation of long-term care acceleration riders. Also, proposed section 818A(d) is necessary given the existence of products such as the extension rider. To alleviate any potential confusion arising from this bifurcated treatment, it would be helpful if this Committee's report, in addressing the accelerated death benefit provisions of H.R. 8, included the following language:

> The treatment of benefits from long-term care insurance riders to life insurance contracts that accelerate the life insurance death benefit is addressed in the accelerated death benefit provisions of the Act. In contrast, the treatment of benefits from other long-term care insurance riders is addressed in the long-term care insurance provisions of the Act.

TESTIMONY OF JENNIFER WARREN
MARKMAN COMPANY

Sharing the Responsibility In Long Term Care

With the Republican's Contract With America, a new opportunity exists to finally create a policy that will have multiple economic and social benefits. The introduction of tax incentives for long term care insurance will have far-reaching repercussions. Long term care costs bore by the public sector amounted to $108 billion in 1993. Medicaid pays for a good portion of our nation's long term care tab by default. Due to Medicaid's role in long term care, people have come to use this system for purposes which were not intended by the taxpayers. Many have stopped planning responsibly knowing that the government will pickup the bill.

About the Long Term Care Market
America is about the face a demographic-induced economic challenge which must be dealt with now in order to maintain fiscal responsibility. In the US, we spent approximately $108 billion in 1993; the government paid for about 65 percent of the total expenditures. The 32 million Americans aged 65 and over will double to 65 million by the year 2030. The $108 billion long term care figure does not even include acute care spending supported by Medicare. Long term care expenditures have been growing steadily and rapidly. Home health care spending alone will grow at a rate of 12% per annum between 1991-1996; other research indicates a 14.6 % growth rate.

What Should Be Done
A few facts will start the analysis in the proper direction. Medicaid spent $42 billion, mostly for the elderly, on long term care in 1993. It is estimated that 25% to 50% of beneficiaries receiving Medicaid long term care involved some form of divestiture or "spending down" to qualify for Medicaid. Medicare has also entered the long term care arena by discharging beneficiaries sooner from hospitals and there being the need for ongoing care. This has created an area called "post-acute care" which grew at a rate of 37% between 1988- 1991, the amounts being $4.7 billion to $12.2 billion respectively. Post-acute care is comprised of home health care and skilled nursing facilities, both "long term care" providers. Hence, Medicare now pays for small, but growing percent of long term care type services though its intended for acute care needs.

What should be done:

• Provide tax incentives for long term care insurance. Long term care is an additional insurance expense for the elderly just like Medicare Supplement insurance. Since the taxpayers would be partially relieved for some of the elderly's LTC costs by them planning for their own needs, a tax incentive would create a better environment for coverage like the premise of our employer-provided insurance system.

• Stop producing regulation that obstructs the private market for long term care

insurance. The industry is being constantly barraged by a bureaucracy that would ultimately like a public LTC system. Many insurer's have left the market due to perpetual, ongoing regulation. This regulation is causing policies to become more expensive and prohibitive to the middle class who very much needs to purchase the insurance so that taxpayers don't inadvertently pay for their LTC.

These are easily implemented, symbolic gestures that the government can and should initiate. With the focus once again on less government and fiscal responsibility, some honesty about the way things are in our health care and tax system is due. The country of Chile had a bankrupt public pension system; the government allowed the public to choose between contributing to a private scheme or a public scheme. The net result is that most Chileans now contribute to their own private pension and the savings rate for the country as a whole has risen. If you let people do for themselves what they know is right, mostly they will. The obstacle here in long term care is a lack of understanding of what has happened in a system supported by people in government who do not believe in individual's ability to provide for themselves. They have helped create dependence.

Future Market Development

Long term care in its entirety has grown not only from demographics, increased willingness to use health care services and a wealthier, healthier society but from the "deep pockets" of the government. Aside from eligibility restrictions for Medicare and Medicaid to control expenditures, our government simply writes blank checks year after year for long term care. Having some better accountability via the private market which must provide an acceptable service with an acceptable return on investment in order to perpetuate itself is a desired counterbalance to the bloated public arm in long term care financing. The gatekeepers of the public sector are not strong enough with the proper incentives to motivate efficiency and innovation that will be needed to support our aging population with its greater need for health care services.

Tax incentives, as provided in the Contract With America, are a beginning to encourage the further development of a private long term care market. Programs like Medicaid that were designed for the indigent should remain as the safety net they were intended to be. It is simply one more step that needs to be taken by Americans to provide for themselves once again.

TESTIMONY OF VAL J. HALAMANDARIS
NATIONAL ASSOCIATION FOR HOME CARE

The National Association for Home Care (NAHC) represents the nation's home care providers -- including home health agencies, home care aide organizations, and hospices -- and the individuals they serve. NAHC is committed to assuring the availability of humane, cost-effective, high quality home care services to all individuals who require them. Toward this end, NAHC believes that America must do better at ensuring access to high quality home care and hospice in both the acute and long-term care setting. These vital services provide millions of individuals -- the aged, infirm, disabled, and children -- the ability to receive care in the settings that allow them the highest level of satisfaction, independence, and dignity -- in their homes.

The Senior Citizens' Equity Act acknowledges the growing long-term care need in the U.S. Long-term care is one of the most devastating problems America faces today. Estimates indicate that between 9 and 11 million Americans of all ages require long-term care because of chronic illness or disability that render them helpless to perform basic tasks of daily living without assistance. This number could double by the year 2030 to more than 19 million. The need for long-term care is expected to increase substantially as a result of several factors: the burgeoning growth of the elderly population; increased usage of high technology and new medical breakthroughs that may extend the lives of more mentally retarded, developmentally disabled and physically disabled persons; increased survivorship of low birthright children; greater longevity for children with terminal chronic illness, and earlier detection of chronic health problems; and the growth of the number of persons with AIDS.

Spending for long-term care is currently estimated at $57.8 billion. Yet neither Medicare nor private insurance provides adequate protection against the costs of long-tern care. Many families exhaust their emotional and financial resources providing and purchasing long-term care. A million Americans a year are impoverished trying to meet the cost of long-term care left uncovered by insurance. Only the most wealthy of Americans are insulated from the potential financial devastation. The rest can have their lifetime savings wiped out in a matter of months paying for long-term care.

Long-term home care improves the quality of life because it is more humane. It reinforces and supplements the care provided by family members and friends and maintains the recipient's dignity and independence, qualities that are all too often lost in even the best institutions.

Long-term home care services can also be cost-effective. New York State's experience with its Nursing Home Without Walls program is that the great majority of clients who would otherwise need to be placed in a nursing home can be cared for at home for a much lower cost.

Medicaid waiver programs have increasingly relied on home care services as a way to reduce states' long-term care costs. For example, New Mexico's waiver program for people with AIDS estimates a savings of $1,100 a month for patients who use home care rather than skilled nursing facility care. The average patient plan of care costs $1,000 a month for home care compared to $2,100 a month for skilled nursing facility care, according to the program director. Moreover, New Mexico reports that only about 47 percent of patients receiving waiver services are hospitalized in a given year, compared to 70 percent of those not under waiver.

The National Governors' Association (NGA) has recognized the importance of home care services and in a resolution adopted in 1992 stressed the importance of making home- and community-based services a key component of all long-term care policies and programs. NGA recommended elimination of the current institutional bias in public programs for long-term care in favor of home care as a more preferred and cost-effective method of care.

The National Association for Home Care applauds the Committee's commitment to making long-term home care more accessible for the millions of Americans with chronic disabilities. This crucial component of the Contract with America will help make the promise of long-term home care a reality for the young, the elderly, and all disabled Americans. Home care has a long and distinguished history of caring for individuals of all ages in the setting they like best -- in their own homes where they can maintain their dignity, their independence, and their individuality.

Very few individuals can afford to pay for long-term care at home or in a nursing home out of their own pockets, and yet neither Medicare nor private insurance cover those services to any great degree. Private long-term care insurance policies first appeared on the market nearly 17 years ago, but have grown dramatically in the past several years. Between 1987 and 1991, companies offering policies increased from 75 to more than 130. Although the proliferation of policies has created competition among insurers to significantly improve their products, problems remain in even the most improved policies.

Regulation of the private long-term care insurance market is left up to the states and the National Association of Insurance Commissioners (NAIC) has recommended model laws and regulations. Nearly all states have adopted the NAIC model act, but only 28 states have issued regulations, only 14 require any form of inflation protection, and only 12 have issued home care coverage standards.

Ongoing problems with high lapse rates, coupled with persistent reports about abusive sales tactics, has fueled concern over the ability of states to regulate the private long-term care insurance market to ensure the sale of high quality products and protect consumers from fraud and abuse.

NAHC supports Congressional action to create favorable tax incentives to promote the purchase of long-term care insurance that meet federally established minimum standards by those who can afford it. Tax incentives are especially needed to foster development of long-term care insurance through employer based plans and vested retirement funds. Employment based plans could be more attractive and affordable and extend coverage to the largest number of people. Congress should clarify whether tax exempt status applies to long-term care insurance reserves held by insurers and to the investment earnings credited to them.

Present restrictions on buying long-term care insurance through cafeteria plans and flexible spending accounts should be removed. In addition, individuals should be allowed, before and after retirement, to use money accumulated in pension plans, individual retirement accounts, and life insurance policies for long-term home care needs without penalties or loss of tax deductions. In the alternative, Congress should allow tax deductions for individuals who establish individual medical accounts devoted to long-term care needs.

The Senior Citizens' Equity Act would address two of these issues. Section 302 would allow employers to provide employees with tax free long-term care insurance and to permit exclusion for benefits provided under long-term care insurance. This provision could help promote the growth of the group market for younger purchasers and should be extended to employees who purchase the policies for their parents.

Section 305 of the Act would permit tax free distributions from IRAs and 401(k) plans to purchase long-term care insurance. NAHC supports this provision as well.

Probably the provision in the Act that may be most valuable to individuals in need of long-term care and their families is Section 303(a) which would treat qualified long-term care services as medical care for purposes of the medical expense deduction currently allowed when such expenses are in excess of 7.5 percent of adjusted gross income. This benefit would not be limited to those who purchase private long-term care insurance and would help all families burdened with out of pocket long-term care expenses.

This proposal could even help to delay nursing home placement and help individuals avoid having to spend down their life savings in order to qualify for Medicaid nursing home coverage.

However, tax incentives for the purchase of long-term care insurance must be accompanied by aggressive minimum standards and consumer protections for long-term care insurance. Policies should not be sold, and certainly should not be given preferential tax treatment, that do not meet strict federal consumer protection standards. Only in this way will Congress ensure that individual purchasers are guaranteed a high quality product that will provide them with the measure of protection they expect when purchasing long-term care insurance. Federal tax incentives should not be available for the purchase of inferior policies that offer only hollow promises.

Just as Congress, in 1990, established federal minimum standards for the sale of Medicare supplemental insurance (Medigap) policies, so should Congress establish minimum federal standards for the sale of long-term care insurance policies. These standards should, at a minimum, specify coverage standards for home care and hospice services, require inflation protection and nonforfeiture benefits, and regulate sales practices.

Probably the greatest coverage failing with private long-term care insurance today is the inadequate coverage that most of these policies provide for long-term home care -- undoubtedly the benefit most purchasers prefer over nursing home care. Private policies provide very poor coverage for long-term home care needs. Some companies limit home care coverage by requiring prior nursing home care, paying only a small fraction of the nursing home benefit, covering only medically necessary services, and excluding coverage for home care aide services. Mandatory federal minimum standards for home care coverage can help address this failing, and help make private long-term care insurance policies more attractive to consumers.

State attempts to regulate the private long-term care insurance market have had only limited success. In the absence of federal regulation, it is up to consumers to carefully sort through the myriad policies, riders and features to find an affordable reliable plan. The choices are complex and the figures easily manipulated. Only by mandating federal standards for long-term care insurance will all consumers be protected. Regulation of the market will foster confidence among consumers that private long-term care insurance constitutes a viable option for their protection from large out of pocket expenses in the event that they may need long-term care services.

While NAHC supports tax incentives to purchase long-term care insurance policies, we believe that the Senior Citizen's Equity Act, by restricting use of home care benefits only to cases where they would prevent institutionalization, would severely and unnecessarily hinder a policyholder's choice of health delivery systems.

Home care has long been recognized as an appropriate and cost-effective method for delivery of acute care, as well as long-term care services. Home care has been a mandatory benefit under Medicare since its inception. In addition, federal requirements for health maintenance organizations have, since 1973, mandated the provision of home health services "without limitation as to time or cost." Under employer-sponsored plans, home care is widely available. A survey by the Health Insurance Association of America found that 83-89% of insured employees had coverage for home health services.

Limiting the home health benefit as an alternative to institutionalization could become an administrative quagmire that would restrict access to appropriate in-home care for patients who are not able to prove to their health plans' satisfaction that without home care services they would be institutionalized. Patients should be entitled to receive health services in the most appropriate and least restrictive setting -- be it in the home, skilled nursing facility, hospital or some other setting.

It is the responsibility of the physician to weigh the alternative delivery methods and choose the most appropriate course of treatment.

Moreover, limiting home health benefits to coverage only as an alternative to inpatient treatment would exclude coverage of many patients who clearly need in-home services but do not require an institutional level of services. For example, it is often appropriate to provide monthly catheter changes for patients with multiple sclerosis or other neurological disorders in their homes because of the problems of transporting them by van or ambulance to a medical facility. Moreover, there are other home care patients for whom institutionalization is unnecessary such as blind insulin dependent diabetics, ventilator dependent children, patients with mild strokes, acute infections, chronic asthma or those needing outpatient surgery and control medications.

For the reasons stated above, we urge you to amend the Senior Citizens Equity Act to allow preferential tax treatment for long-term care insurance policies that cover home care without regard to whether institutionalization would occur without this care.

Inadequate access to long-term home care is one of the most devastating problems facing America. Although private long-term care insurance will not be a total solution for financing long-term care, it can help protect some people against large out of pocket expenses. It gives some individuals the opportunity to retain choices and develop a flexible, planned response to a potentially ruinous event that will confront many people over 65 as well as many disabled people under 65.

Thank you for your interest in this important area and for the opportunity to present our views for consideration by the Committee.

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TESTIMONY OF SPENCER A. LEHMANN, RHU
NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

SUBCOMMITTEE ON HEALTH

Dear Mr. Chairman, Mr. Stark, Members of the Committee:

I thank you for the opportunity to give testimony on behalf of the **National Association of Health Underwriters (NAHU)** regarding the Senior Citizens' Equity Act and to specifically address long term care insurance tax deductibility issues, long term care insurance minimum standards and agent educational requirements.

My name is Spencer Lehmann. I am advisor to the **National Association of Health Underwriters (NAHU)** on senior health care issues and served on the Board of Trustees as chairman of the Health Insurance Training Council. I am past president of the Washington State Association of Health Underwriters and a member of the Washington State Insurance Commissioner's advisory committee. I have 27 years of experience in the insurance business and am principal in Lehmann-Wood Associates, an agency in Bellevue, Washington, specializing in group and individual long term care insurance. I am also author of a monthly column on long term care for the *Health Insurance Underwriter*, **NAHU's** national monthly magazine.

With more than 13,000 members, **NAHU** is the largest and only independent association representing professional insurance benefit advisors specializing in health insurance in the U.S.

The National Association of Health Underwriters appreciates this opportunity to submit testimony regarding the Senior Citizens' Equity Act. We would like to specifically address long term care insurance tax deductibility issues, long term care insurance minimum standards, and long term care insurance agent educational requirements.

Prefacing our specific comments we offer the following for consideration: The subject of long term care is not a concern exclusive to the senior population. Long term care affects citizens of all ages. Recent studies have shown that the possibility of needing long term care can be as great as one chance in four for those who are under 79 years of age, and one chance in two for those who are 80 years of age and older. The results of a study published in the New England Journal of Medicine in May 1992 revealed that of those Americans who turned 65 in 1990, 43% will live in a nursing facility at least once during their lifetime. Many who are under the age of 65 experience medical trauma and chronic disability due to accidents or illness and will undergo long term care in both rehabilitative and custodial settings.

Long term care insurance first became available in the early 1970's and has evolved exponentially since it was first introduced. The vast majority of policies now being offered contain very liberal benefit triggers. Most require that the claimant meet one of the three criteria in order to be eligible for benefits: medical necessity; the inability to perform two or more of the activities of daily living (ADL's), most commonly defined as eating, dressing, transferring, bathing, toileting, and continence; and cognitive development. We no longer find unrealistic gatekeeping hurdles such as a three-day prior hospital requirement, nor entry to nursing facilities at a level of care higher than custodial, unlike Medicare.

The need for long term care as an integral component in health care delivery continues to grow as our society ages, lives longer, and endeavors to contain escalating health care costs. Funding for long term care delivery is available from only three primary sources; personal income and assets, Medicaid, and private long term care insurance. Unless a private long term care insurance policy is already in place, once personal assets have been exhausted Medicaid becomes the only viable funding source for the long term care patient. In the 1988 study performed by the Long Term Care Task Force of Health and Human Services, under the auspices of Dr. Otis Bowen, private long term care insurance was found to be the most cost effective method of funding long term care. That is still the case today.

We have been embroiled in health care reform debate for several years. One outcome of that debate has been the recognition that long term care funding carries too high a price to be included in any government program as another entitlement whose cost would be borne by the already overburdened US taxpayer. It has become equally clear that we must now promote health care reform legislation that will encourage a philosophy of individual responsibility, and not

"societal welfare-ism." To that end, preferential tax treatment of long term care insurance premiums is imperative. Additionally, all states should be encouraged to establish long term care public/private partnerships, such as the Connecticut Partnership. Further, a floor of long term care insurance minimum standards should be recommended for all states, and educational programs should be developed for all agents and home office personnel involved in marketing long term care insurance.

The National Association of Health Underwriters suggests that regarding:

1. **Tax issues**: all premiums paid for long term care insurance should be tax deductible. Employer contributions to long term care insurance premiums should be tax deductible to the employer. Policy benefits for long term care should be tax free, and long term care expenses should be viewed as a deductible medical expense.

2. **Individual responsibility incentives**: public/private long term care partnerships, such as those established in Connecticut, New York, California, Indiana, Illinois, and Maryland should be encouraged in all states. The asset protections afforded by these partnerships serve as model incentives for the states to promote to their citizens in an effort to encourage their citizens to purchase long term care insurance and not have to access Medicaid. The discriminatory provision in the "Waxman Amendment" in OBRA 93 relating to the public/private partnerships and addressing estate recovery after the death of the "well spouse" should be repealed. Individual responsibility needs to be encouraged and the public/private partnerships offer a viable means of achieving that goal.

3. **Consumer protection**: Minimum standards should be enacted by all states regarding long term care insurance policy components. It is critical that these standards meet the test of protecting the consumer without infringing on the consumers' right to choice, and not inhibiting policy benefit innovation. Certain components of the NAIC Long Term Care Insurance Model would protect the consumer to the extreme, deny the consumer choice, and drive the cost of long term care insurance up so dramatically that many would not be able to find affordable coverage. Examples of these onerous components are mandated non-forfeiture benefits and rate stabilization.

4. **Educational requirements**: Insurers should establish long term care insurance education programs for agents. In states requiring continuing education, agents marketing long term care should have to meet a minimum number of credits in long term care insurance. States not presently requiring continuing education should be encouraged to do so.

5. **Additional consumer protections we suggest**: Federal standards should be developed requiring that licensing forms. policy forms, disclosure forms, replacement forms, medical authorization forms, and claim forms be uniform. Further, all physicians, medical clinics, labs, hospitals and all other health care deliverers and providers should be required to accept the standardized forms. Implementation of standardized forms is a needed component in cost containment and will help reduce consumer confusion.

The National Association of Health Underwriters applauds the efforts of the sponsors of the Senior Citizens' Equity Act for recognizing the need to develop incentives to encourage the growth of the private long term care insurance market, and to encourage the citizens of our country to be individually and socially responsible. A commitment by the public and private

sectors to work together in an effort to develop strong and responsible long term care financing solutions is imperative to the future financial strength of our country, and its citizens.

The National Association of Health Underwriters would like to serve as a resource for, and stands ready to assist in any way that it can, the members of Congress and the Administration as we move forward in developing solutions to the important problems in long term care financing that face us today.

We thank you for this opportunity to contribute our remarks.

GEORGE ROSS FISHER, M. D.
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Long-Term Care Tax Clarification

(Testimony Submitted to Committee on Ways and Means, Health Subcommittee, Congressman Bill Thomas, Chairman)

George Ross Fisher, MD
Trustee for Philadelphia, Pennsylvania Medical Society

In response to your public invitation for testimony on this important subject, I submit the following simple suggestion, which I believe would make an important contribution.

Retired persons can be generally divided into the group younger than roughly age 80, who are vigorous and active, and those over roughly age 80 who are often or mostly infirm and needful of assistance. Members of both groups are concerned about limited finances.

Many voluntary organizations and organized retirement communities are composed of members of both groups. That is, some are passing through each stage of retired life. The thought has occurred to many such organizations that the younger group might volunteer to help the older ones, looking forward to the day when they would be needful themselves.

Unfortunately, the Internal Revenue Service has taken a position that such activity is equivalent to in-kind income, subject to income tax. While voluntarism will always be a vigorous part of the character of most Americans, nevertheless the IRS policy has a chilling effect on the incentives to do a little more. It is particularly chilling to more organized concepts of accumulating service credits or transferable vouchers. Many seniors might want to perform volunteer work in a location different from the location where they might later receive some benefit themselves. And some forms of volunteer effort are less attractive than others, so that availability may not match the actual need, unless some more organized recognition were made possible .

Mr. Chairman, I will not further embroider on this idea, whose consequences seem self-evident. I hope your subcommittee can consider it.

TESTIMONY OF
CONGRESSMAN CHRISTOPHER SHAYS

BEFORE THE
HOUSE WAYS AND MEANS COMMITTEE

Chairman Archer, Congressman Gibbons, and members of the Committee, thank you for providing me the opportunity to testify before your committee to discuss the five bills within the Contract With America that are under the committee's jurisdiction. This is an important part of moving the contract forward. I would like to take this opportunity to share my views with you on these five proposals.

I. THE AMERICAN DREAM RESTORATION ACT

H.R. 6, the American Dream Restoration Act, of which I am a cosponsor, will help restore economic viability to the American family, and promote greater individual savings.

As you know, the bill provides a tax credit of up to $500 per child for families with incomes under $250,000. Phase out of the credit would begin at $200,000, with full phase out at $250,000.

The legislation also provides tax credits to individual affected by the marriage penalty, which occurs when a married couple pays more as a couple than they would as individuals.

Finally, the legislation creates a new type of Individual Retirement Account (IRA) which would permit individuals with any income level to contribute up to $2,000 per year ($4,000 for married couples) into a new IRA, called the American Dream Savings Account (ADSA). These new accounts differ from conventional IRAs in that individuals would pay income tax on contributions to the accounts, but would be able to make withdrawals tax free. Current IRA participants would be allowed a two-year window to roll over existing IRAs into an ADSA.

I strongly support these provisions. As you may know, the Republican Budget Alternative for fiscal year 1995 (FY 95), written by the Republicans on the Budget Committee, included provisions providing for expanded IRAs and a $500 tax credit per child. Our alternative budget not only provided for greater deficit reduction in FY 95 than the President's budget but also paid for the tax incentives. It is equally important that the tax provisions in H.R. 6 and all the tax provisions within the Contract With America be paid for. Tax provisions will not help if ultimately they contribute to the federal budget deficits.

II. THE JOB CREATION AND WAGE ENHANCEMENT ACT

H.R. 9 is an effort to do just what its title states -- help create jobs and enhance the wages of American workers.

Small business continues to be the job creator in our economy, but federal taxes and regulations have stifled small business creation. While the United States and the Soviet Union were fighting the Cold War, our trading partners in Europe and Asia have been fighting an economic war. It is essential that we provide ways to help businesses advance in the global market. This bill is an effort to create a better environment for growth in what has become a very competitive global economy.

I support the tax provisions in H.R. 9, which include: cutting the capital gains tax; increasing capital investment depreciation; raising the estate tax exemption; providing greater expensing on equipment for small businesses; and restoring the deduction for individuals who work out of their homes.

One of the ways we can help businesses is by reducing the burden of

taxes. As you know, the bill provides a 50 percent capital gains tax rate cut and prospectively indexes capital gains to account for inflation. It will reduce the current tax rate from 39.6 percent to 19.8 percent. It also allows those who lose money on the sale of their home the ability to deduct the loss from their taxable income.

The neutral cost recovery system allows businesses to depreciate the original cost over the life of the equipment, plus inflation, plus 3.5 percent each year. This provides the opportunity for businesses to deduct the true value of this investment by factoring in the effect of inflation.

Accordingly, businesses that invest less than $200,000 in depreciable property each year will be able to receive an immediate $25,000 deduction on the purchase of new equipment, which represents an increase of $7,500.

Also included in the bill is an increase in the exemption of the estate tax from $600,000 to $750,000. The increase in the exemption is phased in beginning at $700,000 in 1996 and increasing $25,000 over the next two years.

H.R. 9 also clarifies current regulations concerning the deduction of home office expenses by allowing those who perform essential administrative and managerial duties of the business in their homes to take these costs as a business deduction.

Under the Taxpayer Debt Buy-down provision, taxpayers could designate up to 10 percent of their taxes to reduce the federal debt. Congress would be required to reduce government spending by the amount in the Public Debt Reduction Fund or mandatory sequestration would take effect. The Congressional Budget Office (CBO) has calculated that if all taxpayers checked off the maximum level of 10 percent, and Congress was then forced to make the reductions in spending necessary to comply, the federal budget deficits would be eliminated by the year 2000. While I cosponsored the Taxpayer Debt By-down last Congress when it was introduced as a separate bill by Congressman Bob Walker of Pennsylvania, I believe this provision of H.R. 9 should not be included if the balanced budget amendment is ultimately ratified.

The Taxpayers Debt Buy-down provision is a tool to force Congress to reduce our annual federal budget deficits, but in my opinion, the constitutional amendment is a far stronger tool. I believe it might be ultimately harmful to our economy if both the Taxpayer Debt Buy-down and the balanced budget amendment were in place.

While I support many of the provisions in this bill, I have concerns with Title IX: Private Property Rights Protections and Compensation. As you know, under this provision private property owners would be compensated by the Federal Government if the use of their property is limited as a result of actions taken by the Federal Government.

I agree private property owners should be protected from undue financial harm caused by an overzealous federal government. But the Fifth Amendment of the Constitution provides this protection and the courts have, in most cases, been an appropriate forum to address these issues.

Title IX raises several questions that I would like to share with you. One question I have is related to retroactivity. I am unclear as to whether people would be able to receive compensation for property depreciation as a result of a regulation that is already in place. If this is the case, it seems the bill would open up the possibility for people to apply for compensation above and beyond what was paid for the property.

It is also unclear whether H.R. 9 would apply to potential loss of property value, or just actual loss. For example, suppose an individual planned to build an apartment complex on a piece of property, but then found out that an endangered species lived on the land. It is not clear to me if property owners would be compensated for the potential increased revenue that might have

been gained had the apartment complex been built. It seems it would be difficult to determine the amount of compensation due a property owner under this type of scenario.

Another issue raised by the bill's provisions is that of direct versus indirect loss of property value. Most property value is in some way linked to other nearby property. If a wetlands regulation meant that an amusement park couldn't be built in a particular community, I am unclear whether a neighboring property owner could receive compensation because his plans to develop the land based on the development of the neighboring amusement park were no longer economically viable.

I recognize that regulations sometimes result in decreased property value, but they also can result in increased property value. The federal government does not expect to be compensated for such "givings," and it seems to me this understanding should be a part of the debate on "takings."

Clearly, compensation under this bill could be extraordinarily expensive. By requiring agencies to use their own appropriations to fund the compensation, the intent seems to encourage agencies to loosen regulations. But we, as lawmakers, must hold ourselves accountable for making good laws that make sense. If we feel a law does not make sense, we should change it.

Finally, I wish to express my concern about how this law might affect our environment. Our nation's environmental laws and regulations were created to protect the health, lives and safety of American citizens. In addition, they aim to preserve and protect our natural resources for future generations to use and enjoy. This lofty goal should not be taken lightly and we must take responsibility for achieving and maintaining it. Environmental laws and regulations need to be debated, and at the end of that debate some laws might need to be strengthened, and others weakened. But they should be assessed based on the merits, and not on the broad ramifications that could result if Title IX of H.R. 9 became law.

My staff and I have spoken with many people and organizations who have brought up these and other questions regarding possible scenarios under which people could be compensated under Title IX.

These concerns, among others, lead me to believe that the issue of federal takings is best left up to the courts. Every claim will be different, and should be decided on a case-by-case basis, not on a sweeping law open to wide interpretation.

If we decide that Congress, not the courts, is that best forum for deciding the issue of "takings," I hope some changes will be made to the pending legislation. I support raising the percentage of property loss meriting compensation. In addition, I hope that any "takings" legislation passed by Congress is more narrow in scope, so the ambiguities such as the ones I have outlined are made clear.

III. THE FAMILY REINFORCEMENT ACT

I would also like to thank you for allowing me to testify on H.R. 11, I am proud to be a cosponsor of this important legislation.

The Family Reinforcement Act, of which I am a cosponsor, offers tax relief for an already overburdened middle class by providing credits in two areas which have previously been overlooked. The $500 per person eldercare credit will give needed assistance to families who are caring for the elderly, and the $5,000 credit for adoption expenses will help find new homes for displaced children.

Another area which needs strengthening is child support enforcement. H.R. 11 includes provisions that help prevent non-custodial parents from turning their backs on their children. Given the fact that child support payments often determine whether a family remains financially stable or is reduced to poverty, it is imperative our government actively and vigorously enforce child support regulations.

A third provision of the Family Reinforcement Act which I believe is extremely important is the increase in sentences for sexual offenses against children. I am glad the bill also provides for a minimum three year sentence for anyone who forces children into prostitution, a provision I strongly support. It is about time criminals who commit such horrific acts on our children begin to pay for their crimes.

It is my hope the passage of H.R. 11 will be a major step in ensuring that the interests and needs of our children are protected. This bill will offer a better, brighter future for the families of our great nation.

IV. THE SENIOR CITIZENS EQUITY ACT

I would like to express my support for the provisions of the Senior Citizens' Equity Act which would raise the earnings limitation on older Americans, and commend the Ways and Means Committee for acting so promptly in the 104th Congress to correct this injustice.

I believe Social Security recipients who want to continue working should be able to earn outside income without being penalized. Senior citizens, like any other group of Americans, have a right to work to achieve financial independence without being penalized by the federal government.

Unfortunately, that is not currently the case. The earnings test imposed on senior citizens, taxing their Social Security benefits if they earn more than a certain amount, is an unfair punishment for those who wish to stay productive and contribute to our economy.

Persons aged 65 to 69 can receive full benefits as long as they earn no more than $11,160 in outside income. Benefits under this category are reduced $1 for every $3 earned above this amount. For those citizens 70 years old or older there is no earnings test.

The Senior Citizens Fairness Act, of which I am a cosponsor, would phase in an increase of the earnings limit over five years, raising it to $15,000 in 1996, $19,000 in 1997, $23,000 in 1998, $27,000 in 1999 and $30,000 in 2000.

Support for this change is strong, both from the public and here in Congress. We cannot afford to ignore the experience and professionalism older Americans bring to our workforce. In addition, these older Americans will be working longer and paying more taxes.

The earnings test, developed during a depressed economic environment, was designed to drive workers out of scarce jobs. Its repeal is long past due as a recognition of the changing needs of businesses struggling to find qualified workers and remain competitive.

V. THE PERSONAL RESPONSIBILITY ACT

As this committee knows all too well, many welfare recipients view employment as a threat to their standard of living. We have created a culture of dependency where getting a job may actually result in a decreased income. This must end. We must change the welfare state so that people are encouraged to work and save in an effort to become self-sufficient.

In a perfect world, certain provisions of H.R. 4, the Personal Responsibility Act, could be seen as outdated, but unfortunately we do not live in a perfect world. When you have 12 year-olds having babies, 14 year-olds selling drugs, 15 year-olds killing each other, 18 year-olds who can't even read their own diplomas, and 30 year olds who have never held a job, you see that measures such as orphanages and foster homes must be considered as possible solutions in reforming the existing welfare system.

We also need to encourage our young people to focus on moral living. Government legislates immorality when it encourages our children to have babies out of wedlock rather than in wedlock and doesn't hold the fathers accountable.

H.R. 4 contains provisions, which I support, that reform our welfare system and provide greater control to the states in the use of federal welfare funds.

The legislation will terminate Aid to Families with Dependent Children (AFDC) payments to unwed mothers under age 18 and their children, while allowing the states to have the option to extend payments between the ages of 18-20. The savings from these programs will then be given to the states in the form of block grants. These block grants may be used to establish orphanages or group homes for unwed mothers. Also H.R. 4 requires paternity to be established to receive full benefits.

The Personal Responsibility Act also will eliminate welfare benefits to legal permanent residents. I support placing this limitation on federal assistance programs because it will preserve the original intent of social service programs -- to protect citizens of our country -- and discourage immigrants who come to the United States intending to apply for benefits.

There is one element of H.R. 4, however, that gravely concerns me. I am opposed to any provision that would silence health professionals from advising their clients about abortion services. I believe the government has no business interfering in the relationship between a doctor and their patient. The "gag rule" denies all women, especially those less fortunate, information about the full range of available medical options. This could cause them to make uninformed decisions and deprive them of needed medical services. I have always voted against the "gag rule provision" and will do so again should this language remain in H.R. 4.

A fifth provision of the Personal Responsibility Act is the consolidation of 10 nutrition programs such as food stamps, Supplemental Nutrition for Women, Infants and Children (WIC), and the school lunch and breakfast program into 1 block grant. I support this idea because I believe each state and town should be able to decide where it can best use the money. For some it may be in the schools, while others may desire to utilize the moneys to strengthen the food stamp program. I also believe competition is important and only those programs which truly need the funding will receive them under this proposal.

Thank you for your consideration of this testimony.

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HEALTH INSURANCE PREMIUM TAX DEDUCTIONS FOR THE SELF-EMPLOYED

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

JANUARY 27, 1995

Serial 104–36

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

90–457 CC WASHINGTON : 1996

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-052535-7

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HEALTH INSURANCE PREMIUM TAX DEDUCTIONS FOR THE SELF-EMPLOYED

FRIDAY, JANUARY 27, 1995

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

The subcommittee met, pursuant to call, at 12:06 p.m., in room 1310, Longworth House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
January 23, 1995
No. HL-2

CONTACT: (202) 225-3943

THOMAS ANNOUNCES HEARING ON TAX TREATMENT OF HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will conduct a hearing on allowing self-employed individuals to deduct a portion of their health insurance premiums. **The hearing will be held on Friday, January 27, 1995, in 1310 Longworth House Office Building, beginning at 12:00 noon.**

This hearing will feature invited witnesses only. In view of the limited time available to hear witnesses, the Subcommittee will not be able to accommodate requests to be heard other than from those who are invited. Those persons and organizations not scheduled for an oral appearance are encouraged to submit written statements for the record of the hearing.

BACKGROUND:

Under present law, the tax treatment of health insurance depends on whether the taxpayer is an employee and whether the taxpayer is covered under a health plan paid by the employee's employer. An employer's contribution to a plan providing accident or health coverage for the employee and the employee's spouse and dependents is excludable from an employee's income for income and payroll tax purposes. In addition, businesses can generally deduct, as an employee compensation expense, the full cost of any health insurance coverage provided for their employee. In the case of self-employed individuals (i.e. sole proprietors or partners in a partnership), no equivalent exclusion exists. However, prior law provided a deduction for 25 percent of the amount paid for health insurance for a self-employed individual and the individual's spouse and dependents. The 25-percent deduction, which expired at the end of 1993, was not extended because it was anticipated that it would be addressed in the health care reform legislation of 1994.

The 25-percent deduction was first enacted on a temporary basis by the Tax Reform Act of 1986 (for taxable years beginning before January 1, 1990). Certain technical corrections to the provision were made by the Technical and Miscellaneous Revenue Act of 1988. The Omnibus Budget Reconciliation Act of 1990 extended the deduction through the end of 1991. The Tax Extension Act of 1991 then extended the deduction through June 30, 1992. The Omnibus Budget Reconciliation Act of 1993 extended the deduction through the end of 1993.

DISCUSSION:

Under present law, the Federal tax laws encourage the provision of health care insurance coverage by providing favorable tax treatment for an employer's contribution to a health plan for an employee and his family. Self-employed individuals have been entitled to a deduction of a portion of their health insurance costs.

The availability of the 25-percent deduction disadvantages self-employed individuals compared to individuals who organize their businesses in corporate form under subchapter C of the Code. In such a case, the individual could be the sole shareholder and the employee of the company. Any employer contributions for health care insurance would be fully excludable by the employees. Thus, an inequity exists between self-employed individuals and other employers and employees.

From a policy perspective, it is difficult to justify different federal tax subsidies for health insurance expenses based upon the status of an individual's employment or the form in which an entity does business. One of the key questions remaining is: What tax treatment of health insurance costs is likely to increase self-employed individuals' willingness to purchase insurance for themselves, their families and their employees?

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 by the close of business, Friday, February 10, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth 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, 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.

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

3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.

4. A 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.

*****

Chairman THOMAS. Welcome to the Health Subcommittee hearing on tax deductibility of health insurance premiums for the self-employed. This afternoon, we do want to focus on all the issues surrounding the question of tax deductibility of health insurance premiums for the self-employed.

As many of you know, I assume all of us know, the 25-percent health insurance premium deduction expired on December 31, 1993. It was anticipated that a permanent resolution, and I think we can almost say it has been permanently anticipated, that a permanent resolution of the self-employed health insurance tax deduction would be addressed in the health care reform legislation of 1994.

With the failure to enact any form of health care reform, we find ourselves once again dealing with the retroactive window either in a stopgap procedure or a look-back, look-forward discussion.

I do want to announce that yesterday I introduced a bill cosponsored by all of the Majority Members of the Ways and Means Committee, H.R. 697, to deal with the 1994 year and the legislation is a very simple document. It says, strike December 31, 1993, and change it to December 31, 1994, in the hopes that we can move just that provision through Congress in time for people to make realistic decisions for the 1994 tax year.

That means, as far as I am concerned, considerably before April 15 which is a deadline certainly but not one that I would define as reasonable for most people to fully appreciate, understand, and use this provision.

Chairman Archer and I are committed to making every effort possible to get this legislation through the House and the Senate as quickly as possible.

We have also, obviously, a prospective question to deal with. Just because Chairman Archer and I are more than willing to make sure that the Band-Aid extension is handled, we still want to push for the right tax policy in terms of the self-employed on health insurance deductibility. Today's hearing is intended to continue to get information.

The first panel will be our colleagues in terms of their views on this question, and then I believe we have an excellent series of panels which will give us a broad understanding from folks who have been looking at it from afar and from people who have been living it on a daily basis.

Part of the concern that I have is that we have tended to be almost formula-like in our responses to the question of the self-employed. It was 25 percent, so we renewed the 25 percent. Then there is a discussion of a march on fixed percentages up to 100 percent.

One of the things I hope to get out of this hearing is the reaction from the real world not about theoretical equity, that is the potential for 100 percent deductibility, but to what extent is the real world operating at a percentage which is below that and would it be meaningful for us to explore a realistic relationship rather than the theoretical capability for deduction.

These are some of the questions I am looking forward to getting answers to and also, for the record, a feeling from the real world about our failure to make a permanent change and how difficult it is for people not to know what tomorrow brings in this area.

With that, I would yield to my friend from California.

[The prepared statement follows:]

OPENING STATEMENT OF CHAIRMAN THOMAS HEARING ON THE TAX DEDUCTIBILITY OF HEALTH INSURANCE PREMIUMS FOR THE SELF-EMPLOYED

January 27, 1995

Welcome to today's hearing of the Ways and Means Health subcommittee. This afternoon our hearing will focus on the issues surrounding the tax deduction of insurance premiums for the self employed. As many of you know, the twenty-five percent health insurance premium tax deduction for the self-employed expired in December of 1993. It was anticipated that a permanent resolution of the self-employed health insurance tax deduction would be addressed in the health care reform legislation in 1994.

With the failure to enact health care reform we find ourselves once again moving a expedite retroactive tax provision -- a stop gap measure -- in order that hundreds of thousands of self-employed individuals can prepared their 1994 tax returns with some level of certainty and avoid having to submit amended returns later.

My Republican colleagues on this committee joined me yesterday in introducing a bill (H.R. 697) to do just that. I want to emphasize that Chairman Archer and I are committed to making every effort possible to get this legislation over to the Senate as quickly as possible. We are also encouraged by the Senate's interest in this legislation. We urge our colleagues in the House and Senate, however, to keep the legislation focused on the problem at hand and to avoid attaching any extraneous, unrelated or non-germane provisions which will hamper or prevent its timely passage.

Because Chairman Archer and I do not intend to end our interest in this area with the passage of a simple " band-aid" extension. -- we will continue to push for the right tax policy on health insurance deductibility for the self-employed. The intention of today's hearing is to examine the issues a permanent deduction. for the insurance costs of the self-employed and the level at which such a deduction should be set. Our purpose today is to listen -- to listen to the people who are most affected by this deduction and to gain a better understanding of the hardships of living with this erratic, uncertain and inequitable tax policy.

We are here to seek the help of experts who have studied the effects of the temporary deduction on the purchase of health insurance for the self-employed , their families and their employees.

We are also here to seek guidance on what policy makes the most sense. Is the twenty-five percent deduction adequate? or should it be increased? What level of deduction would be "real world" comparable to that of employees in c corporations? Is there some deduction level that is less than one-hundred percent which will encourage the purchase of health care insurance -- some level that will help optimize the number of people who are covered by insurance and limit rewarding the purchases that would have occurred anyway? What these are the questions we are seeking to answer with this hearing. These are the questions that I believe need to be answered as we proceed toward future congressional action.

Mr. STARK. I thank the Chair, and I want to help see this tax question resolved and I think we have an opportunity. I think there is bipartisan interest, and I think we have an opportunity to improve the health care situation for many Americans and reduce their fear with no cost to the Federal Government and, as a matter of fact, I think no cost basically to the private sector. It is one of those win-win situations.

I would like to note early on that we are going to spend at least $2 billion over the 5-year window if we go to 25 percent. My hope is we will not attempt to pay for that out of the Medicare trust fund. That is just my hope.

I would like to suggest that if a small businessperson is to receive more than the 25 percent, it should be a requirement that that small businessperson makes available to his or her employees the same insurance, whether or not they have to pay for it. I don't care whether they have to pay for it, but they should make it available. Second, employees who for one reason or another must pay for their own health insurance, who are not self-employed, should also be able to avail themselves of the 25 percent. Those should be modest improvements and not difficult for both sides.

The most important part is to expand the program that has served since its bipartisan inception in this subcommittee, 45 million Americans who otherwise would have lost their health insurance, and that is the COBRA, Consolidated Omnibus Budget Reconciliation Act, extension of benefits upon termination. It costs the Federal Government nothing.

I see no reason at this point—we may wish to change it later when other great reforms are made—for us not to extend the COBRA time indefinitely for a person who is laid off or otherwise loses their job. For them to be able to continue at 102 percent of the cost of their benefits under a group plan seems to me to be the first small step that this subcommittee could take to taking the fear of losing your job and with it your health insurance coverage off the minds of Americans. It is something I hope this subcommittee will consider seriously.

We give an advantage to the insurance companies by allowing deductibility of insurance premiums. The modest inconvenience that we may cause for the extension of COBRA benefits, I think, is far outweighed by the great relief that we can offer to working Americans who fear that they may indeed lose their benefits, and I hope that my colleagues will consider what I believe are compassionate amendments to this legislation.

Mr. Chairman, I thank you for calling these hearings. I look forward to hearing the witnesses. I hope they are quick so they can get back up here and help us pass this legislation.

[The prepared statement follows:]

Opening Statement of Congressman Pete Stark
Ways and Means Health Subcommittee
January 27, 1995

Mr. Chairman:

If we can find the money, it would be nice to assist the self-employed, the uninsured, and really everyone in America buy health insurance so that the uninsured problem would end.

The key is finding the money, and I hope today's witnesses will offer some suggestions.

I hope they do not suggest more Medicare cuts. The Republican Contract on America already cuts $15 billion out of the Medicare Hospital Trust Fund. The Democratic professional staff on the Joint Economic Committee have also estimated the impact of the Balanced Budget Amendment on Medicare. If Social Security, defense, and interest on the debt are exempt from cuts, then in the year 2002, each beneficiary will see a Medicare cut of $2,223. That means $2,223 in higher copays, deductibles, or reduced access because of provider cuts.

Again, I urge that we not pay for the self-employed deduction out of Medicare.

I also urge that we put some conditions on a tax deduction for the self-insured:

1) they should provide health insurance for their co-workers.
We shouldn't provide tax relief for people who are likely to be the highest paid in a business without also assisting those who are paid less.

2)We should also extend the same tax deductibility to individual workers who purchase insurance for themselves when it is not provided by their employers.

Let's not kid ourselves. The Republican proposals do little or nothing to reduce the number of uninsured. They do not address the problem that health insurance premiums are too high--particularly for small groups and individuals. For example, I have just received a letter from a 59 year old self-employed realtor in California--a man who has no serious medical conditions. Several years ago, he was divorced and used COBRA to keep his wife's Prudential group rate policy of $275.96 per month. At the end of his COBRA health continuation period, he asked Prudential to convert to an individual policy. As the gentleman wrote me, that's when Prudential 'dropped a piece of the Rock' on him. The monthly cost of a $100 deductible policy was $1,714.29--- or $20,571 a year! For a $1000 deductible, the monthly premium was $1,030---or $12,360 per year.

Mr. Chairman, in order to help address the issue of affordability, I urge the Subcommittee to use this bill to extend the COBRA time limits indefinitely. Once you are in a group policy you should be able to stay in at the group rate plus an administrative fee.

Thank you.

Chairman THOMAS. I thank the gentleman. I also thank my colleagues for their continued interest in this area. I would say to each of you that your prepared remarks would be made a part of the record and you can proceed as you see fit, and that I would prefer we hear testimony from each of our Members before we go to questions.

I would start with our friend and colleague on the subcommittee, Ben Cardin.

STATEMENT OF HON. BENJAMIN L. CARDIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. CARDIN. Thank you, Mr. Chairman. Let me thank you very much for these hearings. I am pleased to hear about H.R. 697 and I hope that our subcommittee will move that quickly.

Let me say from the outset that I do think we need to move forward on health care reform whenever we can. Reinstating the deductibility for the self-employed is an important step forward and we should move it quickly. I agree with the chairman.

I was pleased to hear President Clinton in the State of the Union Address speak about the need for this Congress to deal with health care reform. I hope that we will move forward on this issue of health care for the self-employed, the COBRA issue that Mr. Stark referred to, and other issues that may come before our subcommittee.

The number of uninsured, as President Clinton pointed out in his speech, has increased over the past year. Those people who are self-employed are one-and-a-half times more likely to be uninsured than a person who is employed for a corporation.

We must take action to reverse that. I have introduced H.R. 691. Like the chairman's bill, it would extend for 1994 the self-employed deduction at 25 percent but would then, beginning in 1995, institute an 80-percent deduction. Let me just talk about that for one moment, if I might.

I think the Tax Code should be a positive reinforcement of the people to be insured. For the people who work for companies, for corporations, it has been a powerful tool for those companies to provide health benefits for their employees. For the self-employed, at 25 percent, it is an incentive but it does not offer parity for those people who work for corporations. Eighty percent, I believe, under the current circumstances would provide parity.

The average company that provides health benefits pays 80 percent of the premium cost with the individual employee paying 20 percent. To provide parity for the self-employed, I believe 80 percent would provide that goal. It is interesting, of course, that the Ways and Means Committee last year did approve legislation to use the 80-percent mark.

I look forward to working with the chairman to not only reinstate the deduction for 1994, but to permanently establish a policy that will encourage more people who are self-employed to have insurance.

[The prepared statement follows:]

TESTIMONY OF REP. BENJAMIN L. CARDIN
ON THE TAX DEDUCTIBILITY OF HEALTH INSURANCE PREMIUMS
PAID BY THE SELF-EMPLOYED

before the
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

January 27, 1995

Chairman Thomas, fellow members of the Subcommittee: As this is the only hearing scheduled to take up this important matter, let me express my appreciation for the opportunity to testify regarding my proposal to amend the Internal Revenue Code of 1986 as it applies to the self-employed.

Yesterday I introduced a bill to first restore, and then to increase, the income tax deduction for health insurance premiums paid by those who are self-employed, at a rate of 25% for 1994, and 80% for 1995 and thereafter.

Fully one-quarter of self-employed Americans - 3.1 million farmers and craftsmen, professionals and small business proprietors - have no health insurance. Compared to all other workers, the self-employed are one and a half times more likely to lack essential health care coverage.

As we search for methods to increase access to necessary medical services and reduce the crushing burdens of uncompensated care, which threaten the fiscal stability of both affected individuals and the entire health care system, there can be no doubt that U.S. tax code should encourage the self-employed to purchase health care insurance. Instead, current regulations discriminate against the self-employed and discourage the individual initiative that has always been a bedrock of the American economy.

As part of the expense of employee compensation, businesses can deduct the full cost of any health insurance provided to employees. Similar treatment of health care premium costs has never been fully available to the self-employed. And, unless we act quickly, the loss of the limited deduction in effect during recent tax years will soon be keenly felt by the self-employed. In order to provide consistent tax treatment of medical insurance expenses, my bill restores for 1994 the 25% deduction that has enjoyed nearly a decade of strong bipartisan support.

The availability of this deduction should not only be renewed, it should be adjusted equitably. Because businesses, on average, contribute - and fully deduct as an expense - 80 % of the total cost of employee health insurance premiums, my bill increases the percentage of premium costs which can be deducted by self-employed persons to 80%, effective with tax year 1995. This is similar to the provision thoughtfully considered and passed by the Ways and Means Committee of the 103rd Congress.

With approximately 41 million medically uninsured persons in the United States currently, measures which encourage working people to provide for their health care coverage within the private sector are essential. The particular form of an individual's employment situation should not determine the tax treatment of health care costs incurred as part of the cost of doing business. Rather, as nearly as possible, parity of deductibility should be obtained within the tax code.

In the interests of both fairness and sound health care policy, I urge my colleagues to join me in support of H.R. 691.

Chairman THOMAS. I thank the gentleman for the content and brevity of his statement.

Our colleague from Massachusetts, a Member of the full committee, Mr. Neal.

STATEMENT OF HON. RICHARD E. NEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. NEAL. Thank you very much, Mr. Chairman. I agree with your opening remarks as well as was pleased to hear of your intent.

First, let me thank you for allowing me to testify here at the Health Subcommittee on the issue of health insurance tax deduction for the self-employed. This is an important issue on which the Congress should be able to agree and take swift action.

On the opening day of the 104th Congress, I introduced legislation to restore and increase the deduction for the health insurance costs of self-employed individuals. This is identical to the legislation that Mr. Grandy and I offered last year as well. Self-employed businessowners and small businesses should be able to share in the same tax treatment of health benefits as large corporations.

Prior to 1993 self-employed businessowners were allowed to deduct as a business expense up to 25 percent of their medical insurance payments for an individual, an individual's spouse and dependents provided that that individual or the individual's spouse was not able to participate in an employer-subsidized health insurance program. This provision was extended as part of the Reconciliation Act of 1993. The deduction that expired on December 31, 1993, I believe, should be restored. I was pleased to hear the chairman's comments a few moments ago.

Unfortunately, before the 103d Congress adjourned, agreement on health care could not be reached. However, consensus was reached on one issue, the ability of the self-employed to deduct the cost of the health care insurance. A major health care reform proposal included a provision to allow self-employed workers this 100 percent deduction. I hope we can reach agreement on this issue and take quick action.

I recently introduced legislation which restores the 25-percent deduction and gradually increases the deduction to 100 percent. I think the testimony by you and Mr. Stark this morning indicates that there is room for consideration of these numbers and, at the same time, there also is room for I think some compromise.

The bill phases in the deduction over a period of 4 years. For calendar years 1994 and 1995, health insurance would be 25 percent deductible. In 1996 and 1997, it would become 50 percent deductible. In 1998, and thereafter, it would be 100 percent deductible.

When I first came to the Congress, I served on the Committee on Banking, and one of the issues I worked on diligently was business lending. Small businesses, for a long period of time in New England, were not able to receive financing as easily as large corporations. I worked to have included in the banking reform legislation a provision that required the promulgation of a regulation addressing the disclosure of loans made to small businesses.

Since I joined this subcommittee, I tried to make permanent the deduction of health care costs for the self-employed. It was the first

tax issue I undertook as a Member of the subcommittee, and I hoped that small businesses could receive the same favorable treatment as corporations.

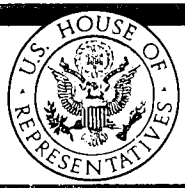
Mr. Chairman, my district includes several small businesses in small towns and rural areas, and many of the constituents that I represent fall into this category of self-employed. Increasing the deduction would allow businessowners to spend more of their resources on health care. This legislation gives businesses an opportunity and an incentive to purchase health care insurance.

The deduction should be made permanent to give individuals certainty. An individual should not have to wait for action by the Congress next year to know if they will be able to take and make a deduction for health care insurance. Individuals should be able to plan for their health care and the health care of their families.

I thank you for your time, and I also thank you for allowing me this opportunity. I do have constituents waiting for me, and I am sure that you and Mr. Stark will offer representative views of the entire body that is known as Ways and Means.

[The prepared statement follows:]

Congressman
RICHARD E. NEAL



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January 27, 1995

Testimony of Congressman Richard E. Neal of Massachusetts
Health Subcommittee of Ways and Means
Health Insurance Tax Deduction for the Self-employed

Mr. Chairman, first of all, I would like to thank you for allowing me to testify before the Health Subcommittee on the issue of the health insurance tax deduction for the self-employed. I believe this an extremely important issue on which Congress should be able to agree and take swift action.

On the opening day of the 104th Congress, I introduced legislation to restore and increase the deduction for the health insurance costs of self-employed individuals. Self employed businesses owners and small businesses should be able to share the same tax treatment of health benefits as large corporations.

Prior to December 1993, self-employed business owners were allowed to deduct as a business expense up to 25% of their medical insurance payments for an individual, an individual's spouse and dependents, provided that the individual or the individual's spouse was not able to participate in an employer subsidized health insurance plan. As many of you know, this provision was extended as part of the Omnibus Reconciliation Act of 1993. The deduction expired on December 31, 1993. The deduction was only extended to the end of 1993 because we believed this issue was going to be adequately addressed in health care reform.

Unfortunately, before the 103rd Congress adjourned, agreement on health care could not be reached. However, consensus was reached on one issue--the ability of the self-employed to deduct the cost of health care insurance. Major health care reform proposals included a provision to allow self-employed workers this 100% deduction. We should be able to reach agreement on this issue and take quick action.

I recently introduced legislation which restores the 25% deduction and gradually increases the deduction to 100%. The bill phases in the deduction over a period of four years. For calendar years 1994 and 1995, health insurance would be 25% deductible, in 1996 and 1997 it would become 50% deductible. In 1998 and thereafter, health insurance would become 100% deductible.

As many of you know, when I first came to Congress I served on the House Committee on Banking. One of the issues I worked on was small business lending. Small businesses are not able to receive financing as easily as large corporations. I worked to include a provision in banking reform legislation to require the promulgation of a regulation addressing the disclosure of loans made to small businesses.

Since I joined the Ways and Means Committee, I have tried to make permanent the deduction of health care costs for the self-employed. It was the first tax issue I undertook as a Member of the Committee. Small businesses should receive the same favorable treatment as corporations.

Corporations are permitted to deduct 100% of the cost of providing health insurance. The self-employed should receive the same treatment. One of the basic principles of tax policy is fairness. One dimension of tax fairness has been described as the "equal treatment of equals." This can be interpreted as the imposition of similar tax burdens on taxpayers in similar circumstances. Why should health care costs of one type of business be treated differently than the health care costs of another type of business? It does not seem fair.

Small businesses and the self-employed are the engine of economic growth for our economy. The ranks of the self-employed include the likes of farmers, craftsmen, shop keepers, day laborers, ranchers as well as accountants, lawyers, and doctors who practice either in partnerships or as sole practitioners. As you can see, this provision affects a wide variety of individuals.

My district includes several small towns and rural areas. Many of my constituents fall into the category of the self-employed. Increasing the deduction would allow business owners to spend more of their resources on health care. This legislation gives businesses an incentive to purchase health care insurance. The deduction should be made permanent to give individuals certainty. Individuals should not have to wait for action by Congress to know if they will be able to make a deduction for health insurance. Individuals should be able to more easily plan for their health care needs.

I look forward to working with the Health Subcommittee and the full committee on a quick resolution of this issue.

Chairman THOMAS. Thank you very much, Mr. Neal. Your suggested solution is one of the four in front of us. Neither one—and none of the four are exactly identical, and you provide an approach which we have discussed at some time and we appreciate that approach.

The chairwoman of the Small Business Committee, who is not here, her approach is a 25-percent fixture, both for the retroactive year and prospectively, so you have given us a nice smorgasbord of choices and I thank the gentleman.

Mr. NEAL. Thank you, Mr. Chairman.

Chairman THOMAS. Our next witness is someone who is not new to this subcommittee and was of enormous help to us as we were trying to put together health care reform in the last Congress, because in his former life as the insurance commissioner in North Dakota, he had wrestled with a number of these decisions and had overseen the decisions that had to be made at the State level.

It is a pleasure to have you, Earl, once again in front of us.

STATEMENT OF HON. EARL POMEROY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH DAKOTA

Mr. POMEROY. Mr. Chairman, thank you. It is a pleasure to be back in the subcommittee and it is a pleasure to see Chip Kahn back behind you and back in public service. I worked with Chip back with my first trip to Washington as an insurance commissioner. I have the highest regard for his polish and expertise in this area.

I also want to commend you for H.R. 697. Our people are telling us that if they have to chase after this 25 percent deductibility through an amended return, the cost of an amended return is $75 to $125 depending on your accountant, it pretty well wipes out the deduction. So you are quite right, we need to move it and move it quickly. It is a component of H.R. 52 which I have sponsored. I am delighted that you have created a vehicle that might allow it to move on a faster track.

Of the proposals before us, I would represent the most generous deduction, the 100 percent, but it isn't a Pomeroy bill. It is very much a bipartisan bill, 60 cosponsors, and they are split about even between Republican and Democrat support for this measure.

The plight of the people who have to write their own premiums is that they are not in an employer group so their premiums are higher. I have observed this as an insurance commissioner. Second, they get no tax deduction for it and so it is kind of a double hit. I think that as we deal with this matter, we need to make permanent a component of deductibility of individually written health insurance and then the amount we discuss is debatable. I strongly favor the 100-percent approach.

Just let me give you a couple of reasons that would, in a very real way, help people that month to month write their premium checks. I have 32,000 farmers, an awful lot of self-employed people in the State of North Dakota. A typical young farm family in my State makes $20,000 a year, pays about $2,700, even though they are age rated at the young end of the age scale in a Blue Cross & Blue Shield policy. If this deduction was at 100 percent, they would save $400 a year. For many, that is the difference, on a

monthly basis, between affordability of premium and nonaffordability of premium.

Also, I have seen age ratings take its effect just before Medicare eligibility gets socked, paying in excess of $5,000 a year, $500 a month on coverage. For them, a married couple aged 60 struggling on the farm, the savings would be $750 a year. This is a group that is beginning to most acutely understand their need for coverage and all too often inability to afford it.

You and I have often seen eye to eye, Mr. Chairman, on our preference for private sector approach to health care financing. I think deductibility of premium can really be a cornerstone for meaningful health care reform achieved entirely through the private sector. If we pass H.R. 52 making coverage more affordable, followed by insurance reforms to deal with some of the underwriting questions, we will have gone a long way to dealing with some of the coverage gaps under our present system.

That concludes my initial comments. I would be quite happy to engage in any questions on what amount might be the appropriate deductibility level.

[The prepared statement follows:]

TESTIMONY OF REPRESENTATIVE EARL POMEROY
HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
JANUARY 27, 1995

Mr. Chairman, I want to commend you for holding this hearing. The subject matter is very important and very urgent and your efforts to call attention to the issue are much appreciated.

On the opening day of this Congress, I introduced H.R. 52, a bill to retroactively reinstate the 25% deduction for health insurance premiums for the self-employed for 1994, and to expand the deduction to 100% in future years. My bill now has 58 cosponsors, almost evenly split between Democrats and Republicans. This is not a partisan issue, it is a fairness issue.

As the Congress approaches a reworking of the tax code in order to provide well-deserved relief for the middle-class, I believe the very first item of tax business must be to address this unfinished business from last year.

Self-employed taxpayers in my state North Dakota are rightfully shocked and angry that Congress allowed the 25% deduction to expire. When they ask me what they should do, all I can say is either go ahead and file, hope that Congress acts, and if it does, file an amended return. Or, simply wait as long as they can before filing.

I have never been able to understand why the self-employed are treated any differently than other workers. Not only do the self-employed pay taxes on the income used to buy their health insurance, they also generally pay higher rates because they do not purchase their insurance through a group plan. This is blatantly unfair!

Granted, increasing the deduction to 100% will not be cheap, but it can be done for a fraction of what is being talked about in terms of other tax cuts. And it will provide real help to families that need help the most.

The health care reform debate that fizzled out last year was aimed at making health care more affordable and extending coverage to more Americans. Well, here is one easy step that we should all be able to agree on which will help achieve both goals.

I have 32,000 farmers and thousands of other self-employed workers, such as real estate agents, in North Dakota who need our help. Let me give you a couple examples.

A typical young farm family in my state pays about $2700 per year for a standard Blue Cross/Blue Shield health policy. Bringing their deduction into line with the tax treatment of health insurance for other workers will save that family over $400 per year, assuming they're in the 15% tax bracket.

For a married couple age 60, who would pay about $5000 per year for coverage, the savings would be almost $750. That is true middle-class tax relief.

Thank you again Mr. Chairman for holding this hearing. I hope you will exert all the influence your Subcommittee can generate to help us get this matter addressed just as quickly as possible.

Chairman THOMAS. I thank the gentleman for his testimony. Obviously the argument that the cost of the insurance is relatively high and therefore 100 percent is worth more hopefully will be dealt with in this Congress like it should have been in the last Congress with some form of health reform, even if it is just a slimmed-down package of insurance reforms, some kind of a voluntary pooling concept for individuals or small businesses or malpractice reform and the rest.

What I really am interested in getting out in this hearing is the theoretical 100 percent match, my friend from Maryland's 80 percent parity concept. Then I would hopefully conclude today with some questions to some people that will begin to provide us with the answer of what is the behavioral tip percentage because they may or may not be the same.

Given the timeframe that we are going to be in in terms of the amount of money that we can provide for this kind of a benefit which I think is essential, should be enough to make sure that we maximize the number of people who avail themselves of this opportunity which will provide much-needed insurance. But I am not anxious to provide a percentage beyond that which, in essence, is a windfall to people which would have produced a behavior at a lower percentage, and I do not want to perpetuate the feeling that the self-employed are somehow second-class citizens under the Tax Code because they chose to organize themselves for economic or business reasons along a certain line versus another line of organization.

So I am open to any suggestion. Your argument on the need to go to 100 percent immediately is because of, in essence, the relative cost difference for these people in terms of their real life situation?

Mr. POMEROY. No. Actually, I was arguing that as a further point. There are two principal points of equity behind the approach represented by H.R. 52. First, parity means identical treatment. Business corporations, 100 percent deductibility. Parity for the individual or self-employed is 100 percent deductibility. Parity is a simple concept, identical treatment of tax treatment. Second—that is the tax fairness component. The affordability of coverage is the second, I think, compelling rationale behind H.R. 52 or the other related proposals as well.

First of all, let me discuss the graduated approach and then the less than 100-percent concept. As to the graduated approach, I don't think we should proceed that way. I believe this will be the Congress that passes middle-class tax relief. I think the compelling rationale behind this particular tax relief ought to have it at the front of the line as we address middle-class tax relief.

To give you some rough comparison figures, we still have got our request in front of Joint Tax for evaluation purposes, but I believe it is about $11 billion a year cost at 100 percent deductibility. That compares to $17 billion on the Social Security tax repeal, OBRA 93, which is contained in the contract, $56 billion to the capital gains feature in the contract, or $107 billion annual contained in the contract for the child tax credit.

Now, if you compare with Clinton's tax credit proposals, tax relief proposals, $11 billion compares very favorably to the $21 billion for his education deductibility and $36 billion to the President's child

credit tax credit deductibility. I think the rationale is more compelling.

We give people necessary tax relief. We lay the foundation for private sector health insurance reform. We ought to put this at the front of the line. I think if we graduated in, Mr. Chairman, economic reality, it will force us to freeze the graduation before we get to the end of the line. We will have 100 percent and 50 percent or 80 percent at the end of the day, but we will stop at the 25 percent before we get there.

As to 80 percent, I believe that people buying their own coverage are generally buying more skeletal coverages than businesses are making available. So if you try to do a parity deal based on business providing 80 percent coverage, I think the individual purchasing the coverage is buying higher deductibles and copayments than is generally afforded in employer plans. That is why 100 percent deductibility is appropriate.

Mr. CARDIN. Let me speak to that point—and Earl, I think we need to work this out and we can debate this in committee—if in fact you get tax favored treatment, it seems to me that the self-employed would want to make sure that they include in their policies the expected out-of-pocket costs, because they could then use it as a tax deferred payment rather than having to pay after-tax dollars on it. That is another reason why I am trying to develop parity between the self-employed and an employed person who works for a company, but you do raise a good point.

Mr. POMEROY. You raise a good point as well. I would say the focus of my legislation is the people that aren't covered now because they just can't afford it. I mean, if we bring them into the net, and that is my target market.

Chairman THOMAS. I am always nervous about talking parity with someone from North Dakota. If you go back and look at farm legislation, somehow parity wound up way above 100 percent. The other problem I have is that when you talk about giving it to the self-employed, you have got the problem of the employer and employee being one in the same.

Although the employer may have 100 percent deductibility if they only provide that 80 percent to the employee, the employee only gets the 80-percent benefit. I prefer, in terms of looking at parity or equity, the employee side of the self-employed and still looking for that behavioral tip point which I assume somebody has some knowledge on, and if we don't, then I am interested in why we haven't. We have got about 6 minutes. We will recess.

Mr. POMEROY. I said it is $11 billion a year. It is over 5 years.

Chairman THOMAS. It is about $2 billion a year. We will talk on the way to the vote. We will be back.

[Recess.]

Chairman THOMAS. Resuming the Member's panel. We want to thank the chairwoman of the Small Business Committee for coming before the panel. I know she has held hearings on the deduction for the self-employed as well.

I would tell the gentlewoman that we have had among the four Members as presentation of what amounts to, I think, a universe of options from your simple 25 percent to a 25, 50, 100 percent. The gentleman from North Dakota offered 25 percent retroactive 100

percent prospective. The gentleman from Maryland, Ben Cardin, offered 25 percent but moved to a parity that he believed to be 80 percent which was contained in a package.

So we would very much like to hear from you. Your written testimony will be made a part of the record and anything that you would like to say at this time.

The chairwoman of the Small Business Committee.

STATEMENT OF HON. JAN MEYERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Mrs. MEYERS. Thank you very much, Mr. Thomas.

I appreciate being here today and hearing the options that you just mentioned. I like any and all of them. The reason my bill was introduced as it was—to make the 25-percent deduction retroactive and permanent—is because I wanted something that could move very quickly. If we don't move very quickly on the retroactivity, a lot of people are going to have to file an amended return. It is a hassle and an expense for small business to do that. So we would like to move as fast as we can.

We have had experience with the cost of the 25-percent deduction. Later I will introduce a bill taking it to 100 percent or perhaps cosponsor one of the others, because I certainly support that concept. But knowing that paying for it is going to be difficult, I started with retroactivity and making the 25-percent deduction permanent.

I might say that we heard, when we had hearings in the Small Business Committee, from Ms. Damon who is herself a small businesswoman, speaking for the National Association of Home-Based Businesses; Jeanie Morrissette who is also a small businesswoman from the National Association of the Remodeling Industry; from the National Association of the Self-Employed; from the NFIB, National Federation of Independent Business; and from the U.S. Chamber of Commerce. All of those that spoke to us were small businesspeople themselves with the exception of the individual from the Chamber of Commerce.

We appreciate the consideration by this subcommittee, and I won't go into all of the concerns and problems. I think you all understand the issue very well. I would like to mention that if we are going to address the problem of health care incrementally, that this is an extremely important component.

It has been estimated that 400,000 people in this country have health insurance because of this 25 percent deduction, and that is a great many people. I appreciate your consideration and I thank you for allowing me to speak.

[The prepared statements and attachment follow:]

TESTIMONY OF THE HONORABLE JAN MEYERS (R-KS-3)

before the

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
on
HEALTH INSURANCE DEDUCTION FOR THE SELF-EMPLOYED

January 27, 1995

Mr. Chairman, Thank you for the opportunity to appear before you this morning to discuss the importance of the 25% health care deduction for self-employed individuals and small business people, and I congratulate you for holding this very timely hearing. I believe we should act immediately to make this deduction retroactive to December 31, 1993, and to make it permanent.

Last week our Small Business Committee held a hearing on this very subject, and I would like to submit the statements of our witnesses to you for the record. Most of them are self-employed people, and I am certain their testimony about the importance of this deduction will be helpful to this Committee.

I think it is important to know the history of this deduction: It was first enacted in the Tax Reform Act of 1986 (P.L. 99-514) for a period of three years. The deduction was the extended for nine months in the Omnibus Budget Reconciliation Act of 1989. In 1990 it was extended for one year, through 1991. In 1991 it was again extended through June 30, 1992. Then it expired, but Congress included a provision in the Omnibus Budget Reconciliation Act of 1993 which applied retroactively, and extended the credit to December 31, 1993. Then it expired again.

Congress failed to act on an extension last year, and because we have been consistent since 1986, I am sure many small business people provided health insurance and felt as if the rug had been pulled from under them when we failed--without any warning--to renew the deduction. We should act now to make the deduction retroactive and permanent.

I sponsored a bill last year, and reintroduced it early this month (H.R. 442) to retroactively restore the deduction, and to make it permanent. The bill currently has more than 70 cosponsors. Several other Members who are concerned about this matter have introduced similar proposals--are several are here to testify.

The 25% tax deduction was available to self-employed individuals, including sole proprietors, working partners, and employees of S Corporations who own more than 2% of the corporation's stock. A self-employed business person who offers coverage to an employee could also take the deduction for the premiums. No deduction was permitted if the self-employed individual is eligible

to participate on a subsidized basis in a health plan of an employer of the self-employed individual or individual's spouse. According to information presented to our Small Business Committee, approximately 400,000 people have health care insurance because of this deduction.

Unfortunately, as I mentioned, Congress has allowed this deduction to expire several times, and on previous occasions, has only reauthorized it on a temporary basis. As a result, some small business people have dropped their insurance coverage because they simply cannot rely on the 25% deduction which they need in order to afford coverage.

Most small business people must develop a financial plan prospectively, and I believe we should make the 25% deduction permanent so that in their planning, they can count on this tax deduction. As you know, C corporations have the advantage of a 100% permanent tax deduction for health care premiums, and I hope we can move toward providing this same benefit to self-employed individuals in the not-too-distant future.

Since the IRS has already mailed out tax forms for 1994, we must act immediately to restore this deduction so that small business owners can deduct 25% of their health insurance costs for themselves and their families. They believed that this deduction would be available to them and planned accordingly. Congress should keep its word, and immediately reinstate this deduction retroactively.

I also believe we should make the deduction permanent so that these small entrepreneurs can avoid the year-to-year anxiety over whether they will be able to afford health insurance for themselves and their families. And, hopefully in the future, we can give our smallest business people the same benefit we extend to our largest corporations: a permanent, 100% deduction of health insurance premiums. This action would go a long way in extending health care coverage to the uninsured, a goal we all support.

I realize there is a cost involved in extending this benefit to our smallest businesses, and I don't advocate this lightly. However, the ever-increasing costs of medicaid and medicare demand that we take every action possible to expand the availability of private health care coverage. By extending and increasing this tax deduction, more people will have access to health care coverage, and we will probably save federal dollars in the long run.

Thank you again, Mr. Chairman, for the opportunity to come before you today to discuss this is important issue. I'll be happy to answer any questions you or other members of the Committee may have.

Statement of
Jeanie Morrissette, Homestead Construction Co., Inc.
before the
House Small Business Committee
regarding the
Reinstatement of the Self-Employed Health Care Deduction
January 20, 1995

Madam Chairman, honorable members of the Committee, I am honored to provide testimony on the proposed reinstatement of the self-employed health care deduction. My name is Jeanie Morrissette and I am the owner of Homestead Construction, Company, Inc. Homestead Construction is a small remodeling firm located in Annandale, Virginia, specializing in residential remodeling. I am also a past president of the Metro Washington chapter of the National Association of the Remodeling Industry (NARI).

Homestead Construction is a Subchapter S Corporation that currently provides health care insurance to its shareholders— that being myself and my husband. While Homestead can deduct one-hundred (100) percent of the health insurance premiums, under current tax law, as shareholders, we must report the value of the premium, which is over $5,000 a year, in our W-2s. This then subjects that value to federal and state income tax on our individual returns. In our case, the taxes are more than one-third (⅓) of the value of the premiums. The tax could easily be

over fifty (50) percent of the premium, based on an individual's state of residence and tax bracket.

For tax years prior to January 1, 1994, we were entitled to deduct twenty-five (25) percent of the value of the premium as an adjustment to income, on Page One (1) of Form 1040. The twenty-five (25) percent deduction has now been eliminated, since Congress has not passed any legislation to extend the deduction that expired on December 31, 1993. The elimination of this partial deduction, along with the taxation of our health insurance premiums, results in fewer spendable dollars. These dollars could be used to reinvest in my business, to fund a retirement plan, or to save for our child's education. With the continued rise of health care costs and the associated tax burden, we, as small business owners, will have to seriously consider whether continued coverage is possible.

Besides the question of affordability, I believe it is patently unfair for S Corporation shareholders and other self-employed individuals to pay tax on these benefits, while C Corporations and their employees enjoy 100 percent deductibility with no strings attached. Please do not misunderstand me, I am not

advocating that all employee health care benefits be taxed. I sincerely believe that more small business owners would be able to afford health care coverage if provided the appropriate tax incentives. I do not understand why the tax code discriminates against the self-employed. We are the ones that need the most help in being able to provide health care coverage for ourselves and our employees. If we cannot take any deductions, our ability to provide coverage, at all, is severely hampered.

I understand this deduction was established in the Tax Reform Act of 1986 for a three-year period. NARI members have actively pursued the continuance of this deduction every year since 1989, when it was first set to expire. We've been fortunate enough to extend the deduction until last year. It is time this deduction was made permanent and increased to 100 percent. While I realize that tax deductions cost the U.S. Treasury money, so does the rising cost of Medicare and Medicaid for those people who require care and have no insurance. Encouraging greater employer-provided coverage through this tax incentive may end up saving the government money. Equal treatment for all types of business organizations,

large and small, will go a long way in reducing the number of uninsured in this country. I think that is a goal everyone can agree on.

I understand there is growing Congressional support for the permanent extension and gradual expansion of this deduction. On behalf of the 6,000 NARI members companies, I soundly applaud those efforts. Extension and expansion of the deduction makes sense for the following reasons:

1. It is a matter of equity and common sense. There is no practical argument for the current distinction between the treatment of C corporations, which enjoy one-hundred (100) percent deductibility, and S corporations and the self-employed, who no longer enjoy even a twenty-five (25) percent deduction.

2. Reinstating the twenty-five (25) percent deduction and increasing it to one-hundred (100) percent will reduce the number of uninsured and ease the government burden of caring for these individuals.

3. Health care insurance is a significant cost to small business, one that is often priced out of the range of affordability. A complete deduction and cost controls will bring it back into the realm of possibility for many that have had to drop coverage.

4. Enhancing this deduction will help many people. According to a study by the Employment Benefits Research institute, nearly a quarter of small business owners have no health insurance and half of all the uninsured are either self-employed or work for small firms. A complete tax deduction for health insurance is a strong incentive for small businesses to provide such an important employee benefit.

I appreciate the concern of this Committee and truly hope that immediate action is taken to restore the deduction retroactively for 1994 and that serious thought be given to expansion of the deduction to one-hundred (100) percent.

Again, I thank you Madam Chairman, for inviting me to appear before you and your committee today to bear witness to the need for this positive legislation. I am willing to answer any questions I can.

Respectfully Submitted,

Jeanie Morrissette
Homestead Construction Co., Inc.
3909 Annandale Road
Annandale, VA 22203
703/642-2366

NARI is a not-for-profit trade association with nearly 6,000 member companies nationwide, representing over 40,000 remodeling industry professionals. NARI members are primarily residential home improvement contractors, and include national manufacturers and distributors of home improvement products and services.

Residential remodeling constitutes a $100 billion industry that has grown over 130 percent in the last ten years. With over 50 years of experience, NARI is committed to enhancing the professionalism of the remodeling industry and serving as an ally to homeowners. NARI is dedicated to the growth and betterment of the remodeling industry and related small businesses. For more information about NARI, contact Patti Burgio, director of government affairs, NARI, 4301 North Fairfax Drive, Suite 310, Arlington, VA 22203, 703/276-7600.

The 25% Medical Insurance Deduction for the Self-Employed

by: Betty Kohls Stehman, CIA
President and CEO, Entrepreneurial Financial Services, Inc.
National Director and Chief Financial Officer, American Association of Home-Based Businesses
Recently applied for CPA license in the state of Maryland

The 25% self-employed medical insurance deduction expired on December 31, 1993. The effect of this missing deduction is to have the self-employed pay more in taxes when they already carry a heavy burden in the United States Taxation System. Just how big a problem is this?

According to the IRS statistics for 1992, 21.3 million business tax returns were filed. The breakdown of these returns is as follows:

Sole Proprietorships	15.10 million	70.9%
Partnerships	1.60 million	7.5%
Small Corporations	4.48 million	21.0%
Large Corporations	.02 million	.6%

Of the 21.3 million businesses, 5.7 million or 26.8%, are large enough to have employees. From these statistics one can conclude that approximately 15.6 million businesses are one-person shops or family run businesses.

In the IRS Code, Section 162 is titled ITEMIZED DEDUCTIONS FOR INDIVIDUALS AND CORPORATIONS. The tax code in Sec. 162 begins with "There shall be allowed as a deduction all the ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business. . . ." All forms of business entities are included in this section because business entities pay taxes either at the corporate level or at the shareholder/partner/individual level. C Corporations are allowed to deduct 100% of the medical insurance premiums and expenses that they incur for their employees which also includes the owners of the corporation or its five top officers. Based on the statistics above, only 21.6% of all business entities get the 100% deduction. Sub-Chapter S corporations are included in this 21.6% figure and their medical insurance premiums and expenses are passed through to the individual shareholders. Thus, they do not receive the 100% deductibility of their medical insurance costs. Although I was unable to find out how many Sub-S tax returns are in the corporate numbers above, I believe we can safely conclude that less than 1 in 5 businesses can deduct 100% of their medical insurance premiums and expenses.

What level of deductibility do 80% of the businesses receive for their medical insurance premiums and expenses? Under the pre-

January 1, 1994 tax provision, 25% of the medical insurance premium expense was totally deductible. The remaining 75% is first subjected to the 7.5% Personal Adjusted Gross Income exclusion that individuals are not allowed to deduct. Since income levels can be any amount, it is not possible to state in dollar terms how much money is lost in the medical insurance premium deduction at the individually taxed business entity level. It can be said that the maximum amount that could be deducted under the old laws is 67.5%. Thus, 80% of the businesses only receive a partial deduction for their medical insurance premium expenses.

The above information for 80% of the businesses only concerns the medical insurance premiums. Yet, there are other medical insurance expenses that only 20% of the businesses can deduct 100% of the cost 100% of the time; the other 80% of the businesses cannot deduct this same type of expenses 100%of the time for 100% of the amount spent. While we do not have information concerning the dollars involved in this issue, we can say that 80% of the business entities are not entitled to the same level of deductions for medical insurance expenses that large corporations are entitled to. We do know that, at a minimum, 80% of the business entities lose at least 7.5% of their medical insurance expenses forever. The reason the 7.5% dollar amount is lost forever is that there are no carryforward or carryback provisions for this type of deduction in the individual tax code which is where these businesses are taxed.

Suggestions for law changes

In order to foster equity between all business entities, the tax code needs to treat all business entities in the same manner. As quoted in my third paragraph, the present code states that ALL necessary and ordinary expenses should be deductible for individuals and corporations. At the present time, only C corporations are allowed to deduct all necessary and ordinary expenses incurred in their trade or business. Since the maximum percentage of entities which are allowed to do this is 21.6%, 78.4% of the business entities have been singled out to carry an additional burden in the tax system. The business entities which range in size from 0-4 employees created 2.6 million jobs during the time period of 1989-1991. Large companies (500+ employees) created 122 thousand jobs during this same time. All other business size classes lost jobs during this time. The constant downsizing of large corporations continues to place a heavy burden on the small business sector in terms of tax revenue, job creation, and the associated business expenses. Medical insurance premiums and expenses are some of the associated business expenses that increase with job creation. Without full deductibility of these medical costs, small business may not be able to offer medical benefits to their employees and/or their families/dependents. The additional problem of uninsured people spills over into other areas of our

society. Thus, it is essential that the medical insurance premium and expenses deduction be equalized for all business entities, regardless of how they are taxed.

Resource Material

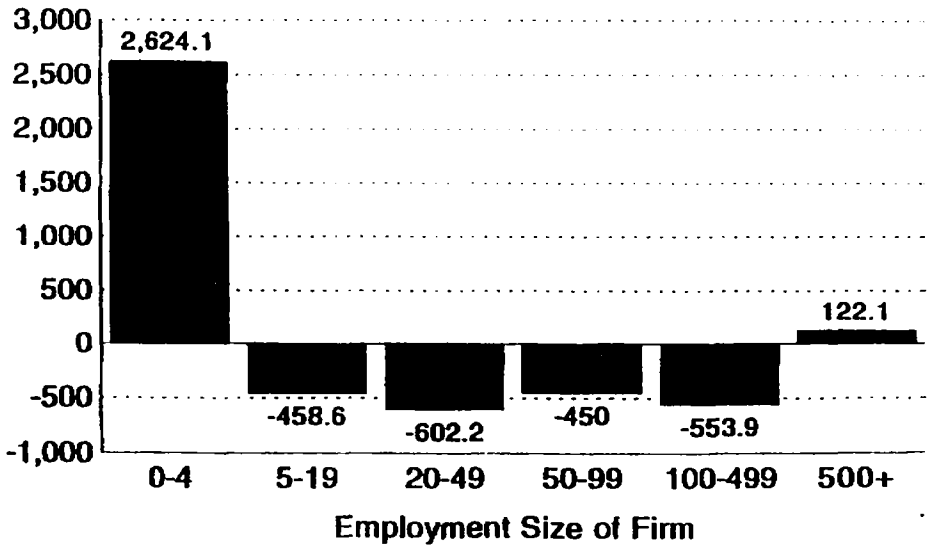
1. The Internal Revenue Code as amended through August 15, 1993

2. The White House Conference on Small Business Issue Handbook.

3. Small Business Administration resource material.

4. Hands-on experience with home-based and small business.

Net Job Creation in All Industries by Employment Size of Firm, 1989-1991 (in Thousands)



Source: U.S. Small Business Administration Off

Chairman THOMAS. I thank the gentlewoman for her testimony. I just want to inform you, as I said earlier to the other Members, that I have introduced a bill with the cosponsorship of all the Republican Members of the Ways and Means Committee to simply move retroactively on the 25-percent fix for 1994 because of the very same concerns the gentlewoman has about a time line. I understand also that two gentlemen from Maryland, Roscoe Bartlett and Kweisi Mfume—so apparently we have a 696 and 697.

So we are thinking along the same lines in trying to do an adjustment in time so as not to have to file amended returns, but look prospectively at some options that may begin with the 25 percent on a permanent basis but then possibly offer some other alternatives.

I wonder if the gentleman from North Dakota had any final statement?

Mrs. MEYERS. If the gentleman would excuse me for a second, I would like to say that in the Small Business Committee, the hearing indicated one thing that is different from large business and small business and that is the matter of cash flow. Our small businesses need the permanence of the 25 percent because of planning.

Again, I thank you very much.

Chairman THOMAS. Absolutely. Thank you.

Mr. POMEROY. I have nothing further to add, Mr. Chairman, other than commending you for your attention as well as the Chair of Small Business who held a hearing last week. This is a vital topic and I hope we can move it quickly.

Chairman THOMAS. I thank you both very much. I appreciate all the Members taking their time out to testify.

If we could have the panel of Jere Glover and Jonathan Gruber, please, SBA, U.S. Small Business Administration, and Associate Professor of Economics at MIT.

Mr. Glover, would you begin, please.

STATEMENT OF JERE W. GLOVER, CHIEF COUNSEL FOR ADVOCACY, U.S. SMALL BUSINESS ADMINISTRATION

Mr. GLOVER. Thank you very much, Mr. Chairman and Members of the subcommittee, for holding this hearing and giving me the opportunity to testify.

Let me tell you just a little bit about the unique role of the Office of Advocacy at the U.S. Small Business Administration. First thing, this is one of the few jobs in Government which requires that the President appoint someone from the private sector to give a little different perspective. Second, we are able to present views before Congress that are unique and perhaps somewhat different from views of other agencies.

Our job is to represent the views and interests of small business. Specifically concerning the subcommittee's hearing today, we have the duty to determine the impact of tax structures on small business and make legislative and other proposals for altering the tax structure to enable small business to realize their potential for contributing to improving the Nation's economy.

Given this role, my testimony is pretty much what you would expect it to be. Small business needs, deserves to have—especially

the self-employed and partnerships—need to have the deductibility for their health insurance restored.

There is a process going on throughout the country where White House conferences on small business are being held in each of the States. To date, we have been to 38 different conferences. I was in the conference at Birmingham, Ala., yesterday. The one issue which has come out of each of these conferences, the only issue that has unanimous support in every one of the States is the restoring of the deductibility of health insurance to 25 percent and going to full 100 percent deductibility for health insurance. So the small businesses in this grassroots process throughout the country are speaking very loudly and very clearly on this one specific issue.

Now, I think that we also have a situation where the entire small business community is behind this. There is unanimity and we are speaking basically with the same voice.

There have been some discussions about the impact. One of the impacts is very subtle and that is that we have a pattern of retroactively approving this deduction for small business.

We did it in 1993. Basically, we had a lot of people say at the end of last year that this was going to be renewed. Clearly we have a situation where, while it is not ideal, at least let's not create a pattern of promises and then not do it again. So that is one of the subtle reasons.

The other reason—Professor Bruce Kirchoff did a study for the National Association for the Self-Employed. He is the former chief economist for the Small Business Administration. He did a study in which he indicated that 400,000 individuals took health insurance because of the deduction. Without that, they would not have taken health insurance. There is another factor that we need to consider. Ordinarily, one would think the 25-percent deductibility might not be that important, but let me put it in context for the subcommittee.

The average sole proprietorship makes less than $15,000 per year in total income. So we are talking about an amount of money that is very important to those small businesspeople. While the average income is $15,000, there are many, many more that make far less than that. So the deductibility, not only the 25 percent but hopefully the full deductibility, is of critical importance to those small businesses, especially those who have very small incomes.

Let me just conclude by saying that I think it is important that this subcommittee is considering this issue. I would urge you prompt consideration of the 25-percent deductibility for last year, and I would urge you to raise that as much as you possibly can looking toward 100 percent or something close thereto in the future.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF JERE W. GLOVER, CHIEF COUNSEL FOR ADVOCACY
U.S. SMALL BUSINESS ADMINISTRATION

Thank you Mr. Chairman and Members of the Subcommittee for this opportunity to appear before you today to discuss an issue of vital importance to this nation's small business community. I appear as Chief Counsel for Advocacy to express my own views which may not reflect the views of the Administration.

Prior to my appointment by the President as Chief Counsel I established and operated several small corporations in addition to managing a private law practice. As a result, I have "hands-on" experience with the issues challenging small business. I might add that private sector experience is a statutory requirement for the job. When Congress created the Office of Advocacy in 1976, it had the wisdom to specify that the Chief Counsel should come from "civilian life" to ensure that the occupant of the office would have a clear perspective of the impact of public policy on small business and the needs of small enterprise.

I congratulate the Chairman and this Subcommittee for moving so quickly to give serious consideration to extending the deduction for health care premiums to the self employed, including sole proprietorships, partnerships and subchapter "S" corporation. Hopefully, these hearings will convince the subcommittee of the need to extend the deduction and to increase it to 100% of the insurance premiums paid by business owners.

The overall mission of the Office of Advocacy is to represent the views and interests of small business. And in the context of this hearing, the Office has the specific duty to

> "....determine the impact of the tax structure on small businesses and make legislative and other proposals for altering the tax structure to enable all small businesses to realize their potential for contributing to the improvement of the Nation's well-being".

Given this mandate, my testimony will come as no surprise to you. I support treating the health insurance cost of self-employed small business men and women as a fully deductible business expense. I join prior Chief Counsels who also supported the deduction when the issue was before Congress in prior years.

My reasons are rather straightforward. The deduction should be allowed because:

- it's fair - there is no rationale for treating unincorporated business owners differently than incorporated business owners, and
- it is consistent with a national objective to encourage health care coverage for all working people.

Mr. Chairman, I and other members of my staff have spent the last several months in meetings across the country with thousands of small businesses in preparation for the White House Conference on Small Business which will be held in Washington this summer. One of the top recommendations expressed at every one of these meetings is continuation of the deductibility for health insurance premiums.

I was encouraged by the President's State of the Union address when he mentioned that he wants to make health care insurance more affordable for everyone, including small businesses. The proposal you are considering today is a good start towards achieving that goal. Allowing the owners of sole proprietorships and "S" corporations to deduct the cost of their insurance provides a greater incentive to offer health insurance to their employees. You can count on the full support of small business and, judging by recent history, widespread support here in Congress.

Small businesses have been encouraged by the level of support shown in Congress last year for restoring the 25% deduction for the self-employed for tax year 1994. They are still hopeful this can be done retroactively. In addition, although some small business owners may have had differences over health care reform, there was no disagreement in the small business community over the proposal contained in most of the health care bills to make premiums paid 100% deductible.

HISTORY OF THE TAX DEDUCTION FOR THE SELF EMPLOYED

It has long been the policy of the United States, as expressed by Congress, that health benefits provided by employers should have a special status in the tax laws. Section 106 of the Internal Revenue Code makes employer contributions to accident and health plans fully deductible. The Conference Committee which adopted the original self-employed health care deduction had this to say about the public policy of health care deductions in general:

> "...the tax-favored treatment of employer-provided employee benefits reduces the Federal income tax base and reduces Federal budget receipts. However, the Committee believes these costs are justified because employer-provided employee benefits fulfill important social policy objectives, such as increasing health insurance coverage among taxpayers who otherwise would not purchase or could not afford such coverage. For example, employer provided health insurance and life insurance coverage is currently provided to more than 80 percent of workers in the United States". (Conference Committee Report which accompanied the Tax Reform Act of 1986, P.L. 99-514; H. Rept. 99-841, p. 650)

In 1986, during consideration of H.R. 3838, the Tax Reform Act of 1986 (P.L. 99-514) the Senate amended the House originated version of the bill by adding a section which provided a 50% deduction of health insurance premiums paid by self-employed individuals under certain circumstances. The Senate Finance Committee offered the following paragraph to justify its inclusion:

> "The committee believes the present-law rules relating to the exclusion from income for benefits under employer accident or health plans create unfair distinctions between self-employed individuals (the owners of unincorporated businesses) and the owners of corporations. The ability to exclude health benefits to the extent provided by a corporate employer creates tax incentives for incorporation that the committee believes leads to inefficient tax-driven decision making.
>
> "More importantly, the committee is aware that access to employer health plans is lowest with small employers (particularly with small, self employed employers). The need for adequate health coverage is so important that the committee believes it is essential to encourage a narrowing of the gap in health coverage. The committee concludes that a partial exclusion for health plans maintained by self employed individuals will accomplish this goal." S. Rept. 99-313, p. 666

The Senate also concluded that if small businesses were to have the same benefits as large businesses, they should also abide by the non-discrimination rules which apply to plans which are purchased by incorporated businesses.

The Conference Committee in an effort to reconcile the House bill, which contained no deduction, and the Senate bill, approved a compromise which cut the proposed deduction to 25% and, in the

interest of simplicity for small businesses, excluded the non-discrimination requirements.

The deduction for the self-employed was to sunset in 5 years but was subsequently extended to 1992 under the Tax Extension Act of 1991, and finally through 1993 under the Omnibus Budget Reconciliation Act of 1993. Though there was widespread support for extending the provision last year, Congress adjourned without acting on the matter and the deduction will be unavailable for 1994 tax returns.

IMPACT ON SMALL BUSINESS

If the deduction is not restored, the House Small Business Committee has estimated that this could cause an increase in the number of uninsured self-employed of more than 400,000 individuals.

As it is, currently 26% of the unincorporated self-employed lack health insurance, compared with 8.8% of the incorporated. It is clear from the data that incorporated businesses are more likely to provide health insurance coverage for the owners as well as employees.

In evaluating the impact of the tax deduction on the self-employed, it is important to keep in mind that the average age of a business in the U. S. is seven years. During the first two years, these businesses just survive and show little profit. Of the 21 million entities filing business tax returns (15 million of which are unincorporated businesses), only 4-5 million have actually taken advantage of the deduction in the past. The average annual net income of the self-employed is between $15,000 and $25,000. From a public policy perspective, anything that can raise the bottom line, i.e. net profit, is significant for the survival of these firms.

The pre-tax deductibility of insurance premiums as a business expense involves real money to small business. Why should they pay more taxes merely because of their legal structure? If health insurance costs are a necessary cost of doing business for corporations, why are they not a necessary business expense for the unincorporated self-employed? A further inequity is the fact that their tax payments indirectly underwrite the deduction of corporations.

HEALTH CARE AVAILABILITY-PUBLIC POLICY

We now know how right the Conference Committee that considered the Tax Reform act of 1986 was in their analysis of the need for a deduction. The world has changed a great deal since 1986 and high cost of health care coverage has moved to center stage. Small businesses have become the dominant creator of new jobs in this country. Now, more than ever before, it is clear that it is in the public interest to encourage as full a participation as possible in health insurance plans. Yet, if the present law remains unchanged, it is estimated that 9 million small business owners (approximately 10% of the working population) will be unable to deduct their health care premiums. Our research shows that there are 2.6 million uninsured self-employed Americans, making that group one of the largest groups of uninsured citizens. Within this group are 2.3 million unincorporated entities and 300 thousand incorporated self-employed. The House Small Business Committee Chairman, Jan Meyers, has estimated that the number of uninsured self-employed could increase by more than 400,000 due to the loss of the deduction. Clearly, if public policy is to encourage the participation of as many income producing citizens as possible in private health insurance plans, small business owners is the easiest and largest group to choose.

COST

The main objection to the adoption of a deduction for self-employed health insurance costs will be the costs to the treasury. The original cost estimate for the 25% deduction was projected to be $481 million by 1991. Costs estimates of the 100% deduction are very speculative since the figures are dependent on the cost of a plan an individual chooses, how much a business earns and which businesses decide to purchase coverage. The costs attributed to the 100% deduction provision during the consideration of last year's major health-care proposals ranged from $500 million to $2.5 billion. The Congressional Research Service, specifically Health Care Policy analyst, Beth Fuchs, who has been keeping track of the estimates, says that she feels $2 billion is a reasonable figure.

Costs could be kept down by phasing in the deductions over a number of years or by continuing the requirements which existed under the 25% deduction, which are:

1. premiums can be deducted only to the extent of income;
2. no person who could qualify for a subsidized plan (or be covered by the subsidized plan of a spouse, can receive the deduction.

FUNDAMENTAL FAIRNESS AND SIMPLICITY

The legislators who first drafted the health insurance deduction for the self-employed had the right idea, both from the public policy standpoint and also from a fundamental fairness standpoint. I ask you to consider the following:

Congress made the decision long ago that the cost to the government of the deduction by corporations of health care insurance for their employees was far outweighed by the public benefit of having those employees covered by insurance. Congress should do not less for the sole proprietorships, partnerships and subchapter "S" corporations.

Corporations have a 100% deduction, unincorporated self-employed business owners have none.

Corporations, generally because of their size, can negotiate favorable rates for their health plans. Small businesses have a difficult time finding any affordable health plan. Without a deduction, their costs are even greater.

Finally, self-employed individuals, left without a deduction for tax year 1994 will see their tax bill go up!

In conclusion, I urge this subcommittee to act favorably on this proposal and restore the 25% deduction for the 1994 tax year.

Further, I ask that the self-employed, partnerships and subchapter "S" corporations be given the same tax treatment as is given to corporations, namely, 100% deductibility of health insurance premiums.

Finally, for ease of compliance with the tax code, I believe any qualifiers should be as simple as possible so that small businesses will have no confusion about what is deductible. I believe Congress was on the right track back in 1986 when it threw out the non-discrimination requirements as they applied to these very small privately owned businesses because they were too cumbersome and complex under the circumstances.

Thank you Mr. Chairman. I sincerely hope that this subcommittee will recommend that the playing field be leveled so that the tax code treats all business entities the same as far as health insurance premiums are concerned.

Chairman THOMAS. Thank you very much.

Professor.

STATEMENT OF JONATHAN GRUBER, ASSOCIATE PROFESSOR OF ECONOMICS, MASSACHUSETTS INSTITUTE OF TECHNOLOGY, CAMBRIDGE, MASS.

Mr. GRUBER. Thank you.

Thank you for allowing me to speak to you today about the tax treatment of health insurance expenditures for the self-employed. Let me start by just saying one word of background about the tax treatment of health insurance for both employed and self-employed individuals. For the past 50 years, the value of employer provided health insurance has not been included in an individual's taxable income. This provides a substantial subsidy to the purchase of health insurance by employed individuals amounting to roughly 35 percent of the cost of health insurance.

For self-employed individuals, however, there has not traditionally been such a subsidy and perhaps as a result, insurance coverage rates among the self-employed were about 20 percent below those of employed persons. To partially remedy this discrepancy, Congress introduced in 1986 the 25-percent partial tax deduction. In research with my colleague, James Porterba at MIT, we found that this partial tax subsidy had a dramatic increase on the health insurance coverage of the self-employed.

We estimated that the introduction of this subsidy lowered the uninsured rate among the self-employed by about 13 percent; or to put it in other words, this partial subsidy reduced the gap between self-employed and employed individuals in insurance coverage by about one-fifth. So this suggests that the insurance demand of the self-employed is very sensitive to the price that they pay and sensitive to the kind of tax subsidization that we are discussing today.

Now, in that research, we had one other finding which is of interest I think for the subcommittee's deliberation today which is that the response to this subsidy was mostly concentrated among the high income self-employed. That is, coverage rose only slightly for lower income self-employed persons. But for those with income above $50,000 a year, it rose dramatically.

This reflects the fact that a tax subsidy is much more valuable for higher income taxpayers because it is worth more in dollar terms since they have a higher tax rate.

Now, with that background in mind, what I would like to do is talk about a couple of notions that that leads to in terms of thinking about future tax policy.

First of all, I think the generosity of the tax subsidy for the self-employed could and should be increased. Insurance coverage among the self-employed remains roughly 15 percent below that for the employed, and since my research suggests that the insurance coverage of the self-employed is sensitive to the tax treatment of their health insurance expenditures, increasing the tax subsidy could further narrow this inequity between employed and self-employed individuals.

But second, I would suggest that we think about the insurance deductibility being replaced with a limited refundable tax credit. For example, the self-employed individual could be offered a credit

up to 50 percent of the cost of a typical employee's health insurance plan. A limited tax credit has two advantages relative to tax deductibility. First of all, a credit offers equal benefits to both low and high income self-employed individuals, rather than deductibility which favors high income self-employed individuals. By making the tax credit refundable, the subsidy could extend even to those low-income self-employed individuals whose tax credit would exceed their tax liability, such as individuals who may be starting up new businesses.

Second, a limited credit offers incentives for the self-employed to seek out low-cost insurance plans, while an unlimited deduction equally subsidizes efficient low-cost insurance and excessive—what are known as "Cadillac" policies. Many analysts have expressed concerns that rising medical care costs in the United States are due to excessively generous insurance policies so that limiting the amount of the subsidy would offer incentives to avoid these types of policies.

Third, the tax subsidy should be more effectively advertised. Whatever the form of this tax subsidy, be it deduction or credit, whatever the amount, a critical problem with effectiveness appears to be a lack of awareness on the part of the self-employed. My coauthor and I estimated that fewer than one-half of the individuals who are eligible for this subsidy took it up only on their tax forms.

This suggests that individuals may be unaware of their entitlement which may in turn limit the effectiveness of this subsidy and is especially important if you are thinking about extending it further. So any expansion of the subsidy must be accompanied by an advertising effort which is designed to make the uninsured self-employed aware of their entitlement under the tax law.

Thus, in summary, I would recommend a nationally advertised refundable 50 percent credit for insurance costs up to the national average costs of a group insurance plan. That is, for example, if the national average cost of a family insurance policy in the United States is $4,000 today, the self-employed person would have a credit of one-half of the cost of the insurance up to $2,000. Such a policy would increase insurance coverage for the self-employed and would do it equitably between low and high income self-employed persons.

Let me conclude by raising one final important issue which has not really, I think, come up today which is how do we set the required floor for self-employment income?

The current tax subsidy can only be taken up to the amount of your self-employment income. The policy I described can be designed in the same way. Individuals could deduct up to $2,000, say, but only if their self-employment income is at least $2,000. But by raising or lowering this required floor of self-employment earnings, Congress can target this subsidy to very specific populations. This is because there are large segments of the population which are not self-employed but which also don't have access to employer provided health insurance, like the unemployed or those employees who work in firms that don't offer insurance.

If this floor were very low, for example, there were no floor at all, then I anticipate many individuals relabeling themselves as self-employed just to get this subsidy. As the floor rises, the credit

will be targeted more specifically to the truly self-employed. So in setting the floor, I think the goal of this tax policy has to be clearly delineated.

Is the goal to use this effective instrument to redress coverage differences between the self-employed and employed? If so, I would suggest that a reasonably high floor be set. However, is the goal to introduce a tax policy which might more broadly address inequities between those that have access to health insurance and those that don't? If that is the goal, then a lower floor might be more sensible.

Thank you very much.

[The prepared statement follows:]

Health Insurance Tax Subsidies for the Self-Employed

Testimony of

Jonathan Gruber

Assistant Professor of Economics, Massachusetts Institute of Technology
Faculty Research Fellow, The National Bureau of Economic Research

before the

House Ways and Means Committee
U.S. Congress
January 27, 1995

Thank you for allowing me to speak to you today about the tax treatment of health insurance expenditures by the self-employed. For the past 50 years, the value of employer-provided health insurance benefits has not been included in an employed individual's taxable income. This provides a substantial subsidy to the purchase of insurance by employed persons, amounting to a reduction in the price of insurance of roughly 35%, relative to the price of other goods. For self-employed individuals, however, there was traditionally no such tax subsidy to the purchase of insurance. Perhaps as a result, insurance coverage rates among the self-employed were 20% lower than the coverage rates of the employed.

To partially remedy this discrepancy, Congress introduced in 1986 a partial tax subsidy for the self-employed: they could now deduct 25% of the cost of their insurance policies from their taxable income, up to the amount of their self-employment earnings. In research with my colleague James Poterba of MIT, we found that this partial tax subsidy had a dramatic effect on the insurance coverage of the self-employed. We compared the insurance coverage of the self-employed before and after this tax subsidy was put in place, and contrasted that to the coverage of the employed over this same time period. We estimated that *this subsidy raised the coverage of the self-employed by 4 percentage points*. In other words, this partial subsidy reduced the coverage gap between employed and self-employed by one-fifth. This suggests that the insurance demand of the self-employed is quite sensitive to the tax subsidization of insurance purchase.

In that research, we had one other findings of interest for the design of future tax incentives to the self-employed: *the response to the subsidy was mostly concentrated in higher income self-employed*. Among self-employed persons with incomes below $20,000, only 15-20% claimed this subsidy on their tax forms; but for those with incomes above $50,000, over 50% claimed the subsidy. As a result, while coverage rose by only slightly for lower income self-employed persons, for those self-employed with incomes above $50,000 per year coverage rose much more rapidly. This reflects the fact that the tax subsidy was much more valuable for those higher

income self-employed persons, who faced higher marginal tax rates. That is, if your tax rate is high, a deduction from taxable income has a much greater dollar value, so that the subsidy had its greatest impact on high income self-employed.

Designing an Improved Tax Subsidy for the Self-Employed

The results from our research suggest three ways in which the tax subsidy for the self-employed could be improved. *First, the generosity of the tax subsidy could be increased.* Insurance coverage among the self-employed remains roughly 15% below that of the employed. Since we find that the insurance coverage of the self-employed is quite sensitive to having a tax subsidized price, increasing this subsidy could reduce the coverage disparity between the two groups.

Even with equal tax treatment of the two groups, however, insurance coverage rates among the self-employed would most likely remain below those of the employed. The self-employed, by the nature of their career choice, have revealed themselves to be less averse to risk in general, so that they are probably less likely to feel that they need medical insurance, all else being equal. Nevertheless, increasing the tax subsidy would almost certainly help to reduce the coverage gap of the self-employed

Second, the tax deduction could be replaced with a limited refundable tax credit. For example, the self-employed could be offered a credit equal to 50% of the cost of their insurance, up to the average cost of a typical insurance plan. A limited tax credit has two advantages relative to an unlimited tax deduction. First, a credit offers equal benefits to low and high income self-employed persons, while a tax deduction offers larger benefits to higher income taxpayers. By making the tax credit refundable, the subsidy would extend even to those low income self-employed whose tax credit exceeds their tax liability. Second, a limited credit offers incentives for the self-employed to seek out low cost insurance plans, while an unlimited deduction equally subsidizes efficient low cost insurance and excessive "cadillac" policies. Many analysts have expressed concern that rising medical care costs are due to excessively generous insurance policies in the U.S., so that limiting the amount of the subsidy would offer incentives to avoid these types of policies.

Third, the tax subsidy could be more effectively advertised. Whatever the form of the tax subsidy, a critical problem with effectiveness appears to be low awareness of its existence. Even among the high income self-employed, for whom there is a large subsidy under current law, takeup of this subsidy is only 50%. This suggests that individuals may not be aware of their entitlement, which may in turn limit the effectiveness of this subsidy in increasing insurance coverage. So any expansion of this subsidy should be accompanied by an advertising effort which is designed to make the uninsured self-employed aware of this opportunity to buy subsidized insurance.

A final design issue is the *required floor for self-employment income.* The

current tax subsidy can only be taken up to the amount of self-employment income. Such a rule is important if the goal of the policy is to restrict the tax benefit to the truly self-employed. Otherwise, individuals with only marginal amounts of self-employment income will claim this credit. This could lead to the establishments of artificial self-employment jobs for persons who do not otherwise have access to group insurance, in order to claim this credit.

Combining these four considerations, a sensible policy for the tax subsidy to the self-employed could take the form of a *nationally advertised, refundable 50% credit for insurance costs up to the national average cost of a group insurance plan, that can be taken up to the amount of your self-employment income*. That is, if the national average cost of a family insurance policy is $4000, the self-employed persons could have a credit of one-half of the cost of their insurance, up to $2000 or their self-employment income, whichever is lower. Such a policy would increase insurance coverage among the self-employed, and would do so in an equitable way across high and low income self-employed persons.

Costs and Benefits of Restricting to the Self-Employed

In conclusion, let me focus on a broader question that must be considered in the design of this tax subsidy: why the self-employed? There are two additional groups of persons in the U.S. that do not have access to the employer-provided insurance subsidy: the unemployed, and those in firms that do not offer insurance. Why should we favor the self-employed relative to these other groups?

This question is important for the final consideration mentioned above, the floor of self-employment income required to claim the tax credit. If this floor were zero, then this credit would essentially be available to any person who decided to call themselves self-employed, so that it would extend to members of both of these other groups. As the floor is raised, the credit is restricted more and more to the "truly" self-employed.

So, in setting the floor, the goal of tax policy must be clearly delineated. If the goal is to use this effective instrument to redress coverage differences between the self-employed and employed, then the floor should be set reasonably high. But, if the goal is to more broadly address inequities between individuals who have access to employer-provided health insurance and those who do not, a lower floor, and perhaps no floor at all, would be more sensible.

Chairman THOMAS. Does the gentleman from Nebraska have any questions?

Mr. CHRISTENSEN. I don't, Mr. Chairman, not at this time.

Chairman THOMAS. Thank you.

Mr. Glover, Mr. Gruber talked about the apparent lack of awareness of this obviously desirable deductible provision, and I know that we have been inundated by a number of groups representing small business and others.

Do you have any kind of studies or indication of outreach programs in trying to deal with the awareness, or do you in fact agree with the professor that there is a problem of awareness?

Mr. GLOVER. I agree very much and it is probably out of my bias or prejudice over the years dealing with the Internal Revenue Service some years ago. Generally speaking——

Chairman THOMAS. In a personal or professional way?

Mr. GLOVER. I personally have always done all right. I wouldn't get through Senate confirmation if I had done anything that didn't work out. But professionally, what we see is if it is a benefit to small business, it often times doesn't even make it on the form. For example, right now we are in a situation in which we were last year when we extended it late in the game.

Often there is not even a blank on the tax form for it. The IRS doesn't do much to promote those kinds of things. One other thing, we had a job tax credit some years ago, and one of the reasons the IRS said that it should be abolished was because small businesses weren't using it. The fact is, there was nothing on the form that indicated you could.

Clearly there is an education problem. Small businesspeople often don't know about the deductions permitted. Given the reaction we are getting in the White House conferences, small businesspeople are fully aware of the fact that the deduction for health insurance has been taken away. Clearly promoting it would probably help. We are hearing a lot of noise and very articulate concerns about it in each of those State conferences.

Chairman THOMAS. In addition, Mr. Gruber indicated that there were options like a tax credit. I think also within that, as you saw in the testimony of the Members, we tend to be almost locked into a ritual in terms of the options available to us. Not only could you look into a tax credit structure, but you could also get into that percentage where the behavioral tip is to try to motivate.

You could also talk about a top end which would be a flat dollar amount that would be available. Has the Small Business Administration done any polling or studies among small businesspeople to determine if there have been indications of which profiles would be more acceptable or more desirable?

Mr. GLOVER. One of the things that I would caution the subcommittee on is that at any given time, 30 to 40 percent of sole proprietorships and partnerships are losing money. The average income I gave you of under $15,000 includes those that make money and those that lose money. When you have income restrictions, there are often years in which small businesspeople simply don't make very much money and especially in the beginning years.

Now, I don't want the deduction to be extended to those who are not engaged in the ordinary course of trade and commerce and ac-

tually involved in business, but the income restrictions can be a hardship for those businesses especially where they are starting off. One of the things that we have found is there are an awful lot of barriers to just starting your business.

In most States you are charged more for unemployment compensation in the first year. They give you the highest rates then. You are hit immediately with self-employment taxes. You are hit with the burden of learning how to do all these things and, quite frankly, our indications are the first 2 or 3 years of people starting businesses, they almost always lose money. I would be careful to try to outline any restrictions on income in such a way that those businesses who were just getting started would still be permitted a tax break, provided they could meet some other ordinary course of business test that we see in the Code for other reasons.

Mr. GRUBER. I think that is actually a very important point and that comes back to why I think a tax credit makes a lot more sense than a tax deduction. If you consider a business that is starting out maybe making $15,000, $20,000 a year, they are in the 15-percent tax bracket. Compare them to the established business and now it could go up to the 39-percent tax bracket.

Why do you necessarily want to give a tax break that is almost three times as large to that established business as opposed to maybe the person who needs it more which is the start-up business. A tax credit gives it equally to both and that is an argument for doing that.

Chairman THOMAS. Obviously, we need to explore that at greater length. In that regard, once again, Mr. Glover, in terms of any research, we have heard testimony from Members in terms of a mix and match of ways in which to deal with the percentages.

I am most interested in wondering if there have been any studies, Professor, about the behavioral tip point. Clearly, it is a question of whether or not you have made any money or not, but I would love to see some indication that at 50 or 75 percent, you get a percentage of people who respond to it above which we simply are giving away a portion of a tax deduction because you don't get any marginal behavioral benefit from it.

Do you have anything like that at all?

Mr. GLOVER. I think we have some related information depending on the wide variety of earnings that you have. Clearly, as for the smaller firms, you are not going to be having the same tip point for a firm that is making $7,000 a year and who is looking at a 50-percent deductibility versus someone who is making—for example, a lawyer—who is making $300,000 a year. The tip point may be entirely different for those two individuals.

The credit idea is something I just heard about today, but I will tell you it certainly has some real merit, especially for the smallest of the firms that are just getting started. Very interesting proposal.

Mr. GRUBER. I think, unfortunately, we don't have a lot of evidence on the tip point. I think I agree that the tip point argument is once again an argument for why you would want a credit, because a lawyer earning $300,000 a year, even 50 percent deductibility, is largely not going to affect their behavior. But I do think one thing we do have evidence on that comes back to this question of how you set the floor is that the choice of form in terms of self-

employment or nonself-employment is something which is fairly fungible.

If you make it very generous, then you have got to realize what is going to tip is a lot of people are going to start calling themselves self-employed and that is something where we do have evidence on the tip point. We don't have evidence as to specific numbers, but it is something to keep in mind in terms of cost estimates.

Chairman THOMAS. OK. I appreciate your testimony very much and, without objection, I will make the written testimony part of the permanent record, and I believe I want to include your study.

Mr. GRUBER. That would be great.

Chairman THOMAS. Thank you very much.

[The study is being retained in the committee files.]

Chairman THOMAS. Call the second panel.

The next panel is Bob Vice, listed as an avocado and nursery plant grower in Sacramento. I also know him as the President of the California Farm Bureau, so that he can speak not only in terms of the large group but as a businessman himself. Sal Risalvato, who is a small businessman himself in New Jersey; and Sally Nelson who is an insurance agent from Portland, Maine.

I guess we will begin with you, Bob. We will make any written testimony that you have a part of the record, and we would request that you proceed how you see fit in the 5 minutes that have been allotted to you.

Mr. Vice.

STATEMENT OF BOB L. VICE, PRESIDENT, CALIFORNIA FARM BUREAU FEDERATION, SACRAMENTO, CALIF.

Mr. VICE. Thank you, Congressman. Mr. Chairman, good afternoon. My name is Bob Vice and I am a citrus and an avocado grower in San Diego County. I also serve as President of the California Farm Bureau which represents about 42,000-member farm families who produce over 250 different commodities throughout our State. Most of our members are self-employed and they have a great interest in tax fairness issues. We appreciate this opportunity to make comments on the tax treatment of health insurance premiums.

The Farm Bureau strongly supports allowing self-employed taxpayers and all others who pay the full cost of their health and dental and disability insurance to deduct them as an expense. We seek no special treatment. We simply feel that from the standpoint of fairness, that the self-employed deserves the same considerations as corporations. The motivation is not simply about leveling the playing field for various categories of business in this country. This is important, but even more so is providing all citizens the same tax incentives to pay for health insurance and health care costs.

A tax deduction for the costs of insurance premiums would go a long way toward helping the self-employed provide for their own insurance needs, and this is especially true with farmers and ranchers because we have a relatively high insurance premium cost due to the hazardous nature of our industry.

Many farmers reduce their coverage or drop it entirely because they cannot afford it. Tax deductibility would soften the blow. Of course, medical savings accounts would also help.

I know I do not need to remind this subcommittee that the 25-percent deduction expired on December 31, 1993. It is urgent that this be reinstated soon before farmers, ranchers, and people throughout this country have to file their 1994 taxes. Of course we, too, would join the voices of previous panel members advocating that 100 percent deduction would be the next logical step.

Congressman Thomas, you have been a great friend to agriculture and all small business over the years. We have not forgotten, for example, your leadership in incorporating a targeted export assistance program in the 1985 farm bill, a successful trade program which basic components are alive and well and taking on even more importance today as a consequence of our recently signed international trade agreements, which you also can take some credit for. This important subcommittee which you now chair will provide you many more opportunities to exert the type of leadership that small business in this country needs. We thank you for putting this tax treatment of health insurance high on your list. We hope that your next project will be to provide estate tax relief to the owners of so many small businesses, such as farmers and ranchers, who are now finding it nearly impossible to transfer their life's work to the next generation.

We thank you again for inviting us to speak before this subcommittee, and we look forward to seeing this broadly supported proposal turned into law.

Thank you.

Chairman THOMAS. Thank you, Mr. Vice.

Mr. Risalvato.

STATEMENT OF SAL RISALVATO, OWNER, RIVERDALE TEXACO AND PRECISION ALIGNMENT CENTER, RIVERDALE, N.J., ON BEHALF OF NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Mr. RISALVATO. Good afternoon. Mr. Chairman and Members of the subcommittee, I thank you very much for allowing me to come here this afternoon to explain to you as a small businessowner how this legislation will have an effect on both my business and the small businesses of other small businessowners across the country.

Mr. Chairman, I have to specifically thank you for your introduction of H.R. 697. I think that it shows that you are in tune, and I think it is going to be a great step to getting the ball rolling.

We are here to address the on-again/off-again deduction of our health care premium, and I say on-again/off-again because it is debated every year and it is baffling to me that in 1986, when Congress first put this in place, why it was given a sunset of 1989. I don't understand why something like this would have even been allowed to continue. But it did and we have debated it every year, and hopefully we are going to do something about it permanently here today.

I would like to accomplish two objectives here this afternoon. I would like to make you understand the plain, simple, and obvious unfairness about the lack of deductibility or only a 25-percent deductibility. It is blatantly unfair in comparison to everybody else. The other thing that I would like to help make you understand is that we can use this as sort of an incentive for small

businessowners to get into the insurance market if they are not in it or to continue in it if they are in it presently.

As you know, free enterprise must thrive and it thrives on incentives and rewards, and this 25 percent deduction would be considered an incentive.

I got into the insurance market in my business back in 1983, I believe it was, or 1981. At that time I was very young. I had never had a job for anybody. I worked in my own business all my life and I never really thought about health care insurance. At that time, because I wanted to compete in the marketplace for better employees, one of the things I decided I would do is provide health care benefits because I wanted to keep the good employees that I had.

I always had difficulty making comparison with my business and other businesses in terms of what the pay scales were. There is no real way of learning what another business pays its employees without some sort of espionage or spying so you kind of put feelers out, but you want to make sure you are paying your employees in a competitive fashion.

One thing that was real easy to learn was that the other shops were not providing these benefits, so I knew if I provided health care benefits and paid for them, that this was a reason for my employees to stick with me. This, by the way, is participating in a marketplace. The marketplace I call it, the playing field of free enterprise. I was competing because I was offering something, I am competing for my employees.

Now, at the time that I provided these benefits, I was totally unaware of the fact that I could not deduct it. I just was using some common sense and figured that I am writing a check at the end of every month to pay for these benefits, and I did not learn until the end of year from my accountant that we had to subtract mine out because I couldn't deduct that. I was very, very angry. My first reaction was, well, then I am not going to provide these benefits. Of course that was senseless and I did continue the benefits.

In 1986 I was very, very pleased when we got a 25-percent deduction. But I have to tell you, quite frankly, I felt like I was being thrown a bone. The 25 percent was just something to keep us quiet for a while. It did end in 1989, and right now we are faced with—all small businesses across America—not being able to deduct their own health care for 1994.

I think that we are going to lose the incentive that should be provided to get small businessowners to provide this for their employees, and in the time right now where we are talking about health care reform and we are trying to get more people into the marketplace, it is very important that we do that.

I see my time is up, so I will cease and I will be able to answer any questions that you may have.

[The prepared statement follows:]

STATEMENT OF

SAL RISALVATO

OWNER
RIVERDALE TEXACO
RIVERDALE, NEW JERSEY

Before: Subcommittee on Health
Committee on Way and Means
U.S. House of Representatives

Date: January 27, 1995

Subject: Self-Employed Health Insurance Deductibility

Good afternoon. Thank you Mr. Chairman for giving me the opportunity to explain to you what it is like to own a small business, and to endure the unfairness in our tax code. I am here to speak about the on again off again deduction for health care premiums paid by the owners of small business.

I am one of the owners of a small business. I, along with my brother Vinny, own Riverdale Texaco, a gasoline service station in Morris County, New Jersey. I have been in the service station business since 1978.

As I am sure you know, the 25 percent deduction on health care premiums for the owner of a small business expired on December 31, 1993. I am here to urge this committee to extend the 25 percent deduction retroactive to January 1, 1994. I hope to accomplish several objectives today. First, I hope to make you understand the plain, simple, and obvious unfairness with the tax treatment of health care premiums as they relate to the owners of small businesses. Second, I would like you to understand how that treatment is working against any solutions in the reform of health care.

I first started to provide health care benefits for myself and my employees in 1981. Previously, I myself was not insured. I had always owned my own business from the day I graduated from high school. As a healthy, inexperienced youth, I was not yet wise enough to realize the dangers of being uninsured for serious illness. Had I gotten seriously ill while I was in my early twenties, I would have had no means of paying for my illness, thereby becoming one of those that burden the health care system. I am sure you are all aware of the term "cost shifting". Had I become seriously ill back then, I would have been guilty of "cost shifting".

I cannot say that it was a sudden rise in the level of my wisdom, or the realization that I was a health care deadbeat, that propelled my business into providing health care benefits for myself and my employees. The very force that made me provide health care benefits back in 1981 is the exact same force that is the best solution to your health care crisis today. That force is identified as "the market-place". The market-place is the playing field for free enterprise. It produces quality, efficiency, and excellence. It is sparked by incentive and reward. If it is doused by taxes, punishing regulation, and unfairness then it produces inefficiency and mediocrity.

I had some pretty good employees back in 1981. I hoped I was paying them well enough to keep them. I just wasn't sure. I tried to compare their salaries with those of other shops, but never felt comfortable with the accuracy of the comparisons. One thing I knew for sure was that many shops, with the exception of auto dealerships, did not provide health care benefits for their technicians.

It didn't take a genius to figure out that I could compete for employees better if I provided something only big business was providing. By competing for and keeping better skilled and motivated employees, I was able to sell a better product. When I sold a better product, I attracted more customers. When I attracted more customers, I earned more money. When I earned more money, I spent more money, I saved more money, I invested more money, and yes, I paid more taxes. That simply put is a free enterprise market-place and how it operates. It is not more complicated than that. I hope it is simple enough for Congress to understand.

My accountant at the time almost spoiled the fun of participating in this new benefits game. When it came time to do the end of year tax returns, he pointed out to me that the portion of the health care premium I had paid for myself could not be deducted as an expense, and therefore would be added to my income. I was so angry I felt like canceling the whole benefit. In fact I was a lunatic, being unable to understand why I was being treated so unfairly. It just didn't make any sense. Of course I came to my senses and recognized the whole reason I started the benefits in the first place was for the employees. I would simply have to live with it. But I didn't like it.

I always ask my self, "What decision would I have made if I knew beforehand I would be unable to deduct my share of the premiums?". I still do not know the answer to that question. Perhaps it may have delayed my decision to provide health benefits for my employees.

In 1986 Congress threw me a bone. They now allowed me to deduct 25 percent of my premium. I still can't figure the rationale. If it was unfair to tax me on 100 percent of my premium, why has it now become fair to tax me on 75 percent? It still does not make any sense! Why am I different from the person that works for me? Why am I different from the President of General Motors? I pay the same income taxes as they do, perhaps more or less based on our incomes. Neither my employees, nor the President of General Motors have the amount of their health care premiums added into their incomes at the end of the year. Why do I? Let me ask that question again. Why do I?

The 25 percent deduction wasn't any great thing, but it was better than nothing. Like any begging dog, I took the bone and chewed on it. Unlike the majority of the senseless things that Congress sees fit to impose on small business, they had a built in bone throwing stopper for this dog. Congress built right into the tax reform act of 1986 a sunset for the 25 percent deductibility of my health care premium. The deduction ended in 1989.

Every year since then, Congress has debated extending the 25 percent deduction. Every year Congress makes the same mistake. They don't do the fair and sensible thing. They don't do the one thing that will add incentive to small employers to seek heath care benefits for them and their employees. Congress doesn't make the deduction permanent, and they don't make it a 100 percent deduction.

Instead after each annual debate and holding the dogs at bay, they always choose to spare another bone. Congress has extended the 25 percent deduction every year since 1989 with the exception of 1994.

It is now time to pay taxes for 1994. A few years ago, I hired another accountant. Every year he calls and asks me to retrieve the invoices from my health care carrier from the file in order to calculate how much of the premium was paid for myself and my brother. Each year I dutifully retrieve them. I guess that makes me a Retriever. I report the numbers knowing that only 25 percent of those numbers will actually be deducted as expenses. My bone. The remainder is added to my income. I would like some meat on my bone thank you.

Unfortunately, I am here begging for my bone again. Congress has not extended the 25 percent deduction for 1994. If Congress does not act quickly, small businesses throughout America will not get any deduction this year. At a time when most small businesses are finding it difficult to continue providing health care benefits for themselves and their employees, it is bad for the market-place to not provide them with as much incentive as possible.

I ask you, in the spirit of fairness and in the spirit of concern for health care reform, please to pass legislation that will permanently restore the deduction on health care premiums for the owners of small businesses. I also ask that you make the deduction retroactive to include 1994. Most importantly, I ask that you phase in 100 percent deductibility, with an immediate increase to 50 percent. Members of the Committee, I think this will be a great first step, and a great signal that health care reform will be brought to a successful conclusion in this Congress.

I apologize if there seems to be a facetious tone to my testimony. I mean no disrespect. I make the analogy of the dog and the bone only as a means of highlighting the silliness of this debate. This debate should be over and done with. I am frustrated, and my fellow small business owners are frustrated by the obvious and blatant unfairness of this tax policy. I do detect a new aura in Washington. I was here last week to testify on regulatory reform, and I felt a renewed electricity in the halls of Congress. It felt good. I think the time is right to act on the legislation I have requested here today. I wish you well in your efforts to achieve a more fair tax policy for all Americans.

Chairman THOMAS. Thank you very much.
Ms. Nelson.

STATEMENT OF SALLY I. NELSON, PRESIDENT, LONGVIEW GROUP, PORTLAND, MAINE, AND PRESIDENT, ASSOCIATION OF HEALTH INSURANCE AGENTS, A CONFERENCE OF THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS

Ms. NELSON. Thank you. Good afternoon, Mr. Chairman and Members of the subcommittee. My name is Sally Nelson and I am a professional health insurance agent. My clients are almost all self-employed small businessowners and their employees. I myself am a small businessowner with three employees. I am president of my professional association's conference on health insurance, and for myself, my employees, my clients, and my fellow association members, I thank you for this opportunity to share with you our views.

We each know personally just how important it is to us that you extend the deduction for health insurance premiums paid by the self-employed. The deduction is vital to achieving maximum quality health insurance protection for, literally, millions of small businessowners and their employees.

First, let me state the obvious. It is unfair to treat incorporated businesses and their owners and employees more generously than unincorporated firms. An incorporated business can provide its employees and owners health insurance that is 100 percent tax free. On the other hand, the owner of a small business can deduct no part of the cost of his or her own employer-provided health insurance premium. Until 1993 we could deduct only 25 percent of our insurance costs.

We know of no policy reason for this difference in treatment which is based solely on the form of our business organization. It is not fair and we urge you to change it. We recognize real revenue considerations may prevent a speedy resolution to this issue. We support your effort to address this problem in a fiscally responsible manner, and we would be most pleased to work with you and your staff to find a way to achieve fairness.

Let me spend just a moment describing my own situation, and the situation of two of my clients. These real world scenarios demonstrate just how important it is to at least extend retroactively the 25-percent deduction that expired at the end of 1993.

The yearly premium for health insurance for the four of us employed by my unincorporated business, The Longview Group, was $5,900 in 1994. Our insurance requires a $500 deductible and an 80-percent copayment up to a maximum of $1,000 out-of-pocket costs. Until last year, I could deduct 25 percent of the cost of my share of the premium. I planned on being able to deduct it this year. I planned on it because, although section 162(l) had been scheduled to expire, it had been extended over and over again. Once it had been extended retroactively. In total, it has been extended four times in the last 8 years. Never had it been allowed to expire in a way that resulted in a lost deduction.

One of my clients, Corson Auto Supply in Rockland, Maine, is in much the same position. In 1993 their health insurance premium was $6,500. In 1994 it went up $2,150 to $8,650 a year. If Mr.

Corson loses his 25 percent deduction for his share of that $8,650, as will happen unless you act quickly, he tells me he will be forced to revise his company's coverage. It is likely his group plan will cost 7 to 12 percent more in 1995 and he just cannot afford to absorb that increase and the cost of the lost deduction as well. He will look at increasing deductibles or decreasing benefits for himself, his employees, and his family.

Whitten Architects of Portland is another of my clients. Mr. Whitten employs three people. Over 50 percent of the 1994 annual cost of his group plan is due to his personal family coverage. In 1993 with his 25 percent deduction, his out-of-pocket costs for his family coverage was approximately $2,800 a year. In 1994, without the deduction, his out-of-pocket costs for his family coverage was $4,384.

That is approximately a 60-percent increase in 1 year. He seriously worried about how to handle this. Should he shrink benefit levels, increase deductibles, ask for employee contribution? Right now he is waiting for my recommendation.

Mr. Chairman, what do I tell my clients, that Congress wants to provide the deduction? I am afraid that won't be good enough when it comes time to make the decisions that will be followed by writing a check.

I hope, Mr. Chairman, that you will at least extend section 162(l) before April 15. Save us the extra cost of having to file amended returns if in fact the deduction is extended. I understand that over 60 Senators have signed a letter pledging not to amend a one-issue bill that would extend section 162(l). This would solve our 1994 problem and give us more time to work out a way to extend the deduction.

I thank you very much. My association, my clients, and I offer whatever help you need and I would be happy to answer any questions you have.

[The prepared statement follows:]

STATEMENT OF SALLY I. NELSON, PRESIDENT, THE LONGVIEW GROUP, AND PRESIDENT, THE ASSOCIATION OF HEALTH INSURANCE AGENTS, A CONFERENCE OF THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS

Good afternoon, Mr. Chairman and Members of the Subcommittee. My name is Sally Nelson. I am here today as a self-employed small business owner, and as a professional insurance agent whose client base consists primarily of self-employed small business owners. I am a member of the National Association of Life Underwriters–NALU, a trade association of over 135,000 professional life and health insurance agents whose businesses are much like mine. I am also President of the Association of Health Insurance Agents (AHIA), a conference of NALU, which represents more than 10,000 insurance agents who specialize in health insurance matters. On behalf of myself, my clients, AHIA and NALU, I thank you for this opportunity to present our views on this important issue.

When I was called earlier this week and asked if I could fly down here today to testify on the value of the deduction for the cost of health insurance for self-employed people, I was struck by just how appropriate the request was. I am one of the people most affected by this issue. I am a full-time, self-employed health insurance agent in Portland, Maine. My business, the Longview Group, employs 3 full-time people. I not only sell individual and group health insurance to self-employed people with small firms of their own, but also I am a self employed person with my own small business. I buy what I sell. My employees and I myself are every bit as personally affected by the outcome of the effort to extend the deduction for health insurance for the self-employed as are my clients. I hope you'll agree that this means that my perspective on the value of a deduction for the cost of health insurance for self-employed people is uniquely personal, and hopefully uniquely valuable.

First and foremost, I must comment on the fairness issue. To condition the availability of a deduction for the cost of health insurance on a person's form of business organization is blatantly unfair. My self-employed clients and I need affordable health insurance for ourselves, our families and our employees just as much as the owners and employees of firms that have incorporated. There is no policy justification for differentiating between incorporation, SubChapter S, sole proprietorship, partnership or any other form of business organization in determining whether or not to provide a tax incentive for the purchase of health insurance. Equally, there is no policy justification for providing a 100% deduction for owners of incorporated businesses, but only a 25% deduction for the self-employed business owner. However, we do understand that there is a compelling issue with respect to the availability of Federal funds with which to pay for an expansion of the 25% deduction. Therefore, while we support without qualification the need to enact a permanent, equalized deduction of 100% for the cost of health insurance premiums for all forms of employers, we acknowledge that fiscal reality may make this difficult to do. We would be most pleased to work with you and your staff, however, in trying to find a way to maximize the health insurance deduction for unincorporated businesses.

While ultimately we support a permanent, 100% deduction for all forms of businesses for the cost of health insurance, that is not the issue in question here today. Today we are here to discuss the ability of the Congress to, at a minimum, extend the now-expired provision of the tax code–Section 162(l)–that allows self-employed people to deduct up to 25% of the cost of their health insurance. That provision expired on December 31, 1993. So, currently, no amount of health insurance premium is deductible by people who are self-employed. This of course makes an already unfair distinction between incorporated and unincorporated businesses even more egregious.

As you well know from years of dealing with this issue, one major factor in an employer's decision to purchase health insurance is its cost. Particularly for small businesses–and almost all self-employed people operate small businesses–affordability is a key issue. Of course, the price of a small group health insurance policy is not a function of whether or not the premium is deductible. But the deductibility of the premium has a direct effect on the scope of the insurance purchased. Where an employer has determined that a certain amount of money can be spent on providing health insurance, then decisions regarding how to get the most value for the money must be made.

For example, in my own firm the premium for health insurance for me and my employees costs $5,900 a year. That insurance provides for a $500 deductible and an 80% copay up to a maximum of $1,000. I pay 100% of the cost of coverage for myself and my employees. To that $5,900 a year I must now add the value of the lost 25% deduction for my portion of the premium. The loss of the tax deduction effectively raises my cost by that amount. I can reduce my contribution to the cost of coverage for my employees. Or, I can shop for

alternative insurance that is less expensive–probably because of fewer benefits, higher copays or bigger deductibles. So, the loss of the deduction affects the quality of coverage I can provide, along with its price.

There is another, complicating factor that makes this issue even more frustrating and expensive both for small self-employed business people themselves and for those of us who earn our living by serving these people. And that's unpredictability. It takes time and it costs money to locate and analyze the coverage available to small businesses. The frustration of having to spend that time and to incur that expense as a result of needing to make adjustments to existing coverage caused by the expiration of a tax deduction is compounded by not knowing whether the deduction is lost for good, for a year, or not at all. Not only that, both I and my clients are right now in the process of preparing and filing our 1994 tax returns. If there is too much delay in resolving this issue, we face the possibility of additional expense in order to pay for the filing of amended returns.

As you know, Section 162(l) has always contained a provision dictating that the deduction would expire at a specified point in time. That "sunset provision" has been extended time and time again over the past decade, once retroactively. We are here now talking about extending retroactively a deduction that expired December 31, 1993. That means we are talking about whether the cost of insurance coverage for 1994–last year–a cost already incurred–may change by a significant amount.

Some of my clients, basing their decision on historical Congressional action and public, bipartisan Congressional statements, kept existing levels of coverage in place. We believed that it was almost certain that Congress would again extend the deduction's availability even if Congress turned out to be unable to expand it and/or make it permanent. (Of course, as you'll recall, the focus of last year's debate on this issue was on finding a way to make it a permanent, 100% deduction. The need to extend the deduction at a 25% level was minimalized because of the effort to expand it.) We are now faced with the possibility of having to absorb a higher health insurance cost because we guessed wrong. And at the same time we are facing the need to guess again about how to handle our health insurance purchasing decisions for 1995 and 1996.

Mr. Chairman and Members of the Subcommittee, it is wrong to impose on America's small businesses a requirement that they have to guess at whether a tax rule will operate in a way that can cause one of their major costs to fluctuate so widely. The lack of certainty or even predictability over whether this basic, important, widely-supported deduction will continue can cause real damage.

For me and most of my clients, the cost of 1994 health insurance will be, unless you act, substantially higher than any of us had budgeted for. We will lose extra dollars that we already spent on enhanced coverage. We will have to decide for both ourselves and our employees whether next year we'll provide an insurance plan that costs less. We'll have to cope with determining how to absorb the higher-than-anticipated cost of 1994's coverage. We'll be forced to choose between fewer benefits, higher copays, bigger deductibles, less of an employer contribution or some combination of these painful alternatives. And those choices may be even rougher because similar quality coverage may not be available at the lesser amount of premium dollars we'll have to spend. And as I make my own personal decision on these issues, I'll also have to decide how to advise my clients who are in exactly the same position.

The bottom line is that Congress' inability to stabilize the existence of the deduction for self-employed health insurance, or to establish with some certainty the size of it, could cause America's self employed small business people to choose health insurance coverage that is considerably less valuable than they would otherwise purchase. This adds to the costs of the employees of these businesses. It could ultimately add to the cost of the government's share of the total health care bill as well. There will be those instances where businesses choose to forego providing insurance due to the higher cost; there will be other instances where employees will skip insurance for themselves or for their families where employer shares of the premium shrink; and there will be instances where coverage levels fall short in meeting people's health care needs and government will have to step in and help out.

I would like to share with you two examples of the affect of this deduction on my clients, in addition to the information I've already given you about the affect of the deduction on my own business. Two of my small business clients, firms that are not incorporated, have authorized me to tell you their particulars.

First, let me tell you about Corson Auto Supply Company, an auto parts company in Rockland, Maine. In 1993 the cost of Corson's health insurance was $6,500 a year. Last year, it was $8,650 a year. Thus, Corson's health insurance cost went up $2,150 in 1994 over 1993, and that doesn't include the lost deduction of 25% of the value of the portion of the premium that the business owner, Mr. Corson, paid for his own insurance. I am just now reviewing his coverage as it's up for 1995 renewal. He's probably looking at a 7-12% increase in premium for the same level of coverage. He just told me that if in fact he loses the tax deduction, he will be forced to either increase his deductible or decrease the benefits he provides.

Another of my clients is Whitten Architects of Portland, Maine. Whitten employs three people. Their 1993 health insurance premium was $6,700. In 1994, the premium was $8,500. In 1993, Mr. Whitten, the self-employed owner of the firm, paid $3,688 for his own and his family's coverage under the group plan. In 1994, his family coverage share of the total premium rose to $4,384. With the 25% deduction, his 1993 out-of-pocket premium cost was $2,766 rather than $3,688. Without the deduction for his 1994 $4,384 premium, his yearly increase in cost was 58%! Mr. Whitten is seriously considering whether he can afford to insure his employees when his own costs are subject to such an astronomical annual increase. The availability of the tax deduction is key to his decision, and he is waiting for my recommendation about what he should do in 1995.

What am I to tell my clients? That Congress wants to allow a deduction? Unfortunately, wanting to allow the deduction is simply not a good basis on which to make a business decision about what kind of health insurance to purchase.

Mr. Chairman and members of the Subcommittee, we are of course very much aware of the ambitious and important Contract with America agenda items facing your committee. We know that this deduction is not among the issues to be addressed as part of the Contract with America. However, we also know that a retroactive extension of the deduction for 1994 health insurance purchases really must be done by the time tax returns are due on April 15, 1995. We also know that enactment of a single issue tax bill such as this is usually difficult to accomplish, especially on short notice. This is particularly true, we know, because of the risk of amendment under the very different rules in the Senate. However, we believe that the commitment of well over half of all U.S. Senators to oppose any amendments to a clean, single issue bill that would simply extend Section 162(l) so that it covers 1994 could resolve that worry. That commitment is in writing, in a bipartisan letter signed as of January 25 by 58 Senators. I sincerely hope you will be able to at least extend Section 162(l) prior to April 15 even if it takes somewhat longer to accomplish the larger goal of expanding the deduction.

In summary, Mr. Chairman and Subcommittee Members, thank you again for this opportunity to provide input. And thank you for your effort to extend the deduction quickly, and to expand it ultimately. May I repeat that we are sensitive to the tension between a conviction that a permanent, 100% deduction available to all businesses is the right policy coming in the context of very scarce Federal dollars. We do understand that enacting the right policy must be conditioned on finding sufficient revenue from an acceptable source. Again, we would be very pleased to work with you and your staff as we strive together to resolve this very important issue.

Thank you. I'd be glad to answer any questions you might have.

Chairman THOMAS. Thank you very much.

Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman. I would just make a brief statement.

Mr. Vice, I am a member of the Farm Bureau. Mr. Risalvato, I am a member of the NFIB. Ms. Nelson, I am a member of National Life Underwriters as well as the Association of Health Underwriters. It is hard to present any question on which I disagree with you.

The one matter I want you to know that we are working on is to make sure that we are able to pay for everything, and we want to make sure that the deduction is reinstituted as soon as possible.

I know that, Mr. Vice, it would mean a great deal to your association and the number of small businessowners out there to get this done by March 1, and I know we are going to try everything we can to make sure that that would happen. But, as you know, it takes time.

I appreciate that the chairman has pushed this issue to the forefront and he has done a great job, and I really don't have any questions for you. You have done a wonderful job. I want to thank you for your time.

Ms. NELSON. Thank you.

Chairman THOMAS. Thank you very much. I do have a question. Mr. Vice, probably given the number of people that you talk to in your position, to what extent do you have any information to corroborate what Mrs. Nelson is saying? Obviously, on this on-again/off-again, I am most interested in not so much the level of frustration Mr. Risalvato clearly indicates would be present when it is on-again/off-again, but full change of insurance coverage or plan being offered because of, although it is certainly not adequate, the 25-percent difference.

Do you know of any situations of people who are talking about the fact that, given the margins they are dealing with, if they don't get the 25-percent deduction, they are simply going to not offer or change substantially the insurance?

Mr. VICE. I think probably agriculture among small businesses is unique in one aspect and that is with the market in agriculture, and we are going through the floods right now. There will be many farming operations that won't even exist in terms of gross income much less any net income this year. You always have that spike and it is a year-to-year proposition.

I think most of us who like to provide health insurance for our employees believe that that deduction helps at least level that part of it out. The frustration level is not only in terms of this just being a year-to-year proposition and never knowing when it is going to be there. That is bad enough. But then to have the 25 percent versus what they really believe should be treatment like everyone else at 100 percent, it really raises a two-step frustration level with our members.

We constantly hear about it. One of the things that is very high on our agenda is to have this reinstituted for 1994 policy.

Your comments, Congressman Christensen, about March 1, reminds me that a lot of people in agriculture file at that time, file their estimates, so it is not April 15, it is March 1 for a lot of our

members, so it is immediate. The frustration level is high and we hope that you can find a mechanism for getting it addressed by then.

Chairman THOMAS. For the record, and what I hear when I try to discuss it with people who aren't as familiar with the choices that would be available, the immediate response is, "Why don't you just go ahead and incorporate?" If you see this disadvantage between a particular structure versus a C Corporation, why don't you just go ahead and change your structure?

Mr. RISALVATO. If you change your structure, then you are going to actually be paying a double tax on all of the income of the corporation because right now as an S Corporation, we are paying tax. It gets passed through as personal income which you look at. It makes it even more unfair because the income that is being added to our W–2 is not cash. It is already spent and we are being charged for income being taxed on income that we haven't received. So it makes it that much more difficult.

If we change to a C Corporation, then the corporation pays taxes, what is left over gets distributed to us as stockholders, so we would lose either way.

Mr. VICE. The reality is there are other differences between sole proprietorships and corporations; some are positive, some are negative. The filing date alone in agriculture, you file March 1 and you don't have to file the estimated return. That can't be done if you incorporate. There are more tradeoffs between the two than just this issue.

Chairman THOMAS. The real answer, if you are provided a choice in the Code, should not be determined in terms of something that we are trying to have people have a real incentive going for. I just wanted to get that on the record.

Mr. RISALVATO. Mr. Chairman, it really is just very, very impelling. This is an issue that should have been done a long time ago and I can tell you, both for myself and for the small businessowners, we need this to be passed. We need it to be retroactive to 1994 and we really need to start phasing in the one—up to 100 percent deductibility.

Chairman THOMAS. Obviously, you know that I am committed in dealing with the retroactivity. I wonder if you will allow us some leeway on a prospective. Maybe you have heard the earlier discussion whereon the 100 percent theoretically versus what is actually being offered versus an upper limit which might be a fixed dollar amount, or even the potential for a cap so that we can deal with costs versus providing the option to you, and that, quite frankly, we might be able to lead changes in the corporate areas as well as in terms of fringe benefits.

So I am looking for just a little bit of leeway there. But clearly from the bottom end up, it is a question of equity, and we will do everything we can to make sure that you get that 25 percent for 1994 and you get it in time not only for the April 15 date, but at a time when you can actually use it before you have to file an amended return.

Mr. RISALVATO. I just wanted to let you know there are a lot of small businessowners that, when I have told them that their 25

percent deductibility is not going to happen for 1994, that it is expired, they don't even believe me.

Chairman THOMAS. On that point, from an earlier panel, the awareness question. Do you find that even with the possibility of the 25 percent, people aren't aware of it, but of course they haven't followed the fact if they knew they had it, they didn't get it?

I am concerned about the fact that even if it is only 25 percent, there are people who are not aware of it which of course might mean that they may not be offering some form of insurance that they would otherwise offer.

Ms. Nelson.

Ms. NELSON. I think my comment to that would be, if in fact we have someone doing our taxes for us, we are going to know because that adviser is going to tell us. I think what is happening, you have got some of these self-employed people who can do their taxes themselves, they think, and they miss that and they don't know that it is there. Unless they belong to an association, talking to someone else you find out or their agent, hopefully, tells them, they don't know.

Chairman THOMAS. We have 7 minutes.

Of course the problem is compounded by the on-again/off-again. If you were able to get some certainty to it over the years, people would go into it with that knowledge, and it would become an automatic part of the decisionmaking process. That is obviously our goal.

I want to thank this panel very much. We are going to run over and vote and be right back for the third panel.

Thank you.

[Recess.]

Chairman THOMAS. If we could start the third panel, I would appreciate it. I would ask Jack Faris, Don Dressler, Lisa Sprague, and I believe Julia Whitt is going to be with us instead of Bennie Thayer.

All of your written testimony will be made a part of the record without objection. You will have 5 minutes to proceed as you see fit in the timeframe.

I guess, Jack, we will start with you.

STATEMENT OF JACK FARIS, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Mr. FARIS. Mr. Chairman, thank you, first of all, for inviting us to be here today on a subject that is close to the heart and pocketbook of everyone on Main Street, everyone on a farm, and everyone that is gainfully employed trying to be a successful entrepreneur. We do want to applaud you for the bill you have introduced to get the 25 percent as a matter of the retroactivity, to be assured when small businessowners are filing their taxes they will know that they can still have 25 percent for last year.

I am representing the National Federation of Independent Business. We are the Nation's largest and oldest organization of our type representing over 600,000 small businessowners from all 50 States. Our typical member has five employees, $250,000 a year in gross annual sales, and we set our policy based on the regular poll-

ing of our membership. They have spoken loudly and clearly for years about this particular issue.

My compadres at the table today will get into more of the detail, I am sure, as it relates to the self-employed. What I would like to focus on, and just for few minutes, is the word fairness because that is in reality what this is all about.

In Nashville, Tenn., and maybe it is true in California, but we would call this a no-brainer. Just to think about the fact that General Motors is able to have 100 percent deductibility for purchasing insurance and the person who is buying the Chevy pickup on Main Street who is self-employed does not get the 100 percent but only gets 25 percent. But yet we are a nation of entrepreneurs and we say it is the backbone of our economy and we say that is what is really important about America. Small businessowners are ready to say, "Let's put some walk in our talk." We talk good entrepreneurship. Now let's let the votes show it.

What we do not understand is why it is not 100 percent. You say, well, it is an economic situation. If it is an economic situation, then if we take the 45 point—right at $45.6 billion that are now being deducted by all of those covered under deductibility and we add approximately $2 billion, it would cause the entrepreneurs to be the 100-percent deductibility. We just average that out and say, let's all be fair and pay the same. It would be until 95.2 percent.

We are ready to play by the games General Motors plays, but we do not think we should finish the road of inequity and unfairness for the new job generators in America that are on every Main Street in every congressional district that were saying on November 8, and they are saying today, walk the walk.

I want to applaud this subcommittee and you, Mr. Chairman, for having these hearings, putting forth this legislation. It is time to get on with the program for the entrepreneurs so we can continue to keep that American dream alive of entrepreneurship.

Thanks again for allowing me to come and speak today.

[The prepared statement follows:]

TESTIMONY OF
JACK FARIS
PRESIDENT AND CEO
NATIONAL FEDERATION OF INDEPENDENT BUSINESS (NFIB)

Before: Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Date: January 27, 1995

Subject: Self-Employed Health Insurance Deductibility

Thank you, Mr.Chairman. My name is Jack Faris, and I am President and CEO of the National Federation of Independent Business (NFIB). NFIB is the nation's largest small business advocacy organization, representing over 600,000 small business owners from all fifty states. The typical NFIB member has five employees and has $250,000 a year in gross annual sales. NFIB sets its public policy positions through regular polling of the membership.

I want to take this opportunity to thank you for inviting NFIB to participate in this hearing today, and also to commend you for bringing attention and urgency to the issue of health insurance deductibility for self-employed Americans -- sole proprietorships, partnerships, and subchapter S corporations. I am very hopeful that this hearing will begin a process by which a major unfairness in our tax code will be eliminated.

Attaining full tax deductibility for the self-employed has been a top priority for NFIB for many years. Eighty-two percent of NFIB members support full deductibility of health insurance premiums, according to a 1993 survey. Health insurance deductibility has also been designated a top priority in several state conferences leading up to the 1995 White House Conference on Small Business.

Approximately half of our more than 600,000 members own unincorporated businesses. In fact, a majority of all businesses in this country are self-employed. Self-employed businesses are the cradle of job creation and the American dream: the newer and smaller the business, the more likely it is to be unincorporated. These self-employed business owners are the very people whose firms need to start, survive, and grow in order to create the jobs of the future. These are often people with very little cash, a good idea and talent -- struggling to make it work. And once they do make it work, they are a major part of the group that creates nearly all new jobs in our economy. Government data shows that small business has created two of every three net new jobs since the 1970s, and a substantial majority of those jobs were created in the smallest firms -- those with fewer than five employees. Firms of this size, which constitute 60 percent of all employers in this country, tend to be unincorporated.

These unincorporated business owners -- some with employees, some working on their own -- experience the worst of all possible worlds in the health insurance marketplace: an insufficient product for a high price and denial of the same incentives and tax treatment enjoyed by big business.

The High Cost of Health Insurance

Self-employed business owners often pay approximately 30 percent more than larger companies for similar benefits because of higher administrative costs. In addition, they often pay another 30 percent in premiums because of costly state mandates for specific types of insurance coverage, which prevent self-employed business owners from shopping for only the basic care that they and their employees might need. Larger firms that self insure, by contrast, are not subject to these costly mandates. The self-employed usually lack access to cost-saving managed care arrangements because of a reluctance by insurers to create and market them in small towns and rural areas. Additionally, a small, unincorporated firm is far more likely than others to feel the painful brunt - both economic and emotional - of the pre-existing condition exclusion or, when an employee gets sick, the 20 percent to 300 percent premium hike or sudden cancellation of insurance. Insurance companies are much more likely to require exclusions, raise premiums or cancel policies to shield themselves from risk when insuring a small firm or a one person firm rather than a large business.

All of this accounts for a trend found in NFIB Education Foundation studies that began in 1986. In that year, small business owners -- both self-employed and incorporated -- for the first time identified the cost of health insurance as their number one problem in a study entitled Small Business *Problems and Priorities*. That trend has continued ever since, with the cost of health insurance proving to be twice as critical a problem as the number two problem (federal taxes on business income) in a follow up study published in 1992. With health insurance premiums still growing faster than the rate of inflation today, this problem has not abated.

No Deductibility

On top of all this, self-employed Americans cannot deduct any of their health insurance premiums. C corporations have a permanent, 100 percent deduction; self-employed business owners have none. The self-employed had a 25 percent deduction until December 31, 1993, when it expired. The 103rd Congress adjourned without renewing the deduction for 1994, (despite your great efforts and those of your bipartisan cosponsors). This means that self-employed business owners will experience a tax increase on their 1994 returns -- unless Congress acts before April 15.

Using Joint Tax Committee cost estimates and Foster-Higgins survey data on premiums, NFIB estimates that approximately 1.4 million self-employed business owners will have their taxes go up if the 25 percent deduction is not retroactively renewed for 1994. Mr. Chairman, we are encouraged by your commitment to prevent this tax increase.

Even before the 25 percent deduction expired, self-employed business owners were buying health insurance on a tax policy playing field that was vastly uneven. The difference between a 25 percent deduction for the self-employed and a 100 percent deduction for C corporations is terribly unfair and arbitrary. But it is not only a philosophical matter of fairness; it is a matter of dollars and cents. Under current law, it would cost a sole proprietor buying the exact same health insurance policy from the exact same insurance company as the owner of a C corporation substantially more in after tax dollars because of the deductibility gap.

Recommendation

NFIB strongly urges this subcommittee to end the health insurance tax deductibility status quo and address the tax fairness issue head on. Specifically, NFIB urges you to retroactively restore the 25 percent deduction to the self-employed and to send a clear signal that business as usual is a thing of the past by increasing the deduction to at least 50 percent and making a commitment to reaching parity as soon as fiscally possible.

Ending the status quo -- setting a course toward 100 percent deductibility -- accomplishes the following:

(1) **Parity.** Full deductibility for the self-employed would end the idea that an executive for a Fortune 500 company can get a full deduction for a gold plated health insurance policy but a self-employed business owner receives no deduction at all -- solely because of the way the business is legally organized.

Some may argue that limited deductibility for the self-employed should be preserved at some level in an effort to make Americans more sensitive to the actual cost of their health care, thereby making the market place more competitive. NFIB believes that concerns about the impact of the tax code on health care cost sensitivity are legitimate. However, any approach to this issue which says that limited deductibility is good policy for the self-employed but not simultaneously for C corporations is unfair and unacceptable.

(2) **Incentive for the self-employed to purchase health insurance for themselves and their families.** Self-employed Americans are one of the largest groups of uninsured citizens. There are nearly three million self-employed Americans without health insurance. The 25 percent deduction is a small but meaningful incentive for unincorporated business owners to purchase health insurance for themselves and their families. If this group of business owners were given the 100 percent deduction, many more would purchase insurance, substantially reducing the number of uninsured Americans in this country. Consider the following example:

A self-employed caterer purchases a health insurance plan for $3,781 per year. [The actual amount would actually be less or more depending on whether the caterer was purchasing an individual or a family policy; $3,781 was the average per person premium in a Foster-Higgins survey of 1993 premiums. A self-employed person would usually pay more than this average because of many of the disadvantages of buying health insurance individually.] The caterer is in the 28 percent tax bracket.

After-tax savings from a 25 percent deduction: $264.67
After-tax savings from a 100 percent deduction: $1058.68

Most self-employed business owners survive on tight margins -- they keep the business afloat on cash flow, not profit. The typical NFIB member makes less than $40,000 a year. Affordability is the most important factor to small business owners when deciding whether to buy health insurance. To people in this position, the savings shown in the example above can make a real difference when making a decision on whether to buy an important, but very expensive product.

(3) ***Incentive for the self-employed to purchase health insurance for their employees.*** NFIB strongly believes that full deductibility for the self-employed would also reduce the number of uninsured among the employees of the self-employed. Under current law, a self-employed business owners find themselves in the peculiar position of being permitted to deduct the health insurance costs of their employees, but not their own premiums. If they have no incentive to purchase health insurance for themselves, they are far less likely to consider buying it for their employees. Full deductibility would change that.

(4) **Tax Fairness: Ending politics as usual.** The 25 percent deduction has been temporarily extended from year to year since it was first enacted in 1986. Because of its substantial bipartisan popularity, it has repeatedly been held hostage in previous Congresses to other, typically very unpopular causes like the tax increases in 1990 and 1993, as well as the Clinton health care plan last year. Again, restoring the 25 percent deduction and moving toward 100 percent would shatter a status quo in which the self-employed are used as a political football.

Self-Employed Health Insurance Deduction: A History

1986-1989:	The self-employed were first given 25 percent deductibility as part of the Tax Reform Act of 1986.
1989:	The Omnibus Budget Reconciliation Act of 1989 extended the deduction for nine months (for taxable years beginning before October 1, 1990.)
1990:	25 percent deductibility was extended through 1991.
1991:	25 percent deductibility was extended through June 30, 1992.
1992:	On June 30, 1992, 25 percent deductibility expired.
1993:	25 percent deductibility was included in Omnibus Budget Reconciliation Act of 1993 and applied retroactively from July 1, 1992, to December 31, 1993. (The deduction was limited if the individual or his or her spouse was eligible to participate in an employer-paid health plan.)
1994:	Self-employed deductibility no longer exists.

(5) **Health care reform: The first step.** The health care debate of the 103rd Congress ended in acrimony and gridlock. The deductibility issue gives the new Congress an opportunity to swiftly set a new tone for the health care debate: taking incremental steps on which most people agree to improve the system. The deduction for the self-employed is a great place to start: a reform with wide bipartisan support that would reduce the number of uninsured and deliver some much needed relief and fairness to others struggling to stay insured.

Conclusion

Again, NFIB urges you to do the following:

(1) Restore the 25 percent deduction retroactively for 1994 and increase it to 50 percent as a signal to every self-employed business owner that the status quo on this issue will no longer be tolerated.

(2) Move toward a permanent 100 percent deduction for the self-employed as soon as fiscally possible.

NFIB hopes that the Subcommittee on Health will take these steps on behalf of the self-employed. Mr. Chairman, we would like to express our appreciation for your leadership on this important issue. Self-employed business owners are calling out for fairness and stand ready to help you and your colleagues achieve it in 1995.

Thank you.

Chairman THOMAS. Thank you very much, Mr. Faris.
Mr. Dressler.

STATEMENT OF DON DRESSLER, PRESIDENT, INSURANCE SERVICES, WESTERN GROWERS ASSOCIATION, NEWPORT, CALIF.

Mr. DRESSLER. I am Don Dressler with the Western Growers Association. We are an association of fruit and vegetable growers based in California and Arizona.

Our members collectively produce half of the fruits and vegetables produced in the United States. A number of our members are self-employed individual farmers, many of which do their work themselves or have a few employees and especially new businesses and new farming operations started on a self-employed basis.

In addition to the equity argument, we think there are several other things that also should be considered when you look at this deductibility issue.

It was interesting in a recent report I saw just preparing for this trip, in the Health Affairs Journal there was a study that was done by a number of different people, including the University of Alabama, indicating among small employers, the prevalence of health insurance is twice as high in corporations as those who are unincorporated. That seems to me to be a pretty significant indicator of the power of the deductibility item because, if you are talking about similar sized businesses and some are incorporated and others aren't, then this has to be a critical factor.

We all know that probably the most important factor in decisions on purchasing health insurance is price. Another interesting thing I thought the study indicated is that price of health insurance is fairly elastic, meaning a small impact can be magnified and have a dramatic effect on purchasing decisions.

Well, first of all, we agree, it should be equal for everyone. But clearly the more deductibility, the more impact it has on encouraging health care. You are reversing it in a sense. In fact, there are some indications a reduction in price by 5 percent would increase purchases by 15 percent. So if you can get that kind of leverage, clearly the more that you can invest in the process, the more important it will be.

I would say secondary to price is the issue of reliability. One of the most important reasons why many people have not purchased health insurance is they are not sure that it is not going to be there and they are not sure they can count on it. Part of that, of course, has to do with if you are an employer with a employee, you don't want to purchase benefits for an employee if you don't have them for yourself.

The second thing is, you don't want to purchase them for your employee and have to take them away because then you have a really unhappy, demotivated employee.

Make this decision once and for all and be fixed and permanent. That will also help us with the knowledge and awareness of the issue because, once it is there and established, it is much easier to start educating people about it and they can make business decisions based upon it.

So kind of in sum, this is a really critical issue. It is very important to us in agriculture. I think it is important to all the business community. You can make a major difference in the affordability of health care by this decision. We would hope that you do it on a permanent basis so we can rely upon it in the future.

I want to thank you very much for your interest in this subject. I want to thank you for your support of our industry, and we very much appreciate the chance to be here.

[The prepared statement follows:]

STATEMENT OF DON DRESSLER

PRESIDENT - INSURANCE SERVICES

WESTERN GROWERS ASSOCIATION

HOUSE COMMITTEE ON WAYS & MEANS

SUBCOMMITTEE ON HEALTH

JANUARY 27, 1995

Mr. Chairman and distinguished members of the Committee, I greatly appreciate this opportunity to present the views of the Western Growers Association concerning the tax-deductibility of health insurance for self-employed individuals. Western Growers Association represents 2,400 members who grow, pack, and ship fresh fruits, vegetables, and nuts in Arizona and California. Our members ship approximately half of America's supply of fresh fruits and vegetables.

Western Growers Association has been providing health insurance to its members and their employees, including seasonal agricultural workers, for over 50 years. WGA currently provides affordable health benefits to over 50,000 individuals in California and Arizona, including members of Western Growers Association and their employees and dependents.

On December 31, 1993, the 25 percent tax deduction for health insurance premiums for self-employed individuals expired. Western Growers cannot overemphasize the importance of restoring this tax deduction. Furthermore, we urge that the deduction for self-employed individuals be gradually increased to 100 percent of health insurance costs and made permanent. Full deductibility of medical coverage costs is the amount corporations are allowed to deduct for the cost of providing medical coverage for their employees. It is simply unjust to expect independent farmers and producers to shoulder the enormous burden of health insurance costs, while corporations can deduct the entire amount of their health insurance costs, and also while individuals who work for corporations receive their medical coverage tax-free.

With much of last year's Congressional debate focused on health care costs and the importance of making health insurance as affordable as possible, we cannot understand why anyone would choose to deter independent farmers from obtaining adequate health coverage. Essentially, this is what will happen if the 25 percent tax deduction is not reinstated and augmented to 100 percent.

It is important to note that farmers work in what insurance companies consider to be a "high risk" or "hazardous" occupation. In addition, as self-employed individuals, they are generally not covered by workers' compensation. Both of these factors result in insurance companies charging farmers higher than average premiums: too high for most farmers to afford, even if they are allowed a tax deduction of 25 percent. In fact, health coverage is only affordable for many of our members and their employees because we have been able to bring down costs through the use of self-insurance.

Even with the lower rates obtained through the use of self-insurance, many farmers will have great difficulty in affording coverage unless they are able to deduct the full cost of health insurance. Thus, the number of the nation's uninsured individuals will increase even further.

Western Growers is disturbed that the issue of health insurance deductibility was allowed to go unresolved during the recent health care debate. Moreover, we are astonished that the 25 percent deductibility for self-insured individuals' health care costs--an amount which was enacted in 1986 and has been extended or reinstated retroactively ever since--was not continued. Independent farmers and producers do not have the luxury of waiting out the political storms in Washington, D.C. They must soon fill out their tax returns for 1994, and if the 25 percent deductibility is not restored before their returns are due, many farmers may be forced to discontinue the insurance policies that they are already hard pressed to afford.

It should be remembered that if sole proprietors and partnerships were able to fully deduct the cost of health insurance they buy for themselves and their families, more of them would be able to afford to offer insurance to their employees. A study performed recently by the Center for Health Policy at the University of Alabama found that 90% of small businesses listed premium cost as the major factor preventing them from providing insurance to their employees. Moreover, this study found that the health insurance purchase decisions among small employers were very elastic, which means any reduction in the cost would greatly increase the likelihood that the employer would provide insurance to the employee. In quantifiable terms, the study found that a 5% decrease in the cost of insurance increased the utility of the insurance by 15%.

Given this situation, by allowing a tax deduction for health premiums for self-employed individuals, you are attacking the primary reason for why people are uninsured today - that reason is high cost. Another statistic which illustrates the disparity between corporations and non-incorporated businesses is that, while 62% of small firms (50 employees or less) which were incorporated provide health insurance for their employees, only 33% of those which were not incorporated did so.

Clearly, other steps are necessary, beyond extending tax deductibility, in order to expand the availability of affordable health care. We have seen in California that basic insurance reforms for small business group insurance can contribute significantly towards this goal. Currently, only 17% of small employers get their health coverage through group plans. Insurance reform such as that enacted recently in California would certainly increase this number, thus increasing the availability of affordable insurance. Given this experience, Western Growers Association supports reforms such as guaranteed renewability, limitations on experience rating, and limitations on pre-existing conditions, and we encourage Congress to take action in this regard.

Thus, tax deductibility of health insurance costs benefits more than just self-employed individuals. It is one step that Congress can take right now towards increasing the number of Americans with health insurance without enacting problematic, full-fledged reform of the nation's health care system. We urge Congress to reinstate the 25 percent tax deduction for self-employed individuals and highly recommend that the deduction be increased to 100 percent and made permanent.

Chairman THOMAS. Thank you very much.

During the question period, given the type of people you represent, I would like to pursue some of the questions that we had asked earlier. But first let's hear from Ms. Sprague.

STATEMENT OF LISA M. SPRAGUE, MANAGER, EMPLOYEE BENEFITS POLICY, U.S. CHAMBER OF COMMERCE

Ms. SPRAGUE. Thank you, Mr. Chairman.

As you know, the U.S. Chamber of Commerce counts among its members 215,000 businesses, 96 percent with fewer than 100 employees, 71 percent with fewer than 10. I appreciate the opportunity to appear today to speak on behalf of all those businesses on the issue of health insurance deductibility for the self-employed.

Few issues are as clear cut and convincing. Restoration of the 25-percent deduction is a top priority for the chamber. Further, we regard full deductibility as an indispensable element of future reform efforts.

The chamber's membership is diverse, which at times can result in varying priorities within a given legislative issue, particularly one as complex as health care. But we have yet to hear from a single membership constituency, or indeed a single member, any suggestion that equity in the deductibility of health insurance should not be a top priority for the chamber as a whole.

You and others have noted that from 1986, a 25-percent deduction for self-employed persons was granted and repeatedly extended until Congress failed to renew it in 1994. Ironically, then, the one measurable result of the health care reform debate that dominated the year was that the most vulnerable of those who provide health insurance were left in worse straits than before. They do, as others have said, feel this deeply.

The chamber calls on Congress to restore the 25-percent deduction for 1994 and to act quickly enough in order that self-employed filers may reflect it in their 1994 tax filings. In this connection, we welcome and support your bill, Mr. Chairman.

To be sure restoration of the 25-percent deduction is no more than a quarter of a loaf, I join with my fellow panelists in stating that what is really needed is legislation to permit a 100-percent deduction of health insurance costs. The chamber urges this subcommittee to work to enact deductibility in 1995. Recognizing that the major obstacle to such action is its cost in tax revenues, the chamber is willing to consider a phased-in approach to get to 100 percent. But what we cannot accept is that the smallest businesses, frequently new and often struggling, should be denied a measure of security granted to larger businesses.

The chamber wants to commend the subcommittee for examining an issue that has been a thorn in the side of the Nation's smallest businesses for many years. We look forward to working with you to remove that thorn and to enroll the self-employed as full partners in our common effort to make private sector health insurance more available and more affordable.

Thank you.

[The prepared statement follows:]

STATEMENT
on
HEALTH INSURANCE DEDUCTION
before the
SUBCOMMITTEE ON HEALTH
of the
HOUSE COMMITTEE ON WAYS AND MEANS
for the
U.S. CHAMBER OF COMMERCE
by
Lisa M. Sprague
January 27, 1995

Chairman Thomas and members of the Subcommittee, I am Lisa Sprague, Manager of Employee Benefits Policy for the U.S. Chamber of Commerce. The Chamber is the world's largest business federation, representing 215,000 businesses (96 percent with fewer than 100 employees and 71 percent with fewer than ten), 3,000 state and local chambers of commerce, 1,200 trade and professional associations, and 72 American Chambers of Commerce abroad. We appreciate the opportunity to appear before this Subcommittee to comment on the issue of health insurance deductibility for the self-employed.

Few issues are as clear-cut and convincing. In fact, restoration of the 25 percent health insurance deduction is a top legislative priority for the Chamber. Further, we regard full deductibility as an indispensable element of a successful reform agenda, and one that should top the list of incremental improvements to be considered by this Subcommittee.

The business community, in its role as benefit-plan sponsor, has been the driving force in pushing reforms to our health care delivery systems and slowing the rate of increase in health care expenses. Today, we know that employers provides health insurance for the majority of those Americans who are insured. As the engine of the U.S. economy, small businesses -- including the self-employed -- have played a key role in the innovations and economies that have been realized. Yet the self-employed continue to be isolated and denied in terms of health insurance deductibility. That is why your hearing today is so important: to focus attention on and open the way to quick action in rectifying an injustice.

The Chamber's membership is greatly diverse, and at times this can result in its having to choose among varying priorities within a given legislative issue, particularly one as complex as health care. But we have yet to hear from a single membership constituency, or indeed a single member, a suggestion that equity in the deductibility of health insurance should not be a top priority for the Chamber as a whole.

Since 1986, self-employed persons have been permitted to deduct 25 percent of amounts paid for health insurance for the individual, his or her spouse, and dependents of employees. This provision was never written permanently into the tax code, but was repeatedly extended -- until December 31, 1993, when it was allowed to lapse. Congress failed to renew it in 1994. Ironically, then, the one measurable result of the health reform debate that dominated the year was that the most vulnerable of those who provide health insurance were left in worse straits than before fervent discussion of expanding coverage began. The Chamber calls on Congress to restore the 25 percent deduction for 1994, and to act quickly enough that self-employed filers may reflect it in their 1994 tax filings.

To be sure, restoration of the 25 percent deduction is no more than a quarter of a loaf. What is really needed is legislation to permit 100 percent deduction of health

insurance costs. Sound tax policy dictates full deductibility of premium or self-insurance costs as ordinary and necessary business expenses. There is no valid tax policy reason for treating the smallest businesses any differently. The Chamber urges this Subcommittee to work to enact full deductibility in 1995. Recognizing that the major obstacle to such action is its cost in tax revenues, the Chamber is willing to consider a phased-in approach to 100 percent deductibility. What the Chamber cannot accept is that the smallest businesses, frequently new and often struggling, should be denied a measure of security granted to larger businesses.

The Chamber wishes to commend you and the Subcommittee for holding a hearing on an issue that has been a thorn in the side of the nation's smallest businesses for many years: their inability to deduct the full cost of their health insurance, and the inequity inherent in being denied an advantage granted to their incorporated fellows. The Chamber looks forward to working with the Subcommittee to remove that thorn and to enroll the self-employed as full partners in our common effort to make health insurance more available and affordable in the private sector.

Chairman THOMAS. Thank you very much.
Ms. Whitt.

STATEMENT OF BENNIE L. THAYER, PRESIDENT, NATIONAL ASSOCIATION FOR THE SELF-EMPLOYED, AS PRESENTED BY JULIA WHITT, DIRECTOR, GOVERNMENT RELATIONS, NATIONAL ASSOCIATION FOR THE SELF-EMPLOYED

Ms. WHITT. Good afternoon. My name is Julia Whitt and I am the director of Government Relations for the NASE, National Association for the Self-Employed. I am pleased to have the opportunity to present our membership views on this issue in place of our president Bennie Thayer.

The NASE represents more than 320,000 small businesspersons nationwide. Over 85 percent of our members are businessowners with five or fewer employees and more than half are the smallest of small business, independent sole proprietors.

The issue of 100 percent deductibility of health insurance premiums is a paramount concern of our membership. The NASE views this hearing today as part of the Ways and Means Committee's commitment to resolve a significant problem for the small business community.

It is NASE's strong recommendation to the Ways and Means Committee and other Members of Congress to take immediate action to reinstate the 25-percent health insurance deduction for the self-employed. Reinstatement would be a positive step for several reasons.

First, early subcommittee action in 1995 will go a long way toward easing the administrative and compliance burdens for both the Internal Revenue Service and for the small businessowners in terms of processing 1994 tax returns.

Second, prompt reinstatement should help remove the pending tax increase self-employed persons will face in the absence of the deduction.

Third, quick passage of the 25-percent deduction would smooth the way for the health insurance deduction issue to be included in the Ways and Means Committee's deliberations on a tax component in the Contract With America.

Fourth, action also needs to be taken immediately to reinstate the deduction to help the self-employed maintain their current health insurance policies.

The NASE commissioned a study by Dr. Bruce Kirchoff which has been referred to earlier in testimony regarding the number of persons affected by elimination of this deduction. I would be willing to supply a copy of this study to remain part of the record. But according to that study, a total of 412,000 persons would join the ranks of the uninsured based on the loss of the deduction; 117,000 of these people would be children.

As indicated by the Employee Benefits Research Institute, in January 1994 there were already 2.8 million self-employed persons without insurance. One of the major goals of achieving meaningful, cost-effective health care reform was to reduce the number of Americans without health insurance. Obviously, loss of the deduction is health care in reverse for the self-employed.

As indicated by the NASE study, prompt reinstatement of the 25-percent deduction for the 1994 tax year will help mitigate the likelihood of a significant increase in the number of uninsured persons. We also believe that if Congress wants to increase the number of self-employed persons with health insurance, a 100-percent tax deduction is the most effective way to do this.

It wasn't until 1986 that Congress attempted to rectify to any degree the disparity in the tax treatment of health care premiums between unincorporated businesses and corporations by allowing the self-employed to deduct 25 percent of their health care costs. However, even with the 25-percent deduction, a self-employed individual incurs a higher effective cost when purchasing a health insurance policy because the self-employed must purchase their health insurance with primarily after-tax dollars while employees of large corporations have their policies paid with pretax dollars.

To purchase the same $4,000 policy, an employee of a large corporation might receive it tax free, a self-employed individual who makes $35,000 in adjusted gross income, receives a 25-percent health insurance deduction, and must earn $7,075 in pretax dollars. Now with no deduction, that same self-employed person purchasing that same policy will end up paying $8,214 in pretax dollars, a 16-percent increase.

It is obvious this is another example of a group who needs help the most gets the least. More than 12 million Americans are self-employed, and the figures that we used are the people who actually filed returns and claimed a self-employment tax deduction. Nearly 17 percent of these people earned adjusted gross incomes of less than $50,000.

Our figures show, based upon the IRS statistics, that only 22.7 percent of the self-employed actually claimed a health insurance deduction in 1992. Nearly 40 percent of those claiming the deduction had adjusted gross incomes of less than $25,000, and 67 percent had less than $50,000.

The issue of 100 percent deductibility is obviously a middle-class issue. Therefore, we urge Congress to consider it along with other initiatives focused on this needy group. Tax season is upon us and I believe that many of the self-employed are going to be surprised to find out they have no deduction for 1994. Therefore, on behalf of our more than 320,000 members, I urge the Ways and Means Committee to, No. 1, take immediate action to reinstate the deduction; and No. 2, raise the deduction level to 100 percent.

I thank you very much for allowing me to express our viewpoint and good luck.

[The prepared statement and attachment follow:]

STATEMENT OF BENNIE L. THAYER, PRESIDENT
NATIONAL ASSOCIATION FOR THE SELF-EMPLOYED

Chairman Bill Thomas, Ranking Member Pete Stark, and members of the House Ways and Means Subcommittee on Health, thank you for the opportunity to testify today. My name is Bennie L. Thayer, and I am testifying today as President of the National Association for the Self-Employed on the issue of the health insurance deduction for the self-employed.

The NASE represents over 320,000 small business persons throughout the United States. Over 85 percent of the NASE members are business owners with 5 or fewer employees. The membership is involved with a very wide range of businesses, notably in the consulting and retail fields. Our members strongly support 100-percent deductibility of health insurance premiums for the self-employed. This is an issue of paramount importance to the NASE membership. We wholeheartedly endorse Committee Chairman Bill Archer's recent call for a prompt reinstatement of the 25-percent health insurance deduction for the self-employed.

The NASE views this hearing today as part of Chairman Archer's commitment to this effort, as well as an important signal by the members of the Subcommittee on Health that they want to resolve a significant problem for the small business community.

The Need for a Quick Committee Markup

It the NASE's strong recommendation to the House Ways and Means Committee and the other members of Congress to pass a bill before February 15 to reinstate the 25-percent health insurance deduction for the self-employed -- which otherwise expired on December 31, 1993. Early committee action in 1995 will go a long way towards easing administrative and compliance burdens for the Internal Revenue Service in terms of processing 1994 tax returns. Also, prompt reinstatement of the 25-percent deduction should help remove the pending tax increase self-employed persons face in the absence of reinstatement.

Quick passage of the 25-percent deduction legislation would then smooth the way for the Ways and Means Committee's important deliberations involving the tax component of the Contract of America. As part of the committee's markup of Contract With America over the next two months, the NASE strongly urges the committee to go the next step with respect to the self-employed's health insurance deduction. We recommend that you include a provision to increase the deduction to 100 percent for 1995 and all tax years thereafter.

The Number of Self-Employed Persons Who Will Drop Insurance Coverage

Dr. Bruce Kirchhoff of the New Jersey Institute of Technology completed a study for the NASE in 1993 regarding the number of persons affected by elimination of the 25-percent health insurance deduction for the self-employed. According to this study, 295,000 self-employed persons would stop purchasing health insurance due to the loss of the deduction. Because some of these self-employed individuals have dependents, the study suggests that a total of 412,000-persons would join the ranks of the uninsured based on the loss of the deduction. As indicated by an Employee Benefits Research Institute study, there are already 2.8 million self-employed persons without insurance.

One of the major parameters of achieving meaningful, cost effective health care reform is to reduce the number of uninsured Americans. As indicated by the NASE study, prompt reinstatement of the 25-percent deduction for the 1994 tax year will help mitigate the likelihood of a significant increase in the number of uninsured persons.

Tax Equity

Current inequities in the federal tax law make it more difficult for the self-employed to be able to afford health insurance. It has been a long-standing practice under the tax law that corporations have been permitted to deduct all of the health insurance premiums paid on behalf of their employees.

However, it wasn't until 1986 that Congress attempted to rectify to any degree the disparity in the tax treatment of health care premiums between unincorporated businesses and corporations.

Beginning in 1986 and continuing through the end of 1993, self-employed persons had been permitted to deduct 25-percent of their health insurance premium costs from their taxes. However, even with the 25-percent deduction, a self-employed individual incurs a higher effective cost when purchasing a health insurance policy because he or she primarily pays for the insurance with after-tax dollars. This is in contrast to employees of large corporations who generally have their policies paid for by the company with pre-tax dollars.

As I stated previously, the health insurance deduction for the self-employed expired at the end of 1993. I am fully aware that Congress did attempt to address the issue last year within the context of health care reform.

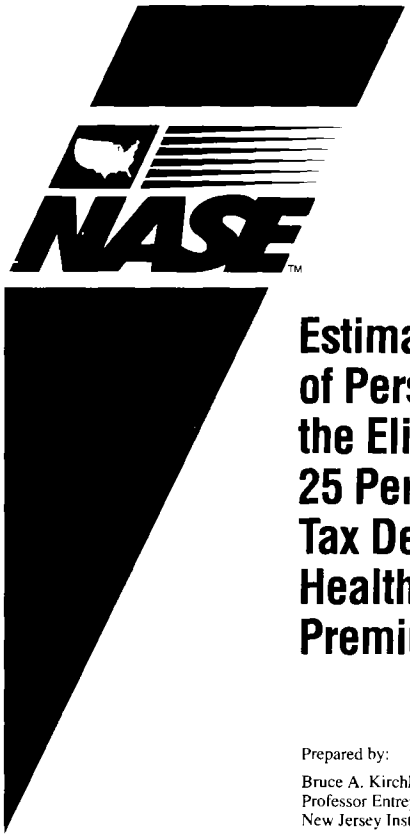
Throughout the initial discussions on reforming our health care system, the self-employed were promised that their quest for a 100-percent health insurance deduction would be answered affirmatively through the passage of final health care legislation by Congress. The NASE had every reason to believe this -- the 100-percent deduction had been a common theme in every major health care bill introduced in Congress in 1993 and 1994, including President Clinton's Health Security Act. Last year, everyone assumed that the deduction would be re-instated to at least the 25-percent level. Most of the major legislation addressed the issue retroactively and raised the deduction to 80 or 100 percent over a period of time. However, when health care reform died, so did the deduction.

Several bills have been introduced this Congress that would reinstate the 25-percent deduction for 1994 and raise it to 100 percent from 1995 on. The NASE and I support those pieces of legislation.

Unfortunately, we have found the road towards 100-percent deductibility to be one with many promises and little delivery. Even retention of a 25-percent deduction since 1986 has been fraught with much frustration. Every year the self-employed community would be promised a permanent, full deduction of their health insurance premiums, only to find themselves held hostage to federal revenue and budgetary concerns. In this way, self-employed persons have found their partial health insurance deduction subject to continual renewal on a year-to-year basis.

I urge the Ways and Means Committee to: (1) take immediate action to ensure re-enactment of the 25-percent deduction for 1994 and (2) raise the level to 100 percent for 1995 and beyond so that the self-employed can buy quality health care coverage for themselves and their families.

[Dr. Kirchoff's study was subsequently received:]



Estimating the Number of Persons Affected by the Elimination of the 25 Percent Income Tax Deduction for Health Insurance Premiums

Prepared by:

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January 27, 1993

July 13, 1993

Much has been written about the millions of Americans without health insurance, but little is noted about one of the biggest reasons: unfair federal tax policy.

Since January 1, 1993, self-employed Americans have not been able to deduct any portion of their health insurance premiums from their federal income taxes. Loss of this deduction represents a minuscule savings to the federal budget, but financially affects thousands of hard-working Americans.

That's why the National Association for the Self-Employed — representing more than 300,000 such Americans — commissioned a noted economist to determine how the loss of this deduction impacts self-employed Americans who pay for their own health insurance.

The study's conclusion: 400,000 Americans will no longer be able to afford their health insurance because federal tax policy makes it more expensive.

Thousands of Americans are suffering because Congress has failed to fulfill a promise it repeatedly made to self-employed Americans — fair and equal tax treatment.

Self-employed Americans create jobs. Many large businesses started in a garage or a basement. These same self-employed preserve jobs — laid-off workers of big companies often re-enter the work force as an entrepreneur.

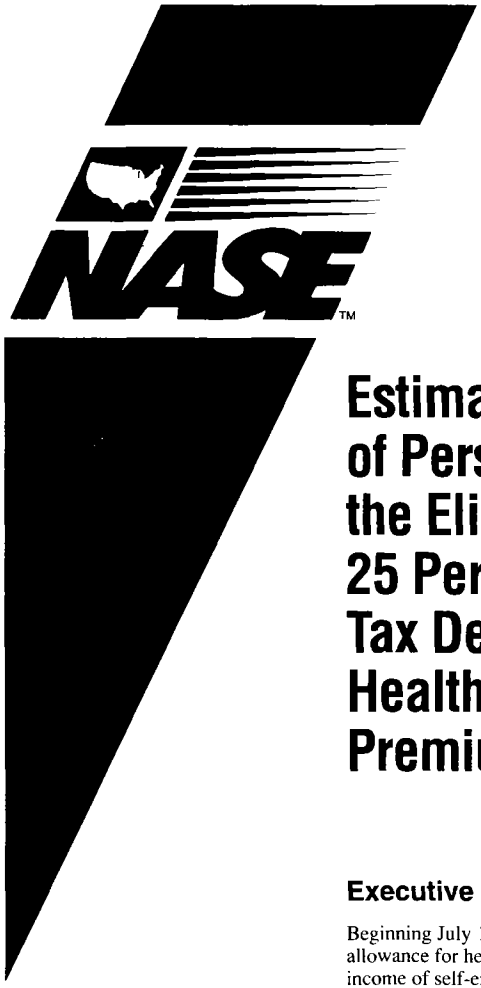
Yet, these are the very people whom our elected officials say no longer deserve a tax break when buying health insurance. While it is true that Congress and the President have indicated they plan to restore a partial deduction for the self-employed, this tax break would only be effective until December 31, 1993.

Next year, the financial pain begins anew. We challenge any group to tell us why self-employed Americans should not receive permanent, equal tax treatment when paying for health insurance premiums.

As you read this report, I'm sure you'll reach the same conclusion we did: the time to talk about tax fairness is over, the time act it is NOW.

Sincerely yours,

Bennie L. Thayer
Chairman, National Association for the Self-Employed

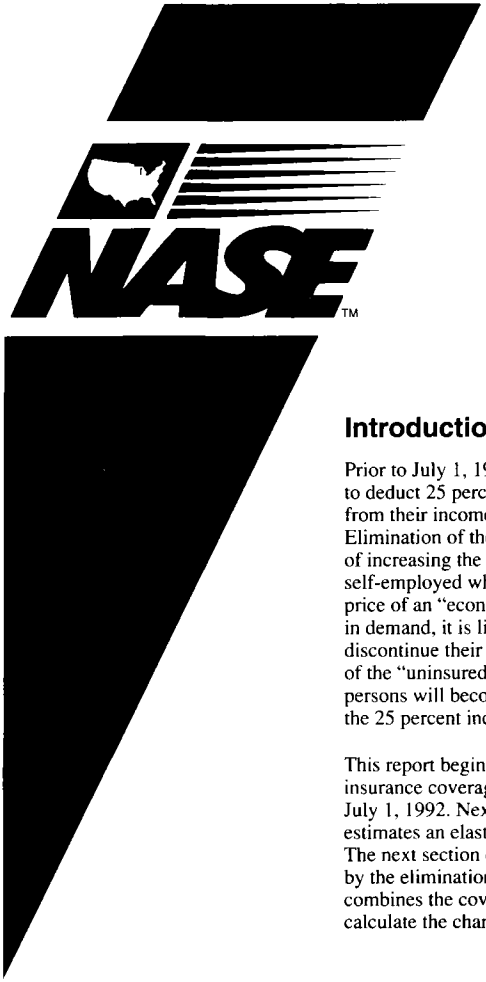


Estimating the Number of Persons Affected by the Elimination of the 25 Percent Income Tax Deduction for Health Insurance Premiums

Executive Summary

Beginning July 1, 1992, the 25 percent deduction allowance for health insurance premiums from the income of self-employed persons came to an end. This raises the question: "How many persons will become uninsured because of the elimination of this 25 percent income tax deduction?"

The answer, based on estimates drawn from analysis of statistics from the ***1991 Current Population Survey***, and published economic research, is 295,000 self-employed persons will stop purchasing health insurance. Because some of these have dependents, a total of 412,000 persons, including 117,000 children under 18, will join the ranks of the uninsured.



Introduction

Prior to July 1, 1992, self-employed persons were allowed to deduct 25 percent of their health insurance premiums from their income before calculating their income tax. Elimination of the deduction on July 1, 1992, has the effect of increasing the after-tax price of health insurance for the self-employed who subscribe. Since an increase in average price of an "economic good" typically results in a decline in demand, it is likely that some of the self-employed will discontinue their health insurance thereby entering the ranks of the "uninsured". The question of importance is, "How many persons will become uninsured because of the elimination of the 25 percent income tax deduction?"

This report begins with an estimate of the self-employed health insurance coverage prior to the change in the tax law on July 1, 1992. Next, it reviews the price elasticity research and estimates an elasticity for computing the change in coverage. The next section determines the effective change in price caused by the elimination of the 25 percent credit. Finally, the report combines the coverage, price elasticity and price change to calculate the change in number of insured citizens.

Previous Health Insurance Coverage

The 25 percent income tax deduction was available only to those persons who were self-employed (sole proprietorship, partnership, or "S" corporation).

Thus, the change in the tax law will affect only that portion of the population that is self-employed and has health insurance coverage.

We begin by defining the number of self-employed workers with health insurance and then extend that to the number of persons having coverage through self-employed workers.

Analysis of the ***1991 Current Population Survey***[1] reveals that there were 12.6 million self-employed workers of whom 9.6 million (76.7 percent) had private health insurance. Of these, 6.2 million (49.1 percent) have employer provided coverage.

Further analysis of the ***1991 Current Population Survey***[2] shows that there were 17.6 million self-employed workers and dependents with health insurance. These dependents are almost entirely children under 18[3]. Since there were 12.6 million self-employed, this equals 1.4 persons per self-employed worker with health insurance.

Price Elasticity of Demand for Health Insurance

Economists use the term "price elasticity" to denote the change in purchases that accompany a change in prices. Not surprisingly, price elasticities are negative, i.e., as prices increase, purchases decline.

The range of price elasticities for health insurance as published in economic research journals varies widely from a low of -0.06 to a high of -0.67[4]. Selecting a specific elasticity from among this wide range is made somewhat easier by Holmer's research. Holmer demonstrates that the elasticities calculated prior to his work were too large because of methodological errors. He reports smaller elasticities than previous research. His price elasticities are calculated for different income groups; -0.39 for families with annual incomes below $15,000; -0.14 for families with incomes from $15,000 to $25,000; -0.08 for families with $25,000 to $40,000; and lastly, -0.06 for families with over $40,000 annual income. The overall weighted (weighted for income distribution) price elasticity is calculated to be -0.16[5].

Given the wide variation in elasticities among income groups, calculation of the appropriate elasticity for the self-employed who purchase health insurance requires an estimate of self-employed income. Statistics from the ***1991 Current Population Survey*** show that employer-provided health insurance coverage is related to family income. The greater a family's income, the more likely it is to have employer-provided private health insurance. Families with incomes under $6,000 have coverage of 5.4 percent; $5,000-9,999, 12.6 percent; $10,000-14,999, 32.7 percent; $15,000-19,999, 43.4 percent; $20,000 to $29,999, 65.4 percent; etc.[6]

The employer-provided coverage of the self-employed (49.1 percent) is essentially equal to that of families with annual incomes of $14,000 to 19,999.

Thus, one can assume that this income level represents the average income of the self-employed. This income level is approximately $10,000 below the median for all American families. Thus, Homer's weighted average price elasticity understates the elasticity for the self-employed and needs to be adjusted.

We can adjust Homer's weighted price elasticity by changing the weights, or distribution of families, among income classes based upon the assumed lower average income for the self-employed. Essentially, this increases the percentage of self-employed families at lower income levels and reduces the percentage at higher income levels. Adjusting the income distribution of the self-employed so as to reduce the average income $10,000 results in an increase in the weighted average price elasticity from -0.16 to -0.19.

Change in Effective Price of Health Insurance

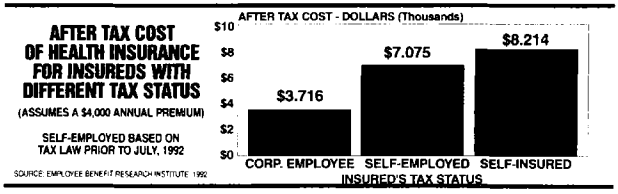
Tax policy affects the effective cost of health insurance premiums because some premiums are paid with tax deductible dollars and some are paid with after-tax dollars.

The law allows three different forms of health insurance premium payments. First, corporations that purchase health insurance for their employees are allowed to deduct the total cost from their income before paying taxes. This tax deduction effectively decreases the after-tax price of health insurance for those so insured. Second, self-employed persons could (prior to July 1, 1992) deduct only 25 percent of their health insurance premiums from their income before paying taxes. Thus, tax policy causes the after-tax prices of self-employed health insurance premiums to be greater than those paid by corporate employers. Third, individuals cannot deduct any health insurance premiums from their income tax so they have the greatest after-tax premium prices.

Thus, for any one health insurance premium amount, there are three different "after-tax", or effective, premium price groups: (1) 100 percent tax-free payments by the employer; (2) 25 percent tax deductible purchases by self-employed; and (3) zero percent tax deductible purchases by individuals. Assuming a premium of $4,000, and taking into account state and federal taxes, including income, social security, and Medicare taxes as paid by the average middle class family, these payments have been estimated as $3,716, $7,075, and $8,214 respectively[7].

From this, we can calculate the increase in effective premium prices beginning July 1, 1992. With the removal of the 25 percent tax deduction, the self-employed became members of the zero tax deductible group.

Thus, the self-employed's health insurance price rose from $7,075 to $8,214. This is a increase of $1,139, or 16.1 percent.

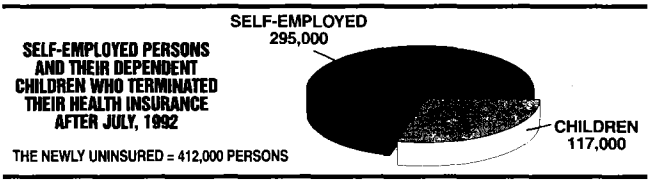


Estimating the Number of New Uninsured

The increase in price will cause some self-employed to terminate health insurance.

Multiplying this 16.1 percent price increase by the price elasticity of demand (-0.19) yields an estimate of the change in demand, at -3.1 percent. The number of privately insured self-employed workers prior to the tax change (9.5 million) times the -3.1 percent change in demand equals -295,000 self-employed. This multiplied by the number of persons per self-employed (1.4) equals -412,000 persons in total who will fall outside the health insurance system because of this change in the tax law[8]. This 412,000 persons includes 117,0000 children under 18 who will no longer have health insurance coverage.

Thus, 412,000 persons, 295,000 self-employed and 117,000 dependent children, will enter the ranks of the uninsured because of the elimination of the 25 percent tax deduction allowed prior to July 1, 1992.



[1] The 1991 Current Population Survey reports the results of a survey carried out in March of 1991. The questions about health insurance asked respondents to describe their health insurance status during the year 1990. Thus, the analysis reported here is relevant to health insurance experience in 1990.

[2] The statistics reported here are taken from: Employee Benefit Research Institute, An EBRI Special Report: Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March, 1991 Current Population Survey, (Arlington, VA: EBRI) February, 1992.

[3] This is taken from the EBRI report, Table 18, page 40.

[4] EBRI Report, Table 34, page G3.

[5] It is important to note that the negative sign denotes the direction of the relationship (increased price causes decreased demand) so that -0.67 describes a greater demand effect per unit price change than -0.06. Thus, an elasticity of -0.67 is referred to as "greater than" -0.06.

[6] Holmer, Martin, "Tax Policy and the Demand for Health Insurance." Journal of Health Economics, Vol. 3, (1984), pp. 203-221.

[7] EBRI report, Table 11, page 27.

[8] This calculation is taken from an analysis found in: Federal Tax Policy and the Uninsured; How U.S. Tax Laws Deny 10 Million Americans Access to Health Insurance, published by Health Care Solutions for America, Washington, D.C., January, 1992.

About the Author

Bruce A. Kirchhoff, Ph.D., prepared this analysis for the National Association for the Self-Employed. He is Professor of Entrepreneurship at New Jersey Institute of Technology. His prior credentials include service as Chief Economist for the U.S. Small Business Administration and as Assistant Director of the Minority Business Development Agency in the U.S. Department of Commerce.

Dr. Kirchhoff has published over 150 articles and papers on entrepreneurship, economic development, and business strategy in a wide variety of academic journals, books, trade and popular media. His book, *Entrepreneurship And Dynamic Capitalism* (to be published by Praeger in 1994), describes his research on the economics of small firm formation and growth. He has conducted research among large and small businesses and has received international acclaim for his work on formation, growth and survival of small firms.

Chairman THOMAS. Thank you very much.

The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, panel. I really appreciate your testimony. Ms. Whitt, you just stated that your figures reflect 12 million self-employed individuals.

Ms. WHITT. That is based upon the people who on their tax returns actually made money and paid a self-employment tax, so it is a little lower than some of the figures that were discussed earlier by the SBA because their figures also included those people that had a loss.

Mr. CHRISTENSEN. I missed the SBA. What was the number they stated? Do you know, Mr. Chairman?

Chairman THOMAS. No.

Mr. CHRISTENSEN. The reason I asked is the Treasury states that almost 3.2 million self-employed individuals would claim a 25-percent deduction on their 1994 tax returns if it were made available to them.

I wanted to know if that is a figure that is low compared to the 12 million. Do you have any——

Ms. WHITT. Actually, I just asked our tax consultant prior to coming up here because I was wondering myself if a person claimed a loss on their tax return, if they would be able to still take the deduction. We can turn around and ask him.

Mr. CHRISTENSEN. Mr. Faris, do you have any idea on the number?

Mr. FARIS. The 12 million is a very close number. Again, it goes back to those who filed tax returns. When it comes to tax deductibility, the ones who file tax returns are the ones we are most interested in right now, so we think that is a good number.

Mr. CHRISTENSEN. I agree with you, Mr. Faris. Earlier you stated that it is a slap in the face to every small businessman or woman out there that we are only looking at the 25 percent. We want to do what is right, I know.

I have a lot of small businessowners in my district. We shouldn't treat small business differently than large corporations. Nearly every large corporation was once a self-employed business that grew. That is not always the case, but this country was founded on entrepreneurial spirit and to punish success is just not right.

I know we are talking about the revenue shortfall and trying to be careful with the budget, but if there is ever a time that we should restore some common sense to the Tax Code, it would be at this time where we could make a large step instead of just a small step toward that balance.

Do you have the numbers that reflect the number of people that would be reinstated with the 25 percent? Do you know how many this past year, Mr. Faris?

Mr. FARIS. Well, right now, we are talking in terms of specific numbers. I will have to get those to you to have a part of the record. I think the specific number in having those back on the roll, it goes back again to what you said, what we are telling the small business community in the numbers. It is very easy inside the beltway to focus on where we have shortfall and where we make it up, but all the people on Main Street hear is that the result is you are

going to give General Motors 100 percent and you are going to give me 25 percent and I have to ask for it every year.

There is just—it is just a hard place. I think for us, we see an immediate step, if you go to 25 percent and lock it in and say for sure you are going to have one-fourth, you still have the crumbs. We won't let you have the cake yet but the crumbs can still be yours.

Mr. CHRISTENSEN. I absolutely agree.

Mr. FARIS. I think small business is tired of hearing it. On November 8 they said it. They said it with the health care mandate, employer mandate.

Again, we get in this whole issue that I know the chairman and I have discussed a number of times, is that this is all a part of the whole health care issue. We have people in the highest places of our government go on record as saying these small business entrepreneurs who don't furnish insurance for their employees are just lower than dirt, and these same people don't even have 25 percent deductibility for themselves. They have 100 percent. The numbers are going to be—back again, do we look at the 25 percent, everyone that has been getting it will go back on the board again if 100 percent of the number is realized.

Mr. CHRISTENSEN. Mr. Faris, have you conducted any studies with the FIB to see what the number of people that would join the ranks of the insured would be if we were to restore 100 percent deductibility to the self-employed?

Mr. FARIS. We have tried that survey. We found it is in three tiers. We ask someone, do you think you would like to buy the product? They say yes. Second, here is the price of that product, then yes. The third is, could I have your check.

Well, that is kind of how it goes when you talk about insurance. You say if you could have full, 100 percent deductibility, would you then offer insurance? Well, sure, sure we would. Then you say, OK, now here is how much the insurance costs for you and for everyone else with 100 percent deductibility and here is what that means to you. Then that number drops. Then, third, is they have to write a check and then the number drops considerably. We assume that would be true here, but we don't know. We will see.

We would love to have everyone take advantage of this because they would be purchasing health insurance, but we all know that is just not going to happen. So therefore, I think we can look and see if we move to 100 percent, I don't think the numbers we are using today will be real hard numbers, because I don't think we will have that many people purchase into the system.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman THOMAS. In pursuit of that point, to what extent Mr. Faris, Mr. Dressler, or anyone can give us any indication of the fact that setting aside the 25, 50, or 100 percent that if in fact people, based upon the 25 percent, had offered health insurance, given its more critical role now in terms of the sensitivity of people about health insurance and its component in attempting to hire and keep labor, that you may not be able to be a free agent in making the decision of not having it or it would be a major impact on the company in terms of its employees or trying to replace employees.

Is there any feedback from your people along those lines?

Mr. FARIS. That is happening right now and it has been happening for some time.

One of our frustrations about the whole health care issue is that all the issues that impact the small business disproportionately—this is on the top of the list as we have discussed for the last 6 years. It goes into administrative costs. It runs over 30 percent compared to General Motors of 8 to 9 percent. It goes to cancellation when you have one claim. It goes to not being able to reissue or even to cancel because you have had minor problems, haven't even had a major claim. Or they just decide to drop you. So there is a credibility problem with small businessowners as it relates to health insurance and how it is provided in the first place. What this is is a rifle shot, a single focus that we have the power to do, can do, should do. It is immediate. It is a no-brainer.

Now, getting to 100 percent and the fairness and inequity and how much that would trigger the incentive to purchase, no matter what poll you see or research you see on that, no one knows. We will not know until we put it into effect. What I am saying is that if we put it into effect and we see how it impacts the budget, if we all need to drop to 97 percent coverage or 96 percent coverage, if it is fair for the goose, it is fair for the gander and we feel our goose is being cooked.

Chairman THOMAS. We have talked a lot about dynamic scoring in the budget area, and obviously if we made some reasonable reforms in the broader health care area, combined with changes in the percentage, you would see behavior modified in many ways. You indicated, Mr. Faris, you didn't really want the crumbs. At this stage you would take the crumbs.

Mr. FARIS. That is right.

Chairman THOMAS. Because you don't have them, and you are complaining because the other people have cake.

My concern is that I would kind of like to move into the bread category for everyone. Before I took on the awesome responsibilities of chairing this subcommittee, I would have been inclined to ask, Ms. Sprague, about your idea in terms of balancing between corporations who now have it and those who don't.

I do think, though, that we as a subcommittee have talked about in the last Congress, and obviously will continue to talk about, refocusing on the history of how corporations wound up with an open-ended, 100-percent deductibility and that perhaps that needs to be focused on in terms of a reasonableness. I wouldn't want to have this hearing focusing on the self-employed and on reinstating a percentage lead us into that discussion. But I just want everyone to know that I think that has to be part of the ongoing discussion.

I would say that Ms. Whitt or Mr. Faris or anyone else, if you have any studies that shed light on this, we would love to have them as part of the record because I found that there tends to be a dearth of any kind of solid statistics, which I know are difficult to obtain but would give us some guideline on the phasing in.

This is almost a self-answering question, but obviously if we can do the 25 percent on a retroactive basis and you are asking for 100 percent, can you give me any indication that might help us, what might be, from your point of view, a reasonable progression or a willingness to accept our exploration of a parity along the lines

from the gentleman from Maryland of an 80-percent rate or a suggested phase-in, as was indicated earlier by Mr. Neal—25, 50, 100 percent?

How critical do you want to make it to us in terms of willingness to work to not make it 100 percent immediately on a prospective basis, notwithstanding the unfairness? Any help for us in terms of what would be meaningful in making a behavioral change in keeping people with their health insurance or getting people into the market that are not now in the market at 25 percent?

Mr. DRESSLER. Mr. Chairman, I think working with young farmers and farm families, and from my own perspective, rather than talk about a percentage of deductibility, think about the real dollar cost. Because a young family has significant health care needs and they are less expensive to insure. But if they are in the childbearing years, we know how important prenatal care, newborn care is. I would urge you to think about some kind of 100 percent deductibility, up to a certain dollar amount, that would get them into the game of having access to health care.

Also, among our membership as people get older, we tend to take more catastrophic care, higher deductibles. In California, in our Bakersfield area, for example, it is not uncommon to have a $1,000 deductible plan. The person can handle the minor expenses. What he is afraid of is the major costs that unfortunately increase as we get older. He is trying to buy less expensive care because of the cost. So you might want to think about instead of just a percentage phase-in, 100 percent up to a certain amount of expenditure.

I know that was the subject of discussion last year when we were looking at comprehensive reform and deductibility of so-called "open-ender" or "golden" health care plans. It really comes to play in my membership because I know we are struggling to hold the costs down in every phase of life, but the needs are different at different stages of their life.

Chairman THOMAS. Does the gentleman from Maryland have a question?

Mr. CARDIN. Thank you, Mr. Chairman.

Just very quickly, Mr. Dressler. I appreciate that because I do think, I agree with the chairman; I am glad we are having these hearings to try to figure out what the appropriate amount should be. I put 80 percent in. Let me explain the reason why I think 80 percent is the appropriate level. You may not have been here at the opening of the hearing.

For a corporation, there are other considerations in the health care plan. The corporation is concerned about the cost of the plan and would be looking at cost-saving measures, including the employees' participation in the cost of the plan. For a self-employed person, that may not hold true, because a self-employed person can calculate how much money they will spend on health care and then if 100 percent of the premium is deductible, try to develop a plan that comes as close as possible to their out-of-pocket costs in order to maximize the tax advantage. So I think there is an argument against the 100 percent of any premium in an effort to try to provide parity between corporations and self-employed companies. That should be one consideration.

The chairman has raised a second consideration which is a very valid one: What percentage or what amount would maximize the number of people who would be insured? That is a second consideration. On the parity issue, it seems to me that allowing a 100-percent deduction would give self-employed individuals an advantage over companies.

Jack, you disagree?

Mr. FARIS. I really missed the first part of that.

Mr. CARDIN. Well, since the self-employed can calculate the total amount that they anticipate spending for health care and make sure that equals the premium amount by buying an insurance plan that covers that, they can shelter their entire medical cost. Most companies require employees to participate by paying part of the premium. Therefore, on average, today corporations are paying, and deducting, 80 percent of the premium costs and individuals are paying 20 percent.

Mr. DRESSLER. If I could just respond to that. A critical part of that, the large companies have access to what we call section 125 or cafeteria benefit plans, and they can actually allow the employee to pay part of the premium pretax through—I am not sure of the exact phrase, but basically a pretax deduction to pay the employee share of the cost plus the access to medical spending or flexible reimbursement accounts which therefore also lets them pay their so-called deductibles and other costs out of pretax dollars. This, of course, takes a fairly large business and a lot of access to tax incentives.

Mr. CARDIN. Absolutely right. Congress is going to have to take a look at the cafeteria plans. We can't allow that to continue uncapped in the future.

Chairman THOMAS. Might it be possible that if you included that with a "must offer" in terms of the employer to his employees, that that would temper the attempt to match on both sides?

Mr. CARDIN. It may.

Chairman THOMAS. That would be kind of a tempering effect.

Mr. FARIS. Just as I missed the first part of your statement, you have missed the first part of mine, so I would like to restate that briefly. And that——

Chairman THOMAS. We have 7 minutes left to go in a vote.

Mr. FARIS. To basically—real quickly. One is the economics of it all. The economics of the problem to get parity, real parity and that is the entrepreneurs of America are not just—saying they are important and the backbone but not try to break that backbone at every chance we get. Let's let everybody pay the same amount. The $45.6 billion is now being paid, and we are going to have to have $2 billion more to get to 100 percent, then let's all go to 95 or 96 percent. If we can move that up to 100 percent at some time, fine. But what is fair for Main Street ought to be fair for Wall Street.

The second part about this is the political issue of how people feel who have their house on the line who every time they turn around, I am from the government and I am here to tell you, that means you have got a short stick. In fact, you have to refile your taxes now. You will enjoy paying that money to the CPA. So I think the thing to do now is move quickly to the heart of it and let's get the 25 percent, but we need to move to 100 percent.

Mr. CARDIN. We are close.

Mr. FARIS. We are close.

Chairman THOMAS. We have to move quickly to a vote. But we appreciate the evidence.

It is clear we really would like to have a better research grounding so when we make a decision and we make it permanent, that it is a good, responsive one. The ultimate solution could be along your lines, Jack. You need to talk with the other people on the panel about that and I would love to hear the discussion. For now, though—and I appreciate all of your attendance, the subcommittee is adjourned.

[Whereupon, at 2:18 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF
LESLIE B. SAMUELS
ASSISTANT SECRETARY (TAX POLICY)
DEPARTMENT OF THE TREASURY
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

Mr. Chairman and Members of the Subcommittee:

I am pleased to present the views of the Administration on the 25 percent deduction for certain health insurance premiums paid by the self-employed. Under Internal Revenue Code section 162(l), certain sole proprietors, partners and more than two-percent shareholders of Subchapter S corporations are permitted to deduct 25 percent of the amount paid during the year for insurance that constitutes medical care for the taxpayer and the taxpayer's spouse and dependents. The deduction is not available, however, for taxable years beginning after December 31, 1993. Consequently, unless the Congress acts, self-employed individuals will not be able to claim any deductions for health insurance premiums on their 1994 income tax returns.

As the members of this Subcommittee know, the Clinton Administration proposed the extension of the 25 percent deduction, followed by an increase in the deduction to 100 percent of health insurance premiums in the Administration's health reform bill of last year. We continue to believe that allowing a deduction for self-employed individuals more closely conforms their tax treatment to the treatment of other employers with employees. This would recognize that these taxpayers share many attributes with both employers and employees. We also believe that the deduction for the self-employed will help to make health insurance more affordable for this segment of the population and will therefore contribute to expanded insurance coverage.

On behalf of the Treasury Department, I appreciate the opportunity to state for the record that the 25 percent deduction

issue needs to be dealt with expeditiously. If Congress does not act before 1994 tax returns are filed, substantial new administrative burdens could result for taxpayers and the Internal Revenue Service.

The Treasury Department estimates that almost 3.2 million self-employed individuals would claim the 25 percent deduction on their 1994 tax returns if it were made available to them. Those tax returns are due on April 15, 1995, although these taxpayers could request an automatic extension through August 15, 1995. If the Congress fails to act to extend the 25 percent deduction prior to the due date for income tax returns, millions of taxpayers will be forced to decide whether to incur the costs of filing amended income tax returns. Any such amended returns will also impose additional administrative burdens and costs on both the Internal Revenue Service and State and local governments.

As members of this Subcommittee may know, the Department of the Treasury has already taken steps to make it easier for taxpayers to claim the deduction if timely Congressional action occurs on this matter. The 1994 Form 1040 includes a line for claiming the self-employed health deduction, with a caution that taxpayers cannot claim the deduction unless the law is changed. But only swift Congressional action can minimize taxpayer uncertainty, compliance costs and administrative burdens.

As the President emphasized in his State of the Union message earlier this week, we should work together to assist self-employed individuals and others in buying more affordable health insurance. The extension and expansion of the self-employed health insurance deduction should be an integral part of that effort. We look forward to working with the members of this Subcommittee and others in the Congress to find a way to restore this deduction without increasing the Federal budget deficit.

STATEMENT OF THE AMERICAN FARM BUREAU FEDERATION
TO THE HOUSE WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH
ON THE TAX DEDUCTION FOR HEALTH INSURANCE PREMIUMS
PAID BY THE SELF-EMPLOYED

January 27, 1995

Farm Bureau is the nation's largest general farm organization with a membership of 4.4 million families in 50 states and Puerto Rico. Farm Bureau members produce virtually every commodity grown commercially in this country. Our policy is developed by producer members at the county, state and national levels of our organization. Farm Bureau appreciates the opportunity to comment on the tax deduction for health insurance premiums paid by the self-employed.

The 25 percent tax deduction for health insurance premiums of self-employed sole proprietors expired on December 31, 1993. Farm Bureau must stress the urgency of reinstating the 25 percent deduction for health insurance premiums paid by the self-employed before farmers file their 1994 tax returns. In addition, Farm Bureau supports a permanent 100 percent deduction for health insurance premiums paid by self-employed individuals.

High health insurance costs are particularly troublesome in farming and ranching because it is a hazardous occupation. High risk translates into high insurance premiums, and many farmers are reducing their coverage or dropping it entirely because they cannot afford it. A tax deduction for the cost of insurance premiums will go a long way toward helping farmers and ranchers provide for their own insurance needs.

Providing self-employed persons the ability to deduct 100 percent cost of their health insurance premiums is also a matter of fairness. Corporations, including farms that are incorporated, are able to deduct the entire costs of their employees' health insurance. It is only fair that all farmers, regardless of how their businesses are organized, be able to deduct their entire health insurance costs.

During last year's health care reform debate, the provision to make health insurance premiums deductible was part of virtually every proposal. Now it is time to translate that support that into action. Farm Bureau urges quick action to reinstate the 25 percent deduction for 1994 and put into place a permanent 100 percent deduction for health insurance premiums paid by the self-employed.

Tax policies that are fair and equitable promote both the economic well-being for farmers and our nation's food supply. Thank you for the opportunity to present the views of the American Farm Bureau Federation about this matter of importance to all self-employed people.

AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS
TAX DIVISION

The American Institute of Certified Public Accountants (AICPA) is the national, professional organization of CPAs comprised of more than 320,000 members who advise clients on federal, state and international tax matters as well as prepare income and other tax returns for millions of Americans. Our members provide services to individuals, not-for-profit organizations, small and medium-size businesses, as well as America's major businesses, including multi-national corporations. Many serve businesses as employees. It is from this base of experience that we offer our comments on the tax treatment of health insurance costs of self-employed individuals.

The decision in 1994 to postpone consideration of health care reform legislation has resulted, among other things, in the loss of a deduction by self-employed individuals for <u>any</u> health insurance premiums they have paid in that year. As part of the 1993 Omnibus Budget Reconciliation Act, when a number of other "expired provisions" were retroactively re-enacted (targeted jobs tax credit, low-income housing credit, employer-provided education and training expenses, etc.) and allowed to remain in the law past the end of 1993, the deduction for 25 percent of self-employed insurance premiums was terminated at the end of the calendar 1993. The committee reports noted that this provision should be considered in conjunction with forthcoming health care reform (as indeed it was, in virtually all the health care bills proposed during 1994).

Since, however, there were no health care changes in 1994, there was also no extension of the deduction for self-employed health insurance. This is a highly unfortunate result, and puts a significant penalty on the health costs of those who operate as proprietors, partners, or S corporation shareholder/employees, vis-a-vis those who are employees of C corporations.

Pending whatever changes are made to health care legislation in the future, we think it critical that Congress re-establish the right of self-employed persons to receive even that limited deductibility for health insurance costs that they enjoyed before 1994. We do recognize that this provision, on a stand-alone basis, is a revenue loser for the government. Nonetheless, there remains a major issue of fairness for a significant part of the business community, and we would urge your attention to this matter.

As an organization that values simpler approaches to tax legislation, we would greatly prefer to see action taken immediately, before the bulk of 1994 returns have been filed, rather than the added complexity of amended 1994 returns and refund claims that even a minor delay will cause. Still, we believe the self-employed business person has now – even with the best of congressional intentions – been further disadvantaged with respect to the cost of health care, and is entitled to a restoration of the deduction for the current year.

We appreciate your consideration of our views.

RICHARD J. DURBIN
20TH DISTRICT, ILLINOIS

AT-LARGE WHIP

COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON AGRICULTURE AND RURAL DEVELOPMENT
SUBCOMMITTEE ON TRANSPORTATION
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January 27, 1995

The Honorable Bill Thomas
Chairman
Ways and Means Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am writing in support of the legislation introduced by Representative Pomeroy to retroactively reinstate the tax deduction for 25% of health insurance premiums for the self-employed for 1994 and permanently increase the deduction to 100% of premiums for 1995 and beyond.

This legislation provides equity for self-employed taxpayers, who are currently at a disadvantage relative to incorporated business entities when they provide health insurance to themselves and their employees. The corporations they often compete with can take an income tax deduction for the full cost of the health insurance premiums they incur. The self-employed are not eligible for such a deduction today and could only deduct 25% of their premium costs before the provision expired at the end of 1993.

Farmers, ranchers, and small business owners who conduct their businesses as sole proprietors deserve the same treatment on this important matter as the corporations they often compete with.

Because of the high cost of health insurance -- especially insurance purchased by individuals -- the tax deduction is of critical importance to people who hope to provide themselves and their families with basic protection against catastrophic health care bills. A 100% deduction for health insurance premiums can reduce the net cost of health insurance for a farm family by as much as $500 to $1,000. This savings can make the difference between whether health insurance is affordable or unaffordable.

I am pleased to learn that you are holding a hearing on this subject. I would appreciate it if you would include this letter in the record for that hearing.

I urge your committee to act on Representative Pomeroy's legislation so that farmers and other self-employed people can receive equal treatment in the deduction of health insurance premiums.

Thank you for your consideration of my views.

Sincerely,

Richard J. Durbin
Member of Congress

RJD:tf

STATEMENT OF

HOME OFFICE ASSOCIATION OF AMERICA
SUBMITTED TO
HOUSE COMMITTEE ON WAYS AND MEANS

RELATING TO THE SAVINGS AND INVESTMENT HEARINGS

February 2, 1995

Chairman Archer, Representative Gibbons, and Members of the Committee on Ways and Means, my name is Richard Ekstract. I am Chairman of the Home Office Association of America ("HOAA"), an organization dedicated to serving the needs of individuals whose offices are in their homes. I appreciate the opportunity to submit testimony on two issues of vital importance to HOAA: the home office expense deduction and the self-employed health insurance deduction.

Background on Home Office Expense Deduction Issue

Up until enactment of the 1976 Tax Reform Act, taxpayers were able to take liberal advantage of home office deductions for most types of work conducted at their personal residences, either as an ordinary and necessary business expense under tax code section 162 or as an expense for the production of income under section 212. In response to perceived abuses of the deduction, Congress enacted section 280A, which sets forth rules and limits on the deductibility of expenses attributable to the business use of homes for individuals and S Corporations.

These rules and limitations no longer reflect the realities of how individuals work in today's world. Section 280A states that no home office deductions are allowed unless the deduction meets specific, and in our view overly complex, statutory requirements. It is virtually impossible for a large number of home office workers to qualify under these rules, and those that qualify cannot be sure that they do.

The rules state that the portion of the home that is used for business must be used exclusively on a regular basis,1/ and in only one of the three following ways: (1) as the principal place of business for any trade or business;2/ as a place normally used by clients, patients, or customers;3/ or in connection with the taxpayer's trade or business if the taxpayer is using a separate structure unattached to the personal residence.4/ Of these additional requirements, we have found that defining a taxpayer's

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1/ See § 280A(c)(1).

2/ § 280A(c)(1)(A).

3/ § 280A(c)(1)(B).

4/ § 280A(c)(1)(c). Two additional exceptions are provided in the statute which do not require exclusive use of a portion of a residence. A taxpayer in the business of selling products at retail or wholesale may take deductions allocable to space within the residence which is used on a regular basis as a storage unit for inventory of the business. This exception is only available if the residence is the sole fixed location of the business. See § 280A(C)(2). A taxpayer regularly using the residence to provide day care for children, adults over age 65, or mentally or physically disabled persons may qualify for deductions allocable to the day care business. See § 280A(c)(4). Deductions under § 280A are limited to the excess of (1) gross income from the use of the dwelling unit over (2) the deductions allocable to the unit which are allowable without regard to business use. See § 280A(c)(5).

"principal place of business" is the most difficult, and the various tests which have been formulated by the courts cannot achieve equitable results.

Supreme Court Restrictions Are Not Reasonable

In *Soliman v. Commissioner*,5/ the Supreme Court exacerbated the statute's already confusing scheme. In that case, the Court attempted to address the appropriate factors a taxpayer must use in determining whether a home office is his or her "principal place of business." The taxpayer in *Soliman* was an anesthesiologist who was employed by three hospitals, but who maintained a home office as a principal place of business used exclusively two to three hours a day for contacting patients and surgeons, and for performing related activities.

Even though the hospitals provided no office space to the taxpayer in *Soliman*, the Supreme Court reversed the lower court decisions which had allowed the deduction.6/ The Court's effort significantly narrowed the scope of the home office deduction by setting up a comparative test for determining whether an individual's home office is that person's principal place of business.7/

The comparative test does not work. The Court's two primary factors -- (1) the relative importance of the activities performed at each business location, and (2) the amount of time the taxpayer spends at each place of business -- are too vague.8/

The IRS' subsequent explanation of how it will apply the "relative importance" and "time" tests highlights the complex problems that the normal, unsophisticated home office worker must now confront.9/ Under this ruling, the Service said it will first apply the "relative importance" test, and if this test yields no definitive answer, it will look to the "time" test.10/ There is no way for a home office worker to achieve any level of comfort with these rules without expending considerable funds in lawyer or accountant fees.

5/ 113 S. Ct. 701 (1993).

6/ 113 S. Ct. at 708.

7/ Id. at 706. The Court rejected both the "focal point" test formerly favored by the Tax Court and the facts and circumstances test subsequently adopted by the Tax Court, which had won approval of the U.S. Court of Appeals for the Fourth Circuit.

8/ Id. In denying the home office deduction, the Supreme Court determined that the taxpayer's treatment of patients at the three hospitals was the "essence of a professional service" and the "most significant event in the professional transaction." The home office activities were regarded as less important to the taxpayer's business than his work at the hospitals. Id. at 708.

9/ Rev. Rul. 94-24, 1994-15 I.R.B. 5. The IRS had previously announced that it will not challenge home office deductions taken for 1991 and earlier tax years if the taxpayer reasonably fell within the scope of previous guidance issued by the IRS. See Notice 93-12, 1993-8 I.R.B. 1. The Service has also withdrawn a portion of proposed regulations under § 280A (issued in 1983) to reflect the *Soliman* decision. See IA-23-93, 59 Fed. Reg. 26466 (May 20, 1994).

10/ Rev. Rul. 94-24, 1994-15 I.R.B. 5.

Responses to *Soliman*

We applaud Congress' response to the *Soliman* decision, as numerous bills were introduced in the 103rd Congress. In particular, we strongly supported the Home Office Deduction Act of 1994, introduced in the House by former Representative Hoagland (D-NE) (H.R. 3407) and in the Senate by Senator Hatch (R-UT) (S. 1924).11/ The bill would have provided that a home office can qualify as a principal place of business if "the office is the location where the taxpayer's essential administrative or management activities are conducted on a regular and systematic (and not incidental) basis by the taxpayer," and the office is necessary because the taxpayer has no other location for the performance of such activities. The bill also contained a provision allowing for the deduction of business expenses attributable to home storage space for product samples. Currently, tax code section 280A(c)(2) allows a deduction for storage space for inventory only.

We were extremely pleased to see that Chairman Archer included the provisions of the Home Office Deduction Act in sections 12003 and 12004 of the Job Creation and Wage Enhancement Act of 1995 (H.R. 9), introduced on January 4. We urge their inclusion in the first tax bill which the Congress sends to the President this year.

Clarifying Home Office Expense Deduction Makes Sense for the 1990s and Beyond

The *Soliman* decision is not in step with commercial practice and economic reality. Home-based businesses have been growing in number and will likely continue to do so for the indefinite future.12/ These businesses create opportunity and jobs.

Many individuals affected by corporate downsizing have responded by creating small businesses operated out of the home. With the advent of fax machines, personal computers, and other telecommunications advances, these entrepreneurs have been able to run businesses out of the home that traditionally required an office setting. The success of many of these businesses has depended on whether or not they could be started up as home-based enterprises. The existence of a tax deduction for home office expenses can make an important difference for these fledgling companies.

Clarifying the home office expense deduction also makes sense from a family perspective. Home-based businesses have become an attractive option for parents who choose to work at home to spend more time with their children or elderly parents. Taxpayers should not be penalized for making such a choice.

Background on Self-Employed Health Insurance Tax Deduction

We also strongly support enactment of legislation allowing self-employed individuals to deduct their health insurance costs.

11/ H.R. 3407 had 83 cosponsors (37 Democrats/46 Republicans), including 13 Members of the Ways and Means Committee. S. 1924 had 15 cosponsors (7 Democrats/8 Republicans), including 3 Members of the Finance Committee.

12/ One 1992 news article reported that approximately 30 million Americans work out of the home. See G. Hall, Home Based Businesses Create Local Controversies, Gannett News Service (Nov. 10, 1992); see also New Publishers Serve At-Home Workers, L.A. Times, Feb. 14, 1993, at D10. The number of publications serving the growing number of at-home workers has risen dramatically. At present, there are approximately 50 publications. See id.

Prior to January 1, 1994, a self-employed individual generally could deduct 25 percent of the amount paid for health insurance for the taxable year on behalf of the individual and his or her spouse and dependents.13/ Congress' purpose in establishing this deduction in 1986 still exists today. At that time, lawmakers expressed concern about the disparity in tax treatment of health benefits between self-employed individuals and owners/employees of incorporated businesses.14/ The 25 percent deduction that self-employed individuals received for their health insurance premiums was designed to provide at least some portion of the favorable treatment for health insurance afforded employees covered under an employer-provided plan.15/

Restoring Self-Employed Deduction Would Represent Strong Step Toward Providing Equitable Treatment to Home Office Businesses

Mr. Chairman, a sense of excitement exists when entrepreneurs start up their home office businesses. Many express relief to be free from headaches like commuting, endless meetings, and office politics. They feel that they will be as free to go as far as their abilities will take them. Then, reality sets in. They realize that they often have to pay more for everything. For starters, they realize that they have to buy their own health insurance coverage at outrageous costs, and that the Federal Government, by providing disparate treatment with respect to health care expenses, caters to big business, not to them.

HOAA believes it is unfair and unjustified to premise the availability of a tax benefit on whether a taxpayer works for a Fortune 500, Subchapter C corporation or for himself or herself in an unincorporated business. Such treatment is simply one example of the ways home office businesses operated by self-employed individuals are treated as second-class businesses. Retroactively restoring the 25 percent deduction for self employed persons would represent a strong first step toward providing more equitable treatment to home office businesses. We urge you to do so prior to the April 15 filing deadline for individual tax returns. We also hope that lawmakers will ultimately enact legislation providing a 100 percent deduction for the health care costs of self-employed individuals, as has been proposed by numerous lawmakers and the Clinton Administration.

Conclusion

To conclude, I appreciate the opportunity to submit testimony on the importance to HOAA of preserving the home office expense deduction and reinstating the health insurance tax deduction for

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13/ This provision expired on December 31, 1993. See § 162(l). Sole proprietors, working partners in a partnership, and S corporation employees who own more than two percent of the corporation's stock could take advantage of the deduction. See Senate Committee on the Budget, Tax Expenditures: Compendium of Background Materials on Individual Provisions, S. Prt. 101, 103rd Cong., 2d Sess. 425 (1994) ["Tax Expenditures"].

14/ Tax Expenditures, supra note 13, at 428. An employer's contribution to a plan providing accident or health coverage to an employee and the employee's spouse and dependents is excludable from an employee's income. Further, businesses can generally deduct as an employee compensation expense the full cost of health insurance coverage provided to employees. See Joint Committee on Taxation, Summary of Revenue Provisions in the President's Budget Proposal for Fiscal Year 1993, JCS-3-92 46 (Feb. 6, 1992).

15/ Tax Expenditures, supra note 13, at 428.

self-employed workers. The *Soliman* decision is ill-suited to the modern economy. Clarification of the home office expense deduction rules makes sense from both a business and family perspective. Further, extending the health insurance tax deduction for self-employed workers will at least begin the process of equalizing the treatment of self-employed workers and those who work for Subchapter C corporations.

NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF ORTHOTICS AND PROSTHETICS

INTRODUCTION

The National Association for the Advancement of Orthotics and Prosthetics (NAAOP) is a national, non-profit organization comprised of orthotic and prosthetic health care practitioners (orthotists and prosthetists) who clinically and technically design, fit, and fabricate orthopedic braces and artificial limbs (orthotics and prosthetics) for this nation's two million amputees and other people with physical disabilities requiring orthotic and prosthetic care. Quality orthotic and prosthetic care can be extremely cost-effective by enabling people with disabilities to achieve high levels of independence and function in the workplace, in the home, and in all aspects of community life. Appropriate orthotic and prosthetic care also helps prevent secondary disabilities and decreases long term health and welfare costs to society.

Orthotic and prosthetic services are reimbursed under Part B of the Medicare program through a fee schedule known as the "L-codes." Although the four recently-created Durable Medical Equipment Regional Carriers (DMERCs) currently administer reimbursements for orthotics and prosthetics under the Medicare program, there is a major distinction between durable medical equipment (DME) and orthotic and prosthetic (O&P) services that justifies separate consideration and treatment when regulating these sectors of the health care field.

ENSURING QUALITY ORTHOTIC AND PROSTHETIC CARE

Practitioner Education

A critical distinction between the provision of durable medical equipment and the provision of orthotic and prosthetic services entails the level of education and training necessary to provide comprehensive O&P services. Comprehensive orthotic and prosthetic care requires highly specialized and trained practitioners in order to design, fit and fabricate a customized artificial limb or orthopedic brace for the particular needs of each patient. These highly specialized services combine the disciplines of medicine and engineering like almost no other area of health care. The successful custom replication and restoration of functional human body parts, which are in a multitude of shapes, sizes and complex contours, is fundamentally different from most types of durable medical equipment which tend to be more generic, pre-fabricated, and less clinically intensive to provide.

In addition, significant variation exists in the delivery of quality orthotic and prosthetic services, primarily due to the range of physical disabilities orthotic and prosthetic care can benefit and the explosion of technology over the past decade. To keep abreast of clinical and technological developments, individual practitioners participate in continuing education, research, and the frequent exchange of information among professionals. The orthotic and prosthetic profession has a defined body of clinical and technical knowledge and a core of over 3,000 specially credentialed practitioners with formalized education provided by well-established baccalaureate and post-baccalaureate education programs offered at eight major American universities.

Certification and Accreditation

Currently, the American Board for Certification in Orthotics and Prosthetics (ABC) offers the highest level of credentialing standards for orthotists and prosthetists and is the most widely recognized credentialing organization for orthotic and prosthetic services. ABC was founded in 1948 and conducts a comprehensive credentialing process for both orthotic and prosthetic practitioners as well as facilities in which they provide their clinical and technical services.

ABC-certified orthotists and prosthetists are the only orthotic and prosthetic practitioners recognized by the American Medical Association (AMA) as true orthotic and prosthetic allied health professionals. The education requirements for ABC certification are the only educational pathways recognized by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the U.S. Department of Education.

The ABC awards practitioner accreditation in three categories, Certified Orthotist (C.O.), Certified Prosthetist (C.P.), and Certified Prosthetist/Orthotist (C.P.O.). The minimum entry level requirements for practitioner education and certification are:

(a) a bachelor of science degree in orthotics and prosthetics or a bachelor of science degree in a related allied health or engineering field along with successful completion of specific undergraduate courses in orthotics and prosthetics at accredited schools,

(b) one year of clinical residency in each discipline, and

(c) successful completion of a comprehensive written, oral, and clinical examination for practitioners administered by the American Board for Certification in Orthotics and Prosthetics.

These stringent standards help ensure that ABC-certified orthotic and prosthetic practitioners are competent to provide the full range of comprehensive O&P care to patients with a multitude of varying disabilities. This high level of education and training helps assure quality in the clinical service element inherent in the delivery of these highly technical customized devices.

The Service Element of Orthotic and Prosthetic Care

Quality orthotic and prosthetic care is as much a professional service as it is a device that results from this service. While there is a service component in the delivery of some types of durable medical equipment, such as the design of customized wheelchairs and the delivery of certain home health services, orthotic and prosthetic care is generally far more service-oriented and specialized to the needs of each patient. Yet, when Congress and the Health Care Financing Administration (HCFA) have regulated durable medical equipment in the past, through fraud and abuse and reimbursement reforms for instance, they have tended to blindly cast the same net over the very different fields of orthotics and prosthetics.

The lack of separate treatment between DME and O&P has resulted in widespread confusion and limited understanding of this small but critical component of rehabilitation in our health care delivery system. This failure to separately address DME and O&P often creates unintended consequences and unfairly punishes the orthotic and prosthetic fields for problems in other areas of the health care delivery system. Two recent examples of this is the inappropriate reclassification by HCFA of custom orthotic seating systems as "inexpensive/routinely purchased" DME and the fraud and abuse orthotic body jacket investigation conducted by the Office of Inspector General.

HCFA'S RECLASSIFICATION OF ORTHOTIC SEATING SYSTEMS AS DME

Custom orthotic seating systems are designed and fabricated to meet the unique needs of people with severe physical disabilities requiring seating support usually associated with long term wheelchair use. Custom orthotic seating systems are needed in this instance to avoid serious health complications--such as decubitus ulcers and spinal collapse--and to maintain functional activities of daily living. Depending upon the severity of the patient, these customized orthoses range in cost from a few hundred to several thousand dollars. Until recently, HCFA reimbursed these orthoses using an orthotic L-code and individually considered each device to determine a reasonable fee.

With the creation of Medicare's Durable Medical Equipment Regional Carriers, these custom seating orthoses were inappropriately reclassified as "inexpensive/routinely purchased" durable medical equipment and assigned three different "K-codes," obviously not part of the orthotic and prosthetic L-code system. Instead of individually considering the fee for each custom seating orthosis claim, HCFA and the DMERCs now reimburse claims for these devices at a fixed allowable fee, regardless of the level of complexity involved in designing and developing the individual orthosis. Despite the fact that the descriptions for these three new K-codes include the

words, "orthotic" and "custom fabricated,"--which clearly demonstrate the propriety of reimbursing these devices under the L-code system--they continue to be treated as "one size fits all" durable medical equipment.

The DMERCs have recently stated that this action was taken because these custom orthotic seating systems are merely permanent accessories to wheelchairs and are not transferable. While custom orthotic seating systems are often fabricated to mount onto a wheelchair, the DMERC's rationale fails to consider the frequent use of these devices, particularly among children, as transferable between wheelchairs, as car seats, and in a variety of other situations, including allowing one to sit independently supported at a table to eat a meal.

HCFA and the DMERCs have been fully informed of this problem throughout the past several months, but have failed to remedy the situation to date. As a result, some of the very specialized orthotists who fit and fabricate these orthoses have begun to deny these services to Medicare beneficiaries. We point to this situation as an example of the problem of not recognizing the separate treatment of DME from orthotics and prosthetics. We request this Subcommittee, HCFA, and the DMERCs to consider reincorporating these newly-created K-codes into the L-code system where custom orthotic seating systems truly belong and determining fees for these orthoses based on individual consideration of each claim.

THE OFFICE OF INSPECTOR GENERAL'S TESTIMONY

The Office of Inspector General (OIG) testified today on the issues of fraud and abuse in the area of durable medical equipment generally, and specifically as to the investigation of "orthotic body jackets." The OIG testified that "payments for [orthotic body jackets] went from $217,000 in 1990 to $18 million in 1992. We estimated that 95% of those payments were for devices more properly categorized as [prefabricated wheelchair] seat cushions, rather than body jackets." Seat cushions are items of durable medical equipment that cost Medicare $200 to $300 per unit. An "orthotic body jacket" is a thoracic-lumbar-sacral orthosis (TLSO) designed for the treatment of spine or trunk musculoskeletal disorders such as fractures, spinal cord injuries, post surgical stabilization, scoliosis, congenital deformities, etc. The custom design and fitting of a TLSO requires sufficient medical knowledge of these complex disorders for one to possess the clinical and technical skills necessary to provide this complex and comprehensive orthotic service.

This type of orthotic body jacket is identified as L-0430 in the Medicare O&P reimbursement system and has a reimbursement value of approximately $1,000 to $1,200. According to the OIG report, unscrupulous providers began submitting claims for simple seat cushions using the L-0430 reimbursement code in 1990. By the time HCFA identified this fraud and abuse, nearly $18 million in fraudulent claims had been reimbursed under this L-code in 1992 alone.

What the Inspector General did not mention was that the 5% of "orthotic body jackets" that were deemed by the OIG report to be "legitimate" claims were, in almost every instance, provided by certified orthotists "whose primary occupation is supplying orthotic and prosthetic devices to patients. The non-legitimate body jackets in our sample were supplied by Durable Medical Equipment (DME) suppliers that primarily supply DME equipment and supplies, not orthotics." OIG Report , p.4.

THE IMPORTANCE OF CONDITIONS OF COVERAGE

Recognition of provider credentials in the delivery of quality orthotic and prosthetic care is a critical point that we strongly request this Subcommittee consider when attempting to legislatively ferret out health care fraud and abuse in the Medicare program. NAAOP believes that an effective way to curb the type of fraud and abuse that occurred with orthotic body jackets would be to establish conditions of coverage for reimbursement under the orthotic and prosthetic L-codes. By limiting reimbursement of orthotic and prosthetic services to qualified orthotists and prosthetists who are certified to provide these services, HCFA could dramatically reduce the likelihood of this type of fraud and abuse in the future, as well as, the additional costs of adjudicating these fraudulent claims.

Currently, as a practical matter, any provider who obtains a Medicare billing number can submit a claim for orthotic and prosthetic reimbursement. Until 1992, HCFA's Medicare policy carriers manual on orthotic and prosthetic coverage restricted reimbursement to ABC-certified orthotists and prosthetists. HCFA changed its policy to allow O&P reimbursement to any provider credentialed by a membership organization of the National Organization for Competency Assurance (NOCA). NOCA is not a credentialing organization, but rather a membership organization open to all organizations interested in credentialing issues.

Realizing this error in recognizing the NOCA and instead of limiting reimbursement to practitioners qualified to provide comprehensive orthotic and prosthetic care, HCFA further expanded the range of providers eligible to provide O&P services reimbursable under the Medicare L-codes in September 1994. HCFA, therefore, currently has no substantive restrictions or apparent monitoring procedures as to who is qualified to submit orthotic and prosthetic claims under the Medicare program.

HCFA, has potentially exacerbated the likelihood foı the type of fraud and abuse that occurred with orthotic body jackets by recognizing and allowing "anyone credentialed by any certification organization in orthotics and prosthetics" to acquire an O&P provider specialty code and use the L-code designations in submitting orthotic and prosthetic reimbursement claims. This HCFA Medicare carriers manual policy change only increases the likelihood for fraud and abuse and provides virtually no control over the use of the O&P L-codes. Further, HCFA's relaxation of its conditions for orthotic and prosthetic coverage may lead to further proliferation of "new" orthotic and prosthetic credentialing organizations wishing to meet the relaxed requirements for orthotic and prosthetic reimbursements.

The creation of orthotic and prosthetic conditions of coverage under the Medicare program, therefore, would serve to promote quality control of orthotic and prosthetic health care services provided to Medicare beneficiaries and would lead to easy identification of fraudulent and abusive activities by unqualified providers. HCFA should consider reincorporating the ABC practitioner certification and facility accreditation standards into its conditions for O&P coverage. These certification and accreditation standards include physical facility requirements and the prerequisite that an ABC-certified practitioner be employed full-time in an O&P facility.

CONCLUSION

NAAOP welcomes the opportunity to work with this Subcommittee, the Health Care Financing Administration, and the Durable Medical Equipment Regional Carriers to eliminate fraud and abuse in the Medicare program, to appropriately regulate orthotics and prosthetics separately from durable medical equipment, and to ensure the provision of the highest quality orthotic and prosthetic care to Medicare beneficiaries. Thank you.

○

MEDICARE HEARINGS ON CONTROLLING COSTS AND IMPROVING CARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

FEBRUARY 6, 7, AND 10, 1995

Serial 104–19

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

91–134 CC WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-052043-6

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ISSUES REGARDING EXTRAORDINARY GROWTH IN CERTAIN MEDICARE COSTS

MONDAY, FEBRUARY 6, 1995

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

The subcommittee met, pursuant to call, at 10:05 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

[The press releases announcing the hearings follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
January 30, 1995
HL-3

CONTACT: (202) 225-3943

THOMAS ANNOUNCES THREE HEARINGS ON MEDICARE ISSUES
-Focus on Controlling Costs and Improving Care-

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee next week will hold three hearings on Medicare related issues.

The hearings will examine issues related to controlling growth in Medicare costs; income-relating Medicare Part B premiums; and improving care through Medicare reform and innovation.

The first hearing on issues regarding the growth in certain Medicare costs will be held Monday, February 6, 1995, at 10:00 a.m. The second hearing on Medicare part B premiums will be held on Tuesday, February 7, at 2:00 p.m. The third hearing on Medicare reform and innovation will be held on Friday, February 10, at 10:00 a.m. All three hearings will be held in the main Committee hearing room, 1100 Longworth House Office Building.

Invited witnesses will include representatives from the Administration, Physician Payment Review Commission, Prospective Payment Assessment Commission, General Accounting Office, a variety of health experts, and other interested parties. 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:

Several areas of the Medicare program have grown at alarming rates over the last several years and may represent significant fraud and abuse. These areas include spending for post-acute services furnished by skilled nursing facilities, home health agencies, and rehabilitation and long-term care hospitals. For example, real average growth rates per enrollee for nursing home care have risen 39.3 percent from 1991 to 1993. Similarly, home health services per enrollee have grown at 31.1 percent over the same period.

The Medicare Part B Supplementary Medical Insurance (SMI) Trust Fund finances primarily physician and outpatient services. The Part B trust fund is financed by premium payments from enrollees and by general revenues from the U.S. Treasury. SMI is voluntary and all individuals electing the program receive a 75 percent premium subsidy regardless of their income.

Medicare is currently engaged in some innovative programs providing beneficiaries access to managed care. These include Risk Contracts, Medicare Select, Cost Contracts, Health Care Prepayment Plans, Group Prepayment Plans, and Social Health Maintenance Organizations. Enrollment of Medicare beneficiaries in these managed-care alternatives has lagged far behind enrollment in the private sector. Several features of these programs act as impediments which discourage some plans from participating and deter beneficiaries from enrolling.

In announcing the hearing, Chairman Thomas said: "There are many successful, private-sector programs that can serve as models for improving the Medicare system. This series of hearings will explore several of these programs. As we lay the foundation for the work the Subcommittee will engage in over the next several months, we will examine how we can provide quality services while slowing the rate of growth in medicare spending."

FOCUS OF THE HEARING:

The first hearing will focus on areas of alarming cost growth for the Medicare program, with an emphasis on underlying causes and recommendations to address these growth rates. The second hearing will review issues related to fairness under the Part B premium. The third hearing will review existing Medicare managed-care programs, focusing on their effectiveness, beneficiary satisfaction with the programs, impediments to broader utilization of the programs, and ways in which the program can incorporate some of the more promising private sector innovations.

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 by the close of business, Friday, February 17, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the 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.

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

3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.

4. A 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.

* * * * * *

*** NOTICE -- CHANGE IN LOCATION ***

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 6, 1995
No. HL-3-Revised

CONTACT: (202) 225-3943

THOMAS ANNOUNCES CHANGE IN LOCATION FOR HEALTH SUBCOMMITTEE HEARING ON FRIDAY ON MEDICARE REFORM AND INNOVATION

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 Medicare Reform and Innovation which was originally scheduled for Friday, February 10, 1995, at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building, **will be held instead in Room B-318 Rayburn House Office Building.**

All other details for the hearing remain the same. (See Health Subcommittee press release No. HL-3, dated January 30, 1995.)

******

Chairman THOMAS. The subcommittee will come to order.

Today, the Ways and Means Health Subcommittee begins a series of three hearings on Medicare policy, which will continue on Tuesday and conclude on Friday. In this morning's hearing, we will examine Medicare benefits, growth in Medicare costs and other areas of provider public policy which may require assignment.

The second hearing on Tuesday, the 7th, will focus on the issue of income relating to Medicare part B premiums.

The third hearing on Friday, February 10, will concentrate on the potential of managed care for Medicare beneficiaries.

These hearings reflect the manner in microcosm, in essence which the Health Subcommittee will approach Medicare policymaking in the 104th Congress. We should continue the work of reforming the current system, but we must also now look to the future to transforming Medicare in order to bring it into the nineties and prepare for the next century.

First, as we will do in this hearing, we should closely examine the current fee-for-service side of Medicare. Where there are changes in law that can be made in the context of the current benefit and payment structure to curb costs and inappropriate uses of services, we should obviously take those steps. We have a responsibility to assure the beneficiaries and the taxpayers that a fee-for-service Medicare payment policy is designed with clear incentives to promote quality and cost-effective care at the best price that can be obtained.

Then, on Tuesday, we will examine the financing of Medicare part B, which, as you know, is funded by beneficiary premiums and the Nation's general fund. This hearing on income relating to part B will answer two simple questions: Should the taxpayers who now pay for almost 75 percent of the Medicare cost part B benefits subsidize Americans who can well afford to pay more of that cost? And if the Congress should income relate part B premiums, what are the design issues raised by such a change in the law?

Under today's program, if Donald Trump reaches 65, he will receive the same 75-percent subsidy as other Americans under part B, whether they live from Social Security check to Social Security check or on top of the tower. This fact cannot be justified to the average taxpayer. So we should examine income relating part B of Medicare.

This reform should be considered as the subcommittee discusses other incremental revisions of Medicare policy that will increase the financial integrity of the program without undermining its promise of protection for senior citizens.

However, incremental change in payment policy or financing, as we know, is not sufficient to maintain the promise of Medicare. We need to assure all Americans that they will have health care when they get older.

Fortunately, it is not written in stone that the structure of the Medicare program has to remain the same for all time. The fact is, in contrast to health insurance coverage in the private sector, which has evolved in recent years to meet the needs of customers concerned about both the cost of care as well as its quality, Medicare continues to operate basically under midsixties rules.

Of course, the Congress has refined the Medicare payment policy in ways that have had some beneficial effects. But the program remains fundamentally a fee-for-service health plan with incentives that increase volume and with little or no assurance that care will be cost-effective or high quality.

And that is why the third hearing on Friday in this series is so important. It will begin to address the issue which reflects the priority question for this subcommittee in 1995. How do we transform Medicare to improve it for the beneficiaries while making the program relevant to this decade and beyond? So Friday's hearing will focus on managed care in Medicare, both the use of health maintenance organizations and Medicare Select.

But this is only the start. We will begin a complete exploration of the models that the private sector may have to offer as examples for Medicare reform. The tinkering with Medicare payment policy over the last decade and a half was done in good faith. Nevertheless, we must now move on to ask more fundamental questions about the structure of Medicare if it is to survive.

It is our responsibility, this subcommittee, to make Medicare all it can be. However, to enable Medicare to continue into the 21st century, we must begin to reform it now. Otherwise, the structure that is in place will lead to bankruptcy of the system, and future Congresses will not be able to keep the promise of health care made to this Nation's elderly or will have to do so in such a drastic way in a short time that the popular support for Medicare may be greatly undermined.

And, with that, I will yield to the ranking member.

Mr. STARK. Thank you, Mr. Chairman.

These are indeed significant hearings, the stated purpose of which I thought was to identify areas of growth in the Medicare program that may represent significant fraud and abuse. And I congratulate the Chair on focusing on this, and we are ready to lend a hand.

In March 1993, I introduced the National Health Care Anti-Fraud and Abuse Act to combat health care fraud in the entire American health system. Mr. Gingrich forbade the Republican committee members from supporting those efforts, but I again encourage the members of the Republican Party to again seriously consider these initiatives.

I will provide you, Mr. Chairman, with an additional list of anti-fraud and abuse items that I hope will prove useful.

We could adjust the figure with which we reimburse Medicare HMOs. We know that the 1995 percent rate is somewhere between 6 and 28 percent too high. Hospital-owned DME and home health services I think bear close scrutiny. And we can show that banning hospital referrals to home health agencies that they own might be a productive way to save money.

There is physician office abuse and other services we might look at. And there is a lot of waste in the transportation service that we might look at.

We must, to combat fraud and abuse, be willing to invest in its enforcement. Over the past year, the Inspector General reports increased complaints of fraud and abuse in the neighborhood of 30 percent. Last year we passed legislation that would have expanded

the resources available to the Inspector General by establishing a fund dedicated to increased antifraud efforts and the fund to be replenished with the dollars secured from successful health care fraud enforcement. If we are serious about stopping fraud, we must be willing to make this kind of investment.

I would like to talk about what we should not do in the area of health care fraud and abuse.

I don't think we should kid ourselves that even complete elimination of fraud in the Medicare program will achieve the drastic cuts that some in the majority are calling for. In fact, the Office of Inspector General, and the GAO, both concluded that Medicare, while not immune from thieves and scalawags, is several steps ahead of private insurers in preventing fraud.

I certainly hope it is not the intention of the Chair to use the label of fraud and abuse to describe efforts to chop away at Medicare—a tremendously successful program that provides health security to 99 percent of our over-65 population.

The Democratic members of this committee will oppose all changes to Medicare that do not strengthen the program directly or remedy defects in the broader health care system.

It is apparent that there is newfound interest in making contracts with the American people. But for 30 years, we have been working to uphold a true contract with America—that is Medicare. We have not and will not agree to breaking the Medicare contract of health care security to our Nation's disabled and elderly in order to finance today's Republican tax cuts for the wealthiest.

The Republican Contract calls for taking $48 billion out of the Medicare Hospital Insurance Trust Fund in order to pay for tax cuts to the wealthiest 15 percent of the seniors. I believe that is wrong. If we wish to combat fraud against the Medicare program and the American people, that proposal should be removed now.

The last comment is that, as we speak, the room is full of lobbyists who would like to increase the abusive practices by repealing one of the strongest propatient, antifraud laws.

In 1989, under George Bush and with the active participation of Harry and Louise, who now serve the industry and the majority of this committee, Congress prohibited physicians from referring patients to clinical labs. But unfortunately, it got dubbed the Stark law; and it was, in fact, the Bush law.

Studies show that patients of referring physicians who own or invest in clinical labs receive 34 percent more unnecessary testing from those clinical labs than when no ownership interest exists. In 1993, patients were further protected through an expansion of the list of designated services.

If we are serious, Mr. Chairman, about protecting patients and the integrity of the Medicare program from fraud, we will not acquiesce to those who are begging us to repeal the antireferral laws.

Thank you.

Chairman THOMAS. Any other members may submit comments so we may begin this committee hearing.

[No statements were submitted.]

Chairman THOMAS. We have before us Dr. Eisenberg, who is the Chairman of the Physician Payment Review Commission; Dr. Stu-

art Altman, who is the Chairman of the Prospective Payment Assessment Commission, and has been since its inception.

We ordinarily would tell you your written statement would be made a part of the record and that you have 5 minutes to proceed as you may see fit. Given the positions that you have and the information that you are going to provide in terms of historical overviews of the existing Medicare payment mechanisms, problems arising from these mechanisms and recommendations for addressing these problems, we might be a bit more lenient on the time.

Dr. Eisenberg, if you would like to begin.

STATEMENT OF JOHN M. EISENBERG, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION; ACCOMPANIED BY LAUREN LEROY, ACTING DIRECTOR

Dr. EISENBERG. Thank you, Mr. Chairman, members of the committee.

I am pleased to represent the Physician Payment Review Commission today with the committee to discuss growth in Medicare expenditures for physicians' services and its causes; and I am accompanied by Lauren LeRoy, who is the Acting Director of the Commission.

As Chair of the Physician Payment Review Commission, I will focus on the issues relating to physician payment as they contribute to the increase in Medicare costs, and I will divide my comments up into two parts. First, I will talk about mechanisms that can be used to reduce future spending; and, second, options for legislative changes that are going to be needed to put those mechanisms in place.

First, we ought to ask the question what kind of growth in expenditures are we talking about today?

Between 1992 and 1993, Medicare growth was 11.5 percent. That was greater than the 8.6-percent growth that we saw in the private health insurance market. And if we focus on physician services, we can see that between 1986 and 1991 the annual rate of growth was 10.5 percent for physician services. But then between 1991 and 1993, that rate of increase in physician services expenditures dropped. It dropped to 3.8 percent. But even at that reduced rate the rate of increase in physician expenditures was greater than that of gross domestic product per capita.

From the preliminary data that we have, the Physician Payment Review Commission has suggested that the growth rate in 1994 and in 1995 will likely be higher than the 3.8 percent that we have experienced between 1991 and 1993. So the problem seems to have abated some. We are not sure at this point, whether that abatement is temporary.

Why did we experience the growth in Medicare physician expenditures in the first place? The population of Medicare beneficiaries has increased, and that is one of the reasons. About 1.5 to 2 percent of the increase in physician services expenditures has been due to that factor, the increase in the number of the beneficiaries each year.

Second, there has been an increase in the volume of services. That is the most important factor today. Between 1988 and 1992, a period of time when there was a 7.7-percent increase in physician

expenditures, the volume increase accounted for 6 percent of that 7.7 percent.

The increase in the number of beneficiaries, as I said, was about 1.5 to 2 percent. The aging of the population accounted for only 0.1 percent, and the remainder was due to increases in prices, a very small increase during that period of time.

Much of the reason for that is because the focus of the Congress during the past few years has been on fees and limiting the fees in the Medicare system for physicians. Through the Omnibus Budget Reconciliation Act of 1989, Medicare fees were adjusted to address many of the problems that contributed to that rate of increase during the preceding years.

And, like any other prudent purchaser, Medicare decided that it would not accept the historical charges that physicians were rendering. That it, like any other prudent purchaser, like a health maintenance organization, would establish fees that were based on what both it could afford and on what seemed to be able to provide reasonable access to high-quality care for beneficiaries.

The PPRC has worked with the Congress and will continue to work with the Congress to improve the way in which this fee schedule has made Medicare a more prudent purchaser. But our preliminary data suggests that the Medicare payment level today is about 70 percent of the payment level that exists in the private sector. Therefore, we believe that the focus in the future should not be so much on the fees but rather on the volume of services that is provided by physicians in the Medicare system.

And Medicare's primary control of the volume of services provided is in the Medicare volume performance standard, which was also enacted in the Omnibus Budget Reconciliation Act of 1989.

Now, this MVPS, Medicare volume performance standard, gives the Congress two tools. One, is it gives it a tool for budgeting. Two, it gives the Congress a tool that offers the physician community a collective incentive to try to reduce the number of inappropriate or unnecessary services that are provided.

So this MVPS, this volume performance standard, gives the physician community a target rate of growth that is set by Congress yearly after consultation with our Commission and with the Secretary of Health and Human Services.

The key here is this: That the volume performance standard is established and payment levels are adjusted up or down depending on whether aggregate expenditures by the physician community achieve that goal. It is a method that is similar to that which is used by some managed care organizations which offer physicians an incentive to meet a certain target or they do not receive the full price that they were expecting.

So, in essence, this MVPS, the Medicare volume performance standard, is seen by many people as sort of a bargain between the Congress or the Health Care Financing Administration and the physician community. The bargain is we will pay you higher fees if you can keep your volume increases down. But if the volume increase goes up, you are going to get a lower fee.

Now, the facts of the past 2 years with the decrease in the rate of increase in physician expenditures makes it seem as if the VPS mechanism has worked reasonably well. And, in fact, the VPS

mechanism has been tied with this resource-based relative value scale which was also introduced in 1989, and the combination seems to have helped to reduce the rate of increase, at least in the past 2 years.

In fact, the resource-based relative value scale seems to have been picked up by the private sector, including about one-third of managed care organizations. A large number of States for their Medicaid plans have picked up the concept, using the resource-based relative value scale as they move to new ways of paying physicians.

But there are still very serious problems in holding down the rate of increase in volume. Let me just emphasize again, that is where the focus has to be.

One of the problems with the Medicare volume performance standard is that there are currently three different updates with what we believe to be a flawed methodology for calculating what those updates ought to be. That has led over the past 5 years—or 5 years of updates—1992, 1993, 1994, 1995—to a cumulative 18.37-percent increase in fees offered to physicians overall but large differences among groups of services rendered by those physicians.

Surgical services have had an increase of 29.7 percent; primary care services an increase of 19.6 percent; and other nonsurgical services an increase of 13.8 percent. So there are large differences in the rate of increase in the conversion factor, which is the dollar amount that is multiplied times the resource-based relative value scale to come up with the price that doctors are paid.

So as we consider opportunities for the future, I want to divide them into two parts: First, for the current Medicare plan, the current paradigm of Medicare, we believe that improvements can be made in the volume performance standard that would help to address the topic of today's hearing, that of volume of services on the physician side. We believe that these corrections in the VPS could help to decrease the rate of increase in the volume should it start to increase again. And, as I mentioned, our early data suggest that it likely will.

But, second, we believe more fundamental changes can be considered by the Congress that would change the way in which the Medicare program is structured in order to allow beneficiaries more access to managed care plans, to changes that have occurred in the private sector, and to enable Medicare beneficiaries to participate in those new programs in a way also that would enhance the willingness of those plans to participate in Medicare.

Now, as always, PPRC's position is as follows: That if Congress decides that it wants—needs to reduce spending, our job, as we interpret it, is to help you to accomplish those savings in a way that is consistent with the long-term policy goals of the Medicare program. So let me divide my remaining comments into changes in the fee-for-service Medicare plan and then changes that might be considered under a managed care approach.

First, under the fee-for-service plan, we believe that we should focus on the conversion factor, not on the relative values. That by focusing on the conversion factor that changes in the relative values can remain consistent with the principles of the relative value system and not threaten the integrity of that scale, which, as I

mentioned, has been picked up by the private sector as a reasonable model for paying physicians.

Our major point is this—that there are serious technical problems with the way in which the default formula calculates what the update for physician payment ought to be. Our preliminary analyses tell us by the year 2003 with the current default formula that physician payment may well be—in fact, is likely to be lower than the payments today, even correcting for inflation. And that is a result of the technical problems that exist in the current mechanism for calculating the VPS.

The reason for this is because there is an automatic 4-percentage point reduction that is embedded in the formula for the Medicare volume performance standard; and this automatic 4-percentage point reduction, which might have made sense when the rate of increase was 10 or 11 percent but does not seem to make sense when the rate in increase in physician expenditures is 3.8 percent, is embedded in the formula. That 4-percentage point reduction, plus the anticipated lower rate of increase, will make it difficult, very difficult for the Congress to achieve additional savings by reducing physician payment in the future if that 4-percentage point default—4-percentage point factor in the default is not corrected.

So we would recommend—PPRC would recommend that we replace this formula with a formula that is linked to the projected increase in the gross domestic product so that increases in the Medicare program are affordable, given the increasing wealth of the Nation.

Second, that we eliminate the separate payments and the separate performance standards, the separate updates that are used for different groups of services or at least change the baselines upon which those calculations are made or, as one other alternative, make the changes only for 1 year.

Third, that we use a cumulative target so that there is a cumulative comparison of actual expenditures and targeted expenditures rather than just doing this on a year-by-year basis, which causes us, we believe, to chase our tails.

And then, finally, we believe that there should be a limit to the size of the increases in physician payments just as there are currently limits to the size of decreases in physician payments.

Now, finally, with managed care, we believe that changes can be made in the Medicare program to make it possible for beneficiaries to enroll in managed care programs and to have a wider choice of plans that they could enter.

Currently, only 9 percent of Medicare beneficiaries are in managed care programs. There are a variety of reasons for that, but a key one is because the managed care programs don't find it beneficial to participate in managed care.

There are wide geographic variations in the prices available to the HMO. There is a tremendous amount of volatility from county to county and from year to year. There is inadequate risk adjustment, and there is unrestricted movement for the HMO, if it decides that it is not doing well with the calculated cost that is made available, to a cost-plus formula or a cost-based formula. And 25 percent of HMOs are still operating under cost-based reimbursement.

Given that scenario, we don't think that, with the current formulation, Medicare will be able to see as large an increase in the participation of its beneficiaries in HMOs as the Congress would likely want to see. With changes, we believe that more opportunities would be available to the beneficiary, including Medicare Select and others, to give the beneficiary more choice.

And, therefore, the PPRC suggests that the Congress consider four options:

The first option is to consider a competitive pricing system for managed care that would allow more creativity on the part of the managed care plans and a more competitive mechanism for establishing a price for the Congress and for the Health Care Financing Administration. Now, this competitive pricing mechanism could use market mechanisms to establish payments. It could use a bidding process, for example, so that a price could be set through a bidding process.

Individual beneficiaries then could choose whether they wanted to go to a higher cost plan, in which case they might be required to pay the difference between what Medicare would pay and what they would choose to—what they would need to pay in order to enter that higher cost plan.

So we would recommend that the Health Care Financing Administration be given the authority to introduce competitive bidding in markets that have the best chance of success, that is, those areas where there is a competitive managed care market and then expand this plan as it is possible to do so as managed care becomes more competitive in other regions of the country.

Second, we believe that the AAPCC, the average adjusted per capita cost, the way in which Medicare calculates what it will pay the HMOs, the managed care programs, needs to be changed. It needs to be changed so that it includes multiple counties, so that it considers different input costs for the various managed care programs in different parts of the country, and so that it improves the risk adjustment capacity of this program, thereby paying health maintenance organizations more appropriately in a system where competitive bidding is not being used.

So it is an alternative to the competitive bidding process or it could be embedded in the competitive bidding process, letting the AAPCC serve as a kind of benchmark for the bidding process.

Third, the PPRC is interested in considering the possibility of partial capitation demonstration projects. By that I mean that Medicare would offer the opportunity for a health maintenance organization to enroll beneficiaries with partial capitation, a part of the payment would be capitated, perhaps it would be blended with partial fee-for-service payment or cost-based payment to the HMO so that we could gradually move into a situation where the HMO felt more comfortable taking the risk that is incumbent in the Medicare risk contracting program, or alternatively risk corridors could be used for those HMOs.

And, finally, PPRC is concerned about the continued presence of the cost contracts in managed care and believes those cost contracts should be limited at least, if not eliminated.

Let me end by commenting on the fact that there are a number of other factors that influence expenditures in the Medicare system, many of which are part of the health care system in general.

The PPRC is convinced that the capacity of the health care system is too large. We have focused, given our focus on physician payment, on the physician work force. And we believe that, as the Congress reconsiders direct medical education payments to teaching institutions, that it ought to consider a national per resident amount rather than the widely variant amounts that are currently paid to hospitals.

We also believe that the direct medical education payment should encourage ambulatory education. This is an area where the Prospective Payment Assessment Commission has done a tremendous amount of thinking, as well.

So, in conclusion, Mr. Chairman, members, the Physician Payment Review Commission believes that there are opportunities for the Congress to achieve savings, both in the traditional Medicare fee-for-service plan but greater savings, perhaps, in moving Medicare to a system whereby beneficiaries would have a choice of Medicare plans which would include managed care opportunities, and we have offered you a number of suggestions about ways in which we might move in that direction. We look forward to working with you to try to develop these plans and to consider their feasibility.

Thank you.

[The prepared statement follows:]

TESTIMONY OF JOHN M. EISENBERG, M.D.
PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman, I am pleased to be here today to discuss growth in Medicare expenditures for physicians' services and its causes. Since it was established by the Congress in 1986, the Physician Payment Review Commission has devoted a substantial portion of its work to issues related to physician payment under Medicare. Our work assisted the Congress in shaping the Medicare payment reforms enacted in the Omnibus Budget Reconciliation Act of 1989 (OBRA89). We have followed up on that work by monitoring implementation of those reforms and developing refinements to ensure that the policy meets its objectives of holding down the rate of expenditure growth, removing distortions in physician payment, and limiting beneficiary financial liability.

As this subcommittee considers reforms in the Medicare program and takes on the challenge of reducing the federal deficit, it is important to understand recent trends in program spending and the impact of past policies on growth in price, volume, and total expenditures. My testimony today first reviews those trends and policies. It then considers the mechanisms that could be used to reduce future spending and options for legislative changes that would be needed to accomplish those changes. Different strategies will be appropriate for the fee-for-service and managed care sectors. Moreover, any short-term steps should be consistent with the anticipated direction of more comprehensive reforms, particularly those that would permit Medicare to take advantage of the innovations in service delivery and payment that are now being used in the private sector. I will conclude my testimony by commenting on the relationship between physician supply and and expenditure growth and Medicare's role in financing graduate medical education (GME). The Commission has made budget recommendations concerning GME in past years and can offer some general advice in this area.

Let me also add that my comments reflect the Commission's evolving views as it shapes its 1995 *Annual Report to the Congress*. These recommendations will be finalized later this month. They will be transmitted formally to you as required by law at the end of March, but we will work closely with your staff before then to provide the assistance you need in shaping Medicare policy.

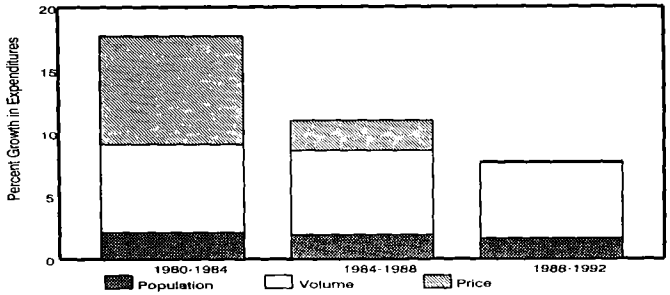
BACKGROUND: TRENDS IN EXPENDITURE GROWTH

Physicians' services account for about 50 percent of spending under Medicare Part B and in fiscal year 1994, amounted to $29.9 billion. After extremely high growth during the early 1980s, annual growth in expenditures for physicians' services has slowed considerably relative to the historical trend. Between 1986 and 1991, expenditures grew at an annual rate of 10.5 percent. By contrast, between 1991 and 1993, estimated expenditure growth slowed to an average rate of 3.8 percent. Even at this level, however, growth in Medicare expenditures exceeds growth in the gross domestic product (GDP). Moreover, preliminary data suggest that the rate of expenditure growth for 1994 and 1995 is likely to rise.

Medicare expenditures as a whole are outpacing growth in private sector health expenditures (11.5 percent growth in Medicare versus 8.6 percent growth for private health insurance expenditures between 1992 and 1993). Growth in Medicare physicians' services, however, was substantially lower than growth for other types of services financed by Medicare.

Increased Medicare outlays can result from two sources: increases in payment rates and increases in the quantity or mix of services provided. Increases in services can be separated further into two components: those due to growth and aging of the population and those due to changes in the practice of medicine. While population growth is often mentioned as being a major cause of rising physician expenditures, in fact, its impact has been relatively small with Medicare beneficiaries growing at between 1.5 percent and 2 percent annually [Figure 1]. But, if the rate of expenditure growth declines, as it did in recent years, increases in the Medicare population become a more significant factor in overall spending growth.

Figure 1. Growth in Medicare Physician Expenditures (for Aged Enrollees), by Component, 1980-1992



SOURCE: 1994 Annual Report of the Board of Trustees, Federal Supplementary Medical Insurance Trust Fund

The distinction between growth attributable to price and growth attributable to volume is important for understanding past congressional action to slow expenditure growth. During the 1970s and 1980s, the primary policy levers to restrain Medicare expenditure growth were restraints on price, either through across-the-board fee freezes or via fee cuts for procedures that the Congress specified as overvalued. The latter were intended to be consistent with the direction of payments under the Medicare Fee Schedule established as a part of physician payment reform in OBRA89. First implemented in 1992, the fee schedule's purpose, however, was not to constrain prices but to eliminate distorted incentives and inequitable payments across specialties, services, and geographic areas.

Constraints on prices resulted in slower expenditure growth and were consistent with the goal of moving fees towards resource-based payment. During the late 1980s, when fee constraints were in place, volume became the principal force driving up expenditures for physicians' services; from 1988 to 1992, payment rates accounted for about 0.1 percentage points of total growth in expenditures while the volume of services accounted for 6 percentage points of the 7.7 percent total growth in expenditures for elderly enrollees (Figure 1).

There are questions, however, about whether such constraints can hold down expenditure growth over the long term. Also at issue is how much Medicare fees can be reduced without jeopardizing beneficiaries' access to care. Medicare fees are now near 70 percent of what private payers now offer to physicians.

The Commission has long held that a direct measure to contain volume is needed to maintain program expenditures at a sustainable level. Medicare's primary mechanism for addressing volume growth is the system of Volume Performance Standards (VPSs), enacted as part of physician payment reform in 1989. The VPS serves two purposes. First, it is a budgeting tool that improves predictability in expenditures by linking payment levels to the growth in volume and intensity of physicians' services. Second, it is intended to serve as a collective incentive to the medical profession to find ways to reduce inappropriate care, such as developing and disseminating practice guidelines that promote cost-efficient practice styles.

Under OBRA89, a performance standard (essentially a target rate of expenditure growth) is to be set annually either by the Congress after consulting with the Commission and the Secretary of Health and Human Services or by a default formula specified in law. (In fact, the default formula has been used in most years.) Then payment rates are adjusted in subsequent years as actual expenditure growth exceeds or falls below these standards. Performance standards were first applied to physicians' services in 1990; fee updates based on how well physicians met these standards were first applied in 1992.

Although the Commission had recommended a single performance standard, OBRA89 created a system with two: one for surgical services and one for nonsurgical services. A third standard (primary care) was added under OBRA93 in response to concerns that growth in volume for technical procedures in the nonsurgical service category was depressing fee levels for primary care. Even though this has resulted in larger fee updates for primary care than under the two standard system, even higher updates for surgical services have resulted in distortions in the patterns of relative payment, the very problem the Medicare Fee Schedule was intended to correct.

Beginning in 1992, volume growth slowed substantially. As a result, Medicare fee updates for 1994 and 1995 were much larger than had previously been anticipated (Table 1). The reasons for this slowdown in growth are unclear (as are the prospects for its continuation). Possible explanations include responses to the incentives created by the VPS and secular changes in the practice of medicine. The latter include slowed growth in technologies introduced during the mid to late 1980s such as cataract surgery and magnetic resonance imaging, and more efficient practice styles as a result of the increased penetration of managed care. Others suggest that low volume growth in recent years merely reflects its inherent volatility. In fact, the trend probably reflects a combination of these factors.

Table 1. Conversion Factor Updates for 1992 through 1995 (percentage)

Categories of Service[a]	1992[c]	1993[c]	1994[b]	1995[b]
All Services	1.9	1.4	6.8	7.7
Surgical	--	3.1	--	--
Nonsurgical	--	0.8	--	--
Surgical	--	--	10.0	12.2
Primary Care	--	--	7.9	7.9
Other Nonsurgical	--	--	5.3	5.2

SOURCE: Physician Payment Review Commission compilation of final updates from Federal Registers.

[a] A single update for all services was made in 1992, separate surgical and nonsurgical updates were required in 1993, and a separate update for primary care services began in 1994.

[b] Set by congressional decision.

[c] Determined by default formula.

PHYSICIANS' SERVICES: OPPORTUNITIES FOR THE FUTURE

Future efforts to limit Medicare spending for physicians' services may focus on either the fee-for-service sector, still the predominant form of payment under the program and the option chosen by over 90 percent of beneficiaries, or on expanding enrollment in managed-care plans in anticipation that such systems of care will be more efficient providers. Efforts to attain savings in the short-term, however, should not lose sight of structural problems that could impede achievement of policy goals in the long-term. Specifically, changes in the VPS are needed to ensure its ability to control the rate of volume growth should it begin to rise again, while changes in the method for paying managed care plans are needed to enhance their willingness to participate in the program. The Commission has some suggestions in each of these areas which would enhance program performance and help it capitalize on innovative changes in the health care market.

The Commission recognizes the difficult task the subcommittee will face in finding budget savings in physicians' services and we stand prepared to advise you on these issues.

Traditionally, the Commission has not commented on the overall magnitude of cuts in Medicare. Instead, we take as our assignment the following: if the Congress should decide to reduce spending, how can that be accomplished in a way that is most consistent with long-term policy goals.

Fee-for-Service

In the past, proposals have been offered to slow growth in spending through selective changes in relative payments for certain services (so-called overvalued procedures). While this was an appropriate strategy during the years of transition to a new payment system, making such cuts now would threaten the integrity of the resource-based relative value scale. This is a problem not only for Medicare but for the many private payers and Medicaid programs that use Medicare's relative value scale. Instead, payment policy changes should focus on changes in the conversion factor, which would decrease fees across the board, rather than on changes in payments for specific services.

Given the large fee updates awarded in 1994 and 1995, the Congress may be inclined to achieve budget savings by rescinding previous fee updates or by making further adjustments to the VPS default formula. It is the Commission's view, however, that technical problems with the default formula used in setting volume performance standards should be corrected first. This is because despite recent high updates in Medicare fees, the current policy in place will result in substantial reductions in the conversion factor over the next five years. In fact, conversion factors in 2003 are projected to be lower than when the policy was first implemented in 1992, even without accounting for inflation. Moreover, the existence of three performance standards is introducing serious distortions in payment rates.

Once these problems are addressed, then an across-the-board cut in the conversion factor could be considered as a means of budget savings. For example, the size of the cut could be set so it would be comparable to rescinding part or all of the 1994 and 1995 updates. If the Congress decides to take this approach, however, it should be mindful that it would widen the gap between the fees paid by Medicare and those of private payers. These issues are considered below.

Fixing the Default Formula. The current VPS system has several flaws. First under OBRA89, performance standards are determined in part by the historical trend in volume growth. At the time the law was written, historical trends were viewed as including some amount of inefficiencies and inappropriate care and therefore a decision was made to reduce the performance standard formula accordingly. Initially, deductions of one half of a percent were taken from the historical trend, phasing in over time to two percentage points. Under OBRA93, the deduction was increased to four percentage points.

The problem is that this deduction is now permanently embedded within the default formula and applies even as the 1991 to 1993 growth rate is the lowest two-year growth rate since 1985. In effect, the formula demands that however well physicians did in meeting the previous standard, they must reduce volume by an additional 4 percentage points each year or pay a penalty in reduced fees. Clearly, it is impractical to expect that physicians will continue to achieve such reductions year after year.

The combination of the four percentage point deduction enacted in OBRA93 and a lower than anticipated volume growth rate may make it extremely difficult to get additional savings by reducing physician payment. Since it is unlikely that volume growth will fall four points below current levels, maximum deductions in fees are already expected to be taken beginning in 1998 and continuing through 2002.

The bottom line is that changes in the VPS default formula are urgently needed. To address this problem, the Commission recommends replacing the current formula (historical trend in volume and intensity minus four percentage points) with a formula

linked to the projected growth of real GDP per capita. This would permit a reasonable rate of growth that is affordable over the long term.

The Commission also recommends two additional changes to limit further distortions in relative payments and to improve accuracy and accountability within the system. First, to ensure the integrity of the resource-based relative value scale, separate performance standards and updates for categories of services should be eliminated. If they are retained, they should be based on the trend in volume growth for each category as required by OBRA93, and differential updates should be in effect for one year only. As long as you have differential updates and allow the differences to be built into the baseline, you will distort relative payments.

Second, fee updates should be based on comparisons between total actual expenditures and total targeted spending since a base year. Under current policy, comparisons are made between expenditure growth and the performance standard for a single year. Missing the target in one year does not affect the update for the following year. A policy that makes comparisons between total actual expenditures and total targeted spending since a specified base year, on the other hand, accumulates year-to-year surpluses and shortfalls and applies them to subsequent years.

In addition, limits on the size of both reductions and increases should be established to lessen the volatility of fee increases and reductions. Currently, updates are limited to a 5.0 percentage point penalty if actual expenditures exceed the performance standard by more than 5 percent. No comparable limit constrains the size of increases. Symmetric limits of 5.0 percentage points should be used to prevent both extraordinarily high increases as well as reductions. These two changes combined will add full accountability for total expenditures for physician services while ensuring that annual fee updates are relatively stable and reasonable.

The Gap between Medicare and Private Fees. Medicare fees are currently near 70 percent of those paid by private payers. The gap between Medicare fees and those of private payers in 1995 is less than the Commission reported last year because of higher Medicare fee updates, reduction in the trend for private fee growth, and more accurate data on "deep discount" payers. The gap between Medicare and private fees is of concern because large differentials in payment between Medicare and private payers, coupled with discontent about Medicare's level of payment, could compromise access to care for Medicare beneficiaries. Even if the payments cover the cost of care, physicians may prefer to accept patients with private insurance over those with Medicare. The Commission has found no evidence that the current gap is causing an access barrier. It is possible, however, that a substantially larger gap could affect physicians' willingness to treat Medicare patients, but the size of that threshold is unclear.

Managed Care

As the health care system has moved toward managed care and integrated delivery systems, both the willingness of health maintenance organizations (HMOs) to participate in the Medicare program and beneficiary enrollment in these plans have increased. Currently about 9 percent of Medicare beneficiaries are enrolled in HMOs, up from 7 percent in 1993. Enrollment rates vary considerably across the country, with higher rates tending to occur where commercial HMO penetration is high. About 75 percent of enrollees are in HMOs with risk contracts which are paid on a per capita basis; the rest are in plans with cost contracts that are paid based on reasonable costs.

Further expansion of managed care within the Medicare program will depend upon the capacity of HMOs to accommodate elderly and disabled patients, plans' willingness to do business with the program, and beneficiaries' willingness to receive care under these arrangements. Although short-term budget savings could be achieved by reducing capitation rates, this approach would risk making the program less attractive to plans and

thus would be counter to long-term goals. My remarks will focus primarily on needed changes in the current payment methodology that could ultimately encourage a more substantial role for managed care within the Medicare program. These reforms also offer some opportunities for savings.

Inadequacies of the current Medicare payment policies have created problems of limited HMO participation, low beneficiary enrollment rates, and higher costs per enrollee than their fee-for-service costs would have been. These payment problems include:

- wide geographic variation in payment rates due to local variations in fee-for-service patterns of use;
- volatility of county-level payment rates, particularly for those with small Medicare populations;
- inadequate risk adjustment methods; and
- unrestricted movement between risk and cost contracts, resulting in HMOs with risk contracts attracting patients with less expensive patterns of use.

Without addressing these problems, a greater role for managed care will not necessarily lead to cost savings.

In the Commission's view, the first step in expanding managed care should be improving payment policy for risk contracts by correcting flaws in current capitation rates (referred to as average adjusted per capita costs or AAPCCs). Building upon this foundation, additional managed care choices (such as Medicare Select and other preferred provider or point-of-service options) could be expanded. Other approaches that would create competition among both fee-for-service and managed care options within Medicare could also be explored.

Capitation payment rates should be improved so that they (1) cover costs of an efficient HMO, (2) are better adjusted for risk selection, and (3) are predictable from year to year. The Commission suggests two approaches for improving capitation payments: competitive pricing methods and refinements to the current AAPCC geographic adjustment method. Because competitive pricing would be effective only in markets with multiple HMOs, both approaches are needed in the short-term. Also important is the need for payment adjustments that mitigate the financial impact of adverse risk selection (having a patient population with higher than average health care use) and reduce the incentives for HMOs to select good risks. Given the inadequacies of current risk adjustment methods, partial capitation methods that base HMO payment partly on a capitation rate and partly on actual experience could also be tested. Each of these is discussed below.

Competitive Pricing. Competitive pricing would uncouple HMO payment rates from Medicare fee-for-service expenditures, using market mechanisms to establish payments that reflect the costs for an efficient HMO. The process could work as follows. First, HMOs meeting the qualifying conditions for risk contracts would submit offers of the minimum payment rate they would be willing to take. Then the Health Care Financing Administration would establish a payment rate based on the bids submitted. To create incentives for plans to bid low, plans that bid higher than the final rate should be penalized, perhaps by requiring these plans to charge the balance of their bid to beneficiaries in the form of premiums.

Whether Medicare would save money from using competitive bidding would depend upon the design of the bidding process, how competitive the bidding becomes, the final payment rates, and the level of the AAPCCs in those markets. Cost savings for Medicare might be achieved if the final payment rate is set close to the low bids or if competitive bidding results in rates lower than the AAPCCs. On the other hand, if bidding results in a rate higher than the AAPCC, a decision could be made to use the national average per capita cost as an upper limit. (This rate should be adjusted for local input prices and possibly for some variation in service use.) Such an approach is not an ideal one,

however, because it would reintroduce the very problems that competitive pricing was intended to correct and distort competition by preventing the established price from reflecting local market conditions.

To enhance prospects for successful implementation, the Commission recommends that the Health Care Financing Administration (HCFA) be given sufficient authority and flexibility to introduce competitive bidding in markets with the best chances for success (e.g., those with high HMO penetration) and gradually increase the number of markets as competitive conditions change.

Refinements to the AAPCC Geographic Adjustment Method. Because competitive pricing would be effective only in competitive markets, there will continue to be a need for the AAPCCs or some other form of administered payment rates in the forseeable future. AAPCCs also might be used during an interim period in locations designated for competitive pricing, until the new method was ready to implement. Adjustments are currently made for differences in costs across geographic areas by taking the ratio of county-level per capita costs to the national average. This method is flawed because it establishes payment rates that are unstable over time and are susceptible to extreme geographic variation in service use patterns. It also creates an incentive for HMOs to choose to serve those counties within their service area with the highest payment rates.

Theoretically, these problems could be addressed by making appropriate payment adjustments that recognize input price factors that HMOs cannot control, such as local wage rates or supply costs, and service use variation attributable to differences in health status. Because we are now unable to adjust accurately for differences in service use, the Commission's recommended short-term strategy for improving the AAPCCs is to establish payment rates for multi-county areas instead of individual counties. Such rates for multi-county areas would improve payment predictability, particularly for rural areas, and would eliminate payment variation across counties within HMO markets. In the long-term, better adjustments for service use should be developed.

Partial Capitation. When an HMO assumes full risk for its enrollees' health care costs under capitation, its financial results could range widely from large gains to large losses. Partial capitation would minimize these potential swings by having Medicare share risk with HMOs that had losses or gains outside specified thresholds. Two different partial capitation methods could be used (1) blended rates based on a weighted average of a capitation payment and fee-for-service payment for actual health care services provided, using existing Medicare fees, and (2) risk corridor payments that would adjust capitation rates in proportion to its net financial gains or losses exceeding established thresholds.

Despite its promise, partial capitation could be difficult to adminster. Before using this method widely, therefore, demonstrations are needed to test different models and their data requirements for HMOs, and to develop needed information for setting risk thresholds and risk sharing percentages.

The Role of Cost Contracts. Cost contracts have long been made available for HMOs that do not want risk contracts. While this flexibility has ensured that a range of options is available to Medicare beneficiaries, it has also contributed to favorable selection for risk contracting HMOs with increased costs to Medicare. In markets where competitive pricing or partial capitation are implemented, limits should be placed on the use of cost contracts.

GRADUATE MEDICAL EDUCATION

Another factor affecting Medicare expenditures is the supply and distribution of physicians. The fact that per capita spending is positively correlated with the number of physicians has been well documented, and there is some evidence that care provided by specialists is more expensive than that provided by primary care physicians. Since the Commission's

mandate was expanded in 1990 to include consideration of Medicare financing for graduate medical education and the supply and specialty distribution of physicians, we have developed substantial expertise on these issues.

Recognition of the need to address supply and specialty distribution and the substantial contribution of Medicare to supporting residency training prompted both the current and prior Administrations to revise the payment methods for GME. Under current law (established in the Consolidated Omnibus Budget Reconciliation Act of 1985), payments are made to hospitals based on institution-specific per resident costs from the 1984 or 1985 reporting years, updated for inflation. These costs are multiplied by the number of full-time equivalent (FTE) residents in the hospital during the payment period. A modification of the OBRA85 provisions calls for residents being weighted as one-half an FTE beyond the initial training period.

Previous proposals have suggested restructuring Medicare support by (1) introducing weighting so that residents in primary care disciplines are treated as more than one FTE and others in the initial training period are treated as less than one FTE and (2) basing payments on the national average salary for residents rather than hospital-specific historical payments. Such proposals can be designed to be budget-neutral or to achieve savings.

While the Commission has long supported moving to a national per resident amount, it questions whether weighting will actually increase the proportion of residents trained in primary care. This is because direct payments go to the hospital and not necessarily to the primary care training program. Moreover, the additional funding from weighting may not be sufficient to increase the supply of primary care physicians; training programs in these fields already have substantially fewer filled positions than those in many other specialties. To better inform the Congress about the implications of such proposals, the Commission is planning to model the impact of proposals to change GME financing. These analyses should provide a more complete picture of the financial impact of Medicare budget cuts by specialty and by type of hospital.

In addition, the Commission can provide additional advice on broader reforms in GME financing that would move specialty distribution and supply in a direction consistent with the need to reduce Medicare expenditures. These might include shifting funding to support training in ambulatory sites or other mechanisms that would break the linkage between hospital payment and GME financing and thus allow more creative and effective uses of Medicare dollars.

Chairman THOMAS. Thank you very much, Doctor, for your ideas and rather extensive options available to us.

Mr. Altman.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION; ACCOMPANIED BY DONALD YOUNG, M.D., EXECUTIVE DIRECTOR

Mr. ALTMAN. Well, thank you, Mr. Chairman. It is really a pleasure to be here. I have really appreciated the opportunity over the years to testify before this committee, working with you as well as Mr. Stark and the staffs.

I have with me Dr. Donald Young, who is the Executive Director of the Prospective Payment Assessment Commission.

As you know, Mr. Chairman, ProPAC was originally established to help the Congress think through the complexities of the prospective payment system diagnosis related groups, which is the system which was put in place in 1983 to pay hospitals, but the Congress has expanded our mandate considerably over the years. We now focus on skilled nursing facilities, home health, hospitals which are excluded from PPS, as well as working on end-stage renal disease for dialysis.

In addition, the committee has asked us to look into several other plans for the Medicare program, as well. We have looked quite extensively at how Medicare has operated over the last several years; and, as Dr. Eisenberg has pointed out, we share his focus that while the price increases have been important, one needs to focus attention heavily on volume. And we, too, have been looking into different ways of focusing on volume.

But you asked us today to give you our best assessment of how you, in the short run, can control Medicare costs as well as plan for the future, so I will focus most of my testimony on changes in the Medicare program in the short run but look to the future, as well.

As we look to the short run, we should recognize Medicare is a fee-for-service system. In the hospital payment, we created in 1983 a minicapitation system for inpatient hospital care. Prior to that, Medicare paid on the basis of cost. The more a hospital spent, the more it got paid.

Now Medicare says to a hospital, here is a fixed amount of money. You manage that amount. If you provide more tests and procedures, you have to do it within that fixed budget. But it doesn't control services outside the hospital in the same way.

So much of the growth over the last 3 years has not been in the prices paid to hospitals. It has been in the growth of home care services, in the growth of skilled nursing facilities, as well as some increase in the number of admissions.

Now, in thinking about how we might be able to control the hospital side first, we really have two basic paths to go down:

One, we could reduce the update factor, which is the method we use to increase hospital payments by a fixed amount for every hospital. And there is a certain appeal to that. It is simple. It has a sense of fairness.

The problem with it is that some facilities are in a much better position to take those reductions than others, and it may turn out that the ones you want to preserve are just the ones that are going to be in trouble if you introduce across-the-board reductions. So the alternative would be to focus reductions on institutions that may not need the money as much or where there is a questionable amount of money that has been flowing to them.

Let me indicate some of the areas where we might go. And, by the way, I have appended to my testimony a number of charts which you may want to refer to as I just quickly move through this testimony.

The first chart indicates the fact that Medicare was a fairly prudent controller of expenditures from 1983 to 1991. But, beginning in 1991, the growth rate of 6.5 percent on average per year was significantly more than the private sector, which was 4.7 percent.

Chart 2 demonstrates what I was talking about, that while overall Medicare expenditures grew by 11.8 percent between 1991 and 1993, it grew by 38 percent for home health. It grew by 46 percent for nursing homes, while hospitals grew at about 10 percent.

Now, let's focus more specifically on the hospitals, particularly the hospitals that receive most of the money. Even though the inpatient sector is declining, it is still where most of your money goes in the Medicare program. Of the total $151 billion that Medicare spent in 1993, about $80 billion went for inpatient hospital care or about 52 percent of the total.

Now, when you look at the growth rates, they have been fairly moderate in recent years. The update factors have been held down, but the current law which allowed the Medicare program to essentially pay 2 percent less than the market basket is going to phase that reduction down to and, by 1998, that would essentially go to zero.

One real possibility that you have is not to allow that reduction to take place and to keep the 2 percent below market basket in place. I say that, and I feel more confident in saying that because the hospital cost structure, which resisted reductions even though Medicare was paying out less because of the ability to charge private patients more than their costs, is now beginning to fall and is being pushed by private-sector reductions in prices that they pay to the hospitals.

I think the Medicare program should essentially ride that curve down, not be excessive about it, because you don't want Medicare to get out of balance any more than it already is with what private payments are. But neither do you want Medicare to become the best payer in town, except when you design it specifically for a specific hospital.

So one possibility would be to focus on that update factor and to tie it more closely to where it had been during the middle eighties.

Now, we can focus on a number of special issues. One of the most complex and controversial is the teaching adjustment. The Congress, in establishing the PPS, decided, based on analysis, that it was important to pay teaching hospitals more than just their flat DRG payment because teaching hospitals get sicker patients. They also are training our next generation of physicians, and these

younger physicians use more tests and procedures and they also treat larger numbers of uninsured people.

And so the Congress built into the legislation an increased payment. Unfortunately, they overshot the mark a bit. Well, that is being kind. They overshot the mark a fair amount and wound up paying hospitals about 11.2 percent for every 10-percent higher ratio of the interns and residents to beds. Over the last several years, that teaching adjustment has been reduced somewhat to about 7.7 percent.

We at ProPAC have been looking at this. Our best estimate is that that teaching adjustment should be around 4.5 percent, not 7.7. But we believe it would be a mistake to simply reduce that amount from 7.7 to 4.5 in one shot.

You have to appreciate the problems of teaching hospitals. They are, after all, often located in our urban centers, treating many of the uninsured. They do have higher costs because of the factors that I indicated, and they are the group that are the most negatively affected by this pressure for managed care in the private sector.

That doesn't mean that we support just continuing to pay them higher rates. Our recommendation would be this year to reduce the 7.7 percent to 6.7, which is about a 13-percent payment reduction, followed in the second and third year by comparable reductions. Over time, that would reduce teaching payments by about 40 percent, which is a significant reduction.

We also have looked at the graduate medical education component that Dr. Eisenberg talked about, and we have similar thoughts about that in terms of either freezing the payment rate, the number of residents, or reducing the payment rate per resident to something above the national average or in some way focusing the payments much more on primary care and away from specialty care.

Now, as we look at other areas, we need to recognize that one of the other adjustments that the Congress put in the DRG system was to focus extra dollars to what we call disproportionate share hospitals. These are hospitals mostly in our urban areas, some in rural but mostly in our urban areas, that treat large numbers of people, Medicare people and Medicaid and uninsured people that can't pay their bills.

These are very financially vulnerable hospitals. So the Medicare program provided an extra subsidy. In 1989, this subsidy was $1.1 billion. By 1994, this subsidy had grown to $3.4 billion, representing over 5 percent of the prospective payment system.

Our estimate of what the disproportionate payment would be in 1995 is $3.7 billion.

In general, ProPAC has supported the disproportionate share adjustment. It has provided a very meaningful averaging and allowed institutions to survive. However, like any blunt tool, it has allowed some institutions to get this payment without providing quite the level of uninsured or uncompensated care as others.

We believe a much more focused disproportionate share payment could be devised, and we are working on that and would be glad to work with you and your staffs to see to the extent to which we

can focus those dollars more specifically at the hospitals that bear the largest burden.

The third group of hospitals that have benefited from very specific legislation by the Congress and the administration has been rural sole community hospitals. The DRG system unintentionally in the beginning did serious financial harm to rural hospitals, but over the last 10 years the Congress and the Commission has rectified that to the point that, in many communities, Medicare is the best payer for rural hospitals.

But here, too, we believe those dollars can be better focused; and we need to work with States and rural areas to make sure that we are keeping going only those hospitals that should be kept going.

Nevertheless, we at ProPAC support the continued rural adjustment, particularly for sole community hospitals—these institutions which, if they were to stop, would cause serious harm to the limited number of people that live in those areas.

One of the complicated aspects of the prospective payment system is the fact that capital which, after all, is about 10 percent of payments has now been restructured in a way that fits within the DRG system we at ProPAC support. That we believe that was a good adjustment. However, there was a mistake made in the early stages, not intentionally, but based on limited information; and there is an overpayment in the capital structure that we believe should be over time reduced; and there is substantial dollars that could be saved by focusing on reducing that payment.

There are hospitals which are excluded from PPS, children's hospitals, certain hospitals that do rehabilitation and others. These, too, can benefit—have benefited from increases in the update factor. It is not as complicated a system; and there is not as much to squeeze out here; but here, too, dollars can be better targeted.

When we shift from the inpatient to the outpatient, you are dealing with a major increase in spending. And, as I referred to back in chart 2, hospital outpatient has been growing by almost 14.3 percent per year between 1991 and 1993. Again, much of the increase is the result of volume which cannot be dealt with by just changing the payment structure. Medicare is not a high payer for outpatient services, but it is a fee-for-service outpatient system; and, therefore, some of the potential savings that the private sector has generated through managed care is lost. So here, too, we would recommend thinking seriously about developing some partial capitated or fully capitated system to benefit from reducing outpatient services.

It is only reasonable that as the hospital length of stay has fallen off, more people should use skilled nursing facilities. They are less expensive, and they target services better. However, we are getting very concerned about the growth in ancillary services that are being provided to these patients once they are in the facilities. Much of the annual spending growth of 46 percent is the result of ancillary services being given and charged on a fee-for-service basis in addition to the base payments.

We at ProPAC are completing our study, and we hope to have it done within the next several months to give you some recommendations on how you might deal with this. Again, some

growth in skilled nursing facility payments was very appropriate. But the 46 percent leaves us with significant concern.

And that brings me to the second major growth area, which is home care. Again, home care tied into a balanced delivery system makes a lot of sense. True, as we have cut back length of stay and admissions, growth in home care should have increased. But we are getting concerned, as are most others here in Washington and around the country, about growth rates which are 30, 40 and 50 percent per year. Much of the growth is in the number of visits per beneficiary, not in the price.

Medicare has a tough home payment system. You could get some reductions by limiting that payment rate, but you need to focus on controlling volume.

In another life of mine at Brandeis, we have conducted over a long period of time a demonstration which was called the Social Health Maintenance Organization System where we gave a limited number of HMOs 100 percent of the AAPCC and told them they needed to provide home care and some long-term care, as well. What that experiment clearly indicated to me was that in a managed care environment home care can be delivered much more efficiently without the growth that you have seen in the fee-for-service.

In my testimony, I have laid out other home health options. An introduction of coinsurance is possible, putting back the 100-day limit which used to exist or even putting back the prior hospitalization.

I personally don't favor putting back the prior hospitalization. I think a much better managed care environment is the way to go.

Now, finally, we, too, have looked hard at the issue of Medicare managed care. There is no question that 5 percent of the Medicare population in managed care is too low. It is growing, and what is interesting is that the people that go into managed care among seniors are as satisfied or more satisfied with their care as individuals who are under 65. That doesn't mean that managed care is for everybody, particularly for many very sick seniors, but there is much greater growth that is potentially available.

To do that, however, requires substantial changes in the law. And I would emphasize we need to change the law. We need to change the way Medicare pays for managed care, not only because it would expand the number of managed care plans coming in, which it would, but also, if we are not careful, Medicare could actually lose money by putting more people into managed care because the current system allows a Medicare beneficiary to go into managed care and then, when they get sick, to drop out of managed care and go back into the fee-for-service system. Well, that may be good for the beneficiary but just think about the program.

The program is paying an average payment which includes not sick people and sick people, and then if the sick people go back into the fee-for-service system, it offers the real potential for the managed care plans to do quite well but for the Medicare program to wind up paying too much money.

The current Medicare program pays an average amount. It has a few categories, but we are just not capable of coming up with what are called risk, really risk-adjusted premiums. So if you are

not careful you could wind up with the younger, less sick people in managed care and the older, more sick people in fee-for-service; and we have sort of blown the 5-percent savings.

Again, this need not be the result of the managed care plans doing anything. It is not that they have done anything wrong. They are just sitting there taking people who are coming in, and the people who are likely to come in are likely to be less sick and younger.

Now, if they had stayed in over their whole lifetime, they would get sick, and then the managed care plans would deal with them. But if they bought back out into the fee-for-service, Medicare could lose money. So we need to look hard at this, but that is clearly an area for future growth. And we at ProPAC are working hard to try to help you think about that.

Again, Medicare embarked on an interesting change in its payment system in 1983. For the most part, it has worked pretty well, not perfect, for inpatient hospital care, but it has not been broad enough, and it has not encompassed the kind of managed care aspects that the private sector has, and there are clearly things that we could learn from them.

Thank you, Mr. Chairman.

[The prepared statement and attachments follow:]

TESTIMONY OF STUART H. ALTMAN, PH.D.
PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Good morning, Mr. Chairman. I am Stuart Altman, Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied by Donald Young, M.D., Executive Director of ProPAC. I am pleased to testify today as you begin to consider alternative ways to control the rapid rise in Medicare spending. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

Because many new members have joined the Subcommittee since I last appeared before you, I would like to briefly describe the mandate and work of the Commission. ProPAC is an independent Congressional agency that was established in the 1983 legislation that created the Medicare prospective payment system (PPS) for inpatient hospital services. Originally, the Commission's primary responsibility was to examine issues related to PPS and provide advice for updating and improving it. Over time, Congress has expanded our mandate to include providing analyses and making recommendations concerning Medicare policies for facilities excluded from PPS and hospital outpatient, skilled nursing facility, home health, and end-stage renal disease dialysis services. In addition to an annual report containing ProPAC's recommendations, we also are required by statute to submit each year a report to Congress describing the relationships between Medicare and the American health care system. Periodically, the Congress also requests other reports concerning Medicare, Medicaid, and the changing health care system.

MEDICARE SPENDING GROWTH

Between 1992 and 1993, Mr. Chairman, Medicare spending for services furnished to its beneficiaries increased about 11 percent, to $151 billion. The Medicare population is growing faster than the general population and about 20 percent of this spending growth can be accounted for by more beneficiaries and their increased age. Inflation in the general economy, as well as additional growth in the price of medical goods and services providers purchase, also contributes to the escalation in Medicare spending. But there is one other responsible factor that I will return to frequently during my testimony: much of the recent acceleration in expenditures is due to more Medicare beneficiaries receiving more and more services each year.

As members of this Subcommittee are aware, Medicare continues to be predominantly a fee-for-service payment system. This payment method provides strong incentives for physicians and other providers to furnish more services to beneficiaries who are willing to receive them. Many of these services, however, may be of limited medical value to specific individuals. The private insurance market is responding to this problem by developing alternative payment systems based on capitation and managed care. These methods contain strong financial incentives for providers themselves to control the cost of each unit of service furnished as well as the number of service units. There also are incentives to furnish high quality care to the extent purchasers and their enrollees also consider this factor in selecting among competing plans and providers.

While more and more Medicare beneficiaries are choosing capitated, managed care plans, overall enrollment lags well behind that of the private sector. There are a number of reasons for this, several of which I will discuss in a moment. To explain all the issues involved with Medicare managed care, however, would require me to go into considerable detail and to suggest a number of changes to the Medicare law. We at ProPAC have been working on these issues, and I would welcome the opportunity to give you our thoughts at the appropriate time. You requested, however, that today I focus on changes to the existing Medicare program that might control spending growth in the short term. This I will do, but I want to emphasize that much of this growth is due to Medicare policies that encourage increases in the volume of services provided and more fundamental changes in the law are necessary to correct these incentives.

Over the past decade, the Medicare program generally has done a good job in implementing policies that controlled increases in payments for individual services. The first major change was the shift from cost-based reimbursement for inpatient hospital services to the Medicare prospective payment system (PPS). While some considered this an administrative pricing system, it also could be considered a mini-

capitated payment plan for inpatient services during each patient admission. The effects of the PPS system and other Medicare policy changes over the past decade can be seen in Chart 1. Between 1979 and 1983, real Medicare spending per enrollee--that is, adjusted for inflation--was growing faster than private health insurance expenditures per person. Medicare policies enacted in the early 1980s reversed this trend, with Medicare spending between 1983 and 1991 rising much more slowly than the private sector. Between 1991 and 1993, however, Medicare spending growth accelerated, exceeding private sector increases.

Spending increases in settings outside the hospital are partly responsible for the renewed rise in Medicare expenditures (see Chart 2). While the bulk of Medicare spending continues to be for inpatient hospital services, home health and skilled nursing facility expenditures are growing rapidly. Between 1991 and 1993, hospital inpatient spending increases averaged 10 percent annually, while payments for home health and nursing facility services grew at rates of 38 percent and 46 percent per year, respectively. As I will discuss in a moment, increases in the number of these services furnished to beneficiaries is a major contributor to this spending growth.

MEDICARE PAYMENT POLICIES

Mr. Chairman, given this brief background, I now would like to turn to a discussion of possible changes in Medicare payment policies in the short term that could alter overall spending growth. There are two broad ways of approaching these changes. The first is to apply an across-the-board reduction in the level of the update factors that determine how fast payments for each unit of service rise. The Medicare program periodically applies an update factor to the base payment amount for hospitals, skilled nursing facilities, home health agencies, and other providers. A similar reduction in update factors for all facilities could be seen as being fair, in that all providers will contribute to the slowing of Medicare spending growth. This approach, however, may fail to recognize the special needs of certain types of providers that Medicare patients rely on. Accordingly, a second approach could target slowdowns in payment growth to specific groups of facilities through differential payment updates or through refinement of other payment policies that target these facilities.

I now would like to turn to several specific suggestions on possible changes in Medicare payment policies.

PPS HOSPITALS

Medicare payments for individual PPS hospitals reflect both capital and operating expenses. For operating expenses, hospitals receive a payment based on the hospital's location and the assigned diagnosis-related group (DRG) plus additional payments if the hospital qualifies. These include special payments to teaching hospitals and hospitals that serve large numbers of low income individuals. PPS hospitals also receive additional payments for their capital costs and, for teaching hospitals, the direct costs of graduate medical education programs. PPS spending can be constrained by controlling increases in the base payment rate, the individual payment adjustments, capital payments, or a combination of approaches. The route that you choose to slow spending growth will impact hospitals differentially, depending on their current level of overall Medicare payments and the degree to which they rely on the additional payments. Many of the options that I am going to discuss would affect the same groups of hospitals, and therefore the impact on access to care for Medicare beneficiaries of the total package of spending changes also must be carefully assessed.

Limiting the Increase in the PPS Update Factor

Since the third year of PPS, the increase in the annual update factor has been less than the rise in the market basket index that measures the rate of inflation in the prices of goods and services hospitals purchase. Inpatient hospital payments per case, however, have grown somewhat faster than the market basket as hospitals submitted bills for more complex and costly patients (see Chart 3). Until recently,

however, hospital costs have grown even faster than payments. As a result, hospital PPS margins (or profits) have been negative since 1990 (see Chart 4).

The overall financial effect of Medicare's update policies is related to hospitals' ability to reduce cost growth or to obtain additional revenue. Until recently, instead of reducing costs as Medicare (and Medicaid) constrained payments, hospitals responded by increasing revenues from private payers. Consequently, in 1992 hospitals spent $26 billion more than they received from public payers for the costs of furnishing services to Medicare, Medicaid, and uninsured patients. In the same year, they received $29 billion more from private payers than their costs of providing care to privately insured patients.

More recently, increasing price competition in the health care market place is affecting the ability of many hospitals to obtain excess revenues from private payers to subsidize losses from government programs. Many hospitals are responding to these market pressures by reducing costs. Hospital cost growth began to fall dramatically in late 1992, and the decline is continuing (see Chart 5). Prior to 1993, real hospital costs per case--that is, adjusted for inflation--were growing about 4.7 percent annually. In 1993, this rate dropped to 1.7 percent. This downward trend continued in the first nine months of 1994, with the change in real costs actually becoming negative.

This dramatic decline in cost growth must be considered as Medicare determines its update policies. Current law sets the PPS update factor at 2 percentage points less than the market basket for fiscal year 1996. The update factor is scheduled to increase by the market basket minus 0.5 percentage points in 1997 and by the full market basket in 1998. If the current cost slowdown continues, the updates scheduled under current law would be higher than anticipated cost increases.

Consequently, you may wish to continue with an annual update factor at 2 percentage points less than the market basket beyond 1996. You could then examine this factor each year and adjust it further if hospital cost reductions continue.

Currently, the financial condition of the average hospital continues to be good, although many individual hospitals are experiencing financial distress. A number of these hospitals treat large numbers of Medicare beneficiaries, as well as Medicaid and uninsured patients. These facilities have a limited ability to obtain surplus revenues from private payers to cover losses from the care of their other patients. The effects on Medicare beneficiaries served by these hospitals, therefore, must be considered as we examine alternative ways to slow spending growth.

Reducing Differences in Base Payment Amounts

The payment each PPS hospital receives for each case is determined by the hospital's standardized payment amount (SPA) and the relative weight of the assigned DRG (diagnosis-related group), together with certain adjustments and additional payments. When PPS was implemented, there were two standardized payment amounts, one for rural areas and one for urban areas. Subsequently, Congress split the urban hospitals, creating one SPA for hospitals located in metropolitan statistical areas (MSAs) with populations of 1 million or more (called large urban areas), and another SPA for all other urban hospitals. In fiscal year 1995, the difference between the large urban and the other urban SPAs is about 1.6 percent.

In OBRA 1990, Congress mandated a phase-out of the differential in the SPA between rural and other urban hospitals. This phase-out was completed in 1995. Consequently, there are now only two SPAs, one for large urban areas and one for all other areas. Congress could consider phasing-out the differential between the large urban and the other standardized amounts. This differential was put in place in the early years of PPS, to recognize the slightly higher costs of hospitals located in large urban areas. Since that time, many of these hospitals have benefitted from increases in the disproportionate share adjustment and from the teaching adjustment. Payments to these hospitals account for 53 percent of all PPS payments (see Chart 6). They also receive 74 percent of IME payments and 61 percent of DSH payments. In 1992, their PPS margins were a full percentage point better than that for all hospitals combined (see Chart 7). It also should be recognized, however, that because of the

patient populations many of these large urban hospitals treat, their total margins were less than average.

Reducing Growth in Payments for Medical Education

The Medicare program provides extra payments to hospitals with graduate medical education programs. There are two types of these payments. First, teaching hospitals receive an adjustment to their PPS payments to reflect the added patient care costs associated with operating a teaching program. This indirect medical education (IME) adjustment will account for about 5.3 percent of total PPS operating payments in fiscal year 1995, or about $3.7 billion. Medicare also pays teaching hospitals an additional amount, separate from the PPS payments, for the direct costs of maintaining graduate medical education programs. These payments (referred to as GME payments) cover resident salaries and benefits, the salaries of supervising physicians, office space, and other overhead. These payments are expected to total $1.4 billion in 1995. I will first discuss the IME adjustment and then return to GME payments.

The amount of the IME adjustment depends on a hospital's teaching intensity, measured by the number of interns and residents per bed. Currently, payments increase about 7.7 percent for each 10 percent increase in teaching intensity. Each year, ProPAC estimates the relationship between teaching intensity and standardized Medicare operating costs per discharge. The most recent analysis indicates that, on average, a 10 percent increase in teaching intensity is associated with a 4.5 percent increase in Medicare operating costs per discharge.

As we have reported to you previously, since PPS began, the Medicare program has more than adequately compensated teaching hospitals for the costs of treating Medicare patients. In 1992 major teaching hospitals, those with 25 or more interns and residents per 100 beds, had the highest PPS margins of any group of hospitals. Their total margins, however, were among the lowest of any group, related in part to the large amount of uncompensated care many of these hospitals furnish. The PPS and total margins for other teaching hospitals were similar to the average for all hospitals.

This year, as we have for several years, we are recommending a reduction in the IME adjustment. We recommend lowering the adjustment in 1996 from 7.7 percent to 6.7 percent for each 10 percent rise in the number of interns and residents per bed. This is equivalent to a 13 percent reduction in the amount of IME payments. This reduction is the first phase of a three year plan which will bring the teaching adjustment in line with the amount our analyses suggest is appropriate. We have chosen this phasing approach to allow teaching hospitals time to adjust to the large reduction in payments this would represent. The Commission also is concerned that accelerating price competition in the private sector is reducing the ability of teaching hospitals to obtain the higher patient care rates from other payers that traditionally have contributed to financing the costs of medical education. While we are not suggesting that all of these costs should continue or that all of the current payments are necessary, we believe that this country should also consider an alternative financing system for graduate medical education.

As I indicated, Mr. Chairman, Medicare also pays teaching hospitals a share of the direct costs of maintaining graduate medical education programs. These GME payments are based on a hospital's per resident costs in a base year, updated to the current year. Hospital-specific per resident costs in 1990 ranged from less than $10,000 to more than $100,000. Consequently, Medicare per resident payments also vary widely across teaching hospitals. Payments also differ if the resident is in an initial residency or in a second residency, or in a primary care or specialty program. GME payments have increased in recent years, as the number of residents has grown.

There are a number of ways Congress could slow the growth in spending for GME. For example, it is not clear that the value to Medicare of the increasing number of residents is worth the cost. One approach would be to set a cap on total GME payments related to the number of residents in a base year. If the number of

residents increases, then payments per resident would be reduced to keep the pool constant.

As I noted, there are large variations in per resident payments across teaching programs. Another option, therefore, is to set an upper limit on the amount of the payment per resident. The annual update in per resident payments could also be reduced for specialty residents or for all residencies. In addition, Medicare could restrict payment to only one period of residency training or to a certain number of years of training.

Targeting Payments to Disproportionate Share Hospitals

Hospitals that treat a disproportionate share of low income patients also receive an adjustment to their PPS payments. Many of these hospitals experience difficulties recruiting physicians and other staff, meeting the special needs of their patients, and obtaining sufficient revenue to cover the costs of caring for large numbers of individuals without insurance. The DSH adjustment is intended primarily to help assure access to care for Medicare beneficiaries who rely on these hospitals. In contrast to the IME adjustment, the DSH adjustment is not closely tied to additional Medicare operating costs per discharge, except for large urban hospitals.

In the Omnibus Budget Reconciliation Acts (OBRA) of 1989 and 1990, Congress substantially increased the amount of DSH payments. In 1989, these payments were $1.1 billion, representing 2.4 percent of PPS operating payments. In 1994, they are expected to be $3.4 billion and to account for 5.1 percent of PPS payments (see Chart 8). In 1995, DSH payments will rise to an estimated $3.7 billion.

Some hospitals, however, benefit from these extra payments without bearing the same burden in terms of financial losses as other hospitals. For example, disproportionate share hospitals in large urban areas have the lowest average total margin and the highest share of negative margins of any group of hospitals. In contrast, disproportionate share hospitals in other urban and rural areas have much higher than average total margins.

One approach the Congress can consider is scaling back the substantial expansions in DSH payments that were enacted in 1989 and 1990 and better targeting the available funds to those hospitals with the largest share of low income patients that are essential to maintain access for Medicare beneficiaries.

Targeting Payments to Sole Community Hospitals

Sole community hospitals (SCHs) are considered to be the main source of care for a geographically isolated population. SCHs are paid the higher of the applicable PPS payment or their hospital-specific costs in 1982 or 1987, updated to the current year. About 60 percent of SCHs currently receive payment based on their hospital-specific base year costs. In addition, other Medicare policies allow many of these hospitals to qualify for DSH payments under policies applicable to urban hospitals.

About 600 hospitals are designated as SCHs. The PPS margins for these hospitals have increased substantially as a result of recent changes in Medicare policies. The overall financial condition of these hospitals also is better than the average hospital (see Chart 7).

Many of the hospitals that receive special treatment under the SCH provisions are not truly isolated, because they were "grandfathered" when the current designation criteria were implemented. The Congress may wish to limit the special treatment for SCHs to those that are truly isolated and serve as the only available hospital for Medicare beneficiaries residing in remote areas.

Correcting for Capital Cost Overestimates

The costs hospitals incur to acquire capital were excluded from PPS when it was implemented beginning in late 1983, with payments continuing on a reasonable cost basis. In fiscal year 1992, hospitals began a 10 year transition to a fully prospective payment system for capital. During the transition, each hospital's capital payment is based on one of two methods. The determination of the method as well as the

amount of payment to each hospital is based in part on a comparison of each facility's "hospital-specific rate" (updated base year capital costs) and the adjusted "Federal rate" (a national average capital cost per discharge).

The base year capital costs were estimated using the best data available at the time. Similar data was also used to project the expected growth in capital costs from the base year to 1992, the first year of the capital transition. In fact, we now know that actual hospital capital costs were less in the base year than was estimated. In addition, the updates applied to inflate the rates to 1992 also were too high. Consequently, both the hospital-specific rate and the Federal rate are higher than they would have been if actual data had been available. In OBRA 1993, Congress partially corrected for the overestimates by reducing the Federal rate. Both the hospital-specific rate and the Federal rate, however, continue to be higher than intended. Congress may wish to reduce the level of both rates to bring them in line with actual base year costs and actual capital cost growth prior to the beginning of the transition.

EXCLUDED HOSPITALS

Certain specialty hospitals and distinct-part units of general hospitals are excluded from PPS, if they meet certain requirements. These facilities include psychiatric and rehabilitation hospitals and distinct-part units, as well as children's, long-term care, and cancer specialty hospitals.

Each excluded provider is paid on the basis of its current Medicare allowable inpatient operating costs or a target amount. The target amount is based on the provider's costs per discharge in a base year, updated to the current year by an annual update factor. This payment mechanism rewards providers that keep their costs below the target amount and penalizes those that exceed the amount.

From 1989 to 1993, a market basket measure of price increases was used to update the target amount for these facilities. In OBRA 1993, Congress reduced the update factor by up to one percent for certain facilities for fiscal years 1994 through 1997.

These facilities account for a small share of total Medicare spending, although this share has been growing rapidly as more beneficiaries use these services. Congress could slow spending growth modestly by further reducing the annual update factor. They could also apply the reduced update to all facilities.

HOSPITAL OUTPATIENT SERVICES

Mr. Chairman, I would like to turn now to Medicare reimbursement for hospital outpatient services. Because of its rapid growth--14 percent in 1993--hospital outpatient spending is an increasing share of total Medicare expenditures. For the past several years, the Commission has recommended a correction to the formula that determines hospital outpatient payments for ambulatory surgery, radiology, and other diagnostic services that would generate significant savings.

Currently, hospitals are reimbursed for these services based on a formula that incorporates the hospital's costs and charges, and a prospective rate. Medicare program payments are then reduced to reflect beneficiary coinsurance. The problem, Mr. Chairman, is that the beneficiary coinsurance is not based on Medicare's payment but on each hospital's charges. Hospital charges are about two times higher than Medicare payments, according to HCFA estimates. Thus, the beneficiary coinsurance is significantly more than the traditional 20 percent of payments. Because the Medicare payment formula does not fully offset these higher beneficiary copayments, hospitals end up receiving more than Congress intended.

While correcting this formula-driven overpayment could generate significant savings, ProPAC has recognized that beneficiary payments representing 50 percent or more of total payments also is not what Congress intended. The Commission believes that these amounts could be reduced by linking the coinsurance payment to an estimate of payments, rather than charges. We are aware that correcting this flaw would increase Medicare outlays and, therefore, have recommended that the savings

achieved by correcting the payment formula should be used to reduce the excessively high beneficiary copayments.

SKILLED NURSING FACILITY SERVICES

Mr. Chairman, I next would like to turn to Medicare's post-acute benefits--skilled nursing care and home health services. The Medicare skilled nursing facility (SNF) benefit is intended to be an extension of a hospital stay, at a lower level of care. As I mentioned previously, Medicare spending for SNF services is escalating rapidly. This growth is related to the rising number of beneficiaries using SNF services and increases in the number of days per person served (see Chart 9). These increases are due in part to decreasing lengths of stay in the inpatient hospital setting. Spending growth has also increased recently due to substantial increases in average daily SNF reimbursement (see Chart 10). ProPAC is examining this recent growth. We believe it may be related to a surge in the number of ancillary services being furnished and billed for separately from the routine per diem payment.

SNFs are paid their costs for routine per diem operating expenses, subject to a limit. A separate payment is made to cover capital costs. In addition to these payments, skilled nursing facilities receive reasonable costs (without limits) for the ancillary services provided to patients receiving SNF-level care. They also may bill under Part B of Medicare for ancillary services furnished to inpatients who have exhausted Part A benefits or to outpatients.

Currently, free-standing skilled nursing facilities are paid the lower of their costs or 112 percent of the average per diem costs for urban or rural providers during a base year period. Hospital-based facilities receive a higher limit that is based on a combination of the free-standing limit and 112 percent of the average costs for all hospital-based facilities. These limits are periodically updated.

OBRA 1993 froze the SNF cost limits for fiscal years 1994 and 1995. Congress could continue to freeze or limit the increase in per diem cost limits for these facilities. An alternative is to reduce the cost limit level from the current 112 percent to a lower amount. Another option to slow spending growth would be to reduce or eliminate the differential between hospital-based and free-standing limits. I need to note again, Mr. Chairman, that while these changes would slow the growth in per diem payments, they would have little impact on the increase in utilization that is primarily responsible for driving up spending. We will provide you with the findings from our examination of the increasing ancillary usage as soon as possible.

HOME HEALTH CARE

Home health services are the fastest growing spending category in the Medicare program. As I mentioned earlier, increases in the number of beneficiaries who use this benefit and the number of services they receive are responsible for almost all of this growth (see Chart 11). The number of beneficiaries using this benefit has doubled over the past 10 years. In addition, the average number of services used by each of these individuals has increased by almost one-fourth in just the last two years.

To qualify for the home health benefit, beneficiaries must be confined to the home, be under the care of a physician who prescribes home care, and require either intermittent skilled nursing or physical therapy services. Prior to OBRA 1980, Medicare required beneficiaries to have been in the hospital for a minimum of three days prior to receiving the home health service. Medicare also limited the number of visits to 100 per year. Since then, there has not been a hospitalization requirement or a limit on the number of visits a beneficiary may receive.

Medicare reimburses home health agencies their costs for the services they provide, subject to a limit. Each of the six types of services has a separate limit that is based on 112 percent of the mean cost per visit for all providers. An aggregate limit is then set for each agency that equals the limit for each type of service multiplied by the number of visits of each type provided by that agency. Separate limits are set for rural and urban providers. The cost limits are updated annually using the home health market basket and adjusting labor costs by the current hospital wage index. As

you can see, Mr. Chairman, this reimbursement scheme encourages these facilities to increase the number of visits they provide.

Over the past several years, Congress has attempted to rein in spending for home health care. The cost limits have been reduced from 120 percent to 112 percent of the mean cost per visit, the annual increases in the limits were frozen for fiscal years 1994 and 1995, and the administrative and general add-ons for hospital-based providers were eliminated.

While the Congress could reduce the cost limits per visit from 112 percent of the mean to a lower limit or continue to freeze or restrain the annual update, these actions will not address the fundamental factor driving spending growth, which is the increased utilization of services.

Similar to the Medicare SNF benefit, home health care was intended originally to be a post-acute benefit. Congress could change the current nature of the benefit and return to the policies that were in place prior to the 1980 law. That is, it could place a limit on the number of visits that a beneficiary could receive. Alternatively, a more formal managed care system could be developed to accomplish this goal. In 1992, 6.3 percent of all Medicare beneficiaries used home health services. The average number of visits per person was 54, although half of the beneficiaries used less than 25. On the other hand, almost 18 percent of the users had more than 100 visits and 10.8 percent of the users had over 150 visits (see Chart 12).

Congress also could return to the prior hospitalization requirement for beneficiaries to be eligible to receive home health services. Because the use of this benefit is growing so rapidly, it is difficult to get good data on the number of beneficiaries that have a hospitalization prior to using home health services. An analysis by ProPAC using 1990 data indicated that about 40 percent of users did not have a hospital stay within 30 days. A more recent analysis by HCFA indicated this proportion had increased to about 70 percent.

A final option that has been previously considered is to institute a copayment. Unlike hospital, nursing facility, or physician services, the beneficiary does not have any responsibility to share in the rapidly growing costs of this benefit. If Congress were to consider this option, there would be other questions to address. These include determining the amount of the copayment and whether it would apply from the first visit or after a certain number of visits.

The average reimbursement per home health visit in 1994 is estimated to be about $63. A copayment of 10 percent from the first day for 100 visits would total $630. This amount is less than the deductible for an inpatient hospital stay in 1994. If Congress decides not to require a prior hospital stay, an alternative would be to require a copayment only for users who did not have a prior stay.

MEDICARE MANAGED CARE

As I have described, much of the growth in Medicare spending is due to increases in service use inherent in Medicare's fee-for-service policies. While some of the growth can be slowed by tightening up on current policies, other approaches are necessary in the long term. Increasingly, private sector payers are turning to managed care as a way of controlling their rising health care expenditures. Managed care plans rely on a limited number of providers and capitated payment rates to manage both the price and volume of services.

Medicare offers beneficiaries the option of enrolling in a risk-based managed care plan that is similar to private sector managed care. Overall enrollment in these plans has risen slightly since the late 1980s, from 3 percent of the Medicare population in 1988 to almost 5 percent in 1994 (see Chart 13). While these figures lag behind the 19 percent enrollment rate in the general population, in several states, such as California and Arizona, almost 25 percent of Medicare beneficiaries are enrolled in risk plans. At the other end of the spectrum, states such as Alabama and Mississippi have virtually no Medicare managed care.

The Medicare risk program has the potential to reduce Medicare spending. Under its risk program, Medicare pays plans 95 percent of fee-for-service payments in a local

area. In addition, volume is controlled because Medicare pays a fixed amount for each enrollee, regardless of the number or type of services delivered.

Under current law, however, Medicare may be paying too much for its managed care program. Studies of the risk contracting program to date indicate that Medicare savings have not been realized. The reasons are complicated, but relate to the methodology used by Medicare to pay managed care plans (including the absence of an adequate way to measure risk and set appropriate levels for the capitated rates) and the ability of plans to enroll healthier individuals. In addition, the requirement that all Medicare beneficiaries be allowed to disenroll from a plan with 30 days notice opens the possibility that enrollees will stay in a plan until they get really sick and then switch to the fee-for-service system to obtain maximum flexibility to choose their providers. This legal mandate also impairs the continuity of care offered by a plan. ProPAC is currently analyzing a number of these issues, including the Medicare payment formula and its relationship to private sector payment levels.

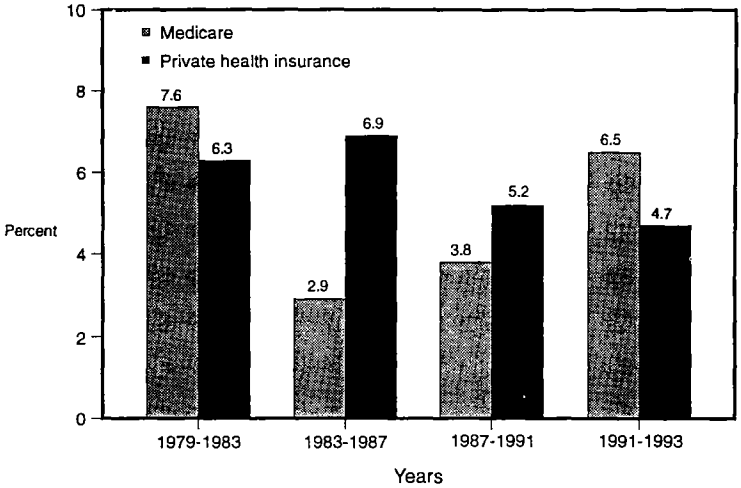
Managed care represents a fundamental change in the way Medicare services are delivered and paid. Currently, beneficiaries have a large choice of providers who are paid on a fee-for-service basis. While managed care controls volume-related spending increases, it also limits beneficiary choice as to the number of participating providers. Increasingly, however, beneficiaries are choosing this option and the satisfaction rate among those who choose managed care is very high. Other policy changes are needed to enhance the attractiveness of this program. The Commission believes that enhancing the opportunity for Medicare beneficiaries to select managed care and improving its payment methods has the potential to slow Medicare spending growth and to improve the quality of care for beneficiaries.

CONCLUSIONS

Mr. Chairman, today I have suggested a number of areas that the Congress could consider for reducing Medicare spending growth in the short term. These approaches parallel past practices of modifying the payment level for specific services furnished by specific providers. I must caution, however, that the Medicare program may be nearing the limits of its ability to slow spending increases using these methods. Over time new strategies are necessary to control increases in the volume of services that are characteristic of fee-for-service payment systems. Managed care may be one option. The challenge is to make short-term adjustments that will set the stage for these long-term goals and strategies.

The Commission would be pleased to work with you and your staff as you struggle with both short and long-term options for controlling the growth in Medicare spending. This completes my testimony, Mr. Chairman. I would be pleased to answer any questions you and the members of the Subcommittee have.

Chart 1. Real Change in Medicare Expenditures Per Enrollee and Private Health Insurance Per Member, 1979-1993 (In Percent)



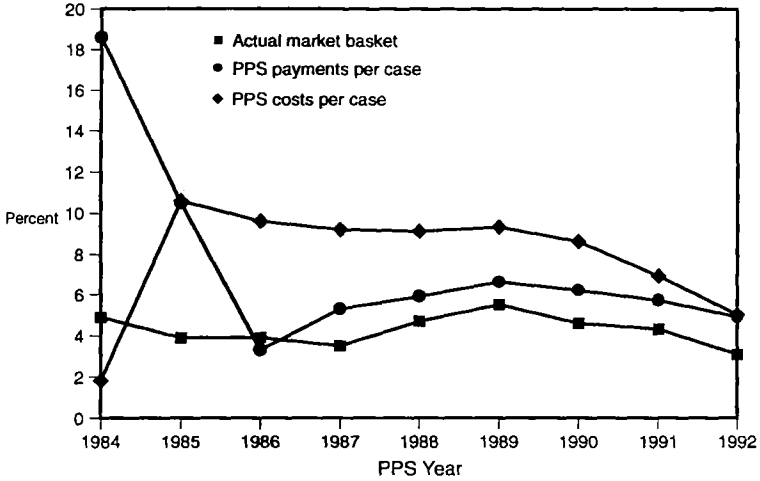
SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of the Actuary.

Chart 2. Medicare Benefit Payments, by Sector, 1991 and 1993 (In Millions)

Sector	1991 Expenditures	1993 Expenditures	1993 Share of Total	Annual Percent Change 1991-1993
Total Medicare benefits	$120,497	$151,101	100.0%	11.8%
Hospital inpatient	65,123	79,012	52.3	10.1
Hospital outpatient	8,342	10,897	7.2	14.3
Physician	31,380	34,817	23.0	5.3
Home health	5,695	10,862	7.2	38.1
Nursing home	2,859	6,124	4.1	46.4
Other	7,096	9,388	6.2	15.0

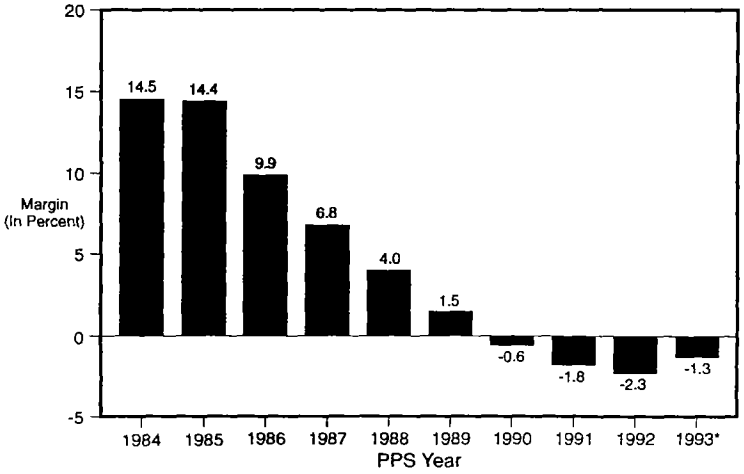
SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of the Actuary.

Chart 3. Annual Increase in Actual Market Basket and PPS Payments and Costs Per Case, First Nine Years of PPS



SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

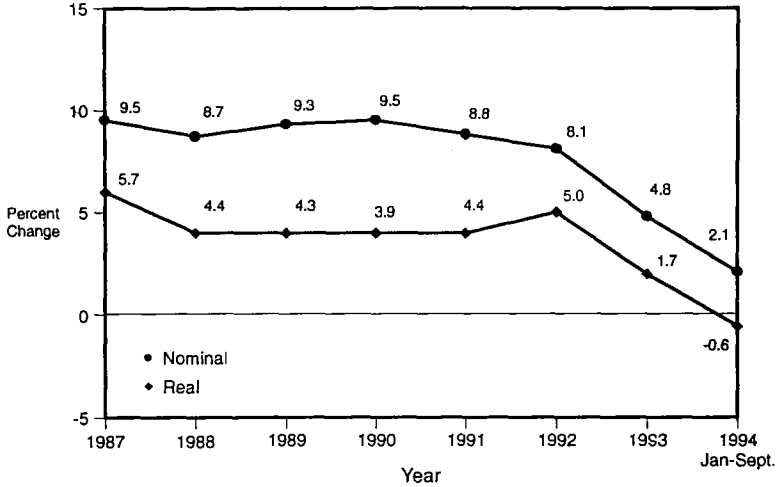
Chart 4. PPS Margins for All Hospitals, First Ten Years of PPS



* Preliminary data based on non-representative subset of all hospitals.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 5. Annual Change in Hospital Cost Per Adjusted Admission



Note: Value for January to September 1994 compared with same months in 1993.
SOURCE: American Hospital Association National Hospital Panel Survey.

Chart 6. Distribution of PPS Hospitals, Discharges, and Payments by Hospital Group, FY 1994

Hospital Group	Number of Hospitals	Percent of Discharges	Percent of Payments	Payments (In Billions) Total	IME	DSH
All hospitals	5,251	100%	100%	$66.0	$3.8	$3.4
Urban	2,932	80	87	57.5	3.7	3.2
Rural	2,319	20	13	8.5	0.0	0.2
Large urban	1,609	45	53	35.2	2.8	2.1
Other urban	1,323	35	34	22.3	0.9	1.1
Rural referral	246	7	5	3.4	0.0	0.1
Sole community	576	3	2	1.4	0.0	0.0
Other rural	1,497	10	6	3.7	0.0	0.0
Major teaching	229	10	17	11.2	2.4	1.1
Other teaching	801	32	34	22.8	1.4	1.1
Non-teaching	4,221	59	49	32.1	0.0	1.1
DSH large urban	727	21	28	18.6	2.0	2.1
DSH other urban	621	19	19	12.8	0.7	1.1
DSH rural	458	5	4	2.4	0.0	0.2
Non-DSH	3,445	55	49	32.2	1.1	0.0
IME and DSH	609	24	32	21.1	2.7	2.2
IME only	421	18	19	12.9	1.1	0.0
DSH only	1,197	22	19	12.7	0.0	1.1
No IME or DSH	3,024	37	29	19.4	0.0	0.0
New England	225	6	6	4.1	0.4	0.1
Middle Atlantic	538	17	20	13.2	1.2	0.8
South Atlantic	749	17	16	10.6	0.4	0.6
East North Central	804	18	17	11.3	0.8	0.4
East South Central	459	8	7	4.4	0.1	0.3
West North Central	742	8	7	4.8	0.3	0.1
West South Central	740	10	9	6.1	0.2	0.4
Mountain	348	4	4	2.7	0.1	0.1
Pacific	646	11	13	8.8	0.3	0.6
Voluntary	3,006	74	76	50.0	3.0	2.2
Proprietary	751	12	11	7.1	0.1	0.3
Urban government	434	8	10	6.4	0.7	0.7
Rural government	1,024	6	4	2.4	0.0	0.1

SOURCE: ProPAC estimates based on ProPAC PPS payment model and fiscal year 1992 MedPAR file from data from the Health Care Financing Administration.

Chart 7. PPS Operating Margins and Total Hospital Margins, by Hospital Group, 1992 (In Percent)

Hospital Group	PPS Margin	Percent w/ Negative Margin	Total Margin	Percent w/ Negative Margin
All hospitals	-2.3%	59.4%	4.3%	25.7%
Urban	-2.2	61.6	4.1	28.2
Rural	-3.0	56.7	5.0	23.7
Large urban	-1.3	59.3	3.5	25.9
Other urban	-3.6	64.3	5.2	21.1
Rural referral	-0.1	49.2	6.3	12.0
Sole community	-1.1	49.7	5.0	28.0
Other rural	-5.6	60.8	4.2	30.6
Major teaching	8.6	24.4	3.0	25.5
Other teaching	-2.4	59.9	4.3	23.2
Non-teaching	-6.0	61.2	4.8	26.2
Disproportionate share:				
Large urban	4.2	45.5	2.8	30.8
Other urban	-1.4	58.2	5.3	17.9
Rural	-1.2	47.5	6.8	20.1
Non-disproportionate share	-7.0	64.7	4.6	27.1
Payment adjustments:				
IME and DSH	4.5	41.8	3.5	26.0
IME only	-5.1	68.6	4.6	19.8
DSH only	-3.1	54.6	4.9	22.2
No IME or DSH	-8.3	64.1	4.7	28.0
Voluntary	-2.5	60.8	4.0	24.1
Proprietary	-2.1	54.6	5.7	27.6
Urban government	0.9	57.4	4.5	25.7
Rural government	-5.4	58.7	5.1	30.6

Note: Data for hospital cost reporting periods beginning during Federal fiscal year 1992. Excludes hospitals in Maryland and other hospitals with waivers from PPS. IME = indirect medical education. DSH = disproportionate share.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 8. Medicare Indirect Medical Education (IME) and Disproportionate Share (DSH) Payments, 1989-1994 (In Billions)

	IME Payments		DSH Payments	
Fiscal Year	Amount (In Billions)	Percent of Total PPS Payments	Amount (In Billions)	Percent of Total PPS Payments
1989	$2.2	4.8%	$1.1	2.4%
1990	2.5	5.3	1.6	3.3
1991	2.9	5.5	2.2	4.1
1992	3.1	5.7	2.2	4.0
1993	3.7	5.6	2.7	4.1
1994	3.8	5.7	3.4	5.1

SOURCE: Prospective Payment Assessment Commission, *Medicare and the American Health Care System Report to the Congress*, June 1989, 1990, 1991, 1992, 1993, and 1994.

Chart 9. Medicare Skilled Nursing Facility Utilization, 1980-1994

Year	Persons Served: Number (In Thousands)	Persons Served: Per 1,000 Enrollees	Days: Number (In Thousands)	Days: Per Person Served
1980	257	9	8,645	33.6
1981	251	9	8,518	33.9
1982	252	9	8,814	35.0
1983	265	9	9,314	35.1
1984	299	10	9,640	32.2
1985	314	10	8,927	28.4
1986	304	10	8,160	26.8
1987	293	9	7,445	25.4
1988	384	12	10,667	27.8
1989	636	19	27,780	43.7
1990	638	19	25,200	39.5
1991	671	20	23,700	35.3
1992	785	22	28,960	36.9
1993	870	24	34,437	39.6
1994*	925	25	36,865	39.9

* Estimated

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 10. Skilled Nursing Facility Reimbursement Per Day

Year	Reimbursement	Annual Rate of Increase
1980	$47.5	—
1982	55.8	8.4%
1984	58.2	2.1
1986	70.9	10.4
1988	86.7	10.6
1990	98.4	6.5
1992	148.1	22.7
1994*	207.3	18.3

* Projected

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 11. Medicare Home Health Care Utilization, 1980-1994

Year	Persons Served: Number (In Thousands)	Persons Served: Per 1,000 Enrollees	Visits: Number (In Thousands)	Visits: Per Person Served
1980	726	26	16,322	22.5
1981	948	34	22,688	23.9
1982	1,154	40	30,628	26.5
1983	1,318	45	36,898	28.0
1984	1,498	50	40,422	27.0
1985	1,549	51	39,449	25.5
1986	1,571	51	38,000	24.2
1987	1,544	49	35,591	23.1
1988	1,582	49	37,132	23.5
1989	1,685	51	46,199	27.4
1990	1,940	58	69,565	35.9
1991	2,223	65	100,044	45.0
1992	2,523	72	134,844	53.4
1993	2,900	81	173,953	60.0
1994*	3,220	88	209,149	65.0

* Estimated

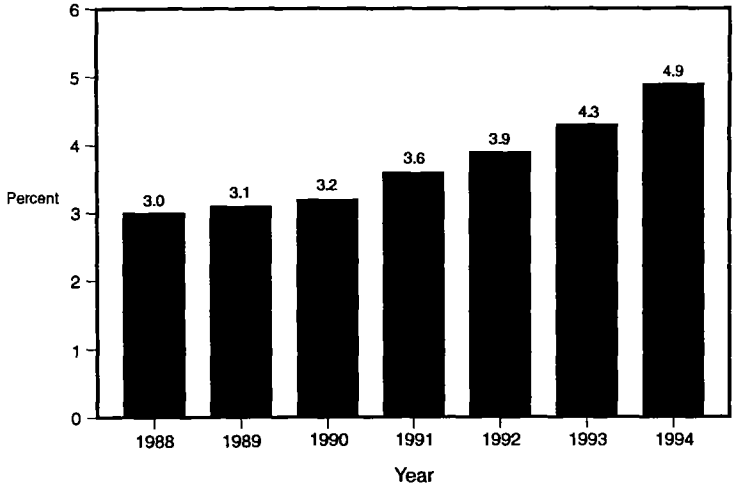
SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 12. Distribution of Visits Across All Home Health Users, 1992 (In Percent)

Number of Visits	Percent of Users
1-20	45.2%
21-40	19.2
41-60	8.9
61-80	4.6
81-100	4.4
101-125	4.1
126-150	2.8
151-175	2.2
176-200	2.3
Over 200	6.3

SOURCE: Health Care Financing Administration, Office of Research and Development.

Chart 13. Medicare Beneficiaries Enrolled in Managed Care Risk Contracting Programs, 1988-1994 (In Percent)



SOURCE: Health Care Financing Administration, Office of Managed Care.

Chairman THOMAS. Thank both of you very much. And, obviously, we have gone far beyond the usual 5-minute rule. But the points that you gentlemen have made after many years of examining the system in terms of alternatives, I believe are extremely important in enlightening and laying the groundwork for the additional panel members who will be held to the 5-minute rule and the members.

According to my notes, the first member to inquire will be Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

Maybe both of you can address this a little further.

Volume increase seems to be the primary problem, as both of you clearly pointed out. Mr. Altman, you gave a couple reasons in the home health care and skilled nursing care, but maybe you can go further into some of the other underlying reasons why we are seeing such a tremendous increase in the volume. You mentioned it wasn't necessarily the increase in the age of the population, but what are some other reasons for this increase in the volume?

Mr. ALTMAN. We have had some subtle and some not-so-subtle changes in coverage rules over the last several years, partly generated by court decisions that required the Medicare program to liberalize their definition of who qualifies for home care, as well as freeing up the ability to go into a skilled nursing facility and stay there. I would think that, as much as anything, has led to the growth in the home care and skilled nursing care.

And, as I said, it was generated by the courts that said, basically, Medicare could not put in the restrictions that it had previously had. And so it sort of opened up the floodgates to the ability of individuals who—I am not saying they don't need it. The question is whether the need was as strong or is as strong as it might be, given the fact that this is an expensive service.

Chairman THOMAS. Dr. Eisenberg, could you address the rest of the system as well, some of the growth in volume?

Dr. EISENBERG. As we have looked at this, we have described seven different reasons for the volume increasing. One of them—two of them I have mentioned. One is the increase in the number of beneficiaries, 1.5 to 2 percent per year; the second is the increasing in the aging of the population. That is about 1 percent. The substantial part of the increase we believe has to do with the services that result from incentives in the fee-for-service payment system.

The third factor is the way in which the payment system is still constructed. Even though we are moving away from it, it is a system which pays more relatively for providing procedural services than for not providing those services. And so there is an incentive for physicians to provide those services just because of the way in which the rewards are set up in the fee-for-service system.

The fourth reason, which is related to that, is that physicians are able to increase the demand for their services—it is called induced demand—if they believe that more services might be justified or even if they are questionable. And in an unconstrained fee-for-service world, that has been a factor that has led to increases.

Technology is another. Technology cuts both ways, interestingly. We believe that one of the reasons why the rate of increase re-

cently has been slowed is because of technological changes that have occurred in prostate surgery and cataract surgery, which have led during the past few years to a decrease in expenditures.

So technology can cut both ways, but usually it is a driver for increased volume. And a careful look at that technology and the way in which it is disseminated and the way in which it is used we believe could address that factor—for example, guidelines on appropriateness or outcomes research.

Another factor has to do with consumer cost sharing. At present, most Medicare beneficiaries have some kind of a Medigap policy and pay very little out of pocket. We are concerned about striking the right balance between not having beneficiaries liable for large expenditures that would bankrupt them, but on the other hand, having some fiscal responsibility on the part of the recipient.

Mr. ENSIGN. We have heard a lot about Medisave accounts in the context of the Medicare population. Do you see any way that the Medisave accounts can be incorporated into the Medicare population so there is incentive for them to shop?

Dr. EISENBERG. I think that the concept of the MSA, which enables the individual to put aside a certain amount of money so that the discretionary expenses which I am alluding to could come out of their own pocket, would probably be beneficial in that it would give them a deeper pocket effectively to pay for those expenditures, so long as there is some—we want to eliminate the possibility of catastrophic expenses or large expenses for those individuals.

It would take some time to build up an MSA that would be capable for paying for one hospitalization or one large procedure, so I think we would need to look with you at what the size of that MSA would be and what the risk ought to be, what the power ought to be, where the individual is protected against larger expenditures. I think it would be helpful.

Mr. ENSIGN. Thank you, Mr. Chairman.

Dr. EISENBERG. The last factor is the overcapacity of the system.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Mr. Stark will inquire.

Mr. STARK. Thank you, Mr. Chairman.

I would like to thank the witnesses. I just wanted to talk a little bit here about the numbers and the growth, just to make sure that we are all reading from the same page.

I'd like to ask Dr. Eisenberg and Dr. Altman both, it is my understanding that in the period from 1984 to 1993, as a comparison of private health insurance versus Medicare per enrollee, the annual rates of growth were lower for Medicare to hospitals, 6.1 to 7.7.

Do you agree with that Dr. Altman?

Mr. ALTMAN. If you go from the full period from——

Mr. STARK. 1984 to 1993, the annual rates of growth.

Mr. ALTMAN. I think if you added all them in, those three periods we have in chart 1.

Mr. STARK. I am just quoting from Bruce Lattig's stuff here from Health and Human Services on the annual rates of growth for private health insurance versus Medicare per enrollee.

Mr. ALTMAN. Is that for all services? I don't have——

Mr. STARK. Let me say that again. It is for hospital.

Mr. ALTMAN. Yes. I don't think there is any question that on the hospital side, the growth rate for Medicare—over that whole period has been less.

Mr. STARK. Thank you, and the same thing is true for physician reimbursement, Dr. Eisenberg. I have 7.9 percent for Medicare versus 11.2 percent for private.

Does that ring correct with you?

Dr. EISENBERG. 11.2 percent in which period?

Mr. STARK. 1984 to 1993, the last 10-year period for which we have numbers, that the private health insurance versus Medicare per enrollee, that the growth in expenditures was 7.9 percent for Medicare and 11.2 percent for private insurance.

Does that comport with your figures?

Dr. EISENBERG. It sounds right. I don't have the data in front of me.

Mr. STARK. What I am trying to do here is just reclaim a little of Medicare's rightful credit for being what I will call the most efficient health reimbursement system in the United States today.

I want to take it a piece at a time. There are some flaws, no question, but it is my understanding that the recent unusual growth that we have had in the last 2 years has been largely on the side of home health care in skilled nursing facility services, not in physician-hospital reimbursement.

Would both of you agree with that premise?

Dr. EISENBERG. Yes.

Mr. ALTMAN. That is true.

Mr. STARK. So what I guess I am saying is that we have, largely with the help of the organizations that you two gentlemen represent, over the last 10 or 12 years, done a pretty credible job of holding down the reimbursement growth for physicians and hospitals.

There has been a lot of disagreement as to whether we are paying rural hospitals enough or teaching hospitals enough or surgeons more than primary care, and we have debated that in this committee for—long and loudly.

But I do not know of an insurance or payment scheme in the United States that has a lower overhead than Medicare. Do either of you?

Mr. ALTMAN. Not that I have seen.

Mr. STARK. Dr. Eisenberg.

Dr. EISENBERG. No.

Mr. STARK. All right. Now, you may know this or not, but I would further say that there is no health insurance operation that has a lower rate of employees to beneficiaries.

We have around 4,500 bureaucrats, somewhat less, in HCFA and Medicare and in Baltimore working on Medicare, and we have 35 million beneficiaries, and I do not know of a private operation, be it Kaiser Permanente or anybody, that has a lower ratio of administrative personnel to beneficiaries.

Do either of you know of any?

Dr. EISENBERG. No.

Mr. ALTMAN. Well——

Mr. STARK. Even Georgetown, Dr. Eisenberg?

Mr. ALTMAN. I think it is only fair that in doing that calculation, we should include the amount of money we spend for the intermediaries and stuff, and so we would have to look at it.

I just don't know what——

Mr. STARK. That includes the intermediary fees.

Mr. ALTMAN. Does it?

Mr. STARK. Yes, but not the overhead, but not in the personnel. You are right. We do contract out.

Mr. ALTMAN. I just—we need to do this fairly, and I just don't know. I haven't looked at the numbers.

Mr. STARK. The only other question that I would raise in whatever limited time, and this would go to Dr. Eisenberg, is that we did, after a long debate, a lot of hard work and soul searching here, revise the manner in which we paid physicians, and it was a Republican administration that proposed the payment structure. It was proposed by some doctors' groups and opposed by others. It has been adjusted once I think in major legislation since we put it in, and it is working marginally, but it is working. It is running. It starts on a cold morning.

Many health insurance—private health insurance companies are copying it. In California, Blue Cross uses it with a resource-based relative value system. Do you think that we should be very cautious in amending or changing any contract with the physician community lest we lose our credibility in being able to work with them and end up like the baseball players and owners? And I ask that as your personal opinion as a physician.

Chairman THOMAS. In a word, Doctor.

Dr. EISENBERG. In a word. Medicare led the way in changing physician payment and did so in a fashion which I think was fundamental and very, very important and very salutary in improving physician payment and it is being picked up by the private sector.

The question today is not, I think, whether the RBRVS needs to be overhauled. I didn't hear very many people talking about doing that, but rather how we deal with the conversion factor and the rate of increase in volume so that Medicare, which led the way for the past 5 years, can now benefit from what is happening in the private sector to enjoy continued savings.

Mr. STARK. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Mr. Christensen will inquire.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Altman, would you agree that Congress' attempt in 1993 to contain hospital costs by limiting payment increases to two points above the market basket may not have impinged much on hospital margins at all because the actual rates in hospitals did not achieve the rates the market basket model predicted?

Mr. ALTMAN. It was 2 percent below market basket. What happened prior to this year is that Medicare has put very tight limits on what it pays hospitals.

Hospitals' costs have been able to continue to grow at their PPS rates because they were able to shift onto private patients higher and higher extra payments so the hospitals didn't feel the pressure from the Medicare payments and Medicare didn't feel it.

It was kind of the best of all worlds for the government. It could establish lower and lower rates and nobody felt it, except, of course, the private payers, but beginning in 1992, 1993, and particularly 1994 and 1995, the private payers are no longer paying these higher rates and so that is why we are seeing the reduction in hospital costs for the first time.

Mr. CHRISTENSEN. If the current hospital inflation rate remains what it has been, what effect do you see by limiting the hospital payment increase to minus 2 percent of the market? What will we have in the future?

Mr. ALTMAN. If the hospital cost structure continues on its current path, which is 1994, 1995, then the minus 2 percent will not be as serious a problem. If it would have jumped back up to what has existed prior to 1992, then hospitals are going to have one serious problem.

Mr. CHRISTENSEN. You stated earlier in your testimony that there is a problem with the market basket index.

Mr. ALTMAN. Yes.

Mr. CHRISTENSEN. In terms of predicting the future prices for goods and services that hospitals purchase, do you have any suggestions on how we can make them more accurate?

Mr. ALTMAN. We have been shocked is probably too weak a word by the gap that has—we just did a study last month and looked at what was forecasted for the market basket next year and what actually the market basket was and that gap has gotten very wide.

As an economist, I am sort of a little chagrined that my fellow economists have done such a poor job in terms of anticipating what has been going on in inflation. But now I can see why the bond market and the derivatives got into so much trouble.

So our recommendation is we should not—we don't need to be quite so futuristic and we should be adjusting, once we realize what the true market basket is. As it has turned out, the program has overpaid hospitals in the last couple of years because it used a market basket that was significantly higher than what true inflation was.

But to be fair to hospitals, though, the whole procedure that the Congress uses by having that minus 2 percent below the market basket on average probably worked out OK. In other words, we sort of had countervailing mistakes.

So when you look at what the hospitals actually received from Medicare and what it turned out to be, it is very close to what their true cost increases were. But I will tell you, it is a very dangerous way to sort of have countervailing mistakes. I would rather see us adjust after we realize what the true numbers were.

Mr. CHRISTENSEN. During the ranking minority member's comments, I heard him laying the foundation for his belief that big government knows best how to run Medicare and should be allowed to take over everyone's health care.

It is not your philosophy that government knows better how to run the health care system better than the private sector, is it?

Mr. ALTMAN. No.

Mr. CHRISTENSEN. I didn't think so.

Mr. ALTMAN. I think the balance is—you know, it is that tricky balance here, but for the most part—to be fair to everybody here,

there have been times when Medicare, as Dr. Eisenberg has pointed out, where Medicare has been ahead of the game and the private sector borrowed from government. But the government has gotten behind the curve and it is way behind the curve in some very major areas.

Mr. CHRISTENSEN. We have to be reminded that the American people resoundingly rejected the big government philosophy on health care last year, and I would remind the ranking minority member that big government doesn't know best when it comes to health care in America.

Chairman THOMAS. Thank you.

Mr. Lewis will inquire.

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

Let me thank members of this panel for being here this morning.

Dr. Altman, if Congress adopts the recommendation to cut IME and some other requirements, what would that mean in terms of caring for the uninsured? Would that simply put more of the costs on the back of local government? If it does, then are we saving any money overall or simply transferring the cost?

Mr. ALTMAN. Mr. Lewis, we at ProPAC have been very concerned about both the preservation of teaching hospitals in this country and in making sure that there is adequate money for the uninsured and others in urban and rural areas.

The question becomes whether the teaching hospitals, like every other sector, can reduce its costs, not cut care. I have lived in Boston for a long time. You know that Boston is the citadel of—let's say a major—a number of major teaching hospitals in this country, and for a long time there was absolutely no give on their parts in terms of recognition that they needed to cut their costs.

We are seeing some extraordinary things happen in Boston, merging of teaching hospitals, affiliation agreements, cutbacks. So, you know, to be honest with you, I don't know where those numbers are going to come out. But I tell you, I think we can anticipate, if we are tighter with that teaching adjustment, that we can do it without affecting negatively quality and access. I think we ought to monitor it very carefully.

I don't think we ought to be blind to this, but I don't think we should just establish what used to be. We were paying those hospitals too much. So that is why we recommended reducing it in stages and watching to make sure that we don't do harm, because we share your concerns. We really do. I do.

Mr. LEWIS. Dr. Eisenberg and Dr. Altman, can you address payments by private managed care companies and how those payments relate to Medicare payments? In other words, is Medicare paying as well, worse than, or equal to managed care in the private sector?

Dr. EISENBERG. It is a—from a physician payment perspective, it is a moving target. The data that we have analyzed in the past suggests that Medicare pays somewhat less than most of the managed care programs who use the resource-based relative value scale.

That is to say, their conversion factor is higher than that of Medicare's, but it is changing. They are becoming much more competitive and the negotiations between the providers and the man-

aged care companies are leading to those conversion factors dropping further.

So I—as I said earlier, I think at the beginning, Medicare was ahead and now the private sector is catching up and in many cases moving further ahead than the Medicare plan.

The other issue with managed care programs is that this comparison can only be made for those managed care programs who continue to pay physicians fee-for-service. You can't really draw that same comparison when the managed care plan capitates the physician group, in which case it is really a different way of paying and can't be compared very easily.

Mr. ALTMAN. With respect to hospitals, I can tell you what we know and then I can tell you anecdotally what we think because our data which runs through 1992, 1993, suggests that the private sector is still paying significantly more than Medicare.

I know situations where Medicare is actually paying certain institutions more than the private sector, particularly rural hospitals, disproportionate share hospitals and teaching hospitals. Not in all cases, not in all areas, but there are examples where Medicare has become the better payer.

Mr. LEWIS. This is not necessarily related to the issue that we are considering today, but I would like to hear the two of you respond. Wouldn't you agree that the debate, the discussion that we had last year on the whole question of health care reform was a necessary debate and it did move the private sector on toward health care reform?

Dr. EISENBERG. Well, I think first it was a very fruitful debate because it did lay out a number of the options, which we are still considering today, and in that way, was really quite constructive, and yes, it did move the private sector.

I think it was in many ways a wake up call to the private sector, both providers and the purchasers of care, that they needed to look more carefully, both at the prices and at the volume of services that they were dealing with.

Mr. ALTMAN. I am a long-term-trend guy and I think most of what you are seeing today was started a long time ago. I am not—I don't really know how much of it was a result of last year's debate.

I would like to think it was a positive. I have been watching the private sector for a long time, and I was surprised how long it took. I kept waiting for these numbers to come down because I have been part of this managed care environment in certain ways for a long time.

So I don't think there is anything that happened in 1994 and 1995 that was totally unique. How much of it was kick started or expanded, I don't know, but we are dealing with long-term trends that started in the seventies and more importantly in the eighties, I think.

Mr. LEWIS. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you, Mr. Lewis.

Mr. Houghton will inquire.

Mr. HOUGHTON. Thank you, Mr. Chairman.

Gentlemen, thank you very much for being here. I have got two categories of questions. The first is specific, three specific questions, and if it is too difficult to answer them now, maybe you could just send us some answers in writing.

The first is the Physician Payment Review Commission. If I understand it, originally there was sort of—it was sort of one standard which was suggested. Now you have two or three standards. Are there distortions because you have multiple standards rather than just the single one you had before? Now, that is number one.

Number two, I live in New York State and New York State has got a couple of problems. First of all, it has been under constraint, because of a variety of pressures, to keep the hospital costs very low, and I am afraid those people who did a good job earlier may be suffering because of new standards which will be put on by the Federal Government.

And second, in terms of managed care, it is a good idea. As a matter of fact, one of the heads of the Catholic hospital, a nun, had suggested we do away with fee-for-service. That would be the greatest thing that could happen to them. But if we are going to move on the managed care route, it is very difficult in the rural areas.

So those are three specific questions, and any way you can help me on that, fine. And if the answers are too long, because I do have a more general question, then you can send some—send them in writing.

Dr. EISENBERG. I will try to be brief. On the three standards, yes, it is a distortion, and PPRC believes that it undermines the basic premise of the resource-based relative value scale, and we have always suggested that there be a single standard. And we can provide you with more information on that.

One of the difficulties with areas like upstate New York with regard to managed care is, number one, that you did have a lower rate of increase in many parts of New York—upper New York State, and that has made the AAPCC or the calculated amount that the Medicare plan will pay the managed care organizations lower, a serious disincentive for managed care programs to move into areas that had a historically successful limited rate of increase in their expenditures.

And finally, with regard to rural areas, we are concerned about the availability of managed care in rural areas and are thinking through some ideas about ways in which we can make it more accessible and would like to pursue that with you further.

Mr. HOUGHTON. All right.

Mr. Altman.

Mr. ALTMAN. On the hospital side, New York—I am an ex-New Yorker and I spend a lot of time looking at New York. New York is unique.

Mr. HOUGHTON. I think your accent says that.

Mr. ALTMAN. Only you could pick that up. I try. Anyway, New York has been able to keep the price per visit or admission down, but the length of stay in New York is the highest in the United States. Admission rates to hospitals per 1,000 is the highest in the United States. The number of beds per person is the highest in the

United States. New York needs a capacity shrinkage and it is beginning to go through it.

I think managed care is going to have a field day in New York. And it is beginning to—you can see it in the city. There is an awful lot of—I don't want to say waste, but there is an awful lot of potential for savings in New York and you are going to see it happen.

So, Medicare—of all of the places in the United States where Medicare is behind, it is in New York. The difference between New York and California is phenomenal, and I would be glad to give you the data that I have on it, but you are going to see New York go through a very substantial change in the structure of its health care system over the next 4 or 5 years. I am sure of it.

Mr. HOUGHTON. I would like to have you break that down a little bit because there are many things——

Mr. ALTMAN. And obviously there are different parts of New York.

Mr. HOUGHTON. Right, and the question is this. I will shoot it out. I am almost out of time. Are we moving in the right direction? How long can we continue to patch up this system? And in the process, are we really falling behind? I really worry about that.

Dr. EISENBERG. I believe that what we ought to do is to try to develop a financing system which will provide the incentives to physicians and hospitals, and in the case of Medicare beneficiaries, to develop responsible relationships that would move toward their participation in integrated systems of care, and managed care will help us to do that.

Some changes in the way in which we pay in Medicare will help us to do that, but we are not sufficiently or quickly enough moving in the direction of developing these systems that are integrated. It is happening in the private sector, but I don't think that Medicare, as it is currently constructed, helps that to happen as much as it could.

Mr. ALTMAN. Mr. Houghton, I think the patchwork is not only Medicare. The patchwork is our health system. We have a gigantic Ponzi game going on right now where there is all this money being moved around.

Teaching hospitals are being subsidized because they are not getting adequate money for research, so they are grabbing it from patient care. For-profits get it from one sector, not-for-profits from another sector.

The problem I see is that if you start dealing with one sector and you squeeze down on it, the potential for it to balloon up in another sector has been very real.

Medicare was ahead of its time and then went behind its time. Medicare needs to become a much better managed care plan, even within the existing law. It can manage itself better by introducing some of the kind of changes that the private sector has, without necessarily putting it outside.

But the fear I have is you have a delivery system which is playing against a set of inconsistent incentives and we need to be careful about that.

Chairman THOMAS. Thank you.

Mr. McDermott will inquire.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Sometimes—it is good to see both of you. Old friends. Sometimes I think your answers are a tad polite or maybe tailored to who asks the questions, so I want to ask a question from another point of view.

Dr. Eisenberg, I want to really clarify what you said about medical savings accounts, given the various studies that exist that show that widespread use of them will undermine the financing of the health care system because it destroys the idea of risk pool. My feeling is that medical savings accounts discourage use of preventive medicine or any kind of routine things, and I would like to hear a little more. It sounded like you thought medical savings accounts might be a good way to go.

Dr. EISENBERG. Well, my comment was in the context of Mr. Ensign's question about the degree to which Medicare beneficiaries pay anything out of pocket when care is received, and whether or not MSAs, medical savings accounts, or anything like that might help them to be able to pay those copayments or deductibles, and I do think that for the elderly, an account, whether you call it an MSA or a bank account, from which they could pay a copayment or a deductible would help to add a level of beneficiary participation in the payment system.

I don't think that an MSA by itself would be sufficient, but I don't think that was the context of his question. It was more how can we help people to be able to pay a copayment so there is more participation in the payment by the elderly.

Mr. MCDERMOTT. OK, then what you are saying is that widespread use of the medical savings accounts would, in fact, not be a good idea?

Dr. EISENBERG. Well, that is a different question, but I would—first let me just say that PPRC has not studied the MSA proposal, but I think that what we would suggest is given the Medicare program, that an MSA might be an alternative to help the elderly pay those out-of-pocket expenses, so long as, as I mentioned earlier, there are adequate controls for catastrophic expenses.

Mr. MCDERMOTT. Thank you.

Dr. Altman, you mentioned in your written testimony about medical schools or it was Dr. Eisenberg who talked about them. I am not sure everybody on this panel knows, but I checked the University of Washington. Eleven percent of the money for the University of Washington comes from the State legislature, 39 percent comes from physicians' income, and 50 percent comes from Federal grants of one sort or another.

How much can we reasonably cut into Medicare without doing significant damage to the medical schools in this country? There is some suggestion they have been overpaid in the past, but I would just be interested in hearing you and Dr. Eisenberg talk about what happens to medical schools if we go in and make the kinds of cuts that the Contract With America really makes necessary to balance the budget.

Mr. ALTMAN. Well, as I indicated to Mr. Lewis, I think the issue really gets down to the ability for medical schools to restructure, to make significant savings in the way they do business, just like other hospitals have done and other institutions.

And we just don't know to what extent those savings can happen, but we do know the direction, and therefore, I don't think—personally I don't think we need to buy into the idea that what we paid yesterday is what we have to pay tomorrow.

On the other hand, I am very concerned about medical schools and what they have traditionally provided us, that we just don't wholesale cut them. And so that is why we have tried this middle ground of not going down 3 percent, as some have suggested, going down gradually. If you look at our total recommendation, there are a number of areas where we have recommended an increase to medical schools.

For example, our better outlier policy recommendation allows them to get payments when they really do treat sicker people. So I think medical schools, by their necessity, have been the last of the hospitals to get into this cost cutting mode, but I think when they get finished with it, they are going to have a cost structure that could allow perhaps significant reductions in payments because they are going to have to survive a private sector which is being very tough on them. I don't think the government has been nearly as tough on medical schools as has been the private sector which wants much more for their money.

Dr. EISENBERG. There clearly are cross subsidies of one activity for another in medical schools, and recently medical school faculty practice plans have been developed accounting for up to half of the medical school's revenue because of the fact that that revenue is so critical to pay for the teaching and research activities of those faculty.

And certainly as Medicare reimbursement decreases, if the other sources for paying for teaching and for research also decrease, then you are right, the medical schools and their associated hospitals will have serious problems, and we need to look at that.

I am at least as concerned about what happens to the medical schools in a more competitive environment where those cross subsidies are not available and particularly in a managed care world. If Medicare does move to more managed care, then we need to look very carefully at the degree to which those managed care plans choose to work with teaching hospitals, because frankly, a reduction in Medicare payments of the amounts that you are discussing aren't as bad as losing all of the Medicare patients to a managed care plan that decides not to use a more expensive institution or one which has some of these other costs that it needs to take on.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Sam Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

Dr. Altman, you alluded to the fact that home health care services might be bundled perhaps in a managed care type risk contract program.

Can you elaborate on that a little bit, and are there any other options? That is, can we get the private sector more involved?

Mr. ALTMAN. I think it can—as I indicated, we in my research capacity had the government create a—what is called a social HMO model. We had it in California, in Oregon, in New York and Minneapolis, and what we did is we gave these private sector systems

a capitated amount and required them to provide, in addition to acute care, also home care, and as a result of that, they were able to manage their home care and skilled nursing care much better than the Medicare program and fee-for-service could do.

So I definitely see the potential for creating either a fully capitated system, or a minicapitated system which focuses on home care and other what are called postacute care services. I don't think it ought to be only home care.

There are a lot of tradeoffs between home care and skilled nursing facilities, rehab centers, and even some outpatient services. So I see the potential for substantial savings under such a structure, yes.

Mr. JOHNSON. Well, you know, the way you are describing it, we are kind of micromanaging it from the government level.

Is there some way we could actually contract with the private sector?

Mr. ALTMAN. Absolutely. Right now we are not managing it at all. It is a fee-for-service system and there are some very loose safeguards built in, but the growth rate suggests there is not a lot of management going on at all.

Mr. JOHNSON. I thank you, and in the teaching which we were talking about in the previous question, can you tell me—you know, you said they would move the money around once they got ahold of it. How do you keep them from doing that if you more or less grant them the dollars?

Mr. ALTMAN. I don't want to do that. I am saying that right now what is happening is we have a total health care system which underpays and overpays. We have 40 million Americans with no health insurance, yet we provided them with 12 billion dollars' worth of free care last year. Somebody paid that bill.

We have Medicare which pays some hospitals 80 cents on the dollar and some hospitals 110 cents on the dollar. We have other Medicaid, some States are paying 60 and 70 cents on the dollar. Those institutions then go to find money from somebody else. So there is a lot of money.

Now, in the old days there was a lot of extra money sloshing around and we didn't worry about it so much. But in this new environment, both on the private side and the public side, there is not a lot of money sloshing around so therefore I think we are going to have to focus those dollars a lot better and decide from a public policy point of view how many teaching hospitals do you want, how many residents do you want to train? So it is not just Medicare. It is much more, I think.

Mr. JOHNSON. Every now and then I hear even the doctors say there are too many doctors. Have you done any studies on that issue?

Mr. ALTMAN. Well, that is me talking, you know, in an area—I think I will let Dr. Eisenberg respond.

Dr. EISENBERG. Thank you, Stuart.

PPRC has looked at this issue and we believe that there will be, if there isn't already, a surplus of physicians and as we move to managed care, which uses both less physicians and a different mix of physicians, fewer specialists, then we believe there will be an excess of over 100,000 physicians within a few years and that most

of those physicians will be in the specialties that are currently overpopulated.

Mr. JOHNSON. Is that fairly evenly divided across the Nation or is it in specific urban centers?

Dr. EISENBERG. It is mostly in urban centers, although there seems to be a different distribution of primary care physicians than there is a distribution of specialized physicians.

Mr. JOHNSON. So wouldn't that then accrue to a reduction in teaching hospital dollars as well?

Dr. EISENBERG. It could if we reduced the total number of trainees. But the problem is we have approached this by reducing the dollars per trainee in the past rather than decreasing the total number of trainees so that the hospital then doesn't have the money that it believes is necessary to train each of the individuals it is responsible for. But we end up with too many hospitals doing the teaching and too many trainees in those training programs.

Mr. JOHNSON. Thank you, sir.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you, Mr. Johnson of Texas.

Mrs. Johnson of Connecticut.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Currently HMOs have to meet certain conditions to qualify as a risk contractor. Do you think the conditions currently required are appropriate? Are there impediments that limit the number who participate? Are there impediments Congress should look at to expand the number of HMOs that could function as risk contractors?

Dr. EISENBERG. Let me start. In our testimony, we suggested that there were several steps that needed to be taken in order to improve the ability of managed care programs to accept those risk contracts, including corrections in the way in which the current AAPCC is calculated, but perhaps being even bolder and looking at new ways of setting an appropriate price that Medicare would pay managed care organizations through, for example, a bidding process. We have a series of suggestions to offer to you that we believe would make Medicare a more attractive option for managed care organizations.

Mrs. JOHNSON. I will be very interested in talking about the bidding issue with you in greater length at some other time because I think just in the AAPCC it is going to be really difficult and for the same uneven estimates that we currently have.

Mr. ALTMAN. Mrs. Johnson, I go way back in the Medicare, as well as the general HMO system back in the early seventies, and I opposed then and continue to oppose many of the restrictions that are in them.

I think that we have tried to recreate too many restrictions across the board. For example, the idea that Medicare risk contractors have to provide more services, there ought to be a way where the beneficiary might benefit more from a reduction in some price where a Medicare HMO could decide whether it wanted to have a benefit increase or a price increase.

Also, I think the program ought to be able to benefit, and some of these services that we have mandated, I am not so sure they are all that necessary in every place. I think it might be of some value in having Medicare HMOs that have different service compositions.

I am not in favor of one service benefit for everybody. I think we benefit by choice, and so I have opposed them over the years—I believe that there are too many restrictions.

Mrs. JOHNSON. Thank you.

That is very helpful and if you could follow up with more on that subject and if you could help me, Dr. Eisenberg, in how we get a bidding system in place properly. I think that would be very helpful.

[Due to its size, the information is being held in the committee files.]

I think for us to try to amend the current structure which we know has weaknesses and we know through an amendment we can't address those weaknesses except on a temporary basis is spinning our wheels. I would like to look at the bidding system and how we could put bidding in place, and I certainly would like to free seniors to be able to have the choice between increased benefits and lower price, which they don't currently have.

I think those two things in a voluntary opportunity for seniors to participate differently in their own health care choice would radically alter the circumstances and probably improve both the quality of services Medicare provides and reduce costs.

Let me just ask, what is your experience with the social HMO project? Is there anything we can learn from the social HMOs in redesigning the home health benefit, which we know is one of the real cost drivers of current increases?

Mr. ALTMAN. Well, as I indicated, I think the thing that we learned the most from the social HMO is by giving a managed care plan a broader responsibility with slightly higher payments, in this case we went up from 95 to 100 percent and we also allowed them to get extra payments if these people would have been institutionalized, they were able to manage their services better. They were able to choose between home care and more hospital care, between home care and skilled nursing care better than a fee-for-service add-on.

Mrs. JOHNSON. And from that demonstration project, would it be possible this year to nationalize that system?

Mr. ALTMAN. I think so, and I have asked several times for substantial expansion. Now, the Congress did give the HCFA authority to expand by three or four new programs. My own view is it should be expanded much more. It has shown itself to be a valuable addition.

There are problems with it. It didn't work perfectly in all areas. New York had more of a problem than California, but that was as much related to the AAPCC. So, yes, I do believe that there is potential growth in the managed care world to manage particularly home care and skilled nursing care much better than a fee-for-service system.

Mrs. JOHNSON. Let me just correct the record. I didn't mean nationalize. I meant nationwide.

Mr. ALTMAN. That is what I meant too.

Thank you.

Chairman THOMAS. The gentleman from Washington had a brief shining moment there where he thought he had you. You caught

him on the correction. I want to thank both of you for your testimony, especially the specific suggestions that you have made.

Dr. Altman, and Dr. Eisenberg, the discussion with the ranking member, I think was useful in terms of a look back, that is, in the period from 1984 to 1993. We did make some changes which gave Medicare a comparative advantage in the short run.

I think, though, going back to the charts that you showed us, if we look more recently, we have seen that those items that have begun to take hold in the private sector have, in fact, begun to outpace the ability of Medicare to change and I, like you, am a believer in long-term trends.

I remember it was about 2 years ago that you and I were sitting here agreeing that we thought these changes were not temporary, they were long-term, and therefore the folks in the administration and the last Congress had to completely restructure it because any downward trends are really blips and that no one is going to tell us it is not going to go back up again, when clearly I thought we were locking in place some long-term changes and were beginning to see it.

I especially liked both of your testimonies indicating that we can no longer put items on what amounts to automatic pilot, a 5-year change or a 7-year change because frankly in that 7-year period, at least the part A trust fund is projected to go bankrupt. And so it is a 1-year or a 2-year adjustment of various programs until we can rethink the whole structure, and a 10-year look back is nice, but it is just that. It is just nice.

The gentleman from Washington talked about 50 percent of the Federal dollars funding the University of Washington, which I firmly believe, although I don't think it is all on Medicare's back. I think NIH funding grants and contracts are involved there as well, but it gets back to I think a fundamental point, and Dr. Eisenberg, I want you to respond to it briefly, and that is, although hospitals still are the 52 percent, the major funding aspect, clearly the trend is less and less inpatient hospital funds available and more and more, for example, outpatient.

I think in your testimony you talked about moving medical education more toward the ambulatory part of the activities, and doesn't it mean then that what we have to do is perhaps not be alarmed about the funding aspect of hospitals under Medicare if it continues to shrink, which I believe it will because of long-term trends, but that it means we have got to rethink the way in which we fund medical schools, not just the total dollar amounts, but the direction of the dollar amounts, perhaps providing the students with more of an opportunity to have an influence over the education that they get, a bottom-up approach to funding rather than the top-down structure that we have.

Any reaction to that?

Dr. EISENBERG. I think that that kind of flexibility would be a major step forward because it would unleash the medical student or the resident, and in Medicare's case, we are really talking about residents from the site of care, so that education wouldn't necessarily have to be linked with the hospital or even with the place where the care is being rendered.

I think that would be a big step forward and PPRC would like to work with you to think about ways in which we can do that.

Chairman THOMAS. When I say students, I mean it in the larger sense of the word. I think I am an ongoing student as well.

The gentleman from Washington have a comment?

Mr. MCDERMOTT. Thank you, Mr. Chairman. I would just like this one brief question of Dr. Altman.

Would you comment on the feasibility of providing outpatient services under some kind of PPS or DRG kind of system as a cost-saving mechanism that would provide cost savings, but still guarantee people the right to choose?

Mr. ALTMAN. Well, first, we have been trying to develop a partial PPS-type, DRG system for outpatient services. It turned out to be very hard because you are dealing with hundreds of thousands of different diagnoses, people moving from one group of providers to another on different days, you can't measure it.

So there are 10,000 reasons why it is a bad idea, but I think in general it is a good idea that still needs to happen and the way one needs to do it is to bundle it into a bigger set of categories. You can't do it the way you have done the hospital-based DRG. It just won't work, and therefore you need to go to some form of partial capitation maybe.

You don't need to capitate total services. You could capitate all outpatient services to a group of separate individual entrepreneurs or not-for-profit firms, but what won't work to save you a lot of money is a partial DRG system for outpatients, much as I would like to see it done, and the staff and the people at HCFA have convinced me it is a very complicated thing and it is likely to fail. So therefore I would jump over that and go to partial capitation or complete capitation.

Mr. MCDERMOTT. Dr. Eisenberg, do you have a comment?

Dr. EISENBERG. We also are enamored of the idea that partial capitation might be a reasonable way to move as we try to get Medicare more involved with the managed care options. PPRC has not looked at the outpatient departments of hospitals though, and so I can't really speak to that issue specifically.

We do believe that we ought to move more in the direction of considering different ways of bundling services though. As an example, this committee asked the Commission, Mrs. Johnson specifically, to look at the issue of trauma care, which is an amalgam of contributions from a tremendously diverse group of providers and our conclusion was that paying a global payment or a bundled payment for trauma care would also be a reasonable way to reconsider the payment for that service.

So I think the idea of paying bundled or a global payment or trying to move it toward a capitated model makes good sense.

Mr. MCDERMOTT. Thank you very much.

Thank you, Mr. Chairman.

Chairman THOMAS. Certainly. Mr. Altman, you talked about the need for volume control and you indicated the two growth areas, home health and nursing home, although clearly not approaching the dollar volume of other areas. The 46.4-percent growth in nursing home is certainly something to focus on, as well as the 38-percent growth in home health.

In terms of some specific examples, I have seen some on home health in terms of copayment examples. Can you give me any indication of what the effect might be of a 20-percent coinsurance or a copayment on the first 20 days of the skilled nursing facility benefit? Would that have an impact on the utilization?

Mr. ALTMAN. I think we have to recognize that most of the Medicare beneficiaries have some form of extra insurance, Medigap of some kind, so I think the impact on the program, the program would save substantial money.

I think the impact on utilization would be quite limited, and so I support a—some form of coinsurance just as a general policy for home care, but I don't think it is going to have a substantial reduction in utilization, although I do think it will save the program money, but I do believe we need to go more toward a managed care. I think it will work better.

Chairman THOMAS. I thank both of you. We can continue to make changes inside the program that would save the program costs, but we really have to focus on reacting to the world as it is, and the world as it will be so that this program won't be just a cost-effective one, but it will be a utilization-effective one as well.

We appreciate very much your testimony.

Mr. ALTMAN. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. If I could ask the second panel to come forward. Michael Mangano and William Scanlon. The subcommittee welcomes both of you to the hearing, Mr. Mangano as the Health and Human Services Principal Deputy Inspector General. Mr. Scanlon is the Associate Director of the General Accounting Office.

We look forward to your testimony. Your written testimony will be made a part of the record and you may proceed for 5 minutes however you may see fit and we will begin with Mr. Mangano.

STATEMENT OF MICHAEL F. MANGANO, PRINCIPAL DEPUTY INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MANGANO. OK. Thank you very much, Mr. Chairman. It is always a pleasure to testify before this committee. I would like to limit my oral remarks to three primary initiatives that we have launched in the Medicare fraud and abuse area and finish up with a strategy that might help us in that battle.

We devote a significant amount of time to the Medicare program. It is very easy to understand why. With a budget this year of $178 billion, there is a lot of money to look after. That is about a fivefold increase since the eighties. The major initiatives I want to talk about are home health services, nursing homes, and medical equipment and supplies.

I want to begin with the home health area. As you can see from the chart over there, the home health care services have really exploded over the last 4 years. In 1990, we were paying $3.3 billion in Medicare for home health services, and by 1994 it is up to $12 billion. We anticipate that cost to go up to $16 billion this year and $22 billion by the turn of the century. The number of beneficiaries have also increased by about 72 percent since 1990 from 1.9 to 3.3

million, while the average number of visits per person has increased about 80 percent, from 36 in 1990 to 65 in 1994.

There are a number of factors that play into that. First, the increasing aging of the Medicare population. Second, new technology that can now be delivered in the home, and third, recent liberalizations of the home health care benefit.

We are finding several types of fraud and abuse in the home health care area, including cost report fraud, excessive services, or services not rendered, use of unlicensed or untrained staff, falsifying plans of care, kickbacks, and physicians actually not signing plans of care.

Let me briefly describe one example of a recent audit we just completed down in south Florida. In that example, we found that 75 percent of the claims submitted to Medicare, or 26 million dollars' worth, did not meet Medicare guidelines. Twenty-one percent of the visits claimed were not made. Twenty-nine percent of the persons were not homebound. Twenty-three percent of the physicians denied authorizing the visits and 2 percent of the beneficiaries did not want the services.

Second, let me move on to the nursing home area. The nursing home benefit for the Medicare program provides for 100 days in a skilled nursing facility. In 1993 the part A portion of that was $5 billion. But we are beginning to see more and more money moving into part B, which in 1992 is about $4 billion. Those services under part B could include things like physician services, laboratory and radiological services, medical equipment, and supplies. This cost shifting from part A to part B is very significant. The kinds of things that we would have anticipated that the nursing homes would have provided under part A are now beginning to show up more and more under part B.

There is a great incentive for the nursing home to have items and services billed under part B because it relieves them of the expense and the management of those services and beneficiaries may get additional services. But more importantly, billing under part B gives providers an outlet to another market in which to make sales.

The patients do not pay a copayment for Medicare part A, but they do for part B; so when services are shifted to part B, it does put more of a burden on the beneficiaries.

In 1992, $99 million in patient copays and deductibles were paid for these services under part B. I will give you just one example of where we are seeing that kind of problem exist. In that same year, $44 million was billed to part B for things like surgical dressings and minor medical supplies, things that I think most of us would agree that a nursing home should be providing as its staple product.

The third area I want to talk about is the medical equipment and supplies. We have been spending an inordinate amount of time in this area because of the widespread fraud and abuse that we are uncovering. In the last 4 years, we have had 131 successful prosecutions against unscrupulous providers of medical supplies.

When we begin to see a specific spike up in the cost of individual items, that causes us to stand at attention and take a look at those particular items. I will give you one example of that. We began to see a spike up beginning in 1990 in orthotic body jackets. These are

hard covered body jackets that help a person recover from spinal injuries or from muscular problems. In 1990, Medicare paid only $217,000. By 1992, that figure was up to $18 million. We found that 95 percent of the payments there were inappropriate. In fact, we were not paying for orthotic jackets. We were paying for seat cushions and foam covered devices that were keeping people in a chair.

An emerging problem we are seeing is the marketing of medical supplies to nursing home patients. You can take a look at that last chart there that talks about incontinence supplies. These have more than doubled in the last 3 years. It is up to $230 million despite a drop, let me repeat, a drop in the number of beneficiaries using these supplies.

I brought a couple of examples. One of the devices is a female urinary collection device. You can see it here. This device costs $7.38 to the Medicare program. What we were finding was suppliers were billing that but, in fact, delivering this, a common diaper that costs 33 cents. Many of these devices were not needed and clearly Medicare should not have been reimbursing for the diaper when, in fact, the urinary collection device was billed.

Another device that I will bring to your attention is what is called an incontinence kit. This is a kit that helps nursing home staff help clean up a beneficiary who has been soiled. These are not reimbursable by Medicare. Individually, these kits cost $4. What we were finding was that the suppliers were taking the individual items in these kits apart and billing them separately to Medicare costing over $20 per kit. When you add that up to 3 kits per day, 90 kits per month, for each beneficiary, that is an inappropriate billing to Medicare of $1,800 per month. It is these kinds of things that cause us to question about one-half of the costs related to incontinence care and over $100 million that Medicare should not be paying for.

We would like to seek the support of this committee in helping us continue the fight against fraud. With $178 billion at stake, the lure of a fast buck is irresistible to criminals and con artists. Yet at the same time, we are finding ourselves with fewer and fewer resources to fight this battle. We hope the committee will support an initiative that would cause the perpetrators of these frauds to help pay the cost of policing them by establishing a fund at which we would restore the money to the Medicare fund that was lost by fraud and abuse and allow some penalties to be paid to help us increase our efforts. This proposal had widespread bipartisan support in the last Congress. We hope it will have the same support in this Congress.

I will be happy to answer any questions.

[The prepared statement and attachments follow:]

STATEMENT OF MICHAEL F. MANGANO
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning. My name is Michael F. Mangano, and I am the Principal Deputy Inspector General, U.S. Department of Health and Human Services. I am pleased to be here today to discuss issues relating to the Medicare program.

I will focus my testimony this morning on major new initiatives by the OIG, where we are developing recommendations for cost efficiencies. However, I will also catalogue other specific cost saving recommendations that the OIG has made which have not been implemented to date. Finally, I will outline some broader strategies we have established to fight an increasingly complex health care fraud environment and discuss a mechanism we support to finance these new initiatives.

OFFICE OF INSPECTOR GENERAL OVERVIEW

Created in 1976, the OIG is statutorily charged with protecting the integrity of departmental programs, as well as promoting their economy, efficiency, and effectiveness. The OIG meets this challenge through a comprehensive program of audits, program evaluations, and investigations designed to improve the management of the Department and to protect its programs and beneficiaries from fraud, waste, and abuse. Our role is to detect and prevent fraud and abuse and ensure that beneficiaries receive high quality, necessary services, at appropriate payment levels.

Within the Department, the OIG is an independent organization, reporting to the Secretary and communicating directly with the Congress on significant matters. We carry out our mission through a field structure of 8 regions and 65 field offices and with a staff of over 1,200 auditors, evaluators, and investigators.

In Fiscal Year (FY) 1994, we were responsible for 1,169 successful criminal prosecutions and 1,334 administrative sanctions against individuals or entities that defrauded or abused the Department's programs and/or beneficiaries. Last year, the OIG also generated savings, fines, restitutions, penalties, and receivables of over $8 billion. This represents $80 in savings for each Federal dollar invested in our office, or $6.4 million in savings per OIG employee.

THE MEDICARE PROGRAM

The Medicare program is administered by the Health Care Financing Administration (HCFA). Medicare Part A covers hospital and other institutional care for approximately 36 million persons age 65 or older and for certain disabled persons. Fiscal Year (FY) 1995 expenditures for Part A are estimated at $112 billion. Medicare Part B, which covers most of the costs of medically necessary physician and other non-institutional services, has estimated FY 1995 expenditures of $66 billion.

HCFA administers the Medicare program through a contractor system. 43 fiscal intermediaries make payments under Part A and Part B; 34 carriers make payments under Part B; and four specialty contractors make payments for medical equipment and supplies paid under Part B. These contractors operate at 62 sites across the country.

Over the years, HCFA has instituted many significant reforms to the Medicare program to control costs. Payment reforms have included implementation of a prospective payment system (PPS) for inpatient hospital services and a resource based fee schedule for physician services. Administrative reforms have included the regional consolidation of claims processing for durable medical equipment, prosthetics, orthotics and supplies. Medicare administrative costs have been low as a proportion of overall program costs: one percent of Part A claims and 3.5 percent of Part B claims. The implementation of the Medicare Transaction System (MTS) should further streamline claim processing functions.

The HCFA also recognizes the importance of protecting the Medicare program from fraud. A senior official in HCFA, reporting directly to the Administrator, is responsible for coordinating the program's anti-fraud activities. The HCFA has also recently required that Medicare contractors establish fraud units, and we anticipate that these units will increase the number and quality of case referrals to our office.

Nonetheless, as HCFA and we understand, protecting the Medicare trust fund requires continual vigilance. Because of the dollars at stake, the program will always attract unscrupulous actors who attempt to take advantage of loopholes or flout the law altogether in an attempt to enrich themselves at the expense of the taxpayer and the Medicare beneficiary.

Based on our investigative work and ongoing reviews of program costs, we have recently begun major initiatives in several areas where we suspect systematic fraud, waste or abuse: home health, nursing homes and DME. These OIG-wide initiatives have brought the OIG's investigators, auditors and evaluators together as a team, communicating regularly with HCFA officials, to conduct a wholesale examination of these areas. Let me discuss our concerns and activities in each of these areas.

MAJOR OIG INITIATIVES

Home Health

Under its Part A services, Medicare pays for home health services. Among the services beneficiaries may receive under this benefit are: (1) part-time or intermittent skilled nursing care and home health aide services; (2) physical, speech, and occupational therapy; (3) medical equipment and supplies; and (4) medical social services. These services must be provided by a Medicare certified home health agency (HHA).

To receive this benefit, Medicare beneficiaries must be: (1) homebound; (2) in need of care on an intermittent basis; and (3) under the care of a physician with a plan of care established and periodically reviewed by a physician. Once these eligibility criteria are met, the benefit is unlimited as long as the services are considered medically necessary for the treatment of a beneficiary's illness. In addition, beneficiaries are not required to pay any coinsurance or deductibles (except for DME, which requires a 20 percent copayment).

Increasing Costs

Medicare expenditures for home health services have grown dramatically in recent years. In Fiscal Year 1990 the Medicare program spent $3.3 billion on home health. By 1994, four years later, Medicare was spending over $12 billion--a 263 percent increase. These costs are expected to reach $16 billion this year and more than $22 billion by the year 2000, if left uncontrolled--about the same as the entire discretionary budget authority for the Public Health Service in FY 1995.

During this same period, we've seen increases in both the number of beneficiaries using home health services and the average number of visits per beneficiary. The number of beneficiaries receiving home health services has increased 72 percent, from 1.9 million in 1990 to 3.3 million in 1994. Similarly, the average number of visits per person has increased from 36 in 1990 to 65 in 1994, more than an 80 percent increase.

Numerous factors have contributed to the recent growth in home health. The aging of the Medicare population and the development of complex medical technologies that can be provided in the home are two such factors. However, a significant program change in 1988 opened the floodgates for increased expenditures in the home health area. In that year, HCFA issued revised coverage guidelines that liberalized coverage of the home health benefit. The definition of the "part-time or intermittent" requirement was liberalized, and a reinterpretation of the "confined in the home" requirement was expanded to include persons who occasionally leave the home. These changes were largely made to comply with the settlement of a class action lawsuit, which alleged that Medicare contractors were improperly denying home health claims.

Oversight of Home Health

The OIG has observed several types of fraud in HHA operations, including cost report fraud, excessive services or services not rendered, use of unlicensed or untrained staff, falsified plans of care, and forged physician signatures and kickbacks. Between 1990 and 1994, OIG investigations led to 25 successful criminal prosecutions of HHAs or their employees and imposed three civil money penalties. In 1993 and 1994 alone, 39 HHAs or their employees were excluded from participating in the Medicare or Medicaid programs.

To respond to concerns about rising costs and program integrity, the HCFA has launched the Medicare Home Health Initiative. The initiative is aimed at assuring the efficient provision of responsive, high-quality, appropriate home health care. It has established six goals: (1) respond to beneficiaries' needs; (2) enhance providers' flexibility in structuring plans of care; (3) ensure provision of high quality care; (4) improve the efficiency of administration and operations; (5) facilitate appropriate utilization of home health services; and (6) ensure appropriate payments for the

benefit and enhance efforts to detect fraud and abuse. The HCFA asked that we participate in their effort.

As part of this examination, we are conducting provider-specific audits; validating claims in specific regions of the country to determine the nature and extent of inappropriate payments made under current Medicare rules; and conducting studies to explore how physicians and providers respond to the incentives of the current system, and alternatives to the current program structure and system.

Provider Audits

Through cost reports, HHAs can charge general and administrative costs to the Medicare program. We often find problems in the overhead costs billed to Medicare. For example, one home health agency claimed approximately $14 million in unallowable costs during one cost reporting year, including such expenses as theater tickets, alcoholic beverages, bags of vidalia onions to legislators, and gourmet popcorn in tins for physicians.

Our provider audits also examine the direct costs claimed by the HHA. In some cases, the results have been startling. Consider our findings when we audited a home health agency in Miami Lakes, Florida. Seventy-five percent of the claims submitted by this HHA did not meet Medicare guidelines. Visits were claimed but not made; visits were made to persons who were not considered homebound; visits were made when physicians denied that they authorized them; visits were made to beneficiaries who did not want the service. We estimate that of the $45.4 million claimed by this HHA in 1993, well over half, $25.9 million, did not meet reimbursement requirements. We have just issued a final report on these audit results.

Regional Claims Validation

An ongoing audit in Florida is based on a review of 200 randomly selected claims. This data will help us determine if the kinds of problems we found in Miami Lakes are true of Florida in general. We will provide our findings to the Subcommittee when they are available. Similar efforts are planned in other regions where our investigative work, and leads from HCFA, indicate that specific problems exist.

Incentives and Alternatives

In other ongoing work, we are reporting on the physician's role in home health care. Under the Medicare program, the physician must authorize home health services. The HCFA has recently decided to begin paying physicians for plan oversight. Thus, the extent to which physicians are, or could be, true "gatekeepers" for the Medicare home health benefit warrants our attention and scrutiny.

Our preliminary findings indicate that physicians generally have a relationship with patients for whom they sign plans of care, are involved in making referrals for home care, and review the plans of care they sign. Physicians are most involved with patients with complex medical problems. But they don't make home visits, and they don't directly manage the care the patient receives from the HHA.

We will also issue a final report shortly which provides information about how non-Medicare payers structure and manage their home health benefit. We spoke with 15 other payers including State Medicaid agencies, private insurance companies, health maintenance organizations, the Department of Veterans Affairs and the Civilian Health and Medical Program of the Uniformed Services.

We found that the primary difference between Medicare and other payers is not the benefit packages they offer, but the way they attempt to control home health costs. Other payers are more involved in assessing how their beneficiaries might benefit from home health care, and use case managers to ensure that beneficiaries are properly selected, care is properly provided, and utilization and progress monitored. Unlike Medicare, beneficiaries are assessed copayments and told what the insurer has paid the HHA on their behalf. Other health plans often set limits on the benefit—capping the number of visits that can be made over a specified period, for example.

We believe that HCFA and the Congress might study the merits of some of these approaches as it determines how best to control utilization and costs while assuring the appropriate delivery of high quality care to Medicare beneficiaries.

Nursing Homes

Let me now turn to the issue of nursing homes. Medicare pays for services delivered to beneficiaries in nursing homes under both Part A and Part B of the program.

First, Medicare covers 100 days of extended care services for qualified beneficiaries in a Medicare participating skilled nursing facility (SNF). This benefit was designed to reduce the length of stay in acute care hospitals and transition beneficiaries to their homes or to custodial care facilities. To qualify for the benefit the patient must have spent at least 3 consecutive days in a hospital, and require daily skilled nursing care or skilled rehabilitation services. In 1993, Medicare spent over $5 billion for SNF stays, under Part A of the program.

But Medicare Part B also comes into play, regardless of who pays for the stay in the nursing home itself. In 1992, we estimate that Medicare paid approximately $4 billion for services delivered to residents of nursing homes and billed to the program under Part B. Services that can be billed under Part B for such patients include physician services, laboratory services, radiology services, ambulance, and medical equipment and supplies.

The fragmentation of Medicare payment sources, suppliers and providers raises concerns about cost-shifting; inappropriate payments; overutilization of services; and financial burdens on beneficiaries. I will discuss each of these in turn.

Cost-Shifting

Cost shifting refers to the practice of billing SNF services that are covered under the Medicare Part A extended care benefit to Part B of the program.

The HCFA determines the daily rate it will pay for care in a SNF. This rate is calculated to include multiple services including room and board, nursing care, rehabilitation services, and other routine SNF services. SNFs are given flexibility to determine what services they will provide on a routine basis and bill for under the Medicare Part A cost report. As a result:

- Roughly $57 million in total enteral nutrition charges were allowed in both 1991 and 1992 under Part B when much of those costs should have been billed to Part A. It is clear that under Part A, patients' dietary needs should be covered by the SNF daily rate. Enteral nutrition is a liquid dietary substitute for patients who cannot survive on oral feedings.

- As much as $44 million in 1991 and $55 million in 1992 were charged to Part B for rehabilitation therapy. Rather than the SNF providing the ancillary services and charging them to the Part A program, third party providers billed the therapy as Part B services.

- As much as $44 million in 1992 was paid under Part B for surgical dressings, incontinence supplies, braces, catheters, and similar items.

Savings could result if these items were purchased by the nursing home, acting as a prudent purchaser and taking advantage of discounts, rather than being billed to Part B and reimbursed under fee schedules. We will issue a report shortly on the issue of cost-shifting, and further work on pricing of products under Part A and Part B will help determine the amount of savings possible by eliminating separate payment under Part B.

Inappropriate Payments

Durable medical equipment may only be billed to Part B of the Medicare program if the equipment is provided in the beneficiary's residence. The law specifies that a SNF cannot be considered a residence. Payments totalling $8.9 million in 1991 and $10.8 million in 1992 were made incorrectly for DME in a SNF stay. We have recommended that HCFA correct the system to prevent such payments, and HCFA has agreed.

Overutilization of Services

No single individual or institution is held responsible by Medicare for managing the beneficiary's care while in a nursing home and ensuring that only needed services are delivered to the patient. Indeed, the incentives run in quite the opposite direction. A provider who offers therapy services to residents of nursing homes gains a market for his or her services; the patient may well be happy to receive

services of any kind, with any possibility that it might help them medically or socially; and the nursing home's own staff is relieved of caring for the patient during the time the provider is delivering services to the patient.

Likewise, suppliers may deliver unneeded supplies to nursing homes for beneficiaries, but the nursing home has little incentive (except for limited storage space) to turn supplies away. I'll talk about this situation more in a moment.

Financial Burden on Beneficiaries

In 1992, beneficiaries whose stays in SNFs were covered by Medicare paid up to $99 million as their coinsurance and deductibles for therapy, nutrition, and medical supplies and equipment billed under Part B. Had each SNF provided these services under Part A, itself or under arrangement, none of the residents would have been liable for coinsurance or deductibles.

Planned Actions

The HCFA shares our concerns about fragmentation of billing for services delivered to Medicare beneficiaries in nursing homes and is working on possible solutions. With regard to our work on payments to Medicare beneficiaries during covered SNF stays, the HCFA believes that a statutory "rebundling" provision for SNFs, similar to that for hospitals, is needed. Such an approach would also support work to establish a prospective payment system for beneficiaries in SNFs. We agree with this direction, but are also working with HCFA on more short term solutions.

Medical Equipment and Supplies

We continue to focus on medical equipment and supplies, as we have in the past, but in closer partnership with HCFA and the newly established DME regional carriers (DMERCs). Our investigative activity continues to disproportionately fall into this category of service. Between 1990 and 1994, our investigations led to 131 successful criminal prosecutions of DME suppliers or their employees. During the same period, we imposed 38 civil money penalties. In the last two years alone, we excluded 114 DME companies or their employees from the Medicare and Medicaid programs.

We often take a close, hard look at specific items of equipment or supplies when we see a significant increase in payments over a short period of time. In absence of coverage or coding changes, or new medical information about the proper use and application of technology, such increases have often been an indication of fraud or inappropriate billings.

In the past, using this technique, we have identified problems with seat lift chairs and transcutaneous electrical nerve stimulators (TENS) units, both of which have now been corrected. More recently, we reported on a similar trend with orthotic body jackets–customized, rigid devices intended to hold patients immobile and treat patients with muscular and spinal conditions. Payments for this device went from $217,000 in 1990 to $18 million in 1992. We estimated that 95 percent of those payments were for devices more properly categorized as seat cushions rather than body jackets.

As HCFA has moved to process such claims by specialty carriers, such problems are easier to spot and address. In fact, by the time we issued our findings on orthotic body jackets, payments were already on a downward trend because of this change.

But, there are always new twists. Our recent work suggests that an emerging problem in the medical equipment and supplies area has to do with marketing and targeting of patients in nursing homes. We now find that when unnecessary medical equipment and supplies are provided to Medicare beneficiaries, they are often residents of nursing homes.

An example is our recent work on incontinence supplies.

Incontinence Supplies

Incontinence supplies are supplies used for individuals who have bladder or bowel control problems. The Medicare program covers these supplies when incontinence is of long and indefinite duration. Incontinence supplies include catheters and external collection devices such as pouches or cups. Catheters are flexible, tubular instruments used to control urinary flow. The HCFA will also reimburse for accessories that aid in the effective use of such devices, such as drainage bags,

irrigation syringes, sterile saline solutions and lubricants. However, certain items, such as absorbent undergarments or diapers, are specifically excluded from Medicare coverage.

Increases in Costs

Medicare allowances for incontinence supplies more than doubled in three years despite a drop in the number of beneficiaries using these supplies. The amount allowed for incontinence supplies rose from $88 million in 1990 to $230 million in 1993, an increase of $142 million. During the same period, the number of beneficiaries receiving incontinence supplies fell from 312,000 to 293,000, causing the allowance per beneficiary to increase from $282 to $786, a 179 percent increase.

Four types of incontinence supplies account for almost all the increase in Medicare allowances: irrigation syringes, sterile saline irrigation solution, lubricant, and female external urinary collection pouches. These account for 91 percent of the $142 million total increase. Most of these payments were concentrated in one carrier and a small number of suppliers and beneficiaries.

Questionable Payments

Questionable billing practices may account for almost half of incontinence allowances in 1993. Medicare allowed $107 million in 1993 for supplies whose billing is questionable. $88 million was allowed for accessories that were not billed along with a catheter, indicating that coverage guidelines were not met. Another $19 million in allowances were made for beneficiaries who appeared to receive more supplies than necessary.

Supplier Practices

Information from nursing homes indicates that suppliers engage in questionable marketing practices to increase their business in incontinence supplies. Twenty-four percent of nursing homes have reported that supplier representatives decided the number of supplies to be delivered in a given month to beneficiaries. In addition, nursing homes have reported other practices by suppliers such as the routine waiving of beneficiary coinsurance payments as well as offers of inducements in exchange for allowing suppliers to provide incontinence supplies to patients.

Nursing homes have told us that some suppliers present them with false or misleading information. Twenty-two percent of nursing homes received false information from suppliers stating that Medicare is introducing "new broader coverage" for incontinence supplies. One out of ten nursing homes has been misinformed by a supplier that Medicare will cover other routine incontinence supplies such as absorbent undergarments if syringes, sterile solutions, and lubricants are purchased.

We have launched a major national investigation into the marketing and billing of incontinence care kits and supplies to nursing home residents. The potential for great profit provides an incentive for fraudulent marketing and billing schemes which target the entire nursing home population of Medicare beneficiaries. The cost of the supplies contained in an incontinence kit is typically $4. These items are fragmented and upcoded for billing purposes, causing Medicare to be billed about $20 for each kit. Providers usually ship and bill at the rate of 3 kits per day per beneficiary, which is the maximum Medicare will reimburse. At 90 kits per month, the cost to Medicare Part B is $1,800 per month, per patient. It is not surprising that this has turned into a $200 million business.

OTHER COST SAVING IDEAS

Of course, our work and our concerns go beyond the three areas I've just discussed.

Recent Testimony

The Inspector General has recently testified before the Senate on subjects which have cost saving implications. We would like to raise these issues before the new members and new Chair of this Subcommittee as well.

On November 2, 1994, the OIG testified before the Senate Appropriations Committee on oxygen services. At that time, we released a report on services delivered to Medicare beneficiaries receiving oxygen concentrator services. In that study, we found significant variation in the kinds and frequency of services delivered and the frequency of services delivered to Medicare beneficiaries receiving oxygen concentrator therapy. We also discussed our prior work which compared Medicare payments

for oxygen to other payers' payments, including the U.S. Department of Veterans Affairs, which pays significantly less than Medicare. At the hearing, the HCFA Administrator committed to a review of payment levels for oxygen concentrators and related services. Medicare allowances for oxygen concentrator rentals in 1993 exceeded $850 million. The subcommittee estimated that HCFA could save over $300 million if Medicare paid the same rates as others.

On December 13, 1994, the Inspector General testified before the same Committee on ambulance payments. Most ambulance benefits are covered under Medicare Part B and have very strict limits. Ambulance transport must be reasonable and medically necessary. No payment may be made in any case in which some means of transportation other than an ambulance could be utilized without endangering the individual's health, whether or not such other transportation is actually available. Generally, ambulance transport is covered for patients whose condition requires emergency medical attention, or whose condition makes it impossible to sit and requires transfer by stretcher.

Total Medicare carrier allowances for ambulance transportation under Medicare Part B were $1.52 billion in 1993, on behalf of over three million beneficiaries. Our work on ambulance payments leads us to two conclusions: first, many payments for ambulance transports taking End-Stage Renal Disease beneficiaries to and from dialysis violate Medicare guidelines and should never have been made; second, Medicare has a problem in the way it reimburses for ambulance transports--not just for dialysis patients but all Medicare beneficiaries. As a result, it pays too much. We've estimated that a total of $112 million annually could be saved with various program reforms.

Cost-Saver Handbook

The 1995 edition of the Office of Inspector General "Cost-Saver Handbook," also known as the Red Book, contains a number of options that could also be considered by the Congress to attain greater program efficiency and to enhance the viability of the trust funds. For example, we've made the following recommendations:

Expand the Diagnosis Related Group Payment Window. Separate payments for nonphysician outpatient services are not allowable within 72 hours of the day of an inpatient admission, as those costs are considered part of hospital's payment for inpatient services. For the period November 1990 through December 1991, $83.5 million in admission related nonphysician outpatient services were rendered 4 to 7 days immediately before an inpatient admission, just beyond the current "window." We recommend that the window be expanded in order to encompass more admission related services.

Pay Differently for Admissions not Requiring Overnight Stay. Hospitals are reimbursed when the patient is discharged based on established rates which are based on 494 diagnosis related groups. In 1989, the Medicare program paid for 179,500 admissions which did not require an overnight stay. We've estimated the Medicare program could save up to $210 million per year if covered services related to 1-day admissions without an overnight stay were paid as outpatient services.

Reduce the Indirect Medical Education (IME) Factor. Work by the OIG and others has documented that teaching hospitals have consistently had the highest profit margins under Medicare. Although Congress has previously reduced the rates which give these hospitals add-ons for their teaching costs, the IME factor is greater than is appropriate. Reducing the IME factor would be proper and fair and save the program billions each year.

Change the Graduate Medical Education (GME) Payment Methodology. We have found that Medicare will pay more than its fair share of GME costs if changes in two areas are not made. First, the new payment system allows hospital costs with little or no connection to Medicare to be given increased importance in the calculation of GME reimbursement. Second, the Medicare patient load percentage, used to compute Medicare's share of these costs, does not accurately represent Medicare's share of the cost of services provided to Medicare patients. As a result, we recommended HCFA propose legislative and regulatory changes to the new payment system to more accurately identify Medicare's share of GME costs. These recommended changes to the new methodology will reduce Medicare's share of GME costs by an estimated $157 million a year.

Reduce Hospital Capital Costs. We have determined that historical costs used in setting hospital payment rates were inflated because of excess hospital capacity and the inclusion of inappropriate elements. The newly enacted prospective payment system for capital expenditures is based upon inflated historical costs as part of the formula calculation. Continuing mandated reductions in capital payments beyond FY 1995 (when currently legislated limits expire) would be proper and fair and save the program billions each year.

Change Incentives for Billing Laboratory Services. The Medicare Part B program is paying single test payment rates for chemistry tests commonly performed on automated laboratory equipment. Single test payment rates are paid because HCFA's guidelines regarding chemistry tests subject to paneling have not been updated to add tests as laboratory technology has advanced. Savings to the Medicare program would be about $216 million annually if 10 tests were included as panel tests nationwide. The HCFA has agreed to 8 of those tests.

We also believe that the incentives for billing laboratory services need to be changed. We've put forward two ideas in particular: reinstating of beneficiary coinsurance and deductible provisions for clinical laboratory services as a means of controlling utilization; and rolling in laboratory services as part of the payment for a physician office visit. We estimate over $1 billion in annual savings from the first proposal, and another $1 billion annually from the second, exclusive of the beneficiary coinsurance which would be paid for the office visit.

We don't expect that you'll agree with all the cost saving ideas we've proposed in the Red Book, or even with our savings estimates in all cases. But we believe the proposals in our Red Book are useful for policy makers to consider as they look to contain costs and introduce program efficiencies.

THE NEW FRAUD FIGHTING ENVIRONMENT

I would now like to turn to the broad question of how we can best protect the Medicare program from fraud and abuse. If you asked me what is different today from several years ago in the fraud fighting environment, I would point to three factors in particular--increased sophistication and complexity in fraud schemes; rising Medicare costs, creating a more attractive target for the unscrupulous; and the emergence of new "fraud fighters" to meet the challenge.

I'd like to discuss briefly each of these topics and what I believe are possible solutions to address the challenges before us.

Coordination of Anti-Fraud and Abuse Activities

Now more than ever, there are numerous Federal, State, and local law enforcement groups with a stake in investigating and prosecuting health care fraud. These include the Department of Justice and the Federal Bureau of Investigations; the Inspectors General at HHS, the Department of Defense, the Department of Labor, and the Department of Veterans Affairs; the United States Postal Service, State Medicaid Fraud Control Units and State Attorneys General; and HCFA and Medicare contractor fraud units.

It is essential that we take a leadership role in coordinating the fight against fraud and abuse in the health care marketplace. The Inspector General has taken her leadership responsibilities very seriously and has established this as one of the office's top priorities.

The Inspector General is co-chair of the Executive Level Health Care Fraud Policy Group, which includes representatives of the Attorney General's office, the Civil and Criminal Divisions, and the FBI. The Inspector General also chairs the IG Health Fraud Coordination Council, composed of Inspectors General with responsibilities in health care.

Rising Medicare Costs

Willie Sutton was once asked why he robbed banks. His famous answer was, "Because that's where the money is."

Today's criminals may be more sophisticated, but in one way they remain true to their forebears. They go where the money is.

In 1980, Medicare program costs were $34 billion. In 1990, that number had increased to $107 billion; by 1993, $143 billion; and estimated 1995 costs are $178 billion. With that much money at stake, the lure of a fast buck is irresistible to criminals and con artists.

Investment in the OIG

We see a trend towards increased complexity and sophistication in the various schemes used to defraud the Medicare program, and hence a greater need to call on more investigators, along with attorneys and auditors, to penetrate those schemes. Despite the increased threat, the OIG's resources have declined in the past several years as we have absorbed our share of the Department's budget reductions. This has resulted in a decrease in OIG staff from 1,411 employees in 1991 to 1,207 employees in 1995. By the end of FY 1994, 10 OIG investigative offices in 9 States and Puerto Rico were closed. During the same period, the OIG was required to implement the financial statement audit provisions of the Chief Financial Officer's Act of 1990, other new audit responsibilities, and over 40 new civil monetary and exclusion authorities, without additional funding for those new responsibilities. Our next challenge will be to absorb the loss of 262 staff who will be transferred to the Office of Inspector General at the Social Security Administration.

Funding our activities has been hampered by the discretionary freeze provisions of the Budget Enforcement Act. Budget constraints have produced the illogical result that spending on fraud prevention and detection–activities that pay for themselves many times over–has actually been curtailed.

Lack of resources to identify waste and combat fraud and abuse is a major problem because it allows harmful practices to continue and defrauders and abusers to escape detection. The limited resources available are inadequate to address sophisticated and complex schemes to defraud and abuse health care programs.

Health Care Fraud Reinvestment Fund

The oversight and enforcement activities of the OIG and HCFA are among the most productive of Federal programs. I mentioned earlier that for every dollar invested in the OIG, we return $80.

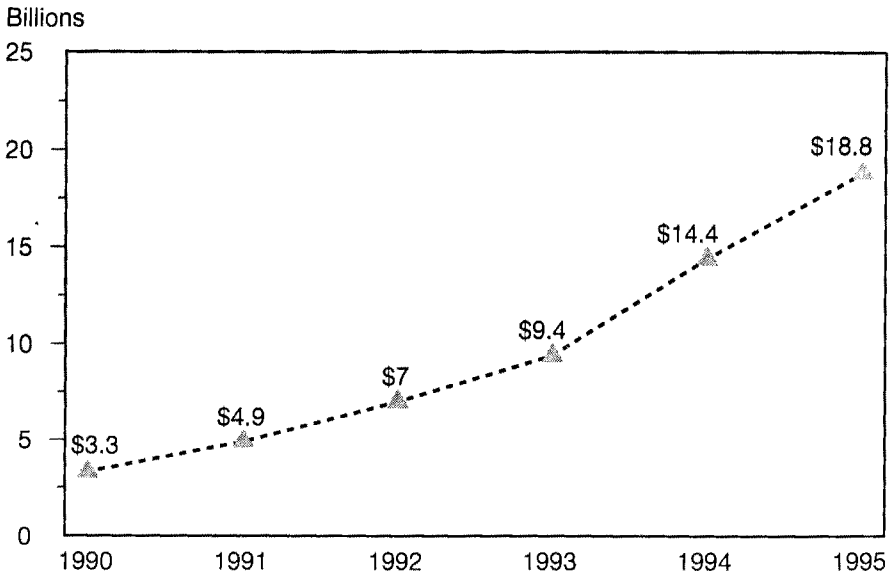
We support a mechanism to increase funding available for combatting health care fraud and abuse without drawing down from the U.S. Treasury, or further burdening taxpayers. Under this concept, certain recoveries generated by our health care anti-fraud activities would be deposited into a reinvestment fund with dollars available to fund additional enforcement activities. Thus, the individuals who actually perpetrate fraud against, or otherwise abuse our nation's health care system, will foot the bill for increasing policing of those programs. Of course, restitution to the Medicare Trust Funds and the affected Medicaid programs would be made before any monies could be deposited into the account. In the last Congress, this concept had wide bipartisan support. I hope, Mr. Chairman, we can win your support for this proposal.

CONCLUSION

Thank you for the opportunity to appear before you today. I look forward to a cooperative relationship with the new subcommittee as the congressional session continues. This completes my written statement. I am happy to respond to any questions you might have.

Home Health

Rapid Growth of Medicare Expenditures



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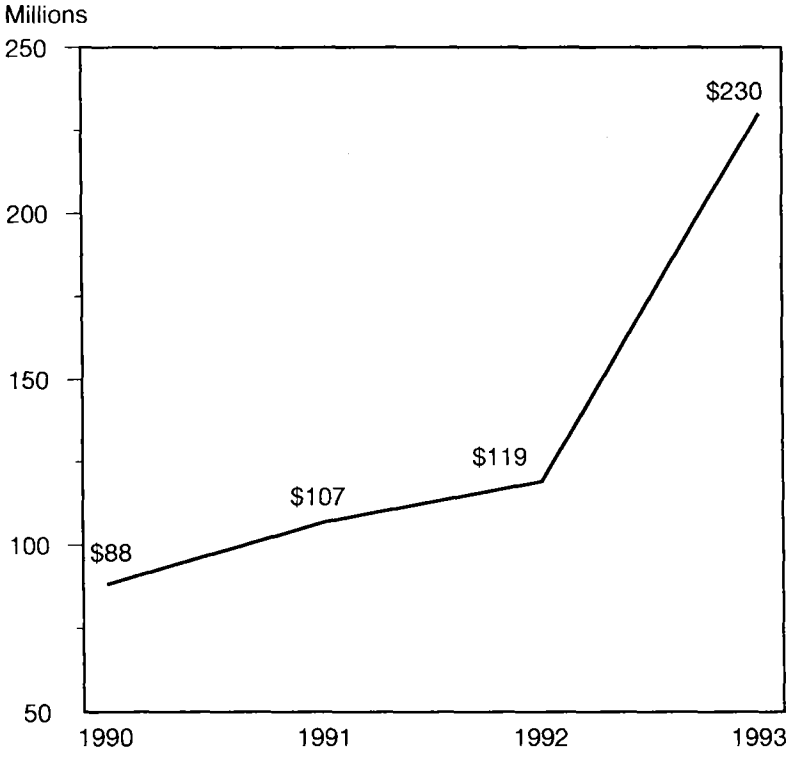
Incontinence Supplies

Payments Have More Than Doubled Over 3 Years



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Chairman THOMAS. Thank you very much for that condensed report. Appreciate it very much.

Mr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON, ASSOCIATE DIRECTOR, HEALTH FINANCING AND POLICY, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY EDWIN P. STROPKO, ASSISTANT DIRECTOR, HEALTH FINANCING ISSUES

Mr. SCANLON. Mr. Chairman and members of the subcommittee, we are very pleased to be here today to talk about ways in which the Medicare program could be improved to avoid excessive and unnecessary spending.

I would like now to introduce my colleague, Edwin P. Stropko, who is Assistant Director of Health Financing Issues at the GAO. Today we will be describing how revising certain reimbursement policies and imposing better controls on fraudulent and abusive payments can conserve program dollars.

In short, I will be discussing how loopholes and other weaknesses in reimbursement policies result in the program paying too much for services. Second, I will indicate how weak or absent controls on fraud and abuse result in the program paying for unnecessary services. Finally, I will note some broad administrative initiatives taken recently by HCFA that hold promise to cut Medicare spending for such unnecessary services.

Let me turn to the first area I indicated, problems in reimbursement policy. Our evidence suggests loopholes in payment rules and flawed payment setting methodologies allow Medicare to pay too much for some services. In the near term, immediate savings are possible through modest adjustments of those policies.

For example, in part because of the difficulty of applying Medicare's general rule of paying reasonable costs to specific circumstances, some skilled nursing homes and therapy companies have been able to pad administrative costs and services resulting in Medicare being charged hundreds of dollars per hour for occupational and speech therapy even though therapists' salaries are generally less than $32 per hour. This and other examples illustrate the government's need to act as a prudent purchaser.

However, taking action is not a simple task. HCFA faces strong pressure from those who benefit from high payments often with little countervailing pressure from any specific constituency to make reducing payments a priority.

The second area that I noted which is worthy of attention involves avoidance of paying for unnecessary services due to fraud and abuse. Opportunities exist to cut possibly billions of dollars in spending by implementing better controls over fraudulent and abusive Medicare payments. As you have heard from the Office of Inspector General, Medicare has paid providers' claims for improbably high levels of service or cost.

Additional examples include paying a clinical laboratory $3.1 million in 5 years for mileage charges to transport specimens. Mileage that would allow one to circumnavigate the globe about 230 times or paying a van service $62,000 for transporting a single ben-

eficiary 240 times in 16 months. These abuses came to light because of whistleblowers, not because program safeguard controls detected them.

Medicare pays more claims with less scrutiny today than at any other time in the past 5 years. Administrative funding declines have led to only 5 percent of claims slated for review in 1994. Profiling individual providers' claims to detect questionable billing practices has also declined. Physicians, supply companies, or diagnostic laboratories have about 3 chances out of 1,000 of having Medicare audit their billing practices in any given year. This limited investment in oversight occurs despite HCFA estimates that at present levels, incremental spending for antifraud and abuse activities would save $11 in benefits for every $1 invested.

Finally, let me note two broad HCFA administrative initiatives that our work indicates could assist considerably in reducing inappropriate payments. First, the Agency is requiring its contractors not just to examine claims from particular providers that might be overbilling but also to examine claims for specific medical procedures to identify questionable spending patterns and trends within geographic areas.

Second, HCFA is also developing a new claims processing system, the Medicare transaction system, to replace the 11 different systems used by the Medicare contractors who process and pay claims. This system will provide HCFA with improved capacity to reengineer its efforts to manage program dollars and properly oversee contractor spending, savings and workload.

In conclusion, it is clear that Medicare is an expensive program that is growing fast. Despite the urgency of controlling Medicare's high spending growth, however, swift, simple solutions may be difficult to identify and implement.

For the immediate future, HCFA can seek ways with the assistance of the Congress to make the government a more prudent purchaser of health services. By correcting flawed reimbursement policies and making adequate investment in and attention to activities like HCFA's recent antifraud and abuse initiatives, Medicare can avoid making unnecessary payments that can amount to billions of trust fund and tax dollars.

Mr. Chairman and members of the subcommittee, this concludes my statement. We will be happy to answer any questions that you have.

[The prepared statement and attachment follow:]

TESTIMONY OF WILLIAM J. SCANLON
UNITED STATES GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the ways in which the Medicare program could be improved to avoid excessive or unnecessary spending. Last fiscal year, federal spending for the Medicare program totaled $162 billion, or over $440 million a day. The Congressional Budget Office estimates that by 2002 Medicare spending could exceed $340 billion. Today we will examine the program's areas of rapid spending growth and ways to conserve program dollars--mainly by revising certain reimbursement policies and better controlling fraudulent and abusive payments. Our findings derive from numerous studies we have done on the Medicare program in recent years as well as ongoing studies. (See app. I for a list of the issued reports.)

In brief, the government faces strong obstacles to bringing Medicare expenditures under control. Broad-based payment system reforms have slowed aggregate spending, but Medicare's growth rates remain higher than overall inflation. And while additional reforms may be needed, their nature is the subject of much debate. There is less dispute, however, that Medicare pays too much for certain services and supplies. Fiscal pressures have led private and state-government payers increasingly to negotiate discounts with providers and to manage the form and volume of care. Medicare has not exercised its potential market power in similar fashion when buying certain services, such as rehabilitation therapy. Our evidence suggests that, in the near term, the government may want to revise the reimbursement policies for these excessively costly services to ensure that it is acting as a prudent buyer. The evidence also suggests that greater vigilance over wasteful or inappropriate payments could better protect Medicare funds against providers' fraudulent and abusive billings.

BACKGROUND

The Medicare program provides health insurance coverage for over 36 million elderly and disabled Americans. Its coverage is quite extensive, including physician, hospital, skilled nursing home, home health, and various other services. About 90 percent of beneficiaries obtain services on a fee-for-services basis, choosing their own physician or other health care provider, with charges sent to the program for payment. Medicare's payments are determined by a complex array of rules and procedures.

Seeking ways to constrain Medicare spending is a daunting task for good reason--the program is typified by paradox. On the surface, Medicare appears to be extensively regulatory, with thousands of pages of laws, regulations, and manuals governing program administration. Yet the individual decisions by millions of beneficiaries and hundreds of thousands of providers determine program spending. On the surface, Medicare is perceived to be a national program that is administered centrally. While on one level this is true, it is also true that commercial insurers--like Aetna, Travelers, and Blue Cross and Blue Shield plans--administer the program locally. By law, HCFA contracts with private insurers to process and pay Medicare claims. Today about 73 contractors perform this function, and each is required to work with its own medical community to set coverage policies and payment controls. Despite its image as a national program, therefore, Medicare's terms for covering medical care depend on each contractor, except in the few instances where HCFA has established national policies.

As intended, the contractor network has kept Medicare's policies within close reach of local provider communities. When HCFA issues guidelines and regulations, it does so only after extensive comment by the relevant segment of the health care industry. The program was designed this way to protect against undue government intervention in the nation's health care. As a consequence, however, HCFA faces obstacles in making the government a prudent buyer of health care services.

CONTROLLING MEDICARE
SPENDING IS CHALLENGING

Competing pressures challenge the government's ability to control Medicare spending. The multiple stakeholders involved and the potential market impact of enacting Medicare cost containment reforms argue for proceeding cautiously, while growing budget deficits call for immediate corrective measures.

In the last decade, the Congress has enacted two major legislative reforms that have slowed Medicare spending. A prospective payment system (PPS) using diagnosis-related groups helped bring aggregate spending growth for inpatient hospital services from about 15 percent in the early 1980s to about 8 percent a year today. A fee schedule known as RBRVS (resource-based relative value scale) and limits on spending increases known as volume performance standards helped reduce aggregate physician payment growth from over 10 percent in the late 1980s to 2 to 5 percent over the last few years.

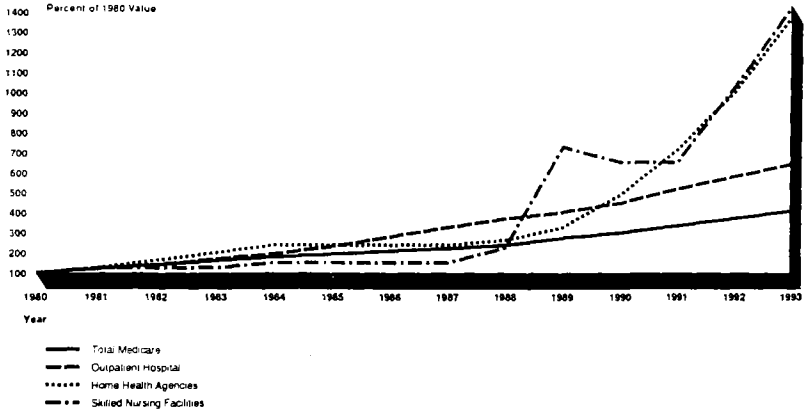
Still, Medicare spending growth remains at high levels for two reasons. First, the inpatient hospital and physician spending categories amount to $112 billion--over 75 percent of total Medicare spending. Despite some moderation, growth in hospital payments, after accounting for the growth in beneficiary numbers, still exceeds the growth of the nation's economy as measured by the gross domestic product. The sheer size of these spending areas means that each percentage point of growth represents hundreds of millions of dollars and helps account for the projected more-than-doubling of spending to $340 billion in 2002. (See table 1.)

Table 1: Medicare Payments and Growth Rates for Selected Service Categories

	Year	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993
Total Medicare	Payments	36.4	43.6	51.1	58.1	65.1	70.3	75.8	80.5	86.8	99.4	109.2	121.2	134.6	149
	% Increase		20%	17%	14%	12%	8%	8%	6%	8%	15%	10%	11%	11%	11%
Inpatient	Payments	24.5	29.4	33.9	37.8	42.3	44.9	46.5	47.1	49.1	55.5	59.8	65.7	72.5	78.1
	% Increase		20%	15%	12%	12%	6%	4%	1%	4%	13%	8%	10%	10%	8%
Physician	Payments	8.4	10.1	12.1	14.2	15.7	17.2	19.6	22.2	24.5	26.8	29.5	31.6	32.3	34
	% Increase		20%	20%	17%	11%	10%	14%	13%	10%	9%	10%	7%	2%	5%

Second, spending growth for other categories--such as outpatient hospital, home health, and skilled nursing care services--has accelerated dramatically. Between 1992 and 1993, spending for outpatient services grew by 11 percent to about $12 billion, and spending for home health and skilled nursing care each grew by about 40 percent to $11 billion and $5.7 billion, respectively. Ironically, this growth stemmed in part from the cost containment success of PPS, which prompted providers to shift the delivery of such procedures as cataract surgeries to outpatient settings. In addition, reduced hospital stays may have increased the demand for services provided by home health agencies and skilled nursing homes. (See fig. 1.)

Figure 1: Growth in Medicare Payments and Fastest Growing Services



Home health and nursing home spending, the program's fastest growing components, have expanded also as the result of external pressure to interpret Medicare's coverage rules for these services more liberally. This pressure, in the form of successful legal actions against the program, was precipitated by Medicare's attempts following the introduction of PPS to scrutinize the appropriateness of home health and skilled nursing home claims. Over the past decade, HCFA has been exploring ways to pay for these services prospectively, both to control prices of services and create incentives for appropriate utilization. However, sweeping changes to payment and coverage policies for major services like home health raise complex issues that may be difficult to resolve quickly.

LOOPHOLES AND OTHER WEAKNESSES PERVADE CERTAIN REIMBURSEMENT POLICIES

Immediate savings in the billions of dollars are possible, though, by modest adjustments to certain reimbursement policies. Loopholes in payment rules and flawed rate-setting methodologies allow Medicare to pay too much, in certain cases, for rehabilitation therapy, magnetic resonance imaging (MRI), and anesthesia services. Consider the following cases:

-- Skilled nursing homes and therapy companies have been able to pad administrative costs and inflate charges because of lax oversight of providers' cost reports and the resources needed to apply Medicare's general rules to specific circumstances. As a result, for some beneficiaries, Medicare has been charged the equivalent of hundreds of dollars per hour for occupational and speech therapy, though therapists' salaries are generally less than $32 per hour.

-- Medicare does not systematically lower payment rates for new technology services as they mature and become more widely used and as providers' costs per service decline. For example, Medicare payments for MRIs supported a proliferation of MRI machines in Florida, where payment

rates were so high that even inefficient, low utilization providers could earn profits.

-- Anesthesia payments, unlike payments to other physicians, are based on units of time, thus providing a financial incentive to prolong anesthesia service delivery. Our studies have shown that reported times for the same anesthesia service vary widely for no apparent reason and that basing fees on a procedure's median anesthesia time could reduce Medicare payments by over $50 million a year.

Together these problems illustrate the government's need to act as a prudent purchaser. In each of these cases, Medicare has continued to pay higher rates than necessary in a competitive health care environment. Yet taking action is not a simple task. HCFA faces strong pressure from those who benefit from high payments, often with little countervailing pressure from any specific constituency to make reducing payments a priority.

For example, despite projected savings, HCFA has been unsuccessful in its attempts to change its method of reimbursing for anesthesia services. Similarly, since 1993 HCFA has been exploring ways to address the inappropriate billing and payment of rehabilitation therapy claims, while spending for these services is growing at nearly 30 percent a year. Finally, HCFA has taken some action to lower spending for MRIs and other expensive technology, but not before its initially generous reimbursements allowed an oversupply of certain technology to drive up overall health care spending. HCFA still needs to develop methods for reimbursing the capital costs of new technology based on the lower operating costs achievable through efficient utilization.

CONTROLS OVER FRAUD AND ABUSE OFTEN WEAK OR ABSENT

Other opportunities to cut possibly billions of dollars in spending involve implementing better controls over fraudulent and abusive Medicare payments. Over 98 percent of Medicare spending is for payments to providers. Program administration--claims processing and activities to prevent inappropriate payments--constitutes slightly more than 1 percent of total Medicare spending. Less than one-quarter of a percent goes toward checking for erroneous or unnecessary payments.

Controls over waste, fraud, and abuse help ensure that Medicare does not pay for unnecessary or inappropriate services. Some controls are electronic and are programmed into computer claims processing software. They trigger the suspension of payments by flagging claims for such problems as charging for an excessive number of services provided on a single day. They also suspend payments for such clerical errors as the incomplete or erroneous number of digits in a provider's billing number. The computer automatically holds the claim until the data are corrected. Medicare's electronic controls are developed and applied largely at the discretion of Medicare's claims processing contractors.

The best way to understand what better Medicare payment controls might accomplish is to examine what has occurred in their absence. In some instances, Medicare has paid providers' claims for improbably high levels of service or cost. For example, the following are abuses that have come to light through whistleblowers, not because program safeguard controls detected them:

-- Over 5 years, Medicare paid $3.1 million in mileage charges to a clinical laboratory for transporting specimens. This amount reflects a distance of 5.7 million miles, equivalent

to circumnavigating the earth about 230 times.

-- Over 16 months, a van service billed Medicare $62,000 for ambulance trips to transport one beneficiary 240 times.

In fiscal year 1993, Medicare processed almost 700 million claims, about 250 million more than it processed 5 years earlier. Yet Medicare pays more claims with less scrutiny today than at any other time over the past 5 years. Funding declines, relative to the growing number of Medicare claims, have forced HCFA to lower the proportion of claims that contractors must review. In 1989, HCFA set targets for contractors to suspend processing and then review 20 percent of all claims; it reduced this target to 15 percent in 1991, 9 percent in 1992 and 1993, and 5 percent in 1994.

Similarly, HCFA's efforts to statistically profile claims that detect providers' questionable billing practices have also declined. Physicians, supply companies, or diagnostic laboratories have about 3 chances out of 1,000 of having Medicare audit their billing practices in any given year.

In some instances, for lack of adequate funding, contractors have curtailed or discontinued reviews of certain medical services, even when there was evidence of widespread billing abuse and potential for significant savings. For example, a contractor we visited last year temporarily reduced or suspended the use of five electronic controls that triggered further claims reviews. These reviews had previously resulted in the denial of claims submitted and $4 million in savings over a 3-month period. The contractor suspended the use of the controls because the volume of claims they generated overwhelmed the claims review staff.

The decline in program spending for fraud and abuse controls corresponds in part with the 1990 passage of the Budget Enforcement Act. That act places stringent limits, or caps, on discretionary spending, which covers Medicare administrative costs, including the cost of contractors' fraud and abuse controls. Benefit payments, however, are not subject to these caps. This creates a dual problem. Any increase in spending for Medicare's fraud and abuse controls would require cuts in funding for other discretionary programs, such as education or welfare. A decline in benefit costs, however, even if attributable to savings from fraud and abuse activities, cannot be used as an offset. In fact, funding for fraud and abuse activities is in continual jeopardy, since cutting this funding frees up money for other discretionary programs.

HCFA studies indicate that spending for antifraud and abuse activities can reduce Medicare program costs on average by as much as 11 times the amount invested. In effect, by not adequately funding these activities, the federal government is missing a significant opportunity to control Medicare program costs.

HCFA'S BROAD ADMINISTRATIVE INITIATIVES COULD CUT MEDICARE SPENDING CONSIDERABLY

HCFA has begun two major initiatives to address long-standing problems with inappropriate payments. First, it established a data analysis requirement, called focused medical review, for contractors to better identify excessive spending. Second, HCFA let a contract to design a single automated claims processing system--called the Medicare Transaction System--that promises greater efficiency and effectiveness in claims processing.

Prior to the focused medical review requirement, contractors were expected to examine claims looking only for physicians and other providers whose claims suggested they might be overbilling or engaged in some other wrongdoing. Under the new requirement, contractors must also examine spending for medical procedures to identify questionable spending patterns and trends.

For example, when a Medicare contractor in Tennessee compared its payments for selected services with those of other contractors, it found an instance where total payments for a service--pathology consultations--were not in line with other contractors' totals. Specifically, the contractor was paying pathologists for consultations when the test results should have been interpreted by the requesting physician. The contractor revised its payment rule governing pathology consultations, and reimbursements for this service declined from $2.7 million in 1988 to less than $11,000 in 1992.

HCFA's development of a new claims processing system--MTS--is intended to replace the 11 different claims processing systems used by Medicare contractors with a single system expected to have improved capabilities. This system will serve as the cornerstone for HCFA's efforts to reengineer its approaches to managing program dollars. Using the current multiple systems, HCFA has difficulty aggregating information on spending, savings, and workload at the various claims processing contractors. Inadequate management information makes it difficult for HCFA to provide the oversight required of a national program. The new system, which promises to format claims data uniformly and produce comparable payment data, is expected to provide HCFA with prompt, consistent, and accurate management information. Full implementation is at least 3 years away. In 1994, we recommended continued top management and congressional oversight to ensure the system's success.

CONCLUSIONS

Medicare is an expensive program that is growing fast. Because of its vast size and the aging of the population, broad-based reforms will be required to keep Medicare from consuming ever-larger shares of the national income. Despite the urgency of controlling Medicare's high spending growth, however, the program's complexities militate against swift, simple solutions. Reforms have moderated spending growth for inpatient hospital and aggregate physician services, but the lower growth still increases Medicare spending in multibillion dollar increments. Moreover, for the program's fastest-growing spending components, such as home health services, the government faces significant challenges to implementing major cost containment reforms.

For the immediate future, HCFA could seek ways, with the assistance of the Congress, to make the government a more prudent purchaser of health services. By correcting flawed reimbursement policies, such as those for rehabilitation therapy, high-cost technology, and anesthesia, Medicare could lower its spending growth rate. In addition, with adequate investment and attention to activities like HCFA's recent antifraud and abuse initiatives, Medicare could avoid making unnecessary payments that could amount to billions of trust fund and tax dollars.

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Mr. Chairman and Members of the Subcommittee, this concludes my statement. We will be happy to answer any questions.

RELATED GAO PRODUCTS

Medicare Part B: Regional Variations and Denial Rates for Medical Necessity (GAO/PEMD-95-10, Dec. 19, 1994).

Medicare: Referrals to Physician-Owned Imaging Facilities Warrant HCFA's Scrutiny (GAO/HEHS-95-2, Oct. 20, 1994).

Medicare: Technology Assessment and Medical Coverage Decisions (GAO/HEHS-94-195FS, July 20, 1994).

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GAO/HEHS-94-42, Apr. 28, 1994).

Health Care Reform: How Proposals Address Fraud and Abuse (GAO/T-HEHS-94-124, Mar. 17, 1994).

Medicare: Greater Investment in Claims Review Would Save Millions (GAO/HEHS-94-35, Mar. 2, 1994).

Medicare: New Claims Processing System Benefits and Acquisition Risks (GAO/HEHS/AIMD-94-79, Jan. 25, 1994).

Medicare: Adequate Funding and Better Oversight Needed to Protect Benefit Dollars (GAO/T-HRD-94-59, Nov. 12, 1993).

Psychiatric Fraud And Abuse: Increased Scrutiny of Hospital Stays Is Needed for Federal Health Programs (GAO/HRD-93-92, Sept. 17, 1993).

High-Risk Series: Medicare Claims (GAO/HRD-93-6, Dec. 1992).

Medicare: One Scheme Illustrates Vulnerabilities to Fraud (GAO/HRD-92-76, Aug. 26, 1992).

Medicare: Excessive Payments Support the Proliferation of Costly Technology (GAO/HRD-92-59, May 27, 1992).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992) and related testimony (GAO/T-HRD-92-29, May 7, 1992).

Medicare: Variation in Payments to Anesthesiologists Linked to Anesthesia Time (GAO/HRD-91-43, Apr. 30, 1991).

Medicare: Need for Consistent National Policy for Special Anesthesia Services (GAO/HRD-91-23, Mar. 13, 1991).

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

Mr. Christensen will inquire.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Mangano, I appreciate your testimony because now I know who to call when constituents call me and say that they have got this $90 device in front of them that they know they can make for $20. And I am going to add to your show-and-tell list there.

Mr. MANGANO. OK.

Mr. CHRISTENSEN. You said that HCFA does not have adequate mechanisms for determining which services should be paid by part A or part B.

Can you estimate to what degree HCFA has lost control over the program and how much we are spending as a result of its inability to effectively manage the program?

Mr. MANGANO. It would really be hard to assess how much money is being spent that shouldn't be spent because we only find it when we do find it in our individual studies. In one study that we just completed for Medicare part B, durable medical equipment, as an example, can only be billed in the home. It cannot be billed for a patient that is in a nursing home.

We found about $11 million that was being billed under durable medical equipment in a nursing home under part B services. On the face of it, that should not have been reimbursed. The big problem that occurs in a nursing home is that a nursing home gets to negotiate a little bit about what services they will provide; so when they are getting their part A payment, they can say that Medicare will not cover other kinds of things that you and I would think should have been covered.

In addition to things like medical supplies, about $55 million in 1993 was charged to the Medicare part B program for rehabilitation services. Over $40 million was charged for epidermal nutrition programs. These are nutrition programs where a person cannot eat like you or I but have to take their nutrients intravenously. There are any number of areas where these things are occurring.

We spot them when we see these big spikes start to go up in the reimbursement area. It is very difficult to determine how much actually is being spent out there that should not be spent.

Mr. CHRISTENSEN. At the end of your testimony, you spoke about the Medicare fund and about monitoring it better and having the money go toward that. As a new member on this committee, I am not aware of what you did in the 103d Congress. What suggestions do you have to improve on what we did in the 103d?

Mr. MANGANO. Sure. In any number of bills that had wide bipartisan support, there were suggestions for things called health care fraud and abuse control which basically said that when we investigate fraud and abuse and we have a successful prosecution, the program ought to be restored every penny that it lost because of that fraudulent activity. We would do that first. In addition to that, judges often require that penalties and fines be charged.

They also sometimes award investigative costs for what it cost the government to investigate the individual incident. What we are suggesting is that in the area of fines, penalties, and investigative costs, that a portion of that be put aside to help the Inspector General's Office and the Health Care Financing Administration in-

crease our activity in the fraud and abuse areas. In this way, the perpetrators of fraud will be actually paying for the increased policing, not the taxpayers.

We quite well understand the burdens that you are under in the Congress of not wanting to exceed the discretionary budget caps. The budget in the Inspector General's Office is included under the discretionary accounts so we are very much aware of that. What we are looking for is a funding mechanism by which you would not have to increase the cost to the taxpayer.

We are very proud of the fact that we return about $80 to the taxpayers for every $1 invested in the Inspector General's budget. We would like to help increase that return on investment by having more money to work with to bring more money back.

Mr. CHRISTENSEN. In closing, it sounds like you are doing a good job and I know that we want to do whatever we can to help you in your efforts. But I am always concerned by government agencies that police and monitor everything in the private sector. For example, other organizations, namely the EPA, have been nothing more than huge bureaucracies as far as their fining and overpolicing of the private sector.

What suggestions would you have for us to monitor better through private sector solutions? Any ideas?

Mr. MANGANO. Let me mention that there are a lot of checks and balances against our being abusive in policing the system. The system is replete with checks and balances. We cannot have a successful prosecution unless a U.S. attorney decides the case is worthy of carrying forward. We can't have a successful prosecution unless a judge or a jury awards damages, et cetera.

With regard to the private sector, we helped start about 10 years ago an organization called the National Health Care Anti-Fraud Association. It is an association of large insurance companies that have banded together in this association to begin their assault on fraud and abuse.

We have been working with that organization for the last 10 years and in fact hold a seat on its board. We have training sessions once a year to help them understand the kinds of schemes that we are finding in the government that they can then pick up on and look at in their own insurance companies. Occasionally they tell us of things that they are finding that we could follow up.

Mr. CHRISTENSEN. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from New York, Mr. Houghton.

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

Thank you gentlemen for being here. Your testimony was extraordinarily interesting, as this whole thing is. I have got to say that the study and understanding of our health system is the single most complex issue I have tried to ever wrap my arms around, so I appreciate your particular illustrations here.

I guess I want to ask a broad question here. You both have said, you said, Mr. Mangano, that Congress has got to study the merits of a variety of different approaches and I think Mr. Scanlon you said the same thing. There are specific things that can be done, but

you suggested about correcting fraud reimbursement policies, we really ought to get into the larger picture.

I guess the question I have got is this. I don't know whether we are trying to work a system that has just gotten too big. I don't know how you feel about this. You argue the programs and complexities preclude swift, simple solutions. But are you really saying that this means we should have an entirely different approach?

And let me just add one other thought here. That the bigger the system, the more micromanaging is necessary. So is there a way to flip it so that the individuals are monitoring the systems the way they do in other parts of life, or do we have to continue managing an ever-increasing huge bureaucracy which is called Medicare?

Mr. SCANLON. I think I share your frustration about trying to come to grips with the health care system and I think part of it is the same kind of frustration that individual consumers face in trying to assess what types of health services they need. Basically, we all suffer from an information problem. We don't know what services are really required for our best interest and, therefore, we need to rely on providers, creating an essential conflict of interest.

This problem is being addressed by the private sector. As the previous panel indicated, the private sector is well ahead of the curve in terms of trying to create a set of incentives for both providers and consumers that encourage the delivery of appropriate care. Medicare is a huge program and there have been a number of proposals to reform it that have talked about still giving people maximum choice, including remaining in the traditional program. Our concern is that while taking advantage of the private sector initiatives is essential for Medicare to consider, there is still a need to worry about the management of what remains in the traditional program. And that is a daunting task given the complexity and the size of this activity.

I think the private sector is also not ready to suggest that they have a simple or single solution to insure only appropriate care is delivered, but that they are trying a variety of alternatives. One of the private sector's advantages is that it is able to move much more quickly in terms of changing its system than can a public program.

Mr. HOUGHTON. Would you like to answer, Mr. Mangano?

Mr. MANGANO. I would just like to add we share your concern. This is a massive system. When I talked about $178 billion in Medicare, that was only the Federal money and not the beneficiaries' portion of it. That doesn't even take into effect the Medicaid system, which is another $92 billion Federal money and then States share after that.

I think you have to work a system that is that large from many different factors, many different facets. One of the best ways we get good leads for investigations is when beneficiaries get a notice in the mail from their insurance company saying that Medicare paid *x* amount for these following services and the beneficiary will say, wait a minute, I didn't get that kind of service and they will call our office and tell us about it.

I think some of the approaches through managed care have a lot of promise. Right now I believe Medicare has about 8 to 10 percent

of its beneficiaries in managed care. Managed care presents a different kind of problem.

In the fee-for-service system, we are worried about beneficiaries getting unnecessary services. In managed care, we have to be concerned about some, and granted it would be very few, providers who would provide too few services to increase their profits.

What we can do is automate the system as much as possible to identify where the aberrancies show up. When we see these rocket ship charts where, all of a sudden, for 1 or 2 years costs go up dramatically, we know something's happening in the marketplace. We have to jump in and take a look at it. Medicare has taken a number of initiatives which do take advantage of some of that technology.

Mr. HOUGHTON. I guess the worry I have, I have only got a little time left, is there is such a huge discrepancy between those who pay and those who receive and there are so many inner layers that you said in your testimony, Mr. Scanlon, that the government has tried to take a couple of cuts at this. One was in this PPS, prospective payment system, and the other was in terms of this resource-based relative value scale.

I don't know how many people out there in the United States really understand what that is. But what we are trying to do is to constantly take a cut at a system which is really imperfect and it doesn't give the people who receive an incentive to save money because they don't know how to do it.

Mr. SCANLON. I think that is the case. We have not found the solution as the previous panel indicated. Almost all Medicare beneficiaries have some form of secondary payment that removes the incentive that program designers attempted to create through coinsurance to make people more sensitive to the cost of services.

The resource-based relative value scale and the prospective payment system have had their impact in changing provider behavior, though. As the panel indicated, there are other areas within those two broad systems where things could be improved and what we have tried to identify today are other areas that also are in need of improvement.

Mr. HOUGHTON. Thank you, Mr. Chairman.

Thank you, gentlemen.

Chairman THOMAS. Thank you.

Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Mangano, I have always been of the opinion that home health care in the long run will save dollars versus nursing or hospital care. Now, my question is: If in fact we can root out the payment for nonvisits and some of the other abuses, is that statement not still correct?

Mr. MANGANO. I believe there is great promise in home health care services because it does eliminate the need to have persons go to nursing homes, which is the most expensive care that we can be providing in this country. So if we can ratchet down some of these abuses in the system, I think we also need to be thinking about mechanisms to avoid some of the most prevalent abuses.

In addition to services that are not wanted, you can get into the problem of having services that are beyond what is needed in a

case. A physician has to fill out a form that would allow a person to receive home health care services, but that physician usually does not follow the patient after they have completed that evaluation. They don't make house visits, and they don't look at the managed care.

We have been looking at a variety of other systems used by other payers, like the Veterans' Administration, the CHAMPUS program, Civilian Health and Medical Program of the Uniformed Services, HMOs in which they establish a case manager. That case manager would decide whether the person really appropriately needs those benefits. They will follow the utilization and the progress of the beneficiary. They will also cap the number of visits, and they will require a copayment.

Mr. KLECZKA. We have a project program going on, a 3-year project program in Milwaukee called "I-care" which is doing exactly that.

Mr. MANGANO. Right.

Mr. KLECZKA. During this period, have we seen any reduction in cost for part A or the nursing home?

Mr. MANGANO. Absolutely not.

Mr. KLECZKA. Why? Because utilization has increased? Or is it hard to say?

Mr. MANGANO. In the home health area, the number of visits has doubled in the last 4 years. The nursing home costs have also been going up steadily for the last 4 years. The home health benefit has all of a sudden skyrocketed.

We can claim that there are technologies that can be carried out in the home so that people don't have to go to a nursing home. The numbers of people added to the aged population are also increasing.

Mr. KLECZKA. That is why you can't track cost savings because you are not tracking that one piece.

Mr. MANGANO. That is correct.

Mr. KLECZKA. You might track a bunch in health care, all of a sudden 30 more go into nursing homes. You indicated in your statement skilled nursing facilities are billing under part B where they should be covered under part A. We have intermediaries who are charged the responsibility of reimbursing those providers. Why don't they buck those claims?

Mr. MANGANO. They have trouble matching the person with the two different billings. The Medicare program will receive a billing for part A services for a person in a nursing home. The part B is really a separate process. They have to have a process where they begin to match these. In doing this study, we had to physically do matches between the two programs so we could track the individual beneficiary.

Mr. KLECZKA. But you would think that once they pull up Joe Smith on the screen, and the code is nursing home patient, B should not be applicable for reimbursement.

Mr. MANGANO. Right. That is correct. And clearly Medicare needs to do a better job in that area.

Mr. KLECZKA. The next question is relative to the example you have with the cleanup devices where a packet is $4, but the split up, it is $20. Is there any additional financial incentive to the nurs-

ing home to buy the $20 split package versus the $4? What is their cut? What is their benefit?

Mr. MANGANO. We found some real interesting things when we did that. We found nursing homes getting boxes and boxes of supplies of these kits. The medical equipment supplier was charging them off to the individual beneficiary and sending its bill directly to Medicare so the nursing home never saw the bill.

So there is an advantage to the nursing home in that they have this large supply of medical devices and supplies that they can use on an everyday basis for all the beneficiaries in the home. These are things we think would have been the normal responsibility of the nursing home itself.

Mr. KLECZKA. OK, but what is in it for the nursing home?

Mr. MANGANO. Free supplies.

Mr. KLECZKA. They get free supplies, so that saves them overhead costs and equipment costs.

Mr. MANGANO. That is correct.

Mr. KLECZKA. The supplier is the one making all the money from that transaction?

Mr. MANGANO. That is correct.

Mr. KLECZKA. Mr. Chairman, let me go on to one further question. A letter I received from a constituent who writes to me he has power of attorney for his mother-in-law. She has Alzheimer's and recently became incontinent. They were told, or the family was told by the residence where the mother-in-law stayed, that the devices for the incontinence would cost somewhere around $2 apiece. So the residents went out and purchased these from a company in Florida, Tampa, Fla., called Meditech. And the end result was that instead of $2 per item for the incontinent diaper, they were billed for the urinary collection devices, some $1100, which translates to over $10,000 on average per year. And the constituent talks about Depends. Are you aware of, and I guess there might be many kinds, are you aware of what is a urinary collection device and how does that differentiate from a Depends?

Chairman THOMAS. I tell the gentleman, just earlier, we had a show and tell and we have got to repeat the show and tell?

Mr. KLECZKA. No, no.

Chairman THOMAS. This has an impact and you need to see it.

Mr. KLECZKA. I was here.

Chairman THOMAS. That is it.

Mr. MANGANO. This is one of the devices, the female urinary collection device which Medicare is billed $7.38, as opposed to the 33 cents for the diaper.

Mr. KLECZKA. That could be the urinary device.

Mr. MANGANO. That could be it.

Mr. KLECZKA. Originally the resident said it would cost $2 and they were talking something similar to a Depends.

Mr. MANGANO. Yes. Depending on what the device was itself. An individual diaper, we can buy for 33 cents. But depending on what the specific needs of the individual was, that device may be something more elaborate than that.

Mr. KLECZKA. But the individual indicates that the only difference in his—and he is not a medical expert, is that the Depends are not wrapped separately. The device that they are paying for,

that we are paying $10 for, is wrapped separately. So evidently there must be a comparison with diaper, the diaper versus the device you showed us before.

Mr. MANGANO. Or it could be what we call fragmenting the billing where they take a package which has maybe three or four items in it, separate them and bill separately for each of those particular items so the cost when you are billing separately is much, much higher than billing for the one individual package.

Mr. KLECZKA. Evidently there were two shipments, one for 27 and one for 25, so there is some bulk there.

One last question since I have a little time left, Mr. Chairman, or I can come back in the second round?

Chairman THOMAS. If you have got one last one, go ahead.

Mr. KLECZKA. For a product like this, does a doctor issue an order?

Mr. MANGANO. No.

Mr. KLECZKA. Or can a home go out and get it?

Mr. MANGANO. A home can order it for the patient.

Mr. KLECZKA. It is their decision whether the patient should have a Depend or an individually wrapped device?

Mr. MANGANO. That is correct.

Mr. KLECZKA. Why wouldn't they go local purchase versus running to Meditech in Tampa, Fla.?

Mr. MANGANO. There are any number of reasons.

Mr. KLECZKA. There are a lot of pharmacies where they can be purchased.

Mr. MANGANO. What we found is a very aggressive marketing strategy on the part of medical suppliers to go to the nursing homes and say Medicare has an expanded benefit for this particular type of service. They say, "If you order from us, we would take care of all the needs of your nursing home. You don't have to go and deal with a lot of other providers."

The nursing homes will say, "Are you sure that Medicare covers this"? "Absolutely, and you won't have to bill for it yourself. We are going to bill for it through Medicare part B."

Mr. KLECZKA. Who gets the color TV at Christmas? I am sorry.

Chairman THOMAS. The gentleman's time has expired.

Mr. Johnson of Texas.

Mr. JOHNSON OF TEXAS. Thank you. Appreciate you bringing that issue up.

I, you know, agree with an earlier questioner that looks like to me you guys are getting into micromanaging the system. And even though you claim you make a lot of savings, which I have heard many times in Texas from our own comptroller, give us more people, we will return you more money, somewhere there is a point of diminishing returns or no returns.

Can you tell me what level of additional resources you think you need to maximize your activities and why?

Mr. MANGANO. We are not even close to seeing the bottom of this barrel. We will get a minimum of 2,000 to 3,000 allegations a year. We can't really work but about one-third of those. We will pass them on to other law enforcement organizations in hope that they can cover it.

As the health care dollar has increased——

Mr. JOHNSON OF TEXAS. Well, when it becomes a matter of law or a violation of law, why shouldn't the criminal or investigative processes do this?

Mr. MANGANO. The FBI has authority to do it but they are busy on a lot of other things as well. There are State Medicaid fraud control units.

Mr. JOHNSON OF TEXAS. What you are telling me is you need to be a separate police unit or a separate investigative unit, the ones that are set up to do that work, which are authorized by law to do that work, you are going to usurp their power.

Mr. MANGANO. The Inspector General Act of 1978, which dealt with the Inspectors General, required the Inspectors General to have two basic functions. The first was to audit the programs of our department and the second was to carry out investigations of fraud and abuse against the programs of our department. So we have been doing this for a number of years.

Mr. JOHNSON OF TEXAS. I don't have a problem with that. But you also say that you are going to do studies and provide information about how non-Medicare payer structures manage their home health benefits. It sounds like that is a process that ought to be left to the private sector and not to an IG.

Mr. MANGANO. The kind of studies we do are meant to look at the programs of our department and see where the vulnerabilities are so we can follow up with specific audits or specific investigations. Occasionally we will look to the private sector where we think there is something to be learned about how the Federal Government can do its job better.

For home health services, we took a look at the private sector to see how some of the managed care companies are doing. We think this information can be useful to the Medicare program as well.

Mr. SCANLON. In addition to fraud activities, there is the question of abuse. Not necessarily intentional abuse, but providers unwittingly or unknowingly providing services that the program does not want to pay for. There isn't, in our view, adequate attention to those kinds of occurrences because contractors' budgets, in addition to the Inspector General's budget, have declined over the years relative to the volume of claims that are coming in to be processed. A greater investment in oversight would now seem to be able to generate savings.

But we would agree with you that it is not an unlimited investment that is called for but a carefully monitored investment to see what the returns are in savings. Additional investments should stop as soon as those returns decline to a point where the investments are no longer justified.

Mr. JOHNSON OF TEXAS. OK. And Mr. Mangano, though, is it true or false that you are duplicating some of HCFA's audit processes?

Mr. MANGANO. No, absolutely not. As a matter of fact, at the beginning of the year and many times throughout the year, we will sit down with HCFA to go over the kinds of activities that they are going to be carrying out that year. We work very closely with them to make sure we don't duplicate each other. Neither one of us has a dollar to spare in this activity so we are trying to make it go as far as we can.

Mr. JOHNSON OF TEXAS. Would it be more economical to have it all in one agency, yours instead of the Health Care Financing Administration? Why do they have one?

Mr. MANGANO. There are a number of activities that they carry out that I would consider program management activities. When you cross the line into auditing activities and investigation, you are moving into the Inspector General's area, but there are some activities that sort of look in the middle, in the gray area; and that is where we want to make sure we don't duplicate each other.

Mr. JOHNSON OF TEXAS. Well, I would agree with that. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you, Mr. Johnson.

If anybody is watching this either live or some time in the future, I am sometimes really concerned that folks who aren't in this room think we are as dumb as we appear to be and I want to assure anyone within my voice or picture that we are not. When you set up a fee-for-service program and it is a catch-me-if-you-can operation and there are people out there who are willing to be not just unethical but criminal in their behavior, the report that you have given us would clearly occur.

When you add billions of dollars to that mix, this report, although sad, probably shouldn't be unexpected. If you pay someone money to dismantle a package and you are dumb enough to pay them for the specifics in the package, which total greater than the package itself, someone will do that.

So as we listen to your testimony, it is neither all that enlightening or significant to me except to say that we have been dumb for a long time. But it is just not us. The system was dumb for a long time. And there are ways to learn from what is going on in the private sector to correct our problems.

Isn't it reasonable to say that if you capitated the payments in a general area for services, that crooks would tend to get out of the business because they don't have this multiplier or additive procedure which is of no problem to them but that if it was a capitated system and they had to deliver services under a structure in which all of the dollars didn't matter, just the final service did, that we could go after this problem to a certain extent?

Isn't that true? Either one.

Mr. SCANLON. I think we find that the problems that we have been noting today are in areas where there is no form of capitation. As Dr. Altman pointed out, the Medicare prospective payment system in some ways capitates the admission to a hospital. We are finding that areas where we allow the breakdown of services into their individual components and separate billing are where the problems occur.

The challenge in correcting those situations is to define what is going to be the unit of service that we are going to capitate. Global capitation, such as moving into managed care with HMOs, is one alternative. The HMOs then face the challenge of dealing with their providers to define units. To the extent that we maintain a fee-for-service system in Medicare, we will have to develop alternative capitation units to better manage service provision.

Chairman THOMAS. At least with the managed care, you have turned folks in on themselves in terms of making decisions. What I have heard from this testimony to a great extent, the fraud is detected by individuals who know they didn't receive particular services yet the billing procedure oftentimes does not pass through the individual, so even if they were knowledgeable, which many of them are not nor should they be, even if they were aware of the procedures that were going on, which is very difficult to detect, the way in which we do it now would evade them anyway. Ultimately when you put it under a managed care structure, people can vote with their feet on the overall performance of the structure.

It is now impossible for people to carry out that kind of a relationship. And so you know, your information is useful. It confirms the fact that as we change the system in the larger sense of going to a performance criteria and volume controls, we have had a whole new area open up, not because it wasn't there before but because the people who couldn't make money in other areas were now looking to game the system under new areas.

And Mr. Mangano, in terms of your home health question, there is no question people are aging and no question technology is coming along. I think the real spiker for that curve were court decisions in which HCFA previously was able to deny certain services and the Congress has failed to pass law to match the court case which has opened up the opportunity for these people to be even cleverer than they have been in the past about bilking the system.

Let me ask you about MTS, the medical transaction system. Obviously Mr. Kleczka was talking about catching people in terms of getting a billing in one sense and crosswalking it to another. Would we have had the computer capability to track all of the inputs coming into the system, where are we on MTS?

Mr. STROPKO. I think we are about——

Chairman THOMAS. Would you identify yourself for the record?

Mr. STROPKO. Ed Stropko, Assistant Director, with the General Accounting Office. HCFA is 3 to 4 years from implementing MTS. They have fallen a little behind schedule but it is an important system for them to develop.

Chairman THOMAS. We are going to attempt to provide you with those administrative simplifications and computer capabilities as we move a modest reform bill. It should have been done in the 103d Congress, while people wanted to reinvent the world, we were unwilling to provide you with simple accounting tools which are currently available and more and more people are making use of.

In your testimony, Mr. Mangano, you referred to southern Florida. In terms of the kind of fraud and abuse that you have looked at, have you done sufficient studies to get a feel for the regionality of the fraud and abuse or is it that you just went to particular areas because you thought they were high in fraud and abuse?

Do you have any statement that you might want to make for the record on what you feel, if you are capable, of the regional abuse of the system?

Mr. MANGANO. Well, we are finding that south Florida is an area that is rising dramatically in the fraud and abuse area. We have just, with the very few resources we have had, we just increased the number of investigators we put down there.

The study I mentioned regarding home health services where we found 75 percent of those claimed were not appropriate, we are now doing a statewide survey which we should have complete in a relatively short timeframe to see whether the entire State of Florida has similar problems within that regard.

We are focusing a lot of attention on south Florida. The amount of dollars—it is one of the four top States in Medicare expenditures for the country, so you naturally would think it would have a high rate of fraud and abuse.

Chairman THOMAS. Thank you. Any additional questions?

I want to thank the panel very much for your testimony.

Mr. MANGANO. Thank you.

Chairman THOMAS. I would ask the third panel to come forward.

I understand we have a replacement for the American Hospital Association, Rick Pollack will substitute. Donald Lewers of the American Medical Association; Dr. Nelson Ford, Association of American Medical Colleges, Larry Gage for the National Association of Public Hospitals; and Dr. Paul Ebert for the American College of Surgeons.

We will start the testimony with Mr. Pollack.

STATEMENT OF DICK DAVIDSON AS PRESENTED BY RICHARD POLLACK, EXECUTIVE VICE PRESIDENT AND DIRECTOR, AMERICAN HOSPITAL ASSOCIATION

Mr. POLLACK. Thank you, Mr. Chairman.

We appreciate this opportunity to share our views. Mr. Chairman, there has been a tremendous political change in the country and nobody knows that better than you and your colleagues, and change is what we are here to talk about today.

America's hospitals and health care systems understand that change is needed in Medicare and we favor change if it brings better care to seniors and reduced cost to all citizens who help finance the program. But in bringing about changes, we also must not lose sight of the contract with America that was signed 30 years ago and that is Medicare.

We have heard from many people that they have pledged to protect Social Security from budget reductions while suggesting that Medicare is fair game. Yet for the elderly patients we serve, the fact of the matter is that Medicare is Social Security. For most seniors, the value of the Medicare benefit package is as important as Social Security. Medicare benefits are irreplaceable. They would not be available from any other source.

A large part of Medicare is funded through the same payroll tax as Social Security. Medicare is one of three Social Security trust funds and, like Social Security, Medicare expenditures for part A are supposed to be self-financed and not contribute to the Federal deficit. The bottom line is that Medicare and the people it serves deserve the same protection from political and budget deficit pressures as Social Security enjoys.

While we recognize that Medicare outlays continue to grow at a rapid pace, there are very legitimate reasons for those increases and we have detailed them in our written statement which is based on a recent study by Price Waterhouse that we would also be pleased to make available to the committee.

Having said that, we recognize that doesn't mean we don't have an obligation and responsibility to achieve efficiencies in Medicare. The fact of the matter is that the Hospital Insurance Trust Fund is expected to go bankrupt shortly after the turn of the century. That is why we must fundamentally rethink the way we deliver and finance services to its beneficiaries and how we govern the program if we are to keep it viable for the future.

In our view, there is a right way and there is a wrong way to achieve savings. The wrong way would be to continue business as usual—and that would involve more arbitrary cuts to providers and that would involve using those savings to finance other legislative agendas.

It is important to recognize that since OBRA 1987, medical hospital spending cuts of $48 billion have had a major impact. These actions will cause genuine hardship, particularly to many rural and inner-city urban hospitals who are already in financial peril. Data from 1992 show that hospitals lose 11 cents on the dollar for Medicare services. Clearly, continued ratcheting down of provider payments will exacerbate this already fragile situation. And even ProPAC says that there are limits to the ability of Medicare to reduce payment growth without hurting access to quality care.

To deal with the problems constructively and for the long term, we need to move the part A trust fund off-budget and out of the political crosshairs and then we need to make structural changes. We believe that moving toward coordinated care or managed care is the right way to change Medicare. As we have learned from the private sector, creating an efficient delivery system for Medicare beneficiaries must be a part of the solution.

More and more, coordinated care plans are providing services in a seamless fashion, both providing comprehensive benefits and no longer forcing seniors to bounce around from one unconnected facility to the next. In fact, a recent study found Medicare enrollees in coordinated plans just as satisfied with their overall care as those in fee-for-service, and CBO confirmed that coordinated plans can save money as recently as last week before the Senate Budget Committee.

One last point, Mr. Chairman. We also believe that we need to reexamine how we govern the Medicare program and its trust fund. We think that the best way to accomplish this is through the creation of an independent citizens' commission and a process which involves the following steps from a conceptual perspective. First, the commission would establish a benchmark of what level of funding is needed to maintain current commitments to the Nation's seniors.

Second, Congress would then establish a target for how much it wants to spend on Medicare.

Third, the commission would translate that number—through a process open to the public—into recommendations for a benefit package that those funds would support and the appropriate provider payments. Congress would then vote on this package in an up or down manner on a fast track basis.

In this way, we can have an open discussion about how much we want to spend and what we want to buy for those funds. It doesn't mean that the pressure would be off to achieve savings. What it

does mean is that there would be an open process for balancing available resources with appropriate benefits. What it does mean is that Medicare spending decisions would be made on the basis of what is necessary to keep the program viable rather than using Medicare as the source to finance other legislative agendas.

So in closing, let me reiterate our commitment to change. Let me reiterate our commitment to work with you in a constructive manner to fundamentally rethink how we maintain that promise that was made 30 years ago to our Nation's elderly. And finally let me reiterate our hope that we do not resort to business as usual.

[The prepared statement of Mr. Davidson follows:]

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Statement
of the
American Hospital Association
before the
House Ways and Means Committee
Subcommittee on Health
on
Medicare Budget Issues

February 6, 1995

Mr. Chairman, I am Dick Davidson, president of the American Hospital Association. I am pleased to testify today on behalf of AHA's 5,000 institutional and 50,000 individual members. The Medicare budget issues under consideration are crucial to the lives of older Americans. Hospitals and health systems believe that we have an obligation to be there when they need us. For many hospitals, health systems, and elderly Americans, that means that the federal government must live up to another Contract With America -- a contract signed 30 years ago: Medicare.

MEDICARE IS SOCIAL SECURITY

In all of the political debate and discussion about tax cuts and balanced budget amendments, one government program has remained off the table: Social Security. Many Democrats and Republicans have openly pledged to protect Social Security from budget reductions, while suggesting that Medicare is fair game.

We believe, however, that Medicare is Social Security, and that it deserves the same protection as Social Security. Medicare and Social Security are both "contracts" with our nation's elderly to provide health care and a measure of financial security. A significant portion of Medicare is funded through the same payroll tax as Social Security. Medicare is one of three Social Security trust funds. Medicare serves the same seniors as Social Security serves. Like Social Security, the Medicare trust fund is not adding to the federal deficit.

The Medicare benefits Americans receive are irreplaceable. They would not be available through any other source. And, for most seniors, the value of their Medicare package is as important as Social Security. In short, Medicare and the people who rely on it deserve the same protection from political and budgetary pressures as Social Security enjoys.

America's hospitals and health systems understand that there needs to be change. In fact, we are at the forefront of change in communities all across the country. We strongly favor change that will lead to better care for our nation's seniors and to reduced costs for all consumers.

However, in seeking to bring change to a program that admittedly needs to be fixed, we must be careful not to take short-term actions -- like further arbitrary spending cuts -- that could make long-term solutions harder to implement.

GROWTH IN MEDICARE SPENDING: THE REASONS BEHIND THE RHETORIC

There's no question that Medicare spending is growing. Many policymakers who want to arbitrarily slash Medicare spending will tell you that it is growing faster than other federal programs. And they are right. But it's important to take a closer look at why. The AHA commissioned a study by Price-Waterhouse that was released just over a week ago. We learned some very interesting things. For instance:

- Inflation and enrollment growth accounted for nearly 89 percent of Medicare spending growth since 1980.
- Growth in Medicare enrollment between 1980 and 1993 was double the rate of growth in the general population. At the same time, enrollees over 75 years old as a percentage of all elderly (over 65) grew to 43 percent in 1993 and are expected to reach nearly half by 2005.
- The proportion of Medicare spending on hospital care has declined from 70.2 percent in 1980 to 60.1 percent in 1993.
- Medicare hospital spending growth is lower than growth in Medicare spending for other services.

Since the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) was enacted, Medicare hospital spending cuts of at least $48 billion have had significant impact on hospitals and health systems. So have Prospective Payment System (PPS) payment rates that haven't kept up with inflation. On Medicare inpatient and outpatient care combined, 1992 data show hospitals losing 11 cents on the dollar.

We know in the last year hospital cost performance has improved -- hospitals are working hard to make that happen, and we understand there may be an improvement in hospitals' Medicare margins as a result. Despite this improvement on the cost side, hospitals' overall financial health is less rosy -- the bottom line is that nearly one-quarter of all hospitals are still operating in the red.

In the past, hospitals have coped with Medicare spending reductions by shifting costs -- by passing the difference on to other payers, like non-Medicare patients and their employers. But those days are fast disappearing.

Simply put, the market is shutting down the cost-shift option. Managed care contracts and a growing number of private insurers who negotiate discounted prices are making cost-shifting a thing of the past. This leaves hospitals with unpalatable options: reduce the size of the work force; reduce services and programs; or both. Either action takes us farther from our mission of providing the highest-quality health care to all the people we serve, including America's elderly.

MEDICARE PART A TRUST FUND IS IN JEOPARDY

While we are committed to working with you to achieve further efficiencies in the Medicare program, we will continue to oppose "business as usual:" further arbitrary spending reductions, and proposals that would substantially reduce or freeze the hospital update factor, or lower special payment adjustments like the indirect or direct medical education adjustment, or the disproportionate share adjustment.

Even ProPAC says there are limits to the ability of the Medicare program to further reduce the rate of increase in payments for inpatient hospital service without hurting access to quality care for beneficiaries. The commission says that continued Medicare support for the additional costs associated with teaching programs is especially necessary in the absence of explicit financial support for these activities from other payers. And the commission notes that continued Medicare support for hospitals that are truly isolated or that serve Medicare beneficiaries residing in underserved areas is necessary to ensure access to care. We agree.

To protect Medicare and its beneficiaries, Congress should protect the Hospital Insurance Trust Fund. Balanced budgets, tax cuts and increased defense spending are popular goals, but trust fund balances should not be used to meet those goals. We need to shore up that fund, not weaken it further. Under even the rosiest scenario of the fund's Board of Trustees, the Hospital Trust Fund will be insolvent by the year 2004; a more conservative estimate gives it until the year 2000.

To deal with the problem constructively, and for the long term, we first need to move the Part A trust fund off-budget and out of the political cross-hairs. Then, we need to make fundamental, structural changes in the Medicare program -- like moving it toward coordinated care.

MOVING MEDICARE INTO COORDINATED CARE

In communities all across the country, hospitals, health systems, physicians, health care practitioners, local agencies and business leaders are working together to make their communities healthier. They are forming partnerships that bring a more coordinated health care delivery system to people.

These partnerships -- or networks -- focus on community needs and address underlying problems that contribute to poor health. Networks ensure that the right care is available at the right time. Through cooperation and collaboration, networks reduce excessive duplication of services and technology.

By being paid a fixed, up-front fee per member, they have incentives to use resources for prevention, health education and community outreach. They can also save money. A Group Health Association of America study shows that coordinated care plans, on average, reduced their overall premiums 1.2 percent for 1995. After years of premium increases, these plans are headed in a new direction.

For Medicare beneficiaries, coordinated care means greater ability to meet their needs and to deliver preventive care. More and more, coordinated care is covering all Medicare services, plus coverage for vision, dental, preventive services and even hearing aids -- benefits that most "Medigap" policies don't provide. Many coordinated care plans eliminate the 20 percent co-payment seniors must pay for doctor visits, and at the same time eliminate mountains of claim forms. These may be key reasons why a recent survey by the consulting firm of Frederick/Schneiders found that Medicare enrollees in coordinated care plans are as satisfied with their overall care as those with fee-for-service insurance.

Most importantly, coordinated care networks can bring Medicare beneficiaries closer to a better vision of health care for the future: a connected health system, with everyone who provides care -- doctors, hospitals, nurses and others -- linked together and communicating with each other at every stage of treatment and service.

Moving the Medicare program toward coordinated care is an idea that makes sense and one that many people believe will save money for our health care system. Take a look at the tremendous change that is going on right now in the private sector and the impact this change has already had on health and health care costs. According to the most recent Congressional Budget Office (CBO) projections, a shift from fee-for-service health care to coordinated care in the Medicare and Medicaid programs would generate overall savings of about 8 percent.

Coordinated care works. It works better than the old-fashioned, fragmented system we must pull away from. And it can bring better, more efficient care to older Americans who entrust their health to Medicare. There are a number of options Congress could consider that would help move Medicare into coordinated care. Here are a few:

- **Fix the current methodology used to pay Medicare risk contractors** -- There is general agreement that the current payment system is flawed, and Congress has directed the Health Care Financing Administration (HCFA) to propose revisions by October. Current payment is based on the Adjusted Average Per Capita Cost (AAPCC) of care in a county. Medicare should eliminate geographic inequities in payment across counties, inequities due to variable health status of local populations, and inequities due to differential utilization of services in local area, which affects costs and the calculation of the AAPCC.

- **Model the Medicare program after the Federal Employees Health Benefit Program** -- For federal employees, the government makes a fixed contribution and

the employee chooses from a wide variety of plans. Medicare could do the same on behalf of its beneficiaries if they choose to enroll in a coordinated care plan in the private sector.

- **Provide financial incentives for Medicare beneficiaries** who choose coordinated care options that are available in their area. These plans, offering comprehensive services at lower than current fee-for-service prices, give seniors better value for their Medicare dollars.

- **Explore new ways of paying coordinated care organizations that contract with Medicare** -- a new approach would allow plans in the same market area to bid competitively for Medicare contracts, for example. Bidding would have the effect of setting different market prices in local areas for Medicare coordinated care enrollees in a way that takes into account local costs and health care needs.

- **Expand the types of plans that Medicare beneficiaries can choose** -- Currently, beneficiaries can choose care through some health maintenance organizations (HMO) or traditional fee-for-service providers. Medicare should also contract with the growing number of non-HMO networks of care that meet high standards for quality and public accountability, and offer a full continuum of services for a fixed premium. New types of contracts could be negotiated with these non-HMO networks in which the networks and the Medicare program would share risk.

- **Provide seniors with more information on coordinated care plans** -- send a list of local coordinated care plans directly to beneficiaries and give them an annual report that compares coordinated care and fee-for-service plans on the basis of premiums, supplemental benefits, cost sharing, and quality ratings. This will make seniors more knowledgeable consumers and will highlight the benefits of coordinated care.

- **Allow for an open enrollment period each year**, during which Medicare beneficiaries can elect to receive services from a coordinated care plan -- and make their choice of a managed care plan valid for one year instead of the current 30-day period, to enable the plan to better manage beneficiary needs and practice preventive care.

We are already seeing the beginnings of a transition to coordinated care for many seniors. In the longer-term, this can bring lower costs and more efficient health care to seniors, and ultimately restructure the Medicare program itself. But, what about the process under which Medicare budget decisions are made? That process has to change as well.

BRINGING FUNDING DECISIONS INTO THE SUNSHINE

The American people have a right to know that what their nation spends on Medicare is buying the best benefits and the most efficient care. They should rest assured that federal budget pressures won't get in the way of providing good health services for older Americans. AHA urges Congress to create an independent citizens' commission to do this job.

An independent commission would ensure that the people who rely on Medicare don't fall victim to political horse-trading or pressures to cut the deficit, cut taxes, or increase defense spending. Those pressures have led to congressional, back-room, middle-of-the-night Medicare cuts of $100 billion under the past two budget bills.

An independent commission would get the process out of the back rooms and into the sunshine. The commission would do an independent study on the spending needed to maintain current commitments. Then, Congress can set a target for how much it wants to spend on Medicare. The commission would hold public hearings, translate the congressional target into recommendations for a benefit package and provider payment rates, and present Congress with its recommendations -- which would then be voted up or down as a package.

This way we can have an open and honest discussion about how much we want to spend -- and what we can buy for that money. The commission would also provide an annual report to Congress on the quality of care and access to care under the Medicare program.

Creating an independent commission to make recommendations on Medicare spending and benefits doesn't mean that we won't constrain growth. It does mean that we'll do it rationally, in the full light of day.

CONCLUSION

There is a right way and a wrong way to achieve reasonable reductions in Medicare. The wrong way is to do business as usual, letting short-sighted political pressures squeeze Medicare spending and weaken a program that needs to remain strong for our nation's seniors. The right way is to restructure the program by providing seniors more choice and encouragement to participate in a broader range of coordinated health plans.

And the right way is to establish an independent national commission to make the tough choices that will be needed to keep services and benefits in line with available money -- and to keep Medicare from being a "cash cow" that continually finances other policy initiatives and legislative agendas.

America's hospitals and health systems look forward to working with this panel to create constructive change in the Medicare program -- and to protect the health care of elderly Americans that we all serve.

Chairman THOMAS. Mr. Pollack, thank you very much for your testimony.

Dr. Lewers.

STATEMENT OF DONALD T. LEWERS, M.D., BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. LEWERS. Mr. Chairman, members of the committee, thank you for the opportunity to testify today. I am Dr. Ted Lewers. I am a practicing nephrologist in eastern Maryland and a member of the AMA board of trustees.

In addition, for clarification, I am a Commissioner of the Physician Payment Review Commission, however, my testimony here today is based solely on the behalf of the AMA.

Thirty years ago, Congress enacted a pledge for America: The Medicare program. The program's three promises were that: First, government interference with medical care would be prohibited; second, patient choice of provider would be guaranteed; and third, options for people to protect themselves against the runaway cost of any health services would be preserved.

Americans put their trust in these three underlying guarantees of Medicare—autonomy, choice, and individual responsibility. Sadly, these principles have been eroded in recent years. Simply stated, budget-based reductions no longer work. A transformation of Medicare is required if we are to keep the pledge to Americans.

The answer is not simply to throw more money at Medicare, nor is the answer to continue slashing reimbursement levels. Serious and irreversible consequences to patient access to care could result from yet another series of cuts. Physicians have contributed their fair share to recent deficit reduction efforts.

Physicians account for 23 percent of Medicare outlays, but have absorbed 32 percent of the provider cuts over the last decade. Between 1981 and 1993, budgeted physician payments were cut by $39 billion. OBRA 1993 imposed an additional $47.4 billion in provider cuts. Yet even in the face of these cuts, physicians have succeeded in actually holding down the volume increases below the levels predicted. Physicians actually saved the program billions in budgeted dollars.

At its inception, part B was to have been 50-percent funded from general revenues; that number is now 72 percent. We can probably agree on some of the major factors that have brought us to this point: Demographics, new technology, increased demand for a wide range of health services, and a troubling number of fraudulent providers. But underpinning it all is a fundamentally flawed financing system that begs to be restructured.

The AMA is pleased to learn that Speaker Gingrich has considered the formation of a Medicare task force and we are hopeful it will include patients, practicing physicians, hospitals, and other providers. We urge Congress to build on the experience and expertise of PPRC, ProPAC, and other groups representing a variety of providers and patients and we welcome the opportunity to be a direct participant in this process.

The AMA believes that a meaningful transformation of Medicare must adhere to a few basic principles. First, we must encourage physician and beneficiary cost-consciousness. As you know, Mr.

Chairman, we worked with you, Chairman Archer, and Ranking Member Stark to develop patient protections during last year's health system reform debate. We urge this Congress to include patient protection act language in any reforms of the health system.

Second, we must facilitate price competition among providers to encourage economic efficiency.

Third, we must reduce intergenerational inequity in financing. The burgeoning "65 and over" group is putting a greater and greater burden on a shrinking working population.

Fourth, we need to think about ways to reduce the number of citizens who will be dependent on Medicare in the future.

The AMA supports the enactment of tax incentives for medical savings accounts and privatization using vouchers for beneficiaries to supplement the purchase of private insurance. Other options the AMA believes require further examination relate to the financial status of beneficiaries and the appropriateness of applying means testing or income rating to recipients.

Last, we need to reduce regulatory and administrative complexity. However, we urge caution. Short-term approaches alone will not solve the long-term structural problems of Medicare. Moreover, we cannot be oblivious to the wide variances in need for the elderly; those whose personal resources are inadequate must be helped to assure that their needs are met.

In conclusion, the need for a farsighted transformation of Medicare requires us to look beyond the immediate demand for quick fixes. The truth is that until Medicare's underlying financial dysfunction is addressed, my patients cannot be assured that I will be able to continue giving them the care they require. For my patients, the bottom line is not dollars, it is their health and the quality of their lives.

Physicians want to continue providing reliable quality care to the Medicare population, but we need your help. The physicians of the AMA pledge to work with you to find real answers to these complex problems so that we may all keep the Medicare promise.

Thank you, Mr. Chairman, for the opportunity to appear before you.

[The prepared statement and attachment follow:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health

Committee on Ways and Means

of the

U.S. House of Representatives

Presented by

Donald T. Lewers, MD

RE: FACTORS NECESSITATING THE TRANSFORMATION OF MEDICARE

February 6, 1995

Mr. Chairman, on behalf of the 300,000 physician and medical student members of the American Medical Association (AMA), I thank you for the opportunity to present testimony to the Health Subcommittee today. My name is Donald T. Lewers, MD. I am a practicing nephrologist in Easton, Maryland, and a Member of the AMA Board of Trustees. Today's topic of evaluating the root causes of the overwhelming growth in Medicare spending is a clear precursor to debate on the necessary transformation of the entire Medicare program. We applaud your leadership and that of the full Committee's chairman, Mr. Archer, in holding hearings at such an early date on this important topic.

Mr. Chairman, the AMA and its members are pleased with many elements of the Contract With America. At the same time, in the spirit of full and open debate we have already expressed to the Congress key areas where we urge caution or change as the legislative process moves forward. One of these areas is in rushing to make short-sighted budget cuts in the wake of passing the balanced budget constitutional amendment. For as important as that vote was, and as much as we supported it, we will all lose as a nation unless overwhelmingly important programs such as Medicare are not dealt with deliberately and fairly in the ensuing budget process. Surely, we should all agree that the promises we make to Americans this year will be consistent and build on those made in the recent past.

Thirty years ago, the Congress enacted a pledge for America's future: the Social Security Amendments of 1965 creating the Medicare program. The three fundamental and explicit promises of this health insurance program for the elderly and disabled were that government interference with the provision of medical care would be prohibited, that patient choice of provider would be guaranteed, and that the patient's option to secure "protection against the cost of any health services" would be preserved. These three guarantees -- autonomy, choice, and individual responsibility -- are the underlying principles on which the Medicare system was to be built and upon which the trust of Americans was placed.

Over time, these principles have been grievously eroded by expediency, by inattention, and most of all by repeated short-sighted efforts to prop up a fundamentally flawed financing system. The program began as an open-ended promise, not limited in financial amount or conditioned on financial need. Make no mistake, the program has achieved great success in meeting its objective of providing universal access to high quality medical care for elderly Americans. Today's Medicare patient is generally healthier, lives far longer and is more productive than his or her counterpart of thirty years ago. Physicians are proud of our key role in this record of success, and our goal is to build on these achievements.

Yet as all who study the program now know, Medicare spending has grown much more rapidly than initially projected, as services and populations have been added with an increased demand for the advances of modern health care technology. The growing financial burden of the program has led to increased taxes on working Americans and provider payment reductions that threaten the access to health care of the very citizens the program is designed to benefit. Clearly, basic reform of Medicare

is urgently needed. The time to renew the original vows of the Medicare program has arrived in any legislation you craft in Congress this year.

BUDGET-BASED PROGRAM REDUCTIONS WILL NOT WORK

A transformation of Medicare is required if we are to keep our pledge to Americans. The answer is not simply to throw more money at Medicare. Nor is the answer to continue slashing reimbursement levels. A balanced budget cannot be "balanced" on the back of one program and those who provide that program's services. Serious, and perhaps irreversible, consequences to patient care could flow from yet another series of ill-considered cuts.

Last summer, John Eisenberg, MD, Chairman of the Physician Payment Review Commission (PPRC) established by Congress, was quoted in the New York Times as saying:

> "The problems in access to physician services for Medicare beneficiaries are just below the surface. People in areas underserved by doctors, members of minority groups and poor people already have the beginning of a problem. **This should be a red flag.**"

To put it simply, greater cuts could seriously harm Medicare patients. And the answer is not another round of huge Part B Medicare cuts; physicians have contributed their fair share to recent deficit reduction efforts. Consider, for example, the following facts: **physicians, who account for 23% of Medicare outlays, have absorbed 32% of Medicare provider cuts over the last decade.** Between 1981 and 1993, budget reconciliation has been the vehicle for reducing Medicare baseline expenditures by some $98 billion. In this process, Medicare projected physician payments have been cut by $39 billion. Enactment of OBRA 93 alone imposed an additional $47.4 billion in provider cuts over five years for Medicare, including conversion factor cuts for 1994 and 1995. Even with these levels of cuts, **physicians have succeeded in actually holding down the volume increases below that predicted for 1991, 1992 and 1993, thus saving the program billions in projected dollars.**

We believe that Congress and the Administration should recognize physicians' recent success in moderating growth in Medicare expenditures for physician services. HCFA data indicates that Medicare expenditures for physician services increased by only 3% during FY93. In the two years preceding that, the average annual rates on Medicare physician spending was only 5.8%. Lower rates of growth in physician spending between 1989 and 1993 have reduced the Medicare baseline by $50 billion, **nearly as much as the total 1992 outlays for physician spending.** Physicians should be recognized for these savings and not be forced to shoulder inequitable burdens in another round of budget cuts.

Recent evidence from AMA's Center for Health Policy Research suggests that reimbursement rules set in place by OBRA 93 will cause a nosedive in physician payments later in this decade unless they are remedied now. While the trendline has increased during the first two years since enactment, by the end of the century physicians may be paid less than they are today for treating Medicare patients. This downward slope is from figures calculated without any adjustment for inflation; measured in real dollars, the decline would be even steeper. Thus, even without further legislative modifications to Medicare, payment amounts for physician services will be further reduced below their already inadequate level of 59 percent of private payers' rates.

FACTORS DRIVING MEDICARE GROWTH

We can probably agree on the major factors that have brought us to this perilous point: demographics, new technology, and an increased demand for a wide range of health care services. Underpinning it all, however, is a fundamentally flawed financing system that has gone largely unrecognized until the last decade.

- From 1967 (the initial complete year of program operation) to 1992, the number of enrollees served by the program increased from 19.5 million to 35.2 million.
- From 1967 to 1992, program expenses grew from $4.7 billion to $135.8 billion.
- From 1967 to 1992, the number of claims paid grew from 31.5 million to 496.5 million.

Demographic change has contributed significantly to Medicare's growth. The U.S. population has grown 31 percent since the inception of the program, while the percent of the population aged 65 and older grew by more than 50 percent. Life expectancy of the Medicare population has also increased by more than 14 percent for both males and females. Finally, the age distribution of the elderly has shifted toward an older average age, with the group aged 85 and older growing by 68 percent.

Technological progress in medical care is generally acknowledged as having been a significant factor behind Medicare expenditure growth. Technological advances since 1966, when Medicare was first implemented, have expanded the scope of diseases and conditions that are treatable, increased the treatments available and improved their efficacy and safety, made the treatments less painful and unpleasant, and have often decreased the recovery time necessary for a patient to be able to return to productivity. In recent years, estimates for the impact of new technology on expenditure growth are generally in the 15-17% range (PPRC 1993 estimate; AMA's Center for Health Policy Research 1992 estimate)

Significant growth also has occurred in the rate of use of services, in that the number of enrollees who use more services paid for by the program has increased markedly. The number of persons actually receiving services increased 118 percent between 1966 and 1993. At the same time, the average amount of services consumed by each enrollee receiving services increased 6.5 times. This increased rate of use and more expensive consumption served to increase the amount paid per enrollee by 1340 percent.

Other beneficiary demand factors have been suggested as driving a portion of Medicare's growth. These include growth in beneficiary income and reductions in out-of-pocket liability by way of: (1) increased Medigap coverage; (2) increased assignment of claims, combined with limits on balance billing; and (3) real rate reductions in the deductible. It is well known that patient utilization of services is directly related to the degree of cost sharing for those services. CBO research estimates that beneficiaries with Medigap coverage consume 24% more physician and hospital services than those without such supplementary coverage. Since more than 70% of beneficiaries own such policies (which essentially convert Medicare into first-dollar coverage), program expenditures are significantly increased by defeating the cost-sharing requirements of Medicare.

Finally, health provider fraud and abuse is responsible for some portion of Medicare's growth. Allegations of "upcoding" by physicians, and charges that physicians inflate the number of necessary visits by a Medicare patient are undoubtedly true among a very small percentage of "outliers." Researchers disagree about the effect of these few practitioners; while some have discovered some evidence of upcoding, for instance, others have produced studies repudiating any significant effect from such fringe practices. For example, PPRC's initial investigation of physician coding for evaluation and management services between 1991 and 1992 suggested that no upcoding had occurred (PPRC 1994). A summary of relevant literature prepared by the PPRC suggests a wide variation in estimates of the rate of inappropriate care, with most falling in the 5-20% range. (PPRC 1993). Despite the relatively small number of aberrant or "outlier" practitioners, the damage they do is enormous; the AMA has a zero-tolerance policy in dealing with these physicians. For its part in the battle against inappropriate physician activity and fraud, the AMA is currently working in conjunction with both the Department of Justice and the FBI in stepping up its assault on fraud and abuse within Medicare.

While the Part B Trust Fund is technically considered "actuarially sound," this determination is based on the fact that the Part B side of this entitlement program is financed largely from general revenues. When Medicare was enacted in 1965, general revenues were to have covered 50% of Part B expenses; yet, in 1993, general revenue contributions to the Part B trust fund amounted to about $41.6 billion, accounting for **71.9%** of total Part B program expenses ($57.8 billion in 1993). Premium payments accounted for approximately $14.2 billion, or about 24.6% of program revenue. Interest payments accounted for the remaining 3.5% of fund revenue.

In the twenty-five year period between 1967 and 1992, the program has increased in population by 80.3% (2.4% annual growth), program expenditures have increased by 2,767.7% (14.4% annual growth), and claims paid volume have increased by 1,477.7% (11.7% annual growth. This growth trend is certain to continue well into the future absent determined intervention. Last September, the Congressional Budget Office released figures projecting that Medicare spending will increase from $195 billion in 1994 to $434 billion by 2004.

PENDING BUDGET ACTION

When Speaker Newt Gingrich testified recently before your Committee regarding elements of the "Contract With America" within its jurisdiction, he supported the idea of a market-driven system as the best option for the future of the Medicare program because it offers more choice to senior citizens. His emphasis was on how we can create the most competitive market-driven system for providing health care. He advocated using the Internal Revenue Code to provide incentives for people to "do the right thing." He mentioned professional autonomy, patient choice and individual responsibility -- coincidentally or not, the three promises of Medicare when it was originally enacted -- those same three promises that need so desperately to be reaffirmed today.

The Speaker's remarks should be heeded against the calls of those who would rush to reduce Medicare outlays to shore up the program. This simplistic budget-cutting approach has not resulted in cost-control over recent years, and now severely threatens the promised access of beneficiaries to medical care. The truth is that the Congress could come back every term and, facing intense political pressure, cut and cut payments for physician provided health care under Medicare, and we would still not have resolved the underlying financing dysfunction of the program as whole.

THE LONG TERM MEDICARE TRANSFORMATION

With the potential for patient harm implicit in yet another round of budget cuts in Medicare, the AMA believes that a far different course of action is needed. Budget-based actions simply do not address the fact that the Medicare program is at a crossroads and headed toward a destructive major financial crisis early in the next decade. There simply won't be enough money in the Medicare fund to meet the health care needs of an aging population that is growing larger and larger and living longer and longer without fundamental reform.

In short, a major transformation of the Medicare program is required. This transformation cannot wait. Congress and the Administration should not settle for further short-term cuts at the margins or place an artificial cap on Medicare expenditures in the name of political expediency. The Medicare program urgently requires serious, lasting change if its promise is to be preserved for current and future generations of Americans.

The AMA is particularly pleased to learn that Speaker Newt Gingrich is considering the creation of a Medicare task force that would be managed by this Subcommittee's chairman, Representative Bill Thomas, and the full Committee's chairman, Representative Bill Archer -- both men of proven leadership and vision in the health system reform arena. We applaud the Speaker's explicitly inviting to the table "practical people who run real hospitals and practical doctors who see real patients and ... senior citizens who are directly involved." The AMA will do all it can to provide your task force with the timely and reliable information needed to consider the many options that undoubtedly will come under discussion, and would welcome the opportunity to be a direct participant in this process.

The AMA is prepared to enter into a new partnership in which all parties -- patient, physician, and the government -- work together to develop rational and effective long-term solutions to Medicare's financing problems. We support actions to reduce the expected growth of the program over time. In light of what is known about the program's structural flaws and its dismal prospects if basic reforms are not made, the AMA believes that efforts to formulate long-term reform must adhere to five basic principles:

> **Beneficiary cost-consciousness must be encouraged.** Medicare has deductibles and co-insurance provisions to encourage cost-consciousness. However, 70% of beneficiaries insulate themselves from these provisions by purchasing private supplementary coverage ("Medigap") policies which transform Medicare into first-dollar coverage. As a result, some beneficiaries consume more medical services than they otherwise would, costing the program substantially. The adverse impact of Medigap policies must be critically evaluated as they affect the long-term stability of the program. At the same time, we must be cautious about the burdens on the elderly.
>
> **Price competition among providers must be facilitated to increase economic efficiency.** Medicare payments to physicians and providers are determined in a way that provides little incentive for price competition. Without price competition, beneficiaries have no incentive to be price-conscious in choosing among providers. As patient choice is a bedrock of AMA policy and part of the original Medicare promise, options for selecting coverage and the providers to deliver services must be encouraged. Mechanisms that allow beneficiaries to

participate knowledgeably in their own health decisions on the basis of service, quality and price should be used in the program.

Intergenerational inequity in financing must be reduced. Medicare is funded by pay-as-you-go financing: current workers support the medical expenses of current beneficiaries. Not only are the elderly better off financially as a group than the working population, but the number of workers supporting each beneficiary will begin falling rapidly from four at the present time to two in the middle of the next century. The working population cannot be expected to willingly pay higher and higher taxes over this period -- especially if the long-term future of Medicare is in serious doubt.

Test ways of reducing dependency of future generations on Medicare. To reduce the burden of the program on future working generations and the federal Treasury, the number of beneficiaries should be minimized. Means-testing of benefits has been suggested as one approach; however, additional approaches also merit consideration. Incentives should be created for more people to work towards becoming financially independent of Medicare during retirement. Tax incentives to build Medical Savings Accounts (MSAs), tax-free accounts dedicated to medical expenses, including nursing home and long term care expenses, should be enacted. The availability of Medical Savings Accounts (MSAs) to be used for this first dollar coverage, in tandem with "catastrophic" coverage, would enhance patient choice and encourage individual responsibility, promoting two of the three foundations on which Medicare was originally established. These two measures -- means testing and MSAs -- are, to some extent, a part of "The American Dream Restoration Act" and "The Senior Citizens' Equity Act," both components of the Republican Contract With America that come under this Committee's jurisdiction. Another idea is that of offering vouchers to beneficiaries to supplement their purchase of private insurance, which may be more desirable to some individuals than Medicare coverage.

Reduce regulatory and administrative complexity. It has been estimated that physicians now spend over 25 percent of their time processing paperwork and complying with the technical requirements of an unending blizzard of Medicare regulations. This is time that could be used more productively treating patients. Furthermore, it is one of several factors (including low rates of payment) that discourages physicians from seeing Medicare patients.

These five basic principles should guide the design of any approach to reforming Medicare to correct current structural problems and to reduce the dependency of future generations on subsidized government medical care.

OPTIONS FOR MEDICARE REFORM

A few broad categories of reform have been advocated by an array of interests, both public and private, participating in the public dialogue on Medicare. The first category of reform, reduced coverage and benefits, takes a short-term view. Two others, structural reforms to contain costs and privatization, take the long-term view of transforming the system.

Short-term Options Which Affect Benefits and Coverage

The Bipartisan Commission on Entitlement and Tax Reform staff report presented a short-term approach to reducing Medicare spending which would restructure benefits and/or coverage. The Commission staff did not consider implementing cost containment initiatives in their report, an approach suggested by others for many years. Another set of options aim to privatize the system over various lengths of time. These are discussed in more detail below.

Numerous suggestions for restructuring eligibility and benefits were contained in the Bipartisan Commission staff report and have also been suggested by the Congressional Budget Office (CBO) in past reports to Congress. Suggestions for these types of cuts, accompanied by estimates of savings calculated for each option, are described in Attachment A to this testimony. Such approaches, if applied alone, will not solve the structural problems which must be addressed if program costs are to be contained. Moreover, any approach along these lines should be careful to differentiate between the elderly who have adequate resources and those who do not. For those whose resources are inadequate, such changes should be structured to assure that their needs are met.

Enhancing Intergenerational Equity in Financing

As indicated earlier in this testimony, the taxing of younger workers with modest incomes derived from employment to pay for the routine medical expenses of elderly beneficiaries with substantial assets is unfair as well as irrational. The working population, which is growing smaller in relation to the burgeoning "65 and older" group, cannot be expected to pay increasingly higher taxes when the long-term security of the Medicare program is in such jeopardy. A number of proposals to address this growing problem of intergenerational inequity have been advocated, including:

- means-testing of Part B premiums. The CBO has made a number of suggestions, such as to increase the Part B premium for individuals with an annual income greater than $100,000 and for couples with combined annual incomes greater than $125,000;

- revision of the eligibility age of 65. The arbitrary decision to select 65 as the age of eligibility when Medicare was created has even less justification today: it is a medical fact that the health status of the average 65 year old individual today is not comparable to that of a 65 year old in 1965; and

- reducing the dependency of future generations on Medicare and increase personal responsibility by encouraging the working population to accumulate savings in Medical Savings Accounts for medical care needs in retirement.

Long-term Structural Repairs Are Needed to Increase Efficiency

It is widely recognized that private Medigap insurance places a large financial burden on Medicare when beneficiaries with such coverage demand additional services because of reduced cost-sharing. The program should add insurance options for beneficiaries which ameliorate the effect of Medigap insurance on the Medicare program. Under this proposal, Medicare would combine the current Parts A and B by:

- offering two Federal insurance options to beneficiaries. Medicare Plan I would provide all current benefits without cost-sharing. Medicare Plan II would provide the same benefits, but would include reasonable deductible and coinsurance levels plus reasonable out-of-pocket annual caps on these amounts;

- setting the Plan I premium to be competitive with the current Medicare Part B premium plus the premium for a comparable Medicare supplemental insurance policy. The Plan II premium should be lower than the current Part B premium but the deductible should be higher by a compensating amount; and

- discouraging purchase of supplementary insurance covering Plan II services by requiring Medicare to be the secondary payor if a third party covers the Plan II cost-sharing provisions.

Another commonly proposed approach to dealing with the Medigap problem is to tax Medigap enough to recover the additional cost imposed on Medicare. One should note, though, that the CBO has estimated that a 100% or greater tax on Medigap premiums would have to be imposed to compensate the program for the additional cost.

Privatization of Medicare

Many, including the AMA, have proposed privatization approaches to the Medicare problem. Such a proposal would provide vouchers for beneficiaries to purchase private health insurance and encourage individual savings for retirement medical care needs which would reduce dependency on Medicare over the long-term. Features include:

- giving Medicare beneficiaries vouchers to purchase either existing Medicare coverage or health insurance with some other minimum prescribed benefits (beneficiaries must have the option to purchase additional coverage using their own funds);

- raising Medicare taxes to accumulate reserves sufficient to cover all future program costs by a certain future date; and

- expanding IRAs to provide supplemental funds for health care expenses on retirement (as provided in "The Senior Citizens' Equity Act" of the Contract With America) and creating tax incentives for establishing tax-free Medical Savings Accounts (MSAs).

Others have suggested that Medicare immediately provide vouchers to beneficiaries to purchase private health insurance, which would result in immediate privatization of the system. These proposals also necessitate some reforms of the private insurance system to assure that coverage is available to all beneficiaries. To summarize:

If the Present System is Phased Out:

- Experimental programs to test vouchers for private insurance
- Savings incentives to encourage financial independence in retirement and "prefunding" of medical expenses (as through MSAs)
- Incentives to create more coverage choices, including "catastrophic"

If the Present System is Retained:

- Reduce regulatory and administrative complexity
- Ameliorate Medigap impact on utilization increases
- Reform fee setting to stimulate price competition and economic efficiency
- Means-test benefits to eliminate unjust intergenerational inequity

CONCLUSION

In the process of advancing these systemic reforms, the AMA understands the demand to address the pressing needs of today. This is why we are undertaking two commitments to help reduce unnecessary spending in the Medicare program. We are stepping up efforts to reduce fraud and abuse and are working with the Department of Justice and the FBI. In addition, we recognize that physicians must take the lead in addressing "care at the margins" and "futile care" as death approaches; some of this care is wasteful and even unwanted. Physicians have an obligation to confront these unnecessary uses of Medicare resources. Part of the problem is educational, as patients, doctors, and health care institutions need to better understand the legal and ethical issues involved. The AMA is committed to clarifying these issues for physicians and patients.

Finally, before the Congress becomes immersed in the coming budget process and the battles over specific proposals, we need to accept the fact that Americans can no longer postpone tackling fundamental reform of the Medicare program. Failure to do so is certain to prove even more costly for the millions of Americans who expect to be able to rely on this program in the future. Continuation of past stop-gap measures, such as chopping away at rates paid to providers in hopes of getting more services for less money, will ultimately divorce the Medicare system and its beneficiaries from the mainstream of American medical care.

Americans who depend on the Medicare program for their health care, as well as those who will rely on it in the future, should not have to worry about whether benefits promised them will be forthcoming. In the weeks and months ahead, the AMA pledges to work with the Congress to convince the American people that long-term reform is necessary and in the nation's best interest in order to keep the Medicare promise.

# # #

Summary of "Medicare Savings Through Reform: Options for Change"

prepared by:
The Center for Health Policy Research
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February 1995

Analysts have been studying a number of reform options and have projected fiscal savings associated with each. This report does not include all reform proposals that have been or should be considered; rather, it presents 16 incremental Medicare options for which savings estimates are readily available and timely.

Neither the options nor the estimates are new. The principal sources of material are the Congressional Budget Office and the Bipartisan Commission on Entitlement and Tax Reform final staff report. The options are sorted into two categories. Short term options assume implementation in fiscal year 1996, with savings estimates running to the year 2000. The long term options would, in most cases, also commence in 1996, but their savings implications are projected out to 2030.

Summary of Medicare Reform Options
Savings Estimates (by fiscal year, in millions of dollars)

SHORT RANGE OPTIONS

	1996	5-year 1996-2000
Beneficiary cost sharing:		
1. Increase and index Part B deductible	885	10,405
2. Raise coinsurance rate to 25% for Part B services	2,946	18,200
3. Collect 20% coinsurance for clinical laboratory tests, home health care, and skilled nursing facility benefits	3,349	29,826
4. Phase out Part B premium subsidy to 0% for high income enrollees	179	6,020
Medigap insurers:		
5. Tax medigap insurers	8,314	74,478

LONG RANGE OPTIONS

	2010	2030
Beneficiary cost sharing:		
6. Require a monthly Part A premium, indexed to program costs:		
a. $25 per month	22,053	97,522
b. $40 per month	35,285	159,937
c. $60 per month	51,457	237,955
7. Modify the Part B deductible for increases in program costs:		
a. Start indexing in 2000	5,881	39,009
b. Start indexing in 1996	10,291	58,513
c. Raise to $150 in 2000; index thereafter	8,821	54,613
d. Raise to $300 in 2000; index thereafter	11,762	58,513
8. Replace the Part B premium with a higher deductible:		
a. $800 deductible, indexed after 2000	0	50,712
b. $1200 deductible, indexed after 2000	17,642	128,730

	2010	2030
9. Index the Part B premium to maintain enrollees' current share of program costs	52,927	280,865
10. Phase in reduction of Part B premium subsidy for high income enrollees:		
a. Above $75,000 for couples ($50,000 for individuals)	7,351	35,108
b. Above $40,000 for couples ($30,000 for individuals)	19,113	89,721
11. Charge a 20% coinsurance payment for home health and clinical laboratory services	20,583	81,919

Beneficiary income taxes:		
12. Tax Medicare benefits as individual income:		
a. Include insurance value of Part A in income	30,874	136,531
b. Same as (a), for high income persons only	19,113	81,919
c. Include Part B subsidy in income	29,404	136,531
d. Same as (c), for high income persons only	17,642	81,919
13. Include the value of employer-paid health insurance and health care expenses in income for tax purposes:		
a. Benefits greater than average health insurance premium	64,689	249,658
b. Entire value of benefits	192,597	565,630
Eligibility age:		
14. Raise the eligibility age for Medicare:		
a. Match Social Security eligibility age	13,232	152,135
b. To 67 for persons under 46	20,583	152,135
c. To 68 for persons under 40	20,583	241,856
d. To 70 for persons under 28	20,583	401,793
Provider payments:		
15. Modify Medicare provider payments	69,100	358,883
Payroll taxes:		
16. Increase Part A payroll taxes:		
a. 1%	64,689	167,739
b. 2%	130,848	335,477
c. 3%	195,538	503,216
d. 4%	260,227	670,955

Chairman THOMAS. Thank you very much.
Dr. Ford.

STATEMENT OF NELSON FORD, CHIEF OPERATING OFFICER, GEORGETOWN UNIVERSITY MEDICAL CENTER, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. FORD. Thank you very much, Mr. Chairman. For the record, I am not a physician. I am Nelson Ford, the chief operating officer of the Georgetown University Medical Center.

Chairman THOMAS. Thank you.

Mr. FORD. I am here to testify on behalf of the Association of American Medical Colleges representing 126 accredited medical schools, 300 teaching hospitals, the faculty at these institutions, and over 160,000 students and residents in training to become our next generation of physicians.

I am here to testify on the vital importance of the Medicare program and the financial viability of the Nation's teaching hospitals and medical schools. I am concerned that many of the proposals under discussion today may affect that future viability. We have provided extensive testimony and I commend it to you.

I would like to focus on three issues of particular concern to us. The methodology of calculating the Medicare AAPCC for HMOs and its impact on teaching hospitals; the direct cost of residency training; and the crucial importance of the so-called indirect medical education adjustment on our future financial viability.

First, the Medicare AAPCC calculation has special payments in its base, including costs related to educational programs and disproportionate numbers of poor patients.

This provides additional revenue to precisely those health plans that may not use the types of hospitals for which the payment was intended. In fact, given the relatively higher costs of teaching hospitals and those serving the poor——

Chairman THOMAS. Mr. Ford, if I might interrupt, would you move that microphone more, and talk directly into it? We don't have good mikes for pick up. I appreciate it. Thank you.

Mr. FORD [continuing]. Puts the hospitals at a disadvantage in attracting Medicare patients. We recommend that the payments for teaching hospitals and the disproportionate share be excluded from the AAPCC calculation and that they be paid directly to the teaching hospitals that provide care to those managed care patients.

Second, with regard to the graduate medical education payments, we believe that the current methodology for Medicare's contribution to the costs of medical education, while not perfect, is generally fair and should be continued.

Proposals that suggest that the GME funding methodology be used to increase the number of primary care providers may prove to be ill conceived, particularly given that some research shows that there are sufficient numbers of primary care residency slots today to meet the foreseeable demand for primary care.

If the goal is simply budget reduction, we would argue that cutting Medicare support for training, just because some of the other insurance companies don't provide for these costs, is poor policy. A better policy would be to insure that all payers and all patients bear—who benefit from having high-quality, well-trained physi-

cians, bear some portion of the costs of that training. This has been the general policy goal since the early seventies. We have yet to achieve it. We need to continue to work on it.

Finally, let me come to the proposals to reduce the Medicare IME support to teaching hospitals. As the history of this legislation shows, Congress has consistently recognized the higher cost of teaching care and has provided IME payments in an attempt to level the playingfield. The reasons for these differences in costs are several.

Teaching hospitals have more severely ill patients with more complicated diseases that require more care and incur higher costs for treatment. Second, teaching hospitals have to maintain a broader scope of services and specialized regional services for the completeness of our programs.

We want to avoid closing psychiatry, high-risk obstetrics, or the neonatal intensive care unit simply because they don't make economic sense. Third, students and residents order more ancillary tests, take more physicals, and require more nursing services and physician supervision, making our hospitals less efficient. Finally, teaching hospitals are where the advances in medicine are implemented. The transition from the lab to the bedside is hard and expensive and most insurance companies in the managed care business don't pay for those services.

I wonder where we would be without the past support of teaching hospitals for the development of bypass surgery or joint replacement or dialysis or cataract surgery or bone marrow transplantation. I wonder who will bear these costs in the future.

This role, which is a logical extension of the NIH's research mission, is critical to our future. At Georgetown last year we cut about 12 percent of our staff and we still expect to lose money. Our faculty salaries are going down. We are trying hard to expand our patient base to become more efficient and to work cooperatively with other providers in the community.

But I wouldn't be honest if I didn't tell you that the challenges we face are very real. All payers, government and private, are going to want to pay less for the services we provide. Our services are under pressure and we can't increase tuition anymore. I think we are making changes, but there is some limit to the rapidity with which we can streamline our operations.

There is not a right number for the Medicare IME adjustment, one that will precisely level the playingfield between all hospitals. But I think it would be wrong to target the one group of hospitals for extensive cuts that is responsible for the vast majority of our medical research, development and training, and I would urge you to exercise caution as you look at these issues in the future.

Thank you.

[The prepared statement and attachments follow:]

TESTIMONY OF NELSON FORD
ASSOCIATION OF AMERCIAN MEDICAL COLLEGES

Mr. Chairman and members of the subcommittee, I am Nelson Ford, Chief Operating Officer of the Georgetown University Medical Center. The Association of American Medical Colleges (AAMC), which represents all of the nation's 126 accredited medical schools, approximately 300 major teaching hospitals that participate in the Medicare program, the faculty of these institutions through 92 constituent academic society members, and the more than 160,000 men and women in medical education as students and residents welcomes the opportunity to testify on the importance of the Medicare program to the overall financial viability of teaching hospitals and medical schools. In 1992, nonfederal members of the Council of Teaching Hospitals (COTH) accounted for nearly 2 million Medicare discharges or almost 20 percent of all Medicare discharges.

All health care proposals are of concern to the nation's teaching hospitals, medical schools and teaching physicians. I am pleased to appear before you today to comment on four issues of particular interest to the academic medical community:

- the importance of the Medicare indirect medical education (IME) adjustment to the financial viability of teaching hospitals;
- the role of Medicare payments for direct graduate medical education (DGME) costs in support of residency training;
- the methodology for calculating the average adjusted per capita cost (AAPCC), the rate that the Medicare program pays to risk contractor HMOs; and
- the effect of a new volume performance standard on the medical staffs of teaching hospitals;

Academic medicine is in a period of momentous internal and external turmoil. Teaching hospitals, faculty practice plans and medical schools have recognized the need for change within their own organizations and are actively engaged in helping to reformulate the health service delivery system, find ways to reduce the rate of increase in health care costs, improve accountability, and maintain or improve the quality of clinical service. Teaching hospitals are studying ways to deliver services more efficiently through partnerships with other health care organizations and are seeking new arrangements with payers of services. Medical schools, often in conjunction with teaching hospitals, are working aggressively to: increase the number of generalist physicians; identify new community-based sites for physician education; enhance the curriculum to reflect both new knowledge and new delivery paradigms; and assure the vitality of biomedical and behavioral research.

Federal action to change Medicare payment policy comes at a most difficult time when academic medicine is making major efforts to adapt to a changing delivery system. Even under normal circumstances the four issues mentioned above would be important, but they take on especially critical dimensions in the current environment. While the academic medical community understands the Federal government's need and commitment to reducing the budget deficit and the growth in Medicare and Medicaid expenditures, teaching hospitals and teaching physicians would be particularly harmed just when they are undergoing major change to reflect societal need. For example, while many proposals to change Medicare payments would affect both teaching and nonteaching hospitals, reductions in IME and DGME payments would reduce Medicare payments to teaching hospitals, seriously threatening their financial stability, and affecting access to care and quality of care received by Medicare beneficiaries and other patients. Teaching hospitals and teaching physicians play critical roles in our health care delivery system, and they could be damaged severely unless changes are crafted carefully and are based on an extensive understanding of the education and service missions of academic medicine.

Although efforts to enact comprehensive national health care reform have stalled, the health care delivery system continues to evolve in a way that threatens the stability of academic medicine as both public and private payers struggle to control health care expenditures. In a competitive environment based on price, teaching hospitals and medical schools face special challenges because they have unique missions that, of necessity, add to their costs. Teaching hospitals are important components of the nation's health care system because they:

- provide all levels of patient care-from primary to tertiary services-often to the most disadvantaged members of our society;
- serve as primary sites for the clinical education of health professionals, including physicians, nurses and allied health professionals; and
- provide the environment for the conduct of clinical biomedical and behavioral research and the introduction of new technologies.

Because patient care, medical education, and research are conducted simultaneously, it is not possible to identify fully and uniquely the cost of each specialized activity. However, these additional missions of teaching hospitals leave substantial costs that must be borne in our current system by patient care revenues.

Last year, the AAMC actively supported efforts to achieve comprehensive health care reform, including the creation of all-payer funds for the missions and costs of teaching hospitals, a fund for the direct costs associated with the training of physicians, and a fund for the medical school costs supported historically by clinical revenue. In the current political environment, only incremental approaches to reform are likely to be offered, and proposals to change Medicare payment policy are likely to focus on reducing the Federal budget deficit However, the special challenges facing teaching hospitals and medical schools in a competitive environment still need to be addressed.

The AAMC believes that Congressional decisions on Medicare payment policy should be made in the context of their impact on the entire health care system. As the Prospective Payment Assessment Commission (ProPAC) indicated in its March 1994 report, "the Medicare program's responsibility to its enrollees is broader than merely paying for services for beneficiaries. This responsibility includes maintaining access to the quality of care and types of services available at teaching hospitals..."(page 56).

I urge the members of this subcommittee to consider carefully its Medicare payment policy recommendations for FY 1996. Particularly at this time, any change in Medicare payments to teaching hospitals and teaching physicians could undermine the overall financial viability of teaching hospitals and medical schools. Additionally, failure to address the way in which IME and DGME payments and the disproportionate share (DSH) payment are incorporated in the AAPCC calculation poses a threat to the financial status of teaching hospitals.

Indirect Medical Education (IME) Adjustment

The Purpose of the IME Adjustment

Since the inception of the Medicare prospective payment system (PPS) in 1983, Congress has recognized that the additional missions of teaching hospitals increase their costs and has supplemented Medicare inpatient payments to teaching hospitals with the indirect medical education (IME) adjustment. While its label has led many to believe that this adjustment compensates hospitals solely for graduate medical education, its purpose is much broader. Both the House Ways and Means and the Senate Finance Committees specifically identified the rationale behind the adjustment:

> This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (House Ways and Means Committee Report, Number 98-25, March 4, 1983 and Senate Finance Committee Report, Number 98-23, March 11, 1983).

The IME adjustment is not to be confused with the Medicare payment for direct graduate medical education (DGME) costs, which also is part of the Medicare payment program. Payments for Medicare's share of the direct costs of graduate medical education programs

are separate from the PPS and include payments for residents' stipends and fringe benefits, faculty salaries and benefits, and allocated overhead costs. The AAMC's comments on direct graduate medical education payments are addressed later in this testimony.

The AAMC believes the IME adjustment is an important equity factor that recognizes the additional roles and costs of teaching hospitals. To help ensure that the IME adjustment and its impact on teaching hospitals are understood, this testimony reviews:

- the purpose and history of the indirect medical education adjustment; and
- results of the AAMC's impact analysis of lowering the level of the adjustment.

First, however, a brief overview of the PPS is necessary to understand how the IME adjustment is calculated and why it serves a broader purpose than its name implies.

Overview of the Medicare Prospective Payment System

In December 1982, the Secretary of the Department of Health and Human Services (HHS) proposed a hospital prospective payment system for Medicare. Enacted in 1983, the system was intended to allow the Federal government to hold down health care expenditures and provide hospitals a financial incentive to deliver services efficiently. Hospitals and the Federal government would also benefit from the predictability of the flow of Medicare payments.

In contrast to the cost reimbursement system used for nearly twenty years, the PPS pays hospitals a fixed amount, determined in advance, for the care of Medicare patients in each of 490 valid diagnosis-related groups (DRGs). The DRG classification system distinguishes many important patient characteristics that are highly correlated with hospital costs, such as principal diagnosis, presence or absence of secondary diagnoses, and whether or not certain major surgical procedures were performed during the hospital stay. However, DRGs do not distinguish severity of illness within diagnostic groups nor do they account for many other characteristics that are likely to affect a patient's stay and costs, such as whether patients were transferred from other facilities.

Under the PPS, the amount of payment is determined by multiplying one of two standard, national prices (different for hospitals in Metropolitan Statistical Areas of over one million population and all other hospitals) by a DRG weighting factor that rates a particular DRG's complexity of treatment against the average Medicare case. Hospitals are at financial risk if the cost of treatment exceeds the DRG price, but they may retain the difference between the DRG-based price and the cost of delivering services for patients in given diagnostic groups.

The PPS balances the concept of a standard national price, which is intended to promote efficiency with the recognition that costs vary among hospitals, often due to factors beyond their control, such as location, types of patients, level of teaching activity, and share of low-income patients. As enacted and amended, PPS payments to hospitals are calculated using the standard national price per discharge and computing an individual hospital payment amount based on six factors:

- the location of the hospital determines the base rate paid for a discharge;
- the area wage level for each geographic location adjusts the base rate for labor differences;
- the hospital's case mix adjusts the payment for the types of patients that are treated in a facility as determined by their classification into DRGs;
- outlier payments for cases that have an extremely long length of stay or extraordinarily high costs partially compensate hospitals for the atypical severity of some patients;
- the disproportionate share (DSH) adjustment partially compensates hospitals for the above average costs of caring for the low-income individuals and the aged poor; and

- the IME adjustment compensates teaching hospitals for the cost impact of their special missions.

PPS payments to all hospitals are adjusted by the first three factors: location, area wage level, and case mix. Not all hospitals receive payments for outlier cases, or DSH or IME payments.

Since the PPS constituted a substantial departure from the previous cost-based reimbursement system, its implementation was phased in over several years. In the early years of the PPS, hospitals were paid a blend of their hospital-specific costs and a national standard rate. The IME adjustment was applied only to the Federal portion. By FFY 1988, hospitals were paid 100 percent on the national rate, and the IME adjustment was applied to the entire payment.

The History of the Indirect Medical Education Adjustment

The Origin of an Adjustment for the Increased Costs of Teaching Hospitals. In order to understand the origin and history of the IME adjustment, it is important to understand several events prior to implementation of the PPS, including the initial routine cost limits of the 1970s and how they were adjusted for teaching hospitals. Even though the Medicare program initially reimbursed all allowable costs of hospitals for the care of Medicare beneficiaries, the Federal government recognized that costs among types of hospitals varied, and soon imposed limits on the amount of variability that was acceptable to the program. Section 223 of the Social Security Amendments of 1972 (P.L. 92-603) authorized the Secretary of Health, Education and Welfare to set payment limits on routine inpatient hospital costs. If a hospital's per diem costs were above the costs of comparable hospitals, those costs were not reimbursable under Medicare. The cost limits and the method of setting them evolved between 1974, when the regulations were first published, and 1979, when the cost limits were set at the 80th percentile of the costs of comparable hospitals, and hospital size, location (urban/rural), and area wage rates were taken into consideration in determining comparability among hospitals.

In 1979, when the Carter Administration sought to achieve some of its hospital cost containment objectives by further reducing Medicare payment limits, the teaching hospital community expressed concern that it would be harmed disproportionately. In response to this concern, government researchers studied the relationship between hospital costs and teaching status.

The researchers found that a hospital's intern and resident-to-bed ratio (IRB) was related to an increase in hospital costs, even when direct medical education costs such as residents' salaries were removed from the analysis. Using a statistical technique called regression analysis, analysts were able to predict the change in average Medicare cost per discharge (the dependent variable) associated with a given change in other factors, such as the intern and resident-to-bed ratio or area wages (the independent variables). The results of these empirical analyses provided statistical estimates of changes in average costs associated with changes in each independent variable. Throughout this testimony, the terms "empirical estimate" and "statistical estimate" refer solely to the results of such regression analyses.

Researchers found that routine costs per day in teaching hospitals increased on average 4.7 percent with each increase of 0.1 in residents per bed. As a result of these findings by government researchers, the Medicare routine cost limits for teaching hospitals were increased to incorporate a differential based on the intern and resident-to-bed ratio (IRB) in each hospital.

The adjustment for the costs of teaching hospitals was subsequently included in the extension of the routine cost limits to cover total operating costs per discharge as legislated by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The magnitude of the adjustment was determined by a statistical analysis similar to the one used to set the adjustment to the routine limits.

The Adjustment for Teaching Hospital Costs Under the PPS. In the Secretary's December 1982 proposal for a new Medicare payment system, the resident-to-bed adjustment to the cost limits under TEFRA was converted to a PPS payment (the IME adjustment) to adjust for the

higher costs of teaching hospitals:

> The indirect costs of graduate medical education are the higher patient care costs incurred by hospitals with medical education programs. Although it is not known precisely what part of these higher costs are due to teaching (more tests, procedures, etc.), and what part is due to other factors (the particular types of patients which a teaching hospital may attract), the Medicare cost reports clearly demonstrate that costs per case are higher in teaching hospitals.
>
> It is also true that the mere presence of interns and residents in an institution puts extra demands on other staff and leads to the existence of higher staffing levels. The process of graduate medical education results in very intensive treatment regimens... there is no question that hospitals with teaching programs have higher patient care costs than hospitals without.
>
> The Department believes that recognition of these indirect costs should be accomplished through a lump-sum payment, separate and distinct from the base rate. This adjustment will be computed using methods that are similar to the methods currently used to adjust the old routine and new total cost limits... (Secretary of the Department of Health and Human Services, Hospital Prospective Payment for Medicare: A Report to Congress, December 1982, Pages 48-49).

Using the results of a regression analysis, the Secretary's estimate indicated that Medicare operating cost per case increased approximately 5.79 percent with each 0.1 increase in the number of residents per bed. However, two months after the Secretary's report was issued, the Congressional Budget Office (CBO) presented an impact analysis of the characteristics of hospitals that would gain or lose under the Secretary's proposed plan. CBO's estimate, as presented in Table A, shows that the proposed DRG-based payment system would have adversely affected 71 percent of teaching hospitals if the IME adjustment had been set solely at the level suggested by the empirical estimate.

In response to the CBO analysis, the Administration suggested that the statistical estimate of 5.79 percent be doubled to 11.59 percent for each 0.1 increase in the IRB. The use of the regression estimates as a starting point resulted in an "empirically based" IME adjustment in the PPS. The doubling of the statistical estimate was accomplished by placing a multiplier at the beginning of the formula that calculates a hospital's IME adjustment factor. Congress supported this proposal of modifying the empirical estimate based on its expected impact on teaching hospital finances, and the empirically based IME adjustment was incorporated into the prospective payment legislation. The inclusion of the multiplier in the formula operationalizes the concept of the "empirically based" IME adjustment factor.

As more updated and refined information became available, the IME adjustment was recalculated and lowered. The original adjustment of 11.59 percent was reduced to 8.7 percent in 1986 when better data became available.

However, hospitals never actually received IME payments calculated at the 8.7 percent level because at the same time (1986) the DSH adjustment was added to the PPS. The IME adjustment factor was reduced by 0.6 percent to finance part of the DSH adjustment, resulting in an IME adjustment factor of 8.1 percent, rather than 8.7 percent, during the time the DSH adjustment would be in effect.

With the implementation of the DSH adjustment in 1986, policy makers and researchers recognized that while some hospitals would receive either IME or DSH payments, other hospitals would receive both. The 8.1 percent IME adjustment established by the Consolidated Omnibus Budget Reconciliation Act (COBRA) recognized the possibility of the overlap in these payments. The DSH adjustment became a permanent part of the PPS with passage of OBRA 1993 (P.L. 103-66) in August 1993.

The current 7.7 percent IME adjustment, enacted in OBRA 1987, took effect on October 1, 1988. Table B shows the history of the IME adjustment.

Table A
Estimated Average Penalties and Bonuses Under the Administration's Proposed DRG-Based Payment System By Type of Hospital[a]

	All Hospitals		Hospitals That Would Gain		Hospitals That Would Lose	
	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements[b]	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements[c]	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements[d]
All Hospitals	100	0[e]	61	+23	39	−12
Bed Size						
Less than 100	49	+23	80	+35	20	−10
100–299	34	+2	50	+21	50	−11
300+	17	−6	30	+17	70	−13
SMSA						
SMSA	52	−4	43	+20	57	−13
Non-SMSA	48	+19	81	+29	19	−6
Region						
Northeast	15	−4	45	+19	55	−12
North Central	28	−4	60	+21	40	−13
South	37	+8	72	+26	28	−9
West	20	−2	57	+23	43	−13
Teaching Status						
Teaching	18	−7	29	+18	71	−13
Nonteaching	82	+7	69	+24	32	−10
Ownership						
Nonprofit	57	−2	55	+20	45	−12
Government	31	+9	78	+29	22	−12
Proprietary	12	−1	48	+22	52	−13

SOURCE: Preliminary CBO estimate based on Medicare Cost Reports for 1980.

a. Assumes an average payment level needed to keep outlays at the same level as under TEFRA in fiscal year 1984. Average gains and losses are incremental to those under TEFRA, which are assumed to be the average for each group. Effects of phase-in and adjustments for exceptionally costly cases are excluded, but an adjustment for teaching hospitals is included.
b. Average calculated for all hospitals.
c. Average calculated for hospitals that would gain.
d. Average calculated for hospitals that would lose.
e. Because aggregate reimbursements were assumed to be the same as under TEFRA, increases in payments to some hospitals would be exactly offset by decreased payments in others.

Source: Nancy M. Gordon, statement before the Subcommittee on Health Committee on Ways and Means, U.S. House of Representatives February 14, 1983

Table B
History of the Indirect Medical Education Adjustment

Time Period	Adjustment Factor (%)*
Oct. 1, 1983 - April 30, 1986	11.59
May 1, 1986 - Sept. 30, 1988	8.1
Oct. 1, 1988 - Present	7.7

* Applied only to the Federal portion of a hospital's PPS payment. This portion was 25 percent in Federal FY 1984 and 50 percent through April 30, 1986. Not until FY 1988 was the IME adjustment factor applied to 100 percent of a hospital's PPS payment.

The COBRA legislation modified the IME adjustment in a second very important way. In addition to a lower statistical estimate for the IME adjustment, the linear adjustment formula was respecified as a curvilinear formula. Therefore, as the resident-to-bed ratio rises, IME payments increase at a reduced rate.

Under the PPS, teaching hospitals receive IME payments as determined by their individual resident-to-bed ratios, the empirically based adjustment factor and the type of Medicare patient they treat. The percentage add-on to the DRG payment varies among individual hospitals depending on their resident-to-bed ratios. The average resident-to-bed ratio in the nation's teaching hospitals is about 0.10, or 10 residents for every 100 beds. Government researchers generally define major teaching hospitals as institutions with at least a 0.25 resident-to-bed ratio. Academic medical center hospitals[1] have an average resident-to-bed ratio of slightly over 0.50. For example, using the current IME adjustment factor of 7.7 percent, a hospital with a 0.05 resident-to-bed ratio would receive an additional 3.8 percent IME payment under the PPS. A hospital with a 0.25 resident-to-bed ratio would receive a 17.9 percent increase in the DRG payment and a hospital with a 0.50 resident-to-bed ratio would receive a 33.7 percent add-on payment. Therefore, as the IME adjustment has been reduced, hospitals with relatively high resident-to-bed ratios have experienced a greater percentage reduction in their IME payments than hospitals with lower resident-to-bed ratios.

The Interest in Teaching Hospitals' Financial Performance

Throughout the history of the PPS, the financial performance of teaching hospitals has been an additional consideration, beyond the statistical estimate generated by regression analysis, in determining the level of the IME adjustment. The first evidence of the importance of other factors in addition to the "statistical estimate" was the CBO impact analysis that documented how the proposed payment system would adversely affect teaching hospitals relative to nonteaching hospitals. This analysis resulted in the doubling of the statistical estimate.

As the Medicare PPS was gradually implemented, government bodies, private research economists, and the hospital industry began to monitor the impact of the new payment system on the nation's hospitals. Two closely watched measures of the impact of the PPS on hospitals were PPS margins (the losses or gains associated with Medicare cases paid under the PPS) and total margins (the losses or gains margin associated with all hospital operations, including all patient care and other income from investments and philanthropy). The Inspector General (IG) of the Department of Health and Human Services, the Congressional Budget Office and the Prospective Payment Assessment Commission (ProPAC), issued analyses of hospital PPS margins showing that, through the third year of PPS (1986-87), hospitals in general had fared well under PPS and that teaching hospitals had significantly higher PPS margins than did nonteaching hospitals.
In a statement submitted on August 1, 1988 to the House Budget Committee's Task Force on Health, the AAMC cited three factors that contributed to the unexpectedly high margins of

[1]Academic medical center hospitals are defined as hospitals under common ownership with a college of medicine or hospitals in which the department chairmen of the school of medicine also serve as the chiefs of service at the hospital.

teaching hospitals in the initial years of prospective payments:

- teaching hospitals maintained above average occupancy rates. In a fixed price payment system where revenue varies directly with volume, teaching hospital occupancy rates contributed to positive financial performance;

- HCFA's use of 1981 case mix indices to establish the hospital-specific payment component of the PPS resulted in an overstated hospital-specific price for use during the phase-in transition period; and

- the original IME adjustment was incorrectly interpreted as a linear relationship and was based on incomplete 1981 data.

When the inappropriateness of the linear form was recognized and when more updated information became available, the AAMC did not oppose a recalculation of the IME adjustment, i.e., a decrease in the empirically based adjustment from 11.59 to 8.1 percent and the imposition of a curvilinear form on the adjustment factor. Congress subsequently reduced the IME adjustment to 7.7 percent when the limit on DSH payments was removed. The AAMC did not oppose these changes in light of the empirical findings on hospital costs and the financial performance of teaching hospitals in the early years of the PPS.

Over the years the executive and legislative branches have proposed reductions in the level of the IME adjustment. These proposals have been based on calculations using a variety of regression models, more current data, and different combinations of variables. In January 1989 the General Accounting Office (GAO) issued a report that estimated the size of the IME adjustment using various regression specifications and called for a reduction in the level of the adjustment. Every year since 1989, the Prospective Payment Assessment Commission (ProPAC) has recommended a gradual reduction in the level of the adjustment.

In recent years, however, Congress has indicated that the level of the IME adjustment should reflect the broader mission and overall financial viability of teaching hospitals to assure access and quality of care for Medicare beneficiaries and other patients. Similarly, ProPAC has recognized that the financial success or failure of teaching hospitals could affect access to care and quality of care, and in making its recommendations has tried to assure "rough justice" among hospital groups. "Rough justice" refers to a policy objective of assuring roughly comparable total margins for teaching and nonteaching hospitals.

Last year, in making its recommendation to decrease the level of the IME adjustment to 7.0 percent for FY 1995, the commission urged caution in implementing a precipitous drop in the IME adjustment. While PPS inpatient operating margins for teaching hospitals are on average higher than those for nonteaching hospitals, teaching hospitals' total margins have remained consistently lower than other hospitals' total margins. As analyzed by ProPAC, data from the ninth-year of PPS (1992-93), the most complete information publicly available, show that average PPS margins for nonteaching hospitals were minus 6.4 percent, but total margins were plus 4.7 percent. Major teaching hospitals, however, posted PPS operating margins of 8.0 percent, but their average total margins were substantially lower at 3.0 percent. The average total margin for all hospitals was 4.1 percent.

A more recent ProPAC analysis of preliminary data from the tenth-year of PPS (1993-94) shows the same relationship between financial margins and teaching status. Major teaching hospitals, which are underrepresented in the incomplete tenth-year database, had PPS margins of 11.2 percent, but recorded average total margins of 1.8 percent. Other teaching hospitals, those with IRBs of less than 0.25, had average PPS margins of minus 0.8 percent and total margins of plus 4.4 percent. Nonteaching hospitals had the lowest PPS margins at minus 5.9 percent , but posted the highest total margins at plus 4.8 percent.

Some policy makers have maintained that a significant portion of the IME adjustment is intended to help defray uncompensated care costs. Further, they argue, in a reformed health care system in which more individuals are covered by health insurance, teaching hospitals' burden of uncompensated care would be reduced and would justify a significant reduction in IME payments. Teaching institutions are vital national and community resources, often taking care of the most disadvantaged members of society Yet their overall financial

viability, on average, tends to be more precarious than nonteaching hospitals. The AAMC has noted repeatedly the purpose of the IME adjustment is not to provide financing for uncompensated care, but to recognize factors that increase costs in teaching hospitals. Analysis by government and private researchers consistently has shown an empirical basis for a differential payment to teaching hospitals based on their costs. The justification for a special adjustment for these institutions traces back to the Medicare routine cost limits of the late 1970s and the inception of the PPS in 1983. Even if the health care system is reformed to improve access, legitimate cost differences between teaching and nonteaching hospitals will continue to exist. Teaching hospitals continue to have higher inpatient operating costs because of the types of patients they treat, services they offer, biomedical research they conduct, and residents they teach.

The AAMC's Impact Analysis of Reducing the IME Adjustment

The AAMC is greatly concerned that some policy makers have concluded that the IME adjustment could be reduced substantially without threatening the financial viability of teaching hospitals. The AAMC does not agree with this perspective and believes that a reduction of the IME adjustment would seriously undermine the financial stability of teaching hospitals. While a review of FY 1994 financial data supplied by 91 hospitals belonging to the AAMC's Council of Teaching Hospitals (COTH) suggests that some teaching hospitals are performing well financially, a closer examination reveals that their total margins have been relatively stable for three years and are comparable to the total margins of nonteaching hospitals. Increases in the average PPS margin have contributed to stable aggregate total margins over the period. Further analysis shows that any reduction in the IME adjustment would substantially harm teaching hospitals, destroying the "rough justice" that has been achieved with the current level of the IME adjustment.

Trends in PPS and Total Margins. PPS margins[2] for this group of 91 teaching hospitals, all but 19 of which are "major teaching" hospitals, increased in 1994. "Major teaching" hospitals are defined as those having resident-to-bed ratios of 0.25 or greater. Table C shows that average PPS margins increased from 3.70 percent in 1992 to 11.75 percent in 1994. Of the 91 hospitals in Table 1, 16 (18 percent) reported lower PPS margins in 1994 than in 1993. While 37 hospitals had negative PPS margins in 1992, only 15 hospitals had PPS margins less than zero in 1994. More importantly, however, the average total margin for this group has remained fairly stable (between 4.60 and 5.12 percent) over the three-year period.

PPS Margin Impact Analysis. Table D uses 1994 data to demonstrate the impact of various types of PPS payments on hospital margins and the effect of reducing the IME adjustment from its current 7.7 percent to 6.7 percent, 4.5 percent, and 3.0 percent. The 6.7 percent level is ProPAC's recommendation for FY 1996. It represents about one-third of the difference between the current level of the IME adjustment and the commission's most recent statistical estimate of 4.5 percent. The House Republican Alternative Budget for FY 1995, crafted last spring by the Republican members of the House Budget Committee led by current Budget Chair John Kasich (R-OH), proposed a reduction in the IME adjustment to 3.0 percent from its current level of 7.7 percent for every 0.1 increase in a hospital's intern and resident-to-bed ratio. To estimate the impact of a reduction in the IME adjustment to these various levels, a reduction factor was applied to each hospital's 1994 IME payment. This calculation assumes no change in the hospital's 1994 intern and resident-to-bed ratio and no other changes in Medicare payment policy.

Table D shows that teaching hospitals depend heavily on the IME and DSH payment adjustments to maintain their PPS margins. On average, PPS margins calculated without the IME or DSH payment adjustments--but with only DRG, outlier and "high ESRD use" payments--are minus 31.76 percent. The IME adjustment makes a significant contribution to

[2]The PPS margin is defined as PPS revenue (DRG payment, disproportionate share payment, IME payment, outlier and "high End Stage Renal Disease [ESRD] use" payments) less Medicare inpatient operating costs, divided by PPS revenue. The PPS margin definition excludes Medicare revenues and costs associated with capital, direct medical education, PPS exempt patient care units, and some other categories. Because payments for most of these cost components (except capital) are made on a cost reimbursement basis, the margins for these items cannot be positive. Therefore, the margins for Medicare inpatient beneficiaries are less than the PPS margins shown in this analysis. A more detailed discussion of the data and methodology used in this analysis is included as Attachment A.

TABLE C:
PPS AND TOTAL MARGINS IN SELECTED ACADEMIC MEDICAL CENTER AND MAJOR AFFILIATED HOSPITALS: FY 1992 - 1994
RANKED BY FY 1994 PPS MARGIN

HOSPITAL	FY 94 % MEDCAID CASES	FY 94 % MEDICARE PPS CASES	FY92 TOTAL MARGIN	FY 1993 TOTAL MARGIN	FY 1994 TOTAL MARGIN	FY92 PPS MARGIN	FY 93 PPS MARGIN	FY 94 PPS MARGIN
A	1.22 %	34.63 %	4.18 %	3.81 %	2.21 %	-9.15 %	-6.35 %	-26.39 %
B	0.06	33.69	-36.75	-16.30	0.25	-81.26	-49.63	-22.60
C	10.27	35.01	8.75	10.10	5.64	-9.76	-3.87	-15.87
D	34.79	25.81	3.23	0.15	3.91	-28.50	-23.16	-12.68
E	23.65	29.20	7.49	1.47	3.30	-3.78	-12.88	-8.08
F	12.19	27.81	2.76	2.79	-2.07	-6.62	-9.98	-7.88
G	6.33	21.74	3.00	2.99	2.13	-7.50	1.12	-5.12
H	15.63	37.82	4.28	5.63	4.86	-8.36	-4.45	-4.43
I	9.83	43.79	4.59	4.96	4.92	-8.50	-7.32	-3.33
J	3.71	47.89	4.13	4.60	7.23	8.42	11.91	-3.04
K	21.72	24.46	-2.29	4.00	3.40	0.14	-3.96	-2.69
L	20.75	31.15	11.35	10.24	4.07	-1.12	-3.77	-2.18
M	3.47	40.84	5.12	5.85	6.27	-10.27	-4.92	-1.81
N	15.88	32.03	2.98	0.13	1.03	-4.61	-10.00	-0.39
O	13.77	29.40	0.81	1.25	1.09	-9.29	-8.17	-0.24
P	6.34	52.10	2.78	-1.58	2.87	7.50	12.02	0.57
Q	0.00	42.43	6.40	4.44	6.60	-2.91	-2.58	2.13
R	39.90	20.63	10.45	6.26	4.56	-11.28	-6.31	2.29
S	7.40	21.63	1.12	-1.92	1.39	-15.79	-8.06	2.54
T	6.78	22.76	-3.32	1.47	0.06	9.15	4.03	2.71
U	16.52	38.39	8.65	11.18	12.48	8.22	3.22	2.94
V	23.50	25.11	0.58	-2.75	2.24	8.22	-0.82	2.98
W	7.78	29.28	6.68	6.03	-1.23	-6.52	-7.97	3.52
X	18.11	41.63	7.87	8.50	9.36	-5.16	-2.82	3.73
Y	15.57	37.06	4.41	5.59	3.82	-1.64	4.04	4.07
Z	28.90	31.32	3.34	1.40	14.71	-21.33	-19.21	4.37
AA	12.59	29.09	3.21	1.10	1.14	-9.47	-1.39	4.53
AB	31.44	24.97	9.97	8.25	10.34	-1.44	0.53	4.74
AC	6.92	18.54	10.44	7.80	5.09	9.41	-0.66	4.80
AD	21.47	22.42	7.25	5.71	11.43	8.60	4.58	5.16
AE	14.98	28.29	9.59	13.40	10.53	-6.15	2.66	5.18
AF	6.41	38.93	3.66	10.93	4.98	6.55	11.46	6.00
AG	19.08	32.53	5.03	5.26	6.25	3.56	7.79	6.24
AH	5.48	28.83	5.83	-4.90	7.92	-5.71	-20.50	6.58
AI	9.14	31.38	4.56	4.04	8.13	4.11	2.47	6.95
AJ	10.77	36.61	7.48	6.76	2.57	-1.77	-2.50	7.69
AK	19.80	36.20	1.39	5.22	7.11	0.91	8.97	8.48
AL	23.65	29.20	3.86	4.69	4.94	-6.33	1.55	8.66
AM	18.46	36.67	10.30	9.63	9.50	4.83	8.28	8.95
AN	18.08	26.51	0.63	0.84	7.24	-5.8	1.68	8.95
AO	70.78	9.32	2.18	3.31	2.47	5.10	-2.64	9.11
AP	33.63	25.78	5.27	5.24	5.77	10.80	6.29	10.98
AQ	27.27	26.36	-0.08	3.56	-0.39	12.97	10.21	10.98
AR	11.49	38.28	6.88	7.31	7.83	8.49	9.70	11.03
AS	28.20	21.54	5.30	4.56	7.40	-18.16	-19.54	12.04
AT	14.39	29.46	10.19	9.68	8.05	3.65	0.88	12.30
AU	6.71	54.51	6.26	6.98	5.23	-18.08	3.07	12.42
AV	61.33	10.12	10.66	14.51	1.31	26.08	18.89	12.63
AW	16.43	25.69	6.98	13.11	7.91	-2.00	6.97	12.97
AX	46.42	11.58	-6.14	-15.22	-2.05	17.03	23.31	13.39

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PPS AND TOTAL MARGINS IN SELECTED ACADEMIC MEDICAL CENTER AND MAJOR AFFILIATED HOSPITALS: FY 1992 - 1994
RANKED BY FY 1994 PPS MARGIN

HOSPITAL	FY 94 % MEDCAID CASES	FY 94 % MEDICARE PPS CASES	FY92 TOTAL MARGIN	FY 1993 TOTAL MARGIN	FY 1994 TOTAL MARGIN	FY92 PPS MARGIN	FY 93 PPS MARGIN	FY 94 PPS MARGIN
AY	27.34 %	19.66 %	2.84 %	-3.25 %	1.79 %	-2.10 %	-5.86 %	14.17 %
AZ	18.52	26.10	9.17	9.62	7.14	7.7	22.74	14.67
BA	13.78	21.75	4.55	3.80	2.60	-26.08	-3.87	15.30
BB	12.71	43.42	10.21	9.55	12.16	-0.09	4.43	15.51
BC	15.69	36.00	6.00	32.99	3.79	16.15	18.26	15.99
BD	22.26	25.83	12.08	22.14	21.33	3.64	16.00	16.07
BE	30.39	18.35	6.01	6.25	7.10	25.51	21.00	16.86
BF	27.19	17.87	12.80	14.21	6.68	-31.85	11.83	17.03
BG	14.24	42.61	3.96	2.47	1.91	5.67	10.55	17.12
BH	41.31	21.52	9.42	9.12	6.02	16.22	5.34	18.43
BI	24.10	24.20	-0.60	0.20	6.91	0.85	15.33	18.64
BJ	30.37	33.44	-0.29	0.94	3.76	4.77	15.72	19.16
BK	18.81	30.52	3.80	4.21	4.59	12.88	19.49	19.50
BL	24.54	19.73	4.94	4.93	4.05	11.19	11.56	19.51
BM	9.84	38.22	5.39	5.51	6.61	-1.54	9.57	19.77
BN	16.59	29.15	5.03	3.67	2.95	14.83	12.90	20.34
BO	18.93	33.07	7.34	4.41	4.52	12.85	11.92	20.47
BP	5.67	36.21	1.88	3.04	1.80	7.53	16.18	20.88
BQ	64.43	9.07	8.57	1.23	2.26	19.67	34.18	21.04
BR	47.46	16.71	-1.75	1.17	1.07	-8.88	17.52	21.14
BS	11.74	32.44	1.96	-3.10	4.73	17.34	10.55	21.19
BT	32.36	24.36	5.16	3.90	4.83	11.00	11.99	21.62
BU	45.58	15.08	5.67	11.28	14.30	25.92	17.81	21.78
BV	25.62	17.82	6.12	2.54	4.92	17.81	17.53	22.42
BW	12.52	27.74	7.36	7.01	6.87	10.95	17.33	22.47
BX	27.42	26.66	7.33	5.17	4.55	18.92	21.08	23.37
BY	22.72	23.53	4.57	6.05	2.97	14.94	17.89	24.11
BZ	36.86	29.64	7.07	7.54	4.47	20.20	19.64	24.34
CA	11.53	34.75	4.36	3.39	3.23	8.74	16.62	24.50
CB	33.16	21.83	7.73	5.70	7.79	25.83	26.75	25.38
CD	38.75	20.12	10.70	8.41	10.20	15.15	18.77	26.65
CC	53.97	11.50	-0.55	0.90	-2.89	28.39	29.96	27.06
CE	13.94	28.67	3.18	1.02	3.05	1.00	22.24	28.26
CF	16.47	25.16	2.79	2.07	2.85	15.39	20.06	28.76
CG	56.24	2.75	0.10	-1.37	12.21	19.80	25.58	30.43
CH	34.77	16.64	1.29	-1.18	2.60	-6.34	19.22	32.83
CI	49.20	12.98	-1.95	11.78	4.64	31.52	31.17	33.52
CJ	35.78	15.22	15.30	25.52	4.85	30.44	32.62	34.02
CK	36.62	15.60	6.92	3.94	-0.96	33.72	36.91	35.04
CL	44.95	4.79	5.21	7.66	6.42	34.97	34.89	35.67
CM	31.77	12.60	3.61	9.38	8.85	36.67	29.65	38.32
MEAN (Unweighted)	**22.58 %**	**27.40 %**	**4.60 %**	**5.12 %**	**5.11 %**	**3.70 %**	**7.31 %**	**11.75 %**
MEDIAN	**18.81**	**27.74**	**5.03**	**4.69**	**4.73**	**4.77**	**8.28**	**12.30**

SOURCE. ASSOCIATION OF AMERICAN MEDICAL COLLEGES FROM MEDICARE COST REPORTS.

TABLE D:
CONTRIBUTION OF PPS PAYMENTS TO SELECTED ACADEMIC MEDICAL CENTER AND MAJOR AFFILIATED HOSPITALS' PPS MARGINS: FY 1994
RANKED BY DRG PAYMENT, OUTLIERS, ESRD, DSH & IME @ 7.7%

HOSPITAL	DRG PAYMENT LESS OPER COSTS	DRG PAYMENT PLUS OUTLIERS AND ESRD	DRG PAYMENT PLUS OUTLIERS & ESRD & IME	DRG PAYMENT PLUS OUTLIERS ESRD, IME @7.7% AND DSH	PPS MARGIN W/IME @ @6.7%	PPS MARGIN W/IME @ @4.5%	PPS MARGIN W/IME @ 3.0%
A	-87.41 %	-63.17 %	-34.97 %	-26.39 %	-29.11 %	-35.51 %	-40.25 %
B	-107.62	-41.30	-22.60	-22.60	-24.75	-29.74	-33.37
C	-46.59	-42.47	-15.87	-15.87	-18.75	-25.61	-30.77
D	-109.26	-96.12	-36.32	-12.68	-16.49	-25.86	-33.16
E	-67.64	-60.36	-19.74	-8.08	-11.39	-19.43	-25.61
F	-36.27	-29.21	-15.29	-7.88	-9.32	-12.60	-14.96
G	-63.09	-58.70	-13.46	-5.12	-8.85	-18.08	-25.32
H	-23.26	-17.50	-8.59	-4.43	-5.43	-7.69	-9.29
I	-19.36	-13.26	-3.33	-3.33	-4.52	-7.24	-9.18
J	-12.79	-10.44	-3.04	-3.04	-3.94	-5.99	-7.44
K	-58.38	-51.28	-12.50	-2.69	-5.92	-13.76	-19.81
L	-63.70	-57.64	-11.61	-2.18	-5.86	-14.95	-22.10
M	-43.74	-35.48	-1.81	-1.81	-5.21	-13.53	-20.01
N	-44.39	-33.39	-9.69	-0.39	-2.56	-7.67	-11.45
O	-62.93	-56.42	-5.35	-0.24	-4.46	-15.10	-23.69
P	-15.76	-13.00	0.57	0.57	-1.01	-4.65	-7.30
Q	-17.44	-12.51	-0.49	2.13	0.79	-2.29	-4.51
R	-76.38	-65.99	-15.47	2.29	-1.09	-9.42	-15.93
S	-49.28	-37.01	2.54	2.54	-1.26	-10.75	-18.31
T	-54.62	-43.82	0.93	2.71	-1.31	-11.44	-19.59
U	-15.77	-10.20	-1.91	2.94	2.03	-0.04	-1.50
V	-99.09	-67.16	-16.67	2.98	-0.30	-8.33	-14.59
W	-7.74	-5.52	-0.59	3.52	2.95	1.69	0.80
X	-32.48	-26.83	-12.47	3.73	2.50	-0.31	-2.32
Y	-30.74	-25.79	-0.02	4.07	1.56	-4.45	-9.00
Z	-71.32	-61.13	-21.88	4.37	1.93	-3.88	-8.26
AA	-27.87	-23.66	-1.60	4.53	2.40	-2.62	-6.36
AB	-69.80	-62.11	-13.28	4.74	1.50	-6.46	-12.68
AC	-10.82	-7.02	4.80	4.80	3.41	0.22	-2.08
AD	-54.75	-50.58	-9.75	5.16	2.18	-5.07	-10.66
AE	-44.76	-38.95	-0.36	5.18	1.83	-6.42	-12.90
AF	-39.61	-33.37	1.48	6.00	2.85	-4.87	-10.88
AG	-18.47	-14.12	-4.94	6.24	5.36	3.36	1.94
AH	-27.70	-23.29	6.58	6.58	3.54	-3.88	-9.63
AI	-48.23	-40.65	3.37	6.95	3.16	-6.37	-14.02
AJ	-11.56	-9.33	7.69	7.69	5.78	1.31	-2.00
AK	-53.99	-42.98	1.85	8.48	4.87	-4.17	-11.39
AL	-52.05	-46.54	0.33	8.66	5.04	-4.01	-11.24
AM	-54.20	-46.26	2.29	8.95	6.06	-0.99	-12.25
AN	-47.50	-36.59	-0.79	8.95	5.13	-4.48	-6.44
AO	-75.74	-68.71	-29.79	9.11	7.16	2.57	-0.83
AP	-71.15	-55.11	-4.42	10.98	7.63	-0.68	-7.26
AQ	-29.90	-24.66	-3.14	10.98	9.22	5.11	2.08
AR	-9.46	-7.96	7.39	11.03	9.42	5.68	2.94
AS	-46.07	-40.47	-2.18	12.04	9.28	2.54	-2.66
AT	-6.70	-1.99	6.95	12.30	11.35	9.19	7.65
AU	-1.34	0.97	12.42	12.42	11.08	8.00	5.77
AV	-74.30	-68.90	-29.81	12.63	10.83	6.58	3.45
AW	-45.36	-38.75	8.20	12.97	9.19	-0.41	-8.21
AX	-65.28	-55.25	-21.81	13.39	11.63	7.51	4.46
AY	-52.96	-42.24	-0.71	14.17	11.30	4.27	-1.20
AZ	-13.36	-9.41	4.59	14.67	13.39	10.41	8.27
BA	-55.68	-48.89	2.77	15.30	11.84	3.13	-3.86
BB	-32.36	-28.67	12.57	15.51	11.97	3.03	-4.19
BC	-15.75	-9.93	13.07	15.99	13.73	8.29	4.17

TABLE D:
CONTRIBUTION OF PPS PAYMENTS TO SELECTED ACADEMIC MEDICAL CENTER AND MAJOR AFFILIATED HOSPITALS' PPS MARGINS: FY 1994 RANKED BY DRG PAYMENT, OUTLIERS, ESRD, DSH & IME @ 7.7%

HOSPITAL	DRG PAYMENT LESS OPER COST$	DRG PAYMENT PLUS OUTLIERS AND ESRD	DRG PAYMENT PLUS OUTLIERS & ESRD & IME	DRG PAYMENT PLUS OUTLIERS ESRD, IME @7.7% AND DSH	PPS MARGIN W/IME @ @6.7%	PPS MARGIN W/IME @ @4.5%	PPS MARGIN W/IME @ 3.0%
BD	-66.61 %	-45.06 %	7.08 %	16.07 %	12.37 %	2.98 %	-4.67 %
BE	-45.17	-37.12	4.40	16.86	13.92	6.65	0.94
BF	-50.13	-45.74	-2.37	17.03	14.35	7.79	2.71
BG	-7.40	-3.20	12.75	17.12	15.51	11.73	8.96
BH	-91.25	-54.75	-2.09	18.43	15.44	8.04	2.20
BI	-9.24	-7.70	4.64	18.64	17.59	15.19	13.48
BJ	-15.12	-14.23	3.59	19.16	17.76	14.51	12.14
BK	-39.03	-33.53	11.44	19.50	16.16	7.76	0.99
BL	-50.57	-44.76	0.18	19.51	16.30	10.16	4.99
BM	5.26	6.54	19.77	19.77	18.27	14.76	12.18
BN	-27.85	-24.23	17.23	20.34	16.87	8.07	0.92
BO	-34.40	-30.30	12.10	20.47	17.30	9.38	3.04
BP	3.56	6.16	20.88	20.88	19.23	15.36	12.50
BQ	-50.39	-44.96	-14.14	21.04	19.50	15.90	13.25
BR	-61.49	-55.06	-0.59	21.14	18.22	10.95	5.21
BS	-32.27	-27.10	18.93	21.19	17.41	7.68	-0.38
BT	-32.78	-29.80	12.01	21.62	18.58	11.01	4.97
BU	-41.00	-36.56	-0.69	21.78	19.65	14.53	10.65
BV	-40.17	-37.90	8.20	22.42	19.46	12.10	6.25
BW	10.55	12.13	22.47	22.47	21.27	18.48	16.47
BX	-40.24	-32.73	11.94	23.37	20.33	12.75	6.69
BY	-28.21	-22.58	13.09	24.11	21.52	15.15	10.18
BZ	-39.53	-32.95	9.58	24.34	21.61	14.87	9.56
CA	-30.91	-2.31	19.08	24.50	22.53	17.84	14.30
CB	-38.64	-29.85	5.99	25.38	23.19	17.90	13.85
CD	-36.72	-31.83	6.92	26.65	24.37	18.83	14.56
CC	-38.10	-35.45	4.74	27.06	24.84	19.45	15.31
CE	-7.45	-4.89	25.90	28.26	25.51	18.65	13.20
CF	0.05	3.41	28.76	28.76	26.25	20.04	15.17
CG	-46.51	-35.50	4.91	30.43	28.40	23.49	19.74
CH	-26.39	-20.89	23.85	32.83	29.85	22.28	16.11
CI	-26.85	-23.40	9.16	33.52	31.81	27.72	24.64
CJ	-17.40	-15.96	12.61	34.02	32.38	28.49	25.57
CK	-27.73	-26.19	17.38	35.04	32.67	26.78	22.14
CL	-18.77	-9.96	19.10	35.67	33.86	29.51	26.20
CM	-11.44	-10.68	24.16	38.32	36.20	30.98	26.90
MEAN (Unweighted)	-39.39 %	-31.76 %	0.96 %	11.75 %	9.27 %	3.21 %	-1.49 %
MEDIAN	-39.03	-32.95	1.48	12.30	9.42	3.13	-0.83

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES FROM MEDICARE COST REPORTS.

reducing what would have been unsustainable large losses, increasing the average PPS margin from minus 31.76 to plus 0.96 percent. The addition of the DSH payment to the margin calculation moves the average PPS margin to plus 11.75 percent. If the IME adjustment is reduced from 7.7 to 3.0 percent, as proposed by the Republican members of the House Budget Committee, the average PPS margin would fall from a positive 11.75 to a negative 1.49 percent, a reduction of 13.24 percentage points.

Most important, if the IME adjustment is reduced to 3.0 percent, the impact on average total margins would be substantial (data not shown in table). The average total margin in 1994 would fall from 5.1 percent to 2.8 percent, a decrease of 2.3 percentage points. At the 6.7 percent IME level, the total margin would be 4.6 percent and it would be 3.5 percent if the level of the IME adjustment were 4.5 percent.

Contribution of the DSH Payment to PPS Margins. As the Medicare DSH adjustment has been expanded and increased (as mandated by OBRA 1989 and 1990), academic medical center (AMC) hospitals have come to rely increasingly on DSH payments as part of their total PPS payments. Table E below shows that DSH as a percentage of total PPS payments has more than tripled since 1988. On the other hand, the relative importance of the IME payment to a group of academic medical center hospitals has remained fairly stable since 1989. These data confirm the conclusion that can be drawn from Table D: the DSH payment increases the average PPS margin substantially. Moreover, one-third of the hospitals with negative PPS margins do not receive any DSH payment.

Table E
IME and DSH Payments as Percentages of Total PPS Payments in Selected Academic Medical Center Hospitals: FY 1988-FY 1994

Hospital Fiscal Year	IME as a % of Total PPS Payments	DSH as a % of Total PPS Payments	IME and DSH as a % of Total PPS Payments
FY 1988	19.6	3.9	23.5
FY 1989	23.7	5.2	28.9
FY 1990	23.4	6.3	29.7
FY 1991	24.5	10.8	35.3
FY 1992	24.6	11.9	36.5
FY 1993	24.7	12.7	37.4
FY 1994	25.4	12.9	38.3

Source: AAMC letters to Stuart H. Altman, Ph.D., Chairman, Prospective Payment Assessment Commission, 1989-1995

It is expected that DSH will make an increasingly important contribution to total PPS payments, as OBRA 1990 mandated further DSH payment increases for FFY 1994 and 1995.

Discussion of the AAMC's Analysis. Now in its twelfth year, the current prospective payment system differs significantly from the original system, but it remains a payment system based on national average rates that do not by themselves recognize important differences in hospital costs. Thus, the IME adjustment, which recognizes the special characteristics of teaching hospitals, including the severity of illness of their patients, the range of services provided, and the presence of graduate medical education programs, is of great importance to teaching hospitals' financial stability.

The current IME policy appears to have created "rough justice" across hospital payment groups. The 1994 average total margin of this group of 91 COTH teaching hospitals is now comparable to the average total margin of hospitals that received only DSH payments (4.8 percent in ProPAC's June report) in the ninth-year of PPS and to hospitals that received neither DSH nor IME payments (4.6 percent) in PPS-9. ProPAC's recent analysis of an incomplete sample of hospitals reporting preliminary data from the tenth-year of PPS (1993-

94) shows that nonteaching hospitals' total margins appear to have stabilized at nearly 5 percent, about the same level as the total margins of this group of COTH hospitals.

ProPAC analysis of preliminary data from the tenth-year of PPS (1993-94) also shows that hospitals receiving both IME and DSH payments had the highest PPS margins (6.9 percent), but the lowest total margins (2.9 percent) of any payment group. Hospitals that received neither IME nor DSH payments had the lowest PPS margins (minus 8.0 percent), but the highest total margins (4.8 percent). Hospitals that received only DSH payments had similarly high total margins of 4.7 percent, and improved PPS margins of minus 3.1 percent. Hospitals that received only IME payments (and no DSH payment) had a lower average PPS margin of minus 3.3 percent, and a slightly lower total margin of 4.5 percent compared to DSH only hospitals and to hospitals that neither IME nor DSH payments.

For the COTH hospitals in this analysis, the average total margin has increased slightly over the three-year period. Recent Congressional mandates extending Medicaid coverage to broader populations who previously may have been categorized as indigent patients, combined with favorable changes in Medicaid payment policy, may have contributed to these hospitals' improved total margins during this period. However, recently mandated limits on the amount of Federal funding available for Medicaid disproportionate share payments will moderate or reverse this pattern. In addition, the continued growth in managed care arrangements, which often do not recognize the training and other special costs incurred by teaching hospitals, and pressure by third-party payers to discount high cost tertiary services threaten teaching hospitals' financial stability.

The IME payment is an important equity factor in the Medicare PPS, compensating teaching hospitals for the higher patient care costs they incur as a result of the severity of their patients' illnesses, the scope of services provided and the impact of educational programs on hospital operating costs. However, its "medical education" label causes the adjustment to be viewed incorrectly as a payment for education only.

The IME adjustment was originally developed to create a "level playing field" for teaching and nonteaching hospitals. It serves as a proxy to adjust for inadequacies in the PPS, including:

- inadequate recognition of differences within a DRG of the complexity of disease, intensity of care required, and resources utilized by patients in teaching hospitals;
- non-recognition of the teaching hospital's costs of maintaining both a broader scope of services and the capacity to provide specialized regional services;
- failure of the wage adjustment to account for differences between central city and suburban wage rates within metropolitan areas;
- unavoidable decreases in productivity stemming from the presence of trainees; and
- additional ancillary services ordered by trainees as they learn how to diagnose and treat patients.

The AAMC strongly supports the importance of considering other factors, such as financial impact, in addition to an empirical estimate in determining the level of the IME adjustment. Teaching hospitals are under the same budgetary pressures as other hospitals to provide care efficiently; moreover, they must also fulfill their unique educational and service missions, including provision of health care for the poor. The current IME adjustment of 7.7 percent for each 0.1 increase in the number of residents-to-beds represents a substantial reduction of over 30 percent, or nearly 4 percentage points, from the original adjustment of 11.59 percent. Teaching hospitals have coped with the decreased rate, but in the current health services delivery environment, they will not be able to withstand further reductions without making substantial changes in the programs and services that they offer.

A reduction in the IME adjustment would hinder teaching hospitals' capability to support adverse selection within the DRGs, high technology care, high cost services for referred patients, and unique community services such as burn and trauma units.

The AAMC continues to oppose any reduction in the indirect medical education adjustment and urges the Congress to consider carefully the impact of a reduction in the adjustment on all teaching hospitals.

Direct Graduate Medical Education Payments

Our present system for graduate medical education has much to commend it. However, the system needs to change. The Association recognizes the present system has failed to produce the number of generalist physicians that society believes it may need in a reconfigured health care system. To that end, the AAMC has committed itself to identify ways to reverse the significant underrepresentation of generalist physicians among practitioners in the United States. A 1992 Association policy statement calls for:

> an overall national goal that a majority of graduating medical students be committed to generalist careers (family medicine, general internal medicine and general pediatrics) and that appropriate efforts be made by all schools so that this goal can be reached within the shortest possible time.

The policy document identifies and recommends strategies for the Association, schools of medicine, graduate medical education and the practice environment to facilitate reaching the goal. Its foundation rests on the implementation of voluntary, private sector initiatives. Among them is creating and maintaining incentive programs aimed at individual medical students, resident trainees, and practicing physicians as the preferred methods of inducing career choices in certain specialties.

We may all agree that the imbalance between the number of generalist and specialist physicians is unacceptable to society. Some policy makers and others have argued that the federal government-particularly the Medicare program-should take a more active role in ameliorating this imbalance by changing the way that graduate medical education (GME) is financed. The Association's policy statement on the generalist physician strongly endorses that private sector organizations and governmental bodies should join together in partnership to eliminate the many barriers that exist to meeting the need for generalist physicians. First among these strategies is reducing the marked disparity in income expectations stemming from our current system of physician payment. A second strategy is the development of appropriate training experiences in ambulatory, community-based non-hospital settings. As hospitals encourage shorter stays by more acutely ill patients, training in ambulatory and long-term care settings is needed to supplement the educational experience provided in hospitals to assure that residents receive comprehensive clinical training. With respect to the role of the Federal government, the AAMC policy statement recommends that:

- the Medicare program and other third-party payers should adopt other reforms in physician payment designed to compensate generalist physicians more equitably; and

- mechanisms employed to finance the direct costs of graduate medical education should not create nor perpetuate barriers to shifting the balance between generalist and non-generalist training.

Some changes in direct GME funding will be required to encourage residency training in non-hospital sites and to provide the resources for other initiatives designed to make the generalist specialties more attractive to medical students. However, the AAMC does not believe that weighting Medicare hospital payments for graduate medical education by specialty or that moving to a national average payment for Medicare direct costs will have a positive effect on the decisions senior medical students make with respect to specialty choice. Medical students' career choices are not affected by payments made to hospitals. Before proceeding directly to the debate on these issues, I will provide some background on graduate medical education and its current method of financing.

The Environment for Graduate Medical Education

The nature of graduate medical education is changing. Many factors in the current environment are contributing to changes in how graduate medical education is conducted and how it may be financed in the future. Residency and fellowship education is a system of

learning by participation in the care of individual patients and, therefore, includes elements of both education and service. However, as hospitals increasingly are called on to improve efficiency, residency programs are under constant pressure to emphasize service over their educational role. Additionally, while graduate medical education is organized primarily in hospitals and has been focused mainly on inpatients, its involvement with ambulatory patients is increasing to reflect the shift from inpatient to outpatient care in the overall health care system. Many specialties are requiring residents to spend more training time in ambulatory settings. For example, the Residency Review Committee (RRC) for internal medicine has required that all trainees in internal medicine residency training programs spend at least 25 percent of their time in ambulatory settings.

Residency programs require long-term, stable funding commitments to provide an appropriate education and to enhance the quality of patient services. Graduate medical education has been funded primarily by patient service revenues to hospitals, with significant appropriations supporting some municipal- and state-supported hospitals and military and Veterans Affairs (VA) hospitals. While the Medicare program and some state Medicaid programs make explicit payments for GME costs, private payers have traditionally supported GME through the higher payments that they make to teaching hospitals for patient care services.

AAMC data show that, on average, hospital patient revenues supported 85.2 percent of resident stipends and benefits and 62.9 percent of clinical fellow stipends and benefits, excluding VA hospitals in 1992-93 (see Attachment B). If anything, these data overstate the role of the hospital in financing graduate medical education, particularly for subspecialty clinical fellows, who are often not funded by the hospital, and therefore may not be included in the institution's records.

Faced with pressure to restrain health care expenditures, public and private third-party payers are adopting payment systems that limit or even decline altogether to provide payments for graduate medical education costs. The costs associated with the training of physicians may not be recognized by payers as they shift to fixed price systems for defined "bundles" or packages of services, capitated payments, and negotiated contracts for selected services. Thus, the historic mechanism for financing graduate medical education is being steadily dismantled by the broader focus on price competition among health care providers.

The Purpose of the Medicare Direct Graduate Medical Education Payment

Hospitals that train health professionals have multiple functions. In addition to providing medical care to individual patients, these hospitals provide the resources for the clinical education of physicians, nurses, and allied health professionals. To provide this formal, experientially-based clinical training, hospitals incur costs beyond those necessary for patient care. These added direct costs include: salaries and fringe benefits for trainees and the faculty who supervise them; classroom space; the salaries and benefits of administrative and clerical staff in the graduate medical education office; and allocated institutional overhead costs, such as costs for electricity and maintenance.

When Congress established the Medicare program in 1965, it acknowledged that educational activities enhanced the quality of care in institutions and recognized the need to support residency training programs to help meet the public need for fully-trained health professionals. In drafting the initial Medicare legislation, Congress stated:

> Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program (House Report, Number 213, 89th Congress, 1st Sess. 32 (1965) and Senate Report, Number 404, Pt. 1, 89th Congress, 1st Sess. 36 (1965)).

Similarly, in the regulations governing the Medicare program, the Secretary of Health, Education and Welfare stated:

> It is recognized that the costs of such educational activities should be borne by the

> community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities (42 C.F.R. Section 413.85 [formerly Section 405.421(c)]).

Thus, since its inception the Medicare program has assumed some responsibility for graduate medical education costs, making separate payments to teaching hospitals for these costs.

The History of the Direct Graduate Medical Education Payment

During the 1970s the Congress authorized the Department of Health, Education and Welfare to set prospective limits on the amount of hospital costs that would be reimbursed by the Medicare program. In 1979, it was decided that in calculating these cost limits a hospital could exclude all DGME costs because it did not seem fair to compare the costs of nonteaching hospitals to teaching hospitals if the DGME costs were included. The costs of teaching hospitals would surely be higher. This exclusion set a precedent for separating DGME costs from other costs, a separation that carried over into the design of the Medicare prospective payment system in 1983:

> The Department [of Health and Human Services] believes that the direct costs of approved medical education programs should be excluded from the [PPS] rate and be reimbursed as per the present system. This approach will assure that the base rate is related to patient care outcome and not significantly influenced by factors whose experience is really based on objectives quite apart from the care of particular patients in a particular hospital (Secretary of the Department of Health and Human Services, Hospital Prospective Payment for Medicare: A Report to Congress, December 1982, pages 47-48.)

Until the mid 1980s, Medicare paid for its share of DGME costs based on the hospital's historical and reasonable costs as determined by an audit. Reimbursement was open-ended in that a portion of "reasonable and allowable" DGME costs incurred every year was "passed through" to the Medicare program. DGME payments were also open-ended in that there was no restriction on the number of years that Medicare reimbursement would financially support a resident's training.

In April 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (P.L. 99-72), which dramatically altered the DGME payment methodology. The legislation changed the DGME payment methodology from one based on annual historical DGME costs to a prospective per resident amount. The Medicare program now pays its share of a hospital-specific per resident amount based on audited costs from a base year and updated for inflation rather than on the basis of DGME costs actually incurred. Today, a hospital's DGME payment is calculated by multiplying the hospital's fixed amount per resident by the current number of residents and then multiplying that result by Medicare's share of inpatient days at the hospital. Other legislative and regulatory changes have been made since COBRA, but the basic methodology for calculating the DGME payment remains the same.

In addition to changing the payment methodology, COBRA placed limits on the number of years for which full Medicare payment would apply. In a subsequent change, Congress chose to restrict full support to the direct costs of those residents within the minimum number of years of formal training necessary to satisfy the educational requirements for initial board certification, up to a maximum of five years. The five-year count would be suspended, however, for a period of up to two years for training in a geriatric residency or fellowship program. Payment for residents beyond either the period for initial board certification or the five-year level are reduced by 50 percent.

The change in DGME payment methodology required by COBRA, which the AAMC did not oppose, terminated the previous open-ended commitment to financing graduate medical education. Although COBRA limits DGME payments, it still acknowledges the historical scope of direct graduate medical education costs, including the salaries and fringe benefits of residents and supervising faculty physicians and institutional overhead costs.

Proposals to Change Medicare Payments for DGME Costs

Since the implementation of per resident payments in 1989, policy makers have proposed changes in the methodology to encourage residency training in generalist specialties and to limit the variation in hospital-specific per resident amounts. Generally speaking, these proposals also are intended to limit the growth in Medicare expenditures. Two proposals which will be addressed later in this testimony, weighting payments by specialty and constructing a national average payment amount, appear to have captured the attention of some policy makers. First, however, it is helpful to describe several recent government reports on Medicare financing of graduate medical education.

The Studies Conducted by the Inspector General and the General Accounting Office. Interest in changing Medicare DGME payments has been fueled to some degree by reports issued in 1994 by two government bodies: the Office of the Inspector General (IG) within the Department of Health and Human Services and the General Accounting Office (GAO). In an April 1994 report to the HCFA Administrator, the IG concluded, based on a sample of 120 teaching hospitals, that the per resident payment methodology caused the Medicare program "to share disproportionately in GME costs." The IG recommended that HCFA should propose several regulatory and legislative changes to more accurately identify Medicare's share of DGME costs, claiming that the pre-COBRA method was more comprehensive and representative of Medicare patients' utilization.

In July 1994, the IG issued its study of DGME costs, and recommended that HCFA re-evaluate its current policy of paying DGME costs for all specialties. The IG suggested that HCFA could submit a legislative proposal to "reduce or even possibly eliminate Medicare's investment in GME for specialties for which there is a surplus of physicians." The IG noted that "with the financial difficulties facing Medicare, it can ill afford to be the primary financial support for educational costs associated with surplus physician specialists." The report explains that at the inception of the Medicare program, the nation had a physician shortage and there was little community financial support for physician training.

The GAO has sounded similar themes. In May 1994, the GAO concluded that hospitals were using Medicare funds to support a disproportionate number of nonprimary care physicians, rather than meeting "community needs" by training primary care physicians. The GAO also cited several barriers to primary care training, including restrictive Medicare payment rules regarding DGME payments. In October 1994, the GAO suggested that medical schools and residency programs were not doing enough to increase the number of primary care physicians and again urged Congress to modify Medicare payment rules to provide incentives for ambulatory training.

While the AAMC is encouraged that interest in GME reform to meet public needs remains high, the Association has serious concerns about the reports of both agencies. The GAO's October report does not rely on the most current information available. Medical schools have ignited a solid, positive trend of increased medical student interest in primary care since the period studied in the GAO's October report. Thousands of medical students at more than 98 percent of the nation's allopathic and osteopathic medical schools participated in National Primary Care Day last year. The findings of the AAMC's Medical School Graduation Questionnaire are corroborated by the results of the 1994 National Residency Matching Program, which shows that more medical school graduates are selecting training in the generalist specialties.

The AAMC's Office of the Generalist Physician has established a number of services to support the generalist programs of medical schools, including:

- co-sponsorship of National Primary Care Day;
- educational programs for medical school faculty and administrators designed to assist them in their efforts to strengthen generalist education at their institutions;
- studies to elucidate the factors affecting career choices of medical students and residents and monitoring outcomes of efforts undertaken by schools and programs;

- an information clearinghouse that contains published and unpublished reports of generalsit initiatives and experiences at various academic institutions; and

- annual surveys of all U.S. medical schools on their programs and/or initiatives to increase production of generalist physicians.

With respect to the IG's April report, the AAMC has not had the opportunity to study the technical issues raised in the document. While the AAMC supports the principle that the Medicare program should pay a proportionate share of DGME costs, it should be recognized that the base-year GME costs were audited by HCFA's fiscal intermediaries and in a number of instances, legitimate costs were disallowed. Congress should carefully consider technical changes which could reduce the program's current level of support for GME, particularly in light of diminishing support from other payers and the failure to establish an all-payer fund for graduate medical education.

The AAMC strongly disagrees with the IG's suggestion "to reduce or even possibly eliminate Medicare's investment in GME for specialties for which there is a surplus of physicians." It would be a serious error to adjust the level and/or type of support based upon short-term circumstances in a rapidly changing health care system. This is particularly true of medical education with its extraordinarily long training cycle.

The IG's recommendation violates the intent of the original Medicare legislation which requires the program to support graduate medical education "until communities undertake to bear these [educational] costs." The AAMC strongly believes that in the current competitive environment, in which payers attempt to restrict themselves to paying only for those services they believe are necessary and reasonable for the care of their patients, communities have not undertaken to support the costs of physician training. In the absence of an all-payer fund for DGME costs, the Medicare program must continue to fulfill its original mandate and contribute its proportionate share to the education of physicians in all specialties.

Weighting DGME Payments by Specialty. For several years, some policy makers have proposed changes in Medicare payments for DGME costs that are intended to provide incentives to encourage the training of generalist physicians and to eliminate the variation in hospital-specific per resident amounts. Additionally, these proposals would reduce the Medicare program's role in GME funding.

One payment proposal, made in 1993, would have based Medicare DGME payments on a national per resident amount derived solely from the average of salaries paid to residents. Direct medical education payments would reflect differential weighting of the national average resident's salary, based on the specialty area a resident is pursuing and the length of the residency. A resident in a primary care specialty would be weighted at 240 percent, a non-primary care resident in the initial residency period would be weighted at 140 percent, and a non-primary care resident beyond the initial residency period would be weighted at 100 percent. The average weight would be 175 percent of the national average resident's salary, down from the average weight of about 215 percent under current law.

If it had been adopted, this proposal would have replaced the current Medicare payment methodology for DGME costs with a system based on three national rates. Thus, a hospital's total direct GME payment would be based not on its costs, but on the specialty mix of its trainees. Some policy analysts believe that these types of proposals would not only eliminate the variation in direct GME payments, but also would offer incentives to produce more primary care physicians. The proposal would attempt to accomplish this policy goal by paying relatively favorable amounts for primary care residencies, and substantially less favorable payment amounts for all other residencies.

The Association opposes proposals that intend to stimulate the production of generalist physicians by weighting direct GME payments by specialty and length of training. Although the AAMC strongly supports more individuals entering generalist practice, the Association does not believe this proposal would achieve its intended objective of encouraging the training of more generalist physicians. Proposals to weight Medicare DGME payments by specialty would have a negative effect on most hospitals' Medicare payments for DGME costs, depending on the hospital's specialty mix of resident trainees.

There is no evidence that medical students' selection of residency training programs is related to Medicare payments to hospitals. The task at hand is not to increase the number of generalist training positions, but to increase the attractiveness of the training positions already available.

In its March 1993 report to the Congress, the Physician Payment Review Commission (PPRC) concluded that weighting DGME payments to hospitals is undesirable. The commission indicated that there was already a sufficient number of existing generalist training slots, and weighting would have little influence on hospital management's and residency program directors' decision making. Finally, weighting would not sufficiently penalize institutions oriented toward subspecialty training.

The PPRC also "rejected as unwise the options of paying only for primary care positions or only for the first three years of training" (page 66). While the commission was aware of the need to increase the proportion of generalist physicians, it concluded that the nation will continue to require well-trained physicians in all specialties, and that such a policy would not be "sufficiently flexible" if changes in the health needs of the population called for physicians in specialties that required more than three years of training.

Proposals to weight payments by specialty would, however, eliminate the variation in the current per resident amount methodology across teaching hospitals and reduce support for physicians in training. There are legitimate reasons why there have been variations in institutional costs among residency training programs, including the way the law has been interpreted by the Medicare fiscal intermediaries and providers, and differences in historical funding sources.

It is important to understand the internal institutional dynamics that will result from the implementation of preferential weighting proposals. Those disciplines with an increased weighting factor will argue that they deserve "more" of the direct GME funds for their residency programs. At the same time, other disciplines, as a result of reductions in fee revenue attributable to the implementation of the resource-based relative value scale, are increasing pressure for more faculty salary support. Reports from members of the AAMC's Council of Teaching Hospitals indicate some specialty departments are approaching hospital executives for additional academic supervisory and administrative financial support.

While supporters of preferential weighting proposals indicate that a higher payment differential will be enacted only for primary care disciplines, it is likely many clinical specialties will argue they also deserve a "special weighting factor." It is unclear what criteria will be used to define a "primary care" program. The AAMC notes that emergency medicine was added as a primary care category to the House Ways and Means Committee proposal in 1991, and physical medicine and child psychiatry immediately made a case for inclusion because these specialties are in short supply.

The AAMC strongly supports more individuals entering generalist practice, but data on career choices of medical school graduates indicate that medical students' selection of residency training programs is not affected by Medicare payments to hospitals. On the contrary, personal incentives such as loan forgiveness, tax benefits, and other inducements, such as narrowing the income gap between generalist and non-generalist physicians, are more likely to result in greater numbers of U.S. medical school graduates entering the generalist disciplines. If monetary incentives are to be provided, they should be aimed at individuals, not hospitals and their sponsored residency programs. There are already a variety of federally-sponsored student loan repayment programs that could be bolstered.

Changes in physician manpower supply, pressure from both federal and private payers to constrain the growth in health care expenditures, and changes in medical care delivery have produced significant tensions for residency and fellowship training programs. At the same time, the Association recognizes the frustration of government policy makers in assuring the public has access to an appropriate specialty mix of physicians. The AAMC supports strategies to develop additional generalist physician manpower, but proposals to weight Medicare DGME payments based on specialty and length of training will only contribute to the instability of GME funding. Strong residency programs require continuity of effort and stable support. If future generations of Americans are to have appropriate access to well-

trained physicians, we must maintain and strengthen our medical education system, including its residency training component.

Proposals to Pay a National Average Payment Amount for DGME Costs. Last year, during the debate over comprehensive health care reform, some proposals recommended the development of a national average per resident payment methodology with payment adjustments for regional differences in wages and/or wage-related costs. In some instances, the proposals excluded certain types of costs, such as direct overhead costs or allocated institutional overhead costs. These changes were suggested in the context of a package of proposals for graduate medical education reform, including an all-payer funding mechanism that was to be separate from payments for patient care services.

The AAMC continues to be concerned about proposals to change Medicare DGME payments from a hospital-specific to a national average per resident payment. Such a proposed change likely would result in both a significant reduction in aggregate GME funding and a redistribution of DGME payments. Similarly, **the AAMC is opposed to proposals that would exclude certain types of DGME costs, such as faculty supervision costs or overhead costs, from the calculation of the Medicare per resident amount.**

The AAMC supports the continuation of the current Medicare per resident payment method based on hospital-specific costs. The AAMC believes a national average payment method would fail to recognize structural factors that legitimately affect a hospital's per resident costs. Wide variation in per resident amounts exists among hospitals in the availability and amount of support from non-hospital sources, including public subsidies and faculty practice earnings. The overall financing of teaching hospitals and medical schools often is driven by historic circumstances, which have led to certain costs, especially faculty costs, being borne by the medical school, or in some cases, the teaching hospital. The diversity of supporting the costs of faculty is probably the most important reason for the variation in Medicare per resident payments. Additionally, there are legitimate differences in educational models depending on the specialty and the institution. Residency programs also may have unique histories and differences in the funding available to them, such as state or local government appropriations. While some proposals would adjust the Medicare national average per resident payment for differences in wages and other wage-related costs, these other structural factors would not be reflected in the national average payment methodology, creating inappropriate winners and losers.

The AAMC also supports the current methodology because it recognizes all types of costs, including salaries and fringe benefits of the faculty who supervise the residents; direct overhead costs, such as malpractice costs, and the salaries and benefits of administrative and clerical support staff in the graduate medical education office; and allocated institutional overhead costs, such as costs for maintenance and utilities. The current method recognizes the diversity in how graduate medical education is organized and financed. Further, ample faculty supervision is necessary to monitor appropriately residents' development in an environment of rapidly changing patterns of practice. Graduate medical education in all specialties is based on the premise that residents learn best by participating, under supervision, in the day-to-day care of patients. Supervising physicians must judge the clinical capabilities of residents, provide residents with the opportunities to exercise progressively greater independence, and ensure that the care of patients is not compromised. This supervising responsibility requires substantial time and commitment, and must be compensated.

As noted earlier, in the current competitive environment, teaching hospitals' ability to cover the cost of physician education through those payers who are willing to pay higher prices has been severely limited because many public and private payers are increasingly restricting their payments only to the services that they believe are necessary for their beneficiaries. The AAMC believes that third-party payers, including Medicare, must support their proportionate share of the costs of supervision and other related educational costs to help ensure high quality patient care, and to preserve the high quality of residency programs.

Average Adjusted Per Capita Cost (AAPCC)

As the delivery system moves toward capitated payments for covered lives, separating the

payment for DGME costs and for patient care costs attributable to the special roles of teaching hospitals from patient care revenue becomes necessary. The AAMC believes that the current method of calculating the Medicare average adjusted per capita cost (AAPCC), the rate that the program pays to risk contractor HMOs, results in a payment system that creates an uneven playing field between teaching and nonteaching hospitals and may provide a disincentive for teaching hospitals to enter into contracts with Medicare risk-based HMOs.

The AAPCC calculation includes all Medicare fee-for-service expenditures, specifically the direct graduate medical education (DGME) payment, the indirect medical education (IME) payment and the disproportionate share (DSH) payment. These payments are intended respectively to compensate hospitals for specific missions (graduate medical education), or for providing services to atypical patients who are severely ill or are of low-income socioeconomic status.

Once these payments have been included in the AAPCC and paid to an HMO, there is no assurance that these dollars are used for the purposes intended by the Congress. Thus, teaching hospitals are at a competitive disadvantage when they attempt to contract with HMOs because the HMOs receive the same AAPCC amount regardless of with whom the HMO has a contract. Teaching hospitals have higher patient care costs associated with their additional missions. The Medicare payment system recognizes these higher costs through the IME and the DSH adjustments and the DGME payment.

The AAMC believes that the IME, DSH and DGME payments should be excluded from the calculation of the risk payment rates and paid to a teaching hospital directly when the Medicare HMO enrollee actually incurs a bed day in the teaching facility. Simply put, if the teaching hospital provides the service, it should receive the IME, DSH and or DGME payments directly whether the service is provided to Medicare beneficiaries under the prospective payment system (which would include DGME costs), or through HMOs with risk contracts.

The AAMC urges the Congress to require the Prospective Payment Assessment Commission (ProPAC), as part of its analysis, to develop a methodology for removing these costs from the calculation of the AAPCC and for paying them directly to teaching hospitals when services are delivered to Medicare HMO patients. The Association is pleased that ProPAC has started to analyze how the Medicare program pays risk contractors. The AAMC believes that modifying the AAPCC calculation would at least partially ameliorate the competitive disadvantage that teaching hospitals bring to the negotiating table, remove barriers to expanding HMO use among Medicare beneficiaries and strengthen the existing, risk-based coordinated care program.

Medicare Physician Payments

Since 1991, specialty physicians in teaching settings have experienced significant fee reductions under the Medicare fee schedule system including reductions to procedure-oriented specialties, global surgical fees, bundled services for critical care, volume performance standards, outpatient site-of service limitations, and other payment policy changes for anesthesiology, pathology, and radiology services.

While the Association remains supportive of the original intent and philosophy of the Medicare Fee Schedule, the AAMC is concerned about proposed policies which may not assure appropriate levels of payment to all physicians. One proposal, first made in the Health Security Act, particularly concerns academic medicine.

A Volume Performance Standard for High Cost Medical Staffs

The AAMC is concerned that a deficit reduction bill may include a provision on high cost medical staffs. Under this provision, a new, rather punitive volume performance standard would be applied to medical staffs, holding them collectively responsible for all Medicare physician services delivered to inpatients. The performance standard would be defined in terms of volume per admission, measured as Relative Value Units (RVUs) per admission. RVUs per admission would be adjusted for case-mix using DRGs in the same manner as in the Medicare PPS for inpatient hospital services, except that the DRG weights would be

based on physician, not hospital, services. The proposal also would make adjustments for teaching activity and disproportionate share status. According to the proposal's architects, the costs of physician services and hospital services would be linked for the first time.

Each year, the Health Care Financing Administration (HCFA) would calculate a hospital-specific volume per admission for each hospital in the country and rank these hospitals from the highest to the lowest. Limits would be defined in terms of the volume per admission of the median hospital. HCFA would recognize cost variation among urban-rural providers and adjust the hospital-specific volume accordingly. Initially the limit would be 125 percent of the national median for urban hospitals and 140 percent of the national median for rural hospitals. Similar to HMO withhold mechanisms, HCFA would impose a withhold of 15 percent of the payment for each physician service delivered by a high-cost medical staff, beginning in 1998. Reconciliations would be made the following year. For each medical staff below the limit, the entire withhold would be returned; for each staff above the limit, part or none of the withhold would be returned, depending upon the extent to which actual 1998 volume exceeded the limit.

Discussion of a New Volume Performance Standard for High Cost Medical Staffs. **The AAMC joins the PPRC, and several physician organizations, in opposing the extension of Medicare's volume performance standard (MVPS) to high cost medical staffs.** The fundamental premise of the proposal is that payment under the Medicare fee schedule should be treated like a managed care arrangement by establishing a prospective withhold mechanism. Congress intended that the Medicare Part B program remain a fee-for-service payment system for physicians. This intention was reconfirmed by enacting the Medicare fee schedule system in 1991. Therefore, to apply an HMO-styled prospective withhold of payments is not only inappropriate, but also fundamentally contrary to Congressional intent and every physician's participating agreement with the Medicare program. While the AAMC is supportive of refinements to the national VPS, as well as other positive incentives to reduce inappropriate physician care and Medicare Part B expenditures, the Association believes that this approach is flawed and would only serve to break trust between the physician community and the Medicare program.

This proposal would have a significant negative impact on both teaching and nonteaching physicians. First, the proposal assumes that a medical staff will behave like a cohesive medical group practice for the purpose of reducing Medicare inpatient payments. Typically, a medical staff behaves like loosely affiliated, autonomous physicians. As the PPRC discovered during its debate on the establishment of a national Medicare volume performance standard policy, there is little evidence to support the notion that a state, regional, or even a local level volume performance standard will provide a greater, more effective incentive for physicians to reduce costs than the national VPS.

Most teaching physicians' faculty practice plans are structured along departmental lines and by specialty. Although many are in development, integrated information systems to monitor and support cost and quality of care initiatives at the individual provider level and across departmental faculty practice plans are generally unavailable. Without these kinds of practice management tools, faculty practice plans (indeed all medical staffs) will not be able to identify high-cost providers, influence physician practice patterns, improve medical decision-making, and ultimately control the total cost of patient care.

The AAMC also believes that the methodology of the high cost medical staff proposal to equalize the services of physicians in teaching vs. non-teaching hospitals is flawed. Researchers have presumed that the services of residents, for the most part, are not billed by the supervising attending physician. Therefore, under a special rule, the hospital-specific per admission relative value for a teaching hospital's medical staff is adjusted to account for service volume generated by residents using a proxy. Architects of the high cost medical staff methodology state that this proxy measures the actual inpatient service costs of a resident's inpatient care which ordinarily be provided by attending physicians in teaching hospitals.

The AAMC is concerned that this measure could significantly distort the per admission relative value for physicians in teaching hospitals. This proposal fails to recognize the dynamics of physician billing in accordance with the provisions of IL-372 Guidelines and the

attending physician criteria. The Association believes the methodology potentially overstates the costs of inpatient care by adding the GME equivalent per admission relative value to the service activity already billed by the attending physician supervising the resident's care. **The AAMC strongly recommends that the methodology for calculating the hospital-specific per admission relative value for teaching physicians, specifically the GME equivalent per admission relative value, be studied further.**

Conclusion

The AAMC regrets that Congress seems unprepared to enact comprehensive health care reform that includes all-payer funds for the special missions of teaching hospitals and medical schools. At the same time, all evidence indicates that the health care delivery system will continue to emphasize price competition, challenging the financial viability of teaching hospitals and teaching physicians. The AAMC is deeply concerned that the fundamental structural changes now occurring in the health delivery system will undermine the ability of academic medicine to adapt to the new environment and to fulfill its unique missions.

Academic medicine consists of a diverse group of highly complex institutions providing the environment and resources for medical education and research for the nation and providing both basic and tertiary patient care services. The current emphasis on re-examining national policies in light of limited public resources places these institutions and their vital activities at risk if their special roles and nature are not appreciated.

National policy on health care delivery and payment must recognize the unique characteristics and diversity of teaching hospitals and teaching physicians so that their fundamental missions can be preserved. A poorly conceived or short-sighted policy to reduce Medicare payments to teaching hospitals and teaching physicians will undermine the ability of these institutions to fulfill their multiple responsibilities at the same time they are struggling to adapt to a new delivery environment. Academic medicine supports those changes that assure high quality health care, a vibrant research capability and the capacity to educate outstanding practitioners. Academic institutions need the understanding and support of society to fulfill their obligations. The AAMC looks forward to working with the members of the subcommittee and their staff to meet these common goals.

Attachment A

Data and Methodology

To assist in obtaining a better understanding of the importance of the IME adjustment to teaching hospitals and the negative effect of reducing the IME adjustment on hospital margins, the AAMC analyzed the financial data of 91 COTH members that provided Medicare Cost Report data for the three-year period. A list of the responding hospitals by state precedes the tables. Survey participants reported their data by hospital fiscal year. Thus, FY 1994 contains data from hospitals with fiscal years ending primarily in June 1994. Seventeen hospitals had fiscal years ending in other months in 1994. Hospitals with calendar fiscal year ends (December 1994), such as most hospitals in New York State, have been excluded from this analysis because their financial results are not yet available.

This analysis includes 61 academic medical center hospitals and 30 community teaching COTH hospitals. Seventy-two hospitals have intern and resident-to-bed ratios (IRBs) of 0.25 or greater, classifying them as "major teaching" hospitals. Nineteen respondents are "other teaching" hospitals with IRBs less than 0.25. In general, 1994 PPS data reported in these tables are from hospitals' "as filed" Medicare Cost Reports. Total margin (the margin from all hospital operations, including patient care, government appropriations, and other income from investments and philanthropy) percentages are calculated using data from 1994 audited financial statements.

Attachment A-1

COTH Hospitals Providing Data for 1994 IME Analysis

Hospital	City, State
Baptist Medical Centers	Birmingham, Alabama
University Medical Center	Tucson, Arizona
Kern Medical Center	Bakersfield, California
Valley Medical Center of Fresno	Fresno, California
Long Beach Memorial Medical Center	Long Beach, California
Cedars-Sinai Medical Center	Los Angeles, California
USC University Hospital	Los Angeles, California
Los Angeles County-USC Medical Center	Los Angeles, California
UCLA Medical Center	Los Angeles, California
University of California, Davis, Medical Center	Sacramento, California
University of California, San Diego, Medical Center	San Diego, California
The Medical Center at the University of California, San Francisco	San Francisco, California
University Hospital	Denver, Colorado
Georgetown University Hospital	Washington, D.C.
Howard University Hospital	Washington, D.C.
The George Washington University Hospital	Washington, D.C.
Washington Hospital Center	Washington, D.C.
Shands Hospital	Gainesville, Florida
Jackson Memorial Hospital	Miami, Florida
Tampa General Hospital	Tampa, Florida
Crawford Long Hospital of Emory University	Atlanta, Georgia
Emory University Hospital	Atlanta, Georgia
Medical College of Georgia Hospital and Clinics	Augusta, Georgia
MacNeal Hospital	Berwyn, Illinois
Mercy Hospital and Medical Center	Chicago, Illinois
Northwestern Memorial Hospital	Chicago, Illinois
Rush-Presbyterian-St. Luke's Medical Center	Chicago, Illinois
University of Chicago Hospitals	Chicago, Illinois
University of Illinois Hospital	Chicago, Illinois
Lutheran General Hospital	Park Ridge, Illinois
Memorial Medical Center	Springfield, Illinois
St. John's Hospital	Springfield, Illinois
Indiana University Hospitals	Indianapolis, Indiana
University of Iowa Hospitals and Clinics	Iowa City, Iowa
University of Kansas Hospital	Kansas City, Kansas
University Hospital, University of Kentucky Medical Center	Lexington, Kentucky
Alton Ochsner Medical Foundation	New Orleans, Louisiana
Tulane University Hospital and Clinic	New Orleans, Louisiana
Louisiana State University Hospital	Shreveport, Louisiana
Beth Israel Hospital	Boston, Massachusetts
Faulkner Hospital	Boston, Massachusetts
Mount Auburn Hospital	Cambridge, Massachusetts
University of Massachusetts Medical Center	Worcester, Massachusetts
University of Michigan Hospitals	Ann Arbor, Michigan
St. John Hospital and Medical Center	Detroit, Michigan
Blodgett Memorial Medical Center	Grand Rapids, Michigan

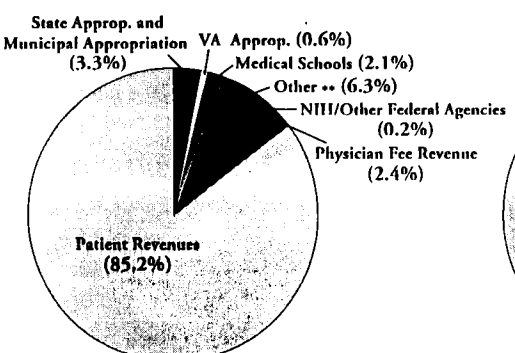
Attachment A-2

COTH Hospitals Providing Data for 1994 IME Analysis (Continued)

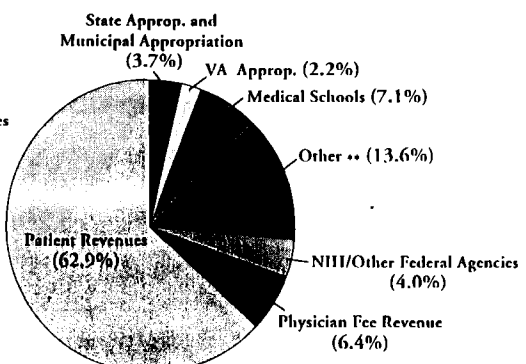
Hospital	City, State
Providence Hospital	Southfield, Michigan
The University of Minnesota Hospital and Clinic	Minneapolis, Minnesota
University Hospital, University of Mississippi Medical Center	Jackson, Mississippi
University of Missouri Hospital and Clinics	Columbia, Missouri
Truman Medical Center	Kansas City, Missouri
St. John's Mercy Medical Center	St. Louis, Missouri
St. Louis University Hospital	St. Louis, Missouri
University of Nebraska Hospital	Omaha, Nebraska
Mary Hitchcock Memorial Hospital	Hanover, New Hampshire
University of New Mexico Hospital	Albuquerque, New Mexico
University of North Carolina Hospital	Chapel Hill, North Carolina
Duke University Hospital	Durham, North Carolina
North Carolina Baptist Hospital, Inc.	Winston-Salem, North Carolina
University of Cincinnati Hospital	Cincinnati, Ohio
Grant Medical Center	Columbus, Ohio
The Ohio State University Hospitals	Columbus, Ohio
Medical College of Ohio Hospitals	Toledo, Ohio
Oklahoma Medical Center	Oklahoma City, Oklahoma
Saint Francis Hospital	Tulsa, Oklahoma
Oregon Health Sciences University Hospital	Portland, Oregon
Lehigh Valley Hospital	Allentown, Pennsylvania
Crozer-Chester Medical Center	Chester, Pennsylvania
Geisinger Medical Center	Danville, Pennsylvania
PennState University Hospital, Milton S. Hershey Medical Center	Hershey, Pennsylvania
Albert Einstein Medical Center	Philadelphia, Pennsylvania
Frankford Hospital of the City of Philadelphia	Philadelphia, Pennsylvania
Graduate Hospital	Philadelphia, Pennsylvania
Hospital of the University of Pennsylvania	Philadelphia, Pennsylvania
Pennsylvania Hospital	Philadelphia, Pennsylvania
Temple University Hospital	Philadelphia, Pennsylvania
Thomas Jefferson University Hospital	Philadelphia, Pennsylvania
Allegheny General Hospital	Pittsburgh, Pennsylvania
Shadyside Hospital	Pittsburgh, Pennsylvania
The Western Pennsylvania Hospital	Pittsburgh, Pennsylvania
Medical University Hospital	Charleston, South Carolina
Regional Medical Center at Memphis	Memphis, Tennessee
Vanderbilt University Hospital	Nashville, Tennessee
Methodist Hospitals of Dallas	Dallas, Texas
Harris County Hospital District	Houston, Texas
University of Utah Hospital	Salt Lake City, UT
University of Virginia Hospitals	Charlottesville, Virginia
Norfolk General Hospital	Norfolk, Virginia
Harborview Medical Center, University of Washington Hospitals	Seattle, Washington
University of Washington Medical Center	Seattle, Washington
University of Wisconsin Hospital and Clinic	Madison, Wisconsin

Source of Funding for Housestaff Stipends and Benefits All Hospitals, 1992-93*

Resident Stipends and Benefits



Clinical Fellow Stipends and Benefits



* Excludes Veterans Administration hospitals

** Includes endowment income and foundation grants

Source: COTH Survey of Housestaff Stipends, Benefits and Funding

Attachment B

Chairman THOMAS. Thank you, Mr. Ford.
Mr. Gage.

STATEMENT OF LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Mr. GAGE. Thank you very much, Mr. Chairman. I am Larry Gage, President of the National Association of Public Hospitals.

NAPH's members include over 100 of America's metropolitan area safety-net hospitals, with combined gross revenues of over $16 billion. These hospitals provide nearly 90 percent of their services to Medicare, Medicaid, and low-income uninsured and underinsured patients.

They also provide many preventive, primary, and costly tertiary services to their entire communities, not just to the poor. These include maintaining a wide variety of round the clock standby services such as trauma units, burn centers, neonatal intensive care, poison control, emergency psychiatric services and crisis response units for both natural and manmade disasters.

I recognize that this hearing is focused primarily on rising Medicare costs. With their overwhelming reliance on governmental funding sources to carry out their essential mission, America's urban public hospitals are also concerned about rising costs. As we stated time after time last year, and as Stuart Altman pointed out earlier today, our current methods of financing and providing health care for the uninsured poor, and underwriting many expensive communitywide services, are both fragmented and fragile. We too are constantly searching for ways to pay for, as well as to provide, these vital services.

In the few minutes remaining to me, I would like to give you an idea of the possible impact on these essential providers of the substantial reductions in Medicare disproportionate share hospital and medical education payments that have been suggested by some this year.

Let me first briefly share with you a few statistics about the volume and financing of uncompensated care and communitywide services. I have charts that show tables that are attached to my prepared testimony. Very simply, table 1 on the right identifies the source of gross revenues for NAPH member hospitals in 1991, indicating that 88 percent were attributable to Medicare, Medicaid, and self-pay or no-paying patients.

Table 2 provides the same breakdown for outpatient and emergency visits, showing in both cases that 33–37 percent of all of our services are provided to the uninsured.

Table 3 on the far left identifies both the total volume of outpatient and emergency room visits provided by just 13 of the larger NAPH member hospitals, as well as the substantial proportion of those services that are not compensated by Medicare, Medicaid, or any other third-party payer.

As you see, these 13 hospitals alone provided over 6.8 million outpatient department and emergency room visits, of which 45 percent were uncompensated. Just to take a random example, the Kern County Medical Center provided nearly 30 percent of all of its outpatient visits on an uncompensated basis.

Finally, table 4, which is now in the middle, provides nearly 50 examples, and again, this is attached to my testimony, of the kinds of additional, often unfunded, services provided by these essential providers.

My point is this: In the absence of systemwide reform or universal coverage, this high volume of uncompensated care and these dozens of unfunded communitywide services can only be funded through the kind of institutionalized cost shifting represented by Medicare disproportionate share and medical education payments.

In 1993, for example, an as yet uncompleted survey of NAPH members preliminarily found that just 48 hospitals collected over $210 million in Medicare disproportionate share payments and nearly $270 million in direct and indirect GME payments.

If the disproportionate share payments were reduced by half and GME payments by approximately 40 percent, as some have proposed, this would be reduced to just $260 million. Since there are equal, if not greater, pressures on Medicaid and direct local subsidies, the other two primary sources of support, no other sources of funding are likely to be available to make up this loss of $260 million. And the results will be dramatic.

To give you an example, the $260 million is enough to fund 3 million uncompensated outpatient visits, or 100 percent of the standby costs of all of the 24-hour poison control, high-risk pregnancy, substance abuse, rape crisis, mental health, tuberculosis, and other services provided by these institutions.

In conclusion, we agree with what Rick Pollack and others have said earlier, Americans clearly spoke in November about their concerns for runaway government spending and programs, but it is important, we think, to ask the right question. We believe that question is not how rapidly can we reduce all governmental spending in all programs, but rather, how best can we determine what is the most appropriate role for government in an era of limited resources?

Thank you very much.

[The prepared statement and attachments follow:]

Statement of Larry S. Gage
President

National Association of Public Hospitals

before the

Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
Washington D.C.
February 6, 1995

I am Larry Gage, President of the National Association of Public Hospitals (NAPH). NAPH's members include over 100 of America's metropolitan area safety net hospitals. These 100 institutions (taken together) comprise America's most important health and hospital system. With combined revenues of over $16 billion, these hospitals provide nearly 90% of their services to Medicare, Medicaid and low income uninsured and underinsured patients. They also provide many preventive, primary and costly tertiary services to their entire communities, not just the poor and elderly. These include maintaining a wide variety of round-the-clock standby services such as trauma units, burn centers, neonatal intensive care, poison control, emergency psychiatric services, and crisis response units for both natural and man-made disasters.

In just the last two years, NAPH members have been at the forefront of the response to community wide crises that have included fires, floods, earthquakes, deadly new viruses, measles epidemics, environmental spills, air crashes, and urban riots. At the same time, their preventive and primary care services have been essential to meeting the day to day health needs of many millions of urban residents with restricted access to "mainstream" health services. In other words, these essential health systems -- which rely on Medicare, Medicaid and direct state and local governmental subsidies for over three quarters of their operating revenues -- already serve as a "national health system" by default in most of our nation's urban areas.

I am pleased to have this opportunity to testify before the Subcommittee on Medicare budget issues generally, and those aspects of the Medicare program that directly affect America's essential providers in particular. NAPH recognizes that the primary purpose of this hearing is to consider ways to curb the continuing growth in Medicare costs. We agree with the AHA and other witnesses testifying today that the hospital industry generally has not been the cause of recent growth in the Medicare program. In addition, those hospital payments that are most vital to essential providers -- such as disproportionate share hospital payments and medical education adjustments -- have also remained stable, with little growth, in recent years.

With their overwhelming reliance on governmental funding sources to carry out their essential mission, America's urban public hospitals are also concerned with rising health costs. As we stated time after time last year, our current methods of financing and providing health care for the uninsured poor, and underwriting many expensive community-wide services, are both fragmented and fragile. For this reason, last year, when the Congress extensively considered alternative health plans, NAPH was willing to support various kinds of adjustments to Medicare spending, in order to obtain a more rational system in which the uninsured would finally receive health coverage. In the absence of such a goal, however, all current sources of safety net funding -- including the Medicare DSH and medical education adjustments -- are more essential than ever, especially for the highest volume providers of care to the uninsured and community-wide public health services.

NAPH has been gratified that the Congress has often achieved a bipartisan recognition of the importance of preserving and protecting these institutions. Throughout the mid-1980s, despite a

number of reductions in the rate of increase in Medicare rates and medical education payments, the Medicare DSH adjustment was actually increased in a carefully targeted way for the highest volume providers of safety net services. Even last year, in the context of health care reform, this subcommittee voted unanimously, by an 11-0 roll call, to extend protections to these health systems and certain other "essential community providers". In terms of health reform, it has been stated by many observers that the most we may be able to achieve this year is modest incremental reform. In the absence of any likely movement toward universal coverage, the continued protection and support for safety net health systems is more essential than ever.

It may be helpful to give you an idea of the possible impact on these essential providers of some of the substantial reductions in Medicare DSH and medical education payments that have been suggested this year. Let me first share with you a few statistics about the volume (and financing) of uncompensated care and community-wide services provided by these health systems.

Table 1 identifies the source of gross revenues for NAPH member hospitals in 1991, and indicates that 88% were attributable to Medicare, Medicaid or "self-pay" (i.e., "non-paying") patients. Table 2 provides the same breakdown for outpatient and emergency visits.

Table 3 identifies both the total volume of inpatient services and outpatient/emergency room visits provided by 13 of the larger NAPH member hospitals, as well as the substantial proportion of those services that are not compensated by Medicare, Medicaid or any other third party payer. In summary, these 13 hospitals alone provided over 6.7 million outpatient department/emergency room visits, of which over 3 2 million (or 45%) were uncompensated.

Finally, Table 4 provides nearly 50 examples of the kinds of additional -- often unfunded -- services provided by these essential providers.

In the absence of system-wide health reform or universal coverage, both this extraordinarily high volume of uncompensated care, and these dozens of unfunded community-wide services, can only be funded through the kind of institutionalized "cost shifting" represented by Medicare DSH and medical education payments. In fact, because there are so few other funding sources now available for these services, it is actually possible to quantify what the loss of a significant part of this funding would mean to the communities served by these hospitals.

In 1993, for example, an as-yet uncompleted survey of NAPH members has preliminary found that just 48 NAPH member hospitals collected over $210 million in Medicare DSH payments, and nearly $270 million in direct and indirect medical education payments. If DSH payments were reduced by half and GME payments by approximately 40%, as some have proposed, this $480 million in essential support would shrink to approximately $260 million. Since there are equal (if not greater) pressures on Medicaid and direct local subsidies – the other two primary sources of support for safety net health systems -- no other sources of funding are likely to be available to make up this loss of $260 million. The result could be dramatic in many communities, when you consider that at just these 48 hospitals, $260 million is currently sufficient to finance:

- Over 3 million uncompensated outpatient or emergency room visits,

- 100% of the cost of all of the 24 hour poison control, high risk pregnancy, substance abuse, rape crisis, mental health, tuberculosis, immunization, transportation and environmental crisis response services provided by these 48 hospitals, or

- All of the standby costs of the nearly 30 Level I trauma centers operated by these 48 hospitals (of which several are the only such trauma centers in their entire urban areas).

While Americans clearly spoke in November about their concerns with runaway government spending and programs, it is important that we ask the right question. We believe that the right question is not "how rapidly can we reduce all governmental spending and programs", but rather "how best can we determine what is the most appropriate role for government" in an era of limited resources? What are the essential services that government must continue to support or provide? Can

we really afford to jeopardize any of these essential health services in our nation's metropolitan areas today? Is it realistic to expect them to be absorbed by the rest of the health system or funded or provided by "volunteers"? NAPH sincerely hopes that the answer to these questions in 1995, as it has been in the past, is an emphatic and bipartisan "NO".

In conclusion, I would like to call your attention to two additional areas of concern to NAPH in the current environment: managed care, and the ongoing need for infrastructure development by both urban and rural essential providers.

With respect to managed care, NAPH is concerned that the headlong rush to enroll millions and millions of Medicare and Medicaid recipients in managed care organizations could also be detrimental to patients and jeopardize many of the essential community-wide services provided by safety net health systems. We are not opposed to the concept of managed care itself. Indeed, we agree that managed care does have the potential to generate at least some initial savings for payers, and could result in improved access for low income and elderly patients to preventive and primary care services. The key, however, is to make sure that managed care is done right. It is imperative that sound, effective systems and networks are both available and accessible to enrollees before leaping into mass enrollment. Otherwise, there is a substantial risk that responsible, well-managed plans and providers will not be ready; that marketing, enrollment and discrimination abuses will occur; and that essential providers and systems will not be given an opportunity to participate on a level playing field with aggressive private organizations, resulting in substantial erosion of access and services for the millions of individuals and hundreds of communities who must continue to rely on these systems. These concerns are not abstract -- we have seen them played out in states like Tennessee, Florida, Arizona and California, and in other areas where premature efforts have been made to push massive numbers of people into managed care plans. A number of potential safeguards and solutions were also discussed extensively during the health reform debate last year, including the unanimous bipartisan vote of this subcommittee to include substantial protections for essential community providers. NAPH simply suggests that these concerns -- and these safeguards -- continue to be before you this year as you debate the potential broadening of Medicare managed care activities.

Finally, I would like to add a few words about the continuing need for federal support for infrastructure development and renovation by essential providers in both urban and rural underserved areas.

Such safety net hospitals face a substantial need for adequate capital to rebuild and equip our nation's health infrastructure. A 1993 NAPH study estimated that there are at least $15 billion in unmet capital needs among these essential urban providers. Yet these hospitals also face significant barriers in obtaining access to capital, as well as in their ability to repay incurred debts entirely from patient care revenues. In order to meet these needs, a Federal capital financing initiative is clearly needed. For the last three years, NAPH has assisted with the drafting of a new urban-rural capital financing initiative that was introduced by Representative Pete Stark in the House, and by Senators Thomas Daschle, Max Baucus and John Breaux in the Senate. Significant portions of this legislation were adopted in both Democratic and Republican versions of health reform legislation last year, including parts of the proposal that rely on private marketplace solutions such as loan guarantees to make capital available at very little additional cost to the Federal government. We strongly urge your continued consideration of these proposals this year.

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

TABLE 1

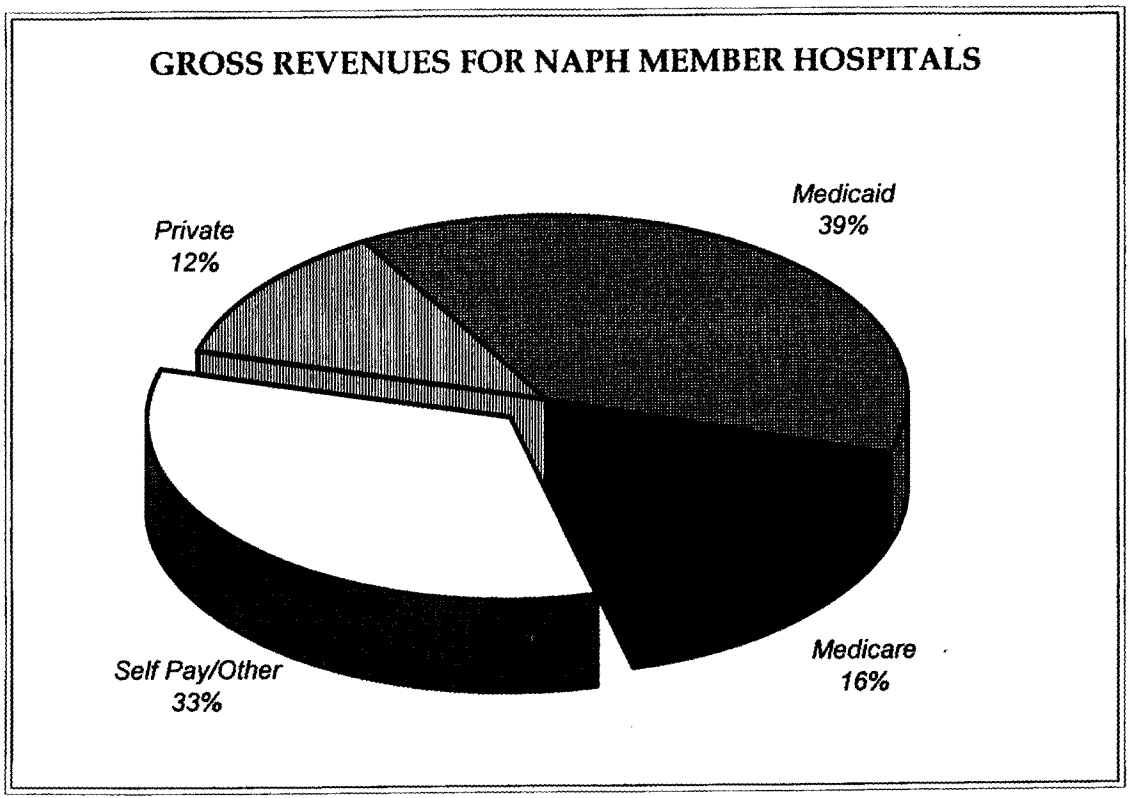

GROSS REVENUES FOR NAPH MEMBER HOSPITALS
Medicaid
39%
Private
12%
Medicare
16%
Self Pay/Other
33%

TABLE 2

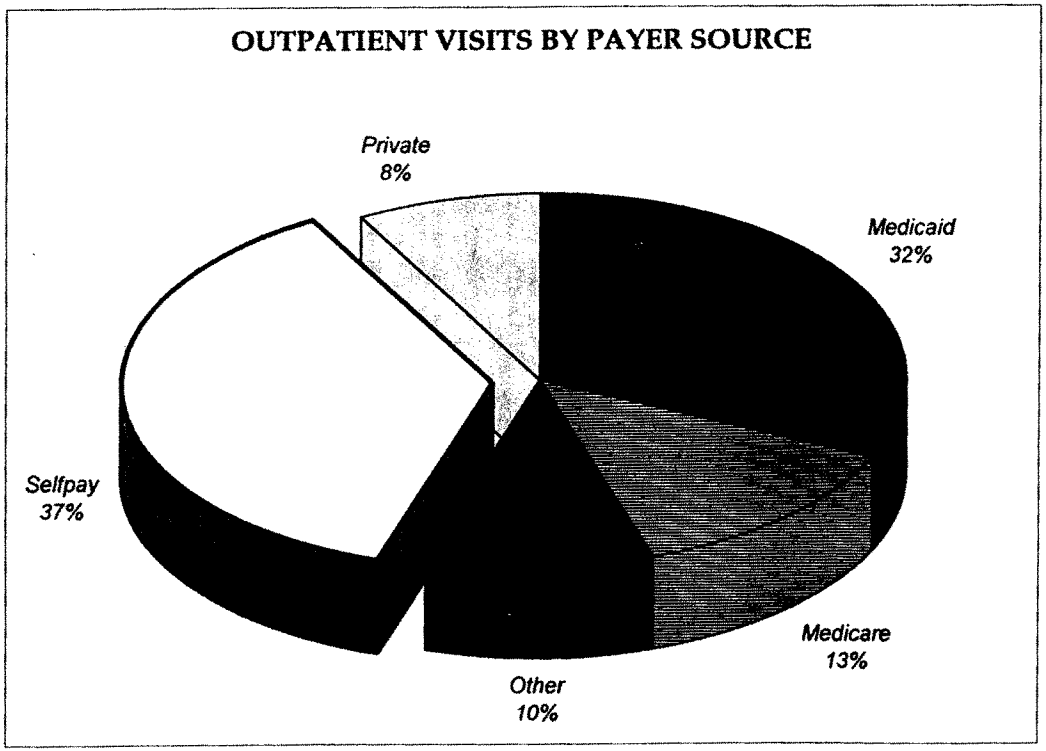

OUTPATIENT VISITS BY PAYER SOURCE
Private
8%
Medicaid
32%
Selfpay
37%
Medicare
13%
Other
10%

TABLE 3

Hospital Name	Uncompensated Visits	Total Outpatient/Emergency Room Visits	Percent of Visits Uncompensated
Harris County Hospital District	436,708	659,112	66%
Grady Memorial Hospital	569,084	864,733	66%
Cook County Hospital	398,570	691,465	58%
LAC+USC Medical Center	357,602	644,453	55%
Kings County Hospital	273,399	857,878	32%
Elmhurst Hospital	203,957	459,837	44%
Harbor-UCLA Medical Center	182,704	332,030	55%
Lincoln Medical & Mental Health	176,517	519,167	34%
Univ. of Texas Medical Branch Hospital	171,408	362,816	47%
Denver General Hospital	150,015	423,971	35%
Bellevue Hospital	139,490	458,202	35%
Medical Center at New Orleans	117,080	358,406	33%
Kern Medical Center	30,189	104,846	29%
TOTAL	3,206,723	6,736,916	45%

TABLE 4

Uncompensated Services Provided by Safety Net Hospitals

- Financial counselors
- Social workers
- Discharge planning
- Additional security for urban providers
- Translators/interpreters
- Financing assistance
- Prison health services
- Special services for AIDS patients
- Injury prevention/safety
- Smoking cessation
- Substance abuse diagnosis and treatment
- Nutrition assessment
- Nutrition counseling
- Child care for children of patients
- Transportation services
- Longer LOS and extra service for inpatients with secondary diagnosis of alcoholism/drug abuse
- Additional services for cocaine-exposed neonates
- Screening/preventative care (e.g. for lead paint poisoning, hypertension, diabetes, vision, hearing)
- Outreach
- School-based services
- Management of patients at risk
- Family planning
- Sex education
- Sanitation
- Case management for elderly
- Geriatric assessment teams
- Extra services/dental, vision, hearing
- Caregivers respite and family support
- Mobile services for homeless, homebound
- Communication services for patients without phones
- Patient advocates
- Legal assistance
- Chronic disease management for the disabled
- Medication management
- Rehabilitation
- Assistance obtaining housing
- Home health care
- OPD pharmacy services
- Day care for disabled adults/children
- Meals (emergency department/home)
- Special vocational education and rehabilitation
- Private, negative pressure rooms with appropriate ventilation for TB patients
- Trauma, burn care, neonatal intensive care and other tertiary services on 24-hour standby basis
- Abused/neglected children services
- Long-term care for boarder babies
- Parenting classes
- Birth centers
- Coordinated volunteer services
- Specialized clinics
- Patient education centers
- Money management/life skills training
- Cultural sensitivity training for physicians and other staff

Chairman THOMAS. Thank you very much, Mr. Gage, for your testimony.

Dr. Ebert.

STATEMENT OF PAUL A. EBERT, M.D., DIRECTOR, AMERICAN COLLEGE OF SURGEONS

Dr. EBERT. Thank you very much, Mr. Chairman. I am Paul A. Ebert, director of the American College of Surgeons. Surgeons always get invited to these hearings I think because we are one of the few groups, I believe, that has actually sustained over the last 8 years an absolute reduction somewhat in the fees that they have been paid under the Medicare program.

Now, we recognize that if you are going to have to enact further massive Medicare cuts, and if they are earmarked for deficit reduction rather than some type of alteration or improvement in a program, it is going to have some major effect on the infrastructure of the program.

This morning, I would like to just ad-lib some of this, because earlier comments were made that in the fee-for-service programs the volume of procedures provided, in general, increased. I wish that the people who mentioned that might have separated procedures from operations, because the college was one of the first groups that supported the Medicare volume performance standard.

We did this on the concept that there probably should be more, rather than fewer. Also, if you were going to have the profession actively involved in attempts to reduce costs, why the best way to do that was to try to get the reasonably sized professional organizations to have some impact on their own constituencies, because, as all of you know, with over 600,000 doctors in the United States, the similarities between surgeons and other individuals practicing medicine is not always as close as one might have anticipated.

Now, I sat in this room and heard that surgeons, since they were reduced the most in the OBRA legislation in absolute amounts, would be the ones that would increase volume the most, and that certainly has not proven to be true as we have come in under our MVPS over the last 4 years, at least to some degree.

I think this has been somewhat surprising to many. But, I just say in response to the comments that were made this morning, that this is a long-term program. I think the MVPS or expenditure target concept, since it does establish some predictability of government spending, is probably one of the few programs that the population of physicians is now finally starting to understand. We certainly hear in our own community more and more about it, and I think there will be efforts made to improve participation, and this should be recognized rather than to going back to a single standard, which I don't think would have the same impact.

Now, the college has strongly supported freedom of choice for the patient, and I think that the Medicare patient deserves the opportunity to go where they receive the best care. I also note in response to the comment that was made this morning, and I don't know if we have the data to show it in the Medicare system, that, very clearly, if you go into some type of managed cost operation, you go in usually at the time you are feeling well, and if you develop some serious type of illness, then you decide to go to some

major medical center. Many times these medical centers are associated with the managed cost program, many times they are not, but the patients then drop out and, in a sense, the government pays twice—once for the lesser, higher priced services, and then more for the true illness when the patient requires this.

Now, we made some critical comments in our written testimony regarding the administrative components of the Medicare system. I would like to at least go on record and say that it is probably by far the worst system that is out there, although I think the MTS program is in the correct direction.

The biggest problem that occurs to surgeons has been that you get different sets of standards and requirements for admissions to hospitals and approval for operations across the country. Reducing the total number of carriers and at least the information disbursement programs that MTS has done so far has certainly decreased the amount of correspondence, and the many complaints we have had.

However, any way you look at it, it is still a sixties program and there are many areas, especially in utilization review and quality assurance, where the college has supported individual doctor profiling and the dissemination of other information that could be obtained, both to educate and to help reduce costs. We are not at the current time, I don't believe, obtaining the full benefits that we might from these capabilities.

I would just like to conclude on the administrative and regulatory comments again to say, you hear many things and many of you ask questions regarding a resource-based relative value scale that was created in 1989. I think it is fair to say it is reasonably refined at the present time. Mechanisms are in place where adjustments have been made, and I would say reasonably well. New technology and new procedures, new tests and so forth, have mechanisms through which they can obtain their code and their valuation.

As you probably are aware, there are 7,000 surgical codes in the RBRVS and in the CPT booklet of the AMA which is used for coding. We would hate to see that structure reexamined. Money is being spent by HCFA at the present time to reexamine the system to see if what was done in 1989 is correct.

Last year, money was approved to figure out how to look at practice cost as another component of the system. I think the college would certainly support the concept of establishing a single payment level. Use the payment schedule or whatever you wish to call it, but let's quit examining it each day. A doctor in his office doesn't have the foggiest idea that he gets paid for three components of his fee. He only understands the amount that comes in. And, consequently, I don't know why we spent millions to look at various components when, basically speaking, we are buying a single service.

We thank you very much, Mr. Chairman, for the opportunity to comment and we would be glad to work with you if at all possible.

[The prepared statement follows:]

STATEMENT
of the
AMERICAN COLLEGE OF SURGEONS

to the

SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON WAYS AND MEANS

presented by
Paul A. Ebert, MD, FACS

RE: Budget Reduction and the Medicare Program

February 6, 1995

Mr. Chairman and members of the Subcommittee, I am Paul A. Ebert, MD, FACS, Director of the American College of Surgeons. On behalf of the more than 60,000 Fellows of the College, I am pleased to share our views with you about the Medicare program and the budget.

Budget Reduction and Medicare

Mr. Chairman, we recognize that your subcommittee and the new Congress face an especially difficult task in seeking to balance the health care needs of older Americans with the enormous pressures confronting you to constrain the ever-increasing growth of the federal budget. We realize that all citizens will be called upon to make some further sacrifices if any efforts to deal with the deficit problem are to succeed. But, we also hope that you will proceed with your review of the program in a most deliberate manner so that the public will fully understand the implications that any budget reduction plan may hold for the Medicare program and its beneficiaries.

On several occasions during the last two years, we appeared before this subcommittee to express our concerns about President Clinton's health system reform plan, which would have been financed largely by massive cuts in the Medicare program. We still believe that dramatic Medicare cuts of the magnitude proposed by the Administration--consisting almost entirely of major payment reductions to those who now provide services to beneficiaries--would seriously undermine continued support for the program. In particular, the disparity in payment levels for surgical services provided to Medicare patients compared with private plans in some parts of the country has widened dramatically in recent years. This is because in several previous budget bills, Congress has already made very significant and, in many instances, absolute payment reductions for the surgical services needed by older Americans. These are real payment reductions for many operations, not just reductions in the rate of increase in the fees for those services. We believe that further massive Medicare cuts--especially if they are earmarked for deficit reduction rather than health reform--cannot be realistically achieved without potential disruption to the infrastructure that now serves the health care needs of millions of older and disabled Americans.

Balanced Approach of Incentives for Providers and Beneficiaries

In addition to our concerns about the magnitude of possible Medicare budget cuts, we are concerned about the underlying design of any budget control plan. The College believes that cost control under Medicare or any other federal program should, insofar as possible, rely on incentives rather than on heavy-handed or formula-driven approaches that simply seek to "ratchet down" payment rates in arbitrary ways. Such incentives should include both performance-based methods and marketplace pressures to make both patients and providers more aware of the costs of medical care. The American College of Surgeons, as you know, has long been a supporter of policy devices like expenditure targets (in the form of Medicare volume performance standards) that provide incentives to meet spending targets for surgical and other physicians' services. These targets also involve physicians and

physicians' organizations in helping to address growth in the cost and volume of services provided to Medicare patients.

We think Congress may want to consider expanding the concept of expenditure targets beyond Medicare physicians' services and applying it to other service categories. Such performance-based approaches are consistent with the notion of using incentives to involve service providers in addressing volume-related issues. Moreover, expenditure targets are explicit, are set in advance, and are clear for all to see before they are applied. This means that Medicare beneficiaries, health care providers, and policymakers would all know "up front" the reasonable level of federal funding needed to address the health care requirements of older and disabled Americans covered by the program.

Devices like expenditure targets make it possible for the government to establish some predictability to spending increases, while transferring the risk for failing to meet reasonable spending goals to those who influence the volume of health services actually provided. Surgeons in the U.S. who treat Medicare patients have consistently met these goals by keeping spending for their services under Medicare's annual targets.

But, expenditure targets are also important for another reason--namely, they can be used to address spending issues while still preserving beneficiary choice of physician, hospital, or other suppliers of services. We believe that the issue of patient choice is especially important for many Medicare patients. The College supports the continuing ability of individuals and families, including the elderly, to meet their health care needs through a variety of arrangements. Indeed, we would be very concerned if Congress proposed to redesign Medicare so that beneficiary choice of health plans is limited to only one kind of arrangement. Today, Medicare patients can choose the traditional program, which fully guarantees patient choice of physician, or they may enroll in a Medicare managed care plan if one is offered in their area. Perhaps Congress should consider new ways to broaden the choice of Medicare plans available in different parts of the country, but the final decision about which plan is best for older Americans should be left up to them.

Benefit Design Changes

Part of your efforts to examine Medicare should include a reexamination of the beneficiaries' responsibilities relating to the overall costs of the program. For example, beneficiaries pay only about one-quarter of the premium costs of the Supplemental Medical Insurance (SMI), or Part B, portion of Medicare; the balance is financed from general revenues. However, these subsidies, which are paid directly from the treasury, are provided on behalf of all enrollees 65 years of age and over without regard to their income or their ability to pay. It seems odd that some of the wealthiest people in America, who are covered by the program, are not asked to pay something more toward the costs of supplemental coverage, or at least to have some or all of the government's currently tax-free contribution counted as income to them.

Home health and skilled nursing facility services are among the fastest growing service sectors in the Medicare program. Currently, copayments are not required from enrollees for home health benefits, while copayments for skilled nursing facility services are required from enrollees for each day after the first 20 days of care. In 1994, the Congressional Budget Office (CBO) described a number of options for reducing the deficit, including a proposal to require patient coinsurance payments equal to 20 percent of the projected average cost for each home health visit and each skilled nursing facility day. CBO also noted that Medicare currently pays 100 percent of an approved fee schedule for clinical laboratory services--another rapidly growing part of Medicare. Beneficiaries currently pay a coinsurance of 20 percent for most Part B services, and a coinsurance did apply to laboratory services before July 1984. Establishing coinsurance requirements for home health benefits and for clinical lab services may be in order and, according to CBO, could yield appreciable savings for the program.

The Part B deductible is fixed by current law at $100 per year. This deductible is the

amount of expenses for covered Part B services that beneficiaries must incur annually before SMI benefits are paid. Unlike the hospital insurance, or Part A, deductible, the Part B deductible is not "indexed" or adjusted annually to reflect changes in the costs of covered services. Indeed, the Part B deductible was last adjusted by Congress in 1991, when it was raised from $75 to $100. Perhaps Congress should adjust the Part B deductible upward beginning in 1996, or else adopt some sort of scheduled adjustment for future years that will set the amount more closely in line with increases in the costs of Part B services.

Administrative and Regulatory Changes

Congress should consider ways to improve the administration of the Medicare program and take other steps to reduce regulatory burdens that impose unnecessary costs on taxpayers, and to reduce paperwork and other administrative burdens on patients and providers of health care. For example, the present system used by Medicare to administer the program is nearly 30 years old, and still consists of an archaic, inefficient, and fragmented system of contractors that perform claims administration and other functions. While Medicare program managers have initiated a number of steps to enhance the efficiency of some aspects of the program, such as implementing the so-called Medicare Transaction System (MTS), Congress should explore other steps to streamline the administration of the program. Substantial improvements in data processing and information technologies should make it possible to update an administrative system developed for the marketplace of the 1960s by applying 1995 management techniques.

Finally, the regulatory framework of the Medicare program should be thoroughly reexamined and overhauled. Over the years, Medicare has developed incredibly complex administered pricing schemes for determining payment amounts for services covered by the program. More recently, the government has spent millions upon millions of dollars conducting studies, holding meetings, and issuing lengthy proposed and final rules to develop three separate components to payments for the more than 7,000 individual surgical, medical, and diagnostic services that make up the Medicare fee schedule. Now, the government is going to start this process all over again to make sure its previous regulatory scheme is "up-to-date."

Last year, Congress ordered Medicare to spend even more money to try to determine the precise relative values that should be recognized under the fee schedule as the overhead (or practice expense) component for each and every physician service. This means yet further micro-management of an already overly-cumbersome approach to setting national Medicare prices. No pretense is made that this change will save any money; in fact, the law specifies that budget neutrality should be observed in implementing the proposal. Certainly, we believe there are some less intrusive, less complicated, less disruptive, and, most assuredly, less costly ways to determine what Medicare will pay for physicians' services.

Thank you again, Mr. Chairman, for this opportunity to express our views. I would be happy to answer any questions that you or the other members of the subcommittee may have.

Chairman THOMAS. Thank you very much, Doctor, for your testimony.

Mr. Christensen, you may inquire.

Mr. CHRISTENSEN. Dr. Ebert, you mentioned the Medicare volume performance standard and the fact that surgeons seem to have done better than the other physicians in hitting those targets.

What differences are there and why haven't other physicians done as well as the surgeons? Do you have any input on that?

Dr. EBERT. Well, I think we took it somewhat as an insult to our integrity when individuals said we would increase service volume just because our payment amounts were decreased. We worked very closely with the various surgical specialty societies and put out a fair amount of publicity, meetings and so forth, and said that, basically, operations ought to be recommended based on the indications that you normally learned.

I think most people did not think that an expenditure target or MVPS program would go through. We were under the belief that you could never have an RBRVS without an MVPS or something to control volume. I still hear the volume issue being discussed here this morning, and for almost every type of service we are seeing increases. I think other groups are getting more active in it now and more concerned about it. That is why I say that I think this is a long-term program, and that it may need to be broken down even into smaller numbers.

Mr. CHRISTENSEN. Dr. Lewers, I wanted to ask you, could you discuss in greater detail the regulatory and administrative burdens that you and other doctors face under the existing program? Also, could you expand on how some of those regulations could be streamlined and made more consumer friendly.

Dr. LEWERS. Two most onerous and regulatory changes that have occurred in a physician's office are those that have been brought about by CLIA, the Clinical Lab Improvement Act, and also the issue of the OSHA regulations. In my office alone, when those two came into being, the cost of implementation, the cost of running my office with two physicians went to close to $10,000; simply the cost of changing and buying all equipment and things of this nature.

The documentation that is necessary in these areas is very onerous. It is not to say that some of the study and some of the material that they have brought forth is not needed. It is. But not to the degree that it has been brought forth. We could provide you more information on that if you would like.

The issue of paperwork is simply the issue of having to sit down and get preclearance on issues and things of this nature. It is now estimated that physicians spend 25 percent of their time doing paperwork in relation to their practice, time that we could be utilizing serving our patients.

In brief, these are two major areas. The issue of OSHA and CLIA are very burdensome on the back of physicians, and we would love to see some changes occur.

Mr. CHRISTENSEN. Well, I know that I concur in that sentiment. I wanted to just briefly touch on Mr. Gage's testimony. My eyes aren't very good, but I could see a couple of things on the fourth chart that was up there earlier. Mr. Gage, with all due respect, I am glad that we are not funding cultural sensitivity and money

management training at the public hospitals, because I don't believe that is the role of the Federal Government to be funding those kinds of programs.

Mr. GAGE. May I respond?

Mr. CHRISTENSEN. Yes, you may.

Mr. GAGE. I think that in a general sense, I might agree with you in the abstract about simply going out into the world and funding services like this.

The problem is, when you are in a public hospital in an inner city, you are often faced with a real, live patient who may have no home to go to, who may have inadequate coping skills to be able to even begin to address the way to get a prescription filled, or to have access to adequate nutrition, or to be able to find someone who speaks that person's language to help care for him outside the hospital. Some of our hospitals have translators in 17 and 18 different languages. You are pretty much required to provide those services before you send that patient back out into the streets whether or not anyone is paying for them. It is not as if the hospitals have asked for this role. They are now performing this role.

This patient—if he doesn't get or she doesn't get these services from this institution—is going to need to find these services somewhere. When you just read them up on a board like that, they may sound as if perhaps they are unnecessary in general or inappropriate for the health system, but I can assure you when you are sitting there with 20 or 30 people in the room waiting to be discharged after being treated for often very, very serious illnesses, you are trying to find ways to help them survive and not become a further economic burden on the health care system.

Mr. CHRISTENSEN. Well, I think your testimony goes to the point that this committee and the Congress as a whole are trying to totally transform the welfare system. One of the items that you have outlined on the chart goes to a bigger picture that I think this committee has been challenged with in terms of transforming and changing the welfare state into an opportunity state.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman.

Mr. Gage, continuing in the discussion on the charts, on the first chart, you had a category which was self or other funded at 33 percent, I recall, and Medicare was 16 percent. Medicaid was 39 percent. What is included in the other portion of the 33 percent? I understand the self, and I guess I would ask you what portion of the 33 is self and what is other, and what portion that would be?

Mr. GAGE. Well, other is actually a relatively small proportion, but, for example, there are certain other sources of funding. For example, some is provided through their States as federally qualified health centers, which many of our hospitals actually have or have that designation.

Chairman THOMAS. I was wondering if any of that was State or local funding that came in under the other.

Mr. GAGE. Yes, that chart showed gross revenues as "self or other." A self-funded patient whose services are provided by a public hospital has to be paid for in some fashion. If you looked at net receipts, for example, Medicare goes from 16 percent to close to 20

percent because Medicare is getting some of that cost shifted to them.

Similarly, Medicaid pays some of these costs, particularly in those States that have used disproportionate share funding, but the bulk of the 33 percent would actually be funded by direct State or local subsidies, by counties.

Chairman THOMAS. OK. So government at the State and local level would be funding it, because I noticed that you included my county hospital operation and although the numbers didn't meet the volume in the urban areas, I thought it was also interesting that your top hospital had, I believe, a 66-percent uncompensated care figure whereas for Kern County Medical Center it was 29-percent uncompensated. I would ask you, does uncompensated mean unfunded?

Mr. GAGE. Uncompensated means that that patient didn't have a third-party payer, didn't have Medicaid, didn't have Medicare, and that the funding had to come from some other source, but clearly there is no such thing as a free lunch.

Funding was necessary and it is this patchwork combination of cost shifting from Medicare and Medicaid, as well as direct—in the case of California, county subsidies, or State subsidies that have come about as a result of proposition 13.

Chairman THOMAS. So what you saw, for example, in Kern County Medical Center with a 29-percent uncompensated——

Mr. GAGE. Yes.

Chairman THOMAS [continuing]. You get probably more local moneys, county or State moneys into that formula than the 66-percent uncompensated.

Mr. GAGE. Probably in California, counties would be paying for a higher proportion of the 29 percent than at a hospital which had 66-percent unfunded.

Chairman THOMAS. No, not unfunded, uncompensated. I thought we established that unfunded was not the same as uncompensated.

Mr. GAGE. Right.

Chairman THOMAS. So there is money going into the program. It is just that you don't identify it from those particular sources. Would this be general funding for the operation of the hospital, allocations from a funding source without tying it to the individual patient?

Mr. GAGE. That is right. It would be local property taxes, for example. The 66 percent I think was the Harris County Hospital District, which is in Houston, and they raise direct local property taxes to pay for the needed subsidy.

Chairman THOMAS. OK. I just want to establish that uncompensated doesn't mean that people haven't figured out a way to pay for it. That is a larger question that we have to deal with.

In terms of the AMA and the College of Surgeons, you understand the schizophrenia we are in in terms of trying to create a formula for paying under the old, as you indicated, Dr. Ebert, fee-for-service structure where we are still looking at ways in which we can make changes to deal with the changes that have occurred in the private sector. What we will be asking of you folk, is all of the help that we can get from you in terms of simplifying models that we use to emulate or try to reflect the private sector without a high

degree of complexity which eats up costs, but which gives us a relative reflection on what is going on out there with the understanding that we are going to pass through that process hopefully within a 3- to 5-year period.

And it is extremely frustrating in dealing with the structure which needs to change fundamentally, but which also has to change incrementally. Dr. Lewers, I don't know if you referred to it. I went through your written testimony in general in terms of the specifics we are looking at, but in terms of outcomes, some of the research that is going on now, are you folks looking at this area, one, in terms of a clear maximization of resources that you have available? Are you focusing on this at all in any area to assist in the question of fraud and abuse? Is that an area that we can utilize these outcomes and tests?

Dr. LEWERS. Yes, outcomes certainly is a very broad term and, yes, we are focusing on it in all areas, other than just fraud and abuse. Basically, the AMA has a zero tolerance for fraud and abuse. We have been working with the Inspector General. We have been working with Justice on this, and we hope to continue; it is a very active part of our program and one that we will continue to work with.

The whole process of outcomes, of practice parameters, are areas that we certainly need to concentrate on. We have one section of our staff that is working completely in that area. We are concentrating on this and I think you will see some reports coming from us on those areas.

Chairman THOMAS. Thank you very much.

Dr. Ebert, I agree that the cynicism in the last round of structuring for surgeons in terms of assuming that you would make up in volume what you weren't going to get in each procedure was not properly founded, and I am pleased to know that you astounded the experts by not carrying out their preconceived notions for behavior.

Having said that, it still doesn't mean that the system was necessarily right to begin with and that perhaps the targets that were anticipated were not as realistic as they should have been. So within the questionable realisticness of the structure, I still want to compliment you folks for not living up to the behavior that a lot of folks thought you were going to. But we have got to get the structure right. I want to thank the panel very much for its testimony. I would ask panel number four to come forward.

As we welcome our last panel today, I would say that all of the panelists' written testimony will be made a part of the record without objection, and would ask that you proceed in whichever fashion you wish for your 5 minutes, and this panel consists of Richard Doherty, National Association for Medical Equipment Services; Dr. David Sundwall, president of the American Clinical Laboratory Association; Dr. Paul Willging, executive vice president, American Health Care Association; Mary Suther, president of the Visiting Nurse Association of Texas; and Eugene Lehrmann, president of the American Association of Retired Persons. I guess we should go with beauty before age, Mr. Lehrmann, so we will start with Mr. Doherty, if you will begin, you have 5 minutes.

STATEMENT OF RICHARD DOHERTY, PRESIDENT, COMPREHENSIVE HOME HEALTH CO., BOSTON, MASS.; ON BEHALF OF THE NATIONAL ASSOCIATION FOR MEDICAL EQUIPMENT SERVICES AND THE HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

Mr. DOHERTY. Thank you, Mr. Chairman. Good morning, Mr. Chairman, members of the committee, my name is Rick Doherty, and I am pleased to be here on behalf of the National Association for Medical Equipment Services, NAMES. I am the president of Comprehensive Home Health Co., a provider of home health equipment in eastern Massachusetts. The testimony I am giving today was done in collaboration with HIMA, the Health Industry Manufacturers Association.

We are pleased to have the opportunity to address the committee on the issue of growth in Medicare expenditures. However, I would like to take a moment to address the issue of fraud and abuse, since the hearing has dealt with that to such a degree.

Mr. Chairman, you said that there are people who game the system and you are absolutely correct. The people that game the system, I would like to point out, however, primarily are people that are on the fringe of the industry, they are not what we consider legitimate providers. They are people that jump in and out and get provider numbers, usually focusing around one or two products and services. They make a lot of money and they are gone again.

We, the legitimate industry, have been advocating and will continue to advocate that there be restrictions placed on the front end preventing people from getting into the system in the first place. We advocate for certification, standardization, even licensure, potentially including onsite inspections of providers to ensure that they are legitimate. We think that although these are not the only steps necessary to curb fraud and abuse, they would go a long way to get the unethical providers out of the industry.

We were asked by this committee to provide you with solutions to the problem with the growth in Medicare. We agree that there has been growth in Medicare expenditures for home medical care equipment services. However, we submit that this is not the problem, but a solution in its own.

First, it is important to state the total Medicare outlays for home medical equipment are a combination of the cost of equipment services and the rate of utilization.

Second, the trend in the per-unit cost for home medical equipment services has been steadily downward for the past decade, even though Medicare expenditures have gone up, which is directly a function of utilization.

Third, many people have a misunderstanding of our industry and the vital cost-effective role that we can play in helping to deliver greater value to the Medicare program.

There are a number of factors that have contributed to the recent growth of home care and specifically home medical equipment services. First, our Nation's elderly population is increasing rapidly from 30.5 million Americans in 1984 over 65 to 37 million Americans this year, a 25-percent increase. Even more significant is the fact that the fastest growing segment of our population is a group

of Medicare-eligible citizens over the age of 80, because this is the group that uses the most home medical equipment services.

Technology previously limited to use in institutions is now being used more readily in the home. It is not necessarily new technology. It is just that the technology is now being used at a less expensive, more effective means in many cases in the home.

While traditional postacute capability remains in place and available, an increasing array of new home care services and equipment is available for postacute and chronic patients who in prior years have required more costly hospitalization.

A 1991 Lewin ICF study examined reimbursement charges for home medical equipment and concluded that while total outlays had increased as a result of demographic changes, the reimbursement per item had decreased as a result of the implementation of the congressionally mandated six point plan in 1989.

The Lewin study further compared the cost of home care using home medical equipment versus hospital care for three diagnoses, hip fractures, amyotrophic lateral sclerosis with pneumonia, more commonly known as Lou Gehrig's disease, and chronic obstructive pulmonary disease. We found that home care using home medical equipment resulted in cost savings of between $300 and $2,300 per patient per episode. When multiplied by the prevalence of each illness, the potential annual savings per year was estimated at $575 million for hip fractures alone.

Again, I submit to you that the growth in Medicare expenditures for home care services is our solution and not the problem, and that that care can save our Nation's health financing system millions of dollars.

The industry recognizes the legitimate interest Congress has in carefully examining all Medicare benefits to ensure that the use of trust fund and taxpayer moneys is as economical and efficient as possible, consistent with the delivery of high-quality services to beneficiaries.

However, despite the critical role which home care plays, home medical equipment continues to be the recipient of budgetary reductions to such a severe level that it creates concern that the ultimate effect may be well the dismantling of the entire home medical equipment service industry as we know it.

We must also keep in mind that the home medical equipment outlays represent only approximately 2 percent of the Medicare expenditures. The solution is simple. The growth in home care expenditures is saving American people money. We want to work with you to assure that patients' needs are met in the most efficient way possible.

In an era of increasing cost consciousness and concern about the long-term care of our Nation's elderly and people with disabilities, it makes good policy sense to preserve and foster the very benefit that provides home care services in a cost-effective and compassionate fashion.

Thank you, Mr. Chairman.

[The prepared statement follows:]

Testimony
of
the
National Association for Medical Equipment Services
on
Growth in Medicare Expenditures

Hearing
of
Monday, February 6, 1995

Before
the
House Ways and Means
Subcommittee on Health

Mr. Chair and Members of the Committee, my name is Rick Doherty. My company, Comprehensive Home Health Company, serves individuals residing in the metropolitan Boston Area. I have 15 years experience as a provider of home medical equipment (HME) services. Currently, I also serve on the Board of Directors and am a former Chair of the National Association for Medical Equipment Services (NAMES). I am pleased to appear before you today to testify on behalf of HME providers across the country and to address this Committee on the issue of the growth in Medicare expenditures. The testimony I am presenting today was prepared in collaboration with the Health Industry Manufacturers Association (HIMA).

NAMES members comprise over 2,000 HME companies which provide quality, cost-effective HME services and rehabilitation/assistive technology to patients in their homes. According to physician prescription, HME providers furnish an extremely wide array of HME and related services to patients in their home, ranging from more "traditional" HME items such as standard wheelchairs and hospital beds, to highly advanced services such as oxygen, nutrition, and intravenous antibiotic therapies; apnea monitors and ventilators; and specialized rehabilitation equipment customized for the unique needs of people with disabilities. Many of these patients are Medicare beneficiaries.

The Health Industry Manufacturers Association (HIMA) is a Washington, D.C.-based national trade association representing more than 700 manufacturers of medical devices, diagnostic products and health information systems. Approximately one-quarter of HIMA member companies have annual sales of less than $2 million. HIMA's members manufacture more than 90 percent of the nearly $40 billion of health care technology products purchased annually in the United States.

Mr. Chair, Members of the Subcommittee, we are all here today to examine the problems with growth in Medicare expenditures. We were asked by this Committee to provide you with solutions to this problem. We agree that there has been growth in Medicare expenditures for home care services. However, we submit that this is not the problem, but a solution in its own.

As the Committee begins its examination of areas of significant growth in Medicare costs, we urge you to explore the important role which home care has played in helping to reduce costs and to provide quality cost-effective care to millions of Medicare patients.

First, it is important to restate that total Medicare outlays for home care are a combination of the cost of equipment services and the rate of utilization.

Second, the trend in the per unit cost for HME services has been steadily downward for the past decade, even though Medicare expenditures have gone up, which is directly a function of utilization.

Third, many people have a misunderstanding of our industry and the vital, cost-effective role that we can play in helping to deliver greater value to the Medicare program.

The growth in the Medicare program and the number of citizens eligible for Medicare presents a challenge for the government and for all Americans. The HME services industry has and will continue to play a vital role in the delivery of cost-effective quality care to Medicare beneficiaries.

Medicare Outlays

There are a number of factors that have contributed to the growth in recent years of home care and specifically HME services.

First, our nation's elderly population is increasing rapidly. In 1984, there were 30.5 million Americans over the age of 65 who were eligible for Medicare benefits. Medicare actuaries project that the number will grow this year to 37 million Americans, a 25% increase. Even more significant is the fact that the fastest growing segment of our population is the group of Medicare eligible citizens over the age of 80, because it is this group that has even more critical need for home medical care. The growth in the Medicare eligible population over the past decade provides a factual history to support the Lewin ICF prediction.

Technological advances also are making possible high levels of quality care in the home that, in prior years, was available only in institutions. As patients' needs have evolved, so too has home care technology. While traditional post-acute capability remains in place and available, an increasing array of new home care services and equipment is available to post-acute and chronic patients who, in prior years, would have required hospitalization.

The 1990 *Green Book*, published by the House Ways and Means Committee, projected that the baseline for HME services would be equal to $3.3 billion in 1995. However, the 1993 *Green Book* baseline projection for HME expenditures for 1995 has been decreased to $2.7 billion. Coupled with the fact that the growth in the number of disabled and elderly Medicare beneficiaries for Part B services increased by more than 14% over this same three year period, it would appear that our services are not growing fast enough to meet the growing number of beneficiaries. Actually, we would argue that the growth in expenditures has fallen behind the growth in Medicare beneficiaries.

Utilization

Currently, there are approximately 5,000 to 8,000 HME providers, about 11,000 home health agencies and some 1,200 freestanding hospices providing home care services to millions of Americans. Home care services come in many forms, from lifesaving equipment to specialized nursing care and financial management assistance for patients and their families. Provision of these services often can be more cost-effective than certain institutional care, while maintaining as high a level of quality of care as hospitals, nursing homes and other facilities.

A 1991 Lewin ICF study examined reimbursement charges for HME services and concluded that while total HME outlays had increased as a result of demographic changes, the reimbursement per HME items had decreased as a result of the implementation of the Congressionally-mandated Six-Point Plan implemented in 1989.

The Lewin study further compared the costs of home care using HME versus hospital care for three diagnoses: hip fractures, amyotrophic lateral sclerosis (ALS) with pneumonia, and chronic obstructive pulmonary disease (COPD). The study found that home care using HME resulted in cost savings of between $300 and $2,300 per patient episode. When multiplied by the prevalence of each illness, the potential annual savings per year was estimated at $575 million for hip fractures alone.

Recent studies also have found that a large majority of Americans believe that receiving treatment in the comfort of their own home when recuperating from an illness or injury would be vastly preferable to some form of institutional care. A 1991 American Association of Retired Persons (AARP) study found that nearly 3 out of 4 older Americans would rather provide care for a disabled, frail or elderly relative or friend at home, rather than have to admit that person to a nursing home. NAMES 1991 "Coming Home" study revealed identical results.

While total outlays for HME services have grown with the increase in the number of beneficiaries that are being cared for, the reimbursement amounts for these services have shrunk in recent years. Let me review briefly some of the history of Medicare reimbursement for HME services so that the Committee can appreciate the magnitude and frequency of the changes. In the past 5 years the HME services industry alone has been subject to extensive Medicare reductions including: $180 million in OBRA '89; $215 million in OBRA '90; and $950 million over 5 years in OBRA '93. These figures are significant when combined with the fact that HME outlays represent approximately only 2 percent of the total Medicare program expenditures and represent more than 3 times the industry's proportional share of reductions. Other reduction in the past decade include:

- 1985 Least Costly Systems Initiatives;
- 1986 Inflation Index Charges/Freeze;
- 1986 Concentrator Equivalency Limits/Freeze;
- 1986-1988 Gramm-Rudman-Hollings Cuts;
- 1987 Lowest Charge Levels/Concentrator;
- 1987 OBRA '87 mandated the establishment of fee schedules;
- 1988 Inherent Reasonableness/Freeze;
- 1989 OBRA '89 eliminated inflation updates for DME, reduced payments for seat-lift chairs and TENS by 15%, and directed that motorized wheelchairs be treated as routinely purchased items;

- 1989 Six-Point Plan;
- 1989 PRN Cuts;
- 1986-1990 Freezes;
- 1990 OBRA '90 established ceiling and floors to the HME fee schedules to make payments more uniform, prohibited suppliers from distributing completed or partially completed CMNs; and
- 1991-1993 CPI Cuts.

Cost Effectiveness

It is important to look at the costs associated with home care support for Medicare, but these statistics fail to tell the most important story about how home medical equipment providers are daily meeting the needs of Medicare patients throughout the country, and at the same time striving to find the most cost-effective methods of delivering care.

For example, two years ago a major health care clinic in the Midwest began a study of Medicare patients who had undergone hip replacement surgery to determine how they might reduce the overall cost of therapy and recovery from this procedure. An initial review of the records of patients over several years disclosed that the average hospital stay following the operation was 11 days, at a cost of more than a thousand dollars a day. Within a year, the health care clinic instituted a new program of aggressive therapy combined with an early patient discharge that had reduced the hospital stay to 5 days at a significant cost savings to Medicare and to the patient or the patient's insurance carrier.

The 1993 Los Angeles earthquake offers another dramatic illustration of the critical role that an HME services provider may be called upon to perform in an emergency. The shock of the quake disrupted electrical power and telephone service throughout the region. Within three hours, the locations of every patient whose medical care might have been disrupted were revealed, and vehicles with technicians and respiratory therapists were dispersed to deliver back-up equipment, oxygen and related supplies which helped keep the patients in their homes and out of hospital emergency rooms. This is just one example in many recent disaster stories like the recent earthquake in Japan, the Florida hurricane a few years ago and the flooding last year in the Midwest where HME suppliers went beyond the call of duty to ensure that their patients were spared physical, emotional and monetary harm.

Fraud and Abuse

The HME service industry takes seriously its mission to promote access to quality home medical equipment (HME) services and rehab/assistive technology and has devoted significant resources for several years to combat fraud and abuse. From the first public allegations of abusive business practices in the HME services industry, the industry has worked assiduously with the Administration and Congress to help eliminate the few unethical suppliers who damage the reputation of an otherwise upstanding industry which helps make "homecomings" possible.

NAMES most visible legislative effort consisted of working during the 102nd Congress with Rep. Ben Cardin (D-MD), who introduced H.R. 2534, the "Ethics and Treatment of Home Medical Equipment Act of 1991." This legislation, which was co-sponsored by 112 Members of Congress, remains the most far-reaching of all subsequent HME bills introduced in Congress to date. Many provisions and concepts in H.R. 2534 were incorporated into legislation that passed the 102nd Congress in 1992, but were vetoed by President Bush. In the 103rd Congress, NAMES help Congress enact legislation, the Social Security Act Amendments of 1994, into law (H.R. 5252 & S. 1668) that incorporates many of the ethics provisions contained in H.R. 2534.

The HME services industry also worked very closely with the Health Care Financing Administration (HCFA) on its decision to establish four durable medical equipment regional carriers (DMERCs) that now process Medicare DME, prosthetics, orthotics and supplies (DMEPOS) claims exclusively. The four DMERCs were established primarily by HCFA to reduce fraud and abuse in the HME services industry.

NAMES has advocated for years that there must be stronger accreditation, certification and licensure requirements, potentially including on-site inspections. Despite the work of NAMES and HME suppliers to create a higher level of service for individuals in need of care, formal Medicare certification standards for the provision of HME services still do not exist today. HCFA has no detailed specific requirements for beneficiaries receiving HME services. There are no provisions regarding type or frequency of services that should be rendered, record-keeping practices, emergency care, patient education, home safety assessments or infection control practices. We urge this Committee to work with the HME services industry to create minimum industry standards and require accountability measures in order to obtain a supplier number from HCFA.

Solution

Again, I submit to you that the growth in Medicare expenditures for home care services is our solution and not the problem. The HME marketplace today reflects the growing number of patients as well as their needs and expectations for quality services. Home care using HME services and rehabilitation/assistive

technology can ensure the continued provision of high quality health care in a setting that the vast majority of patients and their families prefer. And, that care can save our nation's health financing system millions of dollars.

NAMES and HIMA recognize the legitimate interest Congress has in carefully examining all Medicare benefits to ensure that the use of trust fund and taxpayer monies is as economical and efficient as possible consistent with the delivery of high quality services to beneficiaries. Both organizations are prepared to work with Congress to assure that patient needs are met in the most efficient way possible.

However, despite the critical role which home care plays in allowing people to be discharged sooner from an institution and permitting people with disabilities to lead productive lives away from an institution, HME continues to be the recipient of budgetary reductions to such a severe level that I am concerned the ultimate effect may well be the dismantling of the entire HME services industry.

The solution is simple. There is a growth in home care expenditures and yet these expenditures are still saving the American people money. We must focus on consumers and ensure that beneficiaries are receiving quality care and the services they deserve. The HME services industry wants and needs minimum service standards and accountability measures. We want to work with all of you. In an era of increasing cost consciousness and concern about the long-term care of our nation's elderly and people with disabilities, it makes plain policy sense to preserve and foster the very benefit that provides home care services in the most cost-effective and yet compassionate fashion.

Thank you.

Chairman THOMAS. Thank you very much, Mr. Doherty.
Dr. Sundwall.

STATEMENT OF DAVID N. SUNDWALL, M.D., PRESIDENT, AMERICAN CLINICAL LABORATORY ASSOCIATION

Dr. SUNDWALL. Thank you. My name is David Sundwall and I am president of the ACLA, the American Clinical Laboratory Association, and I am very pleased to be able to testify before you today. I will keep my remarks brief and submit our written comments for the record.

I want you to know I am a practicing physician, and have been for over 20 years. I see patients every week, and I know on a first-hand basis how absolutely essential laboratory work is in order to take care of patients well. I also understand, representing ACLA, the challenge you have before you and the importance of this hearing in addressing Medicare expenditures. I want you to know that ACLA is committed to insuring that laboratory services are used appropriately and in the most cost-efficient manner.

This afternoon I am just going to make five brief points. First of all about reimbursement, as all others have testified today, I can't resist telling you that laboratories really are currently in the midst of a 3-year reduction in their reimbursement, thanks to OBRA 1993. These provisions amounted to a cut of about $3.3 billion over 5 years, a reduction of about 14 percent. I also want to point out that unlike some of the other providers that have referred to reductions in their future rate of increases, the cuts I am talking about constitute actual reductions in the amounts received by our labs.

Second, ACLA believes that one of the most important ways to ensure appropriate utilization of laboratory services is by working closely with physicians. Doctors, after all, are the only ones who can order tests. To ensure that they understand the tests they are ordering and the impact of their decisions, ACLA is working to help them understand the costs to the Medicare program of the tests they are ordering.

We also believe that the development of clinical practice guidelines will promote proper use of clinical laboratory testing. We encourage Congress to continue their support for the Agency of Health Care Policy and Research in the Public Health Service and their development of clinical guidelines.

Third, standardization. ACLA strongly believes that if the rules applicable to clinical laboratory testing for Medicare were simplified and clarified, it would also promote appropriate use of laboratory testing. As the GAO noted in their testimony, individual carriers have great discretion in setting payment rules and policies. This is a special problem for our large national labs who deal in many States and therefore have to deal with several different carriers and their jurisdictions.

For example, ACLA and other medical specialty groups have been working with HCFA concerning so-called automated multichannel chemistry testing. These tests are subject to widely different policies, depending on which carrier is involved, which results in widespread confusion in the industry.

ACLA and other groups recently submitted comments to HCFA on their proposal for new policies that would determine how these

tests are paid for. Although we have some concerns about several features of the HCFA proposal, we are very pleased they have recognized the need for national standards with regard to such testing, and look forward to working with them to refine their policies.

In addition, ACLA also believes that administrative procedures could be further simplified and costs reduced if laboratories were permitted to bill through a single carrier rather than numerous different ones. This process would create more uniform interpretation of laboratory policy rules, and we hope the subcommittee will consider recommending such a consolidation of carrier responsibilities.

Fourth, we believe that appropriate utilization of laboratory testing would be helped by enactment of a direct billing mandate, a requirement that the laboratories performing the tests bill the patient or the insurer for those services. Data from a study done by the Center of Health Policy Studies strongly suggests that such a provision would lead to more cost conscious and efficient delivery of testing services, because direct billing precludes physicians from adding a markup to clinical laboratory testing that they do not themselves perform.

The study compared prices and utilization of testing services in States which require such direct billing and compared them with States where direct billing is not required. The analysis determined that direct billing reduced utilization and lowered health care costs overall. Even though Medicare already requires direct billing for their services, the same study found that even Medicare utilization dropped lower in States where direct billing was required. Apparently this is because physicians change their ordering patterns for all patients regardless of the payer.

And finally, my last point is that I—ACLA—must object to another proposal that has been made in the past and which we anticipate will be made again, the reinstituting of coinsurance for lab services. Coinsurance was eliminated in 1984 when the current fee schedule method, which set fees at 60 percent of then prevailing rates, was put in place. We have two objections.

First, coinsurance amounts to an additional cut in lab reimbursement inasmuch as we are still in the process of implementing the reductions required by OBRA 1993. Because of the amount, the coinsurance is often just a few dollars on each claim, the cost of billing this coinsurance is usually more than the amount that could be collected.

I am going to skip an example included in my written testimony, and will simply tell you that for a pap smear it would cost more to prepare and mail the letters to solicit the copayment than if we just ignored it.

The last point I want to make on coinsurance is that we do not believe it will affect utilization, and after all, that is what the purpose of this hearing is about. Laboratory services can only be ordered by physicians and thus both the OTA and the CBO have noted in separate studies that imposing a copayment obligation of Medicare beneficiaries does not curtail utilization.

I want to thank you for inviting us to testify today and I would be happy to answer any questions.

[The prepared statement follows:]

STATEMENT OF
DAVID N. SUNDWALL, M.D., PRESIDENT
AMERICAN CLINICAL LABORATORY ASSOCIATION
TO THE HEALTH SUBCOMMITTEE
HOUSE COMMITTEE ON WAYS & MEANS

February 6, 1995

As the new President of the American Clinical Laboratory Association ("ACLA"), I am pleased to have this opportunity to introduce myself and to present ACLA's view on issues related to the utilization and reimbursement of clinical laboratory services. ACLA is an association representing the leading independent providers of clinical laboratory services, including national, regional and local facilities. All ACLA members will be significantly affected by any action that Congress takes on Medicare reimbursement for laboratories.

As a practicing physician myself for more than 13 years, I know how important clinical laboratory testing is to the delivery of quality health care services. By providing critical information to physicians about a patient's health status, clinical testing is an essential tool in the prevention, diagnosis and treatment of disease; the maintenance of good health; and the delivery and monitoring of effective patient care. ACLA believes it is vital to safeguard patients' access to quality laboratory testing.

Like all health care providers, clinical laboratories have undergone significant reductions in reimbursement in recent years. However, unlike other providers, which have seen reductions in their future rates of increase, laboratories have suffered real cuts in their reimbursement levels. The national limitation amounts, which put a ceiling on the level of clinical laboratory reimbursement, have been consistently reduced over the past eight years. In fact, laboratories are currently in the middle of a three-year reduction in these limitation amounts, which was mandated by OBRA'93. Under those provisions, the national limitation amounts were reduced from 88% of the fee schedule medians in 1993 to 76% of the medians in 1996. In addition, OBRA'93 eliminated the CPI update for laboratory services for 1994 and 1995. These cuts amount to a reduction of over $3.3 billion in laboratory payments over five years.

ACLA recognizes, however, the importance of ensuring that clinical laboratory services are used appropriately, in the most cost-effective manner possible. This morning, I will review several of the actions that ACLA has taken to promote the appropriate utilization and payment of laboratory services and discuss other legislative proposals that will, we believe, further promote these goals. We will also address several other legislative proposals that have been made, which, ACLA believes, would adversely affect the ability of clinical laboratories to provide the highest quality testing services.

In sum, ACLA believes that by clarifying and simplifying the rules applicable to clinical laboratory testing, Medicare will be better able to ensure the appropriate utilization of clinical laboratory services. Further, we believe that enactment of a national direct billing law will reduce utilization for the entire health care system, including Medicare. Finally, ACLA must strongly oppose the reinstatement of coinsurance for laboratories because it will be a burden to beneficiaries, an additional cut for laboratories, and will fail to affect the utilization of testing services.

A. Clarification and Simplification of
Clinical Laboratory Ordering and Billing.

ACLA believes that clarification and simplification of the rules applicable to clinical laboratory testing will have a beneficial impact on the utilization of testing. Such actions will ensure that physicians fully understand the impact of their test-ordering decisions; that Medicare

pays only for appropriate testing; and that the program can adequately monitor and enforce its laboratory policies. Thus, clarification and simplification should have a beneficial impact on both the utilization and reimbursement of clinical laboratory services.

Because clinical laboratories cannot order tests, it is the physician's responsibility to order the testing that is medically necessary for his or her patients. ACLA believes, however, that laboratories must work with physicians to ensure that they understand the appropriate use of clinical laboratory testing and the impact of their test-ordering decisions on the Medicare program. Thus, ACLA has established guidelines for its members that require them to explain the tests that are included in panels and profiles which are offered, and to provide physicians with information about how Medicare pays for the tests ordered. By working with physicians in this way, laboratories can help ensure that physicians understand the tests they are ordering and the financial impact of their decisions on the Medicare program. In the long run, ACLA believes such increased communication between laboratories and physicians should result in more appropriate utilization of services.

Second, ACLA has worked with HCFA and a variety of medical specialty groups to clarify the rules applicable to "automated multichannel chemistry" testing. In the past, HCFA has expressed concern about the manner in which such testing was ordered, coded and billed. ACLA is working with these groups and HCFA to standardize the rules applicable to such testing. Again, clarifying the rules applicable to this testing will help promote the appropriate use of testing services.

Automated multichannel chemistries are a battery of tests, which are usually performed on automated instruments capable of performing a number of different assays simultaneously on a single specimen. Such tests are billed under a single code number, depending on the number of individual tests included in the panel. The Manual of Physicians' Current Procedural Terminology states that up to 19 specific tests, which it lists, may be included under the codes applicable to automated, multichannel chemistries. However, recently several Medicare carriers have unilaterally included additional tests in the list of testing covered by these codes without also increasing reimbursement. In several instances, carriers have proposed including tests that cannot be performed simultaneously with other multichannel chemistries.

This action has caused great confusion and concern in the industry. Each carrier now has its own list of the tests that it includes under these codes. While some carriers permit certain tests to be billed separately, and reimbursed separately, other carriers pay for them as part of the automated, multichannel chemistry panel. As a result, laboratories with multiple locations must be aware of the different carrier policies for each area where they perform testing.

There is little policy justification today for these vast differences on such a basic issue of laboratory reimbursement. As a result, ACLA has been working closely with other medical specialty groups and HCFA to resolve these issues. As part of this process, in April 1994, ACLA cosponsored, with the American Medical Association and HCFA, the first Consensus Conference on laboratory issues, which was held in Chicago, and attended by representatives of 29 different medical groups. Attendees at the Conference frequently commented that greater uniformity among carriers was needed concerning the rules applicable to clinical laboratory testing.

HCFA has recently issued a new proposal on the billing and payment of these automated multichannel chemistries. ACLA and other groups have submitted comments to HCFA on its proposal, and ACLA will continue to work with the agency and other groups on this policy. If the rules applicable to this testing are clarified, it will help to ensure that physicians understand the impact of their test ordering decisions and that laboratories bill correctly for testing that physicians order.

Third, Medicare's payments for clinical laboratory testing could also be streamlined by eliminating the different rules and policies that apply to clinical laboratories. Today, over 40 different carriers, representing 59 jurisdictions, process Medicare laboratory claims. As noted above, because each carrier often has its own policies covering this testing, the rules applicable to Medicare billing and payment vary, depending on where the test is performed. Thus, a laboratory with facilities in different states must monitor and comply with different payment

rules depending on which carrier has jurisdiction. As demonstrated above in the context of automated, multichannel chemistries, such differences on relatively basic issues lead to confusion and wasted effort by all parties, including laboratories, physicians, and the Medicare carriers.

ACLA believes that administrative procedures could be simplified, and costs reduced, if laboratories did not have to deal with numerous, different carriers. It would be far more reasonable if a laboratory with multiple locations could submit all of its claims through a single carrier. In this way, the laboratory would only have to become familiar with a single set of carrier policies and personnel, a change that would greatly simplify the billing process. Although at one time laboratory reimbursement levels varied significantly among carrier jurisdictions--a factor which may have supported the decision to have multiple carriers--those differences are rapidly disappearing. Most testing today is reimbursed at the uniform, national limitation amounts, which cap laboratory payment. Thus, the current system cannot be justified by the existence of significant payment differentials among carriers.

As a result, ACLA urges the Subcommittee to consider recommending a consolidation of the carrier responsibilities for laboratory services, and to encourage the development of uniform policies with respect to coverage and payment issues. We also urge the Subcommittee to consider legislation that would permit laboratories to submit all their claims through a single carrier, regardless of the location of the individual facility performing the testing. We believe that enactment of such policies will help reduce administrative costs for laboratories and the Medicare system.

B. Enactment of Direct Billing Will Promote Appropriate Utilization of Testing.

Appropriate Medicare utilization of laboratory testing would be aided by enactment of a direct billing mandate, i.e., a requirement that the laboratory performing the tests bill the patient or insurer for those services. This provision would simplify the billing structure of the industry and lead to a more rational market for laboratory services. Enactment of such a requirement would promote a more cost-conscious and efficient system for delivery of testing services than currently exists.

Today, laboratories are not required to bill the patient or responsible third-party payor for testing. Billing physicians, rather than patients, promotes the practice of mark-up by the physician, resulting in higher costs to the patient or third-party payor, with no real added value. As reimbursement for the services they provide directly to their patients continues to be reduced, physicians' selection of the laboratory, the number and frequency of tests requested, and the types of tests requested tend to be influenced by the potential for additional income.

In most cases physicians, as wholesale customers, wield sufficient market power to demand and receive significant pricing concessions from laboratories, thus maximizing the potential for mark-ups. The result is that physicians pay lower prices, while other retail payors, including Medicare, pay for laboratory tests at a higher level. Direct billing will eliminate the underlying structural problem that leads to this cost shifting.

Enactment of direct billing would have several important benefits. Most significantly, it would result in reduced utilization of laboratory testing and lower costs as found in a recent study conducted by the Center for Health Policy Studies ("CHPS"). CHPS compared the experience of Medicare and Blue Cross/Blue Shield plans in direct billing and non-direct billing states. CHPS found that laboratory prices and utilization were significantly higher in non-direct billing states than in states that require direct billing. CHPS concluded that if a national direct billing law were enacted, annual savings in total health care expenditures of between $2.4 and $3.2 billion could be achieved, as a result of reduced utilization and lower prices. This translates into savings of between $12 and $16 billion over the next five years.

In addition, CHPS also suggested that the enactment of direct billing could help reduce Medicare expenditures for clinical laboratory services. Even though direct billing already exists for Medicare, the CHPS study found that Medicare utilization was lower when the state required direct billing for private payors. CHPS further concluded that this reduction resulted from a

spillover effect--that in direct billing states, physicians changed their ordering patterns for both Medicare and non-Medicare patients alike. As a result, utilization of clinical laboratory services reimbursed by Medicare was lower in direct billing states than in non-direct billing states. Therefore, ACLA also urges the Subcommittee to consider the enactment of a national direct billing law.

C. **Coinsurance is an Additional Cut for Laboratories.**

In the past, some proposals have suggested the reimposition of 20% coinsurance for clinical laboratory services. Coinsurance for clinical laboratory services was eliminated by Congress in 1984, with the approval of the laboratory industry and HCFA, when the current fee schedule methodology was adopted. Under that methodology, coinsurance was eliminated, but the fee schedules were set at 60% of then-prevailing charges. ACLA fully expects the reinstatement of coinsurance to be proposed again in the upcoming debate over Medicare reductions. ACLA opposes this proposal for the reasons discussed below.

First, imposition of coinsurance would constitute an additional cut in laboratory reimbursement because the cost of billing the coinsurance would frequently exceed the amount collected. Although the amount of the coinsurance is often just a few dollars, on average, it would often cost nearly as much just to produce the additional invoice covering the coinsurance. Further, in most instances, laboratories will have to bill several times, thus further increasing the laboratories' costs. Past experience with coinsurance suggests that in many instances, laboratories would have to write off from as much as 50% or more, of the billed amounts due to the uncollectability of these relatively small amounts. Indeed, these problems are the very reason that Congress eliminated the coinsurance requirement in 1984 and mandated the current methodology.

An example will illustrate the actual impact of the reinstatement of coinsurance. The national limitation amount for a Pap Smear, for example, is $7.33. This is the maximum that can be billed for that test, and in many instances, the laboratory is paid even less than this amount. If a 20% coinsurance were applied to this amount, then the laboratory would have to bill the patient for $1.47. If the laboratory has to bill twice to collect that amount, as frequently happens, the laboratory will have to spend 64 cents just in postage. When the additional cost of paper, processing, labor and administrative costs are added in, it becomes clear that the cost of billing will easily exceed the amount the laboratory will collect. Moreover, the fraud and abuse laws would likely be violated if the laboratory just wrote off this amount without trying to collect it.

Reinstatement of coinsurance would also amount to a new burden to beneficiaries. According to some estimates, it would transfer to beneficiaries additional aggregate outlays of approximately $7 billion over five years. Further, because the laboratory usually does not have contact with the patient, the beneficiary often does not know to what laboratory his or her testing is sent. Beneficiaries may, therefore, be confused by receiving a bill for some small amount from an entity, with which they have had no direct contact. This situation only adds to the difficulties of collection.

Furthermore, reimposition of coinsurance amounts to a substantial cut in reimbursement for laboratories, a cut of at least 10%, according to some ACLA members. This reduction, coupled with the cuts imposed by OBRA'93 would amount to a substantial cut in laboratory reimbursement. Such a cut seems especially unfair in view of the fact that laboratories represent only about 5% of Part B expenditures. In addition, such cuts will make it more difficult for laboratories to serve some higher cost areas, including rural areas and nursing homes.

Finally, coinsurance for laboratory services would have no impact on utilization of laboratory services. For ancillary services, such as laboratory testing, imposition of copayment obligations on Medicare beneficiaries will not curtail utilization because patients do not decide when to order testing nor do they select the testing laboratory. Medicare-covered laboratory services can only be ordered by physicians. As the Congressional Budget Office noted in a 1990 Report:

> Cost-sharing probably would not affect enrollees' use of laboratory services substantially, ...because decisions about what tests are appropriate are generally left to physicians, whose decisions do not appear to depend on enrollees' cost sharing.[1]

A recent report by the Office of Technology Assessment came to a similar conclusion.[2]

In sum, ACLA believes that the reinstitution of coinsurance will have a significant, adverse effect on laboratories' ability to provide high quality laboratory services.

D. Competitive Bidding Would Harm Access and Quality.

In addition, last year, the Administration proposed a competitive bidding procedure for the acquisition of laboratory and other services. Although the actual procedures were unclear, the initial proposal appeared to create a "winner take all" approach, which would have given the winning bidder the exclusive right to provide laboratory services within a given geographic area.

ACLA has numerous concerns about such competitive bidding proposals. First, previous federal use of competitive bidding for laboratory services has been unsuccessful and dangerous to patients' health. When the Air Force awarded a contract to a laboratory for screening Pap smears on the basis of competitive bidding, the laboratory, which won the contract because it submitted the lowest bid, performed so negligently that women's lives were placed at risk. The Air Force was forced to impound over 700,000 Pap smears that they found contained numerous errors. Other experiments with competitive bidding have encountered similar difficulties.

In many competitive bidding plans, there may be a strong incentive for a bidder to submit a "low ball" bid, in order to obtain the contract, a fact that could have disastrous implications for the quality of the testing. In fact, in 1984, a HCFA report on the laboratory industry expressed great skepticism over competitive bidding. It noted that under a competitive bidding system:

> [l]aboratories might knowingly underprice the competition in order to win a Medicare contract, even if they know they will be unable to cover their costs at the bid price. This practice, known as "low-bailing," has occurred in even limited competitive contracts for services awarded by the Air Force and by the District of Columbia.[3]

These risks were dramatically illustrated last year by testimony before a House Subcommittee. At a hearing held by a Subcommittee of the House Judiciary Committee in the summer of 1994, a woman testified about her terminal cervical cancer, stemming from a three-year misdiagnosis by her HMO. The HMO had solicited competitive bids for its laboratory services and awarded the contract to a single laboratory that submitted the lowest bid. After three Pap smears and three biopsies, the cancer still went undetected. In short, the use of competitive bidding for laboratory services has consistently resulted in placing quality and patient health at risk. We urge the Subcommittee to reject both the reimposition of coinsurance for laboratories and competitive bidding.

Conclusion

We would like to thank the Subcommittee for this opportunity to submit our views. We look forward to continuing to work with the Subcommittee on these issues. I would be happy to answer any questions you may have.

Doc #21956

1/ CBO, "Reducing the Deficit: Spending and Revenue Options" at 140 (February, 1990).

2/ OTA, "Benefit Design: Patient Cost-Sharing" at 5 (Feb. 1994).

3/ HCFA, *Report of Laboratory Task Force* at 23 (1984).

Chairman THOMAS. Thank you very much for your succinct testimony, covered a lot of ground.

Mr. Willging.

STATEMENT OF PAUL WILLGING, PH.D., EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

Mr. WILLGING. Thank you, I do represent the American Health Care Association which is the trade association representing by far the vast majority of nursing facilities in this country, including assisted living and subacute facilities.

It is a pleasure to be with you today, Mr. Chairman, although I must admit the pleasure was somewhat less acute when I first read the press release a week or two ago with the focus being the alarming growth of the SNF benefit in Medicare. Perhaps of great concern to me was the following statement: "This may represent significant fraud and abuse."

I thought at least I would have the opportunity to perhaps put that into a different type context. In doing so, however, I do not for a moment wish to minimize the importance of our efforts, yours, the industry's, the executive branch's in ferreting out fraud and abuse in all Medicare programs.

There is no question that how large that is is a factor stimulating the growth of the Medicare SNF benefit. It is in fact something that has got to be dealt with. We have worked and will continue to work with the Congress and the executive branch in making sure that no provider can willfully or intentionally defraud the Federal or State governments and, more importantly, we will work with our own members.

Education is critical. As is going to be suggested in testimony by the American Association of Retired Persons, 75-percent growth in the number of SNFs participating in the Medicare program between the years 1985 and 1993, 6,000 new providers trying to deal with what at best are arcane procedures in terms of billing under part B, and at worse are totally incomprehensible. We have a job, that is, the industry, to make sure that they are educated, even if it is not intentional, even if it is not willful, that we do prevent inappropriate billing.

And finally, oversight. I think we have heard enough today to recognize that the industry I represent cannot assume that this is somebody else's problem, that this is just incontinent suppliers, shipping off guides to the nursing facility and then billing separately. We, as an industry, each facility is responsible for all services provided in that facility. We have got to be equally responsible for at least providing oversight when it comes to the billing that takes place and we will take that seriously.

We are working with the Health Care Financing Administration to deal with a concept called bundling by some, consolidated billing by others, so that the bills are, in fact, brought together in a place where we can see that they meet the needs of the resident in that facility. That same concept is a part of the proposed prospective reimbursement system that we have been talking to this committee and others about in terms of the Medicare SNF benefit, but as we continue to work toward this legitimate concern of fraud and

abuse, let us not confuse that with the underlying factors leading to the growth in the SNF benefit.

As chart 1 will suggest, on the left, the growth between 1993 and 1994 in the SNF benefit was by far largely accounted for by simply population. Of the increase of $1.3 billion in additional growth in the SNF benefit, $800 million, 60-some percent, was population increases, $0.3 billion was price, $0.2 billion was utilization. Even price can contain within it intensity factors so that it is not simply a higher price for the same unit. The unit itself may have changed. For example, as we go from LPNs to RNs delivering an hour of nursing care. So our growth has been, to a considerable extent, more beneficiaries. More utilization, that is, longer lengths of stay in a facility, higher levels of intensity as we move into high acuity patients, and the reasons for those three areas of growth, I think, are clear to all of us.

Certainly it begins way back, 12 or so years ago when the DRG program did what it was supposed to do with respect to hospitals, move patients out of hospitals quicker and sicker. The coverage guideline changes in 1988 for the first time gave Medicare beneficiaries rights to a service that they felt had been denied and that the courts eventually agreed with them had been denied.

The famous catastrophic, or infamous catastrophic legislation back in 1988 developed a new infrastructure in the SNF arena which did not disappear even when catastrophic legislation disappeared 1 year later. And the Nursing Home Reform Act of 1987 where it, one, eliminated the distension between SNFs and ISNFs so everyone essentially became an SNF, also raised the infrastructure level, and two, and perhaps more importantly, put a concept in the law that said, our responsibility as nursing facilities was to bring patients up to the highest practicable level of mental, physical, and psychosocial well-being. Well, if that isn't going to have an impact on the use of therapists in nursing facilities, I don't know what would.

So I think there is no question that the understanding of growth becomes clear when one looks at the factors that make it up. But I think equally important, and at the risk of being considered somewhat too glib, I think there may be areas of growth in the SNF benefit that are extremely beneficial, that we would want to in fact stimulate and foster.

Indeed in the private sector, I know you and your colleagues today, Mr. Chairman, have been looking for what happens in the private sector to control growth in the Medicare program. There are managed care entities. This one, the second chart, happens to be PacifiCare out of California, that are not only not alarmed about growth in the SNF benefit, are stimulating growth in the SNF benefit. That is the lower line; for what effect to see the drop in the upper line. It is called use of subacute care. It is in fact what managed care does so well. And indeed, some of the State programs, not yet Medicare, but at least some of the State programs are recognizing the role of subacute care.

In the last budget presented by Governor Pete Wilson to the legislature in California they are looking for a movement out of the hospital sector into the SNF sector so as to save money, utilizing

subacute care within nursing facilities at one-half the cost of a comparable day of care within the hospital.

We have estimated in a study done by Abt Associates that there is a potential of $9 billion per year at the outside admittedly by utilizing subacute facilities in lieu of hospitals.

So in conclusion, yes, let's worry about fraud and abuse. Let's do what we can to ferret it out, to eliminate it to every extent possible, but let's not always assume that growth is bad. I would contend that a dollar of growth in the SNF benefit, which will lead to two dollars of reduction in the hospital benefit, is good growth.

And then the final statement, remember what Dr. Altman told us, let's not forget the synergism among the various component parts of this program. You want to make sure you understand how they interact and not look at each one independently.

I thank you very much for your attention and I would be happy to respond to questions later.

[The prepared statement and attachments follow:]

TESTIMONY OF PAUL WILLGING, PH.D.
AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman, another explanation for SNF spending growth is the higher acuity of SNF subcacute patients. As our patient population ages and becomes sicker, and we move more patients into residential care and assisted living facilities, SNF spending will continue to grow. This also corresponds to reduced length of stays in acute care settings which is a desired result from the implementation of the Medicare hospital Prospective Payment System (PPS). This, however, means that patients are discharged sicker and quicker. One important factor here is our movement into quality and cost-effective subacute care.

Skilled nursing facilities offer subacute health care services at an average cost of 47% less than hospital-based SNFs. A report by Abt Associates, Inc. issued last June, identified 62 DRGs where SNFs are currently providing subacute care and estimated potential cost savings to Medicare if percentages of patients in these groups were treated in SNFs rather than in hospitals. Abt found a potential savings to Medicare of between $7.535 and $8.906 billion depending upon accounting for empty hospital beds and partial waiver of the 3-day stay rule. I recommend that the Subcommittee examine the Abt report in detail to see how legislative initiatives proposed by AHCA could potentially save billions of dollars to the Medicare program. In short, as SNF spending increases on Medicare subacute care, there is a corresponding decrease in acute care spending, especially for outlier patients.

While it is very difficult to prove that subacute SNF days are replacing acute hospital days, perhaps there is a tell-tale sign in preliminary baseline budget figures released by CBO this month. CBO shows the hospital growth rate increasing at substantially less than previously predicted while the SNF growth rate is increasing, almost correspondingly, faster. Since SNF spending is a small fraction of hospital spending, it makes sense that a small decrease in the anticipated growth in the hospital baseline would show a larger increase in SNF baseline spending if SNFs were competing for, and being utilized more, for subacute patients.

Probably the most important item to look at in terms of the growth in Medicare spending is what are the components of that growth. Our data department ran a comparison of skilled nursing facility expenditures for 1993 and 1994 and found the following:

- Of the factors accounting for the increase from 1993 to 1994 in SNF spending, population accounted for largest amount of the increase compared to utilization and price. Of the $1.3 billion increase, population accounted for $800 million or 62%;

- Of this increase, the costs attributed to price increases showed an increase accounted for only $300 million. This corresponds to an increase in price that is approximately 35% less than the rate of hospital price increases. Clearly our sector specific prices, the only category a provider controls, are going up at a slower rate than hospitals;

- The average length of stay dropped for hospitals and increased for nursing facilities which may correspond to the higher acuity of our patients and entry into subacute care;

- The intensity of services for SNF care increased cost an average of 5 cents more of an increase per patient over hospital patients.

Overall, in examining growth in our costs as an industry, it is not because we are increasing prices and are too profitable, but more clearly because of population demographics and because SNFs are aggressively competing in the health care continuum to treat subacute patients in more cost-efficient settings. Market forces are utilizing SNFs to substitute for more expensive acute care settings. And now, let me outline some of our proposals addressing cost containment.

AHCA COST CONTAINMENT PROPOSALS

I have previously mentioned the Abt study that found a potential of up to $8.9 billion per year in subacute care savings to Medicare. AHCA proposes that hospital subacute DRGs be examined and rebased according to severity of illness and length of stay. Particular attention should be paid to the relative costs of SNF subacute care compared to hospital-based subacute care. It is absolutely clear, however, that SNFs can provide subacute care at substantially lower costs than hospitals. In order to test this, AHCA proposes that the Secretary of Health and Human Services immediately waive the 3-day hospital stay requirement for patients in a group of five DRGs, including skin ulcers and chemotherapy, and achieve an estimated $500 million per year in savings in just a few years. The SNF stay would be allowed only as a substitution to a hospital stay as certified by the admitting physician.

It is very important that CBO give this proposal a detailed analysis and not shrug off mention of the 3-day stay rule because of prior concerns when the Medicare Catastrophic Act was enacted and soon after repealed. We are talking about direct substitution for acute hospital stays and not new patients coming out of the so-called "woodwork."

Our second proposal involves redesigning the Medicare SNF payment system from a retrospective cost-based system to a prospective payment system (PPS). I want to express our appreciation, Mr. Chairman, that you and Mr. Stark have supported this concept in the past and helped us move it toward fruition. Indeed, Congress has twice before requested in OBRA'90 and again in OBRA'93 that we move to a PPS by October of this year. HCFA promised this Committee in testimony during late 1993 to have an interim system to you by last June. We are pleased to continue to work with them on a cost-containing prospective payment system, and we have proposed such a system as introduced by Senators Orrin Hatch and David Pryor in the Senate last year.

AHCA is very serious about curtailing administrative costs and building in incentives to save Medicare dollars. We support a case-mix, facility specific PPS that addresses costs in five costs centers: nursing services, administrative costs, fair rental value for property, ancillary services, and therapy services. In regard to current billing practices for medical equipment, we desire strongly to work with HCFA and the Congress to eliminate any fraudulent billing for such items. In addition, we have been meeting and working with HCFA on salary equivalency issues and wish to address any problems with therapies or billing practices that are identified. Our PPS is designed to be revenue neutral, with incentives built in to control future costs, and we believe that it could be designed to curtail unnecessary billings for equipment or special services.

Our model PPS is designed to promote quality care; to ensure equal access for high-acuity beneficiaries; maintain adequate capital formation to address future demographic trends; and achieve cost containment. In the past, Congress has requested a PPS for SNFs, and HCFA has promised to develop one. We would request that HCFA honor its word with a balanced and constructive interim PPS proposal that can be put in place this October. We ask Congress to provide a statutory requirement to do so.

One therapy service that is being provided in SNFs but is not reimbursed by Medicare directly is respiratory therapy. AHCA estimates that the cost savings of utilizing SNFs rather than acute care settings in one DRG alone, #483 tracheostomy, the most costly DRG, would save up to $990 million over five years. A 1993 CBO preliminary cost estimate predicted a $100 million revenue loss over five years due to a 10% increase in SNF service utilization. However, the estimate acknowledged that offsetting savings may be realized -- "*if ventilator patients were moved from hospitals to SNFs, then fewer resources might be used in the treatment of these patients.*" We strongly concur.

AHCA requests that your subcommittee reexamine this issue in view of recent data and increased utilization of SNFs for such care despite the lack of direct reimbursement. Hospitals providing ventilator care charge upward of $1,000 per day for such care compared to approximately $350 per day charged by subacute SNFs. Costs billed by hospitals for such care are also driven higher when provided in SNFs under contractual arrangement. Administrative add-ons are also billed, when if the services were provided directly by SNF employees, these costs would not be incurred.

Finally, as I stated earlier, your hearing on managed care could be a more appropriate place for this testimony. You see, managed care has recognized the benefit of substituting SNF days for more expensive hospital days. In recent testimony before the Prospective Payment Commission, Dr. Roger Taylor, Executive Vice President with PacifiCare, one of the fastest growing managed care organizations in the nation, stated that a large percentage of their ability to save money was their ability to reduce hospital Medicare days per thousand through the utilization of SNF day substitution. In fact, I have a chart with me demonstrating that PacifiCare has achieved a large part of their savings by reducing hospital stays from 1089 days per thousand members in 1990 to 964 in 1993 and correspondingly increase their SNF days per thousand from 497 to 676.

AHCA supports the utilization of managed care to provide quality care and control costs. In particular, the Medicare Select Demonstration Project should be extended to every state for an extended period of time. In addition, discussions by the House Speaker on reexamining the entire Medicare program and its relationship to private sector efforts in managed care are welcome and should be fruitful. In Orange County, California, where over 50% of Medicare eligible residents are enrolled in managed care risk contracts, artificial barriers that drive up costs - such as the 3-day stay rule - are avoided, and consumers are pleased with their coverage and care. The ability of managed care organizations to achieve cost savings by utilizing SNFs is something the Congress must examine. Follow the lead of the private sector and market-based reforms, and I believe you will find it easier to control Medicare costs.

Let me conclude my remarks on cost containment by endorsing and supporting efforts by the Congress to improve long term care insurance by clarifying income tax rules and providing basic policy standards. Probably the best long-term way to reduce government costs is to build on the private side of the existing public/private partnership for long term care by encouraging more senior citizens to purchase long term care insurance policies early on. A 1994 study by Cohen, Kumar and Wallack found that each long term care policy kept in effect can save Medicaid as much as $15,000 per policyholder.

RELATED ISSUES

Before closing, let me touch briefly on a few final issues. The first concerns proposed regulations by HCFA to "fully certify" Medicaid and Medicare beds in nursing facilities. This proposed policy could lead to upcoding and over-utilization due to the huge number of new Medicare beds that would be made available for services. The potential cost of this proposed rule should be examined closely by this subcommittee.

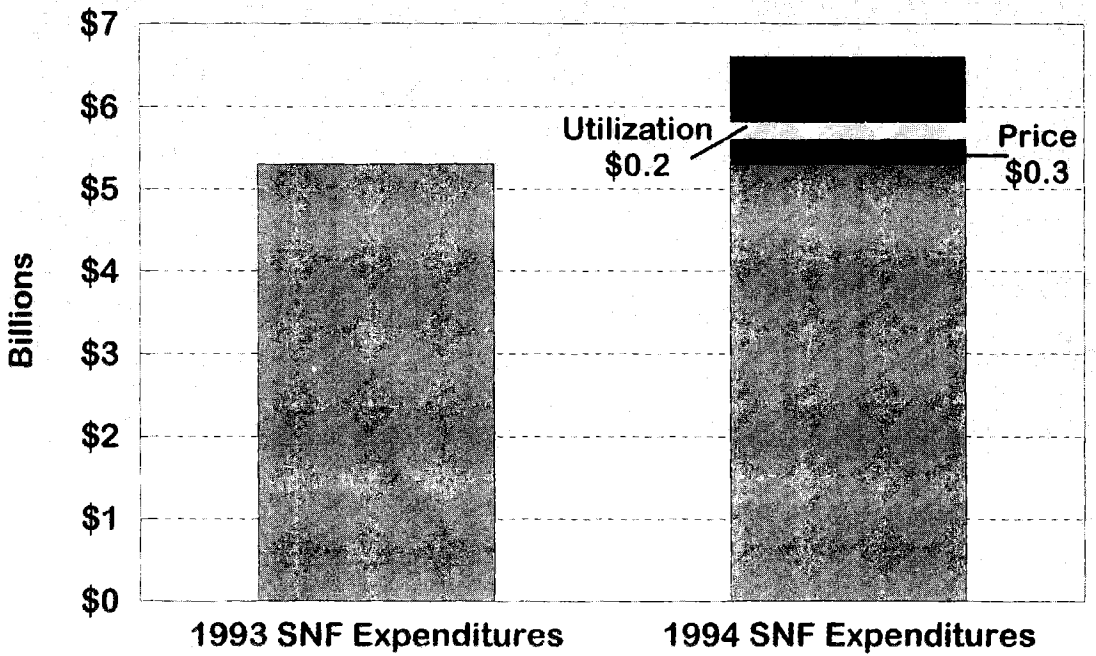
In terms of regulations, you may recall that I have testified before the full committee before that we are one of the most highly regulated industries in America. This is not surprising due to the concern all Americans have over their family members who are away from home and in institutions. However, we recommend an in-depth review of these regulations to determine, which are truly necessary in terms of protecting and improving patient care. Our nurses, our owners, and administrators seem to think that the myriad of regulations imposed on us by literally dozens of governmental entities waste valuable nursing oversight and training and cost patients, the government, and society as a whole billions of dollars. A promising direction is to adopt the outcome measures of managed care in lieu of regulations that specify procedures and inputs.

Finally, in regard to home health care, we applaud efforts to move patients into the least restrictive and most cost-effective setting, but due to the different acuity of nursing facility residents and patients that can be treated at home, we do not see home care as a competing with nursing facilities, only as an essential part of the health care continuum. For instance, average activities of daily living (ADLs) measurements for home health patients are 2.5 of 5 vs. 3.9 of 5 for SNF patients. We would support, however, that copayments be applied equally. SNFs residents are currently burdened with a copayment after 20 days of 1/8th of the annual hospital deductible amount. This is a steep $89.50 per day copayment that almost eliminates any benefit after the 20th day of a SNF stay. We would encourage your subcommittee to impose equal copayments for home care and SNF services outlined by the Congressional Budget Office and eliminate the unworkable current SNF copayment.

Mr. Chairman, let me leave this Subcommittee with a final thought. I have come today to testify and offer you specific proposals to save billions of dollars from the Medicare program. Our nursing facility providers are already operating as probably the most efficient providers in the health care continuum. They have not had a Medicare update since 1990, while according to ProPAC, last year "the overall profit margin for the nation's hospitals reached its highest point since the advent of Medicare's prospective payment system." For instance, our average profit margin in 1991 was only 3.2% compared to average hospital margins of 4.6%. Your examination of nursing facility spending growth under Medicare is warranted and we applaud your efforts. We are, however, more a part of the solution, and not a part of the problem. We encourage you to review our cost containment proposals in time for budget reconciliation later this year, and to review SNF costs centers before determining any potential action. Most of all, we ask you to ensure that a prospective payment system for SNFs be required in statute in time for fiscal year 1996.

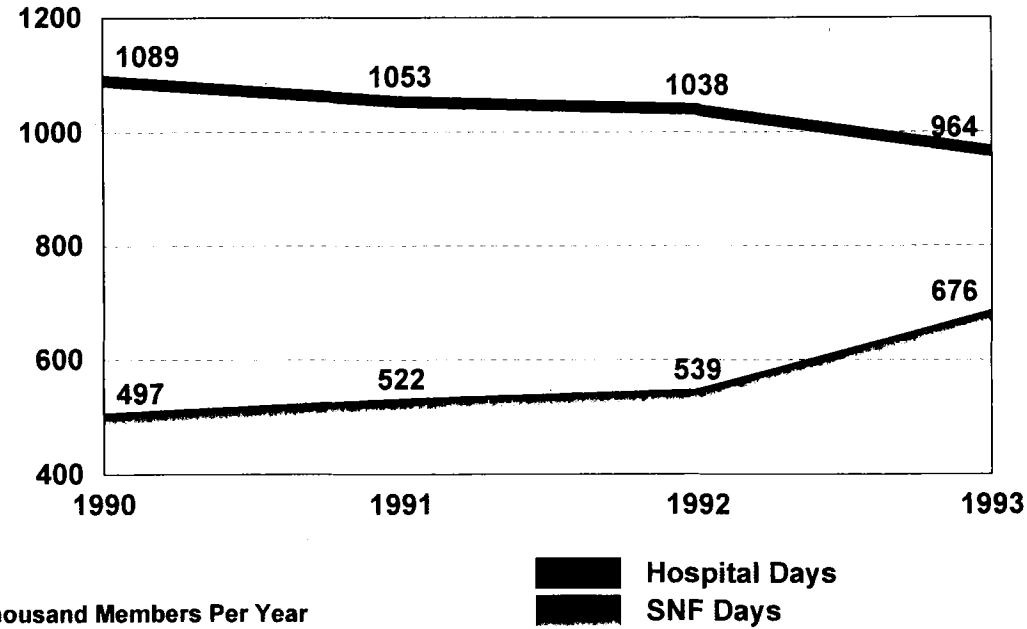
Thank you Mr. Chairman. I'll be glad to answer any questions.

Population Pushes Up Costs



Quicker and Sicker

Utilization Trends 1990 - 1993 *



* Per Thousand Members Per Year
Data from PacifiCare of California

Chairman THOMAS. Thank you Mr. Willging, in your observation about packaging of these hearings, when we put twofers together, it tends toward the blind date syndrome. You don't know what the outcome is going to be. We are trying to whet the appetite of the minority to attend these hearings. Apparently this one didn't work as well as we had hoped.

Mr. WILLGING. Certainly helped my appetite, Mr. Chairman.

Chairman THOMAS. Ms. Suther.

STATEMENT OF MARY SUTHER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, VISITING NURSE ASSOCIATION OF TEXAS; ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

Ms. SUTHER. My name is Mary Suther, and I am president and chief executive officer of the Visiting Nurse Association of Texas. On a daily basis we see over 8,000 patients in both urban and rural areas.

I am representing NAHC, the National Association for Home Care, today. They represent over 6,000 Medicare certified home care service providers. Until this month, I chaired the NAHC government affairs committee for the last 4 years, and I continue to serve on the Fraud and Abuse Task Force.

I would like to commend you, Mr. Chairman, for holding the hearing on issues related to controlling growth in Medicare costs and improving care. NAHC is committed to both these goals. Home health represents a small but growing part of the Medicare program. There are many contributing factors to this growth. But the second part of my testimony will speak to the issues of fraud and abuse in home care.

NAHC has a long history of aggressive action to assure against fraud and abuse and Medicare home health benefit. My testimony will detail NAHC's activities to curb fraud and abuse and provide recommendations to help eradicate these illegal and unethical activities.

Finally, I would like to make some comments about prospective pay for home care. The home care benefit has been maturing for most of its existence in the Medicare program. I have been on this almost 30 years, and I would like to say it is the greatest story never told, but I have heard it told in a way today that I don't want to hear it told again.

The home care benefit became especially useful in the need of meeting patients discharged from the hospital quicker and sicker thus saving Medicare days in those hospitals. Current trends indicate, however, that the home care benefit has peaked and that the Medicare home health expenditure increases will fall to 7.8 percent by 1997.

Both HCFA and NAHC believe that the 1989 to 1992 period of growth was unusual and resulted from several events, including policy and coverage clarifications that resulted in a class action lawsuit, the lessening of personnel shortage which allowed free increase in home health agencies, especially in the rural areas, new requirements, such as home health paid training and competency training, and CLIA was mentioned before, and OSHA, and paperwork, unnecessary paperwork.

The growth of the Medicare home care program is being allocated and can be expected to fall to a modest level within the next 2 years. Sustaining the lower growth rate are a number of underlying factors. Home health has moved well beyond its traditional boundaries making it possible for millions of patients to prevent, reduce, or eliminate the need for more costly inpatient care. The U.S. population is growing older—the significant trend that has and will continue to influence future need for home health services.

Access to in-home services has also improved over the years as much more home health is available for people to choose from. The past decade has seen a dramatic increase in awareness among physicians and patients about the home as an appropriate, safe and often cost-effective setting for the delivery of health care services.

Finally, sophisticated technological advances have made possible a level of care in the home that previously was only available in hospitals. The maturation and simplification of technology has allowed this. As in any area, growth brings with it the potential for illegal behavior. NAHC strongly believes it is the responsibility of all parties involved, patients, payers, and providers, to act aggressively to uncover, report, and act against fraudulent and abusive home care providers.

NAHC has taken a leadership role in combating fraud and abuse. It has engaged in a longstanding effort to maintain the highest degree of ethics. Specifically with regard to the Florida case that the IG mentioned this morning, in April 1994, NAHC met with Inspector General June Gibbs Brown to bring to our attention several areas of fraudulent activity that NAHC had found in that agency.

We suggested a sweeping and aggressive action to eliminate these abuses and take action against this bad apple. In January 1994, NAHC implemented a broad view board policy governing member conduct. The incidence of established fraud and abuse in home care is low, however, even a single occurrence of fraud and abuse is not acceptable and it must be eliminated.

In my written testimony, I have detailed other testimony on fraud and abuse. Let me skip over to prospective pay. NAHC is very interested in prospective pay. We have advocated for a long time that prospective pay provided that it meets the criteria that is necessary to determine what makes a difference in cost and what doesn't. In a per episode reimbursement methodology, the cost would be paid to the provider up front. The provider would be paid one amount for the care of that patient and this would discourage overutilization, it would incentivize the provider.

There is a study that is being conducted by Abt now on that and HCFA has had a lot of input from us on the methodology. Our letter to HCFA is in the testimony. We are very concerned about that study, even though we certainly approve of it. It may not indeed identify the case mix problem that we have identified.

Thank you very much for allowing me to testify today and I will be happy to answer any questions that you have.

[The prepared statement and attachments follow:]

STATEMENT OF MARY SUTHER
VISITING NURSE ASSOCIATION OF TEXAS
ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

My name is Mary Suther. I am president and chief executive officer of the Visiting Nurse Association of Texas, a non-profit home care agency in Dallas. I am pleased to represent the National Association for Home Care at this hearing. NAHC represents nearly 6,000 Medicare-certified home health agencies and hospices, and the individuals they serve. Until this month, I chaired the NAHC Government Affairs Committee for 4 years and continue to serve on its Fraud and Abuse Task Force.

I want to commend you, Mr. Chairman, for calling this important hearing today on issues related to controlling growth in Medicare costs and improving care. As you know, home health represents a small, but growing part of the Medicare program. More enrollees than at any previous time are accessing in-home health services -- about 9 percent in 1994 compared to 2 percent 20 years ago. There are many contributing factors to this growth, and my testimony will attempt to detail the most significant of these.

At the same time, however, we need to make absolutely sure that this growth is appropriate. NAHC has a long history of aggressive action to ensure against fraud and abuse in the Medicare home health benefit. The second part of my testimony will speak to the issues of fraud and abuse in home care and NAHC's activities and recommendations to help eradicate these illegal and unethical activities. Finally, I also would like to take this opportunity to make a few comments about prospective payment.

FACTORS INFLUENCING RECENT AND HISTORICAL INCREASES IN THE UTILIZATION OF MEDICARE'S HOME HEALTH BENEFIT

The home health benefit has been a maturing program for most, perhaps all, of its existence in the Medicare program. In Medicare's earliest years of operation, home health expenditures amounted to only about 1 percent of the total. Therefore, although the benefit has increased at an average rate of 23.5 percent per year, it still represents a relatively small proportion of Medicare spending -- only about 8.7 percent of the total estimated for 1995.

Congress has long considered home health care a cost-effective benefit and has taken steps over the years to encourage its utilization. For example, Congress eliminated the prior hospitalization requirement and the 100 visit limit, the home health deductibles, Part B copays and broadened participation to include nonlicensed proprietary agencies. These amendments removed barriers to needed home health care and recognized the advantages of home health services over other acute care settings from the standpoints of patient preference and cost-effectiveness.

The home health benefit became especially useful in meeting the needs of patients who were discharged from the hospital "quicker and sicker" as a result of the 1983 enactment of the Medicare hospital prospective payment legislation. The percent of all Medicare hospital patients discharged to home health care increased to 18 percent compared to only 9 percent in 1981. Technological advances have also done much to make the home a safe and effective acute care setting. These factors together with the aging of the population, the increased paperwork burden, and an increased public and professional awareness of home health care have all contributed to the home health benefit's rapid increases over the past 25 years.

Estimates from the Health Care Financing Administration's (HCFA) Office of the Actuary indicates they believe that the benefit has matured and that expenditure increases will fall to 7.8 percent by 1997 (see attached chart).

FACTORS AFFECTING RECENT GROWTH

The home health benefit increases that have occurred in the 1989-1992 period are almost double the 23.5 percent average experienced over the life of the Medicare program but have already begun falling to lower rates. As indicated above, NAHC believes this peaking is temporary and that it has been influenced by several recent events.

Coverage clarification. In the mid-1980s, Medicare adopted documentation and claims processing practices that created general uncertainty among agencies about what services would be reimbursed. The result was a so-called "chilling effect" in which some Medicare-covered claims were diverted to Medicaid and regrettably some patients went without care. This "denial crisis" led in 1987 to a lawsuit (*Duggan v. Bowen*) brought by a coalition led by Representative Harley Staggers and Representative Claude Pepper, consumer groups and NAHC.

The successful conclusion of this suit gave NAHC the opportunity to participate in a rewrite of the Medicare home health payment policies. Just as a lack of clarity and arbitrariness had depressed growth rates in the preceding years, NAHC believes the policy clarifications that resulted from the court case have allowed the program for the first time to provide beneficiaries the level and type of services that Congress intended.

The correlation between the policy clarifications and the increase in visits is unmistakable. The first upturn in visits (25 percent) came in 1989 when the clarifications were announced; and an even larger increase took place (50 percent) in 1990, the first full year the new policies were in effect. However, growth in the number of visits is beginning to return to more modest levels.

Personnel shortage. Throughout much of the 1980s, the home care industry, along with the rest of health care, was suffering from a personnel shortage. Although there are still acute shortages of certain disciplines, it would appear that conditions have substantially improved. This increase in available staff allowed the number of certified home health agencies to increase from 5,676 in 1989 to 8,100 in 1995.

New legislative requirements. In the past five years, the home health program has seen the addition of several costly legislative changes, including the OBRA-87 home health aide training and competency testing requirements and the Clinical Laboratory Improvement Amendments of 1988. The costs associated with these changes are reflected in visit charges.

New administrative changes. The 1992 OSHA mandate regarding employee protection from transmission of HIV and Hepatitis B, including employee vaccinations, is a cost that must be borne by employers.

UNDERLYING FACTORS FUELING MODEST GROWTH

As mentioned above, the growth in the Medicare home health benefit is moderating and can be expected to fall to more modest levels in the next two years (i.e., to 7.8 percent by 1997). Sustaining this lowered growth rate are a number of underlying factors that have always influenced growth in home health utilization. Foremost among these is the pursuit of cost-effective alternatives to institutional care.

Cost-Effectiveness. Home health has moved well beyond its traditional boundaries, making it possible for millions of patients to prevent, reduce or eliminate altogether their need for more costly inpatient treatment. A number of studies have documented the ability of home care to hold down use of more costly care. For example:

- A home health agency in Michigan has developed an in-home cardiac recovery program that reduces the hospital stay for patients who require coronary artery bypass grafting (CABG) surgery by 50 percent. The typical CABG patient requires six to ten days at a hospital. But with the in-home cardiac recovery program, these patients can be discharged within two days of surgery. With hospital charges averaging $1,756 per day, enormous cost savings can be achieved through a four to six day reduction in hospital care. In addition, the study found that CABG patients using home care experienced superior outcomes than those who received longer hospital stays but no post-surgical home care.

- An in-home crisis intervention program developed for psychiatric patients has been effective in reducing hospital admissions, length of stay and readmissions. A two-year analysis, involving more than 600 patients, revealed the following findings: 80.7 percent of patients referred for hospital care could be treated at home instead; when inpatient admissions were necessary, the average length of stay could be reduced from 11.97 days to 7.48 days by adding elements of the in-home care program; and patients who received home care services were less likely to be readmitted for hospital care (11.8 percent of home care patients were readmitted compared to 45.9 percent of patients who did not receive home care services).

- A study conducted by Lewin/ICF examined differences in the cost and effectiveness of inpatient care plus home care versus a shorter inpatient stay and more home care for patients hospitalized with a hip fracture, chronic obstructive pulmonary disease (COPD), and amyotrophic lateral sclerosis (ALS) with pneumonia. It found that for all three diagnoses, cutting inpatient days and substituting more home care days reduced costs by: $2,300 for hip fracture patients, $520 for COPD patients, and $300 for ALS patients.

- An innovative home care program for patients with chronic obstructive pulmonary disease (COPD) that was developed and tested in Connecticut has produced significant cost savings. The overall goal of the program was to provide more comprehensive home care services to COPD patients who previously required frequent hospitalizations. The results found that the per-month costs for hospitalizations, emergency room visits, and home care fell from $2,836 per patient to $2,508 per patient, a savings of $328 per patient per month.

- The American Diabetes Association has conducted research which shows that the total economic cost of diabetes is over $91 billion a year in the U.S. The home care component of these costs is only $37 million or just .04% of the total costs. Yet, studies have proven that aggressive long-term treatment of diabetes conducted in the home significantly reduces the risk of diabetic complications including blindness and kidney failure.

These studies highlight one of the primary reasons that home care will continue to be utilized in the future -- it is a cost-effective benefit that works for millions of Americans.

An Aging Population. The fact that the U.S. population is growing older is a significant trend that has and will continue to influence future need for home health services. Older individuals are more likely to need home care and they are likely to use more home care services than younger individuals. For example, the National Medical Expenditures Survey found that individuals over age 85 were three times more likely to use home care as the general elderly population, and their resource consumption was also significantly higher. Individuals over age 65 used an average of 63 visits whereas individuals over age 85 used an average of 71 visits.

Improved Access. Access to in-home services has also improved over the years, as more home health agencies choose to participate in the Medicare program. In 1967, there were 1,753 agencies certified for Medicare purposes. By 1980, that number had nearly doubled to 2,924. As of January 1995, a total of 8,100 agencies were providing services under the program. This represents a marked improvement for enrollees' access to home-based services. Currently, there is one agency for every 4,893 Medicare enrollees, compared to one for every 11,136 enrollees in 1967. Although access varies somewhat from state to state, for the most part enrollees who need home health care now have access to it.

Public Awareness and Preference. The past decade has seen dramatic increases in awareness among physicians and patients about the home as an appropriate, safe and often cost-effective setting for the delivery for health care services. For example, a 1985 survey found that only 38 percent of Americans knew about home care; by 1988, over 90 percent of the public not only understood home care to be an appropriate method of delivering health care, but also supported its expansion to cover long-term care services as well. A new poll conducted in 1992 by Lou Harris and Associates, found that the American public supports home care by a margin of 9 to 1 over institutional care. Nearly 82 percent of all accredited medical schools now offer home health care in their curricula.

Technological Advances. Over the years, sophisticated technological advances have made possible a level of care in the home that previously was only available in hospitals and other institutions. The most significant of these advances have been the introduction of home infusion therapy and radical improvements in ventilator equipment.

Additional Factors. Litigation and workers' compensation claims are two additional factors that affect the cost of delivering home health services.

The Medicare home health program will serve an estimated 3.6 million beneficiaries this year, and expenditures are expected to reach $16 billion. That represents an average increase of nearly 23.5 percent a year in the past 28 years. Much of the increase can be attributed to one-time expansions or clarifications that were specifically designed to allow more individuals access to additional in-home services. Home health growth is beginning to moderate, and it can be expected to fall to more modest levels in the next two years (i.e., to 7.8 percent by 1997).

Sustaining this lowered growth rate are a number of underlying factors that have always influenced growth in home health utilization. These include increased pressure to find cost-effective alternatives to institutional care, a dramatic shift in the age distribution of the US population, improved access to home-based services, and the transfer of hospital technology to the home. These factors in combination with strong public preference for in-home care indicate a future of additional need for and use of home health care.

FRAUD AND ABUSE

As in any area, growth brings with it the potential for unethical or illegal behavior. NAHC strongly believes it is the responsibility of all parties involved -- patients, payors, and providers -- to act aggressively to uncover, report, and act against fraudulent or abusive home care providers.

The National Association for Home Care (NAHC) has taken a leadership role in combatting fraud and abuse. It has been engaged in a longstanding effort to maintain the highest degree of ethics and values in the health care industry through a combination of member education,

cooperation with and assistance to enforcement agencies, and consistent support of federal legislative proposals designed to combat abuses in health care programs.

In January 1994, NAHC implemented a broad new policy governing member conduct. While America has enhanced home care as the site of choice for meeting its health care needs, the growth of the industry has unfortunately been accompanied by a few unscrupulous providers of care who seek only to profit illegally at public expense. The incidence of established fraud in home care services is low. However, even a single occurrence of fraud or abuse is not acceptable and it must be eliminated.

The principles of NAHC's policy are as follows:

I. POLICY ON MEMBER SELF-REGULATION

Where a NAHC member, agency, individual member, or an applicant for membership has been determined or is controlled by an individual who has been determined to have violated a criminal or civil law in either Federal or State Court on issues related to fraud and abuse, the NAHC Board of Directors may consider the imposition of sanctions, including the termination or rejection of NAHC membership.

II. POLICY ON PUBLIC RELATIONS

NAHC shall respond proactively and reactively to any public relations crisis concerning fraud and abuse activity in home care and hospice.

III. POLICY ON EDUCATION OF MEMBERS

Consistent with its mission and commitment to provide educational opportunities for members, and for the purposes of promoting standards of quality and ethics in the delivery of home care and hospice services, NAHC will provide education regarding issues of fraud and abuse in home care and hospice.

IV. POLICY ON ENFORCEMENT

It is the responsibility of any NAHC staff person or any NAHC member to report to the appropriate legal authority any violation of fraud and abuse laws. No report shall be made by NAHC staff except where sufficient information has been obtained which demonstrates that there is a substantial likelihood that the law has been violated. Witnessing or having knowledge of a crime and not reporting it would constitute unethical behavior.

Generally, NAHC will not investigate suspected acts of fraud and abuse. However, when government enforcement officials fail to act to address flagrant violation of the fraud and abuse law, NAHC may act in civil enforcement action where authorized by a super majority of the Board of Directors.

V. POLICY ON SUPPORTING FRAUD AND ABUSE LEGISLATION

NAHC shall actively support and/or initiate legislative and regulatory measures appropriate to prevent or combat fraud and abuse in the home care and hospice industries.

VI. POLICY ON REQUEST FOR ASSISTANCE

NAHC's assistance to member agencies under investigation for health care fraud and abuse shall be available where it is determined that it is in the best interests of the home care and hospice industry at large.

This policy is the embodiment of the efforts of NAHC since its inception in 1983. Its enactment in 1994 was an affirmation of NAHC's commitment to maintain a leadership role in this troubling area. Evidence of NAHC's commitment is most evident in support of legislative efforts to control fraud. In 1993 and 1994, and continuing today, NAHC has publicly supported and worked to advance legislation which would expand existing health care fraud laws under Medicare and Medicaid to all payors in health care. This expansion would work to eliminate activities which escape scrutiny because of the lack of controls in certain states which allow for conduct with private health insurance payments that would be illegal if federal payments were involved. NAHC has also aggressively supported the creation of a private right of action under federal anti-kickback laws to supplement the limited resources of government enforcement agencies. In this same respect, NAHC has repeatedly supported increased funding for the Office of Inspector General at HHS.

Legislation is also needed to control the quality and delivery of home infusion therapy services. This $3 billion segment of the home care industry operates under virtually no regulatory controls and presents an environment for improper, but not necessarily illegal, conduct to occur. In 1994, NAHC highlighted the need for controlling legislation such as that offered by Congressman Sherrod Brown in the so-called "Sarah Weber" bill.

Fraud has also existed within the Medicaid programs. The states' Medicaid anti-fraud units have proven success in attacking this area. NAHC has and continues to support the continuation of these programs.

Legislation alone cannot control fraud and abuse. Health care providers must have a comprehensive understanding of the standards of conduct that are allowable. Internal self-audit and self-enforcement must be done to minimize the risk of illegal activities. Over the past several years NAHC has provided extensive education on the issues involved in health care fraud. National workshops have been held at our regional conferences, annual meetings, and annual law symposiums. State home care associations have joined in this effort to extend this education to the greatest degree possible.

The public must also be fully involved in the process of fighting fraud. It is the health care consumer and the taxpayer who are ultimately the injured parties. While the government should increase the information it provides to the public about known schemes and scams, the health care industry must also do its part. In accordance with the NAHC fraud and abuse policy, the home care industry has not only cooperated with media investigations but has worked to engage the attention of the media to focus on important areas of concerns. For example, NAHC played a crucial role in exposing issues of home care fraud to the public in a Business Week article in March 1994. (attached) Currently, NAHC is working with ABC News on a developing segment regarding home infusion therapy. NAHC believes that increased public awareness is a valuable means of oversight.

One of the most important roles that the home care industry plays in this area is actively integrating its knowledge and expertise with the enforcement authorities. Over the years, NAHC has acted as an extension of the investigatory arm of federal and state enforcement authorities. On the simplest of levels NAHC has connected individuals and providers of services who have evidence of fraudulent conduct with the HHS Office of Inspector General. At more involved levels, NAHC has presented a focus for enforcement authorities on where to commit resources in their home care efforts. For example, NAHC met with Inspector General June Gibbs Brown in April 1994 to outline several areas of concern. Specifically, NAHC suggested a sweeping effort to eliminate the abuses existing in the case of subcontracted care by home health agencies, particularly in South Florida. Growing evidence demonstrated the existence of illegal referral kickbacks between Medicare-certified home health agencies and subcontractors, as well

as, inadequate safeguards to ensure that billed care was delivered care. Further, NAHC described arrangements that had developed between hospitals and home health agencies where free discharge planning services were provided to hospitals in exchange for patient referrals. This is only one example of how NAHC has actively worked with enforcement authorities including the OIG, FBI, and the GAO. As a final note, NAHC has authorized staff to engage in self-enforcement activities under the False Claims Act to initiate litigation against health care providers where enforcement authorities have not acted to stop illegal activity.

Historically, fraud and abuse in health care has taken the form of false claims in Medicare cost reports, billings for services never rendered, and kickbacks for referrals. These types of fraud are now being replaced with an entirely different form of abuse found in managed care. While in the traditional fee-for-service system incentives exist for overutilization and overcharging. But managed care may create financial incentives to improperly underutilize care. The health care consumer is harmed doubly in these circumstances: financially, care is prepurchased but not delivered; and healthwise, necessary care is lost. NAHC strongly recommends that Congress and the enforcement authorities take a long hard look into the abuses in managed care. New strategies must be developed to address this new type of fraud. Clinicians, rather than accountants, will need to operate at the heart of this effort. Good managed care can help bring about economy and efficiency in health care. Bad managed care, controlled by financial greed, can mean the death of the patient.

RECOMMENDATIONS TO COMBAT FRAUD AND ABUSE

1. Enact all-payor anti-fraud legislation.
2. Provide a private right of action under anti-kickback provisions.
3. Offer "whistleblower" protection for good faith activities of information.
4. Institute an anti-fraud review system at OIG and DOJ where planned activities can be subject to analysis prior to implementation.
5. Commit adequate resources to develop expertise and strategic plans to combat improper underutilization within managed care.
6. Enact provisions to regulate home infusion therapy services.

PROSPECTIVE PAYMENT

Finally, I would like to make a few comments about a prospective payment system (PPS) for home health care. PPS would be one way to create incentives for cost-effective utilization management. For example, in a per-episode PPS model, providers would receive a single payment when a patient is admitted that would cover the entire episode of care rather than paying for individual visits when they occur. In this system, providers would have an incentive to manage utilization in the most cost-effective manner.

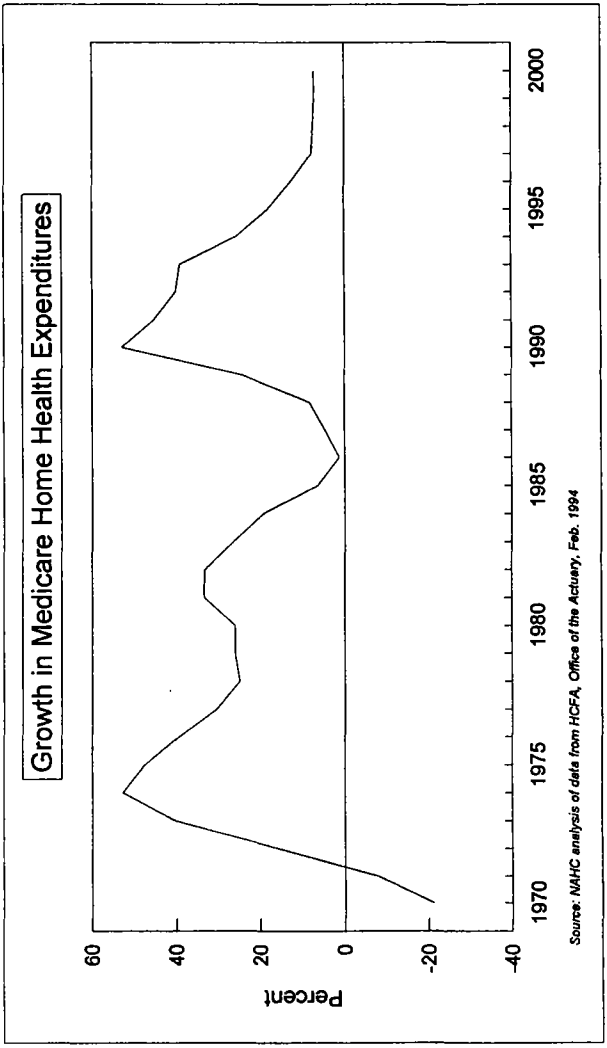
NAHC has long supported a fair and equitable PPS for home health, as long as it has been tested and proven to be an improvement over the current cost-based reimbursement system. To this end, we have been strong supporters of the HCFA demonstrations that would test PPS and the mechanisms within PPS to adjust payments for case-mix variation.

Now, however, we have some concerns about these demonstrations. for one, the demonstration as it is currently constructed, will not resolve the case-mix problems that have stymied the development of an acceptable PPS model. NAHC believes that the demonstration should be reoriented to deal with these case-mix problems now rather than set aside and left for some later time.

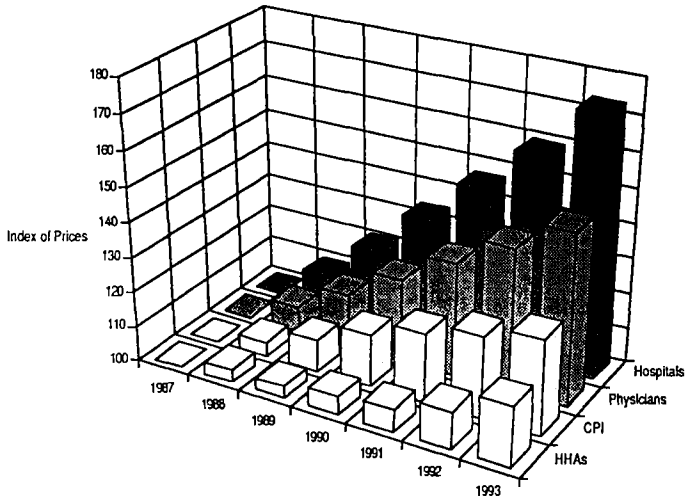
NAHC has made a number of recommendations along these lines to HCFA, and we would appreciate any assistance that your committee could provide in urging HCFA to act on these recommendations (see attached letter to HCFA Administrator Bruce Vladeck).

Once again, thank you for the opportunity to testify on these important issues, and I welcome any questions you may have.

HOMECARE



NAHC Data Show that Home Care Is Still a Good Buy



Data collected from various sources and analyzed by NAHC show that from 1987 to 1993 the cost of living or consumer price index (CPI) increased by 27.1%, the cost of physician's services increased by 48.5%, and hospital costs soared by 73.4%. By contrast, home care costs increased by only 17% during the same period—about 60% of the increase in the CPI, and far below the rates of increase for other health care providers.

INVESTIGATIONS

IS FRAUD POISONING HOME HEALTH CARE?

Critics say lax regulations allow overcharging and abuse

Tom Henry had a good thing going. By padding bills for services provided through six home health-care agencies he owned in Lebanon, Tenn., he easily collected more than $4.4 million from Medicare and Medicaid over four years. Henry spent much of the money on a new home, cars, and lavish toys, including furs for his wife, a jaunt with friends to Cancun, and a trip to Hollywood to appear on *Wheel of Fortune* (he lost). Henry was finally caught and convicted of fraud in 1992, after his schemes became too blatant to escape the notice of insurance investigators, who alerted federal authorities.

The case of Tom Henry is only one of countless instances of fraud and abuse plaguing the rapidly expanding $31 billion home health-care industry. Most are purely financial rip-offs, such as one involving a Florida man sent to prison on Feb. 14 for, among other things, billing Medicaid for home care rendered to three people who turned out to be dead. But other crimes involve willful actions of neglect, abuse, and incompetence that jeopardize the lives of the aged and ill people receiving care at home.

Among the myriad scams already uncovered:

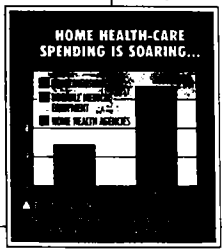
■ Kelly Kare, a home-care company in New York, sent "untrained, unqualified, and unlicensed workers" to care for sick and elderly patients. Their competence was so lacking that one client, Ronald Callahan, had to have his sister teach his alleged nurse how to catheterize him. By the time Kelly Kare's owner was convicted, she had billed New York Medicaid more than $1.1 million for fraudulent services.

■ In Miami, a network of eight companies is charged with offering milk supplements and nutritional therapies free to healthy consumers who didn't need them. The companies then allegedly billed Medicare $14 million, claiming that the products were medically essential. This case, pending in federal court, sparked 14 probes nationwide into similar scams.

■ Robert Desrochers, the owner of two home health-care agencies in Alhambra, Calif., paid the salaries of discharge planners at 10 hospitals as part of his service as long as they sent patients to his agencies. He then shifted that cost, among others, to Medicare. He was convicted of fraud last year. Prosecutors say his scheme is not unusual.

Problems in the industry are not limited to newly formed companies or fly-by-night operators. Some of the largest companies in the industry, such as Caremark International Inc. and T2 Medical Inc., are under federal investigation for alleged kickback schemes. Hospital Staffing Services Inc., based in Fort Lauderdale, Fla., is being probed for its Medicare billing practices. All three companies deny wrongdoing.

"NEXT FRONTIER." Predicting how much fraud and abuse costs consumers is tricky. One congressional estimate puts it at 10% of total expenditures, or $3.1 billion. If the current level of malfeasance continues, experts say, it could wipe out some of the anticipated savings from caring for patients outside hospitals. "Home health care is the next major frontier for fraud and abuse," says Edward J. Kuriansky, New York Deputy Attorney General and special prosecutor for Medicaid fraud. "We've just scratched the surface."



Of course, instances of criminal conduct occur in other segments of the health-care industry. But the nature of home care makes it uniquely susceptible. In hospitals, doctors, nurses, and administrators all monitor the quality and cost-effectiveness of care patients receive. But home care is largely unsupervised. With ill-defined or nonexistent pricing guidelines, poorly conceived federal regulations, and a patchwork of uneven state and local laws, the home-care industry is primarily accountable to itself.

Though the industry has tightened its standards, the guidelines have little or no effect on the thousands of home-care companies that don't belong to the trade groups. And federal investigators are far too understaffed to meet the growing caseload. "We've only been dealing with the most blatant cases because of the lack of manpower," says Jeanne K. Damirgian, an assistant U.S. attorney in Miami. "Only now are we moving into more sophisticated schemes."

The fraud epidemic comes at a time when the industry is experiencing exponential growth. More than 7.1 million people are expected to receive some care in their homes in 1994. That's up from 5.9 million in 1987, the industry's trade group says. Home care, which provides the services of nurses and aides, and home infusion therapies, which include delivery of drugs intravenously,

PHOTO ILLUSTRATION BY MIRIAM HOFMANN & CO. IN PHOTOGRAPHS BY BRIAN LANCRES (PAGES), H. MATTHEW (CRUTCH HOUSE); DATA: LAUNCH MEDICAL; PHYSICIANS' CHARTS BY DAVE BLACKMAN/BW

are expected to grow [illegible] in 1994, according to the Commerce Dept.—three times faster than the rest of the health care industry. The other industry segment, durable medical equipment, such as oxygen tanks and wheelchairs, is also growing fast.

The federal government is picking up a sizable percentage of the tab. Medicare and Medicaid expenditures for home care ballooned to $18 billion last year, from just $8 billion in 1990, according to *Home Health Line*, an industry newsletter. The Health Care Financing Administration, which manages Medicare expenses, predicts a 160% increase in its home-care spending by 1996.

The boom is being fueled largely by the perception that home care is less costly than more traditional venues. A 1991 industry study compared the average cost of treatment in hospitals with treatment in the home for patients with hip fractures, a common ailment treated through home care. It found that by sending patients home six days earlier than normal, $2,300 was saved. That translates into an annual savings of $575 million to Medicare, the study showed.

Such savings, coupled with pressure from insurers to cut costs, is compelling hospitals to release patients sooner. And advances in treatments and technologies have made it possible to provide sophisticated care, such as chemotherapy and respiratory therapy, almost as easily in living rooms as hospitals.

MANY LIMITS. Perhaps nothing has done more for the industry's bullishness of late than the Clinton Administration's plan for health-care reform. Clinton's proposed package specifically calls for universal coverage of short- and long-term home care. Many insurance companies now offer only limited home-care coverage—or none.

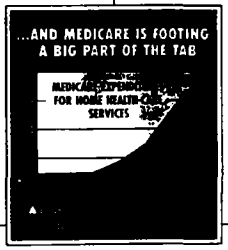
Since Clinton's election, Health Force, an owner and franchiser of nursing and home-aide agencies based in Woodbury, N.Y., says that responses to its newspaper ads seeking franchisees have more than doubled to as many as 125 per week. In Louisiana, the number of Medicare-certified home-health agencies jumped from 270 to 442 in 1992. Growth has been so rapid that Louisiana, along with other states, has placed a moratorium on the opening of new agencies.

Amid the home-care industry's explosive growth, critics are calling for stepped-up enforcement and better guidelines to regulate providers. Although Congress attempted to make some fixes in 1987 by establishing training standards for home health aides and a national hot line for consumer complaints, abuses have proliferated. "There are so many pieces of home care," says Charles P. Sabatino, assistant director of the American Bar Assn.'s Committee on Legal Problems of the Elderly. "Some are state programs. Some are Medicare. There is licensed, unlicensed, and high-tech home care. And there is no comprehensive approach to accountability."

A look at the regulatory landscape makes that all too clear:

- Only seven states regulate home infusion as a distinct industry, leaving this segment most open to rampant wrongdoing, experts say. "The regulatory environment for these services is a little bit like Dodge City before the marshals showed up," said Representative Ron Wyden (D-Ore.) at a hearing last May.
- Virtually no state or federal licensing requirements exist for the 10,000 companies providing durable medical equipment. Although the industry's trade group, the National Association of Medical Equipment Suppliers, imposes standards on its members, only 20% of the businesses belong to the group.
- For the nursing and home-aide agencies, 10 states and the District of Columbia lack special licensing requirements, though certification through a series of inspections is needed to participate in Medicare and Medicaid. Laws that are in place lack consistency in standards, training, or licensing. Independent providers, which make up $3.5 billion, or 17%, of the home nursing business, operate largely outside any regulatory framework. And no federal law requires these agencies to check whether job applicants have criminal records.

Certainly, the concept of home health care is sound and, when implemented correctly, comparatively economical. And the majority of



MOST COMMON FRAUDS IN HOME CARE
PHANTOM SERVICES
PADDING BILLS
TELEMARKETING DOOR-TO-DOOR SCHEMES
KICKBACKS
PROSECUTOR KURIANSKY: PROBES HAVE "JUST SCRATCHED THE SURFACE"

home care provider—to deliver exemplary services. Industry leaders and trade groups have taken it upon themselves to devise rules aimed at ensuring high-quality service. Olsten Corp., based in Westbury, N.Y., the largest provider of nurses and aides for the home, spends close to $2 million annually on compliance programs, which include a criminal background check on job applicants.

But Olsten and some other companies stop short of suggesting that their self-policing mechanisms be applied to the industry at large. Instead, they prefer to rely on a competitive marketplace to wipe out malfeasance.

ETHICS CODE. Trade groups, including the National Association for Home Care, strictly scrutinize their members and have been pushing to expand government oversight. In addition to abiding by Medicare regulations and state laws, members must get the blessing of the Joint Commission on Accreditation of Healthcare Organizations or a similar accrediting body. For accreditation, members must meet stringent standards, including a requirement of 75 hours of training for home-care aides, continuing education for nurses, and agreeing to abide by an ethics code. But these moves only go so far. The standards affect only association members—allowing independent operators to play by their own rules.

So, legislators are readying another try. One bill, scheduled to be introduced in March by Representative Sherrod Brown (D-Ohio) and Senator Howard M. Metzenbaum (D-Ohio), would set limits on prices home infusion firms can charge for their products, establish quality standards for the industry, and require federal licensing. The measure in part responds to protests about extreme disparities in prices for drug therapies offered by home infusion companies (table, page 73). For example, 500 mg of Neupogen, an anti-infection drug, can cost from $266 to $1,128, according to Principal Mutual Life Insurance Co.

C. A. Piccolo, CEO of Caremark, the largest provider of home infusion therapies, concedes that legislation needs to address "escalating costs." But he adds that prices for home-infusion drugs appear high because they reflect numerous overhead costs that must be included in drug charges to get reimbursement from insurance companies. "Insurers won't reimburse us as a line item for services," he says. "They insist that we factor it into the cost of the product."

Another bill, sponsored by Representative Charles E. Schumer (D-N.Y.), would increase funding for health-care fraud investigators as well as provide stiffer penalties for offenders—especially in cases resulting in injury or death to patients. Resources available for uncovering health-care fraud are woefully inadequate. The number of inspectors with

WHO'S BIG IN HOME CARE

1993 TOTAL REVENUES

HOME NURSING AND AIDES — $21 BILLION
- OLSTEN — Westbury, N.Y.
- INTERIM HEALTHCARE — Fort Lauderdale, Fla.
- VISITING NURSE SERVICES OF NEW YORK — New York City

DURABLE MEDICAL EQUIPMENT — $6 BILLION
- HOMEDCO GROUP — Fountain Valley, Calif.
- ABBEY HEALTHCARE GROUP — Costa Mesa, Calif.
- LINCARE — Clearwater, Fla.

HOME INFUSION THERAPY — $4 BILLION
- CAREMARK INTERNATIONAL — Northbrook, Ill.
- T2 MEDICAL — Alpharetta, Ga.
- MEDICAL CARE AMERICA — Dallas

the Office of the Inspector General of the Health & Human Services Dept. has been cut to 249 from 298 since 1989, while workloads have multiplied.

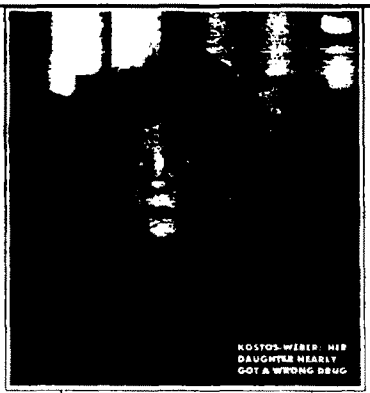
On the local level, New York's Erie County set up an employment registry this year to track home-care workers who have criminal records or other troubling pasts. The law was adopted after local police reported a spike in complaints of abuse against senior citizens by home-care workers, including one of an 82-year-old blind woman with Alzheimer's disease who was so badly beaten that her ribs were broken. Other patients were persuaded to transfer bank funds to their [illegible] and [illegible] to die.

In the private sector, [illegible] are companies have taken root [illegible] their own crusades. They more frequently decline to pay bills as submitted, citing unsubstantiated or inflated claims. Principal Mutual is demanding more proof that services billed for were actually delivered and necessary. At Northwestern National Life Insurance Co., a full-time investigator has been assigned solely to reviewing bills submitted for home nursing services.

HUGE BILLS. Perhaps nothing illustrates the potential perils of home care better than the story of Sarah Weber, a little girl in Cleveland Heights, Ohio, who suffered from cerebral palsy. From the age of 5 until her death last July at age 10, Sarah was able to live at home with the help of intravenous drugs and nutritional therapy.

In congressional hearings last May, Sarah's mother, Marie Kostos-Weber, testified that Sarah's bills for her extensive treatments ranged from $95,000 to $120,000 a month—an amount that ate up the family's $1 million private insurance policy limit in less than a year. She stated that after checking with a health-care consultant, she estimated it cost close to $1,000 a day more to treat Sarah at home than in the hospital. When her insurance lapsed, it took a court order to prevent Critical Care America Inc., Sarah's home-infusion provider, based in Westborough, Mass., from cutting off Sarah's supply of medicine, according to congressional records.

But Sarah had other problems. According to a lawsuit Kostos-Weber filed last September against Critical Care, which alleges overcharging and poor quality of care, she contends that the company mistakenly delivered a lethal dose of the wrong drug for Sarah's intravenous therapy. Fortunately, Kostos-Weber caught the mistake, she says. But when she tried to complain to the state health department, she was referred to the Attorney General's office, which in turn referred her to the National Alliance for Infusion Therapy, an industry lobbying group based in Washington. "There was no one to turn to," says Kostos-Weber. "This is a totally unregulated industry. The health department didn't even know what infusion therapy is." Critical Care, which was recently acquired by Caremark for $175 million, declined to comment on the pending litigation except to say that it "will vigorously defend itself."



KOSTOS-WEBER: HER DAUGHTER NEARLY GOT A WRONG DRUG

THE PRICE ISN'T RIGHT

Range of costs for drugs charged by home-infusion companies*

GANCICLOVIR (500 milligrams) Used as antiviral treatment for AIDS	$150 to $800
NEUPOGEN (300 milligrams) Anti-infection drug	$266 to $1,128
PENTAMIDINE (300 milligrams in syringe) Antipneumonia drug	$180 to $450
GAMMAGARD (25 grams) AIDS treatment to boost immune system	$1,100 to $3,300
ROCEPHIN (2 grams) Treatment for Lyme disease	$147 to $384
ZINACEF (1.5 grams) Treatment for various infections	$135 to $338

*Charges include certain overhead costs such as delivery and mixing of drug compounds

DATA: PRINCIPAL MUTUAL LIFE INSURANCE CO.

It's clear that as health care moves further into the home, it is bringing a whole new set of problems for providers, insurers, regulators, and consumers. Although greater regulation is essential, lawmakers must be careful not to overregulate. According to a yet-to-be-released study by the George Washington University Health Policy Project, North Carolina, Virginia, and Minnesota have come up with the best regulatory mix. Their laws defining home-health agencies are flexible enough to make most services fall under some regulation. The marketplace, too, will impose more scrutiny and reform, and industry trade groups are trying to improve quality.

CASE MANAGERS. Experts say one of the most effective ways to curtail abuses is to increase the role of doctors. "If there is a power broker in home health-care services, it's the doctor," says William Dombi, director of the Center for Health Care Law in Washington, D.C. The American Medical Assn. has advocated using doctors as case managers for home health-care services. That position is backed by an independent study Aetna Life Insurance Co. concluded in 1993. It found that more physician involvement would curb abusive practices. It noted that in many cases it reviewed, doctors had not even seen the patients for whom they were prescribing treatment.

As the law stands now, doctors have little incentive to take a hands-on approach to home health care. They are not paid by insurers for work relating to home health-care planning.

The eventual shape of health-care reform will likely have the greatest impact on the industry. The Clinton plan does include new criminal penalties for bribes and kickbacks in the home health-care industry as well as tougher civil penalties for falsified billing claims. But these provisions—though they go a long way toward separating the good from the bad players—are only a starting point. The architects of health-care reform must address all the present-day abuses and problems before they inadvertently create a whole host of new ones for the future.

By Linda Himelstein in New York, Gail DeGeorge in Miami, and Eric Schine in Los Angeles, with Ann Therese Palmer and Richard A. Melcher in Chicago

HOMECARE™

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September 23, 1994

Bruce C. Vladeck, Administrator
Health Care Financing Administration
Department of Health and Human Services
Attention: BDP-779-NC
P.O. Box 7517
Baltimore, MD 21207-0517

Dear Mr. Vladeck:

I am writing to request a meeting with you to discuss plans for phase II of the home health PPS demonstration.

Our concern is that the demonstration will not resolve the case-mix problems that have stymied the development of an acceptable PPS model. Under the demonstration, PPS rates will be based on each agency's own costs during its base year. This is acceptable for a 3-year demonstration but not for an ongoing program. Although a year-end case-mix adjustment will be tested to take account of changes that may have occurred since an agency's base year, that adjustor has practically no predictive value. Its R-squared value is only 9.79 percent. This poor performance could be improved by the inclusion of additional variables. A model consisting of 40 some data elements has been developed that has been given high marks for its predictive power.

Indicative of the weakness of the system is the fact that the demonstration designers have found it necessary to protect participants against 99%, 98% and 97% of any losses in demonstration years one, two and three respectively.

It seems to us that the demonstration neither satisfies the mandate in OBRA-90, which calls for the development of a new payment system, nor the widespread desire to find a cost-effective alternative to cost reimbursement. NAHC believes that the case-mix problems should be dealt with now rather than set aside and left for some later time -- presumably 5 years or so from now when the current study is completed.

While we made our concerns known when we first learned of the design of the demonstration last month at an industry briefing and have subsequently offered to discuss the matter further, we have now reached a point where we are concerned that we may be running out of time. Home health agencies will be recruited to participate in the demonstration in the near future.

If you would like to have any additional information, please call me or Bob Hoyer, our Vice-President for Public Policy and Research.

Sincerely,

Val

Val J. Halamandaris
President

Chairman THOMAS. Thank you very much, Ms. Suther.
Mr. Lehrmann.

STATEMENT OF EUGENE LEHRMANN, PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. LEHRMANN. Thank you, Mr. Chairman. I am Gene Lehrmann, president of the AARP. I appreciate the opportunity to appear before the subcommittee today to discuss Medicare spending.

Unrestrained growth of costs systemwide drives Medicare spending. Attempts to restrain Medicare without also controlling costs throughout the health care system will fall short, and most likely will result in greater cost shifting onto beneficiaries and the private sector. Moreover, savings from Medicare should not be used to finance tax provisions.

Contrary to what some have stated, Medicare is one of the most cost-efficient Federal programs. Medicare returns between 96 and 99 cents on the dollar. By contrast, administrative costs of private health insurance range from at least 5 to 40 percent of benefit costs.

Since the early eighties, Medicare spending growth has been cut by over $200 billion and strong cost containment provisions on hospitals and doctors have been implemented. As a result, for much of this period, growth in per capita spending for Medicare has been below per capita growth in the private sector.

The rapid rates of growth in Medicare home health and skilled nursing facilities have raised important questions about the reasons for such growth. Numerous studies are now scrutinizing these benefits to look at fraud and abuse concerns, dramatic State and regional differences in growth rates and payment and administrative reforms.

If there are problems with these benefits, then we must address them, but we should act based on a sound diagnosis rather than only on symptoms. We urge this subcommittee not to simply impose shortsighted budget cuts in these programs as a way of complying with arbitrary targets to pay for tax and benefit reductions.

In our view, an objective reading of the available evidence leads to the conclusion that growth rates are due in a large part to clarifications of coverage rules in these benefits in the late eighties that previously had been ambiguous and overly restrictive.

These court-ordered clarifications address the serious denials of Medicare SNF and home health claims that artificially constrained access to these critical rehabilitative services during the eighties. As a result of the clarifications, provider confidence and participations in these programs grew. Not only was beneficiary access to care improved, new small businesses were created. Competition increased and geographic distribution of services improved.

Another factor in the growth of these benefits was important, new technologies that enabled beneficiaries to leave the hospital earlier and receive care in a less expensive setting.

Since the major causes of growth in these programs can be attributed to improvements in program administration in the late eighties, the rate of growth in these programs are likely to be short lived. Many predict that growth in the home health program, for

example, will soon flatten by itself without any legislative or regulatory reforms.

While controlling abuses is absolutely essential, these estimates demonstrate that drastic measures are not needed to slow the future rate of growth in the Medicare home health care program.

We urge the subcommittee to reject the assumption that the growth rates are a result of inappropriate utilization by beneficiaries. There is no clear or convincing evidence to support such an assumption. Moreover, unduly restricting access to home health services through the imposition of an onerous, regressive beneficiary copayment, for example, would seriously harm the most vulnerable oldest Americans, those who can afford least to pay for it.

For the average Medicare home health user, a new 20-percent coinsurance would require them to pay an additional $1,300 out-of-pocket in 2002. The average payment for those who need and use the benefit the most, primarily lower income older women, would be over $4,200 in 2002. The group likely to suffer the most from such a tax is the almost one-quarter of home health users with incomes of between 100 and 150 percent of poverty, too high to qualify for protection under the qualified Medicare beneficiary program and too low to be able to afford a Medigap policy to cover these new costs.

Medicare is a successful and popular program that provides essential services for older and disabled Americans. Administration of the program has been more efficient than many think and costs have been effectively contained, although improvements can be made.

Medicare home health and SNF growth rates raise legitimate questions about the operation and the administration of these important benefits. We would be pleased to work with members of the subcommittee to discuss mechanisms for improving the efficiency and cost-effectiveness of the Medicare program.

Thank you very much.

[The prepared statement follows:]

TESTIMONY OF EUGENE LEHRMANN
AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman and members of the Subcommittee. I am Gene Lehrmann from Madison, Wisconsin. I am President of the American Association of Retired Persons (AARP). I appreciate the opportunity to appear before the Subcommittee today to discuss Medicare spending.

AARP believes that measures to control spending in the Medicare program will fall far short of their goal unless action is taken to control costs throughout the health care system. The unrestrained growth of costs systemwide drives Medicare spending. Attempts to restrain Medicare without also controlling costs throughout the health care system will fall short, and most likely will result in greater cost-shifting onto beneficiaries and the private sector.

AARP believes that, while some refinements are inevitable and necessary as our nation's health care system changes, Medicare must remain a viable health insurance program that provides affordable coverage to older and disabled Americans. To this end, Congress must carefully consider the impact of proposals to restrain program spending -- on the program and on beneficiaries and providers. Moreover, savings from Medicare should not be used to finance tax provisions such as those in the Contract with America.

MEDICARE IS ESSENTIAL

Medicare is the federal health insurance program for the aged and disabled. Created by Congress in 1965, it now provides medical care coverage for roughly 37 million older and disabled people. Medicare is a social insurance program. Individuals pay into the Medicare Hospital Insurance (HI) Trust Fund during their working years through a payroll tax and when they retire they are eligible for the health insurance benefits they have earned. They pay a premium roughly equivalent to 25% of Medicare Part B costs as beneficiaries.

Medicare pays for a wide range of health services. Medicare Part A helps to cover the costs of hospital coverage, skilled nursing facility care, home health care and hospice for the terminally ill. Part B covers physician services, outpatient care, diagnostic tests and durable medical equipment. Medicare does not discriminate -- no beneficiary is excluded from coverage because he or she has a pre-existing condition.

One of the most important elements of Medicare is the protection of beneficiary choice -- beneficiaries can choose where and from whom to receive care -- from physicians or certain non-physician practitioners, through a standard fee-for-service plan or a managed care setting.

Contrary to what some have stated, Medicare is one of the most cost efficient federal programs. Of the roughly $94 billion spent on Medicare Part A hospital benefits in 1993, only 1 percent was spent on administrative expenses. Of the roughly $42 billion spent on Medicare Part B physician benefits in 1993, only 3.6 percent was spent on administrative expenses. This means that Medicare returns between 96 and 99 cents on the dollar. By contrast, administrative costs of private health insurance range from at least 5 percent to 40 percent of benefit costs.

Poll after poll indicates strong support for Medicare across all age groups. While they may be many years away from eligibility, there is recognition among those under the age of 65 that Medicare lessens the burden on families who would otherwise end up paying the medical bills -- often enormous -- of parents and grandparents.

MEDICARE SPENDING HAS BEEN SLOWED

Those who try to blame Medicare for unsustainable spending are ignoring a critical fact: in order to impose real cost constraints on Medicare, private sector health spending must be constrained as well. Since the early 1980s Medicare spending growth has been cut by over $200 billion and strong cost containment provisions on hospitals and doctor payments have been implemented. As a result, for much of this period growth in per capita spending for Medicare has been below per capita growth in the private sector. While this trend was reversed for a two year period between 1992-93, HCFA indicates that a slower per capita growth in Medicare is likely to continue. This experience amply demonstrates the need for system-wide cost containment.

Spending in Medicare is affected, to a large degree, by the same factors that cause unsustained spending growth in the private sector: intensity of services, the use of new technologies that allow the treatment of more complex and costlier cases, fraud and abuse, and changes in the population.

The slowing in Medicare's growth may be attributed, in part, to reimbursement and cost containment mechanisms that have been implemented over the past several years. The implementation of physician payment reform has had an impact on slowing the growth of physician expenditures in Medicare. According to the Physician Payment Review Commission (PPRC), expenditures for physician services slowed to an average rate of 3.8 percent from 1991-93 compared to 10.5 during the preceding five years. In this same period volume growth also slowed.

The Prospective Payment Assessment Commission (ProPAC), has found that hospital growth has varied over the last several years but cost growth appears to have slowed again in 1993. Some of the decreases are due to an increase in the use of hospital outpatient services that constitute a growing share of the revenues hospitals receive from Medicare. This growth in hospital outpatient usage is proving problematic for beneficiaries because of a serious problem with the coinsurance calculation.

Because beneficiary coinsurance for most hospital outpatient services is based on what the hospital charges, rather than on what Medicare reimburses, beneficiaries may wind up paying upwards of 50 percent in coinsurance for outpatient services. This has created an incentive for hospitals to direct more patients into an outpatient setting and shift more costs onto beneficiaries. **As this Committee examines those aspects of the Medicare program that have been growing quickly, we urge you not to overlook this serious circumstance in outpatient services where extraordinary and unmanageable costs are being shifted onto beneficiaries.**

MEDICARE CHALLENGE FOR CONTROLLING SPENDING: GROWTH IN THE MEDICARE HOME HEALTH AND SKILLED NURSING FACILITY BENEFITS

Since 1988, the rates of growth in the Medicare home health and skilled nursing facility (SNF) benefits have exceeded those in the rest of the program. This has raised important and legitimate questions about the reasons for this growth and whether they reflect overutilization by beneficiaries. In our view, an objective reading of the available evidence leads to the conclusion that the growth rates are due, in large part, to clarifications of coverage rules in these benefits in the late 1980's that previously had been very ambiguous and overly restrictive. These ambiguities caused artificial, as well as illegal, constraints on the availability of these services for beneficiaries. For home health in particular, growth rates from 1984 to 1988 were flat and, in some years, actually declined. Beginning in 1989, court ordered coverage changes and the issuance of new intermediary coverage rules increased the number of meritorious claims submitted for Medicare coverage. Many similar claims previously had not been submitted by providers because they feared denials and having to absorb the costs themselves.

We urge the subcommittee to reject the assumption that the growth rates are the result of inappropriate utilization by beneficiaries. There is no clear or convincing evidence to support such an assumption. Moreover, unduly restricting access to home health services through the imposition of an onerous, regressive beneficiary copayment, for example, would seriously harm the most vulnerable, oldest Americans -- those who can least afford it.

Additional research is currently underway to investigate possible billing abuses by providers, the alarming variations in utilization patterns across geographic regions, and growth in the demand for so-called "subacute" care. HCFA also has undertaken a comprehensive study of the Medicare home health program, which has and will continue to recommend and implement reforms to improve the program's efficiency. Preliminary evidence from researchers at Duke University supported by HCFA suggests that growth in the use of home health has occurred among patients with very serious health problems and that cost substitutions may be occurring, as well as positive age-adjusted reductions in long term institutional use. These important initiatives are aimed at identifying the real causes of any problems and proposing targeted and appropriate solutions. We urge this committee not to simply impose short-sighted budget cuts

in these programs as a way of complying with arbitrary targets to pay for tax and deficit reductions. **If there is abuse of these benefits then we must address it -- but we should act based on a sound diagnosis rather than only symptoms.**

Background -- Medicare Home Health and SNF -- To qualify for Medicare home health coverage, a physician must certify that the care is medically necessary and that the client is homebound and in need of only intermittent or part-time care skilled care (skilled nursing or therapy). The need for assistance with daily living activities does not trigger coverage. Persons who need daily care for more than a few weeks also are denied coverage.

To qualify for Medicare SNF coverage, a beneficiary must have had a recent prior hospitalization of at least three days. The services needed must be skilled (not custodial) and medically necessary. The most common diagnoses for SNF Medicare patients are strokes and hip fractures. Coverage is limited to 100 days per spell of illness. On average, the length of a covered stay is approximately 30 days. A copayment of $89.50 is imposed for days 21-100. Rather than basing this copayment on the cost of care, it is based on a formula equal to one-eighth of the hospital deductible amount. **In many areas of the country, this coinsurance amount exceeds what most would consider to be a reasonable daily rate relative to actual daily SNF costs. In other words, beneficiaries often are paying -- out-of-pocket -- more for this benefit than it is actually worth.**

The Medicare home health and SNF benefits are designed primarily to provide rehabilitation, typically after a hospitalization. While all SNF stays follow a hospitalization, approximately two-thirds of Medicare home health users begin their episodes of care within 30 days of being discharged from an inpatient stay. According to ProPAC, almost 70 percent of Medicare beneficiaries hospitalized in 1990 with a hip fracture received post-hospital care from a SNF, Home Health Agency (HHA), rehabilitation hospital, or some combination of the three. Access to these services is critical to proper recuperation and the ability to remain in the community. Such access also permits hospitals to discharge patients earlier and in a more unstable condition than in the past, thereby saving money both through hospital length-of-stay and reduced readmissions. Between 1979 and 1991, for example, average length of stay in hospitals for persons over 65 years of age declined from 10.8 days to 8.6 days.

Problems with the Medicare Home Health and SNF Programs in the 1980's -- When the Medicare hospital DRG prospective payment system was enacted in 1983, it was anticipated that use of post-hospital care would increase in order to care for patients who were being discharged from the hospital sooner than in the past, but were still in need of care. Indeed, since 1983, researchers have documented the increasing severity and instability of illness among patients in nursing homes and receiving home health care.

However, instead of the expected increase in SNF and home health utilization after DRGs were implemented, the opposite occurred. The number of SNF days per patient dropped 25% from 1984-1986. An average of one-third of all claims for SNF coverage were being denied. Moreover, the denials were not consistent throughout the country. A claim accepted by an intermediary in one area would be denied by the same intermediary in another. Denial rates ranged from 10% in Denver to over 40% in Boston and 60% in New York. Within the same region, different intermediaries were making different decisions on similar claims.

The experience with Medicare home health utilization was similar. Home health was expected to increase once DRGs were implemented, but it did not. A 1988 CBO analysis reported a $2 billion reduction from projected spending on Medicare home health services between 1984 and 1988. The number of Medicare home health denials of coverage increased from about 186,000 in 1985 to 408,000 in 1987. Since providers generally must absorb the cost of services rendered for submitted claims that are subsequently denied, the impact of provider behavior was substantial. According to one study, "The 1980's witnessed a serious crisis with denial of Medicare claims for home health benefits, threatening access to home health care for aged and disabled Americans."[1] Unexplainable variation in HHA denial rates among regions was also problematic. According to GAO, in the late 1980's "HCFA's quarterly data on denials of home

[1] Kinney, Eleanor, et al, "Home Health Agency Response to the Medicare Claim Denial Crisis of the 1980s," Indiana University School of Law, June 1989 (pg. v)

health agency bills show significant variation of denial rates among HCFA regions."[2] As a result, according to a 1989 report to Congress:

> "beneficiaries and providers were increasingly confused about Medicare coverage criteria; a 'chilling effect' set in, causing HHAs to reduce the number of services provided to a beneficiary in an effort to avoid costly denials; and a lack of trust existed between HCFA, FIs, and the provider community."[3]

In a 1987 GAO report which surveyed 850 hospital discharge planners, 97% reported having problems placing Medicare patients in skilled nursing facilities, and 86% reported problems with home health placements. The discharge planners cited Medicare rules as the most significant barrier to placement of patients in SNF and home health.

Changes to Clarify Medicare Home Health and SNF Coverage Rules -- In 1987, Medicare beneficiaries, with support from providers and AARP, sued the Department of Health and Human Services, claiming that improper administration was resulting in arbitrary denials of home health services to eligible beneficiaries. In August, 1988, the United States District Court for the District of Columbia ruled that thousands of Medicare beneficiaries had been denied Medicare home health coverage illegally as a result of improper administration of the benefit. Duggan v. Bowen, 691 F.Supp. 1487 (D.D.C. 1988). The court invalidated HCFA's policy of restricting all home health coverage to four or fewer days per week. To implement the ruling, HCFA agreed to cover skilled care, therapy, or home health aide services in any combination, up to 28 hours per week, and up to 35 hours upon individual determination by the fiscal intermediary of the reasonableness and necessity for the additional care. HCFA also agreed to rewrite the Medicare Home Health Coverage Manual, consistent with the court's order. Implementation of the court's order has resulted in increased access to home health coverage for Medicare beneficiaries. These, however, are appropriate, needed services, to which beneficiaries are legally entitled.

AARP and others also pressed HCFA for correction of the unacceptable ambiguities and variations in SNF coverage and demonstrated how the guidelines failed to reflect the legal standards under the Medicare law. HCFA published revised guidelines in 1988, which are faithful to the law and regulations and which, for the first time, offered concrete guidance to intermediaries on how to evaluate claims. Those guidelines have resulted in appropriate increased coverage, so that needed and covered services are provided to beneficiaries.

A March, 1994 ProPAC report concluded that the growth in Medicare home health "can be attributed primarily to coverage guideline changes and other administrative factors affecting use."[4] The report goes on to say that the coverage changes "resulted in more people receiving home health services and more services being provided per beneficiary." (See attached Chart 1). The "administrative factors" referred to represented long overdue improvements and clarifications in the benefit; they were implemented in 1987 and included: (1) elimination of an arbitrary rule imposed on fiscal intermediaries(FIs) that had provided strong incentives for them to save five dollars through medical review claims denials for each dollar spent reviewing the claims (so-called 5 to 1 "savings-payback ratios"), (2) providers were given better information about why claims were denied so they could avoid future mistakes; and (3) providers were given the opportunity to supplement claims submissions so that they would no longer be denied merely because necessary information was missing.
In part, recent program growth could be interpreted as "catching up" to where it would have otherwise been but for efforts between 1984 and 1988 to illegally or unfairly limit growth.

Increases in Provider Participation -- Another important factor contributing to program growth that resulted primarily from the home health and SNF policy clarifications was increased provider confidence and participation in these programs. For example, the number of Medicare certified HHAs increased from 5,780 in 1991 to 7,360 in March 1994 -- an increase of over 27% in a relatively short period of time. The number of Medicare certified SNFs increased from 6,451 in 1985 to 11,309 in 1993 -- an increase of 75% in 8 years. Increasing provider

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[2] GAO, Increasing Denials of Home Health Claims During 1986 and 1987, HRD-90-14BR; January 1990 (page 22).
[3] Advisory Committee on Home Health Claims, U.S. DHHS; July 1989 (page 9).
[4] ProPAC, Interim Analysis of Payment Reform for Home Health Services, C-94-02; March 1994 (page 8).

participation, in general, is a positive trend. Not only does it afford beneficiaries access to care, but new small businesses and jobs are created, which benefit our economy. Reductions in entry barriers improve the market and should increase competition, leading to better services, lower prices and greater geographic distribution. In the past, for example, residents of some rural areas had a very difficult time finding these services because they simply were not available.

Between 1980 and 1993, hospital-based HHAs (as opposed to free-standing agencies not owned by hospitals) grew from 12.3% to 27% of all HHAs. During that same period, growth of proprietary HHAs was even more dramatic -- from **6.4% to 48%** of all HHAs. Data indicates that proprietary agencies have longer episodes of care and provide substantially more visits per episode than non-profit agencies. In all likelihood, this change in the composition of the provider community also contributed to program growth.

Without question, improvements in the SNF Medicare program also boosted provider confidence and participation. According to a 1992 ProPAC report:

> "The [SNF] Medicare program may also seem relatively unattractive because of the administrative burden associated with it. Under Medicare, coverage determinations are made by the fiscal intermediary after a patient has been admitted. Retroactive denial of Medicare coverage is not uncommon. For this reason, nursing homes may be reluctant to admit Medicare patients in favor of private pay or Medicaid patients. *However, this problem has been rectified somewhat by the 1988 coverage guidelines clarification.*"[5] [emphasis added]

The report also cites the Medicare Catastrophic Coverage Act (MCCA), which eliminated the prior hospitalization requirement in 1988, as a factor contributing to increased provider participation. It found that "Even though MCCA was subsequently repealed, the higher number of Medicare certified beds remained, probably due to the impact of the clarification of coverage guidelines."[6] OBRA '87, which eliminated the distinction between SNFs and ICFs, also contributed to the increase in participation because facilities no longer had to increase staffing or services to become Medicare certified. Currently, nursing facilities' interest in the growing "subacute care" market, which is paid primarily under the SNF Medicare program, continues to contribute to growth in participation.

Advances in Technology in Post-Acute Care -- Several important new technologies have enabled Medicare beneficiaries to leave the hospital earlier and receive appropriate care in a less expensive setting. For example, home infusion therapy became available in the early 1980's and, for the first time, permitted cancer, organ transplant and heart failure patients, as well as those needing intravenous antibiotics, pain medication and parenteral nutrition to receive care at home. In addition, home ventilators are now more compact and convenient, enabling many who had previously been dependent on heavy machinery to stay at home.

Nursing facilities' interest in subacute care has also been driven, in part, by the availability of new technologies. According to a recent HHS report: "Technological advances have made it possible for medically complex and/or technologically advanced services previously provided only in acute care hospitals to be more frequently delivered in non-hospital settings."[7]

Billing Abuses in the Medicare Home Health and SNF Programs -- Fraudulent and abusive billing practices currently cost our nation's health care system over $100 billion a year. Although no part of the health care system seems to be immune, major patterns of abuse have been found to exist in the use of durable medical equipment (DME) during SNF stays, and in the home health care industry.

An October, 1994 report by the HHS Office of the Inspector General found that between 1991 and 1992 over $19 million dollars was incorrectly allowed for durable medical equipment billed to Medicare during stays at skilled nursing facilities. Moreover, the report found that incorrect equipment billings during a skilled stay turned out to be for items prescribed for use before or

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[5] ProPAC, Medicare's Skilled Nursing Facility Payment Reform, C-92-01; March 1992 (page 40).
[6] Ibid., page 38.
[7] DHHS Office of the Assistant Secretary for Planning and Evaluation, Subacute Care: Policy Synthesis and Research Agenda, 1994 (page 1).

after the stay had actually occurred. A companion report issued that same month also seriously questioned the appropriateness of shifting millions of dollars each year for SNF services covered under Medicare Part A to Part B, creating additional beneficiary liability.

The GAO has also been working on a report to look at SNF Part B billing practices. Preliminary findings last year indicated serious abuses.

Similar instances of abuse can be found in the home health care industry. Sen. William Cohen (R-ME) issued an investigative report in July, 1994 which found several abusive billing practices, such as billing for services not rendered and kickbacks to referring physicians. In his report Sen. Cohen stated, "Home health care has tremendous potential to decrease costs of both acute and long-term care and to enhance patients' quality of life. It also, however, presents a disproportionate opportunity for abusive practices, hidden from medical professionals and overseers who cannot watch delivery of care at home."
Long-Term Estimates of Medicare Home Health and SNF Growth -- Since the major causes of growth in the Medicare home health and SNF programs can be attributed to improvements in program administration in the late 1980's, the substantial rates of growth in these programs are likely to be short-lived. Many predict that growth in the home health program, for example, will soon flatten by itself, without any legislative or regulatory reforms. **Just last month, HCFA projected that next year, growth rates in Medicare home health benefit payments would decline by almost one-third,** from 18.9% for 1994-1995 to 12.8% for 1995-1996. During this same period, **Medicare SNF growth rates are projected to decline by 36%**, from 26.9% to 17.1%.

In our view, the greater concern lies with controlling the relatively more rapid SNF Medicare growth rates. According to ProPAC: "Between 1995 and 1999, home health expenditure growth is projected to level off at an average annual rate of 9.8% per year."[8] In addition, HCFA's Office of the Actuary has projected that, after 2002, annual growth in Medicare home health expenditures will level off at approximately 6.7% and annual growth in the number of visits received by beneficiaries will level off at approximately 1.5%. (See attached Chart 2) While we acknowledge that projections that far into the future are quite speculative, they do help to show that most experts believe that current growth rates won't be sustained. In our view, these estimates clearly demonstrate that drastic measures are not needed to slow the future rate of growth in the Medicare home health program, but action to root out abuse should be undertaken -- and vigorously.

Need for Additional Analysis on the Causes of Program Growth -- Clearly, the recent rates of growth in the Medicare home health and SNF programs have not gone unnoticed. The programs are being closely scrutinized by the Office of the Inspector General, the General Accounting Office, the Office of the Assistant Secretary for Planning and Evaluation, ProPAC and HCFA. In fact, HCFA recently launched an extensive Medicare home health initiative designed to provide a comprehensive assessment of the program. Among the stated goals of the initiative, in which AARP has been a participant, are enhancing efforts to detect fraud and abuse; improving the efficiency of the program's administration and operations, facilitating appropriate utilization of home health services, and ensuring appropriate payments for the benefit.

There are also some dramatic regional and state variations in the growth and use of the benefits that need further investigation. For example, according to a recent report by Mathematica:

> "Consistent with earlier studies, we found a threefold difference in the (nonregression-adjusted) use of Medicare home health services between the East South Central region of the United States (Alabama, Kentucky, Mississippi, and Tennessee), where episodes included 95 visits and were 180 days long, on average, and the Pacific region (Alaska, California, Hawaii, Oregon and Washington), where episodes included 28 visits and were 60 days long, on average. Home health use was also markedly higher than average in the West South Central region (Arkansas, Louisiana, Oklahoma, and Texas) and markedly lower in the Middle Atlantic region (New Jersey, New York, and Pennsylvania)."[9]

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[8] Supra, note 4 at 13.

[9] Mathematica Policy Research, Inc., "Patient, Agency, and Area Characteristics Associated with Regional Variations in the Use of Medicare Home Health Services," September 1994 (page xiv).

There are a variety of ways to assure appropriate utilization without harming beneficiaries in need of care. For example, consideration should be given to expanding the role of physicians, who are responsible for certifying that services are medically necessary. This may be particularly timely since, as of January 1, physicians can now bill Medicare for care plan management and oversight for patients receiving home health benefits. The OIG documented a serious absence of physician visits to many SNF residents in 1991-1992.

In addition, Peer Review Organizations (PROs), which have not been empowered to carry out their statutory obligation to review the appropriateness of Medicare post-acute care, could do more in this area.

Payment reform initiatives also have the potential for making programs more efficient. The On Lok and PACE demonstration programs, which are experimenting with capitated payments for these services within an integrated system, should be expanded and thoroughly evaluated. Findings from studies and demonstrations on prospective reimbursement for Medicare home heath and SNF services could also lead to constraints on program costs. Prospective payment for SNFs seems more promising in the short term and we urge that particular attention be paid to Part B payments, which have not been subject to the same cost limits as those in Part A. We also look forward to evaluations resulting from home health demonstrations on per-episode reimbursement. Any new payment systems, however, must include adjustments for case-mix so that there are not disincentives to treating patients with heavy care needs.

Proposals to Impose a New 20% Medicare Home Health Coinsurance -- Under current law, there is no coinsurance for persons who use Medicare home health services. This is intended to encourage the use of more effective, less costly non-institutional services. Some members of Congress have proposed the imposition of a new 20% coinsurance on users of Medicare home health. In our view, such a regressive proposal would create great hardship among the most vulnerable Medicare beneficiaries -- particularly older, lower income women. The group likely to suffer the most is the approximately 24% of users with incomes between 100% and 150% of poverty -- too high to qualify for protection under the Qualified Medicare Beneficiary (QMB) program, and too low to be able to afford a Medigap policy to cover these new out-of-pocket costs. AARP opposes the imposition of a new 20% home health coinsurance because:

- In effect, this new out-of-pocket payment would be a new "sick tax" on the most frail and vulnerable elderly and disabled Americans -- those who can **least afford it**.

- The new coinsurance would be unaffordable for most of the frail, lower income seniors who need these services. Almost **80%** of all Medicare home health users have annual incomes of **less than $15,000**. Approximately 24% have incomes between 100% and 150% of the federal poverty line (almost one million beneficiaries in 2002). Most of these vulnerable older Americans would no longer be able to afford these valuable services.

- For the average Medicare home health user, a new 20% coinsurance would require them to pay an additional $1,300 out-of-pocket in 2002. The coinsurance amount for approximately 740,000 Medicare beneficiaries would be **over $4,200** in 2002. This latter group are the very frail individuals who need and use home health care the most, primarily lower income older women.

- Home health users with incomes above 100% of poverty ($7,360 for singles and $9,840 for couples in 1994) would be required to pay a proposed coinsurance. Under the QMB program, the state and federal governments would pay the coinsurance for those with income below these amounts. In reality, the QMB program provides inadequate protection even for those who are eligible, due to inadequate outreach and states' difficulty paying for such an "unfunded mandate." Moreover, new unfunded mandates legislation raise questions about whether states would be required to cover new costs for the QMB population at all.

- The proposal is penny wise and pound foolish because many beneficiaries who could not afford the coinsurance and failed to receive needed services would be forced into nursing homes or hospitals. Those who could afford the new coinsurance would also spend down

onto Medicaid more quickly. State and federal governments would likely end up having to spend much more than they would without the new coinsurance.

Before instituting such a regressive tax under the guise of reducing illusory, unproven overutilization, we hope that the members of this subcommittee will thoroughly explore alternative methods for improving program efficiency that will not inflict such great harm on the oldest, most vulnerable members of our society.

CONCLUSION

Medicare is an extremely successful and popular program that provides essential services for older and disabled Americans. Administration of the program has been more efficient than many think and costs have also been effectively contained, although improvements can be made in both of these areas. Medicare home health and SNF growth rates raise legitimate, serious questions about the operation and administration of these important sub-acute benefits. We would be pleased to work with members of the subcommittee to discuss mechanisms for improving the efficiency and cost effectiveness of the Medicare program.

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

Mrs. Johnson from Connecticut will inquire.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I appreciate your testimony today, but I hope that in the next few months, you will think far more aggressively about how we deal with the problems in front of us.

Mr. Willging, for example, we have devoted enormous resources to trying to weed out fraud and abuse in the medical equipment area and then you see a television investigative report about back braces. I don't know how government can prevent a creative private sector from calling up people and saying, do you have back pain, Medicare covers this, can't we send it to you, and then sending them the $50 version of the back brace or $150, whatever it was, instead of the $10 elastic belt.

I don't see how you can do that through Washington. I think you can do that through integrated systems of care, and I share, Ms. Suther, your concern about HCFA's study of home health and their efforts to adjust for case mix. Our experience in the past is that they cannot adequately adjust for case mix, and if you go to a capitated payment without doing that, the person who is going to be hurt is that isolated senior citizen who has no way of getting some help if they get the wrong service or if the service is denied or tailed off inappropriately because the agency has had a capitated payment.

So I really think we ought to be far more aggressive and creative about how are we going to look at volume and appropriateness through better integration of services at the frontline level.

I do want to pursue specifically though something that is currently going on in HCFA, and that is their decision to require physicians, and I have just gotten one constituent letter about this, but I want to put it on the record and I want to get your response because it is relevant to what we are doing, to document every lab test they require over a base number, I think it is 12. Now, this is a proposed regulation.

Now, particularly for the elderly, and this is the letter I got from a doctor who deals with a lot of people between 85 and 95 who come in feeling tired, well, the problem of documenting those panels, from the point of view of quality of care and also efficiency, this is certainly no way to manage our problem, and if you can shed any insight on what you think we can do better to manage the costs of testing as opposed to this kind of arbitrary bundling and heavily regulatory and redtape oriented solution, I would be happy to hear your comments, Dr. Sundwall.

Dr. SUNDWALL. I appreciate your raising that. I had an opportunity to testify before the Practicing Physicians' Advisory Committee that HCFA convenes periodically and that was especially to comment on this very kind of proposal.

I am a physician and I see patients, and I can't begin to tell you how silly it is, in my mind, to go backward by requiring more paperwork, not less. If I had to sit and write a paragraph about every test beyond the 12 channel that I need to take care of the patients I see, it would add hours to my paperwork, and I don't know how many reams of paper itself.

I think there is a better way and one thing that we have recommended to HCFA is simply to have on requisition forms an attestation, a signature by the physician, that the tests ordered are needed. The physician should be able to determine on a case-by-case basis, considering the patient's clinical condition, and "attest" that the tests ordered are needed for diagnostic and management purposes.

I just don't think we could afford enough regulators to go in and review charts and second guess doctors' judgments. Laboratory data is valuable in making judgments about patients' care, whether they are on medication, whether you are trying to make a diagnosis, or to initiate some preventive service. ACLA's simplest solution to HCFA's perception of need to document necessity was an attestation, some indication that the lab could keep on file. However, we don't think it necessary nor appropriate for HCFA or lab personnel to go into doctors' offices and do more reviews.

Mrs. JOHNSON. The final irony is they will pay physicians $15 for this battery and hospitals $40 for this battery, and it just reminds you that somehow we have to push this system down to the docks and the patients again if we are going to restore access to quality care and control cost.

Any of you who want to get back to us further on thoughts about how we can better integrate care are welcome to do so. We simply have to take a giant step. You recommended some solid baby steps and I appreciate that. In the short term this year, we will certainly need that, but we have to really reverse the terrible trend that was evidenced by this recent ruling by HCFA.

Thank you.

Chairman THOMAS. Gentlewoman's time has expired.

Gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman.

Dr. Sundwall, let's talk about this issue of 20-percent copay for clinical labs. The argument that you make that some of these claims are so small that it costs more to try to collect than the copay you get in is, I think, one for us to look at, and consider. Can you help us with that? Is there a way that we can avoid that problem and yet institute the discipline of the 20-percent copayment on larger claims?

Dr. SUNDWALL. Well, I think that on larger claims, there is an incentive to go after that. We have done some very preliminary analyses (or some of our members have) and the impression is that the administrative costs required to submit those bills, the cost of sending out letters, and then the predictable percentage of nonpayment of the bills sent, means it just wouldn't be in our economic interest to collect the copayment. Coinsurance would simply amount to an additional cut, a cut in payment for lab services.

If there is a copayment that is of sufficient size for someone to go after, it pays for them to invest in the administrative cost to collect it. I think there are other ways to get efficiencies and to make sure there is appropriate use of laboratory services, and those are the things that we are working on with HCFA. I personally believe clinical practice guidelines will help ensure that doctors are only ordering the kinds of tests that are going to be necessary and useful in the patient care.

Mr. McCRERY. Well, do you not see any value in putting at least a portion of the cost on the consumer when it comes to controlling utilization and getting the consumer more involved?

Dr. SUNDWALL. Not when it comes to lab tests. Let me explain. When you are a consumer and you are making a choice about buying something, then it makes a difference. But when you are a patient going to a doctor, I don't think you have much interest in nor an informed perspective about what kind of lab services your doctor orders on your behalf.

It would be the unusual patient, I think, that would engage the doctor in a discussion saying, well, now, do you really need to order that lab test on me because I might have to pay $2 or $3 in addition to what you are going to charge me?

I think that there are instances when a patient really wants that kind of participation, but when a physician believes they need electrolytes tested, or a complete blood count, or a pap smear, I don't think most patients are going to want to talk them out of it in order to save some money.

Mr. McCRERY. Well, again, I am of the opinion that we need to get the consumer—the patient—more involved, and perhaps if we couple medical malpractice reform with a copayment reform, then we will get a better interchange between the physician and the patient; that dialog will take place more often, because you are right, in today's marketplace, it doesn't take place very much at all, if at all. Anything that you can come up with to help us solve your objection about the small claims—which I think is valid. For those of us who want to get the patient more involved in the decisionmaking and in controlling costs generally—would be appreciated.

Dr. SUNDWALL. I appreciate the invitation and I will be glad to get back to you with some ideas.

[No information was received at the time of printing.]

Mr. McCRERY. Thank you.

Thank you very much, Mr. Chairman.

Chairman THOMAS. Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Willging, I wanted to ask you, looking at your chart over there, comparing the skilled nursing facility with a hospital, how much of the health care dollar can be saved by utilizing a skilled nursing facility versus a hospital?

Mr. WILLGING. In this particular area called subacute, Congressman Christensen, that is, services traditionally provided only in the hospital which can be, we now find, provided in a subacute unit in a skilled nursing facility, not all skilled nursing facilities, but those that have geared themselves to subacute, there is a potential savings of up to $9 billion per year. Abt Associates did a study which took 62 DRGs and put together panels of clinicians asking themselves how many of these DRGs really require, as the law specifies, 3 prior days in a hospital before one can move that patient into a subacute unit in an independent nursing facility. They found five DRGs required no hospitalization at all and that would be an automatic savings of $500 million per year if patients were allowed to be admitted directly into a nursing facility.

Of the other 57, they found that most of them did require a hospital stay to stabilize the patient, but that stay required only a day

or two and that they could then be moved immediately into these subacute units. Now, when we are talking about a subacute unit providing the same day of care at commensurate levels of quality for one-third to one-half of the comparable day in a hospital, we are beginning to talk about big bucks and the potential is $9 billion per year, even if you subtract the costs to the hospital of keeping a bed vacant, you are still talking about $7.5 billion per year. Now, that is on the outside, but that is a lot of money.

Mr. CHRISTENSEN. I would be interested in looking at that report. You say that is a study?

Mr. WILLGING. It was completed about 6 months ago. We would be happy to supply one to you, sir.

[Due to its size, the information is being held in the committee files.]

Mr. CHRISTENSEN. Besides the $7.5 to $9 billion that you have just talked about, what other proposals might your industry have for the committee in terms of streamlining Medicare and making it more efficient and saving some dollars?

Mr. WILLGING. Certainly if you want to move beyond the concept of managed care and the use of subacute, which is the big one, there are still numerous others that we have been working with this committee and the Senate on, the development of a prospective reimbursement system, for example, for the SNF benefit.

While hospitals moved to protective reimbursement 12 years ago, the Medicare program still pays on a cost reimbursement system. One, it is inefficient. Two, it doesn't provide flexibility to be able to adapt to the varying needs of the residents, and three, it provides no predictability whatsoever.

We think that is extremely important. There are some arcane provisions in the law which none of us really understand where they came from. For example, a nursing facility may not hire respiratory therapists. We are not sure why. We can hire physical therapists, occupational therapists, speech therapists, but we may not hire respiratory therapists, so if a nursing facility needs to put respiratory therapists on them, it needs to hire them through a hospital with the inevitable billing that the hospital then adds on to the total.

Those are the kinds of fairly obscure regulations that if eliminated would bring immediate cost savings.

Mr. CHRISTENSEN. I wish the members of the last panel were here. I wanted to hear their comments regarding what you just said just to see if they are in agreement or if there is contrary opinion.

Dr. Sundwall, would you have an opinion on those two questions or not, what he has just stated?

Dr. SUNDWALL. Well, I think that, as you have implied, we have to look at a new way of doing business. When it comes to laboratory work, I think the greatest promise really does lie in getting consensus on what is necessary for every stage of a person's life for preventive health or for disease management. That is why clinical guideline development and outcomes research are so important.

But I do want to make a point, and this may sound self-serving, but I don't think there is a whole lot of lab work that is done that is not needed. If you are a patient, you don't want your doctor fly-

ing blind, that is, without information about your body or your health. Lab services are a bargain. They give you a bunch of information about your metabolism, what disease process might be going on, so we don't want to discourage that. What we need to do is make certain that what is ordered is needed.

Under Medicare, I don't think we see overutilization of lab services because we have direct payment to the lab services so the doctor doesn't have a financial incentive to order excessive testing. In fact, like I said in my testimony, where we have States where all insurers bill directly to the lab, the way Medicare requires, you get a lower utilization of lab services because there is no incentive economically to do more than the physician feels like they need. So those are the things I think we need to look at.

Mr. CHRISTENSEN. Thank you very much.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

The gentleman from New York, Mr. Houghton.

Mr. HOUGHTON. Thank you, Mr. Chairman.

I would like to ask a couple of questions. The first one involves technology. Mr. Lehrmann talked about the use of technology, advances in technology in his paper, and yet it seems to me that there is some problem here in some of the working out of the payment schedule, because, you know, it has been urged that new technologies drive down the costs associated with many tests, and I have known this particular instance, I won't give you a litany of those, and yet HCFA for many years pays the costs associated with the old technologies, and I want to know how you feel about that. Now, that is question number one.

The other question is, it doesn't seem in any of the testimony, and maybe even in our questions, that we are really getting at the basis of the incentive to close the gap between the people who pay and the people who receive, and would there be a possibility of considering, and this is a little bit off the wall here, but I ask you, since you are the experts here, to create a system where we could give people a sufficient amount of money to cover them under normal circumstances, just outright, pare that down so it is reasonable, and yet at the same time have on top of that a catastrophic plan so they will not fall off the cliff, any way to create an incentive to pull the costs back and have the people who were involved in receiving the treatment be part of the system?

So those are two questions. Maybe you can—any of you that would like to answer those.

Dr. SUNDWALL. Let me take a crack at the first one. I really think there is a problem with continuing to pay for technologies which may not necessarily be outdated or outmoded, but that have been improved upon.

It seems as though we keep doing additive reimbursement for medical services, whether it be for imaging or various kinds of care. I think that the committee and HCFA might gain some significant savings if they would reimburse only for the most effective technologies without paying for every component of stepwise or additive technologies.

Mr. WILLGING. Let me take a crack at the second. Then I will probably do it in terms of a personal viewpoint rather than representing any particular industry.

I think one of our problems, and this has bedeviled me for years and I have spent 25 years in this town worrying about health care, health care costs, including a stint as Deputy Administrator at HCFA, and the more we have removed the individual, the consumer, the purchaser, and I think this gets to Congressman McCrery's comments about copayment and coinsurance. The more we remove the purchaser from the financial implication of his or her choices for health care services, the more we see the dramatic cost increases we have seen over the past 10, 15, 20 years.

And if one could develop a system, sir, whereby the government is there for some of the major catastrophic events, but relying perhaps a little bit more on the individual consumer or purchaser, and that may be the business, that may be the individual himself or herself, I think we may have a better system.

I do believe strongly that financial incentives are the most critical and impelling incentives we have. And as we take away from the individual who buys the service, who makes the decision, the incentive or the disincentive, I think we find ourselves in the dilemma we are in today.

Ms. SUTHER. I would like to address that also, sir.

I think in the health care industry, we are quite different from all the other industries in the country, or at least the efficient ones, and that is, form follows function in every industry except ours and in government, and in health care, form follows reimbursement, and I think that we have to look at things in a more basic way and look at form following function as opposed to following reimbursement and start over with that system, and again, that is my own opinion, not that of NAHC.

I think that can be done through incentives, both to providers and incentives to users of services.

Mr. HOUGHTON. Mr. Lehrmann, do you have any comments?

Mr. LEHRMANN. Well, one has to look at the program as far as Medicare is concerned. In the first place, why was it devised? Because costs were outstripping what older persons could afford back in 1965, so we reached the point at that time to try and devise a system to put everybody under the umbrella, those over 65 and those that were disabled. I believe it is a system that has been effective over the years.

I think perhaps if there are factors that relate to costs that we are trying to get at, then we ought to look at ways of functioning within the health system for all persons that will bring this to reality.

There are some adjustments that could be made and we certainly think that we could look at some of those as ways of improving the system.

However, to move from that system to a broader approach where you involve individuals, I would have to raise some share of concern because we are dealing with many very elderly people who have limited ability to make decisions, the kind of decisions you are talking about. The kind of competitive arrangements we are talk-

ing about do not exist in many parts of the country, and so we have to be very careful as we take each of these steps.

We also have to take a look at it on a broad base. We have to involve the entire health care system, not just that dealing with Medicare and older persons. If we do that, then let's take a look at the whole thing.

Chairman THOMAS. Mr. Johnson of Texas.

Mr. JOHNSON. Thank you.

Ms. Suther, you talked about how home health care was a tough nut to crack, I guess, and my question is, with all the discussion we have had today, the Florida incident that the IG talked about and the lack of coverage on certain items in areas, is the mandate of Medicare such that it is not sufficiently flexible to take care of new innovations and/or does everybody out there understand when they are filling out the piece of paper to get reimbursed what they are doing? Is there as much fraud out there as they are trying to make believe, or is it that some of the people just don't understand the system when they are filing returns?

Ms. SUTHER. I think it is both. I think there are those that do not understand the system. There are some States that do not have sufficient criteria for running a home health agency and in those States people just simply don't understand the system. I think there is a fair degree of flexibility, and I think that the paperwork has been reduced more in the last couple years than it had in the previous 20.

I think that there is fraud out there. I think it is a minority of providers that are providing fraudulent services. Unfortunately, some of them are large. And unfortunately, the IG's office has not had the manpower to follow up on that. And to that end, our association has been recommending a private right of action under Federal antikickback laws to supplement the limited resources of government enforcement agencies so that in the event that we know of fraud in the industry, we can report that to a private enforcement agency and go against it, because right now if I know of a State case of fraud, I can call the State Medicaid office and that gets taken care of. It gets taken care of immediately. But if I call the IG's office that may not happen, there is so much out there, unless it is an awful lot of fraud, they don't have the manpower to take care of it.

Mr. JOHNSON. Or there is no response from the Federal agency?

Ms. SUTHER. They respond. They just simply don't have the manpower—they put it on a waiting list.

Mr. JOHNSON. How much contact do you have with the IG in HCFA?

Ms. SUTHER. I have contact with HCFA through the association. I chair the Prospective Pay Reimbursement Committee and have worked with HCFA very closely since its inception, even back to the old Social Security Agency and they have been very responsive to the degree that they can respond. HCFA has, within the law, they have been extremely responsive.

Mr. JOHNSON. Are you suggesting that the State is doing a better job than the Federal Government because they have more people? Is that what you are saying? Or are you suggesting that the Federal Government could turn it over to the States?

Ms. SUTHER. Neither. I am suggesting that in Medicaid home care, which is only 1 percent of the budget in the State of Texas, so it is very rare that I would find a case. So that the one case that I may find, there is staff to take care of it.

Mr. JOHNSON. They investigate those homes a lot and have run into some problems with some of them, the elderly care homes.

Ms. SUTHER. In the home care, we don't have but 1 percent of the budget, though.

Mr. JOHNSON. I understand. That is different from what we are talking about.

Ms. SUTHER. Right. And the other thing that could be done, I think is prospective pay. If done properly, that could eliminate abuses and some fraudulent activities as well.

And it is not that we aren't happy that HCFA is doing this study. There are some things that need to happen to that study to make it predictive of cost, because it doesn't make any difference unless you know what makes a difference in cost, it doesn't do any good to come up with a very elaborate regression analysis.

Mr. JOHNSON. Do you find the doctors responsive to you in the home health?

Ms. SUTHER. Very responsive.

Mr. JOHNSON. OK, thank you very much.

Thank, you, Mr. Chairman.

Chairman THOMAS. Thank you, Mr. Johnson.

Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

Let me thank all the witnesses for their testimony. I first want to mention to Mr. Doherty in regards to your efforts and your organization's efforts to curb fraud and abuse, we appreciate very much the suggestions that you brought forward in prior Congresses, and we hope that you will continue to bring forward suggestions from your industry in this area. It has been helpful to us before and I personally thank you for the working relationship that we have had in this area and hope that we will continue it in this Congress.

Mr. Willging, I have a question on the 3-day rule. I have noticed in your written statement that you comment that there are potential cost savings to Medicare if we could have waived the 3-day rule. I have been very interested in this issue. We had some matters put in the last bill that started to go through our committee to start a pilot program in this area. I am just curious as to how much savings you believe we could gain for Medicare if we don't have the 3-day rule requiring the patient first to go into a hospital setting.

Mr. WILLGING. Well, it has been a long saga, as you know, Congressman Cardin, the 3-day rule. It has been our actuaries vis-a-vis CBO's actuaries as to whether one should eliminate the entire 3-day rule.

We argue it would save countless billions and the CBO argued it would cost countless billions, so we learned our lesson and got off of saying eliminate the entire 3-day rule. Rather we sat down and said, let's take a look at just those DRGs which are more appropriately served in the subacute unit in a nursing facility with no 3-day stay or at least less than the 3-day stay, and as I indicated in prior testimony, there is a potential there for up to, I em-

phasize the up to, I don't want to make promises that can't be fulfilled in terms of those total dollars, but $9 billion per year.

When it was enacted in 1966, I am sure the 3-day rule was appropriate, for whatever reason. But as technology has changed and as we recognize that more and more services heretofore provided in the hospital and capable only of being provided in the hospital can now be handled quite easily, not just in the skilled nursing facility, but in home care as well. A ventilator-dependent patient is a very good example. We concentrate more perhaps on the geriatric ventilator. Home care does well with the geriatric patient. These are at-home remedies required given the current state of health care delivery, and yes, there are lots of dollars that can be saved by eliminating, at least selectively, the 3-day rule.

Interestingly enough, that does not require legislation. The Secretary of the Department of Health and Human Services has the authority today to immediately waive all of or at least selectively the 3-day rule.

Mr. CARDIN. I have written the administrator a letter urging him to move forward on at least some pilot demonstrations. I agree with you, I think there are tremendous savings here.

It just doesn't make sense to impose this requirement where you can receive the care in a less restrictive environment that is going to save money and it is going to be better for the patient. We should at least be willing to experiment and move forward in this area, and I thank you for your great help in that matter.

Mr. WILLGING. We thank you for your help too, Mr. Cardin.

Chairman THOMAS. I too want to thank the panel. I think it is the clear understanding that what we need to move into is more of a seamless continuum of care.

Technology has allowed us to do a number of things for individuals in the home or in a less costly facility than we have in the past. We simply haven't availed ourselves of it, and Dr. Sundwall, I hope that the water doesn't rise too much higher before we can make sure that it doesn't rise at all in terms of a change in the structure.

The point that you folks didn't stress that I think we need to talk about, and clearly we are talking about dollars and cents, and this is the Ways and Means Committee, and we are looking for ways to save money in the system, but we need to refocus our attention on the individuals who are receiving the services as well, and that is that there is a quality aspect here, if we can sort out the funding situation on that continuum of care, in which people are receiving better care in places that are more meaningful to them, hopefully more and more in the home.

One of the things that I think all of us have to understand, Mr. Lehrmann, and I appreciate your testimony, we are faced with a part A hospital trust fund that is now contemplated going broke in 2003. We have removed all of the limits off of salaries and wages. We now tax all of the money that people make in this program, and that we are now going to have to focus, if we are going to get more money, on increasing tax rates, and that is people who are working that are paying for that.

On the part B, as you know, 75 cents out of every dollar comes from the general fund, taxpayers paying into the general fund.

Medicare, as you in your testimony focused back on in the midsixties, I believe anticipated a 50/50 split between the beneficiary and government. It is now at 75 cents on the dollar paid for by the general fund.

All of us are concerned about those folks at the lower end of the income, the 100 or the 150 percent of poverty level, or the 200 percent of poverty level, but I think by the time you reach 1,000 percent of the poverty level, or 1 million percent of the poverty level, that we ought to begin talking about perhaps this isn't the best allocation of the taxpayers' dollar for people who can clearly take care of themselves.

But the failure to focus on where the money is being spent and who it is being spent on by virtue of arguing about widows at home on SSI, I think, has allowed us a misallocation of resources, and I hope you will join with us as we go forward in trying to rethink this program that we are going to do it with sympathy and understanding, but changes are going to have to be made, otherwise we are looking at a bankrupt program, and more and more dollars from the general fund going to millionaires in retirement, and I think you will agree that is wrong.

Mr. LEHRMANN. I understand what you are saying and I think that in the process of looking it over, we have to see where all of this fits into the overall picture in terms of how much those individuals paid in initially into the program while they were still being employed, and then what they are paying in now in terms of the taxes that they pay to support the program.

So we are familiar with that and that is what we have to take into consideration.

Chairman THOMAS. And as we move forward in integrating the program, I think the Tax Committee, Ways and Means Committee, can play a vigorous role in beginning to blend what clearly now are supposedly separate views, that is, medical care for the elderly, a lot of the long-term care for the elderly is not really medical.

We are moving in the Contract With America some changes in terms of insurance policy, but there are so many categories for dealing with these and methods of funding that it is, I think, Mr. Houghton said in the middle of it, it is a very complex and difficult area to get your arms around.

We need to do it because of the funding, but I think fundamentally and more importantly, we need to do it to make sure that folks who deserve these kinds of services aren't in fear of losing them.

We believe, as you do, there are models in the private sector that will give us some examples. In the area of fraud, I believe all of us believe we are dealing with not just a minority, a significant percentage of the minority, and our job is to make sure that those people don't define the field for us, and I want to thank all of you for your testimony and look forward to working with you as we try to move legislative solutions to these common problems.

Thank you very much for your attendance.

[Whereupon, at 2:27 p.m., the hearing was adjourned to reconvene on Tuesday, February 7, 1995 at 2 p.m.]

INCOME RELATING THE PART B PREMIUM OF MEDICARE

TUESDAY, FEBRUARY 7, 1995

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

The subcommittee met, pursuant to notice, at 2:08 p.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

Chairman THOMAS. The Health Subcommittee will come to order, please.

Today, the Health Subcommittee continues its examination of Medicare policy with today's hearing on income relating the part B premium. The subcommittee's task is to answer two questions: One, should taxpayers who now fund more than three-quarters of the cost of Medicare part B benefits through the general fund revenues subsidize other Americans who can well afford to pay more of the tab for their own care. And if the Congress should relate part B premiums to income, what are the design issues raised for such a change in the law.

Currently, almost all Americans entitled to Medicare enroll in part B. They pay a monthly premium which currently is $46.10, and receive coverage for 80 percent of the cost of physician and other outpatient services after they satisfy an annual deductible of $100.

All Medicare beneficiaries pay the same part B premium and all receive the same benefits. This is a one-size-fits-all program, without regard to the income or means of any individual enrollee. This may have made sense in 1965 when beneficiaries paid half the cost of their part B benefits and the other half came from the general fund.

However, today, $46.10 covers less than 30 percent of the per beneficiary cost of the part B, and this number will shrink to 25 cents on the dollar in 1996, and even lower after 1997. Eventually, if you carry that out, the premium payers will contribute 8 cents or less on the dollar to the cost of their part B benefits, and the taxpayers of the future, our children and grandchildren, will have to pick up the rest, if they can.

Furthermore, Medicare part B has grown by 26 percent since 1980, and it will cost more than $205 billion by 2005 or almost 2 percent of the Nation's entire gross domestic product.

Medicare part B, despite the cost sharing with the beneficiaries, is a major contributor to the deficit and, therefore, without

changes, a major impediment to balancing the Federal budget in the next 7 years.

It is also worth underscoring that the financing of Medicare part B is fundamentally different from the funding of Medicare part A. With few exceptions, Americans earn the right through the payroll taxes they pay to draw on the part A trust fund when they reach 65. So part A is an entitlement we earn during our working years for the right to participate in part A.

Part B, however, is a privilege subsidized heavily by the nonelderly taxpayers for the elderly. The public, it seems, also senses the need for the well-to-do elderly to pay a greater share of the cost of Medicare. A Kaiser Foundation-Harvard 1994 post-election survey reports that fully 71 percent of the voters in the last election support "having people over 65 who earn more than $50,000 a year pay more for Medicare than other seniors." Interestingly, the result showed those who voted for Democrats in House races felt even stronger about income relating Medicare than did Republicans.

In light of these facts, this subcommittee must address reforming the finance policy of Medicare part B. Of course, in reform of the financing of part B, we should not add to the burden of elderly Americans who live from Social Security check to Social Security check with a fixed income from whatever savings and modest pension they may have accumulated.

Nevertheless, the framers of Medicare did not envision that the part B benefits would be such a huge drain on the general fund or that the average taxpayer would be expected to foot the bill for such a large share of the costs of care for well-to-do Americans.

President Clinton recognized the need to address this issue last year in recommending in his budget and health reform plan the income relating of part B. Members of both the House and the Senate also introduced legislation in the 103d Congress which would have limited the taxpayer subsidy for part B for those well-to-do elderly enrolled in Medicare. It is time to consider these proposals again.

The President has been supportive of income relating part B. However, in the President's most recent budget, there was a reluctance to exhibit any kind of leadership role on new or novel plans. Secretary Rubin said in front of the full Ways and Means Committee this morning that, despite no specific proposals, the President wanted to be partners with the Congress. My feeling was that partners was similar to my wife and I in moving furniture, that is, she wants me to do the heavy lifting and she will tell me where to put it.

Congressional Republicans and Democrats have supported means testing. Today we will hear testimony which indicates why it is important and how best to structure this new Medicare financing policy. Today's hearing offers an opportunity to revisit this reform.

It is important to emphasize, however, that if we income relate part B, it is only an incremental step in Medicare reform. It is no more than a downpayment on the transformation of Medicare, which is our mandate for this year.

Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

I take to heart your remarks about the President's lack of direction, but at least he was going in one direction, unlike the Republican proposal before us, which takes us in two or three directions at the same time. And if it does not utterly confuse my colleagues in the Legislature, it will drive the senior citizens in this country nuts trying to figure out what we are doing.

I will tell you very quickly a story. I am not sure as to its truth, but it describes the point I am about to make. It is a story of the shipyard workers of Mare Island in Vallejo, Calif., who were working on both ends of a submarine tied up at the docks at Mare Island. They like to have it level so that their coffee did not spill. One of the welders in the front would let a little water in the ballast, and they would go to lunch and somebody in the back end would let a little water in the ballast. After 2 or 3 weeks, the last guy let a little water in the ballast and the whole submarine sank.

That is exactly what the Republicans are doing here as they fiddle and faddle with Social Security. Now, we have heard that it is part of the Contract to lower the tax on Social Security benefits from 85 percent to 50 percent on the wealthier Social Security beneficiaries. A great idea. My mother is all for it. I shortly will be all for it.

On the other hand, as we giveth with the left hand, we are now having a hearing today to take away from exactly this same group money by raising their Medicare part B premium. I will give you an example from this committee's minority—the Republicans of last year in their program in the health reform package. If you had a couple with $120,000 a year, we would decrease under the Republican proposal this year their income tax by $1,400 and increase their part B premiums by $1,650.

Now, I ask you, does that make any sense? Could we not just deal with one or the other and not raise or lower? And the real sad effect is this: The amount we lower the Social Security tax by, if we repeal the 1990 act, if that is what it was, comes out of the Health Insurance Trust Fund part A, and everybody is complaining, most loudly Mr. Gingrich, that Medicare is going broke. He takes the money out of the trust fund when he cuts the tax on part A, and then raises the tax on part B and that goes to the Treasury and not into the trust fund.

I would suggest that we wipe the slate clean and start over. If our intention is to lower the taxes for the richest of the rich in Social Security, let us do it. If our intention is to punish them and raise their Medicare premiums, let us do that. But for heavens sake, let us not compound what Rush Limbaugh already tells the public that we do not know what in hell we are doing and that we are raising taxes on one end, lowering taxes on the other, and speeding the bankruptcy of the Medicare trust fund. It makes no sense.

Mr. KLECZKA. Would the gentleman yield?

Mr. STARK. I would be glad to yield.

Mr. KLECZKA. I just wanted to make a comment on the Chairman's contention that the President is not being a partner in deficit reduction and is not looking for ways to cut back on the deficit.

I recall that about a year and a half ago the President brought in a very bold plan before Congress. It was Republicans who left

the room and left all the heavy lifting of the couches to the Democrats and the President. Now that they own the home, they want us to continue the heavy lifting while they still take a walk. No deal, Mr. Thomas.

Mr. STARK. Reclaiming my time, I just want to say that I could support—and we are about to hear from my former colleague on this committee, the distinguished Senator from New Hampshire who I think was the originator of the idea of income relating the premiums in the catastrophic bill of such great fame.

Now, we could do that again, or we could cut taxes for Social Security. I am just suggesting, Mr. Chairman, let us make up our minds which we are going to do and get it straightened out and not confuse the American public, and certainly not confuse the seniors, and hopefully not this Member of Congress.

Thank you.

Chairman THOMAS. I appreciate the ranking member's willingness and commitment to move forward together.

I would tell the Senators in front of us that we have just had our second bell. If you will indulge us, we will run over and vote and be right back. Senator Kerrey, the Congressman from your State would very much like to participate in the introduction. Senator Gregg, if you will bear with us, we will be right back.

[Recess.]

Chairman THOMAS. The subcommittee will be in order.

Our first panel consists of Senator Judd Gregg, the former Governor of New Hampshire, as well as Senator, but, more importantly, a former member of this committee and a seatmate of mine, and Senator Kerrey from Nebraska.

Before I turn to my colleague for the introduction of Senator Kerrey, I want to thank you in terms of your time and commitment on the Kerrey-Danforth Commission. You thought thoughts that absolutely needed to be thought. More importantly, a lot of people are thinking you folks verbalized them and tried to do something about it.

But for a more personal and knowing introduction, I will turn to my colleague from Nebraska, Mr. Christensen.

Mr. CHRISTENSEN. Welcome, Senator Kerrey. I appreciate your testimony today and I wanted to extend a personal invitation to you. As the former Governor of Nebraska and as U.S. Senator from Nebraska, you have always been in the forefront on health care reform. As a businessman from Nebraska, you understand the problems that employers face in providing quality health care for their employees.

As the Chairman stated, recently you headed up the Kerrey-Danforth Bipartisan Commission on Entitlement Reform. You heard countless hours of testimony on the challenges this country and this committee faces in terms of transforming the issue of Medicare.

While we do not always agree on the solution or the method, I know we both have the interests of the Nebraskans and Americans at heart, and I appreciate your work in this effort. I look forward to working with you on this issue, and I look forward to hearing your testimony today.

Senator KERREY. Thank you, Congressman.

Chairman THOMAS. Thank you.

I will tell both Senators that your written statements will be made a part of the record in their entirety, without objection, and you may proceed any way you see fit.

STATEMENT OF HON. J. ROBERT KERREY, A U.S. SENATOR FROM THE STATE OF NEBRASKA

Senator KERREY. Thank you, Mr. Chairman.

I do have a statement that, as I look at it here, more closely resembles either a doctoral thesis or the President's State of the Union Address. I do not know which one. I do not think you want to hear something that long.

Let me try, as I almost every time have been asked to speak on this, to try to describe the problem in a fashion that would stand some possibility of us coming together and taking some action.

First of all, I am pleased to be here with Senator Gregg. I do not believe that this is a problem which we are going to be able to solve, unless we begin, Republicans and Democrats coming together saying we both support Social Security, we both support Medicare, we are not talking about damaging or hurting seniors and so forth. We have got to come and put the political swords at the door, otherwise all hope is lost.

Second, what we tried to do with our commission was not so much solve a short-term problem as solve a long-term problem. Chairman Greenspan came to the commission and said a very important thing, which is that interest rates are a signal of what is going to happen in the future. They describe what the market thinks is going to happen in the future.

Senator Danforth and I heard from economists with our proposal which solves the future problems, say that if the Kerrey-Danforth legislation were to pass, if we were to change our law to solve the problem the way that we described, that interest rates, long-term interest rates would fall by at least 2 percentage points, and maybe as much as 4. And you could get economists that would come, I believe, and people who have studied monetary policy and they would come and say the same sort of thing.

The third thing is that this is a problem that can be solved by any ideological orientation. Whether you are a Liberal or a Conservative or a Moderate, it does not matter. You can still solve the problem. But you will not solve it, if you do not acknowledge the problem exists. If you start off by saying there is no problem, then there is no argument, because what you do then is you are reduced to accusing each other. I accuse Chairman Thomas of being insensitive, and Chairman Thomas accuses me of being insensitive, and we fill the air with political rhetoric.

Any ideological orientation can solve this thing. You can come and say I am for tax increases and, thus, I am going to propose a tax increase, you can say I am not for tax increases, which Senator Danforth and I did. We proposed going on the spending side. But you can come and solve this problem with any ideological orientation.

I suggest, as a consequence of that, the most important thing for us to do is to try to convince Americans that there is a problem. What I tried yesterday to do in response to the President's budget

is the following, to say that the Entitlement Commission did make a recommendation. The myth in the city is that the Entitlement Commission failed to make any recommendation. That is not true.

We did make a recommendation, and the most important recommendation relevant to our discussions here today I think is that if you look at the future for 5 years, everything looks fine. If your view of the future is a 5-year window, the world looks OK. But if the view of the future is a 30-year window, it does not look OK. There you begin to see, as a consequence of demographics, not Ronald Reagan or George Bush or Bill Clinton, but demographics where we have an unprecedented—and I emphasize this, because lots of people are under the impression, well, we have had this problem in the past and we will just come in and fix it as we have in the past.

From the year 2010 to approximately 2025 or so, in roughly a little more than a decade, the number of Americans over the age of 70 will go from 14 million to 28 million. Now, that is not something we have difficulty predicting. Some say, well, you cannot predict 30 years. That is not true. That is a fact. The number of workers per retiree is going to go from 5 to 1 to 3 to 1. There is an unprecedented change on the horizon out there and it is getting closer and closer, and the longer we wait the more likely it is that we will not be able to give people an opportunity to plan.

Key in the Kerrey-Danforth proposal was that most of the changes that we recommended making, with the exception of the changes in congressional retirement which we felt were appropriate, so we could say we are leading by example, are phased in over a very long period of time. But the longer we wait, the less chance is we will be able to give people a chance to plan for the changes that we are proposing.

But unless we can get Americans to look at this long-term problem, unless we get Congress to say that our Budget Act is inadequate—our Budget Act says 5-year budgeting. Well, it is like me saying it is February 7, for the next 5 days my cash flow is pretty good, but the end of the month I have got a lot of bills coming due. Well, the same is true with us. At the end of a 25-year period, we are looking at a problem that really makes it awfully difficult for us to say that we are not hypocrites when we talk about our children and our grandchildren, if we want to ignore what is going on now.

I want to be clear about this. The testimony lays out the details of the proposal and it is almost too hot to handle the testimony, because people say, oh, my gosh, you are delaying the age, we means test part B, we put a premium on part A. I mean there are a lot of changes in here that are controversial and difficult.

We proposed to actually reduce the employee payroll tax by 1.5 percent, establishing a mandated IRA, because we think that the federally operated retirement programs, Social Security mostly, are important and valuable, but Americans need more than just that and have begun in fact to expand consideration to say we need to look at changes in ERISA and our retirement regulation and tax law, because we may have encouraged businesses to decrease the number of defined benefit programs. We are trying to make change that solves the retirement problem that people have.

But even with all those controversial changes, even with everything that we have got on here, to be clear, we do not balance the budget. All we do is balance the promise that we have on the table today. One way of describing this—and I will close—is that the U.S. Government and we on behalf of the American people operate the two largest insurance companies in the world. Social Security and Medicare are social insurance programs, and we have a fiduciary responsibility not to take a 5-year view. We would shut an insurance company down that only took a 5-year view of what their liabilities are.

We have 30 years of liabilities and more, and when you look at the 30-year liability for Social Security and Medicare, it is inescapable, it seems to me, that we begin as soon as we can politically do it, begin to make some changes in our law that bring those entitlement accounts and bring those Social Security accounts into actuarial balance so that we have intergenerational equity, so that the promises that we have on the table we know that we can reasonably keep.

I do not know if this second, third and fourth shot of trying to explain this has been any more persuasive or any more clear than I have had in the past.

Mr. Chairman and members of the committee, I appreciate your interest in this issue. I pledge to you as a Democrat that I intend to work with Republicans like Senator Gregg and Senator Simpson on the Senate side that are interested that want to try to solve this problem, because I believe there is an urgent necessity to do so. And I believe the future will reward us with a round of applause, if we do.

Thank you.

[The prepared statement follows:]

Testimony of Senator Bob Kerrey
Before the House Ways and Mean Committee, Subcommittee on Health
February 7, 1995

I appreciate the opportunity to testify today, Mr. Chairman, on the subject of income relating the Part B premium for Medicare and the broader issue of entitlement reforms.

I have supported income relating the Part B premium for Medicare as part of Kerrey/Danforth recommendations for the Bipartisan Commission on Entitlement and Tax Reform and in other legislative proposals such as the Kerrey/Brown amendment I offered last year with a bipartisan coaltion of Senators and the Mainstream Coalition health care bill. However, income relating the Part B premium for Medicare, while a good start, does not solve either the entitlement problem, the problem of rising health care costs or the more general question of access to health care services. It only gets us 3% of the way to solving our entitlement problems. We still must address the remaining 97% of the solution. Federal health spending has been increasing at annual rates averaging 10 percent or more during the past five years. According the Medicare Trustees, the Hospital Insurance, (HI) Trust Fund is projected to be insolvent by the year 2001. In the long run, spending on Medicare and Medicaid will triple as a percentage of the economy by 2030. Clearly we must make some changes in both health care and retirement entitlements.

Before discussing some of my recommended changes, let me describe what necessitates them.

The American population is aging in a way that requires us to rethink the structure of our entitlement programs. Our two largest entitlements, retirement and health care, were designed as systems in which each generation of workers would pay taxes to support the generation of retirees that preceded it. In return, each generation expects its successor in the work force to support its benefits.

The system succeeds, provided that each generation has enough children to grow up and pay the taxes that support its benefits. Mine, Mr. Chairman, did not. Today there are nearly five workers paying taxes to support each retiree; when my generation retires there will be fewer than three. And as life expectancies continue to expand, Americans will collect more in lifetime benefits.

Quite plainly the arithmetic does not compute. We will be able to support the aging population without immediate consequences for three decades because we have built a massive surplus in the Social Security Trust Fund. The closer it gets to bankruptcy, the more excruciating our choices become. Should it reach bankruptcy, our choices will be severely restrained: either slash benefits dramatically for that one retiree or raise taxes dramatically on those three workers. These numbers are not pulled from thin air; they are documented by the trustees of the Social Security and Medicare systems.

And our retirement entitlements are in much better shape than health care. However, health and retirement programs for seniors are inherently related. Therefore, it does not necessarily help seniors to "take Social Security off the table" while allowing health care costs to increase and making indiscriminate cuts in health programs. Let me also describe some dates at which crucial changes in our entitlement programs will occur.

The first is in 2001, when the Medicare hospital insurance trust fund, soaked up by an aging population and escalating health care costs, goes bankrupt.

The second is in 2008, when the Baby Boomer generation begins to retire. In a single decade beginning at that moment, our overall population will creep up by 2 percent while our retired population skyrockets 30 percent.

In 2012, spending on entitlements and interest on the national debt will consume every dollar we collect in taxes, leaving literally nothing for defense, infrastructure, law enforcement or any other function of government.

If those dates seem too distant to merit attention, consider a figure in the here and now: In Nebraska, we have about 275,000 retirees and another 275,000 children in kindergarten through the 12th grade. We spend $1.3 billion of revenue on our kids and $4.5 billion retirees. More ominous, our spending on children increases $50 million each year; our budget for retirees expands at a rate eight times that fast.

Fixing these problems and building a better future is a challenge because it requires those of us whose occupation teaches us to think in two-, four- and six-year cycles to think instead in of decades and generations. Many of the benefits of entitlement reform will take hold in our economy years after most of us leave this institution -- as will the consequences if we fail to act.

If our political cycle teaches us to think in terms of six years at the most, the myopia of our budget cycle is worse. As families across America evaluate their finances over decades, planning for education, for retirement, for health care, their government looks five years into the distance and then turns its eyes away. The most important recommendation of the Bipartisan Commission on Entitlement and Tax Reform may be the need to expand our budget cycle to include the consequences of our actions 25 and 30 years out.

The other reason entitlement reform is difficult is that entitlements are misunderstood. Politicians turn a cloudy situation downright muddy by intentionally describing entitlement programs inaccurately.

We hear it time and again: "Social Security isn't a problem. It's self-funded." Well, yes. Today Social Security is self-funded with a 12 percent tax on every working American. Tomorrow is a different story. Tomorrow 12 percent won't cut it.

We distort our health-care entitlements as well. I do not exaggerate, nor do I consider it funny, that I could have scored points in my recent re-election effort by promising to keep the federal government out of Medicare care despite the fact that we have, through Medicare, taxpayer-financed national health care for every American over the age of 65.

And while I do not accept the rhetoric of those who describe entitlement reform as a process of pain rather than an opening of opportunity, the fact remains that it is also difficult because it requires us on occasion to utter one of the most uncomfortable words spoken in this city: "No."

We have, Mr. Chairman, all the excuses we need to postpone action. Let me give a few reasons for acting today.

The first and most important is that it is relatively easy to fix the problems today; tomorrow the fixes will be draconian.

The second is that taking action today means we can fix the problems with little or no impact on current retirees.

The third is that planning for our national future today also means we can give workers today time to plan for the changes.

Understanding the problem, what do we do to fix it?

There are several options outlined in the report of our commission and I would be remiss if I did not salute those who had the courage to submit their own ideas. They had much to lose and nothing to gain by doing so.

I want to describe today some ideas laid out in this document by former Senator Jack Danforth and me.

LEADING BY EXAMPLE

We began with the premise that Congress must lead before asking the American people to accept entitlement reform. For that reason, the Kerrey-Danforth proposal would cut in half the rate at which members of Congress accrue pension benefits beginning in 1996. Also in this spirit, we would bring retirement programs for federal workers more in line with private pensions.

Other proposals offered in the spirit of putting the government's house in order first include:

- Raising the federal retirement age to 62. This proposal would gradually phase out eligibility for unreduced benefits for Federal workers before age 60. Beginning in 2000, for workers with at least five but fewer than 20 years of service, the retirement age for unreduced benefits for both CSRS and FERS would be increased by four months each year until it reaches age 62 in 2020. Workers with between 20 and 30 years of service would continue to be eligible for unreduced benefits at age 60. EFFECTIVE DATE: JANUARY 1, 2000.

- Adjust CSRS and FERS benefit formula to "high-five" pay. The benefit formula for both CSRS and FERS would be adjusted by changing the salary base from the employee's highest three consecutive years of pay to his or her highest five years. EFFECTIVE DATE: JANUARY 1, 2000.

- Reduce the rate at which military retirement benefits accrue from 3.5 percent to 2 percent of basic pay for retirees with more than 20 years of service. This proposal would reduce the addition to retirement pay for each year of service after 20 years from 3.5 percent to 2 percent per year. It would also drop the one-time increase in retirement pay at age 62 of 10 percent. It would retain the CPI-minus-1 percentage point COLA that applies until age 62 and the one-time COLA adjustment at age 62. I emphasize that this provision applies only to military personnel hired after August 1, 1986.

- Adjusts Consumer Price Index (CPI) calculation to better reflect inflation.

Mr. Chairman, this is a key provision that has spent a great deal of time in the news lately. A number of federal programs are adjusted annually based on annual increases in inflation as measured by the CPI. The CPI is based on a "market basket" of goods and services purchased by a representative urban worker. Adjusted every ten years, the current market basket was last revised in 1987, using data for the period 1982 to 1984. As a result, the CPI does not capture dynamic annual changes in the pattern of consumer preferences. In addition, the CPI may not adequately measure the consumer benefit derived from improvements in the quality of existing goods or from the introduction of new goods. A number of economists, including those in the Bureau of Labor Statistics, have expressed considerable concern that the current CPI calculation overstates inflation. This proposal would require the Bureau of Labor Statistics to modify the CPI formula to more accurately reflect changes in the cost of living. This change would take effect in 1998 and save

a substantial amount by bringing annual Cost of Living Allowances better in line with inflation.

PRESERVING AND STRENGTHENING SOCIAL SECURITY

A chief goal of the Kerrey-Danforth proposal is fulfilling our promises to today's retirees while ensuring the long-term health of Social Security. I have already described the challenges that face this system.

Our proposal for redressing it is, I believe, among the most exciting in the Kerrey-Danforth plan. We propose reducing the payroll taxes of today's younger workers by 1.5 percent in exchange for a revised long-term contract. It shifts more responsibility, and control, to the individual, provides opportunity for higher returns on investment, and allows us to return Social Security to its intended purpose: as a supplement to personal retirement savings. Let me be clear: No reductions in Social Security benefits affect anyone over the age of 50 and no Social Security reductions are used to reduce the deficit. The savings we proposed to Social Security would go back into the Trust Fund and strengthen the program.

We would require these younger workers to invest the savings from the payroll tax cut in a mandatory IRA-type personal savings account.

The proposal has important economic benefits. Countries that save and invest more grow faster and have more rapid improvements in the standard of living of their citizens. Private savings in the United States have fallen from more than 8% of the economy in the 1960s, to about 5% today. The Kerrey-Danforth proposal takes an important step toward reversing this trend.

More exciting, though, is the fact that this proposal gives workers more control over planning for their own retirements by transferring authority for these investments from the government to the individual. The return on these savings provides workers the potential for far more in lifetime benefits than they can expect from the Social Security system if it continues on its current course. This is, Mr. Chairman, a middle class tax cut with both a purpose and a payoff.

We also propose, over a period of 30 years, to raise the age of eligibility for full benefits from 67 to 70 while still allowing partial benefits at age 62. This option accelerates the phase-in to age 67 that is already in current law. The age for full eligibility will reach 70 for those under age 28 today. No one currently over 50 would be affected.

Let me address a great misunderstanding about the previous two proposals. The term we use to describe the age at which Americans are eligible for full benefits -- the term, "retirement age" --is misleading. Americans do not want to retire at age 70; if anything, they want to retire earlier. They cannot do so, Mr. Chairman, they cannot mathematically do so without a substantial pool of private savings. The previous two proposals, therefore, are designed to increase the individuals' control over when they retire. Make no mistake: the age at which Americans retire is set by economics, not statute. A low statutory retirement age means nothing for those who lack the savings to enjoy it.

Our other proposals to restore solvency to Social Security include:

- Including State & local workers in Social Security program. Starting in 2000, new workers and those with five or fewer years of service would be required to participate in the Social Security program.

- Indexes the Social Security "bend points" for CPI instead of average wage growth. Effective for new recipients only, beginning in 1998, this proposal would index the "bend points" in the benefit formula for inflation as measured by CPI instead of adjusting them for average wage growth. This proposal would adjust the benefit formula to more accurately reflect inflation.

- Reduces growth of benefits to mid and upper wage workers using the 3rd bend point. This proposal would modify the benefit formula over a 50-year period beginning in 2002, gradually reducing the growth in benefits paid to workers with average and above average earnings. No person age 55 or older would be affected, and in the first two decades after it takes effect, the impact would be minimal. EFFECTIVE DATE: JANUARY 1, 2002.

- Adjusts CPI formula to better reflect inflation.

HEALTH CARE AND OTHER ENTITLEMENTS

Many critics who oppose reforms of Medicare point, correctly, to the fact that much of the increases in this program are due to escalating health care costs. This concern ignores at great peril the fact that in addition to higher health care costs, our health care entitlements are growing because more Americans are retiring and taking advantage of them. The fact is that Medicare spending will continue to skyrocket due to an aging population even if the growth in health care costs is -- in what would be a certifiable miracle -- held to the rate of inflation. To address the escalating health care costs, we propose giving retirees the option of using the funds they would normally receive in Medicare compensation to enter managed-care programs that provide incentives to control costs and may provide better coverage. This would give seniors more options and would insert market incentives into the systems.

The Kerrey-Danforth proposal also fairly and evenly controls the growth of all entitlement programs by doing the following:

- Use adjusted CPI to better reflect inflation. The same proposal described above would apply to veterans' compensation.

- Means test Medicare, veterans compensation & unemployment insurance. This option would be phased in over five years, starting in 2000. The sum of income from government payments, earned income, and unearned income would determine the rate of benefit reduction for these three programs. The option would gradually reduce benefits for families with incomes over certain thresholds. For example, reductions would start at 10 cents for each additional dollar of income between $40,000 and $50,000; rise to 20 cents for each additional dollar of income between $50,000 and $60,000; and increase thereafter up to 85 cents for each additional dollar of income above $120,000. Regardless of income level, all beneficiaries would continue to receive a benefit, albeit reduced for those with less need. This proposal, I believe, is both fair and necessary.

- Cut other entitlements by 10% in 2000 and cap their growth accounting only for inflation and population growth thereafter. This option would require a 10 percent reduction in all other entitlements from the 1999 level of spending -- about a $20 billion cut). Programs affected include Food Stamps, AFDC, veterans pensions and compensation, farm price supports, and unemployment compensation. EFFECTIVE DATE: FY2000.

Although Senator Danforth and I did not include a recommendation on overall health care reform, I personally believe that the eligibility for health care should be radically changed. I would prefer a system where you became eligible if

you satisfied one of two things: You are either an American citizen or you are here legally. If you satisfy those two things, you are eligible immediately. You do not have to get blown up in a war as I did, you do not have to wait until you hit the age of 65 as we have with Medicare, you do not have to prove that you are poor or remain poor as we do with Medicaid, and you do not have to trust that your employer will provide you with your insurance or that you won't lose your job and find yourself without health care. We ought to simply say, if your an American or here legally, you are eligible. We also need to follow immediately and say that the only way I can write that contract, the New Covenant as the President describes it, is if you an individual accept the responsibility to pay according to your capacity to pay, and agree to participate in a personal way in cost control. If you do not agree with those two things, then we can't write the contract. But if you agree to do those two things, then I think we can dramatically and radically alter the way we have become eligible. And there is agreement by the way, between Democrats and Republicans who are approaching this issue of health care that would be a reasonable thing to do.

TAX EXPENDITURES

Mr. Chairman, I have described problems and solutions for our two largest entitlements, retirement and health care. The third largest is tax expenditures. The Kerrey-Danforth plan proposes adjustments in the tax code to ensure that the code accurately reflects changes in our economy. We also propose limiting "tax entitlements" in a fashion that makes the tax code more progressive. While I regret that the Commission did not have the time to fully examine our tax code and make recommendations to simplify the code and retool it to promote savings and investment, I believe these changes are imperative and look forward to working toward this goal.

The Kerrey-Danforth plan would:

- Limit itemized deductions to 28%. Itemized deductions would be limited to a rate of 28% regardless of the marginal tax rate applicable to the taxpayer. This would only affect taxpayers whose incomes exceed $91,850. EFFECTIVE DATE: JANUARY 1, 2000.

- The readjusted CPI described above would apply to income tax brackets, standard deduction, and personal exemptions.

- Cap employer-paid health insurance deduction. This proposal, phased in over five years starting in 2000, would limit the amount of employer-paid medical insurance and medical care that may be excluded from an employee's income for income tax purposes. The cap would be based on projected average health insurance premiums.

Mr. Chairman, we offered these proposals, and I describe them today, as a starting point for discussion. I look forward to seeing them criticized, analyzed and improved. I look forward to hearing ideas from others.

The most important thing is that the debate begin in earnest today.

Thank you for giving me the opportunity to discuss the Commission's findings and my recommendations for solving the problem.

Chairman THOMAS. Thank you very much, Senator Kerrey.
Senator Gregg.

STATEMENT OF HON. JUDD GREGG, A U.S. SENATOR FROM THE STATE OF NEW HAMPSHIRE

Senator GREGG. First let me say what an honor it is to have a chance to speak before this committee, having served on this committee and maintaining immense respect for what you do and the work that you have, and especially the work that you have been participating in over the last month or so. It is a pleasure to have a chance also to testify before a committee which I formerly served on.

It is also a pleasure to be testifying here today with Senator Kerrey, who I have immense respect for, who has really carried a very heavy load in a rather lonely trek, which is the load of addressing entitlement spending in our Federal budget. I respect him for it for a variety of reasons.

He is obviously a hero on the physical side from his own personal experiences, but really on the political side he is even more of a hero, in my opinion. He did this while he was running for reelection. He took on the sacred cows and addressed the core issues involving questions like benefits to senior citizens under Social Security and Medicare, and he deserves an immense amount of respect for it.

The Kerrey-Danforth Commission report is an excellent report, because it defines unequivocally what the problem is, and the problem is, as Senator Kerrey has pointed out, that if we do not do something about entitlement spending and specifically about those spending accounts which involve health care in the short run and Social Security in the long run, that we as a Nation will pass to our children a bankrupt country. There is no question about it, we simply cannot afford to maintain the cost of our government, unless we address the cost increases which are driven primarily by demographics, and demographics are undeniable.

You folks are charged with the narrow band of addressing this issue, or in the hearings at least have picked a narrow band of addressing this issue and ask the question of affluence testing the premiums under part B. This has to be done, if you are going to maintain the present Medicare system.

I would like to argue in a few minutes that maybe we should take a look at a broader reform that would eliminate the part B premium altogether, but there is no question, and I think there is general consensus, and if there is any honesty and integrity, it will be passed as a piece of legislation in this Congress that high-income individuals should not be subsidized by moderate- and low-income individuals.

Why should John Jones or Mabel Smith who are working 40 or 50 hours a week at the local restaurant or on an assemblyline be subsidizing my father or the father of Congressman Stark—I am not sure if his parents are still alive, I guess his mother is—or anybody else who has got significant personal income under the part B premium process. But that is what is happening today and it is not right, it is not fair and it is not appropriate to moderate- and

low-income earners that their costs of taxation, that their burden of taxation should include supporting high-income individuals.

So, yes, there clearly should be an affluence testing of the part B premium. If there is not, of course, we will see the costs that are driving this part of the budget rise from about $64 billion up to I think it is $119 billion over the next 5-year span, and that is not an acceptable number and certainly cannot be maintained.

Of course, income relating premiums does set up some questions which need to be addressed. They include, for example, what the definition of the income will be and what the mechanism for income relating the premium will be. From my standpoint, the definition of the breakpoint where you should start phasing this income in, you can look at the report of the Entitlements Commission for some very good numbers for the different breakpoints, and this committee obviously has the capacity to pick whichever one it wants.

Another proposal which the Entitlements Commission toyed with and put forward as an option is, rather than through a higher premium, to do it through taxation, so that you include in personal taxes the income benefit of the subsidized part of the premium. That is an easier way to do it. I think it probably runs into some philosophical problems, but from the standpoint of simplicity in accomplishing the effort, you can do it much more efficiently probably that way than others.

But if you are going to practically address this issue, I think you have to take a much broader approach. And I know that you as the Health Subcommittee are trying to do that. I certainly know that the Chairman is pursuing that. Rather than just looking at the part B premiums, in my opinion, we should be looking at the entire issue of how we address Medicare.

Instead of looking at it in the budgetary context, we should be looking at it in the context of how we can give a better system to our senior citizens, and at the same time potentially save some significant money, and that is doable. I recognize that has not been for years a philosophy of the Federal Government, that you can do anything better with less, but the fact is you can do significantly better with less. I know that, because I served as administrator of a State, and State governments do a great deal with less and they do it a lot better than the Federal Government does. And individuals can do even more and do it better.

So my view is that one of the attractive ways to address this issue would be to do something about replacing the entire system. As the fiscal pressures build, we here in the Congress look for more ways to slow Medicare's incredible baseline growth and for a fair way of doing this. So let us look at an approach which would basically restructure the entire system.

The approach that I would like to see us take is something which has been discussed in broad terms and it still is in the broad term of an approach, but it really is built off the concept of the Federal Employee Health Benefit Program open season approach.

In the last health care debate, we heard a lot of folks saying let's give everybody in America what Congress has. Well, certainly we could give the senior citizens what Congress has, and probably significantly improve the quality of that care or their options, anyway,

and at the same time probably very significantly reduce the cost of that care, especially in the outyears.

I call this approach Choice Care. Each year we would give Medicare dollars directly to the beneficiaries through an annual capitated payment which might be called—and I think the Chairman coined this phrase—Medicheck. Is that the right phrase?

Chairman THOMAS. Yes.

Senator GREGG. Medicheck. I want to make sure I got that phrase right. The insurance plans would compete to offer the benefit at a lower rate than the capitated account level, and when they do so, the plans could then either add benefits as under the current HMO options, offer shared rebates, or a combination of both. A percentage of such rebates in the proposal we have been thinking about would return 75 percent to the beneficiary, with the remaining portion being returned to the Treasury.

A number of the managed care plans have already indicated that the opportunity for increasing market share alone would be enough for an incentive for them to compete for the Medicare risk contracts. Furthermore, the opportunity for a cash rebate would provide beneficiaries with a real incentive to move out of the old Medicare system and spend Medicare money more wisely.

We know that right now the culture of senior citizens is a fee-for-service culture, because that is what they grew up with, and that is reasonable. But if they find that their fellow senior citizens are getting a better deal, a deal that not only costs less, but which they benefit from financially, but also supplies probably more in the way of care, especially in the preventive care areas, they are going to be attracted to it. So this is an attempt to move senior citizens out of the culture of fee-for-service and into a different culture.

As suggested earlier, under this system carriers could even offer current part B premium benefits as part of a basic package which would make the monthly part B premium payment obsolete. Now, that would be a real positive event in the life of a senior citizen not to have that deduction coming out of their Social Security check, the fact that they would no longer be subject to that expenditure, the $40-plus expenditure. Our Nation's seniors would no longer see that deduction.

Importantly, while the new system would provide a meaningful incentive for people to select individualized policies, it would also be voluntary. It would preserve the current system for any Medicare beneficiary or recipient who wished to remain there, and the new system would put the individual in control and increase the coverage choices and opportunities. In my estimation, it would move individuals out of fee-for-service and into this more controlled atmosphere.

The budget process challenge to this new system is providing a guarantee to CBO that the savings will be achieved, otherwise CBO will be quite reluctant to score a voluntary system. To solve this dilemma, I believe we should consider a look ahead/look back approach. First, we would look ahead and capitate the annual Medicare payment to a rate that slows the current 10-percent growth of Medicare to an acceptable level. Second, we would also establish an annual look back process to determine if the new voluntary

structure achieved expected baseline savings, and this could be a phased-in process. And if the annual goal is not reached, set an across-the-board reduction which would be instituted as required to meet the fiscal targets.

This system is just one of many options. The underlying principle, however, must be recognition that the health care system has evolved in the private marketplace. It is about time Medicare caught up. The Medicare system is a dinosaur. It is a state-of-the-art sixties health insurance program. As time goes on, Medicare's shoehorning of modern medicine into its antiquated structure becomes increasingly difficult.

Furthermore, in light of the unavoidable demographic challenges that will be pressuring the Medicare system, the Federal Government can no longer pretend to be able to serve the needs of our seniors without increasing the public/private partnership effort.

These are some of the ideas that we have been talking about on the Senate side. We expect that as we move forward there will be other ideas that will come forth. But essentially what I believe is that we must rethink the entire system, take a hard look at how we can get our seniors to have the opportunity to choose more types of care, and, in the process of choosing more types of care, be giving them an incentive to choose more cost-efficient types of care.

Again, I want to thank the committee for allowing me the opportunity to testify. I would be happy to answer questions, and I appreciate the chance to be here with Senator Kerrey.

[The prepared statement follows:]

Statement of Senator Judd Gregg

Committee on Ways and Means
Subcommittee on Health

February 7, 1995

Thank you, Mr. Chairman, for inviting me to testify today on the subject of relating the Medicare Part B premium to a person's income, a policy which I support. After explaining the reasons for my position on this issue, I would like to take a couple minutes to speak to the Medicare system in general. Relating Medicare benefits to income is important, but only to the extent that we maintain the current Medicare structure. And in my opinion it is time we restructured the Medicare system to increase choices and opportunities for seniors, and to use private sector cost-saving efficiencies.

Medicare's Supplemental Medical Insurance (SMI) System -- Part B

The time has come to adjust the Medicare Part B premium in some fashion, as a matter of both fundamental fairness, and a recognition of fiscal realities. Assuming we maintain the current Medicare structure, income-relating is one of the fairest ways to achieve needed savings.

The Congressional Budget Office (CBO) projects Part B spending to nearly double over the next five years -- from $64 billion in 1995 to about $119 billion in 2000. Because the Part B premium is set each year to collect a given percentage of program outlays, Part B recipients automatically feel the crunch of these rapidly escalating costs. The premium currently collects roughly 30 percent of program costs. Although current law allows that percentage to fall to 25 percent beginning next year, CBO still projects the premium to grow from its current rate of $46.10 per month ($553.20 per year) to $59.00 per month in 2000 ($708 per year). While that extra $150 per year may not seem like much to a wealthy retiree, it is a significant sum to many elderly persons with a fixed income above 120 percent of poverty. For those wholly dependent upon Social Security, for example, this premium increase will likely erode any benefit of the system's COLAs. As this occurs, low-income recipients will confront an erosion of disposable income.

The flip side of this, of course, is that the Federal government also confronts rapidly escalating SMI costs. While CBO projects SMI trust fund receipts to grow from $20 billion this year to $28 billion in 2000, general revenue contributions to SMI will more than double from $44 billion in 1995 to $91 billion in 2000. These figures are consistent with overall Medicare growth. In testimony before the Senate Budget Committee last week, the Congressional Budget Office stated that, "Federal entitlement spending now represents more than one-half of total federal outlays and is projected to constitute more than 60 percent by 2005." CBO also said that, "Medicare and Medicaid account for virtually all of the projected increase." As Senator Kerrey of Nebraska has explained, the problems associated with this rapid growth in federal spending only grow deeper 20 and 30 years from now. Without some adjustments, we are forfeiting our children's prosperity.

Given that some premium adjustments are necessary and likely inevitable, I believe that income relating is the fairest method. Many entitlements are already income-related, and everyone on this committee certainly knows that we also have an income-related tax code. Consequently, I believe that an income-related premium must be looked at carefully and, hopefully, adopted. These hearings are an important first step, Mr. Chairman, and you should be commended for confronting this issue head on. The President's decision to take Medicare completely off the table in this year's budget, as Medicare costs spiral out of control, is an abdication of responsibility.

Income relating premiums does raise many difficult subsidiary questions. For example, what definition of income should be used, and through what mechanism should the income-relating occur? The Entitlement Commission's staff options in this area chose a Modified

Adjusted Gross Income, which included current AGI plus tax-free interest income. The Entitlement Commission options also proposed collecting the increased premium through the tax system. Another simpler system -- which I am not advocating -- would be to base the system on Social Security income, and simply relate the Part B premium deduction to the amount of each Social Security check. These are difficult technical issues on which I know you and other members of the subcommittee understand well, Mr Chairman. I am therefore confident in this Committee's ability to work through them.

A New "Choice Care" System

Mr. Chairman, my support for income relating the Part B premium assumes that the current system will continue in its present form. In my view, however, we should be working toward a system where the Part B premium is not paid at all.

The attractiveness of relating the Part B premium to income is indicative of the problems running throughout Medicare. As fiscal pressures build, we in Congress look for more ways to slow Medicare's incredible baseline growth and for fair ways of doing so. Yet, each one of them, like income relation, brings added complexities and counter-incentives. Relating premiums to income, for example, may add on an incentive for future seniors to save less, if one result of more savings is increased cost sharing. Similar problems exist at every level of Medicare, with respect to almost every line-item change that is proposed for budget savings purposes. It is high time we began approaching changes to Medicare from the recipient perspective, not a budgetary perspective.

In my view, if we're serious about improving how Medicare works, we should move to an individualized account system that provides beneficiaries with meaningful choices, establishes incentives to save, and takes advantage of free market efficiencies. We should go back to square one, and institute a system where individuals, not bureaucracies, control the results.

The system I envision would be similar to the annual open season under FEHBP. I would call it "Choice Care." Each year, we would give Medicare dollars directly to the beneficiaries through annual capitated payments, which might be called "Choice Checks." Insurance plans would compete to offer the benefits at a rate lower than the capitated account level. When they do so, the plans could then either add benefits as under the current HMO option, or offer shared rebates, or a combination of both. A percentage of such rebates -- perhaps as much as 75 percent -- would go to the beneficiary, and the remaining portion would be returned to the Treasury. A number of managed care plans have already indicated that the opportunity for increased market share alone would be enough of an incentive for them to compete for the Medicare risk contracts. Furthermore, the opportunity for a cash rebate would provide beneficiaries with a real incentive to move out of the old Medicare system, and to spend Medicare money wisely.

As suggested earlier, under this system carriers could even offer current Part B benefits as part of a basic package, which would make the monthly Part B premium payments obsolete. Our nation's seniors would no longer see that deduction coming out of their Social Security checks. Importantly, while the new system would provide a meaningful incentive for people to select individualized policies, it would also be voluntary. It would preserve the current system for any Medicare recipient who wishes to remain there. The new system would put the individual in control, increasing coverage choices and opportunities.

The budget process challenge to this new system is providing a guarantee to CBO that savings will be achieved; otherwise, CBO will be quite reluctant to score a voluntary system. To solve this dilemma, I believe we should consider a "look-ahead, look-back" approach. First, we would look ahead and capitate the annual Medicare payments at a rate that slows the current 10 percent growth of Medicare to an acceptable level. Second, we would also establish an annual "look-back" process to determine if the new voluntary structure achieved expected baseline savings. If the annual goal is not reached, a set of across-the-board reductions would be instituted as required to meet fiscal targets.

This system is just one of many options. The underlying principle, however, must be a recognition that health care has evolved in the private marketplace, and that is about time Medicare caught up. The Medicare structure is a dinosaur -- it is a "state of the art" 1960s health insurance program. As time goes on, Medicare's shoehorning of modern medicine into its antiquated structure becomes increasingly difficult. Furthermore, in light of the unavoidable demographic challenges that will be pressuring the Medicare system, the federal government can no longer pretend to be able to serve the needs of our seniors without increased public/private partnership efforts.

As chair of a Working Group on Entitlement Reform among Senate Republicans, I can say that we in the Senate are looking closely at these issues, and considering a structure similar to the one just described. And if I read recent news accounts correctly, we seem to be settling on the same basic plan as you are in the House. The underlying concepts of the plans are very similar, as we both feel it's time our nation's seniors had the same health care choices available to other Americans. Still, Mr. Chairman, I must admit that your phraseology is more highly advanced. I have been referring to "Choice-Care," but suspect that the Senate will soon be referring to your own "Medicheck" terminology.

It's interesting but not surprising that as we grapple with the same problems on opposite sides of the Capitol, we are resolving down to similar solutions. I am sure this results from our approach being based on consistent philosophies. We both agree that the current structure, which relies on command and control, one-size-fits-all federal directives, must be changed; and we both prefer to offer more choices and to take advantage of private sector advances. Let's work together, Mr. Chairman, and get the job done.

Chairman THOMAS. I thank both of you for your testimony.

I will tell you, Senator Gregg, that we are thinking virtually along identical lines in taking an antiquated fee-for-service structure and not just trying to reinvent the formula by which we try to follow the private sector, but by creating an open system in which people through choice—and I believe your concept of the term was Choice Care—give people an opportunity to move into a system in which they can actually get more for their money than provided by the old structure, but with an assurance that if they want to stay in the old structure, they can.

That is where I would seek any guidance, because clearly the format is on the means testing, but our goal is to completely rethink the Medicare structure. My concern is that I think most people, although perhaps not as open or willing as Senator Kerrey to talk about tomorrow, know that tomorrow is coming. I do believe we have to restructure the system, but what do we do about those people who see a short-term advantage in scare tactics or a political advantage in warning people that they may lose something that they are going to lose anyway, if we do not do anything about it?

Perhaps a sentence or two, because I am somewhat pessimistic, because the President did not join in in an opportunity to at least provide a degree of leadership in his budget message this year. I was hopeful that he would either indicate some support or direction that the commission offered him. And I am looking for ways to bring about this shared vision, notwithstanding the enormous obstacles of people who see political advantage in using us as a foil. Any reaction to how we can move together? We have a Senator who is a Democrat and a Senator who is a Republican. I wish we had some Members of the House who will share it. What do we do in getting the President onboard? He was big for reform last year on his form and function.

Senator KERREY. I would say, Mr. Chairman, that my advice may or may not be the kind of advice you would want to take, but my own thinking on it is that, for openers, we have to cool our own rhetoric and be careful in describing the problem that we do not become excessive, and that is sometimes difficult for us to do.

We do not face an immediate catastrophe. Social Security beneficiaries have not caused the problem. Sometimes in our own rhetoric—when I say our, I do not mean to include anybody in this room necessarily, but perhaps just use my own rhetoric—sometimes gets too hot and, as a consequence of that heat, I mislead and make it difficult as a result just for people to come in and say, OK, let us talk. The more we can just calmly present the facts and say, look, this is the truth, the more likely it is that we will get results.

I believe that if we can form a bipartisan group—that was the intent of the entitlement commission to begin with—in Congress that the President would be willing to take some leadership on this. I do not think the President is ducking this at all. He is saying it does not appear at the moment to be much of a critical mess. We are unquestionably going to need presidential leadership to carry the message to the people.

For example, I had staff go get a book that I should have brought with me. What the entitlement commission attempted to do both with part A and part B is to describe the future in chart form. I am going to hold it up and show it to you. But when you see it in chart form, you say, oh, my gosh, we have got to do something.

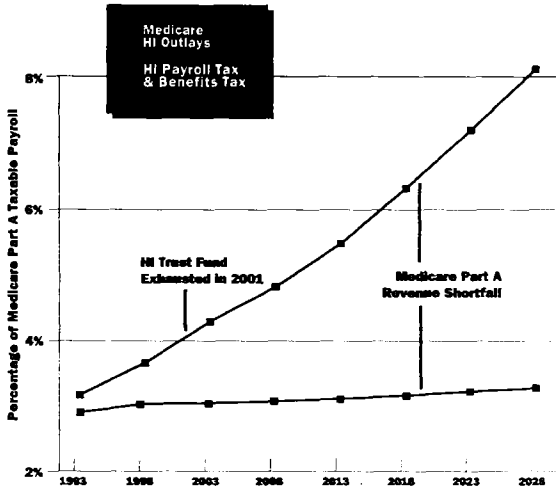
[The following was subsequently received:]

4. WE MUST ADDRESS RISING HEALTH CARE COSTS BY EMPHASIZING MARKET INCENTIVES AND PERSONAL RESPONSIBILITY.

Federal health program spending has been increasing at annual rates averaging 10 percent or more during the past five years. According to the Medicare Trustees, the Hospital Insurance (HI) Trust Fund is projected to be insolvent by the year 2001. In the long run, spending on Medicare and Medicaid will triple as a percentage of the economy by 2030. (Chart VIII)

CHART VIII: MEDICARE PART A IS PROJECTED TO BE INSOLVENT BY 2001

To cover Medicare HI outlays, the payroll tax rate would have to increase from 2.9% today to more than 8% in 2030.



When Medicare Part A was enacted, it was a self-supporting system, financed solely by payroll tax contributions. Today, Part A coverage averages about $3,100 per enrollee, while the average enrollee pays only 32 percent of the cost (26 percent for couples with only one worker). As a result, the average enrollee collects benefits equaling approximately three times the amount contributed during his or her working life.

The Kerrey-Danforth approach creates incentives in the Medicare program to control costs and introduces market forces to allow greater flexibility and a wider variety of delivery systems.

This is part A, and the blue under part A is the payroll tax, and the green here is what we are paying from the general fund. I mean that is the future. That is the fact. That is where we are going. It is not all being paid for with the payroll tax. It is increasingly being subsidized with the general fund. We have got Social Security trustees that filed a report last year that said this part A fund is going to be broke in the year 2000, and yet we are not discussing what to do about it, so just say here is the future. And our solution is apportion the cost. For all those who say, oh, my gosh, all the changes you made, it is horrible, it is terrible, I would say, look, wait a minute, all we tried to do was apportion the cost. We said the providers should take some of it, the beneficiaries should take some of it, and the general fund taxpayer could take a little. That is all we have done.

It seems to me that in the presenting of it—and part B, of course, is worse, this is part B, this red line down here is the premium and the blue line is the general fund—all we are saying is let's apportion that in some reasonable fashion. I do not know, Mr. Chairman.

I would say that the calmer we are and the less thunderous and exaggerated our rhetoric is, the more likely the response coming back, whether it is a politician such as the President, who I think does genuinely want to lead on this issue, or whether it is a group genuinely interested in the issue because they are concerned about what could happen to Social Security or Medicare, I think the more calm that we are in the presentation of the facts in the future and the more we indicate that all we are trying to do is respond to the responsibility we have to plan for that future. The more calm we can say that we are trying to plan for that future, I think the more likely it is that we will build some bipartisan coalitions.

And the more we resist those consultants that come around and say I have got a great 30-second ad that you can run here and that will make Judd Gregg look like a complete heartless fiend with blood coming out of his mouth out there lurking in the shadows ready to pounce on every person over the age of 65, the more we say to those consultants no, we are not going to do that, we are going to hold together at least on this issue, which is the most important fiscal issue that we face.

Chairman THOMAS. Thank you. I think that is an excellent reason for 6-year terms. [Laughter.]

Senator GREGG. I am a little concerned about this ad.

Senator KERREY. Our committee will not do that.

Chairman THOMAS. Thank you.

The gentleman from Nebraska.

Mr. CHRISTENSEN. I am going to remember that, Senator Kerrey, in 2 years when I need your help. That will be a good one liner I can return. I appreciate that.

In your written testimony, you talk about the CPI and how it might possibly be overstated as far as the inflationary figures. I was wondering if you could expand on this and how it affects Medicare, Medicaid and military retirement pensions and what we should do about it. I know you listed a few other statistics as far as the written testimony goes, but do you have any other thoughts on the CPI and where savings can occur?

Senator KERREY. Well, the adjustments in the CPI that we have all heard an awful lot about beginning with the testimony I think that Chairman Greenspan made either before this committee or the Budget Committee, I cannot remember which one it was, but it has gotten lots of publicity and lots of amendments have been offered to things over on the Senate side. It has been a real cause celebre. That recommendation that Chairman Greenspan made is included in the Kerrey-Danforth proposal. We recommended changing, adjusting the CPI both for the calculation of benefits and for the purpose of adjusting our tax rates to avoid bracket creep.

I am going to back up again and be clear on this. This does not solve the problem. We tried to make the problem an easy thing for people to approach by developing the CD–ROM that the Chairman mentioned earlier and by saying that there are two problems that need to be solved. One is a long-term Social Security problem, out of balance, the second is entitlements that are growing beyond the growth of our economy, and so you have got to fix both problems.

In order to make it easier, we said we are going to break the problem down into 100 points. When you get 100 points, you have fixed both of them, 100 points on Social Security and 100 points on all entitlements. The CPI gets you 8 points. So the good news is it has an impact. The bad news is you have got 92 more to go.

As I said, any ideology can solve this. If a guy comes in and says I am against doing that, the next question has to be, well, what do you want to do instead, because the answers have to be I do not want to do anything, in which case they need to be exposed to somebody who is saying I do not want to solve this problem, I want to wait until it gets worse, I want to ignore all the facts, I want to ignore all the statistics, I do not care what happens in the future, all I want to do is worry about what is going to happen in the next 2, 3 or 4 years.

Senator GREGG. If I could address that, following up on Bob's comments. First, the CPI adjustment on the issue of accurately calculating CPI really needs to be done. Now, I was with an administration official yesterday and he was not a high ranking administration official, so hopefully he was not speaking for the administration. But he said they did not expect to see CPI recalculated or recalibrated until 1998. That obviously is not appropriate.

The CPI as it is presently structured, as Chairman Greenspan and a number of economists testified, including Mr. Reischauer, is overstating the cost of living by somewhere between 0.10 and 1.2 percent, which represents somewhere between $40 and $150 billion. The CBO's estimate is that it is overestimating it by $64 billion over a 5-year period.

That really is unfair and it is not right. When I speak to my seniors, they have no problem with this. You know, if you explain to a senior, you say if you go into Mabel's Luncheonette and you buy a $1.50 hamburger and pay Mabel $2, and you have been going there for 20 years, and Mabel by mistake gives you back 75 cents, you do not keep that quarter. You say to Mabel, "Mabel, you gave me the wrong change." Well, that is what is happening here, and the wrong change is coming from the seniors' kids, because those are the ones who are paying the taxes. So that needs to be adjusted.

There are other things that we can do in the CPI that are fair. They go to fairness issues. For example, why should retired Members of Congress have the CPI adjusted on their entire retirement income? Some retired Members of Congress get up to $100,000 or $100,000-plus. They are getting cost of living on the entire number, where a senior citizen on Social Security only gets this cost of living on the amount of their Social Security payment.

The same is true for military retirees. A rear admiral gets a retirement COLA on the entire amount of their retirement income, which might be $65,000 or $70,000. We ought to say to folks, your CPI, your COLA as a civil service retiree or as a military retiree is going to conform to what senior citizens on Social Security get for COLA, so everybody is in the same boat together. And that was a proposal that came out of the Kerrey-Danforth Commission.

So there are things that can be done on the CPI that I think go to fairness and go to accuracy and would have a compounding effect that was rather significant.

Chairman THOMAS. Any additional questions of the Senators?

[No response.]

I want to thank both of you very much. Obviously, we are not going to solve the problems in the short exchange, but I just want to tell you how reassuring it is that on a bipartisan basis you folks are talking about the same thing that we are talking about, and that is a commitment to fundamental change in the long run, because we have to.

Thank you very much.

Senator KERREY. Thank you, Mr. Chairman.

Senator GREGG. Thank you for the opportunity to testify.

Chairman THOMAS. I would ask the new Chief of Staff of the Joint Committee on Taxation, Ken Kies, and I will tell the gentleman that his entire written testimony will be made a part of the record, without objection. You may proceed for approximately 5 minutes in any way you see fit to inform us.

STATEMENT OF KENNETH J. KIES, CHIEF OF STAFF, JOINT COMMITTEE ON TAXATION; ACCOMPANIED BY MARY SCHMITT, DEPUTY CHIEF OF STAFF, AND CAROLYN SMITH, BENEFITS COUNSEL

Mr. KIES. Thank you, Mr. Chairman. I am accompanied today by Mary Schmitt, who is the Deputy Chief of Staff of the Joint Committee, and Carolyn Smith, who is Benefits Counsel.

It is my pleasure to present the testimony of the Joint Committee at this hearing concerning the Medicare part B premium. Medicare part B provides coverage for doctors' services and certain other medical services. Unlike Medicare part A, part B coverage is not automatic, but depends on the payment of a premium. All persons age 65 or older may elect in part B by payment of a monthly premium. Individuals may terminate their enrollment at any time by filing a notice with the Social Security Administration.

The part B premium currently pays about 31 percent of the actual value of the coverage in 1996 through 1998. The premium will be adjusted to be 25 percent of program costs. The approximately 70 to 75 percent part B costs that are not paid by premiums is fi-

nanced through general revenues, as indicated by the two Senators that preceded me.

Over the years, there have been a number of proposals which have received bipartisan support to reduce the subsidy value of the part B program for certain beneficiaries by adjusting the part B premium.

For example, such a proposal was an option under consideration as part of the 1990 budget summit under the Bush administration. In his fiscal year 1992 budget, President Bush proposed increasing the part B premium to approximately 75 percent of program cost for beneficiaries with adjusted gross incomes greater than $125,000 for single beneficiaries and $150,000 for couples.

Last year, President Clinton included a recapture of the part B subsidy for high-income taxpayers as part of the administration's Health Security Act. During the health care reform debate, a number of proposals, including one advanced by the chairman of this subcommittee, were also debated.

If the subcommittee determines that it is appropriate to impose a part B premium that is income related, there are a number of issues that you may wish to consider, if the income related premium is assessed through the Federal tax system. Key issues for the subcommittee to decide include the income levels at which the premium would be paid and the amount of additional premium. Factors that should be taken into account in determining these amounts include the ability of taxpayers at higher income levels to pay additional premiums, revenue constraints, and the effect of increasing the premium on the decision to enroll in part B.

Whenever a tax is imposed on taxpayers with incomes above a certain level, the issue of whether the tax should be phased in should be considered. The Congress often phases in tax increases of this nature so that distortions in marginal tax rates can be minimized. Most of the proposals to impose an income related part B premium would phase in the additional premium for this reason.

The issue then presented is the income range over which the additional premium should be assessed. It may be appropriate to choose an income range that does not coincide with the phase-in range for the taxation of Social Security benefits, because virtually all Medicare-eligible taxpayers are those who are also likely to be receiving Social Security benefits.

In addition, it may be appropriate to select a phase-in range that does not result in the creation of an additional marriage penalty. In order to determine the amount of additional part B premium that is required to be paid by a taxpayer, it is necessary to determine the definition of income to be applied in determining whether the taxpayer is over the required threshold for the phase-in of the part B premium increase.

The principal goal should be to select a definition of income that accurately reflects the taxpayers' ability to pay and that is commonly calculated by the taxpayer so as to reduce the potential complexity of the premium calculation.

There are many possible definitions of income that can be employed. A commonly used definition when the phase-in technique is employed is adjusted gross income.

Whenever Congress enacts new Federal tax treatment of certain income issues, administration and enforcement must be considered. The most significant of these issues in the case of imposing an income related part B premium through the Federal income tax system is how and when all the additional premium payments should be paid and the need for new reporting or recordkeeping requirements.

It would be a relatively simple matter to collect the additional part B premium on a taxpayer's Federal income tax return. It must be determined whether the additional part B premium will be subject to the estimated tax provisions, as well.

Another issue that must be considered is whether it is necessary or appropriate to impose reporting requirements so that the IRS is capable of determining from the face of the taxpayer's return whether the taxpayer is subject to the additional part B premium.

Some people who would be subject to an additional income related part B premium may elect to decline part B coverage as a result of the additional premium. Others who are currently covered under Medicare part B may feel that enactment of an income related part B premium unfairly increases the costs of the program to them.

Under present law, persons in part B may terminate part B coverage by notifying the Social Security Administration. Thus, persons who wish to terminate coverage due to the increase in premium can do so. However, to avoid an appearance of unfairness, the subcommittee may want to consider whether it is appropriate to provide special notice of the right to terminate when the part B premium is effective.

In closing, I would like to give the subcommittee an idea of the magnitude of revenue involved if an income related part B premium were imposed. Assume an individual covered under part B were required to pay an additional premium so that the total amount paid by the individual, including a portion they already pay, equalled 75 percent of the average costs of the program. In addition, assume that this individual premium would be phased in over a $10,000 range beginning at adjusted gross income of $50,000 in the case of a single taxpayer and $100,000 in the case of a married taxpayer filing a joint return.

If this type of proposal were effective beginning in 1996, it is estimated that additional revenues of $8.1 billion would be collected over the fiscal year period 1996 through 2000. Obviously, larger or smaller amounts of revenue could be raised, depending upon where the income thresholds are set and the range over which the additional premium is phased in and the magnitude of the part B premium imposed.

That concludes my remarks, Mr. Chairman. I would be happy to answer any questions.

[The prepared statement follows:]

TESTIMONY OF KENNETH J. KIES, CHIEF OF STAFF
JOINT COMMITTEE ON TAXATION
U.S. CONGRESS

My name is Ken Kies. I am the Chief of Staff of the Joint Committee on Taxation. It is my pleasure to present the testimony of the Joint Committee at this hearing concerning the Medicare Part B premium.

In particular, the Health Subcommittee is considering whether to reduce the subsidy value of the Supplemental Medical Insurance program under Medicare ("Part B") for certain beneficiaries by adjusting the Medicare Part B premium through the Federal income tax system. My testimony will not discuss whether adopting such a proposal is advisable (the testimony of other witnesses should address this issue), but instead will focus on the enforcement, administrative and structuring issues that could arise in implementing such a proposal. We believe that such implementation issues should be considered when proposals are being developed so that problems may be identified and addressed in a manner that imposes the least possible burden on the Internal Revenue Service ("IRS") and affected taxpayers.

First, this testimony briefly describes the Medicare Part B program under present law. Second, background information is provided on previous proposals to increase Part B premiums for higher-income beneficiaries. Third, a general description of the proposal under consideration is presented. Finally, the testimony discusses major implementation issues.

As always, the Joint Committee staff looks forward to working with the Subcommittee to develop and refine specific proposals relating to the Part B premium.

II. PRESENT LAW

The Medicare program consists of two parts: the hospital insurance (Part A) program and the supplementary medical insurance (Part B) program.

In general, and within certain limits, Medicare Part A pays for inpatient hospital care, skilled nursing facility care, home health care, and hospice care. Medicare Part A is financed by the Hospital Insurance Trust Fund, primarily through the payment of payroll taxes.

Most Americans age 65 or older are automatically entitled to protection under Part A of Medicare with no premium requirement based on work performed in employment subject to Social Security payroll taxes. Persons age 65 or older who are not "fully insured" (i.e., not eligible for monthly Social Security or railroad retirement benefits) may obtain coverage under Part A, providing they pay the full actuarial cost of such coverage. Also eligible, after a two-year waiting period, are people under age 65 who are receiving monthly Social Security benefits on the basis of disability, and disabled railroad retirement system annuitants. Most people who need a kidney transplant or renal dialysis because of chronic kidney disease are, under certain circumstances, entitled to benefits under Part A regardless of age.

In general, and within certain limits, Medicare Part B provides coverage for doctor's services and certain other medical services (such as laboratory services and outpatient hospital services), and home health services for persons not covered under Medicare Part A.

Unlike Medicare Part A, Part B coverage is not automatic, but depends on the payment of a premium. All persons age 65 or older (whether automatically entitled to benefits under Part A or not) may elect to enroll in Part B by paying the monthly premium. Persons eligible for Part A by virtue of disability or chronic kidney disease may also elect to enroll in Part B. Individuals may terminate their enrollment in Part B at any time by filing a notice with the Social Security Administration. The Part B premium is increased by 10 percent for each full year out of the program for persons who do not enroll as soon as they are eligible.

The Part B premium for any year was originally set at the lower of: (1) an amount sufficient to cover one-half of the costs of the program for the aged or (2) the current premium amount increased by the percentage by which cash benefits were increased under the cost-of-living adjustment (COLA) provisions of the Social Security program. Premium income, which originally financed half of the costs of Part B, declined under this formula to less than 25 percent of total program income because of the COLA limitation.

The Tax Equity and Fiscal Responsibility Act of 1982 temporarily suspended the COLA limitation for two years, 1984 and 1985. During this period, enrollee premiums were allowed to increase to amounts necessary to produce premium income equal to 25 percent of program costs for elderly enrollees. The suspension of the COLA provision was further extended in subsequent legislation through 1990. The Omnibus Budget Reconciliation Act of 1990 set the premium rates in law for each of the years 1991-1995, based on estimates of the amount necessary to cover 25 percent of program costs for these years. The monthly premium is $46.10 in 1995, which is projected to cover 31 percent of program costs. Because these statutory amounts were based on estimates, the premium income in any year subject to the statutory rates could be more or less than 25 percent of actual program costs. In 1996 through 1998, the premium will be adjusted to be 25 percent of program costs.

In most cases, the Part B premium is deducted automatically from Social Security or railroad retirement benefits. Eligible persons not yet receiving Social Security or railroad retirement benefits are billed quarterly.

The approximately 70-75 percent of Medicare Part B costs that are not paid by premiums is financed through general revenues.

III. BACKGROUND AND DESCRIPTION OF PROPOSAL

Over the years, there have been a number of proposals, which have received bipartisan support, to reduce the subsidy value of the Medicare Part B program for certain beneficiaries by adjusting the Part B premium.

For example, such a proposal was an option under consideration as part of the 1990 Budget Summit between the Bush Administration and Congressional leaders. In his fiscal year 1992 budget, President Bush proposed increasing the Part B premium to equal approximately 75 percent of program costs for beneficiaries with adjusted gross incomes greater than $125,000 for single beneficiaries and $150,000 for couples. Similar proposals have been made in subsequent budgets.

Last year, President Clinton included a "recapture" of the Part B subsidy for high-income taxpayers as part of the Administration's Health Security Act. Under that proposal, the Part B premium would have increased to approximately 75 percent of the program costs for taxpayers with modified adjusted gross income ("AGI") in excess of $105,000 in the case of single taxpayers, $130,000 in the case of a married couple with one spouse covered under Part B, and $145,000 in the case of a married couple with both spouses covered under Part B.

Other health care reform bills considered in the 103rd Congress contained similar proposals, including those sponsored by Congressman Michel (R-IL) and Senator Lott (R-MS) (H.R. 3080 and S. 1533), Congressman Cooper (D-TN) and Senator Breaux (D-LA) (H.R. 3222 and S. 1579), and Congressman Thomas (R-CA) and Senator Chafee (R-RI) (H.R. 3704 and S. 1770). A similar proposal was not contained in the Health Security Act as adopted by the Committee on Ways and Means, but was included in the Health Security Act as adopted by the Senate Finance Committee.

Under all these proposals, additional Part B premiums would have been collected from the affected taxpayers through the Federal income tax system.

In the 103rd Congress, H.R. 3704 was introduced by Chairman Thomas. As I have previously mentioned, this health reform bill also contained a provision to income relate the Medicare Part B premium. Under this provision, taxpayers with modified AGI in excess of $100,000 in the case of a single taxpayer and $125,000 in the case of a married taxpayer filing a joint return would have been required to pay Medicare Part B premiums equal to 75 percent of the average costs of the program for each month of the year that a Medicare Part B premium was paid. The additional premium in excess of the premium collected under present law would have been phased in between $90,000 and $100,000 of modified AGI for single taxpayers and $115,000 and $125,000 of modified AGI in the case of married taxpayers filing a joint return. Modified AGI for purposes of this provision would have been the same as the definition of modified AGI for social security benefit taxation.

I understand that the Subcommittee is considering ideas similar to those considered in the above referenced bills. Although there is no specific proposal under consideration, the general proposal being considered by the Subcommittee is that taxpayers with incomes above certain levels would be required to pay additional Part B premiums. The total premium increase would be phased in over some income levels that would be specified. In the case of married couples, whether an additional premium is owed would be determined for each spouse based on whether he or she is enrolled in Medicare Part B, using the combined income of the couple. The premium generally would be collected the same way that Federal income taxes are collected. Any additional premiums would be included as an additional amount owed on the individual's tax return for the year.

IV. ISSUES INVOLVED IN IMPOSING AN INCOME-RELATED MEDICARE PART B PREMIUM THROUGH THE FEDERAL TAX SYSTEM

If the Subcommittee determines that it is appropriate to impose a Medicare Part B premium that is income related, there are a number of issues that you may wish to consider if the income-related premium is assessed through the Federal tax system. Key issues for the Subcommittee to decide include the income levels at which the increased premium would be paid and the amount of the additional premium (i.e., whether the total Part B premium owed would be 100 percent of the program costs or a lesser amount). Factors that should be taken into account in determining these amounts include the ability of taxpayers at higher income levels to pay additional premiums, revenue constraints (if any), and the effect of increasing the premium on the decision to enroll in Medicare Part B.

My testimony focuses on issues that arise regardless of the decisions as to particular income levels or premium levels. In adopting a particular proposal, I would encourage you to consider implementing it in a manner that is easiest for both taxpayers and the IRS to administer.

Phasing in an income-related Part B premium

Whenever a tax is imposed on taxpayers with income above a certain level, the issue of whether the tax should be phased in must be considered. If a higher rate of tax is assessed on income above a certain level, a taxpayer's marginal tax rate increases as income rises. If a specified amount of additional tax is imposed for taxpayers with income above certain levels, the marginal rate for the first dollar of income above the threshold could be extraordinarily high, unless the additional tax is phased in over an adequate income range to smooth the effects of the phase in.

For example, suppose the Congress imposed a $1,000 surtax on taxpayers with income in excess of $50,000 per year. Ignoring any other taxes that a taxpayer might owe, if this tax were not phased in, a taxpayer with $50,001 of income would be required to pay additional tax of $1,000. This would result in a marginal tax rate (assuming no other taxes) on that $1 of additional income of 100,000 percent. On the other hand, a taxpayer with income of $100,000 would be subject to a marginal tax rate of 2 percent on his income in excess of $50,000.

The Congress often phases in tax increases of this nature so that these distortions in marginal tax rates can be minimized. Most of the proposals to impose an income-related Medicare Part B premium would phase in the additional premium for this reason. The issue then presented is the income range over which the additional premium should be assessed.

It may be appropriate to choose an income range over which the additional Part B premium is phased in that does not coincide with the phase-in range for the taxation of Social Security benefits. Because virtually all Medicare-eligible taxpayers are those who are also likely to be receiving Social Security benefits, the effect of imposing a Medicare Part B premium increase over the same income range as the taxation of Social Security benefits is phased in could result in what the Congress would conclude is an inappropriately high marginal tax rate for the affected taxpayers.

Under present law, taxpayers with income in excess of $25,000 in the case of a single taxpayer and $32,000 in the case of married taxpayers filing a joint return must include in income up to 50 percent of their Social Security benefits. In addition, taxpayers with income in excess of $32,000 in the case of single taxpayers and $44,000 in the case of married taxpayers filing a joint return must include in income up to 85 percent of certain of their Social Security benefits. The additional amount that must be paid phases in as income above these amounts increases relative to the amount of Social Security benefits received. The Contract with America would repeal the second level of Social Security taxation. In general, under present law, if the increased Part B premium began at incomes in excess of approximately $36,000 for single individuals and $52,000 for married taxpayers, the taxation of Social Security benefits would be fully phased in before the Part B premium had an effect. If the Contract With America provision relating to the repeal of the tax increase in social security benefits enacted in the Omnibus Budget Reconciliation Act of 1993 is enacted, then the levels at which the taxation of social security benefits is fully phased in would generally be reduced to $32,200 for single taxpayers and $46,400 for married taxpayers filing a joint return.

In addition, it may be appropriate to select the phase-in threshold and range in such a manner that the adoption of a proposal to income relate the Part B premium does not result in the creation of an additional marriage penalty. Under present law, in the case of a married couple in which both spouses have income, it is possible that the couple will pay more Federal income tax by filing a joint return than the amount of tax that would be due if each of the spouses were eligible to file as single individuals. This is the so-called marriage penalty. The Contract With America contains a provision that is designed to reduce the marriage penalty to some extent. If the Subcommittee believes that it is important to minimize the marriage penalty, then it would be necessary to set the phase-in threshold for a married couple for purposes of the additional Part B premium at two times the threshold for single individuals. In addition, because the amount of the additional Part B premium owed by a couple is dependent upon whether one or both of the spouses is covered under Medicare Part B, it may be appropriate to phase in the additional premium over the same range as an individual taxpayer in the case of a married couple with only one spouse covered under Medicare Part B and over two times the phase-in range of an individual taxpayer if both spouses are covered under Medicare Part B.

You may also wish to consider indexing the income levels over which the increased premium is phased in. If the income levels are not indexed, then, over time, the real income level at which the premium is phased in will decline and people with lower real incomes will be subject to the additional premium. This effect will be exacerbated if the Part B premium increases over time.

Definition of income

In order to determine the amount of additional Part B premium that is required to be paid by a taxpayer, it is necessary to determine the definition of income to be applied in determining whether the taxpayer is over the required threshold for the phase in of the Part B premium increase. The principal goal should be to select a definition of income that accurately reflects the taxpayer's ability to pay and that is commonly calculated by taxpayers so as to reduce the potential complexity of the premium calculation.

There are many possible definitions of income that could be employed. A commonly used definition when the phase-in technique is employed is adjusted gross income (AGI). Often, AGI is the starting point in the definition of income and then additional adjustments are made to reflect more accurately a taxpayer's ability to pay.

One definition of income used by almost all taxpayers who would be subject to the additional Part B premium is the definition used for purposes of the taxation of certain Social Security benefits. This definition begins with AGI, but is adjusted to include tax-exempt interest income and to disregard the exclusion from income for interest on certain educational savings bonds and certain foreign tax credits and exclusions. Use of this definition would have the advantage not only of using a definition already employed by the class of taxpayers affected by the Part B premium increase, but also of ensuring that the marginal tax rate concerns addressed above could be mitigated.

Administrative issues

Whenever the Congress enacts new Federal tax treatment of certain income, issues as to administration and enforcement must be considered. The most significant of these issues in the case of imposing an income-related Part B premium through the Federal income tax system are (1) how and when will the additional premium be paid and (2) the need for new reporting or recordkeeping requirements.

It would be a relatively simple matter to collect the additional Part B premium on a taxpayer's Federal income tax return or Form 1040 for each year. It must be determined whether the additional Part B premium will be subject to the estimated tax provisions or whether it will merely be collected as a separate tax on the Form 1040. If it is collected through the estimated tax system, then the additional premiums will be collected more closely to the time that the Part B coverage is provided. On the other hand, a taxpayer will not know with certainty whether his or her income for the year will be sufficiently high so that the additional Part B premium will, in fact, be owed and, if so, the amount of the additional premium. Thus, it may be a simpler calculation for taxpayers if the additional Part B premium is collected only at the end of the taxable year and is not subject to estimated tax payments during the year. To resolve this issue, the Subcommittee will have to determine whether simplicity of the calculation for taxpayers outweighs the Federal government's interest in collecting the additional Part B premium close to the time that the coverage to which the premium relates is provided.

In some cases, a taxpayer's AGI may be redetermined by the IRS after the tax return is filed. Such a redetermination could affect the amount of additional Part B premium that is owed, and could mean that the taxpayer is entitled to a refund or owes an additional amount. If the Part B premium is treated the same as Federal income taxes, then the IRS will automatically recalculate the Part B premium if AGI is redetermined and will make appropriate adjustments to the taxpayer's total tax liability.

Another issue that must be considered is whether it is necessary or appropriate to impose reporting requirements so that the IRS is capable of determining, from the face of a taxpayer's Form 1040, whether the taxpayer is subject to the additional Part B premium. For example, the Subcommittee might consider whether it is appropriate to require that a statement be provided to a Medicare-covered individual for each year indicating the months of Medicare Part B coverage for the year. This statement could then be attached to the taxpayer's Form 1040 for the year. However, in virtually all cases, a taxpayer who is subject to the additional Part B premium would also be claiming the additional personal exemption for the elderly. In such a case, the IRS would generally know that a taxpayer with sufficiently high income who is also claiming an additional personal exemption for the elderly is likely to be required to pay the additional Part B premium. In some cases, a taxpayer who claims an additional exemption for the elderly will have been covered by Medicare Part B for only part of a year, but it should be a relatively minor problem to resolve discrepancies in such cases.

Some taxpayers who are under age 65 are also Medicare eligible (e.g., certain disabled individuals or individuals with end-stage renal disease) and may have sufficiently high income that they would be required to pay the additional Part B premium. The Subcommittee should consider whether it is appropriate to adopt a specific reporting requirement to ensure that high-income taxpayers who are under age 65 and covered under Medicare are paying the additional Part B premium. However, this may be such a small class of taxpayers that it may not be worth the administrative costs of imposing such a reporting requirement.

Fairness

Some people who would be subject to an additional income-related Part B premium may elect to decline Part B coverage as a result of the additional premium. Others who are currently covered under Medicare Part B may feel that enactment of an income-related Part B premium unfairly increases the cost of the program to them. They may argue that they would not have elected Part B coverage in the first place if they had know that they would be subject to a significant premium increase. Under present law, persons in Part B may terminate Part B coverage by notifying the Social Security Administration. Thus, persons who wish to terminate coverage due to the increased premium can do so. However, to avoid an appearance of unfairness, the Subcommittee may want to consider whether it is appropriate to provide special notice of the right to terminate coverage when the Part B premium is effective, and the consequences if the person would later like to again be covered (i.e., the premium increase). The costs of providing such a notice should be weighed against the benefits to Part B recipients.

V. CONCLUSION

In closing, I would like to give the Subcommittee an idea of the magnitude of the revenue involved if an income-related Medicare Part B premium were imposed. Assume an individual covered under Medicare Part B were required to pay an additional premium so that the total amount paid by the individual equaled 75 percent of the average costs of the program. In addition, assume that this additional premium would be phased in over a $10,000 range beginning at AGI of $50,000 in the case of a single taxpayer and $100,000 in the case of a married taxpayer filing a joint return. If this type of proposal were effective beginning in 1996, it is estimated that additional revenues of $8.1 billion would be collected over the fiscal year 1996-2000 period. Obviously, larger or smaller amounts of revenue could be raised depending upon where the income thresholds are set, the range over which the additional premium is phased in, and the magnitude of the Part B premium imposed.

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

Mr. Crane, do you have an interest in inquiring?

Mr. CRANE. Just one.

Ken, do you believe that using the Federal tax system to impose an income related Medicare part B premium is actually workable?

Mr. KIES. Mr. Crane, it would require relatively little modification to the actual tax return to be able to collect it, so it imposes relatively small additional complexity.

Mr. CRANE. That is all. Thank you.

Chairman THOMAS. Mr. McCrery.

Mr. MCCRERY. Ken, would you go over that revenue estimate again?

Mr. KIES. Under the particular proposal that I——

Mr. MCCRERY. I got the $50,000 and $100,000. I got all the details. I just missed the number.

Mr. KIES. The number is $8.1 billion over a 5-year period.

Mr. MCCRERY. $8.1 billion, that is it.

Mr. KIES. Now, you can change it. For example, if you were to impose it at $50,000 for a single and $75,000 for a married couple, it raises $12.4 billion. So where you put the threshold amounts obviously has a lot to do with it. And keep in mind under that proposal we would be charging 75 percent of the total cost. So if you took it up to 100 percent, you would probably see the revenue increase by 30 or 40 percent.

Mr. MCCRERY. Have you given some thought as to how we should define income?

Mr. KIES. Clearly, the simplest approach would be adjusted gross income. However, in an attempt to more closely approximate ability to pay, you may want to add, for example, tax-exempt interest which would not normally be includable in adjusted gross income. Clearly, I think the simple starting point would be adjusted gross income, since it is already determined on the return and making it easy for people to determine what point they are at relative to the thresholds I think is fairly important for the ability to administer.

Mr. MCCRERY. If we are really looking to get those who are able to pay something closer to the true value of what they are getting, then we should consider something other than the AGI or something in addition to the AGI.

Mr. KIES. If you were trying to get closer to ability to pay, you would want to pick up other forms of income that are significant. Tax-exempt income could be a significant item. There does not immediately come to mind anything else that probably fits into that category that is probably as prevalent among those in the over age 65 category.

Mr. MCCRERY. And how do we go about getting that information?

Mr. KIES. We have data relative to distribution of tax-exempt income. Currently, I think you have to check a box on your return if you do have tax-exempt income, because it can enter into minimum tax calculations and things like that. So that would not be a significant increment and complexity, if that were the definition that the subcommittee wanted to choose.

Mr. MCCRERY. Thank you, Mr. Chairman.

Mr. KIES. The one other element is the fact that Social Security income is not currently all included, because currently you are only taxed certain amounts over certain thresholds, so that is probably the one other significant source of income besides tax-exempt income.

Chairman THOMAS. I thank the gentleman.

Obviously, in your capacity we are going to be asking you to slice this particular apple in a number of different ways. I think the record needs to show that, although obviously the Joint Tax Committee and the Ways and Means Committee ultimately looks at the question of revenue and how these changes might generate *x* number of dollars, what we are also doing is talking about equity and fairness in terms of a policy, since in focusing on part B we want to underscore again that this is money that comes, except for the small portion from the beneficiaries, out of the general fund and that it is a gift to individuals, with no relationship to their wealth.

An idea that I want to begin exploring with you is the idea that Senator Gregg mentioned, the concept of a Medicheck or an ability to allow someone to take the actuarial value of the Medicare program and spend it in the private sector for health goods and services, and that perhaps the amount of the Medicheck might be structured in a way in which the more wealthy individual got a smaller check. As you understand the concept, would there be any more complexity in trying to work out a structure like that than the one that you just discussed, which is the question of how much you have on your AGI and adjust it in terms of how much you would get on the 80/20 split?

Mr. KIES. I guess my initial thought, Mr. Thomas, is that most of the complexity would be associated with the fact it would be something new and different. If we were to use adjusted gross income as the means of determining how much of a Medicheck each individual would be entitled to, then the actual mechanics would not be significantly dissimilar to what we are talking about here.

Chairman THOMAS. So from a mechanical point of view, in a general sense, we do not really have a problem. We worked in this area enough that we could solve it. It is just the policy that has to be determined?

Mr. KIES. I think that is correct, substantially a health care issue policy, as opposed to how you do it through the tax system.

Chairman THOMAS. Thank you very much.

Any further questions?

[No response.]

I do think for the record we should indicate that the U.S. Treasury was asked to testify at this hearing and they declined and submitted no written testimony.

Could we then ask for the next panel, which may begin to bridge the gap between tax policy and health care policy. Coming forward on this panel would be Stuart Butler, who is vice president of the Heritage Foundation, and Gail Wilensky, who is a senior fellow at Project HOPE, and someone who has participated in the previous administrations in a number of leadership capacities, among them HCFA and others in the Bush administration.

Thank you very much for your willingness to testify in front of the subcommittee. I will say that any written statement that you have will be made a part of the record, without objection.

Stuart, if you want to begin, you can inform us in any fashion you see fit that would get the message across.

STATEMENT OF STUART M. BUTLER, PH.D., VICE PRESIDENT, THE HERITAGE FOUNDATION

Mr. BUTLER. Thank you, Mr. Chairman, for the opportunity to testify today on the future of the Medicare part B program.

I believe that Congress needs to approach reform of the program this year with two objectives firmly in mind. First, entitlements like part B need to be reviewed for ways to reduce the net outlays of the Federal Government as part of a general commitment to reducing the Federal deficit. Second, Medicare, like all other programs of the Federal Government, needs to be subjected to a bottom-up review to explore better ways of achieving its objectives, as the two Senators both said earlier. The American people sent a strong message last November that they wanted such a review of all government programs.

The options for changes in part B, as I suggest in my written testimony, are intended to meet the first objective, but are also compatible with the second. To achieve broad-based structural changes in Medicare, I believe Congress should begin to institute changes that will move Medicare away from the current highly regulated system toward a system that provides eligible Americans with a fixed contribution toward the health plan of each retiree's choice. In that way, senior citizens with their doctor's advice could pick the range of benefits and type of plan that best meets their needs. And they would also have the incentive to choose the plan offering them the best value for the money.

In short, Mr. Chairman, retirees and the disabled would be given the same freedom as Members of Congress to choose the type of plan that is right for them. I think as Senator Gregg emphasized, the FEHBP is a very different kind of program in terms of the incentives that apply to Federal workers and to Members of Congress. It is instructive that its rate of premium increase has been so low for many years, and I think it is a clear indication that a different dynamic occurs in that program compared with Medicare. So I would strongly urge Congress to combine changes in part B premiums with initial steps toward a reformed system of that kind.

In my written testimony, I lay out the arguments for raising the part B premium in concert with the general reform of Medicare. It is important to remember some things about part B. As you pointed out yourself, Mr. Chairman, unlike the hospital insurance segment of Medicare, part B is a voluntary program. It is not a social insurance program. In reality, it is a below-cost commercial service offered by the Federal Government. The beneficiaries' contribution is a flat amount unrelated to income, and the program is heavily subsidized by the general taxpayer, even for very affluent retirees.

When the part B program was launched, the subsidy rate was 50 percent. It is now closer to 75 percent of outlays. Thus, part B today allows affluent elderly Americans to choose a health insurance plan offered by the Federal Government in which most of the

tab is picked up by the taxpayer. It is little wonder that 97 percent of the eligible population sign up for part B. It is hard to justify the generous subsidy, however, at least for those who do not need it, when so many cuts are being considered in so many other programs.

Part B costs also are growing at an alarming rate. The trustees' report in 1994 expressed great concern about the growth in spending. As the Kerrey Commission pointed out, the cost to taxpayers will increase sharply in the future. One way Congress can begin to rein in this sharp growth in taxpayer costs is by requiring those who can afford it to shoulder a greater share of the cost.

The heavy subsidy of part B also discourages the elderly from choosing plans that would better provide them with better health care at a lower real cost. Because part B charges the elderly only 25 cents on the dollar, far more innovative and efficient plans in the private sector cannot compete on price. Raising the part B premium would create a more level playingfield and encourage seniors to pick more efficient plans.

Even better, of course, would be for Congress to convert the part B subsidy into a fixed payment toward the plan of the eligible person's choice, one free of the rigidities of the current part B rules. That would allow elderly Americans to choose from a wider array of different types of plans and, thus, stimulate innovation and better services for the elderly.

Raising part B premiums, Mr. Chairman, is not a tax increase. You will not find officials of the Heritage Foundation coming to Congress to advocate tax increases. What we do advocate is that when the Federal Government offers an essentially commercial service to corporations or individuals, generally it should charge the full cost. That goes for airport landing fees, as well as for health insurance. If a particular group of Americans truly deserve to be subsidized, then they should be subsidized directly, not through a price break available to everyone else.

Raising part B premiums means cutting the subsidy that should not be available to many Americans. The issue is how to reduce that subsidy in the fairest way. In my testimony, Mr. Chairman, I suggest three options available to Congress, but several variants are possible.

To summarize them, Congress could look at raising the part B premium to the full cost of the program. That would save a great deal of money, but it would impose enormous costs on low-income Americans. Raising the premium back to the percentage that was envisioned when Medicare was launched, at 50 percent, obviously would save less money, but would still retain a large subsidy to people who do not need it.

That is why I think that the third option, the compromise that others already mentioned, is the one to explore. That would be to means test premiums for upper-income beneficiaries. This option accepts that subsidizing needy Americans is a function of Medicare part B, but would limit that subsidy to those who need it most. A wide range of formulas could be used, but essentially Congress would continue the current level of subsidy up to a certain threshold and then phase out the subsidy—that is, raise the premium in

increments as income rises until the premium covers the full cost of coverage.

Mr. Chairman, I must emphasize again, in conclusion, that premium changes should be instituted in tandem with initial steps toward a general restructuring of the Medicare program. It is necessary to curb the costs of the Medicare program and the costs of other entitlements. The aim of the structural changes should be a Medicare system in which retirees receive a contribution toward the cost of coverage when adjusted according to income which they may use to enroll in the plan of their choice.

Such a system would have to be introduced gradually and would require certain changes in insurance rules for private insurance plans serving the Medicare population. But if the long-run expenditures of Medicare are to be brought under control, while assuring the widest choice and value for money for retirees, budget savings must be accompanied with the first steps toward structural reform.

Thank you, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF STUART M. BUTLER
THE HERITAGE FOUNDATION

Mr. Chairman, my name is Stuart Butler. I am a Vice President at The Heritage Foundation. I appreciate the opportunity to address the subcommittee on the issue of Medicare Part B. I emphasize that the views I express are my own, and should not be construed as representing any official position of The Heritage Foundation.

The American people sent the powerful message last November that they want Congress to undertake a radical overhaul of government. They want Congress to review the activities of the federal government to determine how to move functions closer to the people. They want Congress to curb the growth of government and its intrusion into their lives. And they want Congress to look at how to reform those programs within the domain of the federal government so that they can better achieve their stated purposes.

Congress has an unprecedented opportunity to undertake such a fundamental reform of the Medicare program. It must do so in the context of the immediate need to take steps to balance the books of the federal government and to rein in the huge growth in federal spending over the last several years, which has pushed the country into debt while raising the burden of taxes on Americans. More specifically, Congress must consider Medicare reform in the context of a general reform of entitlement spending. None of the entitlement programs can be considered "off the table" as Congress grapples with the deficit -- especially programs that provide large subsidies to one generation by passing the tab to the next.

The Medicare system thus should come under careful review, to see if sensible savings can be achieved while reforms are undertaken. As I will point out in this testimony, among the many possible reforms to achieve a reduction in the growth of net outlays of Medicare, Congress should consider is an increase in the heavily-subsidized Medicare Part B premium. As I will explain, this can be justified whether or not the objective of the reform is to reduce net outlays.

Still, any changes in the Medicare Part B premium should be taken in tandem with steps towards structural reform of the entire Medicare program. That structural reform should move Medicare away from the current highly-regulated system, characterized by complex price and volume controls and Washington-specified services, towards a system which seeks to protect the health of eligible Americans as economically as possible. In this latter, reformed Medicare system, retirees would have the widest possible discretion to enroll in plans of their own choosing, with the benefits they and their doctors feel are right for the retiree, and with the government making an appropriate contribution towards the cost of the chosen plan.

With the government making a fixed contribution for each retiree, Medicare beneficiaries not only would have the freedom to choose the benefits and type of plan they preferred (such as fee-for-service or managed care), but they would also have the incentive to seek out the best value for money among plans. This reform would give retirees in Part B choices and incentives very similar to those applying to Members of Congress under the Federal Employee Health Benefits Program. It is no coincidence that the FEHBP has managed to keep increases in enrollee costs well below those of Medicare and, more significantly, those of corporate health plans, while maintaining a high level of satisfaction.

The possible changes in the Part B premium I will review are compatible with this structural reform.

The Case for Raising Part B Premiums

The Medicare Supplementary Medical Insurance (SMI) program, known as Part B, pays for physician services, outpatient hospital services, and other medical expenses for Americans aged 65 and over and for the long-term disabled. Unlike the hospital portion of Medicare (HI), enrollment in Part B is voluntary. And unlike the HI program, Part B services are paid for through a system of premiums (supplemented with general revenues) rather than with the payroll taxes. According to the most recent report of the Board of Trustees, SMI disbursements in 1993 were $57.8 billion ($54.0 in benefits). The program received $41.5 billion in general revenue contributions in 1993 (71.9 percent of income).[1]

This subsidized, voluntary program is very popular. At the time of its enactment on July 1, 1966, 17.7 million aged persons enrolled in Medicare Part B. This population has steadily increased over time. In 1990, 32.6 million aged persons were enrolled in Medicare Part B. In 1995, 35.7 million persons are enrolled in Part B, or 97 percent of the total Medicare population. In 1990, 3.2 million enrollees were covered under both the Medicare and Medicaid programs (The state paid for premiums and required cost sharing expenses).

There are several reasons for making changes in the Part B program, and in particular for requiring some beneficiaries to shoulder a higher proportion of program costs. Among them:

1. Part B is a heavily subsidized entitlement without regard to income or any past contributions

Unlike the HI program (Part A), the benefits available from Part B are not even in theory based on contributions made by recipients during their working years. Instead it is a government-sponsored health insurance program that is heavily subsidized by taxpayers (including many elderly Americans who have chosen not to enroll).

The subsidy is roughly three dollars for every dollar of premium paid. More precisely, beneficiaries in 1993 contributed just 24.6 percent of program income.[2]

When Part B was established, it was Congress' intention to provide a subsidy, but at a much lower rate than today. Until 1973, SMI premiums were set by law to finance one half the benefit and administrative costs of the program plus a small contingency amount to go into a separate trust fund. However, in 1972, Congress amended the Social Security Act and drastically altered that arrangement. Beginning in July 1973, SMI premiums could be increased only if monthly Social Security cash benefits were increased. Premiums are permitted to rise no more than the percentage increase in cash benefits. Since the 1972 amendments, the proportion of Part B income contributed by enrollees has declined, and so the degree of subsidy has increased. Enrollees in 1995 pay a premium of just $46.10 for insurance that covers 80 percent of allowable charges with a deductible of only $100. Had the original deductible been allowed to rise in line with outlays, it would be over $1,000 today. With such inexpensive and generous coverage, subsidized by the taxpayer, it is little wonder that almost all eligible Americans decide to enroll in Part B.

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[1] Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, *1994 Annual Report of The Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund* (Washington D.C.: US Government Printing Office, April 1994), p.1

[2]

When working Americans are facing up to the need to tighten their belts and accept reductions in federal programs, it is hard to see why, at the very least, more affluent retirees should not contribute a larger share of the cost of Part B. While Medicare Part B requires the payment of premiums, it is actually an income transfer program, taking away income from one segment of the population and redirecting it to another, without regard to the latter's income.[3]

2. Part B costs are growing at an alarming rate

In the 1994 Trustees' Report to the Congress, the financial outlook for Medicare Part B is not encouraging. While the Trustees believe the SMI program is currently actuarially sound, they "[n]ote with great concern the past and projected rapid growth in the cost of the program...Growth rates have been so rapid that outlays of the program have increased 59 percent in aggregate and 45 percent per enrollee in the last five years. For the same time period, the program grew 23 percent faster than the economy despite recent efforts to control the cost of the program."[4] While the Trustees do not make any long range projections like they do in the HI (Part A) program, they point out that the SMI program will be affected by many of the same factors that are projected to increase Part A's costs (medical inflation, a rapidly aging society, etc.)

Part B outlays are growing at such a rapid rate that they are consuming an ever-larger share of the gross domestic product (GDP), as are HI expenditures. In 1993, Part B spending constituted 0.88 percent of GDP. This year the proportion is projected to be 0.99 percent, and in just 10 year's time the proportion is projected to be 1.17 percent.[5]

Such an alarming rate of increase in a program, particularly a voluntary enrollment program, demands congressional action to curb the growth of future outlays, by benefit reductions and/or by requiring at least some beneficiaries to shoulder a greater share of costs.

3. The generosity of Part B subsidies is a barrier to finding more economical and efficient ways of providing health care services to the elderly

Since enrollees pay only 25 percent of the costs of Medicare Part B, insurance alternatives to the program generally are very unattractive even if they are actually much more efficient in delivering services -- unless the proportion of the premium paid by the private sector enrollee is close to 25 percent. Some corporate retiree plans require low cost sharing from beneficiaries, and so are competitive with Part B. But if, say, a retiree had to pay the full cost of equivalent insurance coverage, Part B could be almost three times as costly in delivering services (including overhead) and it would still be more attractive to the retiree. There are good reasons to believe that because of this wide price differential, made possible by the heavy subsidy, Part B is under less pressure to realize true efficiencies. Its payment schedule is a highly complex price control system, for instance, and is very inflexible, and only nine percent of enrollees are in managed care. In the competitive private sector, by contrast, there is continuous adjustment of pricing and benefit levels as plans seek greater efficiency, and there has been a quite dramatic shift in recent years to managed care.

Reducing the subsidy level in Part B would encourage many retirees to compare the costs and benefits of private alternatives with those of the Part B program. The

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[3] David Koitz, *Medicare Taxes, Premiums, and Government Contributions for 1995*, CRS Report for Congress, p. 2, December 20, 1994.
[4] *1994 Annual Report*, p. 3.
[5] Guy King, "Health Care Reform and the Medicare Program," *Health Affairs*, volume 13, no. 5, Winter 1994, p.41. Projections based on Trustees Report.

further the subsidy were reduced, and hence the more level the playing field, the greater would be the inducement to pick more efficient private plans. That would lead to a reduction in the outlays of the program.

Whether or not the subsidy level is reduced, the desire to introduce greater incentives for efficiency has led many analysts to favor reforms that would reconstitute Medicare Part B (and Part A) into the equivalent of a voucher program, to give the elderly the opportunity and incentive to choose plans and benefits that are very different from Part B. This reform would not, in itself, change the government's contribution to retirees, but it would give them far more freedom of choice and a strong incentive to seek the best value for money among private-sector plans competing on an equal footing with the Part B program.

Options for Raising Part B Premiums

Not a Tax Increase. If this subcommittee gives serious consideration to reducing the level of subsidy by raising the Part B premium, members no doubt will be accused by some critics as favoring a tax increase.

An increase in the Part B premium is *not* a tax increase.

Members of this subcommittee can feel very confident that as a senior official of The Heritage Foundation, I would not come before you and advocate a tax increase. On the other hand, while opposing tax increases, we at Heritage have consistently argued that individuals or corporations receiving an explicit service from government -- especially one which could also be provided by the private sector -- should pay the full cost of that service unless there is some pressing reason for a subsidy (such as poverty). And such as subsidy should be explicit, rather than hidden in the price of the service. This is why scholars from The Heritage Foundation have testified before various committees and published studies advocating full-cost user fees for commercial services available from the federal government.

Part B is a "commercial" service provided by the federal government. If there is to be a subsidy for enrollees in the program, it should be restricted to those whom Congress has determined cannot reasonable afford an acceptable level of physician services and other services available under Part B. There is a strong case for ending the subsidy available to other Americans.

While a case can be made for greater cost sharing in Part A, the case is much stronger for Part B. Americans contribute to their Part A benefits throughout their working life. Those contributions are mandatory and are income related. Thus there is reasonable argument against mean-testing Part A or reducing benefits if they fall below the equivalent value of payroll contributions. No such argument applies to Part B. Part B is voluntary -- retirees and the long-term disabled examine the cost of coverage under the subsidized Part B program and under private alternatives and choose whether or not to enroll.

Under current law, according to the Congressional Budget Office, the federal government is projected to spend $485.9 billion over the next five years in Part B payments (of which premium payments cover just 25 percent).[6]

Outlays (in billions of dollars)

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[6] Congressional Budget Office, "CBO December 1994 Baseline, Outlays by fiscal year, in billions of dollars," January 9, 1995.

1996	1997	1998	1999	2000
75.3	85.3	96.1	108.0	121.2

There are several options available for raising Part B premiums.

Option 1) Raise the beneficiary premium to 100 percent of costs.

While obviously the most difficult option politically, this change could achieve net savings to the program of as much as $364 billion over five years, depending on the assumptions made.[7] Even if this sharp increase had applied in 1995, beneficiaries still would pay just $184.40 per month for good coverage.

But needless to say, this change would be a great hardship for many lower-income Americans. It would also be a new burden to states, unless states chose to maintain their current level of financial support for individuals also on Medicaid -- in which case these low-income Americans would face relatively large premium costs.

Option 2) Raise the premium contribution level to 50 percent of costs.

Congress originally set the premium for Part B at 50 percent of costs, and so this option would merely reinstate that premium percentage. This would still retain a heavy subsidy to enrollees, regardless of income. Had this change been in effect in 1995, premiums would be $92.20 per month. The net savings to the government from this change would be as much as $121.5 billion over five years.

While lower-income enrollees would not be affected by this change as much as under option 1, many would still face hardship -- while upper-income enrollees would continue to be heavily subsidized.

Option 3) Means-test premiums for upper-income beneficiaries.

A compromise change would be to reduce the subsidy as income rises. The savings achievable from such a change would vary widely, depending on what method of means-testing was introduced.

A general concern about any means-testing system is that it has the equivalent effect of raising marginal tax rates for individuals enrolled in the program, since premiums rise with income. Still, this effect could be kept quite small. Consider the following change:

> Gradually reduce the Medicare Part B premium subsidy for "high retirement income" beneficiaries. The threshold begins at $65,000 adjusted gross income for individuals and $85,000 for couples. The subsidy is phased out in increments of 3 per cent per $1,000 of income above the threshold. The full premium would be paid by individuals above $98,000 AGI and couples above $118,000 in AGI.

The increase in equivalent effective marginal tax rate in this case would be approximately 5 percentage points.

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[7] A change of this magnitude would have large behavioral effects which are beyond the scope of this analysis. Clearly one effect would be that the number of persons enrolled in Part B would decline, as individuals comparing premium costs chose more competitive private plans. That would reduce outlays and the net savings to the deficit.

While these reductions in the subsidies in Part B would yield savings to taxpayers, I must emphasize again, in conclusion, that such changes should be instituted in tandem with initial steps towards a restructuring of the Medicare program. The aim of the structural changes should be a Medicare system in which retirees receive a contribution towards the cost of coverage (perhaps inversely related to income) which they may use to enroll in a plan of their choice. Such a system would have to be introduced gradually, and would require certain changes in insurance rules for plans serving the Medicare population. But if the long-run expenditures of Medicare are to be brought under control, while assuring the widest choice and value-for-money for retirees, structural reform is essential.

Chairman THOMAS. Thank you very much, Dr. Butler.
Ms. Wilensky.

STATEMENT OF GAIL R. WILENSKY, PH.D., SENIOR FELLOW, PROJECT HOPE

Ms. WILENSKY. Thank you.

Mr. Chairman and members of the subcommittee, I thank you for inviting me to speak before you today. I know that you are in the middle of a series of hearings on Medicare and commend you for the review that you are undertaking. It is important to consider Medicare in its entirety, although I recognize that today's hearing focuses on part B. It is important that whatever changes are made to the Medicare program are made with long-term objectives in mind.

Medicare is in serious need of reform. Part A, funded by the trust fund, as you have heard is running out of money. According to the intermediate assumptions, the latest trustees' report projects that the HI Trust Fund will be bankrupt in the year 2001. I know you have heard that before, but it is important that we keep stating this fact.

While part A does not have the immediate impact on the deficit of part B, the need for change is clear and unmistakable. Part B, which is financed three-quarters by the general fund and one quarter by premium payments from the elderly, poses a different set of problems. It is not a trust fund which is being drained of resources, but, rather, the Federal budget that is being adversely affected.

At a time when spending in the private sector has slowed dramatically, the increases in spending for Medicare continues in double digits. Between 1983 and 1991, Medicare spending grew more slowly than spending in the private sector. But since 1991, Medicare has grown substantially faster, 6.5-percent versus 4.7-percent growth in real spending adjusted for inflation per capita.

The differential appears to be even more dramatic in 1993–94, where spending in the private sector increased at a rate of 2.5 percent, while spending for Medicare increased at a rate exceeding 10 percent. According to CBO baseline estimates, part B growth for fiscal year 1995 is 10.9 percent, with growth rates between 12 and 13 percent per year for the remainder of the decade.

Even growth rates in spending for the physician component, which in this fiscal year was projected to grow less than 6 percent, are expected to grow between 9 and 12 percent per year throughout the rest of the decade. The growth rates for durable medical equipment, laboratories, outpatient hospital spending, and other part B costs are projected to grow even more rapidly.

But we should not be surprised at this outcome. There are few incentives for the elderly to seek cost-effective providers or for their physicians or medical suppliers to limit the spending on them. It is particularly a problem for hospital outpatient spending and clinical lab procedures, but it is also a problem in your efforts to moderate physician spending.

An individual physician's behavior has little bearing on the changes in fees to that individual physician, as a result of expenditure goals being met or not met. And this combined with the cost-increasing incentives inherent in a la carte fee-for-service medicine

means that there are few incentives for physicians to practice cost-efficient and prudent medicine, and no rewards for those that do.

Effective reforms will need to change the basic incentive structure associated with Medicare. There is no incentive for the elderly to see cost-effective physicians or hospitals or to use lower cost durable medical equipment, laboratories or outpatient hospitals. Similarly, hospitals are encouraged to increase the use of outpatient admissions and procedures and physicians are rewarded for doing more, when doing less might be as good or better.

Ultimately we need to reward the elderly for choosing more cost-effective plans. We need to provide incentives for physicians and hospitals to order and prescribe the cost-effective medicine that is available and to be willing to share the savings which an aggressive reorganization of health care can produce.

I believe that a better use of a redesigned adjusted average per capita payment, the AAPCC payment which is currently used for capitated plans, could become the basis of a voucher or that some other vehicle, like Mr. Thomas' Medicheck, which would encourage the cost-effective choices could be put in place. It would require redesigning the determinants of the AAPCC, making it more stable, taking better account of risk selection, and also opening up more choices toward which the payment can be made.

I have a number of specific suggestions for making these changes, such as having Medicare Select available everywhere, allowing point-of-service plans, having partial capitation and several other specific reforms that I hope you will consider.

In the short term, however, it is possible to make changes that will move the Medicare system toward a better direction. Targeting the subsidy associated with part B so that it is more focused on low-income elderly, and so that it encourages more cost-effective choices of plans would begin to move us in a better direction than where we are now.

There are several ways to do this. One is to keep the part B structure as it is for the poor and middle-income elderly and gradually reduce the subsidy from its current level of 75 percent to a 25-percent level for upper-income elderly. These reduced subsidies could begin for individuals with incomes of $50,000, $75,000 or $100,000, depending on your perception as to where reduced subsidy should begin, and also on the revenue needs of the Congress. Proposals of this nature were included in the previous two sessions of Congress.

A second strategy would be to increase the part B deductible to $1,000 from its current level of $100. This would actually represent the $50 deductible originally introduced in 1965 indexed for medical inflation. As long as you kept the qualified Medicare beneficiary, the so-called QMB program, in place, and regular Medicaid payments for the poor elderly, there would be protection for lowest income elderly people.

The SMI premium could then be lowered to as little as $4 a month for either all elderly or those who are less than twice the poverty line, with increasing amounts of payments for premiums for higher income elderly. Both these strategies would reduce the fiscal pressures on the budget by reducing the amount of subsidies currently being paid. But the second strategy with the higher de-

ductible would encourage the elderly to seek out plans that provide Medicare services in a more cost-effective manner.

It would be desirable to set the combined Medicaid and Medicare subsidy for part B at a level which covers the full costs of the most cost-effective plans in an area, so that even the lowest income Medicare elderly can be encouraged to seek cost-effective care.

There are other strategies which would encourage more cost-effective part B use, such as sharing any savings that result from the elderly using services provided at levels below current Medicare payments and possibly using competitive bid prices where that makes sense.

Medicare is a large and complicated program, and despite the many changes that have been made during the course of the last 12 years, expenditures continue at rates that are unsustainable in the future. No single change will solve all of the program's problems. A better targeting of part B subsidies is a reasonable start, both on grounds of equity, as well as efficiency. But eventually more changes will need to be made to produce a fair and efficient program.

Thank you.

[The prepared statement follows:]

TESTIMONY OF GAIL R. WILENSKY
PROJECT HOPE

Mr. Chairman and members of the subcommittee, thank you for inviting me to speak before you today. My name is Gail Wilensky. I am a Senior Fellow at Project HOPE, an international health education foundation, but I am here today representing only my own views on Medicare reform. My testimony should not be regarded as representing an official opinion of Project HOPE.

I know that you are in the middle of a series of hearings on Medicare, and commend you for the review that you are undertaking. It is important to consider Medicare in its entirety, although I recognize that today's hearing focuses on Part B reform. It is important that whatever changes are made to the Medicare program are made with the long term objectives and goals of Medicare reform clearly in mind.

The Need For Reform

Medicare is in serious need of reform. Part A, funded by the HI Trust Fund, is running out of money. According to intermediate assumptions, the latest Trustees report projects that the HI trust fund will be in deficit in the year 2001. While Part A does not have the immediate impact on the deficit of Part B, the need for change is clear and unmistakable.

Part B, which is financed three-quarters by the general fund and one-quarter by premium payments from the elderly, poses a different set of problems. It is not a trust fund which is being drained of resources, but rather the Federal budget that is being adversely affected. At a time when spending in the private sector has slowed dramatically, the increases in spending for Medicare continues in double digits.

Between 1983 and 1991, Medicare spending grew more slowly than spending did in the private sector. But since 1991 Medicare has grown substantially faster than spending in the private sector, 6.5% versus 4.7% growth in real spending, per capita. The differential spending rates appear to be even more dramatic for 1993-1994, with spending in the private sector increasing at a rate of 2.5%, while spending for Medicare increased at a rate

exceeding 10%.

According to the Congressional Budget Office baseline estimates, Part B growth for fiscal year 1995 is 10.9%, with growth rates between 12%-13% per year for the remainder of the decade. Even growth rates in spending for the physician component, which in this fiscal year is projected to grow slightly less than 6%, are projected to grow between 9% and 12% per year throughout the rest of the decade. Growth rates for durable medical equipment, laboratories, out-patient hospital spending, and other Part B spending are projected to grow even more rapidly.

We shouldn't be surprised at this outcome. There are few incentives for the elderly to seek cost-effective providers, or for their physicians or medical suppliers to limit the spending on services provided to the elderly. This is particularly a problem for hospital outpatient spending and clinical lab procedures, but it is also a problem in your efforts to moderate physician spending. An individual physician's behavior has little bearing on the changes in fees to that individual that results because expenditure goals are either met or not met. This, combined with the cost-increasing incentives inherent in á la carte fee-for-service medicine, means there are few incentives for physicians to practice cost-efficient and prudent medicine, and no rewards for those that do.

Potential Strategies For Reform

Effective reforms will need to change the basic incentive structure associated with Medicare. Currently there is no incentive for the elderly to seek cost-effective physicians or hospitals, or to use lower cost durable medical equipment, laboratories or outpatient hospitals. Similarly, hospital are encouraged to increase the use of outpatient admissions and procedures, and physicians are rewarded for doing more when less might be as good or better. Ultimately we need to reward the elderly for choosing more cost-effective health care, provide incentives for physicians and hospitals to order and prescribe the cost-effective medicine, and be willing to share the savings which an aggressive reorganization of health

care can produce. I believe that the use of a better designed Adjusted Average Per Capita Cost (AAPCC) payment, the payment currently used for capitated plans, could become the basis of a voucher or another vehicle (i.e., Medicheck) which would encourage such cost-effective choices. It would require redesigning the determinants of the AAPCC to make it more stable and take better account of the risk-selection that now appears to occur, and also opening up more choices towards which the payment can be made. Specific changes that I would recommend would include the following:

- Allow Medicare-Select to be available everywhere.
- Allow point of service plans.
- Allow partial capitation or risk-based carve-out plans.
- Move to an annual open enrollment period for all changes in Medicare related policies; discontinue 30 day disenrollment policy for HMOs.
- Remove 50/50 rule for HMOs serving Medicare beneficiaries; require outcomes based reports plus consumer satisfaction measures.
- Allow HMO'S to price underneath the Medicare payment and rebate savings to the elderly.
- Refine/revise capitation rate.
    - Break link to fee for service spending;
    - Experiment with basing Medicare's contribution to the premium on a competitively bid level; use this amount as Medicare's contribution for fee for service plans as well;
    - Experiment with alternative calculations of a capitation payment for areas that can't support competitive bids;
- End tax-exempt status of employer provided supplemental plans and end subsidy to Medigap plans.

In the short term, however, it is possible to make changes that will move the Medicare system toward a better direction. Targeting the subsidy associated with Part B, so that it is more focused on lower-income elderly, and so that it encourages a more cost-effective choice of plans, would begin to move us in a better direction than we are now going.

There are several ways in which this could be done. One strategy is to keep the structure of the Part B premium as it is now for poorer and middle income elderly, and to gradually reduce the subsidy from its current level of 75% to a 25% level for upper

income elderly. The reduced subsidies could begin for individuals with incomes of $50,000, $75,000, or $100,000, depending on the perceptions as to where reduced subsidies should begin and the revenue needs of the Congress. Proposals of this nature were included in the previous two sessions of Congress.

A second strategy is to increase the Part B deductible to $1,000 from the current level of $100. This would represent the $50 deductible, originally established in 1965, indexed for medical inflation. The Qualified Medicare Beneficiary (QMB) program and regular Medicaid payments for the poor elderly would protect the lowest income elderly from the impact of this increase in the deductible. The SMI premium could be lowered to $4 a month for all elderly that are less than twice the poverty line, with higher income elderly paying increasingly higher premium levels.

Both of these strategies would reduce the fiscal pressures on the budget by reducing the amount of subsidies currently being paid. The second strategy would also encourage the elderly to seek out plans that provide Medicare services in a more cost-effective manner, but would allow those who are able and willing to choose more expensive care to do so. It would be desirable to set the combined Medicaid and Medicare subsidy for Part B at a level which covers the full cost of the most cost-effective plans in an area, so that the lowest income Medicare elderly can also be encouraged to seek more cost-effective care.

There are other strategies which would encourage more cost-effective use of Part B services, such as sharing any savings that result from the elderly using services provided at levels below current Medicare payments, and possibly using competitively bid prices for those services where competitive bids make sense.

Medicare is a large and complicated program, and despite the many changes that have been made during the course of the past 12 years, expenditures continue at a rate that is unsustainable in the future. No single change will solve all of the program's problems. A better targeting of Part B subsidies is a reasonable start, both on grounds of equity as well as efficiency, but eventually more changes will need to be made to produce a fair and efficient program.

Chairman THOMAS. Thank you very much, both of you, for your testimony, especially the succinct review and then concrete suggestions. We often wind up agreeing on the problem, without having anyone present options as to solutions.

The gentleman from Louisiana will inquire.

Mr. MCCRERY. Thank you, Mr. Chairman.

I thank both of you for your excellent testimony. As the Chairman said, we do appreciate the concrete suggestions that you offered us.

I know we are not here to talk about health care reform in general, but it seems to me that with a couple of your suggestions we would need to put in place some sort of medical malpractice reform before those types of suggestions could be taken seriously. Do you agree with that, either of you or both of you?

Ms. WILENSKY. I think that this is an important addition that we need to consider. We now have powerful drives in place because of concerns about product liability as well as malpractice liability, that lead physicians in hospitals to do more, when less may be as well, in order to protect themselves legally.

I think there has been some very interesting legislation that has been drafted in the last few years by Members of the House and the Senate, particularly those that fundamentally change the way malpractice and product liability would occur, and I think it is something that we ought to consider, if not part of the Medicare changes, as an accompaniment that needs to occur which will also benefit the Medicare program.

Mr. BUTLER. I think it is also true that there are other areas that one would have to explore, as you do with health care reform generally, such as insurance rules and so forth. If you are encouraging people to take a Medicheck or some payment and to shop around among different plans, then there are issues associated with how rates and premiums are set.

If you have a fixed payment irrespective of age of people, then there are going to be problems of adverse selection. So there are a number of issues you have got to look at. But these are the same issues, it seems to me, that you have got to look at for general health care reform.

I think part of what we are arguing is that one must see Medicare reform as part of a general approach to health care reform in this country and apply essentially the same principles, moving away from a price control regulated system in Medicare toward one where individuals have an incentive to look for choice, and also one in which providers of plans and designers of plans have a wide degree of freedom to innovate, particularly in the Medicare case, to begin simply to catch up with the private sector in terms of what is available. That is the way to get long-run reductions in the costs of the Medicare system.

You have got to make some short-term changes, as we all know, to meet budget requirements, but we should just make sure that those are compatible. But the long-run savings are achieved through structural reform, not through tightening up the existing system.

Mr. MCCRERY. I agree that it would be difficult for us to encourage or to use incentives for physicians to do less without some

backup on medical malpractice, because I do not think you get the results we desire if we did not do that.

In all this talk about means testing or income relating part B, I did not hear either of you in your oral testimony—I have not had a chance to read your written testimony—talk about part A. In fact, it is already income related, is it not, to a great extent?

Ms. WILENSKY. Well, it is partly in place now in that the Medicare portion of the wage tax that is financing part A occurs without limit on the income base which provides some relationship to income. It is important, though, for people to understand that what they receive from the part A trust fund is far greater than anything they ever put in.

Even if you count the employer contribution as part of the individual's contribution, somebody who is retiring as late as the early nineties can expect to take out two and a half times more than they have put in. So it is true that the way it is financed provides for some built-in income relationship, but it is important for people to understand there is a lot of money being transferred between the currently working and the currently retired population in part A that is going to come back to haunt all of us.

Mr. MCCRERY. Will that continue to be true in the outyears? I know you have said through the nineties, but we just lifted the cap just a couple of years ago, so eventually will that——

Ms. WILENSKY. No, that will still continue to be true.

Mr. MCCRERY. It will continue to be so?

Ms. WILENSKY. In fact, it is part of the problem that we face with the financial insolvency of the trust fund. It did not matter so much when we had fewer users relative to the payees of the trust fund, the wage earners, that people were taking more out than was being put in. But as those demographic dynamics have changes, it is tipping the fund into insolvency. So it is going to continue to be a problem, just less of a problem than if limits had not been eliminated.

Mr. MCCRERY. Mr. Chairman, my time is up, but——

Chairman THOMAS. If you want to continue, go ahead.

Mr. MCCRERY. Briefly to kind of wrap up this point. Even though part A is subsidized by general revenues——

Ms. WILENSKY. By the working population.

Mr. MCCRERY. By the working population. There is at least in part A some relationship to income in terms of what a person pays into the system. Whereas, in part B there is no relationship. So it would seem to make some sense if we have chosen that in part A to also apply that to part B to some extent, would it not?

Ms. WILENSKY. Of course, there is also the different precedent of Social Security in terms of including part of the Social Security payment as taxable income which also income relates that social insurance program, as well.

Mr. BUTLER. I think it is important also to recognize that there are fewer issues associated with part B than part A. In part A, one is contributing through one's working life and it is essentially a service which you have been mandated to pay for. Part B is an option and a voluntary system. Therefore, it seems to me that, in terms of fairness and equity, there is less concern about addressing part B in terms of the payment schedule and the premiums than

there would be in changing part A, even though a strong case can be made for changes in part A as well.

Mr. McCrery. As a matter of fact, Mr. Chairman—and, Ms. Wilensky, you correct me if I am wrong—as of the years 2001 and 2002, if we do not make any changes in Medicare part A, we will have to start subsidizing it with general revenues.

Ms. Wilensky. Right, the fund will be bankrupt.

Mr. McCrery. Thank you.

Chairman Thomas. Mr. Ensign.

Mr. Ensign. Thank you, Mr. Chairman.

Just to follow up on what Mr. McCrery said, I think that our Social Security system, as well as with our Medicare system, because it was not set up like an annuity type of a program, is almost like a pyramid scheme where at some point the people that are in at the beginning benefit, but the people that come too late pay the cost. People my age certainly are not looking forward to Social Security some day. They are not looking forward to Medicare being there some day. Obviously, unless some pretty severe and drastic changes are made to those systems, I do not think that they will be around in 30 to 40 years.

My question—and either one of you feel free to address—is about incentives in the system, having talked a little about Medisave accounts for the general population. Could you address whether you think Medisave accounts would work as well? If we did go to the Medisave accounts for Medicare, what level would those Medisave accounts have to be to provide the proper incentives for people to shop?

Ms. Wilensky. Well, it depends on how you want to structure it. One of the concerns with Medisave, where you have some pretax dollars set aside for health care, is self-selection or adverse selection, whether some of the sicker people will find themselves in a difficult position, unable to finance their insurance purchase and their medical purchases.

If you think about the average payment that we use for HMOs or the Medicheck concept as being an amount that can buy an insurance plan, an average insurance plan, but one for which you can receive refunds or rebates, there really is a very natural linkage to the Medisave logic. That is, a person could buy a more catastrophically oriented health care plan, receive a rebate, a savings over what that smaller coverage would cost and be able to have that amount of money available for the direct purchase of health care.

It is just one of the many ways that this concept encourages people to buy what makes sense for them, to look at the best buy they could get for whatever amount of insurance they want to purchase and to use any additional moneys that may be available for other potential health care spending that may not be covered by Medicare or to have in the future, in case they have higher needs sometime in the future.

Mr. Ensign. Do you know what level that would have to be, that Medicheck, what kind of a subsidy would be required per person?

Ms. Wilensky. I do not, but it is a calculation that would be based in part on what the cost of a catastrophic plan would be and then how much you want to subsidize the spending up to the catastrophic plan, and whether you want that to be equally subsidized,

no matter who you are. You may want to make the amount either greater for greater health risks or greater for poor people.

But it is really the concept of do you want to move away from a heavily insured system or to have one where you have choice. Once you make that decision, technical policy advisers like us can design a plan that will meet your needs and meet your revenue.

Mr. BUTLER. I think one caveat I would want to emphasize is a Medisave component added to the current structure of a heavily regulated fee-for-service system only gets you a very small part of the way. It is very important to bring about a reform that allows very different methods of getting health care, everything from managed care to other things we have not even imagined yet. Simply to have a catastrophic Medisave version of what is currently in place is but a very small reform. You have got to think much beyond that.

Ms. WILENSKY. One of the major problems we have now is that the elderly, unlike the rest of us, have very little option in terms of what they can buy. The evolving, innovative delivery structures are just not available to the elderly. They can buy a very traditional, rigid HMO or they can stay in the sixties organized medicine that Medicare has always been. There is nothing inbetween that has been available, except for 15 States that used to have a preferred provider option, but even that authority has now run out.

So I agree very much with Stuart Butler, it is changing the design so that this is an option compatible with the other changes to make the elderly both more cost conscious and to give them rewards when they are—and to also reward their physicians and hospitals who provide cost-effective care.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman THOMAS. Senator Kerrey in his testimony I thought indicated a number of clear directions that we should go, one, lower the rhetoric so that we can create a bipartisan structure. But he also referred to a timeline in terms of perhaps we do not need to move forward quite as rapidly as some folks think.

I guess I am trying to put together the comments of the gentleman from Louisiana and your response, if we do nothing, part A is going to expire by 2001 approximately. And since we have removed any income limit, the only thing left is to raise tax rates, and that even skews the unfairness even more in terms of the high income paying into a plan for which literally they may not get the benefits out of it that they pay into it, contrary to Social Security now in terms of how much you get out of it versus what you pay into it.

I am just wondering if you share the timeline—I do not want to call it time limit complacency—I guess I do not, and I need to know if you folks think that I am pushing it too much to say we need to put in place some mechanisms in the 104th Congress. Because I believe we have a relatively enormous education process that we need to carry out, and perhaps that is going to be the most difficult thing. Any reaction?

Ms. WILENSKY. There are several points to make about that. First is that 6 years is not very long, no matter what, and then we are in serious trouble—the Congress and the country is in serious trouble in 6 years. The second thing is, if you are looking for reve-

nues from savings from this program, you want to be sure any changes that you make move you in the right direction and do not further complicate the issue.

Third, the sooner you start changes and moving in the direction you want to go, the wider your options, and the fairer in terms of signaling to people what they can expect when they get to be 65 years old. So technically you are not absolutely with your back against the wall in 1995. But, the sooner you start making these changes, the better the Medicare system and the fairer these changes will be.

Mr. BUTLER. I think also it is very important not to wait until the tidal wave engulfs us. The kind of changes we are suggesting, in terms of restructuring the system, will lead to cumulative savings over time. They are changing the basic dynamic of the system such that you begin to rack up savings over time.

If you wait until the crisis is upon you, then you will not get the big savings up front from implementing then what we are talking about now. Then you will tend more likely to put into place bad policies, tighter controls, more restrictions, forcing the elderly into plans they do not want. So I think it is very important that you begin a process where the payoff is down the road, but it is very substantial and in line with greater freedom and opportunity and innovation. So I would encourage you very much to move quickly to begin to put into place the kind of structure now that will be in place to avoid the crisis that otherwise is going to engulf you.

Chairman THOMAS. Let me come full circle so, as we finish this panel, I understand. We have not been talking about part A because of the funding mechanism. It is the part B which, as you correctly point out, Dr. Butler, is voluntary, but you wonder who would not voluntarily join up to a system that is going to give you 75 cents on the dollar, regardless of your income.

Mr. BUTLER. Mr. Chairman, it is what one might call "a steal."

Chairman THOMAS. A steal, rather than voluntary. However, there is going to be some political expense to make this change. We heard, for example, from Joint Tax that a reasonable structure would produce around an $8 billion amount. Obviously, you would get some behavioral reinforcement for the change.

My basic question would be, notwithstanding the desirability to do this for either revenue or behavioral changes, is it worth doing in the short run, when we are trying to keep our eye on that fundamental reform, and perhaps we could bring about a more balanced relationship between government goods and services and wealth in the fundamental reform, or is it one of those preconditions to making it easier to move into that reform, that is, should we do it or should we not, from a political and a policy point of view?

Mr. BUTLER. You are under two broad pressures, Mr. Chairman. Mr. Kasich is looking for all kinds of ways to achieve the objective of a balanced budget, and that is quite proper.

Chairman THOMAS. I thought we could close the doors on that for just a little while and talk about——

Mr. BUTLER. But it is a reality. It is a reality and, therefore, when you look at Medicaid, you want to put into place some changes which do contribute to that budget objective, but certainly

do not conflict with the longer run objective of Medicare reform. Whatever savings one can get now that are politically achievable makes sense. But I think what is crucially important, that whatever you do in terms of savings, whether it is $8 billion or more than that, must be combined with steps to deal with the real problem which is coming down the pike.

Ms. WILENSKY. Let me push you to go further, in part because I think that you will have to consider how much political capital you have to make these changes and how many times you can make them.

I agree that you will need some revenues in this Congress and you may not have the luxury of ignoring that need. But there are ways to partially or fully set in place the kinds of changes we have talked about, and I strongly encourage you to do those in this Congress, as well, such as to allow partial capitation or risk-based carve-outs, to have HMOs allowed to price beneath the Medicare payment and rebate savings to the elderly, to revise and refine how you do the capitation rate, breaking the link to fee-for-service spending in Medicare and tying it to a more reasonable rate of change, to look at the notion of having Medicare's contribution to a premium be based on a competitively bid level, at least on an experimental basis in places that make some sense, to use an outcomes based measure for quality and to include consumer satisfaction, rather than the current 50/50 rule requiring 50 percent commercial enrollees, as well as no more than 50 percent Medicare, and to change the nature of the enrollment period from this continuous 30-day enrollment/disenrollment to a onetime waiting period and then annual enrollment like the rest of us have.

Those kinds of changes are changes that could be introduced in the 104th Congress and that would begin to substantially change to this Medicheck or capitation oriented system, as well as to have some means testing components. So if you think that you can have the support of your committee members to go forward, I would strongly encourage you to have broader visions than only income relating part B.

Chairman THOMAS. I think that is basically the argument that any change is resisted, and that if you do a simple thing like means testing or income relating, you are going to get a degree of opposition. You might as well move as boldly as you can to get as many of these pieces in place, including this, because you will get resistance anyway. I think that is ultimately the political answer.

I appreciate your specific suggestions and, as technical policy advisers, we look forward to seeking your advice on technical policy changes. Thank you very much.

Ms. WILENSKY. Thank you, Mr. Chairman.

Mr. BUTLER. Thank you, Mr. Chairman.

Chairman THOMAS. Now we would ask the last panel if they would come forward: Jay Hopkins, Medicare policy analyst, Seniors Coalition; Martha Phillips, executive director of the Concord Coalition; Margaret Dixon, president-elect of the American Association of Retired Persons; and Max Richtman, executive vice president of the National Committee to Preserve Social Security.

I will tell all of you that your written statements will be made a part of the record, without objection. You have 5 minutes to in-

form us in any way you see fit. I guess we will just start on my left, your right, and move through the panel.

Mr. Hopkins.

STATEMENT OF JAY HOPKINS, MEDICARE POLICY ANALYST, SENIORS COALITION

Mr. HOPKINS. Thank you, Mr. Chairman, for allowing me to testify today.

Members of the Seniors Coalition recognize that the financial viability of Medicare part B faces some very serious hurdles in the next few years. Outlays for the program have increased 59 percent in aggregate over the past 5 years. We cannot stick our heads in the sand in hope to sustain such staggering growth rates without making changes. Members of the Seniors Coalition are also acutely aware of the fact that this country is grappling with major budgetary problems. Hence, our support of a balanced budget amendment.

If approached in a different climate, we would probably not be very receptive to the idea of income testing the part B premium. But the Contract With America is helping to create a new environment for seniors. Certain contract provisions would repeal the 1993 tax on Social Security, roll back the Social Security earnings test and improve access to long-term care insurance. Given that each of these changes would give seniors more control over their money, we feel that means testing the part B premium should be given consideration as being a component of a more comprehensive solution.

Funding for Medicare part B, unlike part A, does not come from a trust fund drawn from payroll contributions from future beneficiaries. Today, more than 70 percent of part B costs are subsidized by tax dollars drawn from the Federal Treasury. Given the system's current strain, it is not unreasonable to ask top-earning beneficiaries to accept a lower subsidy level. Although the resulting savings is unlikely to produce a revenue bonanza for the system, it should be viewed as an important part of the answer.

Let me stress that income testing part B premiums should only be considered within a full range of options to repair the system's troubled finances. The Seniors Coalition strongly supports the concept of a whole market basket of Medicare choices for seniors. Medicare vouchers, Medicare savings accounts, Medicare PPOs and Medicare HMOs are among the options that merit a closer look.

In any case, our members have made it clear that they do not want bureaucratic one-size-fits-all solutions. Seniors want a range of choices that can only be offered through greater participation by the private sector.

Thank you.

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

Ms. Phillips, welcome in front of this committee. You may proceed in any way you see fit.

[The prepared statement follows:]

TESTIMONY OF JAY HOPKINS
MEDICARE POLICY ANALYST
THE SENIORS COALITION

PRESENTED TO THE
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

Income-Testing Medicare Part B is a Reasonable Component of a Larger Solution

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Let me stress that income-testing Part B premiums should only be considered within a full range of options to repair the system's troubled finances. The Seniors Coalition strongly supports the concept of a whole market basket of Medicare choices for seniors. Medicare vouchers, Medicare savings accounts, Medicare PPOs and Medicare HMOs are among the options that merit a closer look.

In any case, our members have made it clear that they don't want bureaucratic "one-size-fits-all" solutions. Seniors want a range of choices that can only be offered through greater participation by the private sector.

STATEMENT OF MARTHA PHILLIPS, EXECUTIVE DIRECTOR, CONCORD COALITION

Ms. PHILLIPS. It is very interesting sitting on this side of the table.

I am Martha Phillips, the executive director of the Concord Coalition. The Concord Coalition is a 150,000-member organization dedicated to reducing the deficit and thereby ensuring the economic prosperity for future generations of Americans. We look at entitlement of issues from the point of view of the overall budget deficit.

Part B of Medicare is an entitlement. When the Concord Coalition put together its "Zero Deficit Plan for the Year 2000," which we now have to update for the year 2002, a central recommendation was entitlement means testing. All entitlements should be paid according to recipients' economic means. We included part B premiums as part of that means testing proposal.

In our plan, we suggested starting means testing in the $40,000 to $50,000 income range and completing the phaseout of entitlements at $120,000 at which point 15 percent of benefits would be paid. We have tightened down on Medicare many times previously, and yet the program still continues to grow, and grow, and grow. And as part of the long-term solution to balancing the budget, the Concord Coalition is convinced that more is still needed to be done and that means testing is a fair and equitable way to do part of the job. It will not do the entire job.

We are not alone in recommending that part B be income related. As early as 1991, in his fiscal 1992 budget, President George Bush proposed that individuals with adjusted gross incomes over $125,000 and couples over $150,000 be required to pay a part B premium equal to 75 percent of program costs.

Similarly, President Clinton's health care plan and last year's Penny-Kasich budget plan both made recommendations in this general direction. Clinton suggested the part B premium for individuals over $90,000 and for couples over $115,000 be gradually increased until the beneficiary pays half of program costs. Penny-Kasich would have required beneficiaries over $100,000 to pay the full monthly premium.

I should say that the Concord Coalition feels very strongly that if we do move to means testing, that money that is saved should be used to help reduce the deficit. We are not particularly excited about using it to pay for income tax cuts at this time. We think that it is more important to solve the deficit problem first.

Some people have suggested that means testing, whether it is for part B premiums or for other kinds of programs, has a number of negative effects that you should watch out for. It is often suggested that means testing will discourage savings. That kind of puzzles me, because there are economists who have studied savings behavior over time who believe that when the creation of Social Security and Medicare came into place, it discouraged savings because people then knew they did not have to save for their old-age retirement or their health care.

Now they say, well, if you tighten down on these programs, that discourages savings. So you cannot have it both ways. In fact, we think that many older people are target savers. They are saving for a specific amount of retirement income or for a cushion against un-

expected expenses. And if they know that they do not have so much safety net from Social Security and Medicare, if anything, it will encourage them to save even more.

We think that these programs can be shifted gradually and fairly and not have an abrupt negative impact on the elderly who do not see it coming. We dismiss the argument that means testing would turn these entitlements into welfare programs and, thereby, lose political support. On the contrary, I think many people would be heartened to know that their tax money was being targeted rather than squandered on benefits paid to people wealthier than they. If you started over and asked the question, "If this program did not exist, would you choose to create a program that provides so much benefit to upper-income people today"? the answer would probably be "no."

In closing, I would like to mention that we are very intrigued with the Harris Poll that has been conducted a number of times and keeps coming up with the same answer. They asked, "For you and your family, how much income do you think it would take to live in reasonable comfort, and how much would it take to fulfill all your dreams"? They broke out the responses by age group, and for people age 60 and over, the answer for living in reasonable comfort was $25,700, and dream fulfillment came at the surprising price of $56,900. Obviously, most of these older people live outside the beltway. But if you were thinking about what is an appropriate level to begin to apply means testing, you should keep these numbers in mind.

Thank you.

[The prepared statement follows:]

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STATEMENT OF MARTHA PHILLIPS,
EXECUTIVE DIRECTOR,
THE CONCORD COALITION
FEBRUARY 7, 1995

BEFORE THE HEALTH SUBCOMMITTEE,
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

Mr. Chairman and Members, I am Martha Phillips, the Executive Director of The Concord Coalition. The Coalition is a 150,000 member organization dedicated to budget deficit reduction and ensuring economic prosperity for future generations of Americans.

I am pleased to be with you to share my thoughts on Supplementary Medical Insurance (SMI), more commonly known as Part B of Medicare, which pays for doctors and outpatient services. Over 35 million aged and disabled Americans are enrolled in Part B. As this subcommittee searches for budget savings in the Medicare program as part of your cost-cutting and reform efforts, I would urge you to examine the nature of the Part B premium subsidy.

Currently, beneficiaries pay only about one-fourth of program costs; the remainder comes from general revenues. The question this subcommittee should ask is: should wealthy families continue to have their Medicare premiums subsidized by other taxpayers, including many taxpayers with far lower incomes.

According to the Congressional Budget Office, a substantial percentage of families with higher incomes currently receive Medicare benefits. In 1990, the CBO found that twenty percent of families with incomes above $150,000 received Medicare benefits.

As the Members of this Subcommittee well know, the Medicare program--both Part A and Part B--has long been a concern. Total Medicare outlays increased from $32 billion in 1980 to $131 billion in 1993, an average annual growth rate of 11.5 percent. Projections are that Medicare growth has slowed, but is expected to continue above nine percent. Medicare is now a full ten percent of the Federal budget.

This Subcommittee took a number of actions during the 1980s to slow the growth of Medicare spending, culminating in the most recent changes in the 1993 budget reconciliation, which together reduced the projected growth in spending in Medicare by a total of $56 billion for Fiscal Years 94-98. These reductions were achieved largely through reduction in inflation allowances for provider reimbursement, along with a continuation of the current policy of setting the Part B premium at a level to cover 25 percent of program costs. [1]

In 1993, following enactment of President Clinton's budget plan, the Concord Coalition put out a "Zero Deficit Plan" to complete the unfinished work of balancing the budget. This plan illustrated what a fair, balanced, gradual implementation of a balanced budget would look like. In the Zero Deficit Plan, The Concord Coalition recommended raising the enrollee share of the premium from 25 to 30 percent. An increase of five percent would mean a modest increase of about $8 to each enrollee. However, the total Federal savings of this proposal is almost $10 billion over five years.

Let me note at this point Mr. Chairman and Members that The Concord Coalition urges that any savings achieved in the Medicare program--or any other entitlement program--be reserved for deficit reduction and not spent paying for any tax cuts.

The Zero Deficit Plan also recommended a comprehensive means-test on all entitlement programs, including the insurance value of Medicare. We believe that means-testing the Part B premium is in keeping with this approach and we urge the Subcommittee to consider it.

As early as 1991, as part of his Fiscal 1992 budget, President George Bush proposed income-testing for wealthy enrollees. In that budget, President Bush said:

> A strong argument can be made that Part B provides benefits beyond the original intent of the program--insuring that affordable, quality care is available to seniors--by providing large subsidies to the wealthy.

President Bush went on to propose that individuals with adjusted gross incomes above $125,000 and couples with AGIs above $150,000 be required to pay a Part B premium equal to 75 percent of program costs. Similarly, President Clinton's health care plan, and last year's Penny-Kasich Budget Amendment have proposed that high-income beneficiaries pay a larger share of their Part B premiums.

President Clinton suggested that the Part B premium for individuals with over $90,000 and couples with incomes in excess of $115,000 be gradually increased until the beneficiary pays 50 percent of program costs. The Penny-Kasich Amendment would have required beneficiaries with incomes above $100,000 to pay the full monthly premium of about $150.

The Concord Coalition and its Members strongly feel the Congress should seriously consider a means-test of Medicare Part B premiums as well as other currently non-means-tested entitlements.

Mr. Chairman and Members, for our purposes today, it might be useful to examine a few of the arguments in opposition to means-testing. First, it has been suggested that means-testing would discourage savings; that people would divest themselves of their income-generating assets in order to qualify for full benefits.

Perhaps this is true for people whose target retirement income was at or below the approximate starting point for the means-test. It is probably not true for most of the people in the group of fortunate achievers who would be most affected by the means-test. In their working years, as they contemplate retirement, they probably have a target retirement income range in mind and an idea of the amount of assets it would require to achieve that income. People who desire to have, say, a retirement income of $60,000, $75,000, $100,000 or more, and understand that this would make them eligible for much less in Social Security and Medicare, would tend to save more rather than less in order to achieve their retirement income.

A second argument has been made that today's elderly should not be required to participate in such an abrupt change of policy direction because they have planned their retirements around a reliance on the existing benefit rules, and for them, it's too late to change their earning and saving patterns. But should the comfortably well-off people in this generation be given a free ride while financially struggling young families shoulder more of the burden? The essence of a means-test is to ask those most able to trim back their dependence on government benefits to do so in order that less can be required of others.

Finally, it is suggested that if the wealthy did not receive full benefits, retirement programs like Medicare would be viewed as "welfare" rather than an earned right and political support for the program would erode. The reality, Mr. Chairman and Members, is that the Medicare program is in very deep trouble, teetering on insolvency. At the same time, the working population supporting Medicare and Social Security is increasingly convinced benefits will not be available when they retire and may not for long support the burdensome payroll taxes required to continue the current program. I would argue that people would be more willing to support the system if they felt it was better targeted to those in need.

We should also ask ourselves if we were setting about not in 1965 but instead in 1995 to create a Medicare system, would we design it differently? I believe the answer is clearly yes, and if we want the system to survive another thirty years, we need to begin today to re-think many of the fundamental precepts of the programs, including whether or not wealthier Americans should be required to pay a larger share of their Medicare program costs.

In closing Mr. Chairman, I am reminded of a recent Harris Poll that asked Americans sixty years of age and older, how much income they needed to live in "reasonable comfort." The answer may shock you: $25,700. When asked how much income they would need to "fulfill all their dreams," the answer was $56,900. Knowing that, makes asking seniors with high-incomes to sacrifice somehow easier to do.

The Concord Coalition urges the Subcommittee to be bold and to be innovative. We believe the American people will support you if you make some tough choices. Requiring high-income beneficiaries to pay a little more of the cost in providing their health insurance is not only equitable and fair, it can be part of the solution that saves the Medicare system for future retirees.

Chairman THOMAS. Thank you very much, Ms. Phillips.
Ms. Dixon.

STATEMENT OF MARGARET DIXON, PRESIDENT-ELECT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. DIXON. Thank you.

I am Margaret Dixon, president-elect of AARP. I appreciate the opportunity to come before you to discuss the impact of income relating the Medicare part B premium. AARP opposes requiring an income related part B premium in the absence of health care reform that includes systemwide cost containment and some new benefits to cover the extraordinary out-of-pocket costs that beneficiaries face for uncovered services like prescription drugs and long-term care.

Without adequate control over systemwide spending, we believe that a new premium on high-income beneficiaries is nothing more than a cost shift. We also question the equity of singling out older persons, while continuing Federal health care subsidies for other Americans. It is one thing to propose progressive financing for health care; it is another thing altogether to support a seniors-only tax.

Older persons already spend more out of pocket for health care than any other age group. In 1995, older Americans will spend over $3,000 out of pocket for health care services and premiums, not including what they will have to pay for long-term care. Increasing the part B premium will only drive these out-of-pocket costs higher.

Imposing an income related premium is really nothing more than a shell game. It places an additional tax on the very people who are supposed to be helped by the Contract With America's provision to eliminate the 85-percent taxation of Social Security benefits. Moreover, the beneficiaries most affected by an income related premium are those who have already paid more into the part B program through Federal income taxes throughout their lives, and they continue to do so.

If Congress believes that income relating premiums is a good idea for the elderly, then private sector premiums for those under 65 should be income related as well. Savings to the Federal Government generated by reducing the tax break for employer provided health insurance for higher income workers would far exceed the increased revenues from the part B high-income premium. It does not seem fair for taxpayers to continue to subsidize corporate CEOs or Members of Congress, while subsidies to Medicare beneficiaries with much lower incomes are substantially reduced.

Many members of this committee were here in 1989 when Congress repealed another seniors-only tax. In that case, important benefits were lost as well. Some members of this committee spoke very firmly about their opposition to that tax. We see little difference between that tax and an income related premium, except that it would be considered catastrophic without the benefits.

The American Association of Retired Persons is prepared to work with members of the subcommittee to identify ways in which we can achieve systemwide control over health care costs, preserve Medicare and not result in the kinds of inequities posed by an income related part B premium.

Thank you.

[The prepared statement follows:]

TESTIMONY OF MARGARET DIXON
AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman and members of the Subcommittee, I am Margaret Dixon from Clinton, Maryland. I am President-elect of the American Association of Retired Persons (AARP). I appreciate the opportunity to appear before the Subcommittee today to discuss the implications for beneficiaries of income-relating the Medicare Part B premium.

AARP believes that decisions about whether beneficiaries should be required to pay more for Part B ought to be the outcome of careful policy deliberation about what is in the best interest of the Medicare program and its beneficiaries -- rather than a hasty attempt to simply shift more costs onto older Americans.

AARP also believes that careful consideration must be given to the question of whether it is equitable to single out older persons by requiring them to pay a significantly higher proportion of health care costs while continuing full federal health care subsidies for working Americans of all incomes. Currently, 75 percent of Medicare Part B costs are paid out of general revenues, Medicare beneficiaries pay the remaining 25 percent of Part B costs. Part A costs are funded by payroll taxes and are paid out of the Hospital Insurance (HI) Trust Fund. Thus, Medicare beneficiaries during working and retirement years pay 70 percent of the cost of Medicare benefits. General revenue contributions represent only about 30 percent of total Medicare costs. By contrast, Members of Congress and federal workers receive on average a 72 percent subsidy for their health insurance. In addition, employer-provided health insurance premiums are exempt from taxation. It is one thing to propose progressive financing for health care, it is quite another to support a "seniors only" tax.

The Medicare Part B Premium

Medicare Part B is financed from two sources -- general tax revenues and beneficiary premiums. Currently, all Medicare Part B beneficiaries pay the same monthly premium -- $46.10 a month or $553 a year in 1995. The only exceptions to this rule are low-income beneficiaries eligible for the Qualified Medicare Beneficiary (QMB) program whose premiums are paid by Medicaid.

Since Medicare was enacted, the calculation of the Part B premium has been reconfigured a number of times as health care costs increased, but in general since 1982 it has been intended to approximate 25 percent.

In the early years of Medicare, the Part B premium was set at a level equal to roughly one half of program expenditures. In 1972, Congress changed the premium calculation to equal the lower of 50 percent of the aggregate program costs for aged enrollees or the prior year's premium increased by the Social Security cost-of-living adjustment (COLA). The Ways and Means Committee's rationale for this change -- as stated in the report language of the 1972 Social Security Amendments -- was the concern over the increasingly severe financial burden that the premium amount would have come to represent in future years and the ability of beneficiaries to pay it. Simply put, it was recognized that premiums would not only absorb the COLA but would exceed it resulting Social Security checks that would fall behind inflation.

In 1982, when it became apparent that health care costs were rising so much more rapidly than the COLA that the premium was dropping below 25 percent of Part B costs, Congress fixed the Part B premium at 25 percent of program costs. This change actually went into effect in 1984. In OBRA '90, Congress set fixed dollar amounts -- projected to cover 25 percent of program costs -- in statute for 1991-95.

What Older Americans Really Pay Out-of-Pocket

The concern raised by the Ways and Means Committee in 1972 remains valid today. The Part B premium, coupled with other out-of-pocket spending, constitutes a very significant proportion of an older person's income. An increase in the Part B premium would mean that an even greater portion of retiree income would be eroded.

In 1995, older Americans are projected to spend over $3,000 for out-of-pocket health care services (including physician, hospital, drug, home health and durable medical equipment) and premiums. This amount does not take into account the cost of institutional care that drives out-of-pocket spending even higher. By the year 2002, out-of-pocket costs for older Americans are projected to increase to over $4,600. Assuming no changes in policy, over the next seven years -- between 1996 and 2002 -- older persons are projected to spend nearly $27,400 out-of-pocket for health care expenses. As a percent of income, older Americans spend about three times as much on health care expenses as younger Americans.

Just for Medicare alone, beneficiaries pay sizable out-of-pocket expenses in 1995 including:

- **Part B Premium:** Monthly premium of $46.10
- **Part B Deductible:** A $100 annual deductible for Part B services
- **Part B Coinsurance:** 20% coinsurance for most Part B services; coinsurance in excess of 50% for some outpatient services
- **Hospital Deductible:** One deductible of $716 per hospital admission (Re-admission within a 60-day period does not trigger another deductible)
- **Hospital Coinsurance:** For the 61st through 90th day of hospitalization ($179 per day); and from the 91st through the 150th day of hospitalization ($358 per day)
- **Skilled Nursing Facility (SNF) Coinsurance:** Daily coinsurance for the 21st through 100th day of SNF care ($89.50 per day)

Medicare beneficiaries are also faced with additional out-of-pocket costs for necessary services not covered by Medicare including:

- **Outpatient Prescription Drugs:** Beneficiaries are responsible for all outpatient prescription drug costs
- **Hospital Coverage Beyond 150 Days**
- **SNF Care Beyond 100 Days**
- **Daily Home Health Care Beyond 2-3 Weeks**
- **Long -Term Nursing Home, Adult Day Care or Respite Care Services**
- **Inpatient Psychiatric Care Beyond 190 Days**
- **Balance Billing:** Additional physician charges up to 15 percent over Medicare's reimbursement
- **Preventive Care Services:** Costs of routine physical exams, colo-rectal and prostate cancer screening, routine foot care and most immunizations
- **Cost of hearing aids and eyeglasses**

Imposing A High Income Part B Premium Is Merely Cost-Shifting

AARP has opposed increasing the Medicare Part B premium for higher income beneficiaries outside the context of health care reform. In the absence of comprehensive reform which would control health care costs throughout the system, a high income premium would constitute nothing more than a cost-shift to beneficiaries without adequate control over system-wide spending. Depending on where the thresholds are set for who is

"higher income" initially or over time, many middle income elderly could find themselves paying significantly higher Part B premiums. This would be similar to the history of Social Security taxation. The initial thresholds for taxation of Social Security affected 8 percent of beneficiaries but because they were not indexed now affect 25 percent of beneficiaries.

Moreover, imposing an income-related premium is really nothing more than a shell game. It places a comparable tax burden on the very people who are supposed to be helped by the Contract With America's provision to eliminate the higher, 85 percent taxation of Social Security benefits.

Ironically, the beneficiaries most affected by an income-related premium are the individuals who have already paid more into the Part B program through federal income taxes throughout their lives -- and continue to through the taxes they pay today.

If Congress believes that income-relating premiums is a good idea for the elderly and disabled, then it is at least as good an idea for the rest of the country. If the Part B premium is income-related, then other public and private sector premiums for the non-Medicare population should be income-related as well -- including those of Members of Congress. In fiscal year 1995 alone, the federal government was estimated to have lost **$56 billion** by providing tax breaks for employer-paid health care premiums.

Is it fair that taxpayers would continue to subsidize the health care premiums of a corporate CEO with a salary of more than one million dollars a year while subsidies to Medicare beneficiaries with much lower incomes are substantially reduced? AARP estimates that income-relating the tax subsidies for private insurance premiums in the same manner as has been proposed for a higher income Medicare Part B premium would raise about $20 billion between 1996-2000. (See Chart I)

Conclusion

Mr. Chairman, many members of the Committee were here in 1989 when Congress repealed another "seniors only" tax. In that case important benefits were lost as well. Indeed, some members of this Committee spoke very firmly about their opposition to that "tax." Aside from a higher threshold, we don't see the difference between that tax and the income-related premium being discussed today -- except that it would be considered "catastrophic" without the benefits.

Rather than beginning to bring health care costs under control, income-relating the Part B premium simply shifts the burdens to older Americans. Rather than addressing cost containment throughout the system, it singles out older persons by requiring them to pay a significantly higher proportion of health care costs out-of-pocket than other Americans.

The Association is prepared to work with you and the members of the Subcommittee on identifying ways in which we can achieve systemwide control over health care costs that will preserve Medicare and not result in the kinds of inequities and cost-shifting posed by an income-related Part B premium.

Chairman THOMAS. Thank you very much, Ms. Dixon.
Mr. Richtman.

STATEMENT OF MAX RICHTMAN, EXECUTIVE VICE PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. RICHTMAN. Thank you, Mr. Chairman.

The National Committee to Preserve Social Security and Medicare appreciates the opportunity to testify about the Medicare part B premium, which most of our members pay. The National Committee strongly opposes means testing the Medicare part B premium.

The Federal Government helps to guarantee health security to millions of Americans through Medicare, Medicaid and health insurance tax subsidies. Medicare should not be singled out for means testing. Means testing the Medicare part B premium also undermines Medicare as an insurance program.

Our testimony, which draws on research by Lewin-VHI in health care insurance tax subsidies and Medicare benefits, which we have forwarded to the subcommittee, will discuss four reasons why the part B premium should not be means tested.

First, adding a means test to Medicare, which is already progressive, we believe is excessive. The Medicare payroll tax is a flat percentage of earnings, currently 1.45 percent. The higher the earnings, the more tax is paid. Benefits, on the other hand, are generally the same for everyone, regardless of income. Consequently, higher income beneficiaries pay more than lower income beneficiaries for the same benefits.

Beginning in 1994, the payroll tax was applied to all earnings, rather than up to a specific limit. The Medicare part B subsidy for upper-income beneficiaries will be more than made up by Medicare part A taxes in excess of part A benefits. Future high-income beneficiaries, as our study shows, will receive on average $159,000 less in Medicare part A and B benefits than they will pay in taxes and premiums over their lifetime. Higher income beneficiaries will, in effect, subsidize lower income beneficiaries.

Congressman McCrery, I believe you asked a question of one of the previous witnesses who was testifying about how quickly the benefits are retrieved. In fact, I think her response was incorrect. I think that may have been true, as you pointed out, up until the point the cap was lifted, and prospectively that statement is no longer accurate that the previous witness made. I would like to clarify that.

Second, the Medicare part B premium should not be singled out for means testing, especially when Medicare as a whole is progressive. The government promotes health insurance coverage through health insurance tax subsidies to working Americans worth $46 billion in 1994. These health insurance tax subsidies are more valuable to higher income individuals. Over a working lifetime, these subsidies add up for upper-income working families. Under current law, lifetime health insurance tax subsidies for upper-income families are 10 times more valuable than the lifetime tax subsidy for low-income families.

Many Members of Congress would like to improve the health insurance tax subsidy for the self-employed. It would be ironic, we think, if the Medicare premium was increased for upper-income beneficiaries, at the same time that the health insurance tax subsidy was increased for equally wealthy non-Medicare beneficiaries.

Third, means testing the part B premium we think tinkers with the insurance design of Medicare and undermines its political support. Eventually, high-income beneficiaries would question whether Medicare as an insurance program would be cost effective, and wonder why they should pay high taxes to support it, when they receive little or no benefit. Disenrollment of high-income beneficiaries also could increase premiums for other beneficiaries, if most of those who disenroll have lower health care costs on the average, which I think most people believe to be the case.

Finally, this proposal we think is budget driven. Savings will be short lived, however, unless the factors that are driving both public and private sector health care cost increases are controlled. This shortsighted budget policy to reduce Medicare coverage we think is bad health policy. Seniors are thankful for Medicare health insurance but no one should exaggerate its generosity.

The bottom line is that today Medicare pays less than half of seniors' health care costs, including long-term care. Total out-of-pocket health care costs are a larger percentage of income now than when Medicare first started. I want to reemphasize that. Seniors today on Medicare pay more out of pocket as a percentage of income than before we had Medicare. I think people need to understand that in the context of some of the myths about senior citizens that we hear over and over again.

In conclusion, it is understandable for Congress to hold hearings on this controversial proposal in its effort to find savings. However, we hope that our testimony will help guide the committee away from this tax increase for higher income seniors. Congress should be very careful about altering the insurance design of Medicare by means testing Medicare part B premiums. If necessary, the wealthy can take care of themselves. But if support from the wealthy for Medicare erodes, it is the poor and the middle class who will suffer.

Thank you very much.

[The prepared statement follows:]

TESTIMONY OF MAX RICHTMAN
NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

I am Max Richtman, executive vice president of the National Committee to Preserve Social Security and Medicare, a grassroots advocacy organization representing millions of Americans. The National Committee strongly opposes any proposal to means test the Medicare Part B premium. The federal government helps to guarantee health security to millions of Americans through Medicare, Medicaid, and health insurance tax subsidies. Medicare should not be singled out for discriminatory treatment by means testing the Part B premium. Means testing the Medicare Part B premium also undermines Medicare as an insurance program. It is not necessary to make Medicare more progressive since it is already progressive, more so than health insurance tax subsidies.

Our testimony will discuss four reason why the Part B premium should not be means tested. It will draw upon research by Lewin-VHI on "Health Care Insurance Tax Subsidies and Medicare Benefits". See Appendix 1 for an Executive Summary is attached.

First, making Medicare more progressive is excessive. Congress has already acted to make Medicare more progressive by raising the taxable wage base for Medicare payroll taxes in 1990 to $125,000 and eliminating the wage base altogether in 1993. Looking only at the general revenue subsidy for Medicare Part B ignores the total picture. The Medicare Part B subsidy for upper income beneficiaries will be more than made up by Medicare Part A taxes in excess of Part A benefits. Future high income beneficiaries will receive on average $159,000 less in Medicare Part A and B benefits than they will pay in taxes and premiums over their lifetime, according to a study by Lewin-VHI commissioned by the National Committee. Higher income beneficiaries will in effect subsidize lower income beneficiaries.

Second, Medicare and Medicaid are not the only government programs providing health security for Americans. The government promotes health insurance coverage through health insurance tax subsidies to working Americans. These subsidies, however, are more generous to high income workers than any Medicare "subsidy" received by high income seniors, according to Lewin-VHI. The Medicare subsidy should not be singled out for different treatment. All subsidies should be treated in a similar manner. We have attached a copy of the Lewin-VHI study to our statement.

Third, means testing the Part B premium tinkers with the insurance design of Medicare and undermines political support. A premium as high as three times the current Medicare premium would discourage many high income beneficiaries from enrolling in Medicare Part B. High income beneficiaries are generally healthier and private insurance, if permitted, would be very competitive. Eventually, high income beneficiaries would question Medicare as an insurance program and wonder why they should pay high taxes to support it when they receive little or no benefit.

Fourth, the real reason for this proposal is to raise revenue because of the failure to enact health care reform with effective cost controls on both the private and public sector. The rapid cost increase for Medicare only mirrors health care cost increases in general. Only comprehensive reform with cost controls will change the long-term trend. Medicare beneficiaries already pay as much if not more in premiums for health insurance than individuals with employer provided health insurance and employer plans are more generous than Medicare.

Medicare Progressivity

One might think that high income Medicare beneficiaries receive a great deal if one looked only at the general revenue subsidy for Medicare Part B. Distinctions between Medicare Part A and B are quite artificial, however. Beneficiaries qualify for Medicare Part A through payroll tax contributions during working years. The payroll tax is a flat percentage of earnings, currently 1.45 percent. The higher the earnings, the more tax is paid. Benefits on the other hand are generally the same for everyone regardless of income. Consequently, higher income beneficiaries pay more than lower income beneficiaries for the same benefits.

While Medicare has always been progressive, Congress has made Medicare more progressive. Prior to the 1990s, the Medicare payroll tax was payable on earnings only up to the maximum wage base for Social Security contributions which was $51,300 in 1990. In 1990, Congress increased the maximum wage base for Medicare contributions to $125,000 and in 1993 Congress completely eliminated the maximum wage base for Medicare contributions.

The National Committee last year commissioned a study by Lewin-VHI which concluded that Medicare beneficiaries in the upper income quartile (average annual family income of $66,000 in 1992) will pay on average $159,000 more in taxes than they will receive in Medicare Part A and B benefits over a lifetime under current law. Medicare beneficiaries in the third quartile will pay on average $25,000 more than they receive. Beneficiaries in the first two quartiles will receive lifetime subsidies. See Table 1.

Table 1. Future Lifetime Net Medicare Benefits by Income Quartile under Current Law

Income Quartile	Net Medicare Benefits
Quartile 1	$72,773
Quartile 2	$15,462
Quartile 3	-$24,530
Quartile 4	-$158,555

Source: Paul F. Hogan and Matthew Reilly, Lewin-VHI, "Health Care Insurance Tax Subsidies and Medicare Benefits," June 20, 1994, prepared for the National Committee to Preserve Social Security and Medicare, p. 12. Lifetime net Medicare benefits based on a 2 percent discount rate.

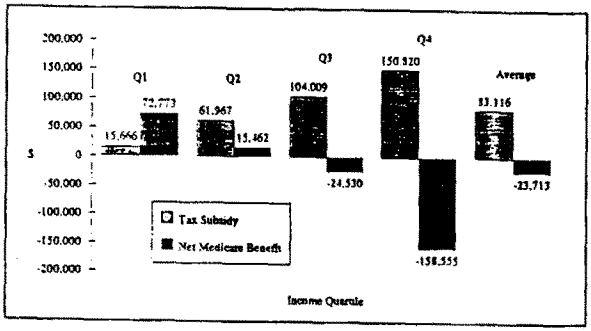
Comparison with Health Insurance Tax Subsidy

It is frequently overlooked that tax free employer provided health benefits are an important government subsidy worth $46 billion in 1995.[1] Approximately 72 percent of families have employer provided health care coverage. These subsidies are more valuable to higher income individuals not only because they have a higher marginal tax rate, but also because they are more likely to have generous employer provided health insurance. Consequently, the average annual tax subsidy for a family with income over $100,000 and employer provided health insurance is $2,261, but it is only $515 for a family with income under $10,000.

Over a working lifetime these subsidies add up for upper income working families. Under current law, lifetime tax subsidies for families in the highest income quartile total $151,000, almost 10 times more than the $16,000 lifetime tax subsidy for families in the lowest income quartile.

While Medicare benefits are progressive, tax subsidies are regressive. Figure 1 compares tax subsidies with Medicare benefits by income quartile. The Medicare Part B premium should not be singled out for means testing, especially when Medicare as a whole is progressive.

Figure 1. Lifetime Tax Subsidies and Net Medicare Benefits by Income Quartile under Current Law



Source: Source: Paul F. Hogan and Matthew Reilly, Lewin-VHI, "Health Care Insurance Tax Subsidies and Medicare Benefits," June 20, 1994, prepared for the National Committee to Preserve Social Security and Medicare, p. 14.

Many Members of Congress would like to make health insurance premiums 100 percent deductible for the self-employed. Based on preliminary data from 1992 tax returns, more than 570,000 tax returns with income over $75,000 claimed a 25 percent deduction for health insurance for the self-employed.[2] It would be ironic if the Medicare premium was increased for beneficiaries with $75,000 in income at the same time that the health insurance tax subsidy was increased for equally wealthy non-Medicare beneficiaries.

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[1]"Estimates of Federal Tax Expenditures for Fiscal Years 1995-1999," prepared for the Committee on Ways and Means and Committee on Finance by the staff of the Joint Committee on Taxation, November 9, 1994, p. 17.
[2]Internal Revenue Service, preliminary data.

Undermining Medicare

Higher premiums for upper income seniors encourages seniors with the lowest health costs to disenroll from Medicare Part B. Under a similar proposal in President Clinton's Health Security Act, it was estimated that 500,000 beneficiaries would drop Medicare Part B[3]—most of the 700,000 beneficiaries who would be affected by higher premiums. Higher income seniors have lower health care costs because they are healthier on average than lower income seniors.[4] In 1987, Medicare spending per upper income senior was only 79 percent of what Medicare spent per capita on all seniors.[5] For healthy seniors, it may make economic sense to disenroll if they have to pay a premium three times higher than the standard premium.

The disenrollment of 500,000 seniors may not seem like much, but it could increase premiums for other beneficiaries if most of those who disenroll have lower health costs on average. Higher premiums also alienate higher income beneficiaries who will be less willing politically to support any general revenue contribution to Medicare. High income beneficiaries after all are also taxpayers who have contributed more than others towards the general revenue subsidy.

Higher Part B premiums would certainly be looked upon as an additional tax if collected through the IRS—the only efficient way to do so. However, some of the higher revenue would be offset by the cost of administering the means test. It would also complicate federal income tax returns, which many people already find incomprehensible.

Even if this proposal would affect only a few beneficiaries with income over $75,000 or $100,000, there is no reason it could not be lowered in the future to $50,000 or $25,000, like the tax on Social Security benefits. An income related premium would be no different than the Medicare catastrophic surtax—without the benefits! In 1989, a "super majority" of Republicans helped to repeal the unfair Medicare catastrophic surtax. The negative reaction may not be as bad as the firestorm over the Medicare catastrophic surtax, especially if the income thresholds are initially set high enough. But higher Part B premiums would neutralize the goodwill earned by House Republican proposals to increase the earnings limitation and repeal the 1993 tax increase on Social Security benefits.

Limits to the Medicare Health Insurance Plan

This proposal is budget driven. Savings will be short-lived, however, unless the factors that are driving both public and private sector health care cost increases are controlled. This short-sighted budget policy is also bad health policy if it reduces Medicare coverage.

Seniors are thankful for Medicare health insurance, but no one should exaggerate its generosity. For full Medicare coverage, including Part B, Medicare beneficiaries pay a premium of $46.10 in 1995. Medicare, however, leaves many gaps in coverage. Medicare does not cover out-of-pocket prescription drugs, dental expenses or most preventive care nor does Medicare have a limit on out-of-pocket expenses. These services are all available in the Blue Cross Blue Shield standard option plan for federal employees for which single employees pay $44.05 a month.

Medicare also has a $100 Part B deductible, a $716 deductible for each hospitalization, 20 percent coinsurance for physician and outpatient services and other co-pays for nursing home care and extended hospital care. A Medicare beneficiary with at least one hospitalization—approximately one out of five beneficiaries each year—could easily incur out-of-pocket costs of $1,000 or more just for Medicare covered services. The bottom line is that today Medicare pays less than half of seniors' health care costs including long-term care. Out-of-pocket health care costs are a larger percentage of income now than when Medicare first started.

As a result more than 70 percent of Medicare beneficiaries have supplemental coverage purchased separately or provided by a former employer. Individuals can pay $40 a month or more just for Medigap coverage. For example, in Ohio in 1995 the average premium for the least comprehensive Medigap plan is $40 a month at age 65—it is almost four times that for the most comprehensive plan.[6] There is no

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[3]"Documentation of Federal Budget Effects for Health Security Act," p. 16, obtained by the Bureau of National Affairs, December 15, 1993. Some disenrollment would have been due to the higher Part B premium for the new drug benefits.

[4]National Center for Health Statistics, "Current Estimates from the National Health Interview Survey, 1989," Vital and Health Statistics Series 10, No. 176, in the 1994 Green Book, p. 871.

[5]Agency for Health Care Policy and Research: National Medical Expenditure Survey. Upper income was defined as four times the poverty line.

[6]Ohio Department of Insurance

market for supplemental health insurance for any other age group, presumably because there is no need.

Premiums now cover only 25 percent of Part B costs because Congress protected beneficiaries from health care inflation by limiting premium increases to the Social Security COLA for most of the 1970s. Congress believed that seniors should not be liable for health care inflation over which they have little or no control. Despite recent talk that the CPI overstates inflation, beneficiaries face higher inflationary costs than non-beneficiaries because they spend a greater percentage of their income on health care.

Conclusion

It is understandable for Congress to hold hearings on this controversial proposal in its effort to find savings. However, we hope that our testimony will help guide the Committee away from this path. Congress should be very careful about tinkering with the insurance design of Medicare by means testing Medicare Part B premiums. Means testing the Premium is naturally a tax increase for higher income seniors, which we would expect Republicans to oppose.

Is it fair to charge high income workers more in payroll taxes than they will ever receive in benefits and then charge them three times as much in Part B premium? We strongly believe that it is grossly unfair.

If necessary, the wealthy certainly can take care of themselves. But if support from the wealthy for Medicare erodes, it is the poor and middle class who will suffer.

Appendix I

EXECUTIVE SUMMARY
HEALTH CARE INSURANCE TAX SUBSIDIES AND MEDICARE BENEFITS
Lewin-VHI, Inc.

The National Committee to Preserve Social Security and Medicare asked Lewin-VHI, Inc., to compare health insurance tax subsidies and Medicare benefits in 1993 dollars for one year (cross-sectional) and over a hypothetical lifetime using current law tax and benefits rules (lifecycle). Tax subsidies refer to the savings related to employer provided benefits not being subject to taxation and the tax deductibility of certain health care expenses. The cross-sectional study looks at Medicare Part B benefits net of beneficiary premiums. The lifecycle analysis includes both Part A and B benefits and Medicare payroll taxes.

Medicare and Medicaid are not the only government programs providing health security for Americans.

Approximately 72 percent of families have employer provided coverage. Annual tax breaks for these families are worth $1,516 in 1993 dollars. This is only 20 percent less than the annual general revenue contribution per Medicare Part B beneficiary family of $1,912.

Using a conservative two percent real discount rate, the lifetime tax subsidy under current tax rules for health benefits will average around $83,000 per family in 1993 dollars.

Medicare means testing is both unnecessary and excessive. Medicare taxes and benefits over a lifetime are progressive and recent tax changes have made them more progressive. Negative subsidies to upper income beneficiaries will more than pay for positive subsidies to lower income Medicare beneficiaries. The well-off will begin to object to paying Medicare taxes if Medicare is also means tested.

Using current law tax and benefit rules, the upper income half of Medicare beneficiaries will pay more in taxes over their lifetime than they will receive in benefits and the lower income half of Medicare beneficiaries will receive more in benefits than they will pay in taxes. While benefits are the same for all Medicare beneficiaries, taxes are a percentage of earnings. Since 1994, there is no limit on the amount of earnings that can be taxed.

Beneficiaries in the first income quartile will receive a net subsidy around $73,000 and those in the next quartile will receive a net subsidy around $15,000. In contrast, beneficiaries in the third income quartile will pay around $25,000 more in taxes than they will receive in benefits and the upper income quartile will pay around $159,000 more.

Tax subsidies provide greater benefits to the upper income than to lower income.

Unlike Medicare benefits, tax subsidies benefit the upper income more than the lower income. Those in the upper income quartile receive around $151,000 in tax subsidies over a lifetime, around ten times more than the $16,000 tax subsidy for those in the lowest income quartile. Those in the second income quartile receive an average tax subsidy of $62,000 and those in the third income quartile receive $104,000.

For working families with employer coverage and income over $75,000, the annual tax break is worth more than $2,000 a year, four times the value of the subsidy for working families with employer coverage and income under $20,000. Those familieswith no employer coverage only receive a $56 annual tax subsidy.

The annual tax subsidy for upper income working families exceeds the annual Medicare subsidy. The average annual Medicare subsidy is $1,912. The annual tax subsidy for families with employer coverage and income over $75,000 is $2,119 or more.

If Medicare benefits and tax subsidies are combined, families in the first three quartiles receive approximately the same net lifetime subsidy while families in the upper income quartile almost break even.

Families in the first three quartiles will receive a net lifetime subsidy from both the tax subsidy and Medicare benefits of approximately $80,000 under current law. Families in the upper income quartile will pay about $8,000 more in Medicare taxes than they will receive in tax subsidies and Medicare benefits.

Prepared by the National Committee to Preserve Social Security and Medicare
Research and Policy Development
February 7, 1995

Chairman THOMAS. Thank you. I thank the panel.

Mr. McCrery.

Mr. MCCRERY. I thank all of you for coming today and sharing with us your thoughts on this subject.

I am going to ask a couple of specific questions to Ms. Dixon and Mr. Richtman. While I am asking, I would like for Ms. Phillips and Mr. Hopkins to be thinking about anything they would like to say in response to the testimony of Mr. Richtman and Ms. Dixon.

First of all, Ms. Dixon, I appreciate your telling us that we are doing just fine in repealing the tax increase in Social Security recipients that was put into effect last year, and then saying that, if we are going to do that, then it does not make sense for us to raise or income relate part B premiums.

I think there is a distinction there between the two. I am for repealing the tax increase on Social Security. I did not vote for the tax increase last year and thought it was a bad idea. But Social Security is something, as you know, that seniors have paid into, have been expecting and have worked into their retirement plans. And for us to impose upon them a very high marginal tax rate, which is what we do, in effect, when we take away Social Security benefits, I think is unfair.

However, income relating Medicare part B, when we know that general revenues are subsidizing 75 percent of the true value of that product or that benefit, is entirely different. So I do not think we are inconsistent by supporting a repeal of the tax increase on Social Security benefits and at the same time suggesting that we income relate to some extent part B premiums.

Also, since you brought it up, the catastrophic health care plan of a few years ago, if I am not mistaken, AARP was in favor of that plan. Is that correct?

Ms. DIXON. Yes, our members felt that they were going to receive certain benefits that they needed very badly, prescription drugs and long-term care. Therefore, we supported it, because our members wanted those benefits. Unfortunately, we did not achieve them.

Mr. MCCRERY. Did you not just 1 year later change your position?

Ms. DIXON. No, we did not change our position.

Mr. MCCRERY. Is not the AARP for repeal 1 year later?

Ms. DIXON. No, it went down, because our members learned that they would have to bear the burden of the financing. AARP never went along with the financing mechanism. We were looking for benefits for our members, but this was the best that we could get, so we went along with it.

However, the financing was never something that we agreed to. And when our members learned that the seniors would have to bear the cost of this plan, that was when they did not want to go along with it.

Mr. MCCRERY. I remember that very well. In fact, I voted against it the first time, so I was against you one year and then I was with you the next year.

The fact is that a lot of seniors, your members, at least in my district, did not really want that program to begin with, because they had options in the private sector that were just as attractive

to them, and in some cases they could get those at less cost than what we were going to impose upon them from the public sector. So I am not surprised that the program was repealed.

Perhaps that is the model we should look at, as more options in the private sector for seniors, instead of creating more and more programs at the Federal level and impose those on seniors.

Ms. DIXON. Well, we definitely believe there should be system-wide cost containment, not just on the Medicare side, not just on the public side, but on the public and the private side. Otherwise, it will always be just cost shifting.

Regarding our members, we have a membership of over 33 million people, and it is very difficult to get complete consensus among 33 million people, so we have to——

Mr. MCCRERY. I suspect you learned a lot from that experience.

Mr. Richtman, I just want to say that I agree with you about the subsidization of private sector insurance. Some of us on this panel would like very much to do something about that and income relate to some extent the subsidy of private health insurance, as well, through some sort of cap on that. But that is another question. I appreciate your bringing that up, and I think you are right.

Ms. Phillips, would you or Mr. Hopkins, like to respond to anything that we have said or that you have heard?

Ms. PHILLIPS. I would like to point out that CBO did a study last September of entitlements and ways to income relate entitlements. They looked at three different approaches. In that volume were some terrific tables showing who gets entitlement benefits and what income levels they are at. They showed that 20 percent of the families with incomes above $150,000 are getting Medicare. I would think that you would be able to do something about income relating benefits for this group of people.

The Concord Coalition has many members who are also AARP members. In fact, our chapter in the State of Connecticut has been supported strongly by people who are endorsing their Social Security checks over to the Concord Coalition to pay for running a State Concord office.

So there are people out there who are very concerned about the way these programs are spending money and who are willing to put their money where their mouth is. They really believe they can be part of the solution. Lower income people who are struggling with two workers in a family or just one parent, children in child care, much less income, and yet paying the taxes that support these other programs, they do not understand why well-off people who are not working and have discretionary income that they can send to outfits like the Concord Coalition should get a free ride.

Mr. MCCRERY. Mr. Hopkins.

Mr. HOPKINS. The health insurance trust fund will go broke, unless we begin making reforms right now, and certainly A and B should be looked at as a whole when we are making the changes. By failing to make changes now, we are becoming part of the problem. Yes, we should not be afraid to make the bold moves now.

It was suggested that out-of-pocket expenses are more expensive today after 30 years of a government-run program. So when we look at our changes, we have got to take into consideration that the government is not the answer to all our problems.

Mr. RICHTMAN. Congressman McCrery, just to complete one of your questions, the National Committee to Preserve Social Security and Medicare opposed the catastrophic health care plan when it passed Congress, and led the fight to repeal it.

Mr. MCCRERY. I remember that.

Mr. RICHTMAN. So we were on the same side with you both times you voted on that.

Mr. MCCRERY. Too bad you were not on my side in the election, but that is another matter.

Mr. RICHTMAN. As for repealing the tax on benefits and the distinction you are drawing, the fact still remains that, even if you use the figures that the Chief of Staff of the Joint Tax Committee was talking about, you are going to, in effect, take about $8 billion from the same people that you are going to give $15 billion to by repealing the tax. So you are talking about money that the same people are going to be paying the government and getting from the government, and we just want to raise that issue.

Finally, if the Concord Coalition is able to get Social Security recipients to endorse their checks right over to them, I want to compliment them on their direct mail.

Ms. PHILLIPS. This was not done through direct mail. This was done through citizens organizing in their communities, and it came as an absolute surprise to us when we opened the letters and found their checks.

Chairman THOMAS. The gentleman's time has expired.

Mr. MCCRERY. Thank you, Mr. Chairman.

There are some folks in my district who refuse to accept their Medicare benefits or Social Security benefits, because they are fairly well off, they have high incomes and they do not frankly see the point.

Chairman THOMAS. I have had people tell me that this was their mad dress money, and it is nice to know that some folks have found a better and higher use for that money.

Mr. Richtman, I do not think I am confused and I do not think you are confused, but someone, in listening to your testimony, may have been confused, so let us see if we can clear it up. You do not mean to suggest by your testimony that Medicare part B is an insurance program, is that correct?

Mr. RICHTMAN. What I was trying to point out is that I think making a distinction between part A and part B is to some extent an artificial distinction, because——

Chairman THOMAS. When one is mandatory and the other one is voluntary?

Mr. RICHTMAN. Because people consider it their Medicare, people that have Medicare do not usually make that distinction. They understand that part B is optional, they can pay for it or they cannot pay for it. What I am talking about is looking at it in the context of the kinds of benefits people receive as opposed to what they pay through general taxes when they are in the work force and through their premiums and through the HI tax.

Chairman THOMAS. Let me go back to my original statement. You did not mean to create the impression that part B is an insurance program, did you?

Mr. RICHTMAN. Not by itself.

Chairman THOMAS. And you mentioned twice now the cap on fringe benefits. In 1983, I voted to cap fringe benefits and we lost it on this committee by two votes. By using that in reference to suggested policy in other areas, does that mean that your organization supports capping of fringe benefit deductions?

Mr. RICHTMAN. Our organization supports treating these essential tax subsidies fairly, treating people fairly, whether they are in the work force or they are retirees. To means test Medicare beneficiaries and not means test people that are getting these benefits by virtue of the Tax Code is not fair. It should be done fairly.

Chairman THOMAS. Does that mean if we go ahead and means test on Medicare part B, which is a general fund subsidy, you would support capping the fringe benefit deductions?

Mr. RICHTMAN. Frankly, I do not think so, because I think that the——

Chairman THOMAS. So you would not support that?

Mr. RICHTMAN. That is right. I do not think we would.

Chairman THOMAS. You use it as an example, but then you would not support it if it was policy?

Mr. RICHTMAN. No. What I am saying is that the current policy I think is a good one. The way health care policy is structured brings more health care benefits to more people. But by making a distinction here and trying to focus just on the Medicare beneficiaries and means testing their benefits to raise revenue that way we think is unfair.

Chairman THOMAS. But you would not support capping fringe benefit deductions?

Mr. RICHTMAN. I cannot decide that by myself.

Chairman THOMAS. That is a sufficient answer. I just wanted to find out.

Ms. Dixon.

Ms. DIXON. Our organization feels that if higher income Medicare beneficiaries have to pay a higher premium, then working people who have higher incomes should also pay a higher premium. When their employers receive tax breaks, therefore, they are subsidized, also. So we just feel that it should be equitable across the board.

Chairman THOMAS. Ms. Dixon, thank you for that refreshing position which is consistent. I understand you do not have to be consistent, but I appreciate the consistency.

Let me try another one on you. You are concerned that this might produce a cost shift. If the original Medicare part B program was a 50/50 relationship between general fund subsidies and recipient payments, and it is now a 75/25 program, did it not result in a cost shift when it went from 50/50 to 75/25?

Ms. DIXON. In our written testimony, we point out the fact that the 50/50 was changed because the costs of medical care were rising so rapidly——

Chairman THOMAS. But that is a cost shift, is it not?

Ms. DIXON. May I finish?

Chairman THOMAS. Surely.

Ms. DIXON. The Congress felt that the 50/50 would put too much of a burden on too many persons who were unable to bear those costs, therefore, it was changed.

What I was referring to by cost shifting was that the cost would shift from Medicare over to the private sector and, therefore, it would do nothing to reduce overall costs and therefore bring down the deficit. Whenever Medicare benefits are reduced or whatever, then the private sector has to pick that up. Employers will probably have to raise premiums for their employees. Perhaps even some would go out of business. So we still do not have any positive effect as far as the deficit is concerned.

Chairman THOMAS. But do you know now that Medicare is lagging behind the private sector, and that in fact there have been so many changes made in the private sector in controlling the costs of health care, that there probably would not be that classic shift that you are talking about. And one of the reasons that we are talking about making changes in Medicare is because Medicare is now a cost driver.

It used to be that there was a cost shift from the private sector to Medicare, and now Medicare is in fact keeping alive a system that has been changed in the private sector. So we may need to refocus in terms of the way we view the relationship between Medicare and "cost shifts" onto the private sector.

Your argument is that it was just too much money for people to pay which led Congress to go from a 50/50 split to a 75/25 split. Would it not then also make sense that if people had sufficient wealth to be able to pay a greater portion of that shift, 75/25, that we should encourage people who could pay to pay?

Ms. DIXON. Now, when it went from 50/50 to 75/25, that was to accommodate those millions of people of low income.

Chairman THOMAS. But what about the millions of people of high income?

Ms. DIXON. I do not know if there are as many millions as there are of low income.

Chairman THOMAS. How about thousands?

Ms. DIXON. What we are saying is there has to be systemwide reform, rather than focusing on a small population.

Chairman THOMAS. I think you heard the testimony today that all of us are committed to systemwide reform. As part of a systemwide reform, would you accept some kind of an adjustment in the general fund contribution that many nonelderly taxpayers now make to our seniors who have income sufficient to pay their own cost?

Ms. DIXON. AARP would be willing to look at incremental reform, if certain safeguards were in place. One is, as we mentioned, systemwide cost containment. Another would be that the senior population would receive important benefits which they do not now have, such as long-term care and prescription drugs, and there was equity in that the persons who are employed and have high incomes would also be subject to this increased premium.

Chairman THOMAS. You know that in the Contract With America we have already held hearings and are moving forward with legislative changes that would allow long-term care insurance to be deducted from your income tax, and that it would make it available for employers to offer without taxes.

Ms. DIXON. That is something our members want very much.

Chairman THOMAS. In addition to that, we are trying to reform the system under a concept that you heard referred to more frequently now as Medicheck, in which, rather than government offering to pay a prescription program, seniors could take the amount that they now have under Medicare and go out in the private sector and look at the offerings that would include prescription coverage and many other benefits as indicated by your magazine and the insurance packages that you offer, which people could purchase with the dollar equivalent of the current Medicare structure. Would that be something that your organization would be interested in supporting?

Ms. DIXON. It is something that we certainly would have to explore. As I have listened to the testimony today, I am just impressed by the complexity of this issue and we certainly commend the committee for inviting opposing opinions. You have a formidable job to try to bring all of these things together, and we are certainly willing to work with you to try to come to a solution that will be amicable and in the best interest of our country.

Chairman THOMAS. We appreciate it, because we know the system has to be reformed. We would much rather do it with you than without you. But we believe that, in a commitment to all seniors, we are going to do it.

I want to thank the entire panel, including Ms. Phillips, for taking her time to come and testify in front of the group. We look forward to seeing you on future panels, as we begin to look at other aspects of change in this program.

Thank you very much.

The subcommittee is adjourned.

[Whereupon, at 4:33 p.m., the hearing was adjourned to reconvene on Friday, February 10, 1995 at 10 a.m.]

MEDICARE REFORM AND INNOVATION

FRIDAY, FEBRUARY 10, 1995

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

The subcommittee met, pursuant to call, at 10:06 a.m., in room B–318, Rayburn House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

Chairman THOMAS. I will apologize in advance: The powerful House Ways and Means Committee has relatively few hearing rooms, and when the main hearing room is not available, unfortunately this is our second largest room. In the spirit of the new majority, we are indicating that if anyone wants to stay longer than 10 minutes there is a fee for the seat. It will be applied to the deficit.

Today is the third hearing in the week-long examination of Medicare policy, and this will be a hearing on Medicare reform and innovation.

Any members who have written statements in their entirety, they will be placed in the record. We have discussed throughout this week the Medicare program, the fact that it needs fixing, and not just in terms of particular details. The program really has to be transformed from the midsixties model into one that clearly utilizes the changes that we have seen in the private sector to get ready for the rest of the nineties and especially the 21st century.

The transformation we hope will be along the lines of improving the program for beneficiaries who will gain greater access to higher quality and more cost effective medical care; but second, obviously we need to rein in the growth of Medicare costs which clearly threaten the future of the Medicare program. Based upon the most recent data and the changes in the private sector, this is a growing problem for Medicare in relation to the private sector.

We have got to talk about the use of managed care and a smoother transition into managed care for the Medicare beneficiaries. As we learned earlier this week, there is growing consensus that the Medicare system is flawed and anyone who wants to try to hang on to it is really not doing a service to either the taxpayer or the Medicare beneficiary.

Our subcommittee has undertaken the task of defining the terms of this transformation. The best place to begin is with the positive experience Medicare beneficiaries are having with managed care.

We should look for guidance from the health care revolution taking place in the private sector. We need to look to the private sector

to learn ways to adapt its models to the framework of Medicare. If grafting is not possible, then we need to talk about more fundamental reform. Today the testimony will provide insights on managed care in Medicare and the private sector.

Among the witnesses we can especially look forward to is not only our colleague Mr. Pomeroy, who has been with us throughout this discussion, but two former administrators of the Health Care Finance Administration, Bill Roper and Leonard Schaeffer, who are now in the private sector and are at the cutting edge of companies who are in managed care alternatives.

We need to receive guidance on how to improve the design for payment of managed care organizations by Medicare. All of us know that in 2001 the part A trust fund is planning to go broke. When you look at the ways in which you can adjust it—increasing the tax rate, reducing benefits—the shifts in those areas become so enormous that it really is not an option; tripling the tax rate, cutting by two-thirds the benefits, for example, if we are going to continue to play the old game to try to buy time beyond 2001.

Obviously these problems represent a challenge not only to Congress, but ultimately to the American people. It is not going to be easy, but as we heard on Tuesday from Senators Kerrey and Gregg, especially Senator Kerrey, from the Kerrey-Danforth Commission, if we do not begin the task of transforming Medicare, we are going to pay a much higher price down the line for that failure.

I would yield to my friend from Maryland for any statement he may wish to make.

Mr. CARDIN. Thank you, Mr. Chairman.

I would ask unanimous consent that the opening statement by Mr. Stark, the ranking member, be made a part of the record, and that my opening statement in full be made a part of the record.

Chairman THOMAS. Without objection.

[The prepared statement follows:]

Opening Statement

The Honorable Pete Stark

Hearing on Medicare Reform and Innovation

February 10, 1995

Mr. Chairman,

I am pleased that you have scheduled this hearing on "Medicare reform and innovation." I hope that this hearing gives credit where credit is due. Speaker Gingrich has characterized Medicare as a "large, clunky, bureaucratic" system. I'll accept the label of Medicare being "large" -- and with some pride -- although a more accurate term to use is universal, as in universal coverage. Medicare covers 99.1 % of Americans who are over the age of 65, and does so without consideration to where they live, how sick they are, or how much money they have.

As to being bureaucratic and clunky, that might have been true with the Medicare program of the 1960's, but it isn't the Medicare of today. Over the past twenty years, Medicare has led the way in innovations in administration, cost containment, and reforms of the financing system.

As we all know Medicare's DRG-based hospital prospective payment system led the way in reforming the way hospitals get paid. Similarly, Medicare's RB RVS physician payment system has changed forever the way in which doctors are paid. Both are now in wide-spread use across the system – public and private.

Medicare led the way in developing utilization review through its Professional Review Organizations, review which is now the underpinning of most managed care in the private sector. Moreover, the federal government's involvement in outcomes research and the development of practice guidelines is serving to strengthen utilization review efforts nationwide. And last but not least, Medicare's leadership led to the development of the first uniform billing form for hospitals, the UB-82 in 1982 and its successor, the UB-92. A second form, HCFA-1500, serves as the uniform claim form for physician billing. These are the only claim forms Medicare requires today.

Of course now we hear calls that Medicare's fee-for-service system is antiquated and should be replaced by something called managed care. Medicare also led the way in that area as well. Since legislation passed in 1982, Medicare has been contracting with managed health plans across the country – 244 such plans at last count. The program has worked well, because choice of managed care in Medicare is voluntary. The plan must provide an attractive enough option so that seniors choose managed care without coercion from anyone.

Medicare's managed care option is not without problems, not the least of which is that seniors who join these plans are generally healthier than the average Medicare beneficiary. Research shows that the cost for beneficiaries joining plans is only about 85% of the average for Medicare. This means that it costs Medicare money, rather than saving money, when seniors join these plans. This problem must be solved before the program can be expanded dramatically. I would note that we passed legislation in 1989 directing the Secretary to improve the payment system, but little progress appears to have been made.

At the same time we are talking about Medicare losing money on every beneficiary that enrolls in an HMO, I read about the tremendous profitability of the managed care industry. If the Chairman would allow me, I'd like to enter in the record a staff review of 15 managed care company financial reports. Roughly twenty percent of every health care dollar in these firms is going for overhead, managers, and profit. This compares to Medicare's overhead of 2% and overhead in the most efficient private HMOs of about 5%. Some HMOs may be giving Medicare beneficiaries their money's worth, but many are not.

It is also possible to point to the kind of reforms we do not want. Recently I received a series of news accounts from the Fort Lauderdale Sun-Sentinel regarding abuse of Medicaid beneficiaries in HMOs and other managed care plans in that State. I'd like to provide to each Member a copy of this series. This report shows that State oversight of Medicaid managed care is abysmal. Because of these findings, Congressman Shaw has stated his intention to call for Congressional hearings as soon as is possible. I support this effort and would like to offer my assistance in holding these hearings.

Medicare is not immune from the problems identified in this Florida Sun-Sentinel series either. In a February, 1994 series by the same paper, Medicare HMOs operating in Florida were found to deny care, provide substandard care, and have unmanageable grievance procedures. I'm glad Mr. Vladeck is here today to discuss these issues that strike at the heart of what Medicare was designed to do – provide America's seniors access to affordable, high quality medical care.

There is one other issue I'd like to touch upon, Medicare Select. It is my intention to introduce legislation regarding this demonstration program. I have not as yet done so in response to an Administration request. I look forward to the Administration's recommendations today on this demonstration program. A preliminary review of the Medicare Select program has found significant reason for concern and caution -- despite the repeated claims by others that Medicare Select is good because it means more choice for beneficiaries. Of course, what all this vague talk about more choice and reform is really meant to do is disguise an effort to *take away* freedom of choice of doctors and hospitals from the nation's seniors. Let us not be confused that choice of plan is the same thing as choice of physician, because America's seniors know the difference.

Mr. CARDIN. I would like to congratulate you for holding these hearings. I think they are extremely important. We need to look at ways of responsibly reducing the cost of Medicare and looking for innovative ways in which to bring down the growth rate in Medicare expenditures.

I would like to acknowledge one of my teachers who is in the audience. Bill Gradison taught me an awful lot on this committee. It is nice to see Bill back in the committee room.

I would also like to point out, if I might, that one of the ways we can look for innovations in health care reform is to look to our States and giving States more flexibility in dealing with the health care system.

I would just like to point out to the committee the record in my own State of Maryland. Mr. Thomas has heard me mention many times about Maryland's all-payer rate system, and the information has just been made available for the last year, in which it shows once again the State of Maryland has kept hospital costs down at a lower growth rate than the national average. That makes 18 out of the last 19 years Maryland has kept its growth rate below the national average on hospital costs, and we do it with an all-payer rate system.

There is no cost shifting in Maryland. There is no discounting in Maryland. All payers pay the same rate for services at a particular hospital. So if you go to Johns Hopkins Hospital in Baltimore, the hospital does not care whether you are a Medicare patient or whether you are an HMO patient or whether you are a private insured patient or a Medicaid patient; the hospital receives the same reimbursement rate for the services performed by that hospital, as it should, for each person should receive the same high-quality care. We have been able to do that.

Now, there are those who believe that a regulated rate system would discourage managed care. It does not. Maryland has the third highest HMO penetration of any State in the Nation, so we have managed care, and we have an all-payer rate system, but what we have shown is that if you are going to save money in health care costs, you need to do it other than by discounting but by managing the care of the individual and promoting preventive health care.

I hope, Mr. Chairman, we will use Maryland as an example as we look for innovative ways of bringing down the cost of Medicare. Yes, I think we should look to the States, and I think we should look to managed care as a way of bringing down health care costs in Medicare, but I hope that as these hearings evolve our witnesses will tell us how we can bring down the costs of health care by managing the care of the Medicare patient, but not by discounting because you happen to be a bully in the marketplace. I don't think that serves any purpose, and I look forward to the testimony today for helping us in dealing with these very difficult issues.

[The prepared statement follows:]

STATEMENT OF
HON. BENJAMIN L. CARDIN
A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

I am concerned at the report that some Medicare Select carriers are achieving savings, and offering lower premiums, based on negotiating discounts of Part A costs, including deductibles, with hospitals. My state of Maryland has almost 20 years of experience with our all-payer hospital payment system. With that system Maryland has taken hospital costs which once ran almost 25% above the national average to 8.1% below that national average over time. Maryland has now outperformed the nation in containing hospital costs in 18 of the last 19 years. Maryland's all-payer hospital system is designed to contain costs, increase efficiencies and spread the costs of uncompensated care equitably across all payers. The results have been impressive: all Marylanders have access to needed hospital services; we have virtually no cost shifting; solvency has been maintained for all efficient hospitals; and our hospitals have retained or enhanced their reputations for clinical and teaching excellence.

The Maryland all-payer system functions on the very premise that all payers - whether public or private, large or small - including Medicare and Medicaid, pay the same prices for the same services. The system is based on principles which have been shown to work: focusing control on costs not profits; establishing attainable and predictable targets; using incentives; minimizing regulatory intrusions on the market; collecting data; focusing on outliers, those providers (and patients) at the cost margins; and taking a long range view.

As we look at reform initiatives it is important to use systems that work not by shifting costs but by actually delivering services more efficiently. The extent to which costs savings in managed care are coming from risk selection and the sentinel effect accomplished by limiting provider panels and requiring massive regulation of medical practice is not a positive development; rather if we are to encourage Medicare beneficiaries to move into managed care, we must encourage those managed care systems to achieve efficiencies and savings by concentrating on their real principles: emphasizing preventive services and managing/coordinating care.

Mr. Chairman, I look forward to a frank discussion of the challenges facing us as we look to improve Medicare services for all of its beneficiaries.

Chairman THOMAS. I thank the gentleman.

As was indicated, anyone who has a written statement that would like to put it in the record, without objection.

Earl, nice to have you back with us again, Hon. Earl Pomeroy from North Dakota, who has had some practical experience at the State level, which is always a danger if you have some knowledge in the area in terms of legislating.

It is nice to have you again. Proceed in any way you see fit.

STATEMENT OF HON. EARL POMEROY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH DAKOTA

Mr. POMEROY. Mr. Chairman, thank you very much.

The scope of this hearing goes to a very critical matter. My testimony will go to a very, very small subset of exploring the issues of greater managed care under the Medicare care delivery system.

I speak to H.R. 483, sponsored by Representative Nancy Johnson and myself. This bill would take the Medicare Select experiment and apply it to all 50 States and give it a permanent authorization.

I have had a long interest in senior citizen health insurance, dating back 10 years ago to my days in the North Dakota State legislature. I was a State insurance commissioner for 8 years, and during that time worked aggressively to advance the standards of senior health insurances in North Dakota and through the National Association of Insurance Commissioners. With the NAIC, I chaired the Long Term Care Insurance Committee, the Medicare Supplement Committee, I was president of the association, and chaired the task force that developed the model standards for Medigap coverage presently allowed under OBRA 1990.

The Medicare Select initiative was from the get go a modest little experiment, a baby step down the lane of incremental health reform. Medicare Select allowed insurers to negotiate with hospitals for reduced part A deductible charges and passed the savings on to the insured. Medicare paid the claims in an identical manner to other Medigap policies but stood to benefit from the utilization reduction generated.

Not surprisingly, the primary arrangement presently in place in these Medigap Select plans is a restricted network of providers that pass on the discount and provide little or no additional managed care to obtain additional savings.

On the other hand, for a number of insurers, the provider networks where the discount is offered is the same network they have constructed to provide cost-efficient managed care services to their insured major medical and Medicare Select alike. In these instances, even deeper premium discounts are made available to the insureds because of managed care savings. Of course, Medicare and taxpayers also benefit because the insured has selected a more cost-efficient health care provider.

Frankly, I thought at the time of enactment that subjecting such a modest project to the status of a pilot experiment by allowing it in only 15 States and giving it a relatively short authorization period was oversight overkill. In my opinion, the biggest consequence of these limitations has been to deprive seniors in 35 States from a Medigap insurance option which would have saved them some money while promoting managed care.

Anyway, now we have the initial results, and the following conclusions are supported. Not many consumers have it, but those who do enjoy lower premiums and register high levels of satisfaction.

Medicare has not quantified savings nor have they quantified costs from the program. Insurers, particularly those with established managed care networks, find Medicare Select a useful policy feature to bring Medicare supplement policyholders to their managed care network.

Maybe I am missing something, but it seems to me we ought to preserve a program that at its very worst has been a benign presence in the senior insurance marketplace.

When I was an insurance regulator, I figured the insurance consumers knew a lot more about their unique circumstances than I did, and they wanted options available in the market to choose from. With Medicare Select there is no demonstration that seniors should be precluded by government from having the option of saving a little money while selecting a Medigap policy that involves a restricted provider network and managed care.

In North Dakota's experience, the Medicare Select program has more than 10,000 enrollees who pay premiums priced at 17 percent below what the identical policy would have been in the non-Medicare Select program. To date, there has not been a single complaint generated by this Medicare Select book of business to the North Dakota insurance department. Not one.

The experience today in each of the 15 States tends to show that when it comes to Medicare Select, those who have it like it. Concerns about the program tend to be theoretical or anecdotal. I find the actual experience of those in the program is much more instructive as to its merit than those who purport to speak on behalf of senior citizens but don't have the direct personal experience of having had this coverage.

In my opinion, applying Medicare Select to all 50 States and making it permanent will have several positive effects; the national trends toward managed care rather than traditional fee-for-service reimbursements make it increasingly likely Medicare Select enrollees will benefit from lower premiums and managed care provided through established networks of providers.

As we take this step it is certainly appropriate to consider improvements to enhance the program in order to generate greater savings to policyholders. Discounts on the part B deductible should be permitted similar to the part A deductible discount presently allowed. The adequacy of consumer protections should be evaluated, provided that the extent of the existing protections imposed by State regulators are found to be insufficient.

In this regard, perhaps more should be done to insure that every Medicare Select insured has an opportunity to change to conventional insurance from a Medicare Select option on a one-time basis. Additional protections should retain regulatory responsibility with State insurance regulators, and any additional protections contemplated ought to be appropriate for the essentially indemnity nature that the Medicare Select product represents.

Unfortunately, the 6-month extension allowed by the 103d Congress is not sufficient to thoroughly consider design improvements without placing existing programs at-risk of having the programs

authority expire. I hope this Congress will not let perfection be the enemy of the good and have the existing Medicare Select program placed in peril while we cogitate about how we might make it better.

In summary, I believe the results of the Medicare Select program justify its extension and national expansion.

Thank you for your consideration of my testimony.

[The prepared statement follows:]

THE HONORABLE EARL POMEROY
before the
SUBCOMMITTEE ON HEALTH

February 10, 1995

Thank you for allowing me to testify on the issue of Medicare Select.

I have had a long interest in senior citizen insurance coverages dating back to my days in the North Dakota State Legislature in the early 1980's. Ten years ago, I became North Dakota's Insurance Commissioner and during the eight years I served in that position, I worked aggressively in North Dakota and in the National Association of Insurance Commissioners (NAIC) to upgrade the health insurance marketplace for senior citizens.

Within the NAIC, I served at various times as chair of the Medicare Supplement Task Force, the long term care insurance task force, as well as President of the association. When OBRA 1990 created the standards for Medicare supplement coverage and the Medicare Select program, I chaired the task force that developed the model statutes and regulations implemented at the state level pursuant to the legislation. These model laws included designing the spectrum of standardized coverages presently allowed in the medicare supplement market.

The Medicare Select initiative was from the get-go a modest little experiment--a baby step down the lane of incremental health reform.

Medicare Select allowed insurers to negotiate with hospitals for reduced part A deductible charges and pass the savings on to the insured. Medicare paid claims in an identical manner to other medigap policies but stood to benefit from utilization reduction.

Not surprisingly, the primary arrangement presently in place on Medicare Select plans is a restricted network of providers passing on the discount and providing little or no additional managed care to obtain additional savings.

On the other hand, for a number of insurers the provider networks where the discount is offered is the same network they have constructed to provide cost efficient managed care services to their insureds--major medical and Medicare Select alike. In these instances, even deeper premium discounts are made available to insureds because of managed care savings. Of course, Medicare and taxpayers also benefit because the insured has selected a more cost-efficient health care provider.

Frankly, I thought at the time of enactment that subjecting such a modest project to the status of a pilot experiment by allowing it in only 15 states and for a relatively short period of time was oversight overkill. In my opinion, the biggest consequence of these limitations has been to deprive seniors in 35 states from a medigap insurance option which could have saved them some money while promoting managed care.

Anyway, now that we have the initial results, the following conclusions are supported:

- Not many consumers have it but those who do enjoy lower premiums and register high levels of satisfaction.
- Medicare has not quantified savings or costs from the program.
- Insurers -- particularly those with established managed care networks -- find Medicare Select a useful policy feature to bring to their managed care network.

Maybe I'm missing something, but it seems to me we ought to preserve a program that at its very worst has been a benign presence in the senior insurance marketplace.

When I was an insurance regulator, I figured the insurance consumers knew a lot about their unique circumstances and they wanted options available in the market to choose from. With Medicare Select there is no demonstration that seniors should be precluded by government from having the option of saving a little money by selecting a medigap policy that involves a restricted provider network and managed care.

In North Dakota's experience the Medicare Select program has more than 10,000 enrollees who pay premiums priced 17 percent below those insured in conventional medigap coverage. To date, the insurance department has not received a single complaint from a Medicare Select policy holder.

The experience to date in each of the 15 states tends to show that when it comes to Medicare Select, those who have it like it. Concerns about the program tend to be theoretical or anecdotal. I find the actual experience of those in the program to be more instructive about the merit of the Medicare Select program than those who purport to speak on their behalf.

In my opinion, applying Medicare Select to all 50 states and making it permanent will have several positive effects. The national trends toward managed care rather than traditional fee-for-service reimbursement make it increasingly likely Medicare Select enrollees will benefit from lower premiums and managed care provided through established networks of providers.

As we take this step, it is certainly appropriate to consider improvements to enhance the program.

In order to provide greater savings to policyholders, discounts on the part B deductible should be permitted similar to the part A deductible discount presently allowed.

The adequacy of consumer protections should be evaluated, provided that the extent of existing protections are found to be insufficient. In this regard, perhaps more should be done to ensure that every Medicare Select insured has an ongoing opportunity to change to conventional insurance on a one-time basis.

Additional protections should retain regulatory responsibility with state insurance regulators and be appropriate for the indemnity-based nature of the product.

Unfortunately, the six month extension allowed by the 103rd Congress is not sufficient to thoroughly consider design improvements without placing the existing programs at risk of having the program's authority expire. I hope this Congress will not let perfection be the enemy of the good. The consideration of refinements must not jeopardize the Medicare Select program or unnecessarily complicate things for those who have stepped forward to provide this coverage.

In summary, I believe the results of the Medicare Select program justify its extension and national expansion. Thank you for your consideration.

Mr. THOMAS. Thank you very much, Congressman Pomeroy.

Mrs. Johnson, the author of H.R. 483, will inquire

Mrs. JOHNSON. Thank you very much.

It is a pleasure to welcome you, Congressman Pomeroy, my cosponsor of this legislation. It is very rare, frankly, that we consider legislation in this body where a Member has had so much direct experience not only with providing the product but with protecting the consumer to guarantee that the consumer does in fact get the care they believe they are going to get, the quality care they think they are going to get, and the options that they want. And I value your experience out on the frontlines in implementing this program as an insurance commissioner, and in helping me do the research that we did last year, to look and see how it is working and what is happening.

I do want to mention to you that as we have spoken that this is not the end of the road, if we make this permanent and available in all States it doesn't for a moment relieve us of the responsibility, especially in the context of the changes that are ahead of us of integrating this design or considering its structure in the years ahead.

I wanted you to be, if you could, a little bit more specific about the regulations that already govern this program. This is not just something out there without any controls around it. There are both Federal regulations and State regulations. If you could point out some of the ones that you think are most important to it, I think it would be helpful to the committee in its considerations.

Mr. POMEROY. Well, the OBRA 1990 legislation that put this pilot out there in place did make requirements that there be certain protections for the consumers, and before a State would be allowed to offer these products they had to have provisions in place that governed these protections.

First of all, the networks must offer sufficient access. In other words, in the city of Los Angeles you couldn't have just one doctor and hospital signed up if it was not sufficiently accessible by the policyholders it was being marketed to. The networks must have ongoing quality assurance programs so that internal quality is assessed on an ongoing basis. The insurer must provide disclosure at the time of the enrollment that this is a different product, this is a limited, restricted access product, and the disclosure must also provide notice as to provisions for out of area and emergency coverage as well as availability and cost of available Medicare supplement policies that are not Medicare Select policies and don't have these restrictions.

From a starting point, that is a pretty good base, I think, of consumer protections and maybe has something to do with the fact that there haven't been more complaints generated on this new product.

Mrs. JOHNSON. In your experience, what do consumers get for choosing a Medicare Select product?

Mr. POMEROY. Well, in the State of North Dakota, for example, they will access the Blue Cross-Blue Shield provider network.

Now, the Blue Cross-Blue Shield provider network in my State includes most everybody. So access is not restricted particularly effectively. The part A deductible is waived, so the cost of the premium is reduced, but I think in addition to that that managed care

devices that Blue Cross-Blue Shield has implemented, which means that Blue Cross is doing more on a given case than simply writing the claims check as has formerly been the case and is still the case with pure indemnity providers of Medigap coverage, means that the care is more cost efficiently provided, that means claims experience is less and that means further savings to the policyholder on their Medigap piece and it means savings to the Federal Government and taxpayers who pay the bulk of a Medicare claim.

Mrs. JOHNSON. Thank you very much, Mr. Pomeroy.

One of the things that I think is being overlooked in this discussion is that managed care does offer to seniors protection against one of the major causes of hospitalization among seniors, which is overmedication.

There is a much greater possibility of your medications being integrated and coordinated in a managed care system, and that has traditionally been a very serious cause of senior hospitalization, so it is a quality issue for seniors as well as a cost issue for us all.

Thank you for your testimony and for your experience.

Mr. POMEROY. Thank you.

I would like to note for the record that we are having this hearing today on a program that was extended because of your efforts. It would have expired without question in my opinion at the end of the calendar year but for a really heroic effort put forth by you at the end of the 103d.

Mrs. JOHNSON. Thank you.

It took a good team. We did manage to save a program that for 400,000 seniors is the difference between more care and less care.

Thank you.

Mr. POMEROY. That is right.

Chairman THOMAS. Would the gentleman like to inquire, the gentleman from Washington.

Mr. MCDERMOTT. Yes, thank you, Mr. Chairman.

Congressman Pomeroy, you are aware that the department is going to follow you and suggest they don't think this is a good program. I am sure you have investigated that, and I would like to hear your answers why you think they are wrong in wanting to get rid of this program.

Mr. POMEROY. Actually, it is my understanding that HCFA will be testifying this morning that this program isn't the greatest thing since sliced bread, that it has had kind of a benign effect out there that it has not saved Medicare money. For the reasons that I indicated in my testimony, I believe they have come to that position. It is not a particularly grand policy change, policy design change. It is a small one.

Moreover, it has only been allowed in 15 States and only for a relatively short period of time, so I don't think we have seen its full fruition. Maybe we see things differently. For me if it generates for those who have it a lower premium and if it provides for those who have it a level of coverage for health care that they find satisfactory in fact that they like it, I am confused about any reason to pull the plug on it.

Now, if HCFA could demonstrate that in fact because of the lower cost of access to care utilization was increased and Medicare

was shoveling money out the door for Medicare Select recipients, that they weren't paying for other Medicare insureds, then I would say Medicare—HCFA has a legitimate gripe with this product, and I would be very concerned about actually having something that we mean to decrease costs, increasing costs. That will not be their testimony today, however, so I am kind of confused that the department would find this to be a big deal one way or another.

Mr. McDERMOTT. Well, have you seen the Research Triangle Institute study? Have you had an opportunity to look at that?

Mr. POMEROY. Yes.

Mr. McDERMOTT. They say that one-third of all the Medicare Select networks include only hospitals. It is not managed care. Blue Cross in three States, including California, converted their entire pre-OBRA people in Medicare into this Select program so they wouldn't have to standardize their programs.

You understand all those things, and you still think it is a good program to keep in place?

Mr. POMEROY. Well, first of all, let's take a look at the design of the program. You can only waive the part A deductible, small wonder, therefore, that physicians on the part B haven't participated. We haven't allowed them by the design of the program to do it.

Second, Blue Cross-Blue Shield I think will tell you as they testify later, in fact the testimony of a former HCFA director himself, that they did not roll their pre-OBRA population into Medicare Select for the exclusive purpose of avoiding standardization.

In fact, when I chaired the committee that developed the standardized products, the Blue Cross plans, including the California plan was very much represented and participating in that process.

Mr. McDERMOTT. So you disagree with the study?

Mr. POMEROY. I think that the study is hardly conclusive evidence that this thing is such a blight on the senior insurance market it ought to be pulled.

Mr. McDERMOTT. Thank you, Mr. Chairman.

Chairman THOMAS. Any other member wish to inquire?

Earl, let me use you in terms of your technical expertise in your previous life. If you have got a product structured like Medicare Select as a pilot program with a limited life, what would be the normal reaction of a company in terms of talking about gearing up to go into a market like that?

Mr. POMEROY. Well, you would certainly let somebody else spend the research and development money to get it on the market and wait and see what the result was, whether it panned out in market experience and whether Congress let it go forward, and so I believe that the relatively short authorization period has discouraged development, and I might also say that by limiting it to 15 States there are networks that cross State lines, and that would also be disruptive, it would disrupt your normal care delivery network and so that would further discourage other managed care insurers from going into this product.

Chairman THOMAS. If someone were to say from your position as an insurance commissioner or even someone who understands the business that maybe we will allow Medicare Select to continue but only for another 6 months, only in the 15 States that we had established it, and you can't really go out and aggressively enroll new

folks, what are they trying to tell you where they want the program to go with that kind of a message?

Mr. POMEROY. That isn't a helpful signal to the market. You know what, on the other hand, that extension might be necessary if we are really going to do a good job of figuring out how we can improve this, and before we apply it to the 50 States I don't take exception to the notion that nothing is perfect.

Maybe we can make this better, but what frustrates me is, this didn't just happen. I was a cosponsor of the bill last session, I didn't have a visit with HCFA about this matter until Monday. I mean, where have we been?

We didn't have to get so close to time running out to roll up our sleeves and get serious about trying to improve it. Now I want to improve it if it can be improved. I want even more incentives for managed care if we can put them in here safely.

I am frustrated, frankly, that our options are a short extension versus the prospect of improving it, but, Mr. Chairman, in that context I might go for the short extension if there were likely improvements that would work, if a prima facie case was made that there were improvements that we probably could implement, we just needed a little more time to look at.

Chairman THOMAS. Thank you very much for your testimony. I look forward to your continued participation with us in trying to reshape the program.

Thank you very much.

Our next witness will be Bruce Vladeck, Administrator, Health Care Financing Administration.

As you sit down, I will just tell you that this Chairman and particularly the members on our side of the aisle are anxious for your testimony because earlier this week in full committee we had both the Secretary of the Treasury, Mr. Simon, and the Health and Human Services Secretary, Mrs. Shalala, as we discussed the President's overall budget, and the key points I think that were made in the——

Mr. MCDERMOTT. If the gentleman will yield, the Secretary of the Treasury is not Simon, I think it is Rubin.

Chairman THOMAS. I apologize. Thank you very much.

Mr. MCDERMOTT. That is another administration.

Chairman THOMAS. Coming out of my time warp. I didn't like what he had to say, either.

Mr. MCDERMOTT. I am listening to you.

Chairman THOMAS. Secretary of the Treasury Rubin in presenting the President's budget indicated there were no significant Medicare cuts, and obviously in the previous budget $124 billion had been slated for reduction to be spent in reforming the health care structure, but also there were no programmatic changes either, and so I am looking forward to your testimony because both Secretary Rubin and Secretary Shalala said that the President's commitment is a hand reaching out in partnership to shape these programs, although it isn't on paper there was a clear indication there was a willingness to work together to make changes, and my assumption as an administrator in the very particular area of this administration that you are going to present us with that hand reaching out

in terms of this new partnership, and I will listen to your testimony in that light.

The gentleman may proceed in any way he sees fit. Obviously his written statement will be made a part of the record, without objection.

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

Mr. VLADECK. Thank you very much, Mr. Chairman. I appreciate the opportunity to put the full statement on the record.

I am very pleased to be here today to begin the dialog, Mr. Chairman, to which you just referred about the current state of the Medicare program, and, more importantly, about its future.

More than any Members of this Congress, the members of this subcommittee have long had an understanding of the complexities of the Medicare program and the vulnerable populations that we serve, and have contributed over the years to major improvements in the program.

Medicare is a popular and a successful program. I believe we need to work together to build on its successes and to strengthen it for its beneficiaries and for the taxpayers who are its future beneficiaries. Together we can improve and expand choices for Medicare beneficiaries without substantially damaging the program.

We in HCFA have been working very hard to make Medicare an effective, affordable, and customer-friendly program for beneficiaries. At the same time we have been working to implement administrative and program improvements that maximize the efficiency and cost-effectiveness of the program.

While my written testimony includes more details, I want to begin by reviewing some of our recent efforts and successes, and then provide you with an overview of our efforts in the area of managed care.

Finally, I would like to discuss some of our other initiatives to improve the administration of the Medicare program. As the world's largest health insurance program, Medicare is by many measures one of the most successful. It is, as you know, administered through a very special kind of public-private partnership in which direct administration of the program is carried out by private contractors under our supervision.

Last year almost 36 million persons were served by the Medicare program, and over 750 million claims were processed. Payments totaled almost $160 billion. Even so, those payments accounted for slightly less than half of the health care expenses of elderly beneficiaries.

Yet, contrary to recent public discussions, it is important to emphasize who our beneficiaries are and that relatively few of them can be considered financially well off. I call your attention to chart 1, which is on the easel. I don't know how Sandy got all of the audience out of the way to see that. Copies of these charts are in my written statement as well.

As you can see, in 1992 approximately 83 percent of our program spending was on behalf of those with incomes less than $25,000. The elderly population is slightly more affluent than the Medicare

beneficiary population, and there is a very strong correlation, an inverse correlation, between the income of beneficiaries and their use of health services that needs to be taken into account as we consider changes in the program.

Currently, if I can refer to the second chart, 20 percent of our beneficiaries are either 85 years old and older or persons with disabilities, including end-stage renal disease. These two subparts of the Medicare beneficiary population are by far the fastest growing parts of the population.

I would submit to you that we have very little evidence on how to optimally take care of the old-old and disabled under any systems of care. One of the major challenges we face going forward in the Medicare program is developing better models to more effectively provide appropriate clinical services to those populations.

I urge you to think about these basic facts as you examine the future of Medicare. Millions of elderly and disabled Americans now have not only health care coverage but a quality of life they would otherwise lack because of Medicare.

Despite the size of the program, we have maintained a very high level of consumer satisfaction while keeping administrative costs at less than 2 percent of Medicare outlays.

In contrast, as you know from all the health care reform discussions last year and the year before, in the small group private insurance market, administrative expenses can run as high as 25 percent and in the most efficient parts of the private large group market they tend to be approximately 5 percent.

One of the reasons we have been able to keep our administrative costs down is because we have the most sophisticated electronic provider communication network of any large insurer in the United States. Ninety percent of our hospital and skilled nursing facility claims are submitted electronically; two-thirds of our physician claims are submitted electronically. As seen in the third chart, we measure up very favorably when compared to private insurers.

We have also focused on reducing the paperwork burden by collaborating with the health care community to develop uniform national claims forms for physicians and for all other facilities. This is now the only claims form that we require from those providers.

Many private insurers use this form but also require significant additional documentation as part of the billing process. During the Clinton administration, the average rate of growth for Medicare has decreased significantly.

As you know, the President's budget for fiscal year 1996 projects a 9-percent annual average rate of growth for the 1996–2000 period. That number is down from the midsession review by more than 1 percent per year.

This decline is largely attributable to decreases in part A expenditures, resulting from decreases in inflation in the economy as a whole, and particularly in hospital cost inflation, as well as a decrease in the case mix complexity of inpatient cases.

As noted by Chairman Thomas, further discussions on reform and innovation in the Medicare program must include discussions of managed care. We are committed to working with you to improve and extend the managed care choices available to our bene-

ficiaries so that they have the full range of managed care options that are available to the privately insured population.

The cornerstone of our policy is informed choice in a fair marketplace where beneficiaries have full and objective information and are not discriminated against on the basis of relative need. Currently 74 percent of Medicare beneficiaries have access to a managed care plan—that is to say, they live in a county in which we have a contract with one or more managed care entities—and 9 percent of Medicare beneficiaries have chosen to enroll in a managed care option. Eleven counties have 40 percent or more of our beneficiaries enrolled in managed care, and more than 80 counties have Medicare managed care enrollment levels that are 20 percent or higher.

The year 1994 was one of particularly strong growth in Medicare managed care. We experienced double-digit increases both in plan enrollment and in the number of plans participating in the program. More than 50 percent of our new risk contracts are in areas that previously had four or fewer plans, and we now have five States in which we have risk contracts where in previous years we had none, including Connecticut, New Hampshire, Delaware, Alabama, and Louisiana.

The total number of plans with which we contract increased slightly more than 20 percent last year alone. However, as we work to extend and broaden managed care opportunities for Medicare beneficiaries, we must be aware both of the practical limitations of a rapid expansion of managed care in Medicare and of past failures from overly aggressive efforts in both the Medicare and Medicaid programs.

The movement to managed care cannot outpace the capacity of plans to serve large numbers of new enrollees, especially enrollees with the expensive and special health needs seen in the Medicare population.

In addition, for Medicare to benefit from the expansion of managed care, we need to improve the way we pay managed care plans.

Currently, the expansion of managed care is costing the Medicare program money rather than achieving savings. Our evaluation suggests that Medicare pays almost 6 percent more for every enrollee in managed care than we would have paid if the beneficiary had stayed in fee-for-service Medicare. This is because managed care tends to attract healthier members of our population whose costs are significantly lower than average.

We are doing a lot of work to improve the payment methodology so that it doesn't deter us from expanding managed care. We have a number of research projects and demonstrations underway to address the situation and we would be glad to describe them to you or your staff in greater detail. We hope by the end of this calendar year to have some significant results.

Again, our position is that the emphasis must be on choice. Medicare beneficiaries themselves should determine the pace of the Medicare movement to managed care. Managed care will succeed only to the extent that plans are able to prove the value of their products to the beneficiaries, and as beneficiaries recognize the benefits of coordination of care and case management that high quality managed care plans do provide.

In addition to our efforts to improve current managed care options under Medicare, we want to make available to beneficiaries a new PPO option, preferred provider organization, similar to what is increasingly the most popular form of plan in general insurance markets and similar to the most popular plan in the Federal employees health benefits program—indeed, the one in which I am personally enrolled.

Under this option, we would like beneficiaries to be able to choose to go to any physician at any time, but with differential cost sharing depending on whether they are in- or out-of-network. In developing a PPO option for Medicare, we think we can learn a lot from our experience with Medicare Select.

As you know, Medicare Select was designed to create a hybrid of managed care and Medigap that would benefit both beneficiaries and Medicare. However, our preliminary evaluation shows that while premiums for beneficiaries have been reduced, Medicare does not share in savings.

The basic problem, as reported in our evaluation, is that Medicare Select plans have limited incentives to manage total costs. Savings from beneficiaries are generally the result of hospital discounting arrangements rather than the act of managing care or the efficiency of particular networks.

As a result, this option does not approve the efficiency of the Medicare program, and beneficiaries do not receive benefits from coordinated care. In fact, if proposals to expand Select discounting to part B services were enacted, Medicare costs, according to our preliminary discussions both with CBO and our own actuaries, would actually increase as physicians increased volume to recoup revenues lost from discounts.

We are also concerned about the adequacy and scope of beneficiary protection standards in the current Select program. We feel very strongly that beneficiaries should not have to worry about the quality or access provisions of any choice they make under the Medicare program, and we look forward to working with you on this issue. We also hope to be able to work with you on developing the PPO option in the months ahead.

In that context, we may wish to consider another extension of the Select demonstration. This would alleviate uncertainty for existing plans as we try to work toward a longer term strategy and allow time to make appropriate changes based on the final evaluation of the demonstration experience, which is expected at the end of this calendar year.

As we work together to extend the managed care options available to Medicare beneficiaries, we need to do a much better job educating beneficiaries about the managed care and Medigap choices that are available. The current lack of information in the face of such a variety of choices generates confusion that works against choosing managed care. To understand their choices, beneficiaries need to negotiate through differences in benefit packages, cost sharing structures, and premium amounts.

In addition, they are faced with enrollment periods that vary by plans, and in the case of Medigap, with health screening and underwriting. Beneficiaries who initially enroll in a managed care plan lose their one-time eligibility for open enrollment in Medigap.

We would like to do everything possible to permit managed care options to compete fairly for beneficiaries in a fair market.

As I mentioned earlier, there has been a lot of concern about the payment methodology for Medicare risk contractors. Very shortly after I became Administrator of HCFA, we invited the industry to propose alternatives to our current methodology. We have no earth shattering results to report from that activity.

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

We think this is a promising idea. We have begun exploring it, and we would like to test variants of it as demonstrations in several geographic areas.

However, in order for these demonstrations to be useful, we believe that competitive bidding should become the payment methodology for all Medicare managed care plans in the demonstration areas, and we would be interested in working with the subcommittee on the structure of such a demonstration.

Managed care options, while of growing importance to the administration of Medicare, are not the whole story. We are also actively working to improve management throughout the program, and to continue to make innovations in the fee-for-service program, which we expect, regardless of the rate of growth of managed care, to be with us for well into the future.

Under the leadership of President Clinton, Vice President Gore, and Secretary Shalala, we at HCFA have focused our efforts on making sure that our nearly 70 million Medicare and Medicaid beneficiaries receive the health care they need when they need it. This means refocusing all our activities around beneficiaries and beneficiary service.

We have undergone significant internal and external change to insure that a customer-first philosophy becomes reality. We are working with our customers to make our publications and notices easier to understand; we are simplifying Medicare claims administrations so the claims determination will be more consistent from one part of the country to another; and we are measuring and improving customer satisfaction on a regular basis through the use of surveys, focus groups, and meetings.

At the same time, we have been working very closely with the Inspector General's Office in the Department of Health and Human Services, and with the Department of Justice, to redouble our efforts to deter, detect and pursue fraud and abuse against the Medicare program, which, given the particular vulnerability of our beneficiaries, has effects not only on our outlays but also on the health of the people we serve.

We are also looking very hard at integrating delivery systems beyond the parameters normally found in existing managed care arrangements. In particular, we are looking at all the long-term care services provided through both Medicare and Medicaid to find ways that they can be better coordinated with one another and with the

acute care system. In particular, we are focusing on the home health care programs, which, as you know, have been growing with particular rapidity in recent years.

In conclusion, for 30 years Medicare has been insuring the Nation's elderly and disabled. We know from our focus groups, and I think you all know from your interactions with your constituents, that beneficiaries feel a certain ownership of the program. That feeling is justified. Through their payroll contributions and those of their employers during their working lives and through their own premium payments, beneficiaries contribute roughly 70 percent of their insurance costs.

We want to work with you to make responsible decisions in planning the next steps for the future of the Medicare program. We do look forward to working with the subcommittee to improve and expand choices available to beneficiaries while protecting quality, access, and value.

Thank you very much.

[The prepared statement and attachments follow:]

TESTIMONY OF BRUCE VLADECK
HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and Members of the Subcommittee

I am pleased to be here today to begin a dialogue with this Subcommittee about the current state of the Medicare program and, more importantly, about its future. More than any other members of this Congress, the members of this subcommittee have long had an understanding of the complexities of the Medicare program and the vulnerable population that we serve, and have contributed to major improvements in the program over the years. Medicare is a popular and successful program. I believe we need to work together to improve on the program's success and strengthen it for its beneficiaries and the taxpayers who support it.

We in HCFA have been working very hard to make the Medicare program an effective, affordable and "customer friendly" program for beneficiaries. At the same time, we have been working to implement administrative and program improvements which maximize the efficiency and cost effectiveness of the program. I want to begin by reviewing some of our recent efforts and successes and then provide you with an overview of our efforts in the area of managed care. Finally, I would like to discuss some of our initiatives to improve the administration of the Medicare program.

I. SUCCESSES

Medicare is the world's largest health insurance program and by many measures one of the most successful. It began in 1966 as a Federal health insurance program for the elderly and was expanded in 1972 to cover disabled persons and those with End Stage Renal Disease (ESRD). The Medicare program was established because our vulnerable populations had difficulty obtaining private health insurance coverage.

Medicare is administered largely by private contractors under our supervision. In 1994, Medicare served almost 36 million persons under Parts A and B of the program. Aged Medicare beneficiaries number 32 million, 3.6 million are disabled and 77,000 have ESRD. Medicare has agreements with over 65 contractors to process beneficiary claims. In FY 1994, over 750 million claims were processed and Medicare paid more than $159 billion for medical services, treatment and equipment.

Today, we maintain Medicare's commitment to serve the most vulnerable. Medicare is the largest payor of the elderly's health care expenses. As the Subcommittee examines the future of the Medicare program, I would urge you to consider the following important facts about Medicare beneficiaries.

- Relatively few Medicare beneficiaries can be considered financially well-off. Approximately 83 percent of program spending in 1992 was on behalf of those with incomes less than $25,000. (CHART 1)

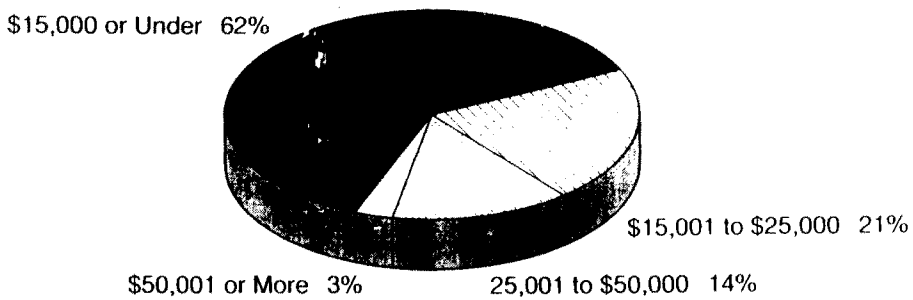
- Currently, 20 percent of our beneficiaries are either seniors age 85 and older, most of whom are women, or persons with disabilities including End Stage Renal Disease (CHART 2).

- Third, per capita health care spending for aged beneficiaries is 4 times the average for the under 65 population.

Medicare is successfully fulfilling its mission and beneficiaries continue to express a high degree of satisfaction with the program. Millions of elderly and disabled Americans now have health care coverage and a quality of life that they would otherwise lack, thanks to the Medicare program.

Share of Program Expenditures by Income

Of Medicare Individuals or Couples, 1992



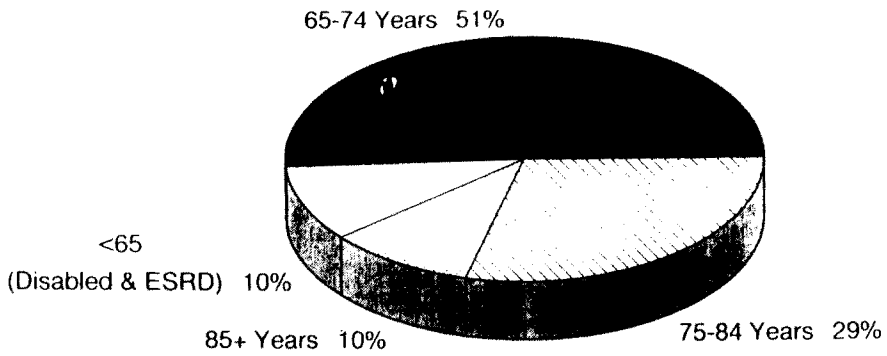
83% of Expenditures: Annual Income of $25,000 or Less

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

Chart 1

The Composition of the Medicare Population, 1992

Elderly, Disabled and ESRD



Total Beneficiaries=35.6 Million

Source: HCFA/BDMS

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Chart 2

Innovative Program Administration

Despite the size of the Medicare program, we have maintained a high level of consumer satisfaction with low administrative costs, less than two percent of program outlays. In contrast, private insurance administrative expenses are about 25 percent in the small group market and about five percent in the large group market.

Medicare has been a pioneer in streamlining program administration and is a world leader in fostering electronic claims submission: Ninety percent of Medicare's hospital and skilled nursing facility claims and 67 percent of its physician claims are submitted electronically. In contrast, 60 percent of Blue Cross' hospital claims and 20 percent of its physician claims are electronically submitted. For commercial carriers, the percentage is 10 percent for all claims. (CHART 3)

We have focused attention on reducing the paperwork burden on health care providers, working closely with the health care community to establish a standard uniform national Medicare claim form for physicians and another for hospitals, Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs). Many other insurers use these forms, but attach additional forms as well. These, however, are the only hospital and physician claim forms that Medicare requires.

Decline in the Medicare Baseline

During the Clinton Administration, the projections for the average annual rate of growth for Medicare have decreased. In the President's FY 96 Budget, the projected annual average rate of growth for 1996 - 2000 is 9.1 percent. In contrast, six months ago in the Mid-Session Review, the projected annual average rate of growth for the same period was 10.3 percent. The primary contribution to lower Medicare projections is slower growth in Part A Hospital Insurance expenditures. The decline in projected Part A growth results primarily from a decrease in forecasted hospital cost inflation and slower growth in the complexity of Medicare inpatient cases.

II. MANAGED CARE AND THE MEDICARE PROGRAM

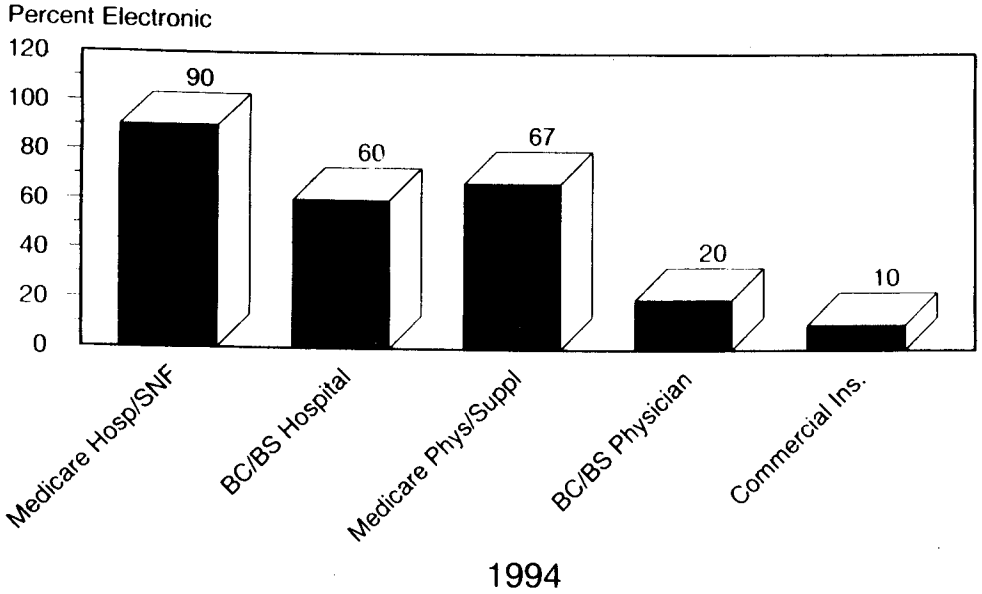
Today, any discussion of the quest to enhance cost effectiveness, as well as the accessibility of quality medical care for beneficiaries, must include managed care. We are committed to working with you to improve and extend the managed care choices available to our beneficiaries so that they have the full range of managed care options available to the general insured population. The cornerstone of our policy is informed choice in a fair marketplace, in which beneficiaries have full and objective information and are not discriminated against on the basis of relative need.

Managed care is not a new concept for the Medicare program. Since its inception in 1966, a portion of Medicare beneficiaries have received care through managed care arrangements. Enrollment is increasing, and we anticipate continued strong growth as newly entitled beneficiaries, who are more familiar with managed care, enter the Medicare program.

Currently, 74 percent of Medicare beneficiaries have access to a managed care plan and 9 percent of Medicare beneficiaries have chosen to enroll in a managed care option. 1994 was a year of impressive growth in Medicare managed care, we experienced double digit increases both in plan enrollment and the number of plans participating in the program. Plan enrollment increased by 16 percent. We now have 11 counties where 40 percent or more of our beneficiaries are enrolled in managed care, an additional 30 counties with enrollment between 30 and 40 percent, and more than 44 counties with enrollment between 20 and 30 percent.

Electronic Submission of Claims

Medicare vs. Private Insurance



Source: HCFA/BPO; Blue Cross Assoc.

P78 HCFACHT2

Chart 3

More important for future enrollment growth is the number of contracts with managed care plans. In 1994, the number of our Medicare managed care plans increased by 20 percent. Many of these new contracts are in regions beyond those that traditionally have had a strong Medicare managed care presence. In our Philadelphia region, the number of contracts increased from 6 to 16 and in the Boston region contracts increased from 4 to 9.

As we work to extend and broaden managed care options for Medicare beneficiaries, we must be aware both of the practical limitations of a rapid expansion of managed care in Medicare and of past failures of overly aggressive efforts in both the Medicare and Medicaid programs. The movement to managed care cannot outpace the capacity of managed care plans to serve large numbers of new enrollees, particularly those with the expensive and special health needs of the Medicare population.

In addition, for Medicare to benefit from the expansion of managed care, we need to improve the way Medicare pays managed care plans. Managed care currently costs the Medicare program rather than achieving savings. Our evaluations have suggested that Medicare pays 5.7 percent more for every enrollee in managed care than would have been paid if the beneficiary had stayed in fee-for-service. The reason for this is that they attract the healthier members of the Medicare population whose health care costs are lower. Efforts are underway to improve the current payment methodology so it doesn't act as a barrier to the expansion of managed care. We have initiated several research projects and demonstrations to address this situation and we expect to have preliminary results later this year.

Medicare beneficiaries themselves must determine the pace of their movement to managed care. The emphasis must be on choice. Managed care will succeed as managed care plans are able to prove the value of their products and as beneficiaries recognize the benefit of the coordination of care and case management that high quality managed care plans can provide.

New Managed Care Options

In addition to our efforts to improve current managed care options under Medicare, we want to make available to beneficiaries a new preferred provider organization (PPO) option. This option has proven to be very popular in the commercial market, and many of us have access to PPOs. We believe that Medicare beneficiaries should have the same range of choices. Under the PPO option, our objective would be to allow beneficiaries to choose to go to any physician at any time, subject to higher cost-sharing.

In developing a PPO option for Medicare, we hope to learn from our experience with the Medicare SELECT demonstration. As you know, Medicare SELECT was designed to create a hybrid of managed care and Medigap that it was hoped would be beneficial both to beneficiaries and to Medicare. However, our experience under the demonstration has been that while premiums for traditional Medigap benefits are reduced, Medicare does not share in the savings.

The reason for this apparent anomaly is that the lower Medigap premiums in Medicare SELECT plans are generally the result of hospital discounting arrangements rather than the active management of care or the efficiency of the SELECT networks. The basic problem with Medicare SELECT is that there are limited incentives for plans to manage the total costs. As a result, Medicare does not participate in any savings, and beneficiaries do not receive the benefits of coordinated care that they would receive in efficient networks. In fact, if proposals to expand SELECT discounting to Part B services are enacted, Medicare costs would actually increase, as physicians increase utilization to recoup their discounts.

A second issue with Medicare SELECT deals with the adequacy of beneficiary protection. We feel strongly that beneficiaries should not have to worry about the

quality and access provisions of their Medicare choices. We look forward to working with the Subcommittee on this important issue.

We also hope to be able to work with the Subcommittee on the PPO option in the months ahead. In addition, given the impending deadline for expiration of the SELECT authority and the need to examine the demonstration experience before the program is expanded to all states, Congress may wish to consider a 6 month extension of the demonstration for existing plans. This would alleviate the uncertainty for existing plans, and provide time to make appropriate changes to SELECT based on demonstration experience.

Beneficiary Education

We need to do a better job of informing beneficiaries about the managed care and Medigap choices that are available. The current lack of information in the face of such a variety of choices generates confusion which works against managed care options. To understand their choices, beneficiaries have to negotiate through differences in benefit packages, cost-sharing structures and premium amounts. Beyond this need for information, beneficiaries are also be faced with enrollment periods that vary by plan and, in the case of Medigap, with health screening and underwriting. Beneficiaries who initially enroll in a managed care plan lose their one time option for open enrollment in Medigap.

We would like to do everything possible to make managed care options very attractive to beneficiaries. We think we can do a better job of helping them to understand the advantages of these plans.

Quality and Managed Care

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

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

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

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

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

- HEDIS is viewed by most of the leading state managed care programs as the appropriate model for Medicaid. Some states are already adopting HEDIS. We feel it is important to provide some national leadership.

- We want to coordinate with the private sector and take advantage of the significant analytical groundwork already produced by NCQA, so as to minimize potential reporting burdens on our managed care plans, many of which are adopting HEDIS.

In Medicare, we are beginning to pilot test a new, performance based approach

to Peer Review Organization (PRO) review of HMOs developed under contract with the Delmarva Foundation. These measures reflect the special health needs of an elderly and disabled population, for example, in management of chronic conditions. These measures will them be considered in conjunction with the broader HEDIS effort.

Payment/Competitive Bidding

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

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

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

III. IMPROVED PROGRAM MANAGEMENT

Managed care options while of growing importance to the administration of the Medicare program are not the whole story. We are actively working to improve management throughout the program and to make continued innovations in the fee-for-service program.

Customer Service Initiatives

Under the leadership of President Clinton, Vice President Gore and Secretary Shalala, we at HCFA have focused our efforts on making sure that our nearly 70 million beneficiaries (Medicare and Medicaid) receive the health care they need when they need it. This means that beneficiaries come first in all that we do. HCFA has undergone significant internal and external changes to insure that the "customer first" philosophy becomes a reality. Throughout the agency, we are working to improve communications with beneficiaries -- whether it be one-on-one in person, on-line through the computer, over the telephone, through our numerous publications or through the media.

The nature of the Medicare program is such that there are numerous other people and organizations that have closer contact with beneficiaries than HCFA. They are also our customers and our partners in providing health care services - providers such as hospitals, nursing homes, home health agencies, physicians and medical suppliers; contractors (carriers and intermediaries) that process and pay Medicare claims; and, Peer Review Organizations that assure the quality of health care services.

We have developed a set of customer service standards that apply to our

interactions with beneficiaries and our partners. These standards apply to all of our communications, claims processing activities, customer satisfaction, consumer choice, health care quality and program administration. For example, we are working with our customers to make our publications and notices easier to understand. We are simplifying Medicare claims administration so that claims determinations will be more consistent. We are placing a premium on measuring and improving customer satisfaction through the use of surveys, focus groups and meetings.

We also believe that the need for integrating delivery systems will become more and more critical as our population becomes increasingly diverse and older with more chronic care needs. In order to meet these needs, it is clear that HCFA must maintain a collaborative relationship with its partners in the provider community and assist them to improve their focus on customer service. Several such initiatives are already underway. HCFA is examining all of the long-term care services provided by both Medicare and Medicaid and is considering ways that these services can be better coordinated with one another and with the acute care system. A similar review of home health care programs has also been undertaken.

Fraud and Abuse

Starting at the Office of the Administrator and at every level of HCFA, we have expanded and strengthened our efforts to root out fraud and abuse against Medicare and Medicaid and to vigorously pursue those who commit such illegal activities. We operate in a partnership, not only with the Department's Office of the Inspector General, but with the Department of Justice, including the FBI, state and local law enforcement agencies, and our contractors. Further, HCFA is increasingly exercising its authority to suspend payments to providers and suppliers when evidence of fraud exists.

In addition, HCFA is reviewing and changing programs and policies that have been found most vulnerable to abuse. For example, in order to better monitor fraud and abuse related to durable medical equipment (DME), HCFA has changed the procedures for claims processing. Four carriers are now responsible for DME claims processing rather than the previous 33 carriers, a system which provided DME suppliers opportunities to submit claims to the carrier whose payment policy was most liberal. The new system of using four regional carriers reduces the chance for fraudulent billing because suppliers must submit claims to the carrier in the region where the beneficiary resides.

The use of more sophisticated data processing systems, such as the MTS system, that I discussed earlier, further increases the chances of detecting aberrant patterns that might indicate abusive behavior. The MTS system will greatly improve HCFA's ability to screen Medicare claims for errors and fraud.

IV. CONCLUSION

For thirty years, Medicare has been insuring the nation's elderly and disabled. We know from our focus groups, and I think you are all aware from interactions with your constituents, that beneficiaries feel a certain ownership of the program. This feeling is justified. Through their payroll contributions and those of their employers, during their working lives, and through their own premium payments, beneficiaries in fact contribute 70 percent of their insurance costs. We want to work with you to make responsible decisions in planning the next steps for the future of the Medicare program. We look forward to working with this Subcommittee as we expand choices available to beneficiaries without compromising quality, access or value.

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

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. Thank you very much, Mr. Chairman.

I welcome you to this hearing, Mr. Vladeck. I will have to say I am stunned by your testimony and disappointed by your comments. Some weeks ago you came to visit me in my office to talk about this matter. This bill passed many months ago; it was only a 6-month extension. You know as well as I know that it has to be done in 4 months or the products will be off the market. We cannot pass a bill at the end of the 6 months, the last day of the 6 months, and expect the market to be there.

There are 400,000 American seniors who have chosen this option. There must have been a reason. They were not compelled. As you said in your own testimony, managed care is going to succeed or fail in the senior population depending on their choice, and if they think it offers them something and they like it. Now 400,000 seniors have chosen Medicare Select.

We have now very few months of the 6 months' period left. We have maybe 1 month left to get this through so the products don't go off the market. You came to see me in my office to talk about this, and I appreciated that courtesy and I told you that at the time. Thereafter I wrote you a short letter saying I appreciated your visit, we must get down to the specifics, what is it you don't like, what would you like changed in the legislation, what are your concerns specifically, let's get to it. Thereafter, your staff called me and asked what questions I would like to have you answer.

Well, you have talked about your work in the Medicare program. It is a very big program, it is a powerful program, it is one of the most important benefits to American seniors, and nobody knows that better or cares more about it than the members on this committee, regardless of party, and I am pleased that you are making some progress. But I am very interested that the charts you used to talk to us about Medicare are 1992 data. This is 1995. Anyone involved in health care knows how rapidly the market is moving. Anyone involved in health care knows that health care costs are being contained in managed care and consumers are liking it because they are continuing to choose it and show positive responses on polls.

Now, that is not to say there are no problems, and in my office I agreed with you that there are problems, and we must look at those, but you did not do that today, and if you are going to be part of this dialog, buckle down, get your staff focused, and let's do it. Now you said in your testimony that Medicare Select will increase costs to Medicare.

Now, I want you to define for me to what extent is that the result of our failure to deal with things like the AAPCC and other structural problems in the way we price in Medicare and the way we contract with the private sector. Contracting is not new, I agree with you, contracting could be a good answer, why aren't we out there? Why have we let 3 months pass? Why aren't we going to try that in Medicare Select? I hope your people will stay because we are going to have excellent testimony that Medicare Select offers seniors more access to prescription drugs, offers seniors some ac-

cess to dental and vision care. They aren't buying it because they are being forced to. They are buying it because it is a good bargain.

Mr. Schaeffer later on will provide us with real data that shows the use of in-network providers under the Medicare Select program in California saves the government money, specifically medical services per admission for network providers was 20 percent lower than for nonnetwork providers, and the average length of stay for network providers was 50 percent lower than for nonnetwork providers.

Now, does HCFA have different figures on this matter? Do you have any contemporary figures on this matter? What is your comment on California's experience, and how does it relate to your broad-brush comment that Medicare Select is increasing Medicare's costs?

Mr. VLADECK. Mrs. Johnson, let me say that we don't believe Medicare Select at the moment is increasing Medicare costs in general. All we know for sure is that, as far as we can tell, it is not decreasing our costs. My comment about increasing costs was a concern about extending Medicare Select discounting to part B services without some assurance that there were real networks out there——

Mrs. JOHNSON. The bill doesn't do that.

Mr. VLADECK. I understand that, and I didn't claim that the bill did.

Mrs. JOHNSON. So you are not claiming that the bill as written and before us will increase Medicare's costs?

Mr. VLADECK. No, we are not, Mrs. Johnson.

Mrs. JOHNSON. Now comment on California.

Mr. VLADECK. In regard to Mr. Schaeffer's plan, as I understand it, the Medicare Select plan that is offered by Blue Cross of California builds on an existing provider network that is exactly what we are trying to get in terms of real managed care and effective managed care choices.

Mrs. JOHNSON. Absolutely, Mr. Vladeck. I would remind you that Federal regulations require that Medicare Select provide a network that is sufficient to provide access to all the services for the provider, so what is going on in California in that regard is not unique, it is federally mandated.

Mr. VLADECK. I don't think that is entirely true, Mrs. Johnson. If you look at the RTI study, you will find that they found that the majority of Medicare Select plans during their preliminary evaluation did not have extensive networks outside of hospitals and that most of the hospital networks, as Mr. Pomeroy suggested from the experience in North Dakota, were comprised of essentially all of the hospitals in the State without the kind of real management of both utilization and care that Mr. Schaeffer's plan provides.

So our question is how to get more of the kind of benefits that are provided in the Select plans that meet the initial expectations people had for Select.

Mrs. JOHNSON. My time has expired, but you will note that Mr. Pomeroy also mentioned that Medicare Select plans are not allowed to include physicians, so, of course, they primarily include hospitals. It is the network itself that includes physicians that you draw them into.

My time has expired. I will remain and perhaps have another chance for questioning later on.

Chairman THOMAS. Mr. Ensign will inquire.

Mr. ENSIGN. Thank you, Mr. Chairman.

Can you tell me, with the HI Trust Fund on its way to bankruptcy just after the turn of the century why the administration has chosen not to include this fact in its current budget and how the administration can tell us that they are concerned about the most vulnerable when they have blatantly ignored solutions to this problem?

Mr. VLADECK. I think there are appropriate places for discussions of appropriate issues. The trustees of the Hospital Insurance Trust Fund and the SMI fund owe a report to the Congress on April 1 of this year, which I expect will be before you are done with your budgetary deliberations for the next fiscal year.

We will obviously address both the short- and long-term solvency issues associated with the fund at that time, and we will be happy, once that report is out to discuss the recommendations in more detail. To do so in advance of the trustees' report would be premature.

Mr. ENSIGN. You mention in your conclusion about 70 percent of the insurance costs are paid for with premium payments. Is that 70 percent of the total medical costs or just the insurance?

Mr. VLADECK. Seventy percent of the Medicare benefits.

Mr. ENSIGN. Are total Medicare benefits paid for through, and that is the average person that is receiving them now through their lifetime of payroll taxes, what they have paid in, what they are paying on their copays?

Mr. VLADECK. The estimate is not derived that way, sir, because of the problem of how you impute earnings on a trust fund. About 60 percent of Medicare benefits are paid from the Hospital Insurance Trust Fund and 25 percent of part B benefits are paid by premiums; between the two, you get 70 percent that is financed either through payroll tax or through beneficiary premiums. Now, those payments only account for about half the medical expenses of Medicare beneficiaries.

Chairman THOMAS. Would the gentleman yield on that point? Because I think it is important.

Mr. ENSIGN. Yes.

Chairman THOMAS. If I say this another way, is this what you are saying, that you used the term 70 percent, and that is the insurance cost to the beneficiary, that they pay about 70 percent?

Mr. VLADECK. They have contributed over their working lives.

Chairman THOMAS. Of the insurance?

Mr. VLADECK. Or they are now paying 70 percent of their insurance costs.

Chairman THOMAS. But the health care costs to Medicare are not the 70-percent figure?

Mr. VLADECK. The health care costs to Medicare are the 70 percent, but the benefits, the total health care costs of the beneficiaries, are substantially more because of the limitations on Medicare's benefits.

Chairman THOMAS. We will pursue that.

Mr. ENSIGN. Actually, even to pursue that further, is this the people that are currently receiving it because obviously the Medicare premiums on payroll taxes and everything have gone up, is that taken into account, the amount that they paid over time, or are you extrapolating somebody that is earning a living now by the time they get to 65 years of age?

Mr. VLADECK. We are talking about a pooled trust fund, and we are saying that probably in the future, with all things being equal, they would be somewhat lower because the proportion of total expenses for Medicare part A is shrinking relative to part B.

Mr. ENSIGN. But you are not looking at the average person that has been contributing for the last 40 years. That is what I am trying to get at.

Mr. VLADECK. For the average person who is currently a beneficiary, 70 percent of the costs of their Medicare benefits are financed from the pooled contributions of people who contributed to the program since it began plus their beneficiary premiums.

Mr. ENSIGN. OK. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

The gentleman from Washington will inquire.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I admire your politeness, Dr. Vladeck. New Yorkers are known for that.

Mr. VLADECK. It is great to set the record straight, Mr. McDermott.

Mr. MCDERMOTT. I think you might have pointed out to Mr. Ensign that the Republican proposal that has been put on the table actually makes the trust fund worse by raising the taxation exclusion from 50 percent to 85 percent, isn't that correct?

Mr. VLADECK. That would shorten the life of the trust fund, yes.

Mr. MCDERMOTT. So it is a little disingenuous to raise questions about the administration when the proposal they are putting on the table is making it worse?

Mr. VLADECK. As proposed, it would shorten the life of the trust fund, yes.

Mr. MCDERMOTT. There has been a lot of talk about the Medicheck proposal which the Speaker thinks we ought to put out for seniors. This Medicheck would send the seniors out with a voucher to buy health insurance, it would get rid of this big bureaucracy of 4,000 people that run Medicare. We know that per capita right now Medicare is spending $4,400 and change for a beneficiary.

Do you think my 85-year-old mother could take that voucher out and buy roughly the same kind of care in the insurance market in this country that she has today under Medicare?

Mr. VLADECK. Certainly not in the insurance market that exists at the moment.

Mr. MCDERMOTT. Well, what would happen to her?

Mr. VLADECK. Well, again, it depends on how one did it. We have looked at so-called voucher proposals, and we believe that in order to avoid a serious, serious risk to the beneficiaries, you would need to do two things for which we just spent the last couple of years being seriously criticized.

One, you have to set some very stringent rules for how the insurance market would operate to make sure that the people with vouchers weren't redlined, that they weren't discriminated against in various ways, that marketers didn't sell selectively, and that there were various consumer protections.

And the other thing you would need to do is have a very sophisticated risk adjustment system, since $4,400 is an average cost per beneficiary and the dispersion of rates across the program is very, very substantial. For example, 5 percent of beneficiaries will incur expenses of $50,000 a year or more, and that is not just random.

We can predict with some accuracy, but not yet enough, that beneficiaries who are older, who have been in nursing homes, or who have a history of cancer, are more likely to incur very high expenses than the average beneficiary.

Mr. McDERMOTT. Would you speculate on what would happen to my father. My father has had a stroke, he has chronic heart disease, he has had cancer, skin cancers, a number of them. What would happen to him with that voucher and what would happen to the rest of us in the family?

Mr. VLADECK. Well, again, unless the voucher were actuarially priced to reflect his particular circumstances, which is a little hard to envision, what would happen to him is probably what would happen to people like my mother, who is still working in her sixties and trying to buy disability insurance on the private market.

An individual insurer has to be pretty dumb to sell an individual policy to somebody that risky. As an insurer for the highest risk part of the population, it is almost impossible to recoup one's—to cover one's risk, except by pricing at such levels that you would get publicly embarrassed when they ran in the newspaper.

Mr. McDERMOTT. So you are saying, really, that unless the Congress is willing to regulate the insurance industry very strictly and very stringently, this simply would be a shift of the cost on to the families and the beneficiaries, it would really be out-of-pocket costs from now on?

Mr. VLADECK. That would be our major fear about it.

Mr. McDERMOTT. I want to enter a letter in the record, and I ask unanimous consent. It was a letter sent to me by somebody who lives in Lancaster, Calif.

He says when his COBRA benefits expired, for which he paid $3,300 a year, he tried to convert them at Prudential to a policy with a $1,000 deductible. It would cost him $12,366 a year with a $1,000 deductible. With a $100 deductible, he would have had to pay $20,000.

When I think of this as being a 59-year-old person trying to buy an individual policy out there with a voucher, something that they were buying in a group at $3,300, suddenly they are buying it individually, it seems to me the same thing is liable to happen to senior citizens when they are sent out as individuals to buy insurance in this present market.

Is that a fair assumption?

Mr. VLADECK. Medicare exists in the first place because before its existence, with the exception of group policies—mostly employer group policies—there essentially was no private market for health insurance for people 65 and over.

Now the world has changed and the demography has changed. One would expect the market to respond to the kind of arrangement you were describing by putting together a number of very attractive policies for younger, healthier beneficiaries. However, the problem of getting coverage for the older, sicker, and more expensive beneficiaries would be exactly the problem we are now having in the private sector where, unless they are employees or retirees of a large company, they can't get coverage.

Mr. McDERMOTT. I actually had my staff postulate that my mother was born in Ireland and was coming over to live in the United States and since she didn't have Medicare, we would try and buy private insurance. When I called the insurance companies, I got some amazing answers.

Blue Cross said, "Well, of course, we medically underwrite, and we wouldn't accept her if she had anything wrong with her," and Aetna actually told me that they would send me to Blue Cross. I mean, they weren't even willing to quote me a price. So I think that this is a very risky thing that is being proposed.

Thank you.

[No letter was received at the time of printing.]

Chairman THOMAS. The gentleman's time has expired and the subcommittee will recess until we go vote and then come back.

[Recess.]

Chairman THOMAS. Mr. Christensen will inquire.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Vladeck, it was my understanding that HCFA was charged with providing the Congress a report on Medicare Select and the demonstration on Medicare Select, and it is my understanding that the report was due last month; is that correct?

Mr. VLADECK. I honestly don't know, sir.

Mr. CHRISTENSEN. You don't know?

Mr. VLADECK. I don't know what the due date on the congressional report was.

Mr. CHRISTENSEN. I think it was due last month. I was wondering, do you know where that report is?

Mr. VLADECK. Again, we have provided a preliminary report. We have been advised by our evaluators that part of the delay is due to the fact that many States got the plans up and running a little bit more slowly than had originally been anticipated. As a result, it will be the latter part of this year before their evaluation is complete.

Mr. CHRISTENSEN. I am new to this process, and it is my understanding that you are in charge at HCFA, and the report was due last month, and you don't know where the report is, you don't know what it will say. Do you know what it says at this time?

Mr. VLADECK. No, sir. If we knew what the final evaluation said we could make more detailed recommendations. The preliminary report, which few have seen, describes largely the structure of the plans and their history.

The real questions for an evaluation have to do with comparisons of the populations enrolled in Select plans and populations that are not. That data analysis is currently underway, and we have been in conversation with the evaluators, but we can't yet give a precise date as to when their work will be finished.

Mr. CHRISTENSEN. Can you give a general date when you think we can expect to see the final version, since it was due last month?

Mr. VLADECK. The latter part of this year.

Mr. CHRISTENSEN. The latter part of this year?

Mr. VLADECK. Yes, sir.

Mr. CHRISTENSEN. I am sure this is not an example of the efficiency of the Medicare system being 10 months late, 9 months late, 8 months late.

Mr. VLADECK. Again, the major constraint on the evolution of this evaluation has been the way in which the plans have evolved in the various States and the regulatory apparatuses in the various States have evolved.

Mr. CHRISTENSEN. Two days ago, Congressman Steve Horn talked about the President's budget, and I would have to say I have not heard it put any better than when he said that this year's budget wasn't DOA, it was totally devoid of accountability, not dead on arrival like the last few budgets have been, and it was devoid of accountability because there was nothing in there regarding Medicare reform. The President totally passed the buck.

The editorials in my paper out in Omaha, Nebr., have heavily criticized the administration for not doing their fair share in this area. We are going to look at another trillion dollars in debt.

I wanted to know when the President called you and the administration asked for your input as far as your ideas, what did you say? Did you say let's let the Congress do it, let's let the Health Subcommittee make the tough cuts? What went on?

Mr. VLADECK. I think it is fair to say, sir, that we haven't had any particularly new conversations relative to the current year's budget proposal since we have been saying and believing the same thing consistently for the last year and a half. Any significant changes in the financing of the Medicare program ought to be addressed in the context of broader health reform strategies.

Last year we tried to make a very detailed proposal to the Congress that included changes in the Medicare program. We were less than fully successful. Given the new leadership and composition of the Congress, the President has already written a dialog about health care reform. Within that context we have always been very clear that changes in the Medicare program were an entirely appropriate part of those discussions.

Mr. CHRISTENSEN. It sure didn't show up in the budget. You did say "under the leadership of President Clinton" earlier in your remarks, and I would say that that is no leadership.

I wanted to ask you a specific question on the problems or incidents of the beneficiary dissatisfaction. Can you cite any examples that led you to the conclusion that we need more regulation on Medicare Select?

Mr. VLADECK. I can't provide you with specific anecdotes. Again, the general question of customer satisfaction will be addressed using survey information in the final evaluation for which we are waiting.

I should tell you, however, that because medicine is a free-choice circumstance, Medicare beneficiaries in almost every setting will report very high degrees of satisfaction. That is to say, our beneficiaries in HMOs are very highly satisfied with their plans, our

beneficiaries in the fee-for-service system are very highly satisfied with their plans, and the anecdotal information suggests that Select enrollees are very satisfied with their plans. When you have circumstances in which people have a voluntary choice of enrollment, and in the HMO setting voluntary disenrollment, that is not a surprising result.

Mr. CHRISTENSEN. Well, with all due respect, Mr. Vladeck, you are the head of HCFA, you didn't know a report was due last month, you don't know when it is going to be on our table, you don't know what the conclusions are going to be in that report, and you can't give me specific evidence of various problems that have led you to conclude that we need additional regulation on Medicare Select. We need to get some answers. When you find those answers out, I would appreciate visiting with you and finding out what they are.

Mr. VLADECK. Again, as soon as the evaluation is complete, we will certainly share it with you, and in terms of the other questions you had, we will be happy to supply you with a more detailed answer.

[No information was received at the time of printing.]

Mr. CHRISTENSEN. Thank you very much.

Chairman THOMAS. Two followups to the questions asked by our two new members of the committee.

Mr. Vladeck, I am looking at the Omnibus Reconciliation Act of 1990 conference report to accompany H.R. 5835. On page 146 of that report, it is outside the courts but it is part of the law, which says the effective dates, amendments made by this section shall only apply in 15 States, et cetera.

D. Evaluation. The Secretary of Health and Human Services shall conduct an evaluation of the amendments made by this section and shall report to Congress on such evaluation by not later than January 1, 1995.

That is the law, and to ask you to further respond to the gentleman from Nebraska's statement, it is in here, the date was January 1, and the reason you are not complying with the law is what?

Mr. VLADECK. Mr. Chairman, I can't really comment at this time on a contract entered into in the previous administration, but I will be happy to provide the subcommittee with the detailed history involving the timing of the contract that we are now discussing.

Chairman THOMAS. OK. I just want to make sure that the statement that was made was a factual one.

I have a sheet that I want you to respond to as well in terms of the question from Mr. Ensign. Let the staff pass that out.

[The following was subsequently received:]

TABLE 5. LIFETIME MEDICARE BENEFITS, TAXES, PREMIUMS, AND TRANSFERS
(in thousands of constant 1993 dollars)

	PERSONS TURNING 65 IN 1995			
	Single Male	Single Female	One-earner couple	Two-earner couple
BENEFITS	75.0	110.7	185.7	185.7
TAXES & PREMIUMS	34.7	45.6	59.0	68.5
NET TRANSFER	40.3	65.1	126.7	117.2

NOTE: All amounts are discounted to present value at age 65 using a 2 % real interest rate. Adjusts for chance of death in all years after age 21. "Taxes and premiums" include the actuarial value of all employer and employee HI payroll taxes, all SMI premiums, and estimated portion of federal income tax burden devoted to financing SMI. Projections are based on HCFA 1993 intermediate assumptions, adjusted for the estimated impact of 1993 enactments. SMI premiums are assumed to remain tied to 25% of program costs after 1995. Recipients are assumed to receive Medicare insurance protection, in each year after age 65, which equals in value the average Medicare outlay per enrollee in that year. Individuals are assumed to earn average wages for their cohort.

Source: Based on Steuerle, E.C. and J.M. Bakija. *Retooling Social Security for the 21st Century: Right and Wrong Approaches to Reform.* Urban Institute Press, 1994.

Chairman THOMAS. I guess it is partly because I am somewhat confused by that portion of your testimony which indicated that. Under the conclusion which indicated that through their payroll contributions and those of their employers during their working lives and through their own premium payments, beneficiaries in fact contribute 70 percent of their insurance costs.

Now, the chart I have in front of me, and you obviously can react to and disagree if you so choose, represents 1993 dollars and obviously they would change slightly in 1994, they would change slightly in 1995, and in 1996; I think you will find they will begin to shift dramatically in terms of increasing the bottom line. But what we have here is a profile on persons turning 65 in 1995, single female, single male, one-earner couple, two-earner couple, benefits in terms of what they are going to receive under the program, taxes and premiums, the amount they paid into the program, and the net transfer which is the burden other than the beneficiary, that is, the taxpayers are going to pay for these individuals.

And I guess my problem was that when you said that individuals contribute 70 percent of the insurance costs, and I said, Is that the health care benefit paid by Medicare, I thought your response was at least not in a way that I could understand it.

Do you dispute the net transfer line on this chart that a single male will receive in essence a $40,000 benefit from the $75,000 benefits allowed in the program. The 34.7 that they would pay into the taxes and premium structure, and of course, as individuals, went up in terms of the amount that they put in, clearly the net transfer is even greater.

Mr. VLADECK. Until I know a lot more about the assumptions underlying this table, I couldn't comment one way or another, Mr. Chairman.

Chairman THOMAS. Well, nowhere do we see anything approaching a 50-percent payback.

I guess we are going to need more information on that statement because it is puzzling to me, too, because it runs contrary to what I have understood to be the problem. I guess if, in fact, these are the kinds of percentages people are paying into the program and the HI fund, which is clearly the most expensive part of the Medicare program, is actuarially determined to go belly up or bankrupt by 2001. Let me ask you the question in another way, currently is the payroll tax 1.45 percent?

Mr. VLADECK. That is correct.

Chairman THOMAS. And we removed the cap on all income to be taxed for that fund. What would be required either in terms of tax increase or benefit modification to make the HI fund sound beyond 2001?

Mr. VLADECK. I don't know offhand. Again, we are pointing toward April 1 for those analyses. If we have them available earlier, I would be happy to get them to you, but they will be part of the trustees' report.

Chairman THOMAS. It is my understanding that the tax rate would have to be at least tripled and benefits cut two-thirds to be able to attain a comfort level about the HI fund.

When you take a look at the employment profile of an open-ended tax tripling or the reaction of beneficiaries of two-thirds of

their benefits being cut, it is a little shocking to me to find out that in the final year of President Clinton's ability to completely control a Federal budget, that virtually no response is made at all, either in terms of offering changes in programs or creative solutions to a problem that is squarely in the middle of the road less than 10 years away.

The gentleman from Wisconsin, if he wishes to inquire.

Mr. KLECZKA. Mr. Chairman, one brief question.

In your testimony, Bruce, you indicate that on average we pay about 6 percent more for every Medicare enrollee in managed care.

Mr. VLADECK. That is correct.

Mr. KLECZKA. The purpose of managed care, I thought, was to save dollars versus cost more than fee-for-service. Is there some problem with the reimbursement formula that this is occurring?

Mr. VLADECK. There are really two problems, and the major problem is the fact that our payments don't adequately adjust for the kind of selection effect we have in the Medicare risk program.

Mr. KLECZKA. The problem is healthier people are selecting managed care?

Mr. VLADECK. Yes. Significantly more healthy people go in than the average. There are some very good reasons for this. There is nothing terribly sinister about it. A large part of the Medicare risk enrollment is comprised of the folks who were enrolled in HMOs before they retired and want to keep their existing source of care.

Another thing that is a very important component of this issue is that people with more serious chronic diseases tend to be more likely to have established relationships with physicians who are not part—or historically have not been part—of HMO networks and are thus more reluctant to leave their existing patterns of care.

In addition, although it is much less of an actuarial effect, currently Medicare HMO enrollees can disenroll at will. This probably leads to some selection against us on the disenrollment side as well as the enrollment side.

Mr. KLECZKA. So what are we going to do about it?

Mr. VLADECK. We have a number of activities underway to try to address both of those issues. In the long term we need a more sophisticated payment method, and we are conducting a number of experiments now with alternatives. As I discussed in my testimony, we would like to test a competitive bidding model as well.

At the same time, to the extent that we can improve our quality monitoring and quality assurance technologies for Medicare risk plans, we probably should over time do away with the continual disenrollment policy; it doesn't work in our interest or in that of the plans, and it would minimize some of the selection effect as well.

Mr. KLECZKA. OK. Reading from Congressman Stark's opening statement, he indicates here that, regarding HMO Medicare coverage, we passed legislation in 1989 directing the Secretary to improve the payment system, but little progress appears to have been made.

Mr. VLADECK. Again, I can only comment on what has occurred in the last 24 months. There was very little progress before then. Since then, we have redirected a major part of our research and

demonstrations budget in the direction of HMO payment methodologies.

We have also worked very extensively both with the trade associations in the industry and with individual plans to try to design demonstrations of new payment methods in managed care.

Mr. KLECZKA. Do you stipulate that the Medicare Select program does save enrollee costs, people in the program do save money?

Mr. VLADECK. It appears to. However, and I believe one of the subsequent witnesses will speak to this, it is not entirely clear the extent to which those cost savings arise from lower utilization and the extent to which they arise from the way the prices are age banded in certain States.

Mr. KLECZKA. But you don't agree with Mr. Schaeffer who will testify I think in the next panel, that Medicare Select does save the government money?

Mr. VLADECK. It is not clear to us. It clearly doesn't save us any money on the part A side. I wouldn't doubt that we save money on the part B side in his plan, but again I think that is atypical among the Medicare Select plans.

Mr. KLECZKA. Fine. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Bruce, in your testimony where in talking about the apparent anomaly, you stated, "In fact, if proposals to expand Select discounting to part B services are enacted, Medicare costs would actually increase, as physicians increase utilization to recoup their discounts."

Wasn't that an argument that was made in terms of the modeling profile when we put in the resource-based relative value scale plan? We had to watch out for surgeons and physicians because if we were going to cut them down on one side, they were simply going to increase visits and do more procedures so that they would make money. Didn't we discover that, in fact, all of our concerns harboring the cleverness of this particular group of physicians?

Mr. VLADECK. Well, that is correct, but we also put a backstop in the physician fee schedule in terms of the RBRVS so that the physician community was well aware that increased revenues from increased utilization would affect subsequent years' rates.

Chairman THOMAS. Then why wouldn't that simple fix solve the enormous threat that this appears to be in your testimony?

Mr. VLADECK. We would be happy to talk about a fix of that kind.

Chairman THOMAS. No, no, but you don't talk about it in your testimony. You create a bogeyman here where we anticipated and didn't see it as you said it anticipated with the backstop. This is the kind of a statement that permeates your testimony that causes me a lot of concern because I don't see any factual evidence.

I see theoretical concepts on models that have already been discounted. I just don't understand why this argument is presented as a realistic one for not going forward. Could you tell me why? Is this a real threat or did it just get thrown into the testimony?

Mr. VLADECK. This is a real issue, sir, that has been studied not only by our actuaries in OMB but also by the Inspector General when the Inspector General declined to provide a safe harbor for part B discounting.

I think your suggestion that we might use some of the techniques that we have used with the physician fee schedule to address those sorts of risks in Select plans is a very good one and we would be happy to think about ways to do that.

Chairman THOMAS. The discussion we had was about being overly aggressive earlier and that we have to be very careful. And in fact, recent evidence indicates that we are not saving money at all, and that we are getting a bit of an adverse risk selection by virtue of the program that we have now.

I think it really comes down to two basic philosophies, and I think we are beginning to understand where you are coming from, and that is one of the things that I have learned in trying to understand the mistakes the private sector made was that early on, they were too timid, they tried to just make minor adjustments, and it wasn't working. It wasn't until they got a complete understanding that you had to make a commitment to change the structure that you began to get the benefits in the private sector, and as we have seen recently in terms of modeling Medicare and the private sector, that in fact Medicare is actually an anchor, a drag on the changes that are occurring in terms of total costs. When I look at those charts, and Mr. Stark and others are anxious to run back to that period in the early nineties and talk about the fact that Medicare was leading the curve at that time.

I have tried to look at the numbers behind it, and my conclusion is that the reason Medicare was leading it was that there were a series of cumulative cuts made in the eighties and they were beginning to compound and that those reductions were leading the private sector but we have kind of ridden that wave. It is over.

Once again, returning to the President's budget, there is no significant understanding apparently that the private sector is going to continue to outstrip Medicare in terms of its changes unless we make some fundamental changes. What I hear in terms of your testimony is we are worried about some decisions that were made 10 years ago without any reflection for the world and how it has changed now or that we understand that what we have to do is more aggressively move into managed care, not more timidly. What I hear in your testimony is we need demonstration projects, we need to go slowly.

We are thinking about a PPO model, so that we drive choice in terms of the consumer. They get only one model; we don't take advantage of the knowledge that we have learned in the private sector to allow as many possible models and put the choice factor on the individual with clear understanding of thresholds and controls, given the type of people that we look at.

I am saying that in sum and substance of this testimony, I am looking at that black hole in 2001, and this administration with its clear actions in the budget, either in terms of reductions, which is the only way we have stayed close to the private sector curve, no reductions at all, no plan offered, but a very timid position in going forward.

And finally, before I let you respond, the gentleman from Washington continues to focus on one small aspect of the Republican plan for change, which was in the Contract. I, at one time, was quite proud of the fact that we were able to hold most of our health

care ideas outside of that contract, not lock ourselves in rigidly to preconceived notions. We are going to offer a significant number of changes in this Congress. We believe one of those is the Medicare Select bill offered by Mrs. Johnson.

We are going to offer reforms in the insurance area, we are going to offer reforms in the malpractice area, we are going to take care of those problems that the Clinton administration in the last year refused to separate out from its goal to completely restructure the health care system in this country. Those changes should have been moved in the last Congress. We are going to do everything we can to move them in this Congress, but without a partnership as described by Secretary Rubin and Secretary Shalala between the two of us, we are not going to lay the groundwork to save this system.

I am just concerned about the timidity, about the failure of you folks to be even anywhere near as bold as you were in the last Congress about the need for change.

Mr. VLADECK. Mr. Chairman, if I could just make two observations in that regard. The first is that I think it is appropriate, when talking about what has happened in the last 18 months or so in the private sector, to also note that the way in which this administration has approached this issue since the President came into office is to recognize that there are two things going on in the private sector.

First, in the last 18 months, costs have been growing much more slowly; second, Americans are continuing to lose health insurance at the rate of 100,000 people a month. One of the reasons that private health expenditures are going up more slowly is because fewer people are being covered in the private sector. If you are going to talk about bold systemic change in this regard, you ought to put all of the important issues on the table, including the deterioration of private sector health insurance coverage, which continues to be a major concern and something we believe the Congress needs to work with us to address.

In that regard, when one talks about a boldness or timidity, I think the place where one should be most risk averse is with the one part of the population that has, in effect, universal health care that they are very well satisfied with. If we are going to take big risks with major changes in the health care system, I would suggest we are happy to work with you on more innovative and exciting ways to cover the 15 percent of the American population that has no health insurance whatsoever.

Chairman THOMAS. Mr. Vladeck, I did hear you just say that the reason that the private sector cost curve is going down is primarily because fewer people are covered?

Mr. VLADECK. I did not say "primarily." I said it is one of the reasons.

Chairman THOMAS. Where would you place that in relation to the bold and dramatic decisions made by the private sector in moving toward and embracing managed care?

Mr. VLADECK. I think it has been much easier for the private sector to embrace the kind of managed care approaches they have as they have reduced the aggregate riskiness of the populations that are covered.

Chairman THOMAS. What percentage of the reduction would be credited with your position versus mine?

Mr. VLADECK. Since these numbers are floating around in a number of ways, I couldn't give you an off-the-top-of-the-head number.

Chairman THOMAS. How about ballpark? Sixty percent of the cost reduction in the private sector is because of their refusal to insure people?

Mr. VLADECK. No, I wouldn't say that.

Chairman THOMAS. Thirty percent?

Mr. VLADECK. In 1993, we are not talking about cost reduction, we are talking about reduction in the rate of growth. I would say if you compare total private expenditure rate of growth in 1992 and 1993—we don't yet have the 1994 numbers with per capita experiences in the insured community—what you find is about two-thirds of it is a reduction. But I wouldn't swear to these numbers. We will get you more precise numbers, but roughly two-thirds is a reduction in the per capita expenses of those who are covered and the rest of the acceleration has to do with the deterioration of coverage.

Chairman THOMAS. This is 1995 and next year 1996, and again I am looking at the timetable in terms of having to make big decisions because the big risks are out there. In my opinion, adopting those changes in the private sector for a government basically fee-for-service sixties program are not big risks. The big risks are not moving forward as rapidly as we can.

Mr. Vladeck, we have a kind of unusual next panel which is two former HCFA administrators, and it would be enormously helpful——

Mr. MCDERMOTT. Who are now insurance company executives, Mr. Chairman, so Mr. Vladeck has good things to look forward to.

Chairman THOMAS. I thought he was going to be devoted to this job for at least the foreseeable future.

Mr. MCDERMOTT. At least the next 6 years, I believe.

Chairman THOMAS. Mr. Vladeck, if you want a recommendation after 1996, November, come and talk to me. Now are we through with this? OK.

The request that I was going to make was that if at all possible, would your schedule permit you to hang around so that we can have a question and answer with the current and previous HCFA administrators, because that would be a very enlightening experience for us, if possible.

Mr. VLADECK. I am afraid I only have another 20 minutes or half an hour, and I don't know how you would want to structure that. I have some folks coming from out of town to see me at 1 o'clock.

Chairman THOMAS. If you aren't going to be able to do it, then I would yield to the gentlewoman from Connecticut for a question or two.

Mrs. JOHNSON. Mr. Vladeck, after the sentence that my Chairman read about Medicare costs would actually increase with Medicare Select, shortly thereafter in your testimony you say: "We feel strongly that beneficiaries should not have to worry about the quality and access provisions of their Medicare choices." And you say this is an important issue and we will work with you and the subcommittee.

Now, on quality and access, there are Federal rules that your department has issued that say that the provider networks have to be sufficient, that emergency services have to be paid for, that quality assurance programs have to be out there, that seniors have to be clearly informed about the choice that they are making.

There are other Federal requirements that regulate the marketing of supplemental insurance policies in general, that deal with waiting periods and preexisting conditions, establish minimum loss ratios and create premium refund provisions in the event that the minimum loss ratios are not met, and so on and so forth. There is quite extensive Federal regulation already governing these plans.

There are also State regulations, and the State regulations address things like rate setting, loss ratio compliance, financial solvency, the extent of provider networks, and the measures of quality assurance, to name only a few.

What evidence would you present to this committee that those two levels of regulation have failed to assure quality and access issues under Medicare Select?

Mr. VLADECK. Well, again, Mrs. Johnson, to have more than hypothetical evidence we really need some systematic research results that we will certainly have for the subcommittee within 1 year of the statutory due date.

Mrs. JOHNSON. Mr. Vladeck, we passed this several months ago. There are only 15 demonstration projects. There are not a lot of plans doing this. And I would think that if you are recommending in your testimony only a 6-month extension, you ought to have some evidence.

Why not just make it permanent, put it out there? It is one of the quick things we can do to begin opening up the system, and let's gather the information.

But you heard the testimony of Mr. Pomeroy during the time he was intimately involved with this program. He never had a single complaint. In the material about Alabama, they don't say that they had any consumer complaints.

So I really ask your department to give us some concrete evidence on the very issues that you raise in your testimony and as we go forward to either support this bill or oppose it.

Mr. VLADECK. Let me only say that we do have a couple of concerns in that regard. We have had some preliminary conversations, and we will be happy to work with you to further identify what they are.

Mrs. JOHNSON. It has been several months and I would hope that preliminary conversations would move forward rapidly, and I would be happy to be a party to any of those.

Thank you.

Chairman THOMAS. Mr. McDermott, did you want to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

You mentioned that part of the cost reduction is due to less people being covered. Isn't it also a big factor that we had a big debate for 2 years in which everybody was a little worried about what was going to happen, and third, the big companies are now much more aggressively willing to shift costs on to the smaller companies? Aren't those also big factors in the reduction in costs?

Mr. VLADECK. I suspect they are. Part of the problem is that this alleged revolution in health care is being established on the basis of only about 18 months of experience. It is true that in previous periods in which Congress was seriously debating major health care legislation, there was a significant deceleration in the growth of private sector health care costs.

So we don't know if what happened in 1993 and 1994 is a permanent change or a blip, and we have asked our actuaries and others who estimate national health expenditures for their opinion; they say, "Well, on the one hand, on the other hand." It is really too soon to say whether the world has been permanently transformed or whether these are transient changes.

Mr. MCDERMOTT. Let me ask you about one specific program in HCFA so—or in Medicare. Do I remember correctly that the end-stage renal disease program is the largest single-cost center in the whole program?

Mr. VLADECK. Yes, on a per capita basis. Since there are only about 80,000 enrollees with end-stage renal disease, the basic Medicare program is obviously more expensive; however, our end-stage renal disease patients are far and away the most expensive on a per capita basis.

Mr. MCDERMOTT. Now, can you imagine those people going out and buying insurance with a voucher from an insurance company?

Mr. VLADECK. Mr. McDermott, once again, the reason a Federal program for end-stage renal disease was created is that when the technology to save the lives of people with end-stage renal disease emerged, people were unable to afford it and they were unable to find insurance coverage to pay for it.

Mr. MCDERMOTT. I remember the start of that program. It started in Washington State, and they had a little plan there, and somebody went to Warren Magnuson and thought it was a good idea, who then mumbled it through the U.S. Congress and it got to be the biggest problem in health care, in Medicare.

What it sounds like to me you are saying is that if we privatize Medicare, as we are sort of going here with the Select program, the opening wedge to privatize, that what is going to happen is we are going to wind up with a lot of very sick people that nobody wants, and we are still going to have a Federal program to cover them, while the insurance companies will have skimmed off all the healthy seniors. As soon as they are sick, they will be plopped back into the government program.

Is that a fair way to look at it?

Mr. VLADECK. That is a very real concern, yes, sir.

Mr. MCDERMOTT. To me that seems like the only way this is going to work because all the evidence I know suggests that all the managed care plans for senior citizens are basically skimming. They are figuring out ways to attract people who are healthy, and it isn't saving money for our program.

In fact, as Mr. Kleczka has pointed out, it is costing a little bit more, and that to extend that out to everybody is simply going to let the insurance companies kind of look through the elderly and try to find those who aren't going to cost them anything and take them and leave the rest for us, and that really is going to make our problem at the Federal level worse because we will look like

we are never controlling costs if all we are dealing with are the sickest people.

Mr. VLADECK. Again, I think if you look carefully at the experience for the nonelderly population in this country over the last 5 or 10 years, you find that on a very small scale some of that has occurred in the sense of the enormous growth in Medicaid, and in Medicare enrollment of disabled folks, and again in the significant shrinkage, much of it at the high end of the risk scale, in terms of the extent of private coverage.

Again, one would think that in a rational market, unless it was highly regulated, people who were predictably the highest risk would have the greatest trouble—or would at least face the greatest out-of-pocket cost—getting good insurance, if they could get it at all. And again, in the Medicare population, the people of highest risks are systematically those with the lowest incomes.

Mr. MCDERMOTT. It seemed in my experience in the State legislature we created a high-risk pool because those people were out there floating around, and finally we just said, OK, at the State level we are going to deal with those people who don't fit Medicare, don't fit Medicaid, but they are still out there bringing in all kinds of costs, so we put them into our own high-risk pool.

And it seems to me that is where we are headed. The government is going to be stuck with the sickest people.

Thank you for your testimony.

Thank you, Mr. Chairman.

Mr. VLADECK. Thank you.

Chairman THOMAS. Mr. Vladeck, for you to indicate that the trends that are going on in the private sector are probably a blip and that we aren't collecting enough data to begin to have any comfort level for any change, runs directly counter to Dr. Altman's testimony not once but several times before this committee, in his analysis of trends that are out there.

Now, obviously I happen to agree with Stuart that these are permanent changes. I just find it ironic that when you want to and the gentleman from California wants to talk about a comparison for Medicare, you are forced to do a reach back of the last decade to talk about how great Medicare was, when it was clearly a cost shifter in the system. When you talk about savings in Medicare it was that the private sector was absorbing the costs of the program and now that the private sector has figured out they aren't going to be the patsies anymore, you are now telling me that you don't want to be aggressive in changing the system that is the anchor dragging down the rest of the system. It just seems to me that in your career—and I am rethinking this letter of recommendation that I talked about——

Mr. MCDERMOTT. I will write one for him.

Chairman THOMAS. Yes, it will be the opening wedge. I just don't want you to be the John Hammond of the Medicare world. He is the fellow in "Jurassic Park" who thought that he ought to bring back dinosaurs after their time has passed.

I would urge you not to take this dinosaur of a program and go slow and be timid and pretend there are blips out there.

I see an enormous chasm in 2001. Your President apparently does not. There are no substantive changes in the budget and dol-

lar amounts to help meet the cost. There are no creative programs in the budget to meet the cost. I thought your testimony today would at least provide some slight hope that you folks would understand that the dinosaur in the health care system today is Medicare and it needs changes.

You ought not to nurture it. You ought to go see the movie if you haven't read the book. There are enormous dangers in not moving, and there are enormous dangers in kidding yourself that what is going on out there in the private sector is a blip.

Mr. VLADECK. Mr. Chairman, if I remember the movie and the book correctly, part of the issue is the danger of experimenting in areas where you really don't know what you are doing. I am afraid that our evidence, based on the experience of the Medicare population, about the performance of managed care for the Medicare population is at some variance with the evidence on the performance of Medicare for privately insured groups. In order to move Medicare in the direction of the private sector, we need to learn a great deal, which we are busily engaged in doing from the most successful practitioners in the private sector. We are finding out what they are doing that we have not been able to do, some of which we may be unable to do because our populations are so different.

Chairman THOMAS. And we thought that at least going forward with the Medicare Select program would be a modest attempt to learn more.

You obviously see it as a significant and dangerous risk, and I think there is the difference. For you to advocate a 6-month extension with no expansion of the program is to tell me where your thinking is.

So I would hope that you could have stayed. Obviously you have got some people to see at 1 o'clock and more important to make that appointment with those folks than to interact with the committee. I didn't tell you about it ahead of time, so it is partially unfair for you to think that a request would be made to interact with former HCFA administrators.

I look forward to sitting down with you. We have had some private meetings which I thought were rather fruitful. Something happens between the private meetings and the public meetings, as indicated by Mrs. Johnson. We will continue to try to work to take some of the discussions we have had in the private meetings and try to get them on the record somewhere. I understand the pressures you are under, Mr. Vladeck, and I look forward to working with you.

Mr. VLADECK. I look forward to working with you.

Chairman THOMAS. Thank you very much.

Mr. VLADECK. Thank you.

Chairman THOMAS. Next panel will be Bill Roper and Leonard Schaeffer, who are former HCFA administrators, and who apparently have taken their knowledge acquired in this taxpayer-supported position and have carried it over to the private sector. I think there has been a very fertile cross relationship that we are going to hear about at this time.

Dr. Roper, you can begin your testimony. Your written statements, both of your written statements, will be made a part of the

record, without objection, and you can proceed for 5 minutes in any way you see fit to enlighten the committee.

STATEMENT OF WILLIAM L. ROPER, M.D., M.P.H., SENIOR VICE PRESIDENT AND CHIEF MEDICAL OFFICER, PRUDENTIAL HEALTH CARE SYSTEM ON BEHALF OF PRUDENTIAL INSURANCE CO. OF AMERICA, INC.

Dr. ROPER. Thank you.

Mr. Chairman and members of the committee, it is a delight for me to be before you today. I am Bill Roper, senior vice president, chief medical officer of the Prudential, and I was HCFA administrator from 1986 to 1989. We look forward to welcoming Bruce Vladeck to the society of former HCFA administrators.

Let me commend you, Mr. Chairman and the committee, for taking on such a challenging and important issue for our Nation.

The message that I have for you today is that the health care delivery marketplace has evolved dramatically since Medicare was created, yet Medicare has not made similar progress. It is a sixties old style fee-for-service system that does not allow the elderly and disabled the opportunity to participate in current systems for delivering health care. The good news—and it is good news—is that it can be fixed by offering new alternatives to seniors without engineering a totally new system.

As you push aggressively on a cost constraining agenda for the Medicare program, I urge you to allow Medicare beneficiaries and providers an attractive alternative based on innovation in the private sector.

This isn't a new idea. I included in my testimony a piece I wrote for the Wall Street Journal in 1987 when I was at HCFA entitled "Medicare's Private Option." The message then and now was simple: Keep Medicare intact, but increase the choices available to Medicare beneficiaries by expanding the role of private-sector health plans in meeting their needs.

I oppose forcing older Americans to leave traditional Medicare in favor of private plans. What I do support is offering them choice. Don't take away traditional Medicare, just give them choice.

When that Wall Street Journal piece ran, President Reagan believed that well-managed private health plans offered an attractive alternative to traditional Medicare coverage. We were committed to giving private health plans a fair opportunity to compete for Medicare enrollees.

Under President Reagan's vision for Medicare reform, we at HCFA advocated this private health plan option based on five goals: Insuring appropriate access to quality care; increasing incentives for efficiency; reducing the government's role in deciding how much to pay; reducing government's role in deciding what constitutes appropriate medical practice; and expanding choices. These goals, I believe, are much in keeping with the goals of this committee.

I think that our plans in the mideighties were a good start, and there are signs today that the marketplace is responding.

At my company, the Prudential, we have health plans with Medicare risk contracts, with growing numbers of members in four States—California, Ohio, Florida, and Texas. We are able to offer

an array of services over and above regular Medicare coverage, such as prescription drugs and routine physicals. There are many fewer worries for members, especially less paperwork.

The experience of our plans and others like them in the private sector has been positive for both Medicare beneficiaries and the plans, but these plans haven't flourished to the degree that they could because of three problems. Many of us have long recognized the problems inherent in the payment methodology for these plans, and I would be happy to elaborate later on that.

Second, Medicare beneficiaries have no incentive to choose a managed care plan except in instances where additional benefits are provided.

And third, the definition of a managed care plan is unduly restrictive.

I believe with the work of this committee, as you have outlined it, and the positive atmosphere for change, there is a ripe opportunity now to complete the journey toward a modern Medicare system that is integrated with the private health care system. Rather than having the government mandate what care should be provided, let the beneficiaries and their doctors and other practitioners be the judge; let them choose among various plans on the basis of which plan they believe is best for them.

Surely there ought to be standard quality and performance measures with public information and accountability. All of these reforms can work on a much bigger scale if the cumbersome statutory impediments are removed, if HCFA makes the process straightforward for the players involved, and if we are not shackled in our ability to do what we do best—organize and deliver quality health care services.

Managed care works. Witness what the private sector is doing today. Don't be distracted by studies based on old data. Look at what is happening today in the private sector.

To sum up, I don't support doing away with the traditional Medicare program, but rather offering much more choice to Medicare beneficiaries.

Mr. Chairman, I urge you, as you were saying earlier, to be bold. Many will tell you that this is difficult, and it is, and they will tell you that it is complicated, and it is, but I would urge you strongly to be bold.

Thank you, sir.

[The prepared statement and attachment follow:]

TESTIMONY OF WILLIAM L. ROPER, M.D.
PRUDENTIAL INSURANCE COMPANY OF AMERICA, INC.

Thank you Mr. Chairman and members of the committee for this chance to share with you some of my thoughts on opportunities for the Medicare program.

First, I would like to commend you, Mr. Chairman, and the committee for taking on such a challenging and important issue for our nation. Assuming a leadership role and being open to new ideas on how to improve the way in which America's Medicare beneficiaries receive health care takes much courage and foresight. So I am particularly pleased and honored to be here.

The message I have for you today is that the health care delivery marketplace has evolved dramatically since Medicare was created, yet Medicare has not made similar progress. Medicare is a 1960s, old-style fee-for-service system that does not offer the elderly and disabled the opportunity to participate in the current systems for delivering health care.

Medicare gives its beneficiaries very limited choice of whether to participate in the innovative organized health care delivery systems that have developed over the last 30 years. Not only is choice missing, but the cost of the program continues to consume a huge portion of federal spending. In 1980, less than 6% of the federal budget was spent on Medicare. In 1996, if nothing is done, Medicare will approach 12% of the federal budget.

The good news is that it can be fixed by offering new alternatives to seniors, without engineering a totally new system.

As you push aggressively on a cost-constraining agenda for the Medicare program, I urge you to allow Medicare beneficiaries and providers an attractive alternative based on innovation in the private sector.

My feelings on how to update Medicare have not changed since I was the Administrator of the Health Care Financing Administration. In 1987, I published an article on the Wall Street Journal editorial page on this subject, entitled "Medicare's Private Option." Major credit for it properly goes to my colleague, Glenn Hackbarth.

The message was simple: keep Medicare intact, but increase the choices available to Medicare beneficiaries by expanding the role of private sector health plans in meeting their needs. Private plans, including managed care and indemnity plans, would compete on the basis of quality and cost.

I oppose forcing older Americans to leave traditional Medicare in favor of private health plans. What I do support is offering them choice. Do not take away the vanilla-variety Medicare system. Just give beneficiaries a choice.

Back when that Wall Street Journal piece ran, President Reagan believed that well-managed private health plans offered an attractive alternative to traditional Medicare coverage. We were committed to giving private health plans a fair opportunity to compete for Medicare enrollees.

Under President Reagan's vision for Medicare reform, we at HCFA advocated this Private Health Plan Option, or PHPO, based on five goals:

- Ensure appropriate access to quality care;
- Increase incentives for efficiency;
- Reduce government's role in deciding how much to pay for individual health care services;
- Reduce government's role in deciding what constitutes appropriate medical practice; and
- Expand the range of choices available to both Medicare beneficiaries and health care providers.

These five goals -- quality, efficiency, less government involvement in pricing and practice, and more choice -- seem to be compatible with the goals of this committee. And I highly recommend them as guiding goals in any effort to modernize Medicare.

The plan recognized that government played too intrusive a role in the health care system, and that a far better approach would be to give both Medicare beneficiaries and health care providers the option of participating in Medicare through private health plans, because this was and is where innovations in the health care delivery system occur. Those private plans, within broad constraints set by the federal government, could determine their own methods for paying physicians and hospitals, for controlling utilization, and for ensuring quality.

I think our PHPO plan was a good start, and there are signs that the marketplace is responding. At the Prudential, we have Medicare risk-contracting plans with a growing number of members, so far in four states -- California, Ohio, Florida, and Texas. We are able to offer an array of services over and above regular Medicare coverage, such as prescription drugs and routine physicals. As important, with these plans members don't need to worry about unplanned medical expenses. And the paperwork that Medicare beneficiaries find so burdensome is dramatically reduced in this environment.

The experience of our plans and others like them in the private sector has been positive for both Medicare beneficiaries and the plans. However, the plans have not flourished to the point of providing marked savings to Medicare because there are serious barriers to full private health plan integration.

We can only offer these plans through Medicare's health maintenance organizations and competitive medical plans rule. This provision does not fully foster private health plan participation because:

- Throughout the United States, the Medicare managed care payment rate is based on the Average Adjusted Per Capita Cost (AAPCC) in each area. Many of us have long recognized the problems inherent in this payment methodology, including fairly reflecting what Medicare is paying in the fee-for-service system, and adjusting payments for a beneficiary's particular health status.

- The Medicare beneficiary has no incentive to choose a managed care plan except in instances where additional benefits are provided. And a managed care plan whose health benefit costs are lower than the AAPCC cannot reduce its price, but rather must make up the difference with increased benefits. This not only costs the government more but also does not encourage the senior to be a prudent purchaser.

- The definition of a managed care plan is unduly restrictive, and does not allow the flexibility generally to offer such plans as POS and PPO's, with the exception of the 15 Medicare Select States, and that is only for Medigap coverage.

Because of the way in which the rates are set, the lack of incentives for beneficiaries, and the definition of managed care plan, only a few Medicare beneficiaries are now able to obtain the benefits of managed care.

The nation has taken a half step toward the goals I outlined earlier. With the work of this committee, and the positive reform statements of Speaker Gingrich, there is a ripe opportunity to complete the journey toward a modern Medicare system that is integrated with the private health care system.

Rather than having government mandate what care should be provided, Medicare beneficiaries and their doctors and other practitioners are the best judges. Let them choose among various plans on the basis of which plan they believe provides the most appropriate care. And there ought to be standard quality and performance measures, with public information and accountability.

To accomplish this, Medicare beneficiaries should be given a voucher from the government to choose among the full spectrum of health plan options that many private sector employees now enjoy.

Initial voucher amounts should be based on an improved AAPCC methodology. As soon as a sufficient number of managed care plans have entered a local Medicare market, HCFA then should set the voucher amount at the average price of the health plans in that area, based on a bidding process. Plans whose rates are above the designated voucher amount would charge beneficiaries the premium difference, whereas plans whose premiums are below the voucher amount could rebate the difference to the beneficiary.

All of these reforms can work on a much bigger scale if cumbersome statutory impediments are removed, HCFA makes the process straight forward for all players, and we are not shackled in our ability to do what we do best: organize and deliver quality health care services.

Medicare beneficiaries will need to have useful and valid means of assessing quality and value across the competing health plans, so that they may choose the right one for themselves. Accreditation by groups such as the National Committee for Quality Assurance (NCQA), and performance measurement tools such as Health Plan Employer Information Set (HEDIS), would provide consumers the tools to make informed choices.

To sum up, again, I oppose forcing older Americans to leave traditional Medicare in favor of private health plans. What I do support is offering them choice, and making it easier for them to exercise that choice. Do not take away the vanilla-variety Medicare system. Just give beneficiaries a choice.

And further, this strategy fits with your efforts to constrain the cost of the traditional Medicare program, giving beneficiaries the incentive to make cost-effective choices for themselves.

The bottom line is that private plans can prove effective in meeting the needs of Medicare beneficiaries, and as they do, Medicare will be gradually converted into a cost-effective, quality program based on private plans.

Thank you Mr. Chairman and members of the committee for your time. I would be happy to answer any questions you might have.

THE WALL STREET JOURNAL FRIDAY, APRIL 3, 1987

Medicare's Private Option

By William L. Roper

When President Reagan asked Congress in February to expand Medicare to include coverage against the high cost of catastrophic illness, some conservatives condemned the president's decision, arguing that private insurers are adequately meeting the needs of senior citizens. By endorsing expansion of Medicare, a pillar of the federal establishment, the president had, according to these critics, sounded the death knell for the Reagan Revolution.

With few exceptions, the press coverage of this story ignored an essential point: Both the president and the secretary of health and human services, Otis Bowen, favor expanding the role of private health plans in meeting the needs of Medicare beneficiaries. The president and the secretary both believe that well-managed private health plans can offer an attractive alternative to traditional Medicare coverage. The administration is committed to giving private health plans a fair opportunity to compete for Medicare enrollees.

Enrollees Total 860,000

Under the administration's Private Health Plan Option (PHPO), the federal government makes lump-sum monthly payments to private health plans enrolling Medicare beneficiaries. All participating health plans must meet certain minimum requirements on benefits, financial solvency, quality and other relevant criteria. In exchange for the monthly payments, the private plan assumes both the financial and medical responsibility for ensuring that its Medicare enrollees receive all medically necessary services. Enrollment is optional; all beneficiaries have the option of remaining in traditional Medicare, or of returning to Medicare on short notice. In the roughly two years since the option was first made available, about 860,000 Medicare beneficiaries have opted to enroll in a private health plan.

The federal government pays private health plans 95% of what it would have cost the government to cover the services in the Medicare benefits package. Since some Medicare beneficiaries use more services than others, the payment is adjusted for key characteristics of the enrollee, including age, sex and place of residence. A fair payment formula is crucial to the success of the PHPO. If the formula overstates the cost of providing services, federal expenditures will increase. If it understates those costs, private plans will refuse to participate. The administration is therefore investing heavily in the effort to refine the rate-setting adjustments.

Unlike so-called Medigap plans, the plans participating under the PHPO cover the complete package of services now covered by Medicare, plus any additional services they choose to offer. Under the PHPO, in short, private plans do not simply supplement Medicare coverage, they replace it.

The government polices the market, channeling competition to achieve socially desirable ends.

The PHPO is an essential element of the administration's Medicare strategy. The policy is designed to achieve five goals:

- Ensure appropriate access to quality care.
- Increase incentives for efficiency.
- Reduce government's role in deciding how much to pay for individual health-care services.
- Reduce government's role in deciding what constitutes appropriate medical practice.
- Expand the range of choices available to both Medicare beneficiaries and health-care providers.

The administration – albeit reluctantly – also must continue its "prudent-purchasing" approach. Under this approach, the federal government remains in its traditional role as insurer of health-care services for the 31 million aged and disabled Americans covered by Medicare. As the insurer, it is obliged to set rules on how much it will pay for individual services and to determine what services are covered. Examples of the prudent-purchasing approach include the prospective payment system for paying hospitals and scrutiny by peer review organizations. Such organizations review services to ensure their necessity and quality.

So long as it remains an insurer, the federal government has no choice but to become a more prudent, and aggressive, purchaser. Medicare will spend roughly $80 billion this year. Notwithstanding the considerable publicity given the "budget cuts" imposed on Medicare, Medicare spending has been rising faster than the general rate of inflation or even the rate of increase in nominal gross national product. But whatever its budgetary merits, the prudent-purchasing approach has the unfortunate consequence of inexorably leading to ever-deeper federal involvement in pricing and medical decisions.

Critics of the PHPO often question whether private health plans should be trusted with so important a mission. Their concern is understandable, and the administration does not advocate blind trust in the ability of "the market" to meet the health-care needs of older Americans. Under its PHPO initiative, government polices the market, channeling competition to achieve socially desirable ends. By the same token, however, the proponents of ever-increasing government control over pricing and medical decisions should acknowledge the risks of that approach. The federal government wields so much purchasing power that it can be a destructive force, even when well-intentioned.

Medicare accounts for 40% of the revenue of a typical hospital; for many hospitals, Medicare's share is much larger. Hospital administrators understandably find it difficult to say "no" to such a powerful customer. The administration fears that government may inadvertently coerce health-care providers to take steps jeopardizing the interests of their patients. That is a real risk when so many decisions are made centrally, far removed from the affected providers and patients.

A far better approach is to give both Medicare beneficiaries and health-care providers the option of participating in Medicare through private health plans. Those private plans, within broad constraints set by the federal government, could determine their own methods for paying physicians and hospitals, for controlling utilization, and for ensuring quality. There is no single right answer to these questions. It is therefore entirely appropriate to permit organizations to experiment with different approaches.

Approximately a third of Medicare beneficiaries live in parts of the country where they currently have the option of enrolling in a private health plan. Two types of plans are now eligible: health-maintenance organizations (HMOs) and competitive medical plans (CMPs). Total enrollment in private plans has increased more than 80% during the past 12 months.

The administration does not expect Congress, Medicare beneficiaries or health care providers to support the PHPO out of allegiance to the abstract concepts of "the market" or "privatization." It asks them instead to support it because it will make the U.S. health-care system fairer and more efficient, while simultaneously protecting the quality of care.

Offering a Choice

To the extent that they can control costs more effectively than Medicare, private plans offer benefits not covered by Medicare. For example, HMOs and CMPs enrolling Medicare beneficiaries often charge lower deductibles and patient co-payments than traditional Medicare, and cover services (such as outpatient prescription drugs) not covered by Medicare.

The administration does not favor requiring older Americans to leave Medicare in favor of private health plans. It only wishes to offer them, and health-care providers, a choice. In other words, it seeks a fair market test for the PHPO. If private plans prove effective in meeting the needs of Medicare beneficiaries and health care providers, Medicare will be gradually converted into a program based on private plans. If private plans cannot compete effectively with Medicare, the traditional Medicare program will remain the financing mechanism for the vast majority of senior citizens.

Dr. Roper is administrator of the Health Care Financing Administration.

Chairman THOMAS. Thank you very much, Dr. Roper.
Mr. Schaeffer.

STATEMENT OF LEONARD D. SCHAEFFER, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, BLUE CROSS OF CALIFORNIA

Mr. SCHAEFFER. Good morning, Mr. Chairman, and thank you for the opportunity to be with you this morning. I would like to ask that my prepared oral statement and written statement be included as part of the hearing record.

Chairman THOMAS. Without objection.

Mr. SCHAEFFER. The Medicare program has accomplished an enormous amount in the last 30 years. As we contemplate changes, we must keep this in mind. We also have to recognize that the program is built on a 1965 fee-for-service model that has not kept up with developments in the private market, namely the move to managed care.

In my limited time this morning I would suggest that the committee focus on restructuring two components of the Medicare program. First, the Medigap market for supplemental benefits, and second, the way that Medicare purchases benefits.

The Medigap market provides one opportunity for immediate action. In this market millions of seniors make local choices about their health care coverage based on real local options. We can harness those local market forces to the advantage of the Medicare beneficiaries and the Federal Government. We need to create a more competitive supplemental market by allowing more choice, especially choice built around managed care alternatives.

Our experience with Medicare Select shows that managed care, including PPOs, lowers costs to beneficiaries and to the government. Medicare Select also improves quality, and expands access to providers beyond those that accept Medicare assignment.

Let me briefly describe our Medicare Select program. Medicare Select from BCC in California is a Medigap PPO. Individuals retain basic Medicare coverage and can still go out-of-network. It is the best of both possible worlds.

The PPO network is made up of carefully selected hospitals, including some of the State's premier institutions, such as Stanford University, and 40,000 physicians. For hospital care, the beneficiary pays no part A deductible in-network; however, they can still go out-of-network but have to pay the deductible.

For physician service, in-network, we cover the $100 part B deductible, and there is no balance billing. Copayments are limited to $5 per visit. Out-of-network, the beneficiary pays the $100 deductible; we cover the 20-percent copay—and the member is subject to balance billing. Other benefits such as a 24-hour personal health adviser often are included in our plans.

The reason Medicare Select works is simple. Members are given incentives to use network providers whose practices are lower in cost and higher in quality than the norm. When beneficiaries stay in-network, significant savings accrue. Maximizing the potential of the supplemental market depends on allowing and even encouraging managed care plans to design Medicare Select alternatives that contain incentives to increase in-network utilization. This is the best possible use of private markets. The government maintains a

role in oversight and funding, but saves money because of beneficiaries' purchasing choices and the private marketplace's downward pressure on cost and utilization.

The first step in Medicare reform, therefore, is to make Medicare Select permanent. The broader issue is Medicare's role as a purchaser of care. If Medicare is to provide coverage comparable to what is available to the rest of the population, substantial changes must be phased in.

Let me review a long-term approach and some practical short-term actions for beginning to get us there. Over the long term we should aim to phase in a Medicare program that will meet the following standards. Individuals should have a choice of qualified health plans, Medicare as a plan sponsor should set its payment level based on premium levels in the local market, paying some percentile of the premiums charged by health plans. And given the fiscal realities in Washington we recognize that payment, like contributions from large employers, will be constrained.

Over time beneficiaries would pay the difference between the premium of the plan they choose and the standard government payment level, paying more if they choose a high-priced plan and less if they choose a low-priced plan.

Now, there are an infinite array of programmatic and political issues to consider as part of such a major restructuring. While the philosophical debate is appealing to many, it is successful implementation that is important.

The practical reality is that you can't enact or implement long-term structural change all at once. If there is any lesson from the health care reform debate, it is that planned incremental change is the most viable course of action.

Let me outline a two-stage plan for legislative action. The first phase is to enact a package of incremental steps this year. First, make the Medicare Select program available to beneficiaries in all 50 States.

Second, revise the definition of health plans that can compete to serve the Medicare population. HMOs are no longer the only managed care entities with a proven track record. Many other managed care arrangements, including PPOs and point-of-service products, are effective and should be available to beneficiaries.

Third, begin to demonstrate and test implementation of three approaches that are critical to the future: These approaches include testing Medicare payment levels that are based on competitive premiums.

They also include testing methods to allow beneficiaries to compare the costs of the underlying Medicare fee-for-service system with the cost of competing health plans. This would require demonstrations in which the Medicare fee-for-service plan is a competing plan itself. Let it compete with the private sector.

Another approach is to test methods for making payments to employment-based retiree health plans so that retired individuals don't have to switch plans but can continue to get benefits in the plans they are accustomed to.

Finally, set up a rigorous monitoring process and prepare to change and change rapidly. If we are to proceed with structural

change, meaningful change, we need to be able to make corrections as we move through time.

The second phase is harder to define because it depends on the findings in the first phase. In general, it would involve phasing in a more competitive Medicare pricing system based on the results of the demonstrations.

In addition, considerations should be given to implementation of payments for employment-based health plans, and further expansion of the definition of participating health plans.

Mr. Chairman, it is the combination of a long-term direction coupled with realistic annual implementation steps that will result in continuous improvement in the Medicare program. Blue Cross of California will be pleased to work with the committee as you pursue the difficult tasks that lay ahead.

I will be happy to answer any questions you might have.

[The prepared statement follows:]

TESTIMONY OF LEONARD D. SCHAEFFER
BLUE CROSS OF CALIFORNIA

Good morning, Mr. Chairman, members of the Subcommittee. My name is Leonard Schaeffer and I am chairman and CEO of Blue Cross of California (a non-profit public benefit corporation) and Chairman and CEO of WellPoint Health Networks, Inc. (a publicly-traded company). Our companies serve older Americans as a Medicare Risk Contractor, an authorized Medicare supplement/Medicare Select provider, and as a Medicare Intermediary.

Let me begin by thanking you for inviting me to share my thoughts on improving the federal Medicare program. My remarks reflect lessons I have learned from working in both the public and private health care arenas.

On the public sector side, I have served as the Administrator of the Health Care Financing Administration (HCFA) and as:

- Health, Education, and Welfare (HEW) Assistant Secretary for Management and Budget;
- Director of the Bureau of the Budget for the State of Illinois; and
- Deputy Director for Management, Illinois Department of Mental Health and Developmental Disabilities.

My private sector experience includes my current roles at Blue Cross and WellPoint and service as President of Group Health, Inc., a large staff model HMO in Minnesota.

Lessons Learned from the Public and Private Sectors

The most important lesson I have learned is that health care is a locally delivered and locally consumed service. This simple observation helped me to understand the frustrations I often encountered as a HCFA Administrator.

Large government institutions want stability, predictability, and control so they enact rules to standardize processes not just for government activities, but for the private sector as well. The problem is that if you are in the business of financing or delivering health services to diverse and rapidly changing populations you must be flexible enough to be responsive to varying consumer and provider demands.

A second observation is that there is a tendency to underestimate the ability of the public to make health care decisions And there is an even greater tendency to underestimate the desire and ability of older Americans to make good choices for themselves. Contrary to this belief, older Americans are among the most knowledgeable and informed consumers.

In looking at the future of Medicare, most of the discussions to date have focused on how Medicare can make better use of managed care as a purchaser of the Medicare benefit package.

That perspective is very important. You will hear a lot of very good testimony today on that subject because it makes sense to most of us in the health care system that Medicare should move rapidly from its anachronistic traditional fee-for-service model to today's managed care approach.

Based on my experience, however, I would suggest that it is also appropriate to view Medicare reform from the perspective of seniors as informed purchasers of health care. If we do so, we will begin to ask different questions that lead to new ways of achieving our goals of expanded choice and provider access, high quality of care, and lower costs.

Creating a More Competitive Supplemental Medicare Market

Viewing seniors as purchasers leads us to explore the "real" market in which seniors are making local choices about their health coverage based on local options. This real market is not Medicare alone, or just Medicare Risk HMOs, but the Medicare supplemental market (sometimes referred to as the "Medigap" market). This private market is a place where Medicare can take advantage of proven managed care models (including flexible PPOs and other arrangements) that lower costs, enhance quality, and expand access to providers beyond those that accept Medicare assignment.

Real savings accrue when managed care plans can design Medicare Select alternatives that contain incentives for beneficiaries to use selected provider networks for their supplemental and primary (i.e. Medicare) medical coverage.

In addition, managed care plans should be given the opportunity to perform the program safeguard activities of Medical Review and Provider Audit. These companies could then supplement or replace these activities with more industry typical pre-service utilization management, case management, and disease state management techniques. In a competitive market, these programs will be much more effective and lower supplemental premiums, while saving money for the Medicare program.

A Closer Look at the Supplemental Market

The vast majority of Medicare beneficiaries have supplemental coverage. Health plans have entered this market to compete for the opportunity to cover the growing costs that Medicare does not pay. Although Medicare is covering less every year, the competition in the supplemental market ensures that health plans find ways to control these cost and provide coverage at affordable rates.

It bears repeating that this is a real market-- millions of older Americans choosing to buy coverage with their hard-earned money. These are out-of-pocket premiums, not government subsidized payments. This market is not that much different than the under 65 individual market except that, like Medicare, it has been largely fee-for-service.

Only very recently, with the advent of the Medicare Select Demonstration, has the government begun to permit options for beneficiaries to join private health plans that compete to develop low-cost, high quality provider networks, incorporate managed care, enhance the benefits, and, as a result, lower beneficiary premiums for supplemental benefits.

Nationally, over 440,000 seniors have chosen Medicare Select as an alternative to other types of supplemental coverage. Purchasing a supplemental policy offered through managed care networks can save seniors 10 to 37 percent over traditional fee-for-service supplemental products. For individuals living on a fixed income, saving as much as $25 per month and $300 per year is significant.

The reason Medicare Select works is simple-- the provider networks that are central to the success of managed care plans include providers whose practices are demonstrably lower cost and higher quality than the norm. If the market is allowed to evolve, more and more managed care features will be employed, creating more savings, flexibility, and choice.

Our Experience in California Has Shown That:

- Medicare Select saves seniors money through premiums that are lower than traditional fee-for-service supplemental products.

- Medicare Select also saves the taxpayer money as well.

Medicare Select members benefit from having the best network providers linked together to create an efficient, coordinated system of care for delivering both their supplemental and primary medical coverage. These savings are passed on to the beneficiary and also to the federal government because these private market utilization changes spill over into the traditional Medicare market-- Medicare does not have to intervene. If you give this market a chance to work nationally, the federal government will save even more.

Analysis of BCC data on our population of Medicare supplement/Medicare Select members show that savings accrue to the government when seniors use in-network providers. Specifically, we have found that for 1993:

- The cost of medical services per admission for network providers was 20% lower than for non-network providers.

- The average length of stay for network providers was 50% lower than for non-network providers.

Our experience with Medicare Select indicates that 70% of services are rendered by network providers, 30% by non-network providers.

The federal government can thus use market forces that exist in the supplemental market to the advantage of the Medicare program. It is the best possible use of private markets-- the government's involvement is limited to plan certification, but the government saves money because of beneficiaries' purchasing choices and the private marketplace's downward pressure on cost and utilization.

The first step of Medicare reform, therefore, is to make Medicare Select permanent.

BCC's Medicare Select Products -- One Company's Example

Blue Cross of California (BBC) provides services to seniors through multiple supplemental options. About half our senior membership remain today in pre-OBRA, non-standard plans and in post-OBRA standard supplemental plans. Between our 3 Medicare Select products, we serve nearly 90,000 members, with 24,000 members enrolling in the last twelve months.

These products provide senior members with access to:

- Nearly 40,000 physicians (half of which are specialists) with no balanced billing to beneficiaries;

- Providers beyond those that accept Medicare assignment.

- Carefully selected providers that meet our quality and credentialing standards;

- Physician management of episode of care, including appropriate utilization and specialty referral,

- Formal administrative, clinical, and peer review of the quality and appropriateness of care;

- Continual improvement of network performance resulting from detailed analysis of more than 30 million claims annually;
- Enhanced benefits that include outpatient prescription drugs, and a range of home health, home support and custodial services; and
- State-of-the-art fraud and abuse detection and profiling.

Our satisfaction surveys for 1994 demonstrated that, overall, our senior members were highly satisfied. Our Medicare Select members were even more satisfied than members in our other supplemental plans.

Consequences of Ending Medicare Select

As you are aware, Medicare Select expires June 30, 1995, effectively freezing enrollment. Clearly this would negatively impact hundreds of thousands of seniors nationally who would see their premiums dramatically increase because keeping the program affordable depends on continually attracting new members. It would also eliminate an important, successful, and very flexible managed care option at a time when seniors are demanding more choices, not less.

As these hearings indicate, there is intense interest in private sector innovations with potential to improve the Medicare program. Medicare Select is an example of such innovation-- applying managed care principles to supplemental coverage-- which has proven successful. Let's extend the program now. Tying the continuation of Medicare Select to the more lengthy process of comprehensive reform of Medicare would threaten the future of supplemental coverage built around choice.

Concerns with Recent Proposals to Improve Medicare Select

The recent RTI report contained some criticism of the Medicare Select program. While I do not seek to minimize such criticism, the program was evaluated in its infancy and RTI itself cautions that "the results are in many ways preliminary." The program has evolved positively and many of the RTI findings no longer apply. For example, our Medicare Select options are now in compliance with NAIC standard plan designs. We have also been approved to market a unique "second generation" Medicare Select product offering even better benefits.

The potential rush to "federalization" of a very young program is a concern. State regulators are better equipped to oversee their respective managed care markets in a way that protects consumers, but also fosters the innovation necessary to serve different markets.

Applying the Section 1876 provisions for Medicare risk contractors to a program providing supplemental coverage, not primary medical coverage, is a second concern. Overlaying these provisions would be duplicative in some areas and inappropriate in others, creating conflict and confusion. A better approach is to develop provisions specific to Medicare Select. Already the Blue Cross/Blue Shield Association has delineated four appropriate areas on which to concentrate:

- Explanation of restrictions/procedures for out-of-network and out-of-area coverage
- Accessibility of providers included in the network

- Quality assurance to ensure availability of high quality care within the network
- Grievance procedures pertaining to out-of-network coverage in emergencies or during travel to areas not served by the network

Conclusion

The first priority with respect to Medicare Select should be kept simple-- make the program permanent and available in all 50 states. This is the thrust of the Johnson (H.R.483) and Chafee bills (S.198). Once seniors can rest easy that this popular program is safe, we can assess potential ways to improve it. Health plans offering this managed care option are certainly willing -- even eager-- to work with Congress and HCFA to make the program better.

Chairman THOMAS. Thank you very much.

Rather than begin the questioning at this point, can we go vote and come back? We will be back as soon as we can.

The committee stands in recess until we return from the vote.

[Recess.]

Chairman THOMAS. The subcommittee will reconvene.

The gentleman from Washington may inquire.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I would like to ask a couple questions. I suppose it is perhaps a tad unfair, but you know this is a great game here; you were both at HCFA for a long time. Why when you were there didn't you institute this managed care business? Because you know and I know that this Communist plot started in the Northwest in 1947, as Group Health of Washington. The doctors were so reviled that they couldn't even get into the medical association, they had to sue, and it went all the way to the State supreme court. So this is not a new idea of managed care, and——

Dr. ROPER. Sure, I will be happy to answer your question.

I don't want to put too fine a point on it, but in the mid and late eighties, the latter part of the eighties when we were pushing this, the makeup of the Congress was different than it is today. We pursued an agenda that fell on deaf ears before this committee.

Mr. MCDERMOTT. You are saying at that time Democrats resisted socialism?

Dr. ROPER. No, sir.

Mr. MCDERMOTT. Is that what you are saying? And now the Republicans are throwing themselves into it?

Dr. ROPER. The leadership of the committee resisted changing the program in the constructive ways that I and others will argue for before you today; that is, removing the unnecessary statutory and then regulatory impediments to making this happen.

Mr. MCDERMOTT. Give me the arguments they gave. What was their argument?

Dr. ROPER. Essentially that managed care is somehow a sinister force that is going to do bad things to senior citizens, when in fact the senior citizens that we do have enrolled in managed care plans tell us and others that they are very satisfied, very happy to be there.

Mr. MCDERMOTT. Mr. Schaeffer, you have had other experiences besides your present position, actually running a big HMO. What is your belief, or do you have any belief that there should be any limitation on the profit that people take out of the health care system? You ran a not-for-profit.

Mr. SCHAEFFER. Right. Well, I think the problem in health care is that doing what we are being asked to do is very, very difficult. There is a lot of good health policy work that has been done in this city and others that talks about what ought to happen to improve the health care system in terms of cost and accessibility, and it turns out that it is very, very difficult to do, and what has happened over time is that organizations that have been able to do that have attracted, you know, investors' interest. So there are people that now see that bringing a lower cost, higher quality product to the market has value, and so you have for-profit players in this business.

I think the market will control the profitability because you have to be competitive. And, you know, companies that are excessively profitable, whatever that means, probably won't be able to compete, but companies that are able to control costs and to assure accessibility will do very well.

Mr. McDERMOTT. Are you suggesting that the company that is making 20-, 30-percent profit and advertising it in their promotional material for selling stock are short lived, that they are going to be short lived, or are you saying that they are grabbing and running? How do you explain that?

Mr. SCHAEFFER. I am saying neither. There is irony in making me the poster child for for-profit companies, but, you know, it has been——

Mr. McDERMOTT. You mean you haven't been profitable?

Mr. SCHAEFFER. No, meaning that I have not been in that situation for very long. But——

Mr. McDERMOTT. That is why I got you instead of Mr. Roper.

Mr. SCHAEFFER. I think if you look back, when I was in HCFA the issue was for-profit hospitals, were they OK or not OK, and I think everyone looked at them very carefully and found that, you know, the quality and the accessibility was there for most of them, and that if they could compete successfully with a not-for-profit hospital, there was probably some added value, and I think that is still the case.

The difficulty is that today to really be an effective managed care company takes technology as well as people, and investors I think have found ways to gather excellent technology and excellent people, make a big investment, and see the result. It is very difficult.

Mr. McDERMOTT. Let me ask you a question before my time runs away. End-stage renal disease—I asked Mr. Vladeck about it—do you think your company is ready to take those people into your health care system?

Mr. SCHAEFFER. It depends on the rules under which——

Mr. McDERMOTT. You offer a policy.

Mr. SCHAEFFER. Unlike some of the comments that were made earlier here about the private sector not covering people, in California we have a government program that was specifically set up for so-called uninsurable individuals, and——

Mr. McDERMOTT. What is the premium?

Mr. SCHAEFFER. I don't know, but I can bring it. It is higher than it is for other people because the costs obviously are higher.

[The following was subsequently received:]

California Major Risk Medical Insurance Program: Access to Private Health Plans for Underserved Californians

The Major Risk Medical Insurance Program (MRMIP) offers affordable state-subsidized health coverage to individuals unable to secure adequate private coverage due to their health status. The program is funded by an annual allocation of $30 million in Proposition 99 tobacco tax funds.

Program Design

Choice of benefits plus subscriber cost-sharing mean affordable premiums.

- Comprehensive benefits including preventive, primary care, maternity care, preventive care for children, mental health care, and emergency care.
- Out-of-pocket expense in limited to $2,000 per member or $3,000 per family unit per calendar year, this includes $500 deductible and co-insurance. Program benefit is $50,000 annual maximum and $500,000 lifetime maximum.

Partnership: state provides subsidy, while health plans assume underwriting risk.

- Subscribers pay a premium equal to 125% of the carrier's standard average individual rate. The state subsidizes the balance of the set premium to the carrier. BCC is the only health plan on full risk for this program.

Principles of managed competition work to create a successful, growing program.

- Subscribers choose from seven competing managed care health plans including both PPOs and HMOs.

Program Statistics (June, 1995)

- 19,235 enrollees
- 43,439 applications
- 1,000 persons on waiting list

Blue Cross of California (BCC) Participation

- BCC offers an interim plan for those on the MRMIP waiting list; currently 330 enrollees.
- BCC is the program administrator for the State as well as a participating health plan offering a PPO product.
- BCC covers and solely underwrites the health risk for nearly 70% of total enrollees.
- BCC consistently offers lowest rates regardless of geographic region.

June 13, 1995

California Major Risk Medical Insurance Program

Area 1

Counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, Yolo.

	Subscriber Only				Subscriber + 1 Dependent			
Age	BC	BS	KPNC[1]	PM[2]	BC	BS	KPNC[1]	PM[2]
< 15	$71.25	$93.00	$72.27	$140.52	$126.25	$171.00	$185.45	$316.79
15-29	$92.50	$93.00	$ 89.51	$149.51	$168.75	$171.00	$185.45	$329.30
30-34	$113.75	$128.00	$111.82	$162.92	$205.00	$239.00	$218.18	$346.05
35-39	$121.25	$128.00	$120.00	$171.08	$220.00	$239.00	$229.09	$372.44
40-44	$123.75	$136.00	$124.09	$214.45	$228.75	$266.00	$235.90	$427.46
45-49	$138.75	$136.00	$129.54	$266.52	$255.00	$266.00	$249.54	$505.88
50-54	$165.00	$193.00	$154.09	$325.95	$301.25	$383.00	$298.63	$616.00
55-59	$188.75	$193.00	$190.91	$459.70	$342.50	$383.00	$368.17	$852.18
60-64	$223.75	$241.00	$216.81	$614.21	$401.25	$483.00	$426.81	$1,132.79
65-69	$250.00	$298.00	$242.72	$703.37	$450.00	$595.00	$475.90	$1,313.89
70-74	$263.75	$358.00	$256.36	$866.81	$473.75	$715.00	$503.17	$1,648.08
75 +	$278.75	$424.00	$271.36	$1,074.82	$501.25	$846.00	$533.17	$2,039.99

1 Kaiser Permanente Northern California available **only** to residents in these zip codes in these counties:
Amador—95640 and 95669;
El Dorado—95613-14, 95619, 95623, 95633-35, 95643, 95651, 95664, 95667, 95672, 95682, and 95727;
Kings—93230;
Placer—95602-04, 95648, 95650, 95658, 95661, 95663, 95677-78, 95681, 95703, 95722, 95736, 95745-47, and 95765;
Sutter—95622, 95659, 95668, and 95674;
Tulare—93618, 93666, and 93673;
Yolo—95603, 95607, 95612, 95616-18, 95645, 95691, 95694-95, 95697-98, 95776, and 95798-99;
Yuba—95692, 95903, and 95961.

2 PM Group available **only** in El Dorado, Kings, Mendocino, Placer, and Tulare Counties.

Area 2

Counties: Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus.

	Subscriber Only					Subscriber + 1 Dependent				
Age	BC	BS	KPNC[3]	MC[4]	PM[5]	BC	BS	KPNC[3]	MC[4]	PM[5]
< 15	$72.50	$93.00	$73.63	$94.99	$144.17	$132.50	$179.00	$189.54	$202.53	$325.37
15-29	$92.50	$93.00	$ 91.36	$202.03	$153.38	$175.00	$179.00	$189.54	$430.72	$338.23
30-34	$113.75	$128.00	$107.73	$215.31	$167.15	$208.75	$239.00	$211.36	$459.07	$355.41
35-39	$122.50	$128.00	$122.72	$219.69	$175.51	$226.25	$239.00	$233.18	$468.09	$382.52
40-44	$130.00	$145.00	$128.18	$242.77	$220.03	$240.00	$283.00	$241.36	$517.59	$438.98
45-49	$150.00	$145.00	$140.45	$291.31	$273.45	$276.25	$283.00	$271.36	$621.10	$519.51
50-54	$183.75	$218.00	$169.09	$365.20	$334.43	$332.50	$423.00	$328.63	$778.64	$632.59
55-59	$210.00	$218.00	$210.00	$500.29	$471.61	$376.25	$423.00	$407.72	$1,066.68	$875.11
60-64	$236.75	$255.00	$225.00	$690.28	$630.15	$422.50	$500.00	$441.81	$1,471.74	$1,163.27
65-69	$263.75	$314.00	$249.54	$882.38	$721.60	$472.50	$616.00	$492.26	$1,881.32	$1,349.25
70-74	$278.75	$379.00	$264.54	$1,072.37	$889.29	$497.50	$741.00	$520.90	$2,286.39	$1,692.47
75 +	$295.00	$448.00	$280.90	$1,378.45	$1,102.70	$527.50	$878.00	$550.90	$2,939.00	$2,094.94

3 Kaiser Permanente Northern California available **only** to residents in these zip codes in these counties:
Fresno—93242, 93602, 93606-07, 93609, 93611-13, 93616, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-88, 93675, 93701-94, and 93844-88;
Madera—93637-39 and 93645;
Napa—94508, 94515, 94558-59, 94562, 94567, 94573-74, 94576, 94581, and 94599;
Sacramento—All zip codes;
San Joaquin—All zip codes;
Solano—All zip codes;
Sonoma—94922-23, 94927-28, 94931, 94951-55, 94972, 94975, 95401-09, 95413, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95485, 95471-73, 95476, 95486-87, 95492.

4 Maxicare available **only** to residents in these zip codes in these counties:
Fresno—93602-09, 93611-13, 93616, 93621-33, 93641, 93646, 93648-52, 93654-62, 93667-88, and 93675-93888;
Santa Cruz—95001, 95003, 95005-07, 95010, 95017-19, 95060-67, and 95073-77.
Solano—94510, 94512, 94533, 94535, 94571, 94585, and 94589-92.

5 PM Group available **only** in Fresno, Imperial, Kern, Madera, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus Counties.

Monthly Rates

Subscriber & 2 + Dependents			
BC	BS	KPNC[1]	PM[2]
$182.50	$276.00	$264.54	$472.03
$280.00	$276.00	$264.54	$484.54
$331.25	$353.00	$297.27	$604.99
$348.75	$353.00	$319.08	$679.58
$352.50	$363.00	$323.18	$771.56
$376.25	$363.00	$331.36	$848.39
$420.00	$461.00	$370.90	$934.44
$460.00	$461.00	$429.54	$1,098.36
$510.00	$533.00	$471.81	$1,288.19
$571.25	$645.00	$526.35	$1,469.34
$601.25	$765.00	$557.72	$1,803.63
$637.50	$896.00	$590.44	$2,195.63

Subscriber & 2 + Dependents				
BC	BS	KPNC[3]	MC[4]	PM[5]
$195.00	$283.00	$275.45	$289.38	$485.02
$291.25	$283.00	$275.45	$615.40	$497.86
$348.25	$368.00	$313.63	$655.91	$621.67
$366.25	$368.00	$321.81	$668.77	$698.34
$367.50	$376.00	$328.63	$739.51	$792.81
$395.00	$376.00	$342.27	$744.25	$871.76
$447.50	$493.00	$398.17	$1,112.48	$960.02
$486.25	$493.00	$479.99	$1,524.02	$1,128.28
$523.75	$543.00	$492.26	$2,102.77	$1,323.13
$586.25	$659.00	$548.17	$2,687.94	$1,509.17
$617.50	$784.00	$580.90	$3,266.68	$1,852.49
$653.75	$920.00	$614.99	$4,199.12	$2,255.07

BC = Blue Cross BS = Blue Shield CC = Contra Costa Health Plan KPNC = Kaiser Permanente Northern California
KPSC = Kaiser Permanente Southern California MC = Maxicare PM = PM Group

Mr. McDERMOTT. So if we gave you the ability to segment into those who are high cost or high users and left you with the other people, you could handle it as long as we gave you the ability to segment?

Mr. SCHAEFFER. We take all comers in California. We have a guarantee issue program that takes anyone.

Mr. McDERMOTT. It sounds like you have a program specifically for high-cost people.

Mr. SCHAEFFER. It was started as a government program and we asked permission to take it on as a private product, and the government ran out of money to fund the program, and we now make it available as a private product from our company.

Mr. McDERMOTT. I would love to see the information. I think the committee would like to see that.

[The following was subsequently received:]

GUARANTEEING ACCESS TO HEALTH COVERAGE
Blue Cross of California's Guaranteed Coverage Program

D. Mark Weinberg
Executive Vice President
Blue Cross of California

Since Blue Cross of California announced its Guaranteed Coverage Program last year, roughly 151,000 individuals have enrolled. The Guaranteed Coverage Program provides health coverage to any uninsured applicant, regardless of health condition. Depending on the individual's health condition, Blue Cross places applicants into one of four levels of coverage. Benefits and premiums for each level of coverage vary by age, region and severity of health condition.

Some 13,200 previously uninsured members accepted into two of the four levels of coverage probably would have been denied coverage by other carriers since no other health plan or insurer in the State offers a program remotely similar to this one. Industrywide, between 10 and 15 percent of individual applicants are denied health benefits. Not so at Blue Cross. No uninsured individual applicants are denied.

The program's design is simple: different levels of coverage and premiums for different levels of health conditions. Level I provides the variety of both PPO and HMO managed care plans currently offered by Blue Cross to individual purchasers. Level IA, costing 20 percent more than Level I coverage, but providing the same broad choice of plans as Level I, covers individuals with health conditions such as ulcers and skin cancer. Level II provides two plan choices with higher patient out-of-pocket cost requirements to customers with higher medical risks, for example, diabetes and hypertension, and costs approximately 50 percent more than similar Level I plans. Level III offers a single plan option with higher patient out-of-pocket cost requirements and is designed for those uninsured individuals with severe chronic and acute medical conditions who have been declined coverage in the past by another health plan. This plan costs about 50 percent more than the comparable Level II plan.

The company has determined that since the program's inception, 91.2 percent were accepted into Level I, 6 percent for the new Level IA, with the remaining 4 percent divided between Levels II and III. None have been declined. The bottom line here is

that Blue Cross took thousands of individuals with health conditions and provided them with the most affordable level of coverage and did not turn away any uninsured individual applicant.

Other health plans providing coverage for individuals might accept members in Blue Cross' "Level I" plans. Those with health conditions would have few or no alternatives. California law prohibits carriers from excluding -- or waiving -- health conditions from their members' coverage. Thus, most carriers usually reject, for example, uninsured diabetic or asthmatic individuals applying for coverage. Under the Guaranteed Coverage Program, Blue Cross covers these uninsured applicants. Individuals in Level III have very serious health conditions such as cancer or AIDS and are uninsurable using a traditional approach. Level III is the only such plan offered by a private carrier in this State and is designed to complement California's Major Risk Medical Insurance Program (MRMIP), a state-funded pool for high-risk individuals, for which there is often a waiting list.

Under California's Major Risk Medical Insurance Program (MRMIP), once a level III member has satisfied a typical waiting list process, the state adds a subsidy to enrollees worth about 50 percent of the premium for a limited number of Californians. The government has a fixed amount of annual funds for MRMIP. When the money is gone, enrollment in MRMIP ends.

Before the Guaranteed Coverage Program, there were no options for those on MRMIP's waiting list. Blue Cross is the only health plan to assume 100 percent of the risk for individuals before they finally get into MRMIP. Blue Cross also offers health coverage under MRMIP, making them one of the few carriers to assume all of the risk for these individuals. Interestingly, over 70 percent of MRMIP enrollees chose Blue Cross for their coverage. Under this unique approach to guaranteed coverage, Blue Cross' responsibility does not change once the majority of individuals move into MRMIP. The Guaranteed Coverage Program covers them before MRMIP and covers most of them when they are enrolled in MRMIP.

This innovative program proves that health plans can guarantee access to health care for all individuals, regardless of their health status. The key, however, is that the carrier must have the ingenuity to skillfully manage health care while ensuring its quality. To date, Blue Cross continues to be the only health plan or insurer in California to offer such a program demonstrating the company's expertise in managing health care. And thousands of Californians have turned to Blue Cross as a result making this company the largest individual carrier in the nation.

Guaranteed Coverage Program Simplified

Level I - Level I Plus 20% - Level II - Level III

Individuals INSURED or UNINSURED		*Only for those wtihout health insurance coverage within the past 30 days of the date of application*	*Available only to Individuals not eligible for Level I or II*
Personal Prudent Buyer **Level I**	*Personal Prudent Buyer* **Level I Plus 20%**	*Personal Prudent Buyer* **Level II**	**Level III**
Standard plans you have always sold.	Based on Medical History, 20% rate up of Level I premium. Basic, Classic, & CaliforniaCare (Not available on Choice). For insureds or uninsureds.	Based on Medical History, applicant may be placed in this level. $500 or %1000 deductibles	For serious medical conditions. In conjunction with the state MRMIP (Major Risk Medical Insurance Plan). If there is waiting list, we will issue this plan while subscriber is on waiting list.
Basic (Hospital) Plan $2,000 deductible ➡ Classic Plans 250, 500, 1000, 2000 ➡ Choice Plans 500, 1000 ➡ CaliforniaCare (HMO) ➡	Basic (Hospital) Plan $2,000 deductible Classic Plans 250, 500, 1000, 2000 Classic Plan 500, 1000 CaliforniaCare (HMO)	• $500 or $1000 annual deductible • 80/20%coinsurance (subscriber) • $10,000 subscriber yearly out-of-pocket stop loss • $5,000,000 lifetime limit Applicants originally applying for 250-500 deductible will be issued 500 deductible Level II. Applicants originally applying for 1000-2000 deductible will be issued 1000 deductible Level II.	• $500 annual deductible • 80/20% coinsurance • $2,000 subscriber yearly out-of-pocket stop loss • $50,000 annual limit • $500,000 lifetime limit • Must be eligible for MRMIP program • Subscriber pays full premium (including the amount the state would have subsidized, if subscriber had enrolled immediately into MRMIP)

Please see brochure and certificate for complete details.

Chairman THOMAS. The gentleman's time has expired, but you are on to something here, and actually I was going to talk about it. I am glad you brought it up.

The contemplating of the unknown in terms of this adverse risk selection problem when people of their own choice walk out of a system has actually been experienced in California where we had a State risk pool. The State refused to fund it because of all of the allegations and the risk. It was almost collapsing. The private sector said, to their credit, "We will take it on," and they have done just that. They have structured—there is no question it is slightly higher, but it is not the scenario that was potentially spelled out earlier. It is interesting. I don't know if any other States have been involved in it.

[The following was subsequently received:]

STATE HIGH-RISK HEALTH INSURANCE POOLS

	Year Oper	1993 Enrollees	Premium Cap*	Funding Source
Alaska	1993	113	200%	Assessment
California	1991	16,785	125%	Tobacco Tax
Colorado	1992	2,046	150-175%	Tax Surcharge
Connecticut	1976	1,610	125–150%	Assessment
Florida	1983	3,476	200-300%	Assessment
Georgia	not	funded	125-150%	Gen Revenue
Illinois	1989	4,693	135%	Gen Revenue
Indiana	1982	4,924	150%	Assessment
Iowa	1987	1,753	150%	Assessment
Kansas	1993	343	NA	Assessment
Louisiana	1992	228	150-200%	Patient Charge
Minnesota	1976	35,296	125%	Assessment
Mississippi	1992	365	150-175%	Assessment
Missouri	1992	987	150-200%	Assessment
Montana	1987	289	150-400%	Assessment
Nebraska	1986	3,282	135%	Assessment
New Mexico	1988	1,294	150%	Assessment
N. Dakota	1982	1,538	135%	Assessment
Oregon	1990	4,091	150%	Assessment
S. Carolina	1990	1,437	200-300%	Assessment
S. Dakota	1994	NA	150%	Assessment
Tennessee	1987	3,411	150%	GR + Assess
Texas	not	funded	150%	Assessment
Utah	1991	681	150%	Gen Revenue
Washington	1988	4,387	150%	Assessment
Wisconsin	1981	12,045	150%	Assessment
Wyoming	1991	206	150-200%	Assessment

* Refers to state-imposed limits that cap premiums at no more than a fixed percentage above the standard premium charged by private carriers to low-risk individuals in the state.

Source: Blue Cross and Blue Shield Associaiton and Communicating for Agriculture, 1994

Mr. SCHAEFFER. Other States have other versions.

Let me just briefly tell you about an anecdote that happened. The State had a very limited budget. Only so many people could get in. There was a long waiting list. We were involved in administering the program. We saw how it worked for a couple of years, and we developed a product for people who were on the waiting list. And so they are covered by a private insurance plan that is very consistent with the government plan until they can get into the program, and oddly enough, as a result, the government has now seen no need to expand the funding for the program. But it is there.

Chairman THOMAS. How long has this been going on?

Mr. SCHAEFFER. Mr. Chairman, I would say 2 years, maybe 3. I don't remember. I can get it for you.

[The following was subsequently received:]

California's major risk medical insurance program (MRMIP) has been in place since 1989. Blue Cross of California's guaranteed issue program has been in place since 1992.

Chairman THOMAS. So in other people's terminology, this is a blip? We don't know if it is going to work?

Mr. MCDERMOTT. The one thing he hasn't told us, though, is the premium. Until we see what the premium is, we will have to talk about how many people could take advantage of it.

Chairman THOMAS. Understood.

Mr. Christensen.

Mr. CHRISTENSEN. Mr. Schaeffer, your testimony indicates that your program is saving the Federal Government money, yet we just heard Mr. Vladeck testify that most Medicare Select programs are just discount arrangements, they are not really managed care.

Can you explain to the committee whether your program can be structured to save money, is saving money, will continue to save money, or is what Mr. Vladeck said the more accurate statement?

Mr. SCHAEFFER. Well, I have talked to Bruce about this on other occasions, and I think he said in his testimony that in California it does work, and so I hope there is no contention over whether we save money or not. I believe that is accepted. I think the question is why. I like to think it is brilliant leadership, but I think it is a little more complex than that.

Basically we have a very—or a more mature and a very hotly competitive environment, and if you want to look at sort of the way HMOs and managed care has evolved there are some theories about what happens in the first stage, second stage, and third stage. We are at that third stage.

You cannot be successful in California on the basis of discounts alone. That just isn't enough. You have to go through a process of identifying the low-cost, high-quality providers, getting them in a network, developing a business relationship with them where you are channeling patients, and in return they are giving you appropriate assurances about cost per unit and number of units, and when you have built a network like that, when you then take Medicare Select and offer Medicare Select beneficiaries the opportunity to go in-network, they get the benefit of the lower utilization in that network, and that is what has happened in California, and clearly, I believe—I can't demonstrate it—but I believe that as

other parts of the country, you know, mature in terms of managed care plans that similar advantages would occur there.

You might ask Bill. I think he has a national plan.

Dr. ROPER. Medicare Select is a good idea. We support making it permanent and nationwide. I would just urge you all to please just do that, but that is not the future of the Medicare program, and get on to the much more basic considerations.

Mr. SCHAEFFER. I think Bill is making an important point. Medicare Select is an easy first step, and it will save money, but there are ways to save lots more money after that, and I think we are just a little surprised, you know.

Dr. ROPER. I would urge you not to be distracted about that.

Mr. CHRISTENSEN. I think that is what this committee wants to hear in more detail, those ideas that are going to save money and continue to implement those programs that are currently saving this country money.

I have great respect for the gentleman from Washington but I also vigorously debate many of his viewpoints. It makes it sound like something is wrong with the word "profit." You know, profit is one of the components of capitalism. There is nothing wrong with profit. If the market allows a 20- or 30-percent profit, that is what I believe is the correct approach. I believe that gives opportunity for another company to come in and to operate at a 10-percent profit and to beat that other company.

I know that my colleague from Washington may disagree with me on how we go about insuring this country, but I do believe that is one of the principles that this country was founded on.

Would the gentleman want to respond at all?

Mr. MCDERMOTT. Oh, thank you.

Chairman THOMAS. He doesn't need prompting.

Mr. MCDERMOTT. The debate is not over profit. The debate is over how much and what you have to do to get the profit, and whether or not you give the same quality of care.

The question really revolves around the whole question of the quality of care. If you can take the same dollar that Medicare is giving 98 percent out in payments for health care, if you can take that and give those same benefits and take away 30 cents, 30-percent profit, that is pretty amazing. I would like to know how you do it.

Mr. CHRISTENSEN. Would the Chairman allow me to ask one more question in my short 20 seconds remaining?

Chairman THOMAS. Certainly.

Mr. CHRISTENSEN. On that basis, Dr. Roper, could you respond? Is that really the true efficiency of the Medicare system?

Dr. ROPER. Sure. The point I would strain to make in response to both of you is what managed care does is not simply go in and deny benefits. I think that is the myth that has arisen by the critics of managed care. If there is any population in America that deserves the benefits, the preventive services, the integrated and coordinated care, it is the Medicare population and the Medicaid population, I would hasten to add.

Somehow or another we have lost sight of the fact that senior citizens—like my dad, Richard Roper, 78 years old, in Birmingham—need the benefits of a system that helps them through

a complicated, difficult time in their lives, and managed care companies offer that to the Medicare population if we will just allow it to happen. Unfortunately, some have tried to turn things around to say that the Yellow-Pages method of organizing the health care system, which is what fee-for-service is all about, is a fond memory that we should recall. But that is just not the case.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I thank you both for your testimony and certainly don't think for 1 minute that we think we will have solved all the problems by extending Medicare Select permanently. We do see that as simply a step that can be taken immediately, we can let the market begin to develop, we can encourage managed care plans, and we will have a better opportunity and we will have stimulated a development in the private sector that will give seniors more choice once we figure out how to give them that buying power in the market.

But, Mr. Schaeffer, I wanted to ask you two things because, frankly, in my conversations with Mr. Vladeck it was clear to me that his concern about Medicare Select is that we don't regulate it enough.

Now, I did try to point out in my questioning what Federal and State regulations are in place, but would you comment for the record both on the RTI study which raises some questions about the Medicare Select program and about the proposal to apply the section 1876 provisions for Medicare risk contractors to the Medicare Select program, which I think is what the administration is under pressure to try to do either on their own initiative or as a result of interest by Members of Congress.

Mr. SCHAEFFER. The RTI study, that was done pretty early, and I think the data is not current, and I think at least in regard to California there really were not, I thought, many serious concerns other than the design of a plan. And when we understood what the concerns were, we immediately went back in and got the design change, and we are now to my knowledge completely copacetic.

I would say, though, that more regulation is probably not what Medicare needs. I mean, generically, and this is just a nice little example where we thought we were in compliance and nobody said we weren't until somebody came in and went through all the Mickey Mouse, but we can live and I think ought to live in a system that says the government has a right to make sure that no one is abused.

I think the concern is if government begins with the assumption that all the players are abusers and that everything has to be regulated, it just gets to be very cumbersome, and a great deal of time is spent on things that don't involve helping people, and I think that is what the program is all about.

In terms of section 1876, you know, I think that that was designed for one purpose, some of the ideas in there are fine, but we ought to go through them one by one and see if they really apply to Medicare Select. Medicare Select is not Medicare risk, it is very easy for seniors to understand, it has all the protections in it of the basic Medicare program. And I would question, as I said in my tes-

timony, the federalization of something that is quite easy to understand and very attractive to seniors. I mean, they get it. This is not a tough program, and because they can go out-of-network, they feel good about it.

Now, they typically end up staying in-network. Our statistics are 70 percent are delivered in-network because we think we choose good network providers, but the savings just accrue. We are not bringing in people from left field who the local seniors don't know.

This is a pretty straightforward extension of Medicare. It saves money, it makes people feel good, it brings in the initial managed care techniques, and, as you have said, Mrs. Johnson, I would like to personally thank you for the battles last year, you know, there are a lot of people who depend on this.

We ought to do it and go. This is not an argument I can understand.

Mrs. JOHNSON. I do think also your testimony was very helpful in documenting the savings in the cost of providing medical care per admission for network providers—20 percent lower than for nonnetwork providers, length of stay down 50 percent.

And the point you made further, which I am not sure you had time to enlarge on, was the indirect effect of this on Medicare costs. Medicare is actually saving money because of these programs where they are well developed.

Mr. SCHAEFFER. Yes. I think it saves money in two ways. One, Medicare Select is immediate. That is a Medicare eligible, but I think that there is a halo effect of managed care, and we see it in California. It is very difficult for a provider to have two kinds of practice patterns. There are very few places you can shift the cost to anymore. We have a fairly sophisticated system and others do as well to track provider behavior. So as the health care system at large becomes more accountable, I think Medicare benefits, and that is to the good.

Mrs. JOHNSON. We do have to go vote, but I do want to thank you both very much for your testimony.

And, Dr. Roper, your comments about the initial voucher and what sum it can be based on and how we could accommodate it, it looks to me like we could do that over a rather short period of time with a fair degree of accuracy. Would you agree with that?

Dr. ROPER. The pricing mechanism can be improved. We need to put the best people together and make it work, yes.

Mrs. JOHNSON. And you would see once we tried to set the price from Washington, once there were a number of providers in the market, we could set the price based on market and competition.

Dr. ROPER. Currently we have the AAPCC methodology, which, when I was HCFA administrator, I appointed a task force 10 years ago to fix the AAPCC. You heard Bruce say he did the same thing. It has problems inherent in it and until we change it fundamentally, we will still have those problems.

It can be made better and ought to be for a year or two, but once there are enough competing plans in a market, put it out for bid, and then set the price based on the bids.

Mrs. JOHNSON. Thank you very much. I appreciate it.

Chairman THOMAS. Let me follow that on with the average adjusted per capita cost mechanism. Since it is tied to the old fee-for-

service, in the timelines and the geography and the rest of it, it isn't a very good tool, but in your estimation I want to understand what you are saying. Would it be worthwhile investing time and attempting to modify it to provide that walkover comparison. Or, would you prefer not spending time on it and moving toward some kind of a blended profile?

Dr. ROPER. There are some straightforward things that could be done immediately. Instead of pricing by county, you could expand it to metropolitan statistical areas, some other steps like that, which people have suggested, deserve being done.

Chairman THOMAS. To me that is the key. We have been using the concept Medicheck, the idea of providing that funding, and the actuarial comparison for the walkover is the key to it. It is just amazing to me that we are carrying on apparently this fight over the extension of Medicare Select. This should be a given and we must—and we are—move on to these larger questions.

When you look at those areas where Medicare Select has been popular, irony of ironies, it overlays where managed care is popular. Over the next several years we are going to have a significant number of people moving into Medicare who are coming from a workplace experience with managed care on programs that apparently were good and workable. I am just scared to death that we are going to set up all kinds of bureaucratic structures. If we allow them to just walk over into a structure for Medicare, you are going to get the same comfort level, but we have got administrators who want to stop that normal transition and set up a highly bureaucratic threshold.

Dr. ROPER. I agree with you. Can I just add one thing. I know you want to go and Len wants to say something.

Chairman THOMAS. I don't want to go, but I have to.

Dr. ROPER. My concern is given the studies that have been done on old data which say that in some cases the AAPCC is too high, you are going to come under pressure from people to say, Let's squeeze down on the managed care side of Medicare. If you do that, it will have just the opposite effect that you are seeking. It will make it less likely that you will ever be able to get Medicare out of the old style fee-for-service and into managed care.

Chairman THOMAS. It just seems to me at this stage since we are not comfortable, we can continue to try to adjust a formula which is to look ahead. But to settle this argument of whether or not these changes are blips or not, why don't we tie in a 1-year look back in terms of the real marketplace and march the two together and take whichever is less, which will move us forward in that structure. That is the kind of approach we are thinking about to get this process moving.

Mr. SCHAEFFER. Mr. Thomas, I think the point about the employment-based plans is very important, and you are increasingly seeing people sophisticated both about managed care and deciding they don't want managed care, and if we could have a system that would allow people to continue with what they have now with the government putting in, you know its appropriate level of payment, whatever that would be, I think you would find an awful lot of happy seniors because that makes sense to them. And this artificial break, some suggestions of a 1-day open enrollment, I mean, we are

talking about a logistical nightmare that I just think we ought to rethink in terms of how people really live and what is a logical expectation.

Chairman THOMAS. I want to thank the panel. I want to assure you that the idea of trying to define what we ought to do, by the worst case scenario, will not drive us. They tried to do it with proposition 13, property tax changes in California.

If we are going to have to reduce it, we will close the library. On the SSI disabled, it isn't the alcoholics and the drug addicts, it is this poor unfortunate individual who has been on it for 10 years, they are the ones who are going to lose it. If we allow ourselves to be defined by end-stage renal disease, therefore we can't go forward with the significant changes, we really don't understand what this process is about. It is going to be fun determining who is leading whom in this process. And frankly I think the private sector on the long-term trend is way ahead of us and we have got to latch on.

I can't stay. You can talk into the mike for the record, but I can't miss a vote. We have a lot of them. I want to thank you.

This is not the termination of this discussion. We are looking for help to create the yardstick or the measure so folks can take that Medicheck and walk over into that other system, so we appreciate your testimony.

We will continue the hearing after the vote. The subcommittee is temporarily recessed.

[Recess.]

Chairman THOMAS. The subcommittee will come to order once again.

The next single panel, Ms. Shikles, who is the Assistant Comptroller General for the General Accounting Office.

Ms. Shikles, your written testimony will be made a part of the record, and you may proceed for 5 minutes in any way you feel would be helpful to the subcommittee.

STATEMENT OF JANET L. SHIKLES, ASSISTANT COMPTROLLER GENERAL, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Ms. SHIKLES. Thank you, Mr. Chairman and members of the subcommittee. I am pleased to be here today to discuss options for expanding managed care under the Medicare program.

The current Medicare HMO option, known as the risk contract program, has not grown much or achieved its cost containment potential. Comparisons therefore with HMO trends in the private sector are instructive. Large employers are using market power to negotiate with HMOs over price and increasingly over quality and the production of report-card-type information. Their efforts are directed at becoming more prudent and sophisticated purchasers of health care.

Today, in connection with our work on health care claims and the risk contract program, we will discuss what lessons the private sector offers for applying managed care strategies to the Medicare program.

Turning first to payment policies, one of the main reasons Medicare's risk contract program has been unable to harness the cost-saving potential of managed care has to do with problems with the mechanism it uses to set HMO payment rates. At present, Medicare does not shop or negotiate but sets HMO rates county by county using a formula tied to fee-for-service. In contrast, large employers and other purchasers can negotiate with managed care providers or shop among them for the best value.

Turning to the area of quality, the Federal Government has had quality assurance standards since the seventies, but has not enforced them aggressively in its risk contract program. For example, in the last 10 years, HCFA has repeatedly opened and closed quality assurance reviews in certain Florida HMOs because of poor quality care.

In contrast, the private sector has taken a different strategy by involving large employers as partners in setting and enforcing HMO quality standards. An independent organization, the National Committee for Quality Assurance, has developed standards and procedures for accrediting HMOs. This accreditation is becoming increasingly important since large employers are beginning to require NCQA accreditation of health plans before they can be offered to their employees.

Finally, the private sector has also taken the lead in developing information for purchasers and consumers to compare different HMOs. A group of large employers has led efforts in developing HEDIS, the health plan employer data and information set, which contains information on performance measures to evaluate plans' quality.

HCFA is beginning to define a similar set of quality measurements targeted to the Medicare population, but expects collection and publication to be several years away.

In addition, HCFA has not spurred HMOs to provide the performance data beneficiaries need to make informed choices in selecting between managed care and fee-for-service options. Even where some data exists such as HMO disenrollment rates or numbers of complaints, HCFA has not published this data which could help beneficiaries differentiate between HMOs.

In conclusion, the history of Medicare and private attempts to control health care costs is discouraging under fee-for-service. Medicare faces the overwhelming task of trying to police upward of 700 million claims each year. Private payers seeking to control costs have moved strongly toward managed care.

HCFA can now move to test proposals drawing on private sector experience. We believe it can, first, test the potential for such strategies as competitive bidding and negotiation to improve Medicare's HMO payment approach. Second, stop the enrollment of Medicare beneficiaries in HMOs that do not meet standards. And third, use its data to publish disenrollment and certain beneficiary satisfaction data in annual reports, comparing plans.

We believe HCFA should move expeditiously in all of these areas.

Mr. Chairman, this concludes my statement and I would be happy to answer any questions.

[The prepared statement and attachments follow:]

TESTIMONY OF JANET L. SHIKLES
ASSISTANT COMPTROLLER GENERAL
HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION
U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to participate in your discussion on expanding managed care under the Medicare program. For the past week you have been examining weaknesses in Medicare's predominantly fee-for-service program, which cost the government $162 billion in fiscal year 1994 and consumes an ever greater share of the federal budget each year. In testimony to the Subcommittee earlier this week, we reported that the magnitude of the Medicare program has overwhelmed the government's ability to police the hundreds of millions of claims submitted annually.[1] Today the Subcommittee is examining managed care options as alternatives to the current claim-by-claim management of program dollars. What we would like to contribute is our perspective on Medicare's HMO payment policy, efforts to enforce quality assurance standards, and the dissemination of consumer information. Our findings derive from numerous studies we have done on the Medicare program in recent years as well as ongoing studies. (See app. II for a list of the issued reports.)

In brief, the current Medicare HMO option, known as the risk contract program, has not grown much or achieved its cost containment potential. Comparisons with HMO trends in the private sector are instructive. Large employers use market power to negotiate with HMOs over price and increasingly over quality and the production of report-card-type information. Their efforts are directed at becoming more prudent and sophisticated purchasers of health care. Although the particulars of these efforts may not be directly transferrable to the federal government, their broad aims of finding incentive-based solutions to containing costs, assuring quality, and informing consumers are worthy of consideration and testing.

MANAGED CARE HAS POTENTIAL TO
ADDRESS MEDICARE CLAIMS VULNERABILITY

Medicare's growing claims volume has placed substantial demands on Medicare's claims processing systems. In fiscal year 1994, Medicare processed nearly 700 million claims. In 1992 and again this month, we report that Medicare is one of several government programs highly vulnerable to waste, fraud, abuse, and mismanagement.[2] Since our first report, the Health Care Financing Administration (HCFA), the agency responsible for administering Medicare, has made various regulatory and administrative changes aimed at correcting flawed payment policies, weak billing controls, and deficient program management. However, these worthwhile improvements still are not sufficient to protect Medicare against continued program losses. The nation's health care delivery system is evolving with such changes as consolidations of various provider types and increasingly complex financial arrangements. In this environment, HCFA is seeking strategies to become less reliant on reviewing claims individually as a means of guarding against overpayment.

During the last decade, employers have increasingly turned to managed care to slow the rising cost of health benefits. As the Congressional Budget Office reported earlier this month, the most effective HMOs can reduce the use of services for the nonelderly population by 22 percent over typical indemnity plans.[3] Industry

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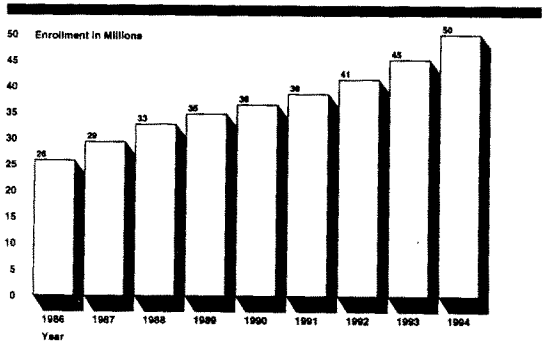
[1]Medicare: High Spending Growth Calls for Aggressive Action (GAO/HEHS-T-95-75, Feb. 6, 1995).

[2]Medicare Claims (GAO/HR-93-6, Dec. 1992) and forthcoming Medicare Claims (GAO/HR-95-7).

[3]The most effective plans were group and staff models HMOs. IPAs, another type of HMO, reduced utilization 2 to 4 percent on average. See CBO testimony on Federal Entitlement Spending, statement by Paul N. Van de Water, Congressional Budget Office, before the U.S.

estimates show HMO enrollment nearly doubled since 1986 to 50 million people in 1994. (See fig. 1.) About 90 percent of the HMO enrollees are in commercial or employer-sponsored programs.

Figure 1: Growth in HMO Enrollment Between 1986 and 1994



Source:Group Health Association of America (GHAA), 1994

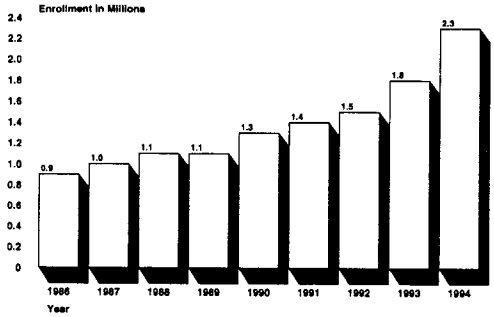
States, too, are looking to managed care to help contain the costs of their Medicaid programs. These programs now enroll nearly 8 million people in managed care plans, about half of whom are in HMOs. Several states, such as Ohio, South Carolina, and Florida, plan to move large segments of their Medicaid population into HMO-type plans in the next few years.

Like states and employers, Medicare has also tried managed care as a way to contain the cost of providing care to over 35 million beneficiaries. Medicare offers its beneficiaries the option of obtaining managed care from prepaid plans or provider networks participating in a 15-state pilot program called Medicare Select. This program offers beneficiaries the incentive of savings on their supplementary insurance premiums if they obtain care from a designated network of providers.

HMOs are the most common form of Medicare managed care. Recently, Medicare HMO enrollment growth has accelerated. In the past 2 years, the number of Medicare HMO enrollees grew 50 percent, from about 1.5 million to about 2.3 million beneficiaries. (See fig. 2.) However, since this is only about 7 percent of the Medicare population, the growth is much lower than in the general population. Medicare HMO enrollment has been uneven, with high concentration in a few areas and no enrollment in others. (See app. I.)

Senate, Committee on the Budget, Feb. 1, 1995.

Figure 2: Number of Medicare Beneficiaries Enrolled in HMOs with Medicare Risk Contracts Between 1986 and 1994



Source: Health Care Financing Administration

PAYMENT POLICIES NEEDED TO ACHIEVE MEDICARE SAVINGS

Medicare's risk contract program has been unable to harness the cost-saving potential of managed care. As we reported in 1994, Medicare's mechanism for setting HMO payment rates suffers from certain technical difficulties.[4] These may be best understood when contrasted with the private sector's rate-setting methods.

In the private sector, large employers and other purchasers can negotiate with managed care providers or shop among them for the best value. Meanwhile, with more HMOs entering various local markets, competition on price has become sharper. Some employers and other purchasers report obtaining reduced premiums compared to the prior year.

In contrast, HCFA does not shop or negotiate but sets its HMO rates, county by county, using a formula. That formula has two key flaws. First, it ties HMO payment rates to a county's fee-for-service costs. As a result, in some counties Medicare's HMO rates factor in excessive use of services and so are too high for Medicare to realize the potential savings from managed care. In other counties with lower service use, Medicare's rates are too low to encourage HMO participation in its risk contract program.[5] Second, Medicare's formula does not adequately adjust HMO rates for enrolled beneficiaries' risk of illness. This flaw in the program's "risk adjuster" results in significant losses to Medicare.

Remedies have been proposed to make Medicare managed care achieve its cost-saving goal. In particular, we have identified several promising health risk adjusters, including one shorter-term fix. Even with better risk adjusters, more fundamental changes may

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[4]Medicare: Changes to HMO Rate-Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

[5]The rate differences can be substantial even in adjacent areas. For example, Medicare's unadjusted 1994 HMO payment rate is 28 percent lower in Montgomery County, Maryland, than in adjacent Prince George's County, Maryland.

be required so that Medicare reduces its reliance on fee-for-service costs as a basis for HMO payment. For example, major proposed reforms include competitive bidding arrangements and negotiations between the government and HMOs.

We have also proposed administrative solutions to the inadequate risk adjustment in Medicare's payment formula.[6] For example, the required period of time that beneficiaries must stay with an HMO once enrolled could be lengthened from 30 days to 1 year. Because such restrictions "lock in" beneficiaries, additional measures would be needed to safeguard against substandard quality.

PRIVATE SECTOR LEADS IN EMPHASIZING QUALITY STANDARDS

The public and private sectors share a common interest in developing the means to ensure that HMOs provide quality as well as cost-effective care. HMOs' restrictions on individuals' choice of physicians, hospitals, and other sources of care create the need to provide payers and beneficiaries assurances that quality of care will be carefully monitored.

The federal government has had quality assurance standards for HMOs since the 1970s but has not enforced them aggressively. Medicare has a process to monitor HMOs' compliance with federal standards. It involves site visits to assess an HMO's financial solvency, quality assurance systems, and other features for ensuring the fair treatment of beneficiaries. In many instances, however, HCFA does not act on evidence of violations or make such evidence public.

For example, in the last 10 years, HCFA has repeatedly found quality assurance problems in certain Florida HMOs. The most recent quality violations included incorrect diagnoses, treatments delayed or withheld, and test results not acted on. One of the HMOs continued to enroll over 100,000 Medicare beneficiaries during a period of noncompliance without any HCFA intervention.

The private sector has taken a different approach in enforcing standards. Large employers have joined with a private accreditation agency in setting and enforcing HMO quality standards. This organization, the National Committee for Quality Assurance (NCQA), has developed standards and procedures for certifying HMOs that request accreditation.[7] NCQA certification is becoming increasingly important since large employers are beginning to require accreditation as a prerequisite to negotiating with HMOs.

PURCHASERS AND ENROLLEES NEED INFORMATION TO MAKE APPROPRIATE CHOICES

The private sector has also taken the lead in developing information that enable purchasers and consumers to compare different HMOs. To enable such assessment of health plans' cost effectiveness and performance, a group of large employers has led efforts in developing the Health Plan Employer Data and Information Set (HEDIS). These data constitute a set of performance measures to evaluate plans' quality of care, access to care, member satisfaction, utilization of services, and financial stability. Although HEDIS standards are still under development, some

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[6]See Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67, May 1991).

[7]The Group Health Association of America in conjunction with the American Managed Care and Review Association, formed NCQA in 1979. NCQA became an independent agency in 1990.

employers already require their plans to submit HEDIS-based information.

The private sector also disseminates quality-related information to purchasers and users. For example, NCQA publishes results of its medical quality assurance accreditation reviews nationwide. Of 15 Medicare HMOs reviewed in Florida, only 1 received full accreditation, 6 were denied accreditation, and 8 received less than full accreditation. With this knowledge, a consortium of employers has elected to exclude Florida's largest Medicare HMO from new business with their employer-sponsored health plans.

HCFA is beginning to define a similar set of quality measurements targeted to the senior population but expects collection and publication of these data to be several years away. HCFA has not spurred HMOs to provide the performance data beneficiaries need to make informed choices in selecting between managed care and fee-for-service options. Moreover, even where some data exist, such as HMO disenrollment rates or numbers of complaints, HCFA has not published these data which could help beneficiaries differentiate among HMOs.

The feasibility of producing and disseminating such information is apparent in a commercial document that compiles information on plans available to federal employees.[8] The publication rates the plans on customers' satisfaction with waiting times for physician office visits, access to specialty care, and making appointments. It also publishes HMO disenrollment rates.

CONCLUSIONS

The history of Medicare and private attempts to control health care costs is discouraging under fee-for-service. Medicare faces the overwhelming task of policing upward of 700 million claims each year. Private payers, seeking to control costs, have moved strongly toward managed care. Their experience suggests strategies for moving Medicare toward more of a managed care approach. As a prudent buyer, the private sector offers lessons in using market power to negotiate favorable payment rates; in being an advocate of value and quality assurance; and in educating consumers to make informed choices about health plan options.

HCFA can now move to test proposals drawing on private sector experience. It can (1) test the potential for such strategies as competitive bidding and negotiation to improve Medicare's HMO payment approach, (2) stop the enrollment of Medicare beneficiaries in HMOs that do not meet standards, and (3) use its data to publish disenrollment and certain beneficiary satisfaction data in annual reports comparing plans.

HCFA has shown a willingness to adopt these strategies by its proposals to test new reimbursement techniques, recent enforcement actions on quality, and a consumer information initiative. Because there may be policy and legislative impediments to moving aggressively in these areas, HCFA may have to ask the Congress for support.

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Mr. Chairman, this concludes my prepared statement. At this time, I will be happy to answer any questions you or other members of the Subcommittee may have.

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[8] Checkbook's Guide to 1995 Health Insurance Plans for Federal Employees, Walton Francis and Editors of Washington Consumers' Checkbook Magazine, Walter Francis and the Center for the Study of Services: Washington, D.C., 1994.

Table 1: Medicare HMO Enrollment by State as of January 1, 1995

State	Total Medicare Population[1]	Medicare Beneficiaries in HMOs	Enrollees as a Percentage of Total Beneficiaries	Enrollees as a Percentage of HMO Program
Alabama	619,000	1,944	0	0
Alaska	30,000	0	0	0
Arizona	581,000	**158,503**	28	7
Arkansas	410,000	0	0	0
California	3,499,000	**975,749**	28	42
Colorado	396,000	50,679	13	2
Connecticut	490,000	257	0	0
Delaware	96,000	109	0	0
Florida	2,519,000	**387,470**	15	17
Georgia	793,000	0	0	0
Hawaii	141,000	13,080	9	0
Idaho	143,000	0	0	0
Illinois	1,592,00	68,018	4	3
Indiana	802,000	2,684	0	0
Iowa	489,000	0	0	0
Kansas	378,000	0	0	0
Kentucky	565,000	2,724	0	0
Louisiana	562,000	6,616	1	0
Maine	194,000	0	0	0
Maryland	580,000	2,118	0	0
Massachusetts	911,000	41,369	5	2
Michigan	1,306,000	6,947	1	0
Minnesota	616,000	58,177	9	2.5
Mississippi	384,000	0	0	0
Missouri	815,000	16,226	2	1
Montana	125,000	0	0	0
Nebraska	245,000	3,271	1	0
Nevada	172,000	36,634	21	1.6
New Hampshire	149,000	53	0	0
New Jersey	1,142,000	5,364	0	0
New Mexico	199,000	28,147	14	1
New York	2,581,000	**106,731**	4	4.5
North Carolina	724,000	0	0	0
North Dakota	102,000	0	0	0
Ohio	1,626,000	20,816	1	1
Oklahoma	474,000	12,933	3	0.5
Oregon	456,000	**100,700**	22	4
Pennsylvania	2,041,000	60,055	3	3
Rhode Island	164,000	11,639	7	0
South Carolina	482,000	0	0	0
South Dakota	114,000	0	0	0
Tennessee	739,000	0	0	0
Texas	1,977,000	87,940	4	4
Utah	177,000	0	0	0
Vermont	79,000	0	0	0
Virginia	781,000	1,535	0	0
Washington	659,000	71,885	11	1
West Virginia	322,000	0	0	0
Wisconsin	745,000	0	0	0
Wyoming	57,000	0	0	0
Total	35,224,000	2,339,592	7	

[1] Total Medicare population as of July 1, 1993

Related GAO Products

Health Care Reform: "Report Cards" Are Useful but Significant Issues Need to Be Addressed (GAO/HEHS-94-219, Sept. 29, 1994).

Health Care Reform: Considerations for Risk Adjustment Under Community Rating (GAO/HEHS-94-173, Sept. 22, 1994).

Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

Health Insurance: California Public Employees' Alliance Has Reduced Recent Premium Growth (GAO/HRD-94-40, Nov. 22, 1993).

Managed Health Care: Effect on Employers' Costs Difficult to Measure (GAO/HRD-94-3, Oct. 19, 1993).

Medicare: HCFA Needs to Take Stronger Actions Against HMOS Violating Federal Standards (GAO/HRD-92-11, Nov. 12, 1991).

Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, Mar. 13, 1991).

Medicare: Increase in HMO Reimbursement Would Eliminate Potential Savings (GAO/HRD-90-38, Nov. 1, 1989).

Medicare: Reasonableness of Health Maintenance Organization Payments Not Assured (GAO/HRD-89-41, Mar. 7, 1989).

Medicare: Health Maintenance Organization Rate Setting Issues (GAO/HRD-89-46, Jan. 31, 1989).

Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (GAO/HRD-89-29, Dec. 12, 1988).

Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988).

Medicare: Uncertainties Surround Proposal to Expand Prepaid Health Contracting (GAO/HRD-88-14, Nov. 2, 1987).

Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986).

Problems in Administering Medicare's Health Maintenance Organization Demonstration Projects in Florida (GAO/HRD-85-48, Mar. 8, 1985).

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

Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I want to talk a little bit about regulation. About 25 percent of the health care dollars spent right now is subject to regulation by State insurance regulation. What is your impression of State regulation, how they carry out that responsibility?

Ms. SHIKLES. The State regulation of health care?

Mr. MCDERMOTT. Yes.

Ms. SHIKLES. Actually States have a decreasing role in regulating health insurance because more and more firms are self-insuring, and they are under State health regulation.

Mr. MCDERMOTT. Who enforces quality standards if the State can't do it because of self-insurance?

Ms. SHIKLES. The quality standards are enforced by many different sectors. HCFA is responsible for quality standards in the Medicare program. Your private employers are involved with——

Mr. MCDERMOTT. They set their own standards and decide whether to follow them? Since the State doesn't do it, you don't do it, who enforces quality standards on the self-insured?

Ms. SHIKLES. There are minimum standards under the ERISA plans under the Department of Labor. If they haven't self-insured, they would be under this State regulatory market.

I think what we are seeing, and I have been doing fraud and abuse reviews for many, many years in the whole health care field, and you are really seeing a dramatic change I think in the last several years where you are finding that large corporations are getting involved not only in cost containment, but in quality reviews.

I think if you look at what is going on with Medicare and HMOs, and that was the point we were trying to make, and we have done a ton of reviews in this area, and in that case, HCFA had the regulatory responsibility, and we never saw any improvement. And I have probably done 10 reports and many testimonies, and nothing ever got better. And the real dramatic change that is going on now is that employers as purchasers are really making some major changes because they are getting so involved in the types of plans that their employees choose.

I think it is pretty impressive what is going on with the National Committee for Quality Assurance. Where there is accreditation, they publish the results. Employers now, based on the results that are published, are going to withdraw from allowing employees to participate in plans that aren't accredited.

That is faster than anything I have seen in HCFA over the past 10 years. So it is a very mixed story.

Mr. MCDERMOTT. Is the California experience, they have at least three departments, I think, that are involved in their regulation of health care. What does that do to the regulation of it? Or the oversight of it?

Ms. SHIKLES. In California I think because HMOs fall under the department of corporations and other insurance products under the department of insurance, I think they have worked to coordinate it. But I am sure it is a more confused——

Mr. MCDERMOTT. And health has the part of quality assurance, don't they? That is a third element in California.

Ms. SHIKLES. That is right.

Mr. MCDERMOTT. How do they coordinate that?

Ms. SHIKLES. I don't know. We haven't looked specifically at California's department of insurance and how they are working with——

Mr. MCDERMOTT. If you were a senior in California and you were in one of these programs and felt you weren't getting good health care, what department would you go to to complain?

Ms. SHIKLES. I think you would file your complaint with the department of insurance, I think.

Mr. MCDERMOTT. You are not sure?

Ms. SHIKLES. I am not sure. We haven't investigated California. Our focus—the work that we have done is following up on complaints in both the fee-for-service program and the HMO program in Medicare.

Mr. MCDERMOTT. You mentioned Florida. Have you done anything with Medicaid HMOs?

Ms. SHIKLES. We have not looked at Medicaid HMOs in Florida. Is that your question?

Mr. MCDERMOTT. Yes.

Ms. SHIKLES. Right.

Mr. MCDERMOTT. Would you think that an HMO that spent 63 percent of their dollar on overhead was a little bit top heavy?

Ms. SHIKLES. You would be very worried that there was very little money for the services that need to be provided, yes.

Mr. MCDERMOTT. If they spent 77 percent, would you think that was excessive?

Ms. SHIKLES. Right.

Mr. MCDERMOTT. You know, all you have to do is read—I am sorry Mr. Christensen's not here, but the Sun Sentinel did a report on HMOs in Florida, and when you look at these administrative costs of 51, 63, 55, 77 percent, you have to wonder, what are they paying for health care for these people?

I mean, I thought 30-percent profit, as some firms estimate, was a little excessive. But when you see this kind of thing you ask yourself, are they delivering any health care whatsoever?

Chairman THOMAS. Will the gentleman yield?

I just got a copy of that reprint. It is headed, "Florida's Medicaid HMOs." Are we advocating an expansion of jurisdiction here? I am with you if we are.

Mr. MCDERMOTT. We are talking about putting senior citizens into managed care by forcing them, for some mechanism, because they can now choose it.

The point, Mr. Chairman, is senior citizens can now choose to go into managed care. They don't. Only some go in.

So now if we want to save money, we are going to have to say to those seniors, OK, folks, line up, you are going into an HMO. That is the way you are going to get the savings. And if you don't do that, then you are not—I don't know what incentive you are going to give them to get them to make a choice now that they don't make.

Chairman THOMAS. The time of the gentleman has expired.

You can also argue that for the general population. However, we are looking at trends, and we have got to keep in mind this is a relatively new and rapidly changing area.

Ms. Shikles, I was interested in your statement about the private sector and the speed with which they are now informing themselves and making decisions. You heard the administrator of HCFA in response to the question from Mr. Christensen about getting a study that was in 1990, based upon the Medicare program, to be done by January 1, 1995, and they are going to get around to it sometime later this year.

The kind of timeframe in which changes need to be made simply cannot have that sort of thing happen. Do you agree with that?

Ms. SHIKLES. We do agree with it.

Chairman THOMAS. And when you say that the suggestions have to be made in a timeframe, these studies, expeditiously by HCFA, do you have any outside timeframe? Is this 5 years, 7 years?

Ms. SHIKLES. We think they should be done this year. We think that in working on the health care field, that changes that are going on in the private side of health care are so dramatic and the different types of products being offered, and the focus on quality is a really new and very strong emphasis.

And so I think HCFA could test a set of things very quickly this year that could give you much more information on how to price different products and how to do different offerings.

Chairman THOMAS. Yes, but you were here. The Administrator chose to take his time to complain about the Medicare Select program, argue that it shouldn't be made permanent, and then throw up some theoretical problems about physicians increasing their money through various schemes. Perhaps you are suggesting that it might have been a bit more valuable for this agency to provide us with some modeling of the way in which they are going to shorten the timeframe to make judgments, like the private sector has done.

Ms. SHIKLES. Right.

Chairman THOMAS. That is really valuable testimony. What I am looking for, and we will visit with you, is to find out what your agency can do to assist us in examining the tools that the private sector is using like the NCQA and take a look at potential tools that we have available to find out if we can't begin to push these government agencies' timelines into the months rather than the years.

And I hope you will be willing to work with us as we go forward.

Ms. SHIKLES. We would love to do that and we think we can offer quite a bit of assistance in that area.

Chairman THOMAS. I think once again people need to appreciate the rapidity with which change is now occurring in the private sector. It started very slowly but is now moving extremely rapidly. The longer we wait and the more we complain about the shift and the more we use anecdotes from other areas in terms of the potential downside problem for a particular group of seniors, we lose significant opportunities in terms of comprehensive care for all of our seniors, but more importantly, any savings that might be achieved from those changes are going to be pushed back. We don't have much room between now and 2001.

Thank you for your testimony.

Mrs. JOHNSON. I just wanted to comment on something you said earlier, because we did have to vote. It is interesting, the article from the Sun Sentinel reports on studies of HMOs under Medicaid. But at the bottom of that article it mentions, "This newspaper's work in revealing real fraud and bad practice in HMOs serving elderly patients." And they say, "Four years ago we did this."

In your testimony you say, in the last 10 years HCFA has repeatedly found quality assurance problems in certain Florida HMOs. The most recent quality violations included incorrect diagnoses, treatments delayed and withheld, test results not acted on. One of the HMOs continued to enroll over 100,000 Medicare beneficiaries during a period of noncompliance without any HCFA intervention.

In other words, I hear your testimony to say not that there are not some problems in some HMOs, but that the government has been totally incapable of identifying them or doing anything about them in contrast to the private sector's actions in the last couple of years where they have really focused on quality issues.

I thank you for your testimony and look forward to working with you to develop more detail in certain areas.

Mr. MCDERMOTT. Mr. Chairman, that study that Mrs. Johnson now refers to was done in October 1990. It isn't as though it happened only on the present watch. It has been going on for a long time.

Mrs. JOHNSON. Over 10 years government has showed itself completely incompetent to do it.

Mr. MCDERMOTT. Even with Republican administrations, I point out.

Chairman THOMAS. From all the testimony I heard, 1990 seems to be current day for some of these folks.

The committee stands in recess until this vote is over.

Thank you very much, Ms. Shikles.

We will ask the next panel to be ready to go. When we come back that would be former colleague Bill Gradison, Karen Ignagni and Stephen Wiggins.

[Recess.]

Chairman THOMAS. The subcommittee will reconvene.

If the panel is willing, we can begin. I know the members have already reviewed your testimony, and they are going to be coming back from a vote that continues to go on.

The witnesses' written testimony will be made a part of the record, without objection.

And it is my pleasure to welcome to the committee as the first testifier, the former Hon. Bill Gradison from Ohio. I don't need to say any more than that.

STATEMENT OF HON. BILL GRADISON, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. GRADISON. Thank you, Mr. Chairman. I have turned in a longer prepared statement. I appreciate your including it in the record.

Mr. Chairman, Medicare is a highly valuable, immensely popular program which has served the medical needs of the elderly and disabled quite well over almost three decades. But the program is not

perfect. And reexamining Medicare probably as you are doing is timely.

In many respects Medicare is a state-of-the-art 1965 health insurance program. Both the benefit package and delivery systems are pretty much the same as they were at the outset.

While important and useful changes have been made in the program, DRGs, RBRVSs, the HMO CMP option and Medicare Select, for example, these amount to tinkering around the edges.

In my judgment, were the Congress to design a new program today to serve the elderly and disabled, it would look very different from Medicare as we know it in at least two regards: The benefit package and the delivery system.

It is inconceivable to me, for example, that Medicare as started anew would exclude outpatient prescription drugs. I am also skeptical that a one-size-fits-all benefit package would be adopted. It is also doubtful to me that the program would be overwhelmingly fee-for-service.

Having grappled with Medicare policy for years as a member of this subcommittee, I know how hard it is to make minor, to say nothing of major, changes in Medicare.

I believe we can be helpful in your deliberations since HIAA members, whom I represent, are involved in all aspects of Medicare as carriers and intermediaries for the fee-for-service segment of the program; as providers of the supplemental insurance that beneficiaries purchase to augment their Medicare fee-for-service benefits; and as providers of the Medicare CMP and the Medicare Select managed care options that are available to beneficiaries in many parts of the country.

Frankly we haven't focused on what specific changes to recommend were Medicare to be restructured. We do know that achieving Medicare program cost reductions through further erosion in provider reimbursements would merely shift the cost to the private sector, making health insurance more costly for the non-Medicare population and making care for the elderly population less available.

Increasing this cost shift from the public to the private sector is in essence a tax on the private sector. Quite apart from whatever major restructuring you may decide upon, Mr. Chairman, we recommend that Medicare's managed care program be expanded now. The cost reimbursement rather than risk contracts may expand access to managed care in some geographic areas.

Speeding up HCFA approval of managed care contracts would also help. This process could be streamlined particularly for managed care plans which have already been approved as risk contractors and are seeking merely to expand or enter new geographic markets.

Beneficiary satisfaction levels within current Medicare managed care plans are high. Medicare managed care choices offer lower costs, expanded benefits, less paperwork, coordination of care, and case management.

Obviously for today's elderly population, a network-based delivery system is largely foreign to them. They should not be forced to participate but rather be given incentives. Many private sector plans offer managed care to their current employees.

HIAA would suggest the development of a mechanism to permit a retired employee to remain in the employer's managed care plan and have that become a Medicare option. For those retirees who choose to remain in the employer's plan, the ability to assure seamless continuation of their coverage would greatly enhance beneficiary satisfaction.

The Medicare Select program is one example of a managed care initiative that is working now to give seniors the option of saving money by moving into a PPO setting. HIAA strongly supports the expansion of this program to seniors in all 50 States and making the program permanent.

In closing, Mr. Chairman, we stand ready to work with the Congress on Medicare restructuring options and health care reform in general. Of course, we will need to see the details of various proposals before we will be able to comment on the specifics. It is healthy that discussion is taking place about a new paradigm for managed care plans.

Well-managed network-based care is a partnership of providers, payers and beneficiaries. All of these parties should participate in discussions regarding the restructuring of this important government program.

Thank you for this opportunity to be present today.

[The prepared statement follows:]

TESTIMONY OF HON. BILL GRADISON
HEALTH INSURANCE ASSOCIATION OF AMERICA

I am Bill Gradison, President of the Health Insurance Association of America (HIAA). The HIAA represents 230 of the nation's commercial health insurers, covering 55 million Americans. I am delighted to have the opportunity to participate in this important hearing on the future of managed care in the Medicare program.

HIAA member companies are involved in all aspects of Medicare: as carriers and intermediaries for the fee-for-service segment of the program; as providers of the supplemental insurance that beneficiaries purchase to augment their Medicare fee-for-service benefits; and as providers of the Medicare HMO, CMP and Medicare- Select managed care options that are available to beneficiaries in many parts of the country.

Among the HIAA member companies involved in Medicare managed care are Bankers Life and Casualty, FHP, Healthsource, Humana, Intergroup, New York Life, Principal Health Care, Sierra Health and Life and Wellpoint. Outside of Medicare, our member companies have enrolled over 25 million of the 100 million Americans estimated to be in managed care plans. Their record in Medicare is similar. They have enrolled nearly 700,000 of the 3 million seniors covered by plans under contract with Medicare.

Looking into the future, Medicare managed care plans will enjoy large gains in enrollment as the current working population covered by managed care will choose to continue to have managed care when they retire. But, unless the overall structure of Medicare is radically altered, there will always be a substantial Medicare fee-for-service population that will want to purchase traditional Medicare supplemental insurance to augment their Medicare benefits.

Over the past decade, Medicare's managed care options have become an increasingly important part of the program - and deservedly so. They offer seniors the benefit of coordinated health care, as well as coverages, such as prescription drug coverage, not provided by Medicare, at a very competitive cost. Yet, the growth of the Medicare managed care has been considerably slower than the rapid expansion of managed care enrollment in the under age 65 population.

Currently, Medicare managed care contractors cover just over 3 million beneficiaries. Compared to the rapid expansion of managed care in the private sector, particularly, among employee group health benefit plans, Medicare managed care, despite recent favorable enrollment trends, has not kept pace. We believe that there are several reasons for this. They have to do with basic differences between Medicare and the employee health benefits market, incentives for managed care plans, the lack of an adequate spectrum of Medicare managed care options for beneficiaries or adequate efforts to inform them about the existing ones, current Medicare beneficiaries' lack of familiarity with network-based delivery systems and, finally, a tendency by government to sometimes overregulate rather than rely on the marketplace to produce desired results.

Risk Contracting

The Health Care Financing Administration (HCFA) is seeking to expand the role of Medicare managed care to help contain its burgeoning program costs. For a variety of reasons, HCFA has come to prefer contracting with managed care plans on a risk rather than cost reimbursement basis. Yet, after ten years of risk contracting with HMOs and Competitive Medical Plans (CMPs), there is still a lively debate over whether the premium that Medicare pays to risk plans is adequate compensation for the risk to be assumed, or is too generous.

Medicare pays risk HMOs and CMPs a premium calculated at 95% of the average annual per capita cost (AAPCC) for Medicare beneficiaries in a plan's operating area. HCFA seems to believe that HMOs and CMPs tend to enroll younger, healthier Medicare beneficiaries. It is argued that this positive selection makes a premium based on 95% of the cost for an average (older and sicker) beneficiary too high, despite the fact that the managed care plans provide a richer array of benefits than is covered by the fee-for-service segment of Medicare.

On the other hand, those who believe that risk premiums under the current formula are inadequate argue that many new enrollees in Medicare managed care plans join because they have been unable to afford Medicare's cost sharing requirements or supplemental insurance. They enroll in a Medicare risk HMO or CMP because the cost sharing requirements are minimal, and, once enrolled, their previously unmet health care needs far exceed the care utilized by an average Medicare beneficiary. Low income beneficiaries, they say, are four times more likely than average beneficiaries to enroll in a Medicare HMO or CMP. This phenomenon may be a major reason why, over the past decade, a substantial number of risk plans have dropped out of the program or have converted to cost-reimbursement contracts.

Many health policy experts believe that if managed care can capture a substantial portion of the health care market in a given area, its ability to provide more benefits for a lower premium will exert a competitive cost containment effect on the entire health care market place. Medicare risk contractors complain, however, that where they have achieved a sizable share of the Medicare beneficiary market - thus driving down the average cost per Medicare beneficiary - the 95% AAPCC formula "rewards" them by diminishing the premium paid by the government to 95% of the lower average.

It may also be appropriate for the government to temporarily ease some of the regulatory requirements for managed care contractors, in the interest of opening new managed care markets. We believe that this can be done, carefully and selectively, without sacrificing the critical elements of consumer protection and quality assurance. However, all plans, in all markets, should have to be certified under the federal HMO law, or state-licensed - in order to assure appropriate oversight of their solvency, fiduciary responsibilities and the quality of care they provide their customers.

Other Obstacles

Our member companies report that it takes up to a year and a half to meet all of HCFA's information requirements and receive approval of a managed care contract proposal. They believe that this process could be streamlined and reduced to less than a year.

HCFA could be authorized to waive some aspects of the application process that are redundant for those managed care plans who have already been approved as risk contractors and are seeking to expand or enter into new geographic markets.

Congress and the Administration might also consider reducing the redundancies that exist with respect to the oversight of quality of care. Managed care plans are reviewed by state regulators and may also be reviewed by private accrediting organizations. It would be useful if appropriate private managed care accreditation could be accepted by Medicare.

Anti-managed care laws, such as any-willing-provider statutes, whether state or federal, can only undercut Medicare's interest in promoting managed care among its beneficiaries. Requiring a network to contract with all providers in its area increases the cost of delivering care and network sponsors are concerned that it may negatively impact quality. Federally qualified HMOs are exempt from the statutory obstacles that have been erected in a few states. Competitive Medical Plans (CMPs), Medicare-Select, and yet-to-be developed additional managed care options for Medicare beneficiaries, should have the same status as federally qualified HMOs.

The Medicare/Medicaid anti-kickback laws frustrate the offering to Medicare beneficiaries of many innovative managed care arrangements that are common in the private sector. Only fee-for-service discounts enjoy a safe harbor under the existing law.
While the federal concern about kickbacks is a legitimate one, there needs to be greater accommodation of worthwhile managed care practices that are effective and serve the interests of consumers.

Beneficiary Satisfaction

Medicare beneficiaries can drop out of managed care plans almost at will. This makes beneficiary satisfaction a critical ingredient that must be addressed by any strategy for expanding the Medicare managed care population.

While beneficiaries drop out of Medicare HMOs and CMPs at much higher rates than they do in private sector managed care plans, the GAO advises that two thirds of those who leave a Medicare HMO or CMP do so to join another one with more attractive benefits.

A more substantial problem than disenrollment is the reluctance of many of today's beneficiaries to enroll at all in managed care options. Managed care networks are foreign territory to them. Even the availability of extra benefits such as coverage for prescription drugs and elimination of the need to pay premiums for Medicare supplemental insurance are insufficient incentives for most of them give up long-term relationships with their physicians.

Except for emergency or out-of-area care, Medicare HMO and CMPs require beneficiaries to get their care within the contractors' delivery systems. In order to broaden the appeal of managed care, Medicare needs to create additional options, emulating private managed care plans that provide consumers managed care coverage while allowing them to sometimes use out-of-network providers if they are willing to accept a reduced level of benefits, such as higher copayments, when they do so.

In 1990, Congress took a major step toward broadening the spectrum of Medicare's managed care options by authorizing a 15 state demonstration of a preferred provider organization (PPO) type of Medicare supplemental coverage called Medicare-Select. This option does allow beneficiaries to use out-of-network providers at the cost of receiving reduced coverage for their services. While the demonstration got off to a slow start, it is now growing rapidly and promises to be attractive to beneficiaries. As discussed below, we urge Congress to move quickly to make Medicare-Select a permanent, national Medicare option.

Another option that would dramatically increase Medicare beneficiary satisfaction with managed care could be based on managed care employee health benefit plans. Many of these plans offer their enrollees greater freedom-of-choice than the current Medicare HMO and CMP options. What needs to be developed is an option that would permit a retired employee to remain in the employer's managed care plan, with Medicare becoming a partner in financing the benefits. The retiree could still choose to enroll in the fee-for-service segment of Medicare, or choose another available Medicare managed care option. For those retirees who chose to remain in the employer's plan, the ability to assure "seamless" continuation of their coverage would greatly enhance beneficiary satisfaction. There have been a couple of successful demonstrations of this concept. What is needed now is a focused effort aimed at making it available nationwide.

Medicare-Select

The Medicare-Select program is one managed care initiative that is working now to give seniors the option of saving money on their Medicare supplemental insurance policies by joining a preferred provider network.

Medicare-Select expands choice for consumers by making Medicare supplemental insurance coverage more affordable, without sacrificing important consumer protections. The program was designed to bring seniors' choices up to date with PPO products widely available to the under 65 population.

In those 15 Medicare-Select states, over 400,000 seniors are paying 10% to 37% less in premium dollars for the exact same
benefits offered by traditional fee-for-service Medicare Supplemental policies. This translates into savings of as much as $25 per month or $300 per year for individuals living on fixed incomes, making over $120 million dollars worth of purchasing power available for other uses by those seniors who are now participating in the program.

For the consumer, Medicare-Select offers more flexibility than the Medicare HMO program. Under the Medicare HMO option, if a individual selects a doctor or hospital outside the network,no Medicare benefits are paid. Under the Medicare-Select program, if services or care is provided outside the network, the beneficiary is still entitled to receive the full normal Medicare reimbursement, and a reduced supplemental benefit is paid. If care is provided by the network's hospitals or physicians, the full Medicare-Select benefit is paid.

The Medicare-Select program is one example of a flexible benefit package that offers seniors another way to protect themselves from health care costs. In addition to monthly premium savings, there are out-of-pocket savings for seniors as well. By seeking care from Medicare-Select networks, subscribers are protected from balance billing.

And, like all Medicare supplemental insurance policies, Medicare-Select products are among the most tightly regulated products today. Current rules safeguard consumers by requiring networks to offer sufficient access, ongoing quality assurance programs, and full disclosure of network requirements. In addition, Medicare-Select plans that offer a fee-for-service product must allow consumers to convert to that product at any time.

Consumer satisfaction is probably the best recommendation for expanding Medicare-Select to all 50 states and making this demonstration program permanent. The August 1994 edition of Consumer Reports, rated the top Medicare supplemental insurance products nationwide, and of the top 15 rated products, 8 were Medicare-Select. In fact, the Research Triangle Institute's interim study of February 10, 1994, indicates that there were no consumer complaints in any of the Medicare-Select states.

HIAA encourages the Congress to act quickly to extend Medicare-Select. Without Congressional authorization, the Medicare-Select program will be expire on June 30, 1995. Unless Congress acts by April 1, over 400,000 beneficiaries will be notified that their supplemental insurance network will no longer be able to take on new members. This will only create confusion and uncertainty. Seniors in Medicare-Select states will not have the choice of using a preferred provider option for their Medicare supplemental insurance benefits. That would be an unsatisfactory answer for the public and for seniors who have challenged us to make government not only smaller, and more efficient, but also more responsive to their needs.

Medicare-Select is one important example of a managed care element that is working now to help protect seniors from the high cost of medical-expenses, without shifting costs to the federal government, and without sacrificing quality medical services.

In closing, the HIAA stands ready to work with the Congress on restructuring Medicare managed care options and on health reform in general. As the details of various proposals become known, we will be glad to provide you with more informed comment upon them. Thank you for the opportunity to participate today.

Chairman THOMAS. Thank you very much, Bill.

Ms. Ignagni.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Ms. IGNAGNI. Thank you Mr. Chairman, Mrs. Johnson.

I am president of the Group Health Association of America. Our 375 members serve 80 percent of the 50 million Americans receiving health care from HMOs today. We thank you for allowing us to testify and would like to review three issues with the committee.

First is the success of the current Medicare HMO program. Second, a long-term vision for bringing the Medicare program up to date for beneficiaries. Third, mechanisms to move toward the vision beginning with the short-term changes.

I might say in commencing, as changes are made in Medicare, we do support reaffirmation of the fundamental goal of the program: To afford older Americans the security of access to a core set of benefits. The Medicare HMO contracting program is success by the most important measure we can identify, the satisfaction of beneficiaries who have chosen this approach.

During the past year, numerous groups have conducted patient satisfaction surveys, all of which show that HMO subscribers are more satisfied with their health plan regardless of health status than fee-for-service subscribers.

There are many reasons for beneficiaries to be satisfied with their Medicare HMO. The track record of the plans is impressive.

Second, there is tremendous coordination of care. Quite a lot of discussion was had on that point earlier, and I don't want to repeat much of it, but to rephrase an essential point, which is that within an HMO there is coordination of care among teams of physicians and other health care practitioners utilizing the spectrum of available services.

Third, there is less paperwork filled out and fewer, more predictable, out-of-pocket cost, which is a significant issue that I think has not yet been fully discussed this morning.

Despite these advantages, Medicare lags significantly behind the private sector in making available options. The question meriting attention by the committee is why. The answer may point the committee to short-term and long-term solutions.

First, the long term. It is crucial that this committee begin its work by developing consensus on its vision for the future. From there an implementation plan can be developed to achieve these goals. With all due respect, we think it is very difficult to work the other way around. We believe that it is crucial that Medicare beneficiaries have the same choices as those under 65.

Second, beneficiaries should have a choice of health plans that meet comparable standards for quality access and solvency. The range of choices should include fee-for-service as well as HMO and other managed care options.

Third, we have been examining efforts to contribute to the body of evidence in discussions with respect to payment methodology and we are now in the process of examining a variety of market-based pricing structures and we hope to have more specific rec-

ommendations on those and other reimbursement issues in the future. In the very near term future, I might add.

Next, the Medicare payments to health plans we believe should be risk adjusted using more sophisticated methods. There was a comment earlier about moving in the current system to metropolitan statistical areas. We think some of the thinking that is going on there needs to be focused in terms of market-based pricing structures.

In our view, every market beneficiary should receive comparative information on the choices available to them. An open enrollment period should be available in each geographic area. However, we want to join those who have raised issues concerning a single 1-month or less open enrollment period for all beneficiaries. We think those would be very difficult to administer and not necessarily in the best interests of beneficiaries. We also join with those who have raised concerns about lock-ins.

Mr. Chairman, we are mindful of the budgetary imperatives facing the economy and the need for all of us to ask if it will increase the rate of spending. The overwhelming evidence we believe suggests that it will. And I would be delighted to answer questions about some of the studies that have been discussed earlier today.

Now is the time to begin, in our view, moving forward in order to bring the Medicare program up to date. And there has been quite a lot of discussion on that.

We do think that there are some short-term issues, Mrs. Johnson, to your question, that might be looked at as a way of moving from where we are to this longer term vision. First, in our view, that involves encouraging choices for Medicare beneficiaries. Many, many individuals report to us they are simply not aware of the many options that currently exist, and I think we probably need to do a better job in that regard.

We join with those who support moving forward on the Medicare Select program, and believe we should move to the longer term vision after that.

Second, developing the statutory criteria to guide the Secretary in providing waivers of the 50-50 enrollment requirement is something that should be examined. Directly calculate fee-for-service costs in computing the AAPCC rather than estimating costs and then netting out estimated HMO payments that you are estimating twice.

There are a number of other issues that have been talked about in our testimony. Again, I would be delighted to comment on that.

I think as members of this committee and others throughout the Congress look at the Medicare issues, the thing that we can contribute, we believe, most importantly is our experience. We would be delighted to work with you, your staff, by providing the track record of what is out there, by commenting on the existing studies that have been done, and bringing to bear the experience of the 375 plans that we represent that have a track record, have a vision, and want to work together with you to refashion the program in the interests of beneficiaries.

Thank you.

[The prepared statement follows:]

TESTIMONY OF KAREN IGNAGNI
GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Introduction

Mr. Chairman and members of the Committee, I am Karen Ignagni, President of the Group Health Association of America (GHAA). GHAA is the leading national association for health maintenance organizations (HMOs). Our 375 member HMOs serve 80 percent of the 50 million Americans receiving health care from HMOs today.

GHAA and its member plans come to the committee not as theorists or academics, but as the nation's largest body of practical, market-based expertise in making HMO options available to beneficiaries and in operating successful plans. We are pleased that the committee is looking at the success of Medicare risk contracting and opportunities for expanding HMO and other managed care choices available to Medicare beneficiaries. We thank you for allowing us to testify this morning, and would like to review four issues with the Committee:

- The success of the current program in which Medicare beneficiaries are offered an HMO/CMP[1] choice;
- Medicare's problems as it lags behind the rest of the health care market in its use of HMO and other managed care arrangements;
- A long-term vision for bringing the Medicare program up-to-date for beneficiaries; and
- Mechanisms to begin to move toward that vision, requiring phased transitions, and starting with some short-term changes in the existing program.

As changes are made in the Medicare program, we support reaffirmation of the fundamental goal of the program -- to afford older Americans the security of access to a core set of health benefits. The program should be strengthened to guarantee the continued fulfillment of the nation's commitment to its older citizens.

Success in offering beneficiary choice under the Medicare risk contracting program

As of this January, 3.1 million Medicare beneficiaries had chosen to be served through one of the HMO contracting options offered by the Medicare program. Since 1990, the enrollment in Medicare risk plans has doubled while combined enrollment in all HMO options has grown by 70 percent. Further, there are 209 plans participating in the Medicare program, representing an increase of 48 percent over the number of plans participating 5 years ago (risk contracting plans alone have increased by 60 percent).

The Medicare HMO contracting program is a success by the most important measure we can identify -- the satisfaction of the beneficiaries who have chosen this approach.
During the past year, numerous groups have conducted patient satisfaction surveys, all of which show that HMO subscribers are more satisfied overall with their health plan than fee-for-service subscribers. This is true for the elderly as well as Americans under the age of 65. Figure 1 is

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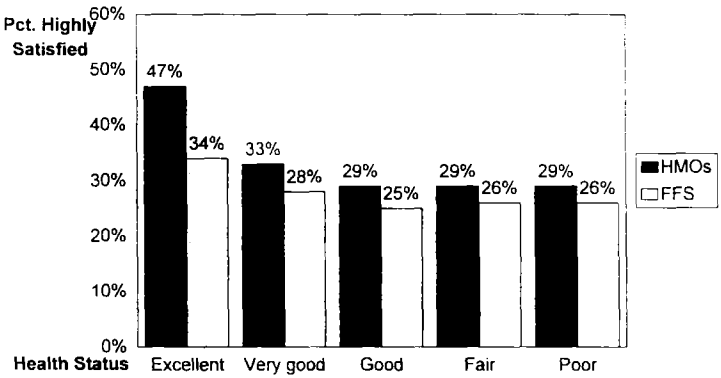
[1] Competitive medical plans (CMPs) are HMOs that have not chosen to become federally qualified but meet similar federal standards. For the remainder of the testimony, we use the term "HMO" to refer to both HMOs and CMPs.

based on a national survey of over 19,000 elderly Americans conducted by the National Research Corporation based in Lincoln, Nebraska. The graphic shows that for all levels of self-designated health status, the elderly enrolled in HMOs are more satisfied with their coverage than the elderly receiving services under the traditional Medicare fee-for-service program. This graphic emphasizes that HMOs achieve higher subscriber satisfaction not just among the healthy, but also among the sick. This is one reason that HMO enrollment continues to grow -- among the young and healthy, and among the older and less healthy populations.

There are many reasons for beneficiaries to be satisfied with their Medicare HMO. First, beneficiaries fill out much less paperwork. Under the fee-for-service Medicare program, beneficiaries file claims paperwork every time they receive services. In Medicare risk HMOs, the paperwork required of beneficiaries is little more than the application to join the plan.

Figure 1

Medicare HMO Members Are More Satisfied with Their Coverage than Medicare Fee-for-Service Beneficiaries, for All Levels of Health Status.



National Research Corporation Survey of 19,523 Elderly Households, 1994

Another benefit to seniors is coordination of care and a comprehensive care orientation. HMOs make preventive services not covered by the fee-for-service Medicare program broadly available to the beneficiaries who select them. The beneficiary's primary physician not only keeps track of all medications and tests that the beneficiary receives within an HMO, but the physician helps the beneficiary coordinate health care from specialists and hospitals. HMOs treat beneficiaries on a continuing basis, as whole persons rather than series of ailments.

In Medicare HMOs, beneficiaries have fewer and more predictable out-of-pocket costs and fewer worries about coordination of out-of-pocket and government payments. Medicare coinsurance and deductibles are translated into a monthly premium so that rather than paying 20 percent of the cost of services after the deductible is met, a beneficiary in an HMO usually pays a nominal copayment (usually $5 or $10) for doctors' services.

Finally, in addition to these benefits, Medicare HMOs offer high quality health care. A recent study by the Health Care Financing Administration showed that elderly HMO members with cancer are more likely to be diagnosed at an early stage than those in the fee-for-service

sector.[2] This is due to coverage and improved access to preventive care under comprehensive HMO coverage which was also highlighted in a study by the Center for Disease Control and Prevention (CDC) and the National Center for Health Statistics.[3] The CDC study showed that women in HMOs are more likely to obtain mammograms, pap smears and clinical breast exams than those in the fee-for-service sector. Another study which supported the HMO approach to care compared the process and outcome of care for hospitalized HMO and fee-for-service patients age 65 and older with acute myocardial infarction (heart attack). This study, published in the American Journal of Public Health, concluded that HMO patients received better care than that received by patients in a national fee-for-service sample.[4] These are just a few of numerous studies showing that Medicare HMOs provide care of an equal or higher quality than that provided by the fee-for-service sector.[5]

Medicare lags behind the rest of the Market

While HMOs and other managed care plans have proven successful in private markets, and in meeting the needs of 3.1 million Medicare beneficiaries, Medicare lags significantly behind the private sector in making available managed care options. Twenty-two percent of individuals with health insurance in the employer-based market were enrolled in HMOs in 1993, and an additional 29 percent are enrolled in a preferred provider organization or point-of-service plan.[6] Under Medicare, approximately 9 percent of beneficiaries are enrolled in HMOs.

While some degree of caution is always appropriate in implementing changes in a program like Medicare, the gap between Medicare and the private market is now far too wide. Medicare was originally designed to provide the elderly, and later the disabled, with health coverage and access to services comparable to that of the rest of the population. But the private health care market has changed dramatically -- most notably in the increased use of HMOs and other types of managed care. Medicare has not similarly changed.

The question meriting attention by the Committee is why? I would suggest two sets of answers -- one short-term, one long-term.

The short-term answer is that the current Medicare risk contracting system, despite its success in some markets, has several problems.

First, the payment methodology, known as the adjusted average per capita cost (AAPCC), is flawed. 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. Problems with the payment methodology have also inhibited expansion of risk contracts in some geographic areas. In addition, the payment rates are unstable from year to year, which makes planning difficult for HMOs. Further, risk adjustment factors must be improved.

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[2] G. Riley, A. Potosky, et al., "Stage of Cancer at Diagnosis for Medicare HMO and Fee-For-Service Enrollees," 84 *Am. J. Public Health* 1598 (October 1994).

[3] *CDC/NCHS Advance Data No. 254*, August 3, 1994.

[4] D. Carlisle, A. Sui et al., "HMO vs Fee-For-Service Care of Older Persons with Acute Myocardial Infarction," 82 *Am. J. Public Health* 1626 (December 1992).

[5] *See* D. Clement, S. Retchin, R. Brown, and M. Stegall, "Access and Outcomes of Elderly Patients Enrolled in Managed Care," 271 *J. Am. Med. Assoc.* 1487 (May 18, 1994); S. Retchin, D. Clement, et al., "How the Elderly Fare in HMOs: Outcomes from the Medicare Competition Demonstrations," 27 *Health Services Res.* 651 (December 1992); J. Preston and S. Retchin, "The Management of Geriatric Hypertension In HMOs," 39 *J. Am. Geriatrics Soc.* 683 (July 1991); N. Lurie, J. Christianson, et al., "The Effects of Capitation on Health and Functional Status of the Medicaid Elderly," 120 *Annals Internal Med.* 506 (March 15, 1994).

[6] KPMG Peat Marwick/Wayne State University Survey of 1,953 Firms, 1993.

Second, some HMOs that are well established in the Medicare program are unable to expand their enrollment despite interest from Medicare beneficiaries because no waiver authority exists from the requirement that no more than 50 percent of a plan's membership can be comprised of Medicare and Medicaid beneficiaries.

In addition, not all Medicare enrollees know about their HMO option. Upon becoming eligible for Medicare, enrollees learn only about fee-for-service Medicare and do not receive information about available HMO options.

Longer term vision

The longer-term answer is that Medicare's overall program design must begin to keep pace with the evolution -- and revolution -- taking place in health care. Let me lay out for you GHAA's longer-term vision for bringing the Medicare program up to date.

Medicare must keep its vitally important promise of health care benefits for the elderly and disabled -- objectives that reflect the key interests of beneficiaries, the government and taxpayers, and health plans.

Beneficiaries should be able to choose the form of Medicare coverage that best meets their needs, including both fee-for-service and HMO and other managed care options. Beneficiaries should have incentives to choose high quality plans that provide Medicare services in a cost-effective manner; and current and future beneficiaries should have the security of a Medicare program that is financially viable and sustainable for the long-term.

Government interests include predictable and fiscally responsible spending; assurances that the payment structure provides health plans and beneficiaries with appropriate incentives for high quality, cost-effective health care; and a program that encourages continuing improvement and innovation in health care and keeps Medicare up-to-date with the evolving health care system.

Health plan interests include a program with realistic incentives and opportunities to meet the needs of the Medicare population; predictable policy; and incentives to organize and deliver high quality care in a manner that minimizes Medicare and beneficiary costs -- health plans should have the opportunity to attract and retain enrollment by keeping quality and service levels high and premiums competitive.

We believe that we must aim toward a system like that prevailing for some of the nation's other large purchasers of health care -- notably, the large employer purchasers. Individuals should have a choice of a wide range of qualified health plans under Medicare. Medicare, as sponsor, should set its premium contribution for Medicare benefits, set reasonable standards and monitor qualified health plans, and then let individuals choose among competing health plans -- including fee-for-service (FFS) coverage. We have identified four initial policy areas that must be addressed, and would like to present our preliminary thoughts in these areas -- standards for health plans; payments to health plans; benefits; and enrollment and marketing mechanisms.

Health plans: Beneficiaries should have a choice of health plans that meet comparable standards for quality, access, and solvency. The range of choices should include fee-for-service, as well as HMO and other managed care options.

Payments: Medicare payments to health plans should eventually be "market-based". Under such a system, qualified competing health plans should establish their premiums for Medicare benefits; and the government should set a contribution level in each market based on some percentile of a weighted average of those premiums. If the premium of the health plan selected by a beneficiary is greater than the government contribution, the beneficiary would pay the remainder. As with the current risk contracting program, Medicare payments to health plans should be risk adjusted. Therefore, it will be important to implement risk adjusters that are more sophisticated than those presently in use.

Benefits: All health plans seeking to participate would have to provide at least the Medicare benefit package defined in statute. Rules must be established for offering benefits beyond the Medicare package, either as part of a plan's basic offering or in the form of supplemental benefits.

Enrollment/Marketing: The enrollment and marketing mechanisms must ensure that beneficiaries can make informed choices. In every market beneficiaries should receive information on all the choices available to them in a form that allows them to make comparisons between different types of plans and among different benefit offerings.

Open enrollment periods must be available in each geographic area during which beneficiaries can enroll without underwriting restrictions. However, a single, massive, one month open enrollment period for all beneficiaries would create logistical, administrative and service delivery nightmares. Given the huge size of the Medicare program, significant enrollment changes in such a 30 day period would pose serious problems for HMOs and other organized plans that must be prepared to deliver care to all those who enroll and therefore, would place service to beneficiaries at risk. In order to increase the availability of HMOs and other managed care options, open enrollment rules must be established in a way that allows them to optimally accommodate enrollment changes.

Mr. Chairman, we are mindful of the budgetary imperatives facing the committee -- and the need for all of us to ask whether such changes will reduce the rate of increase in Medicare spending. We believe they will.

The strategy for controlling future Medicare outlays is not to seek just a one-time savings but to reduce the annual rate of increase. For the past three years, HMO premiums have increased more slowly than per capita costs for the Medicare program. For example, a GHAA survey reports that HMO premiums will decline 1.3 percent in 1995, whereas the Congressional Budget Office projects Medicare to increase about 10 percent a year until the end of the century.

Moreover, recent studies find that rather than shifting costs, the increased presence of HMOs leads to lower rates of increase in the fee-for-service sector. A soon to be published Georgetown University study reports that hospital costs for large hospitals located in high penetration HMO metropolitan areas increased 71 percent between 1984 and 1991 compared to 98 percent increases in metropolitan areas with low HMO penetrations.[7] A 1994 Urban Institute study concludes that for each 10 percent increase in the Medicare risk population's share of the Medicare market, per capita expenses in the Medicare fee-for service sector decline by 1.2 percent.[8] (Figure 2).

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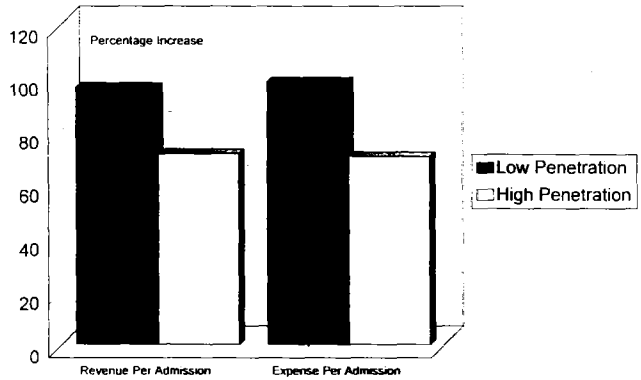
[7] J. Hadley and D. Gaskin, "HMO Penetration and Academic Health Centers: Hospital's Mission," 1984-1991, Forthcoming in *The Proceedings of the Assoc. Of Academic Health Centers*, 1995.

[8] W.P. Welch, "HMO Market Share and its Effect on Local Medicare Costs," in H.S. Luft, *HMOs and the Elderly*, Health Administration Press, Ann Arbor, Michigan, 1994, pp 231-250.

Figure 2
Hospital Expenses Rise More Slowly in Metropolitan Areas With High HMO Market Penetrations, 1984-1991.



Source: J. Hadley, Georgetown University

HMOs, moreover, achieve these savings under a system that subsidizes inefficiency. Beneficiaries and employees can choose more expensive plans and pay no more out of pocket for premiums. With a reorganized system of incentives whereby all stakeholders --- patients, providers, and health plans -- receive financial rewards for making efficient decisions, then the marketplace can produce unparalleled long-term savings.

The market-based system and payment methodology described above will be a critical element in achieving a lower the rate of increase in Medicare spending as health plans compete to serve this population. Such a structure of competing managed care and other plans will provide the framework and incentives for all of us to make such a system work for the Medicare program -- as it already does for many privately insured individuals.

One key question underlying all of this is the matter of risk selection. As I said earlier, we strongly support the development and implementation of risk adjusters appropriate to the Medicare population. But we take issue with a recent study that has biased the debate on this subject.

The HMO community believes that the Mathematica study came to an erroneous conclusion that the Medicare risk contracting program increases Medicare expenditures. First, the study did not make some of the adjustments necessary to ensure that fee-for-service costs are accurately compared to costs for beneficiaries in HMOs. It made no adjustments to the AAPCC for the working aged or individuals who receive their care from the Veterans Administration System. Since Medicare expenditures for the working aged and users of the VA system are substantially lower than expenditures for other beneficiaries and these individuals remain largely in the fee-for-service sector, the AAPCC estimates used in the study for annual reimbursements of fee-for-service enrollees are too low.

Second, Mathematica made no allowances for the spillover effect of HMO competition. W.P. Welch of the Urban Institute has estimated that for metropolitan areas with more than 25 percent of the population enrolled in the Medicare risk program, fee-for-service costs decline by 10 percent. Even Mathematica's econometric work found a spillover effect; however, the authors discounted this as implausible. We believe that as HMOs increase their market share and markets become more developed, the competitive effect of the fee-for-service sector will grow

further.

Finally, as the HMO population has grown in the past few years, we believe that the characteristics of the HMO population become increasingly similar to those of the fee-for-service population. We observe recent surveys of the Medicare population that compare HMO and fee-for-service enrollees and find that the populations appear very similar. This was not the case a few years ago. We are involved in a number of studies testing the Mathematica conclusions.

Transition to the new system

Medicare is a vitally important program for 36 million aged and disabled Americans. In moving toward our vision for the future of this program, we ask that the Congress proceed in a planned, staged manner, and monitor and make changes as we go along. The "big bang" theory of implementation simply will not work, and will do a great disservice to the program.

However we must move forward in order to bring the Medicare program up to date so that it continues to fulfill its promise. As the program stands today, it will fall farther and farther behind the evolving health care system, placing it at increasing political and financial risk. We will be pleased to work with the Committee and staff on both the long-term approaches and mechanisms to transition to such policies over a period of years.

Short-term changes

In addition to developing the long-term vision and transition mechanisms, it is important in the short-term to make changes in the current program that will help expand choices for Medicare beneficiaries.

One such mechanism is the Medicare SELECT program -- a demonstration program under which Medigap plans can use selected, preferred provider networks to meet the needs of enrollees. This 15 state demonstration program was extended at the end of the last Congress, but just until the end of June, 1995 -- less than five months away. It currently serves about 400,000 beneficiaries, and we urge the Committee to take rapid action on Representative Johnson's bill (H.R. 483) to expand this option permanently to beneficiaries in all fifty states.

Second, we believe it important to make changes now in the existing Medicare contracting program. We strongly oppose short-term budgetary price setting "fixes" such as a floor or ceiling on payment rates -- payments to HMOs will fall automatically as part of any budgetary reductions in provider payments or increases in cost sharing. GHAA has developed the following consensus recommendations regarding short-term changes in the contracting program.

- Develop statutory criteria to guide the Secretary in providing waivers of the 50/50 enrollment requirement for health plans after they have established a history of success in the Medicare program.

- Change the rating areas for setting Medicare's adjusted average per capita cost (AAPCC) to MSAs, to make rates more stable and more reflective of service area-wide costs.

- Directly calculate Medicare fee-for-service costs in computing the AAPCC, rather than estimating total costs and netting out estimated HMO payments.

- Begin to structure demonstration projects to lay a foundation for the market-based restructuring of Medicare, such as by demonstrating market-based premium setting and government payment methodologies.

- Work on strategies for implementation of risk adjusters.

Mr. Chairman, as Congress and policymakers continue to consider restructuring the

Medicare program to expand HMO and other managed care participation and choices, we strongly urge that the first priority be serving beneficiary interests and needs. Efforts to make the program more cost effective must be carried out within this framework. HMOs can be a critical element in developing an effective strategy to provide quality care to beneficiaries while at the same time decreasing the rate of Medicare cost escalation. However, they cannot bear the entire burden of solving the Medicare cost problem. Short-term, unrealistic efforts to generate savings through HMOs will be particularly damaging to the longer term effort, because they will harm the infrastructure needed to increase capacity to serve larger numbers of beneficiaries. Similarly damaging will be imposition of anti-managed care requirements, such as any willing provider provisions.

We are continuing to work out details of our long-term vision, as well as transition proposals, and look forward to contributing to the effort to redesign the Medicare program. We believe that an expanded role for HMOs and other managed care organizations holds great promise for beneficiaries, the government and health plans. We would be pleased to work with you, and all of the members and staff of the Committee, as you consider the future of the Medicare program. Thank you.

Chairman THOMAS. Thank you very much.

Mr. Wiggins.

STATEMENT OF STEPHEN F. WIGGINS, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, OXFORD HEALTH PLANS, INC., ON BEHALF OF THE HEALTHCARE LEADERSHIP COUNCIL

Mr. WIGGINS. Thank you, Mr. Chairman.

I am here today on behalf of the Healthcare Leadership Council, which is a group of companies in the health care industry. We represent virtually all parts of the health care industry. It is mostly represented by the leadership of those companies, from the pharmaceutical, the provider side, physicians, HMOs.

I would like to today go off the reservation a little bit here from my prepared remarks and instead address a few things that came up earlier. For starters, I would like to introduce myself. My company, which I started 10 years ago, is the fastest growing public HMO in the country. We are also one of the two fastest growing Medicare risk contractors. We enroll 3,000 to 4,000 Medicare enrollees each month out of a total of about 15,000 to 20,000 enrolling each month in our plans. We have 580,000 people that we cover. We are in Connecticut. We are in New York. We are in New Jersey. We are moving into Pennsylvania.

I would like to say one thing as emphatically as possible. That is, that seniors love these programs. It is clear to me that once they are in, they stay in. Ninety-seven percent, 96.4 percent, of our enrollees stay in the program. Over 98 percent would recommend the program to a friend. And I think that is clear evidence that people want to be in these programs.

Chairman THOMAS. Do you have any statistics? If you have them there, how many were in programs similar to that during their working life?

Mr. WIGGINS. Very few, because metro New York is unusual in that there wasn't much managed care penetration.

Chairman THOMAS. So you are laboring in a field that was not very fertile prior to your coming into it.

Mr. WIGGINS. We are the first-time plowers of those fields. It is no surprise they are joining because the benefits are tremendous.

In our program, there is no premium. We eliminate the deductible. You get full comprehensive benefits. There is preventive care, which you don't have in Medicare. There is no coinsurance, generally speaking. We also cover things like eyeglass reimbursement. There is some prescription drug coverage. So if you are a senior, it is a panacea. And the biggest problem our marketing people have is convincing enrollees that this is for real.

I think I would like to also dispel the myth that we can selectively choose who joins. Anybody can join. We have meetings at diners. Anybody that comes to the diner can get in. The seniors are a pretty communicative group. They talk among each other. They are a very discerning population. They ask one another what health plan they should join. And you generally don't just talk to your healthy friends. You talk to your sick friends too. And we get a fair range of customers.

Once those customers are in my health plan, I expect to have them for life. I presume that they will be in my health plan until

they die. With a 96.4-percent retention rate, I would otherwise have Medicare enrollees for 20-some years, however, their life expectancy is often under 5.

Moving to potential improvements in the Medicare program, obviously, who could argue with promoting choice. I think a big improvement in the system would be to look at Medicare and regulate it more like the SEC style regulations of public companies; have file and use statutes. Right now they try to micromanage virtually everything.

A second thing I would say is this idea of a certificate brought up by Mr. Roper. I believe once health plan managers understand this idea, it would be welcomed by the HMO community.

Additionally, I would like—I wish Mr. McDermott were here because his mother, if she lived in New York, could join my health plan without any questions asked. There are laws in New York that require me to take any individual regardless of their health status or age. If you live in New York right now, you can join Oxford irrespective of your health status or any other factor, whether you are old or young, sick or healthy.

A couple of other issues I would like to touch on: First, risk adjusters and this idea of adverse selection. A few years ago in the commercial market everyone thought what was happening in the commercial market was that the HMOs were taking all the young, healthy people. Well, interestingly, nobody anymore talks about the young, healthy people going into the HMOs, because now that in the commercial market so many people are in HMOs, the law of large numbers has taken over.

We have an average spread of risks. In fact, a program like mine with 17,900 physicians, all board certified or recently board eligible with virtually every teaching hospital in New York, I believe I get more than my fair share of tough risks.

I also think all the adjustment tools to adjust risk are very crude. I am aware of the three tools that are available in the market. They would all create sinister incentives which I would be happy to go into. Karen already talked about the absolute folly of a 1-month open enrollment.

I can't imagine hiring a staff for 1 month and then furloughing them until next year. I can't imagine that Americans would tolerate 1 month only of free choice. I believe that you have to provide that on a rolling basis, and HMOs I believe would be more than willing to accept anyone, any time.

Finally, I don't understand why you are not talking about a defined contribution program instead of a defined benefit program here. If you are a business you would say, OK, we can only spend so much, we have got this 2001 time bomb ticking, and I would advocate we shift away from this idea of a defined benefit to a defined contribution. If you say, we are going to give health plans 90 percent of Medicare fee-for-service costs, I will stay in the process, and if you freeze it for 5 years, I would still stay in the program, because there is such excess capacity in the provider community that for a long time I can achieve the ends you seek.

My time is up. Thank you very much.

[The prepared statement follows:]

STATEMENT OF STEPHEN F. WIGGINS
HEALTHCARE LEADERSHIP COUNCIL

Mr. Chairman and Members of the Subcommittee. I am pleased to be here today on behalf of the Healthcare Leadership Council to discuss with you much-needed improvements in the Medicare program. The Healthcare Leadership Council was formed in 1988 by representatives of each of the various sectors of the health care industry, including doctors, nurses, hospitals, managed care companies, and pharmaceutical and medical technology manufacturers. HLC members are the leaders in the health care industry, working to discover, develop and deliver high quality, innovative and cost-effective health care products and services.

The Healthcare Leadership Council is committed to enhancing consumer choice through the promotion of a market-based health care delivery system. Although Medicare program improvements are not a panacea for balancing the budget, one thing is clear -- long-term cost containment in the Medicare program is dependent upon modeling the program on private sector success. Introducing market-based options into the Medicare program will provide greater choices for Medicare beneficiaries and reduce overall program expenditures through competition. Simply put, the same private-sector choices that are available to the under-65 population should be made available to the over-65 population.

My company, Oxford Health Plans, serves over 580,000 people in New York, New Jersey and Connecticut. Our Medicare program is one of the fastest growing in the nation, adding 3,000 to 5,000 seniors per month. A few facts about our programs deserve mention, because I believe they reflect the advantages of market-based solutions.

- First, Seniors like these programs and choose to stay in them. Our retention rate of Medicare members exceeds 91%. Over 95% would recommend this program to a friend, and in fact many do. Anyone unhappy with our services is free to choose another health plan. This choice is the ultimate expression of our free market system; the power of the individual to take their business elsewhere. Improvements to the Medicare program should promote this continuous free choice of health plans. Clearly, Seniors today are casting their personal votes of confidence by joining managed care programs in record numbers.

- And it's no wonder why. Seniors joining plans such as Oxford's Medicare program enjoy much better coverage. There is no need for supplemental insurance, as benefits include preventive exams, prescription drugs, expanded skilled nursing care and home care, and eyeglass reimbursement. There are no deductibles to pay and no claim forms to submit. All for no monthly premium. One of the biggest challenges our marketing people face is to convince prospective enrollees that this program is for real.

- Seniors are careful consumers. They look to their peers for advice, and the wisdom of years makes them leery of marketing representatives. They've seen it all and have the luxury of time to carefully evaluate and compare the various options available to them. We have found that the best way to communicate with this discerning population is to allow them to meet with, and to question, our existing Medicare members.

- Oxford's Ambassador Program seeks volunteers from among our enrolled seniors who are willing to attend meetings and talk privately with prospective members. These unpaid Ambassadors describe their own experiences and are free to speak their mind. Can you think of a more compelling quality assurance mechanism?

- We are able to deliver expanded benefits at a cost less than the government now spends because our medical cost management programs successfully eliminate wasteful practices and promote healthier lifestyles.

Under the current Medicare risk contracting program , my incentives are simple. I want to cover the total health care needs of enrolled Seniors for no more than the reimbursement available from the federal government. Because of the high level of customer satisfaction and correspondingly high retention rate, I expect to cover each Medicare member for the rest of their life. This gives Oxford an enormous incentive to promote healthier lifestyles and to identify health problems early, before they become serious.

While Oxford has experienced significant success in serving the Medicare population, a number of barriers exist under the current program that both limit the number of private plan options made available to beneficiaries, and that make it difficult for beneficiaries to opt-out of the fee-for-service program and into a private option plan such as ours. A number of improvements could be made that would achieve greater participation in private health plans.

- The number and type of plan options available to Medicare beneficiaries is limited to HMOs and competitive medical plans. Beneficiaries do not have access, for example, to point-of-service (POS) plans. To maximize competitive efficiencies, beneficiaries should have the right to choose among the full array of private options for health care coverage that are available to you and to me in the private marketplace, and we must assure a that a level playing field exists.

- To facilitate enrollment in private health plans options, HCFA should coordinate and sponsor a series of designated annual open enrollment periods for Medicare beneficiaries. In addition, HCFA should facilitate the marketing of private coverage options by distributing information to Medicare beneficiaries regarding all available plans in their area, much like the current process under the Federal Employee Health Benefit Program (FEHBP). Currently, HCFA does little to inform Medicare beneficiaries of their options under the risk-contracting program.

- HCFA should establish standards for disclosure of clear, precise and truthful information of plan benefits to Medicare beneficiaries, including coverage restrictions and beneficiary cost-sharing requirements, to assure quality for beneficiaries, and to avoid confusion and potential misrepresentation of covered benefits. Pre-approval of marketing materials is costly and time-consuming. Rather, HCFA should implement an SEC-like "file-and-use" system to better facilitate marketing of private plan options to beneficiaries.

- Ultimately, the Medicare program should be completely privatized through a system that gives seniors the right and the opportunity to exercise their own purchasing power.

Programs like Oxford's can continue to work as long as the federal government is a responsible partner. Through fair and predictable premium payments, a streamlined administrative process, and efforts to facilitate voluntary beneficiary enrollment in private plan options, government will attract more health plans and thereby achieve substantial cost savings.

Mr. Chairman, the private market is working, as evidenced by the rapidly declining rate of growth in health care costs and increased access to countless new and innovative health care products. Total private sector health costs increased only 2.5% in 1994, with many health plans actually reducing premiums for enrollees. The market has been and will continue to be responsive to the demands of health care consumers for lower cost, higher quality care.

We at HLC are prepared to work with you to advance the market-based health care system and ensure consumers quality, affordable health care. Thank you and I would be happy to answer any questions.

Chairman THOMAS. Mrs. Johnson.

Mrs. JOHNSON. Thank you.

It is a pleasure to have all of you here, each one of whom I worked closely with in various circumstances.

In your testimony, Mr. Wiggins, you talk about the barriers to your ability to offer this kind of option. It is extraordinary, and I wish the other members of the committee were here to hear about the access that seniors could be having to more care with no Medigap premium costs. It is astounding that so much of the world doesn't know about this. And I thought if you would mention a little bit more about the barriers as you see them to expansion of choice, and leave time for Ms. Ignagni and Bill to come in on a couple of things as well.

Mr. WIGGINS. Well, expansion of choice or expansion of enrollment?

Mrs. JOHNSON. Expansion of enrollment. Let's do that first.

Mr. WIGGINS. First of all, as I believe was reflected in earlier testimony, we do not enjoy an administration of this program that is very favorable to HMO enrollment.

We have 4 percent of the people who enroll in our Medicare program, then disenroll before they become effective just because of the letter that arrives from HCFA that scares the daylights out of any senior coming into the program.

Another thing——

Mrs. JOHNSON. Could you provide us with a copy of that letter?

Mr. WIGGINS. Sure.

In fact, I may have a copy with me.

[The following was subsequently received:]

EXHIBIT O

DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
IMPORTANT MEDICARE INFORMATION

ADVANTAGE 65 has notified Medicare that you have joined their health plan. The effective date of your membership is 03/01/93.

ADVANTAGE 65 is a health plan that has a contract with the Federal Government to provide medical care to Medicare beneficiaries. Under the contract with the Federal Government, Medicare makes a monthly payment to the health plan for each Medicare beneficiary who joins. In return, ADVANTAGE 65 must provide or arrange to provide all of the medical care you need that is covered under Medicare. They also must provide any other benefits agreed to under the contract with Medicare and with you. ADVANTAGE 65 is approved to serve members who live in a specific geographic service area.

We are sending you this notice to remind you of the special rules that apply to you as a member of ADVANTAGE 65. As soon as your membership in the health plan is in effect,

- you must receive all of your medical care through ADVANTAGE 65 doctors and hospitals. If you use other doctors or hospitals, YOU WILL HAVE TO PAY for the care you receive.

THERE ARE ONLY TWO EXCEPTIONS TO THIS RULE. THE EXCEPTIONS ARE:

1) *EMERGENCY SERVICES:*

Emergencies are those situations when you need medical care immediately because of a sudden illness or injury and the time needed to reach ADVANTAGE 65's doctors or hospitals would mean risk of permanent damage to your health. In an emergency it does not matter if you are inside or outside your plan's service area, you should go to the nearest hosptial or other health care provider to get care. ADVANTAGE 65 will pay for emergency care you need whether or not you go to a provider affiliated with their plan.

2) *OUT OF AREA URGENTLY NEEDED SERVICES:*

ADVANTAGE 65 will pay for your care if you have an unexpected acute illness or injury while you are outside the plan's service area. This coverage is only available to you if:

- you are <u>temporarily</u> outside the plan's service area;
- your illness or injury requires medical attention to prevent a serious deterioration to your health; and
- required medical attention cannot be delayed until you return to the service area.

You may seek the care you need from a nearby doctor or hospital. If you do receive emergency or urgently needed care from a doctor or hospital not associated with you health plan, you should tell your plan as soon as possible. This is so they can oversee and arrange any follow-up care you may need.

If you have an urgent medical problem while you are inside the service area, but it is not an emergency, you must get care through your health plan. You should contact ADVANTAGE 65 for instructions on what to do.

Please be sure to read the materials ADVANTAGE 65 sends you as a member of their plan. These materials explain the rules of the plan and tell about the benefits they provide. They also explain your Medicare appeal rights. If you disagree with a decision ADVANTAGE 65 makes about a service you believe they should cover, you have a right to appeal. Your membership materials give details on your appeal rights. If you need more information about your right to appeal and how to request it, call your Social Security office or your health plan.

We recommend that you let family members and friends know about your membership in ADVANTAGE 65, especially anyone who may help arrange your medical care.

If you wish to end your membership in ADVANTAGE 65, you may do so in person or by writing directly to your health plan or your local Social Security office. Your membership will end on the first day of the month following the month that ADVANTAGE 65 or Social Security receives your written request for disenrollment (unless a later date is requested).

Your health plan can answer any questions about this notice, or your enrollment in ADVANTAGE 65. When you write to your health plan or to Medicare, include your membership number that appears on your plan's ID card and your Medicare Health Insurance claim number that appears on your Medicare card.

This Message is from:

Health Care Financing Administration--Medicare
1-G-2 Oak Meadows Building
6340 Security Boulevard
Baltimore, MD 21207

—SAVE THIS NOTICE AND KEEP IT WITH YOUR IMPORTANT PAPERS—

U.S. Department of
Health and Human Services
Health Care Financing Administration

Mr. WIGGINS. Another thing that I think is a big problem is we don't know who the Medicare enrollees are so we walk into Brooklyn or——

Chairman THOMAS. We want to make sure those numbers are correct. What was your retention rate in the program?

Mr. WIGGINS. Eight percent of the total people that we sign up do not stay in our program after the first year. Four percent never get to their beginning date of coverage because they have got this letter from HCFA and they disenroll after they have signed up.

That is not uncommon, by the way, in the HMO risk contracting program. And they have modified the letter, to their credit, over time. And it may not just be the letter. It may be other factors as well. They may reconsider, and there is probably some legitimate disenrollment there.

But in specific answer to your question, Nancy, I would like to suggest that one of the ways that you could promote enrollment is work with the HMOs a little more. We have simply asked HCFA to send a letter out. It would sure be nice if they just tell people about our availability. Instead, we have to get databases, employ large telemarketing units, using a kind of a Braille method to find senior citizens, which increases our marketing cost. If the Federal Government could just promote a little more of this option, I believe you would have massive enrollment.

Regarding the way we enroll, we have ambassadors who go to diners and sit with people who are thinking of getting in the program. Sometimes they say things we don't want them to say, but this ambassador program of unpaid volunteers who show up to talk to their fellow seniors, that is the way seniors like to come into a program like this. They are very discerning and often skeptical potential customers.

Mrs. JOHNSON. When you talk about the government helping reduce marketing costs, do you have any idea what the average profitability is of the kinds of plans that serve seniors?

We have heard some extraordinary figures given earlier, and I know you don't work to that kind of profit margin, but I wondered about the rest of the industry.

Mr. WIGGINS. My aftertax profit on premiums is generally just under 4 percent. That is I believe what you need to attract private enterprise. And for the amount of money that we collect, we generally deliver a benefit that is far superior to what they are getting in traditional Medicare. Everybody is happy. No one is a loser, including the Federal Government, who is saving money.

I disagree with the Mathematica study. I think it is fundamentally flawed. It is scary to think about a debate on this subject using the Mathematica study as a foundation for this debate.

It is old. It doesn't reflect the realities of getting increased enrollment into health plans. Karen can probably go point by point through the fundamental flaws of that study. But I would be afraid of using that right now to talk about Medicare reform.

Mrs. JOHNSON. Karen, in your testimony you say that recent studies find that rather than shifting cost, the increased presence of HMOs leads to lower rates of increase in the fee-for-service sector. And you conclude that a 1994 Urban Institute study concludes that for each 10-percent increase in the Medicare risk population's

share of the Medicare market, per capita expenses in the Medicare fee-for-service sector declined by 1.2 percent.

Now, given that information, do you have any idea why HCFA persists in believing that the Medicare risk market and the Medicare Select market provide no savings to the Federal Government?

Ms. IGNAGNI. I think we have had a precedent throughout various sectors with respect to cost estimation that the practice has been to rely on published data, so that you would not, in making judgments, have access necessarily or reach out to find some of the newer data that are available. Indeed, as Mr. Wiggins said, that is the fundamental flaw of the Mathematica study.

Since that study was done, I know, Mrs. Johnson, you are aware that enrollment in Medicare HMOs has increased 50 percent, as have the numbers of individuals participating, that is to say, plans.

So there is that issue. The CBO estimation with respect to HMO effectiveness we believe suffers with the same lag problem with respect to data. Now that you are poised to make major changes, it seems prudent to stop and take a look at the track record we now know exists. Dr. Welch's study, Dr. Hadley's studies, show very important spillover effects. That should be taken into consideration.

Mr. GRADISON. With respect to the question of coverage, we have been talking with quite a few of our members recently about Medicare Select in anticipation of the hearing today. And we came away with the impression that there are a number of insurers and HMOs, of course, which would come into this program if it is made permanent.

A 3-year program is not a powerful incentive to set up all the systems that are involved. So our best judgment is that if it is made permanent, you are going to see a lot of new competitors in the 15 States where it is already permitted.

Mrs. JOHNSON. Thank you. That is an excellent point.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

With all the opportunity that is out there, this continues to baffle me, that HCFA is not willing to move into a little more accelerated examination of options. I think it is fairly clear where their heart is in terms of not even willing to move forward and making permanent what we think is a very simple practice. I guess it is a heart transplant they need more than anything else.

Plus, and this is where I need some help, there was no question that earlier on there were very few insurance products available for seniors, that was one of the reasons there was a major move for Medicare.

To what extent, though, has the creation and the ongoing presence of Medicare been an inhibitor in obviously developing products for that segment of the market given the way in which it is fundamentally structured? And to what extent do we have to be bold again in going to a new model rather than timid, where you never, ever do get a full understanding of the products that could be available?

And the other side of the coin of that is the whole risk selection argument, that you are going to wind up with the healthier seniors going into these programs and Medicare becomes the insurer of last resort, which if that is the case I would like to know what the num-

bers are and what the profiles are, because we can deal with that if that is the result.

Mr. GRADISON. In a sense the creation of Medicare created an opportunity in the private sector, that is to say, Medigap insurance was built as a wraparound policy to a government program, but it was fundamentally built upon the fee-for-service model, which was the way Medicare was created, and that was the world at that time.

I think that one of the difficult conceptual issues in thinking about this is that managed care itself has changed a great deal over recent years from what it used to be. While there are certainly all varieties—there is a broad spectrum of different kinds of managed care plans out there, the most dramatic growth appears to be in plans such as PPOs and point-of-service plans and plans that in other ways offer out-of-network options. That seems to be where the market is growing most rapidly.

And in that sense, the discussion of managed care for Medicare beneficiaries as an option which will limit choice is sort of yesterday's argument, not the future of the program.

Now, I appreciate that that is not the way in which it is perceived by most of the beneficiaries. But I would suppose if you are thinking of restructuring, to pick up on the excellent point made by Karen Ignagni, you would want to figure out where you want to be at a certain point in the future, as your goal, and then figure out the steps necessary to get there.

I am somewhat baffled that there is as much controversy about Medicare Select. I don't think the Sun will fail to come up tomorrow, whether you expand it or don't expand it. It is a very useful program but it really isn't at the heart of restructuring Medicare.

Chairman THOMAS. If we are going to have as much trouble in terms of not getting an agreement on something like Medicare Select and the timeframe in which we have to rethink what we are doing, it just gets a little frightening about the educational curve that we are on with some folks.

Mr. GRADISON. Exactly, Mr. Chairman.

Ms. IGNAGNI. Mr. Chairman, I was just going to observe, trying to cut through a lot of the complexity and admittedly there is quite a lot, if an individual is ill and knows that, I can't imagine the rationale for remaining in the existing fee-for-service system where we know about the copays, the deductibles, the barriers with respect to price. We know about the barriers with respect to administrative responsibility in terms of forms and paperwork.

But we also know that from the studies that we have done, the reason that individuals are exceedingly happy about HMO coverage is that under coordinated care, there is a comprehensive care orientation throughout the system, a very complex one, and I think as we get into exploring the reasons for individuals moving into HMOs, I think you will find some of the newer data suggesting that those who are chronically ill, indeed very ill, are most drawn to a coordinated system of care, which takes you from the point of preventive services to tertiary services and everything in between.

That, to me, is worth something for beneficiaries, quite a lot. I am not so sure we have adequately evaluated that.

Chairman THOMAS. To go back to a point that was made or attempted to be made with the GAO witness, obviously the private sector is moving very quickly, and it is difficult sometimes for government to respond with measuring tools that are meaningful in the new environment.

Clearly HCFA has difficulty in providing those tools. We have seen some examples mentioned of the private sector attempting to create tools for itself to measure quality and cost relationships.

What have you folks who have been out there in the real world experienced with States and their ability to develop measuring tools that are meaningful? Or is the private sector again a 3- to 5-year lead on this? Are there tools out there that you are becoming aware of that would be useful to us in attempting to profile some models for measuring quality and cost?

Ms. IGNAGNI. As you know, there is a plethora of regulation out there. Speaking for our plans, our plans are complying with regulations and statutes associated with the Federal HMO act. They are also complying with and are regulated at the State level for HMO products.

Third, the employers are now using external accreditation mechanisms such as the NCQA, mentioned by Dr. Vladeck, and for the private sector as well as for other kinds of products. So there are a number of other mechanisms out there.

The concern, however, is the need to move to a system where there is a level playingfield across products, hoping and offering the same kinds of services in the market today, or in the future. And it seems that as we talk about appropriate regulatory mechanisms for HMOs, we need to—and our industry has fully supported that and has been in dialog both with employers as well as Federal and State regulators, we also need to think about the same kinds of regulations extending across other products so that at the end of the day the beneficiaries will have the comfort that in fact there are these kinds of comparable regulatory mechanisms.

There has been quite a lot going on in the HMO world. There is very little if anything going on in the fee-for-service side.

So we do have a system of a black box there that I think we need to get our hands around as we move forward to talk about expanding choice. There are some issues that need to be attended to with respect to quality, quality monitoring and assurance in the fee-for-service sector as well as all other sectors.

Mr. GRADISON. Mr. Chairman, for markets to work well, they need information. And the information available to permit intelligent choices in the health care today is inadequate. It isn't that it is not accurate. It is just you can't compare it very well.

I think we need some mechanism which probably could be done by government or the private sector—probably more quickly by the private sector—to figure out what data is important, and then maybe some separate mechanism to monitor the system to see that the data that is coming up from the individual plans is comparable, one to the other, and that they are doing it in a fair and appropriate way.

I don't want to take a shot at HCFA because I recognize the problems that they have. Keep in mind they have been trying for years to put out comparative data on hospital mortality under Med-

icare and they have had difficulty with coming up with something that is accepted as being fair and meaningful, particularly with regard to the severity issue. And they stopped under Dr. Vladeck, and I can see why. And that is a relatively simple thing compared with some of the other comparative data that some folks, including ourselves, would like to have.

I have one other just very brief but general point that I would like to make which is actually in defense of HCFA, Mr. Chairman, and that is that I haven't seen a situation in or out of health care in which government regulation could keep up with changes in the marketplace. I would say that based upon my 18 years of experience, that I had where you are. I would talk about banking, savings and loans, railroads, trucking, before you ever get to health care.

So I think the fundamental assumption that governments, State or Federal, either one, can move as fast as the innovations in the marketplace are taking place, is just unrealistic. It isn't a question that people aren't trying hard. I just don't think it is possible for them to do it, no matter how hard they work, no matter how able they are.

Chairman THOMAS. Yes, but I do believe there are some things that we can do, especially at the Federal level, and one of the things that shocked me most about getting more involved in this area was the lack of information. When you got it, it was 3 to 5 years old, and the world had changed; you were simply looking at a historical model that wouldn't help you at all.

In terms of the outcomes, tests, computerization, administrative simplification, those are the kinds of enabling things I think we could do at the Federal level. Get some uniformity in malpractice so that as you begin collecting this data, it is more reliable. You can do it in a quicker period of time so that you can begin to yardstick the thing.

What concerns me, though, and I will go back to the HCFA question, is that rather than focusing on that and understanding that we might be able to, in the short run, adopt some tools that the private sector is utilizing. I believe that the front end is the difficult part, as more and more people transition from work into this program, and have a comfort level with managed care because of their previous condition. What we ought to be doing is creating a threshold for those folks who have no yardstick or over the years we should develop a comfort level.

What bothers me most about what I am hearing from HCFA in terms of the roadblocks they are trying to put up is a little bit like the Japanese car test program. That is, we want safe cars here so just crash every one that is imported and we will be able to determine whether or not they are safe.

There doesn't seem to be a willingness to focus on the need for change in a timeframe to make that change. And we are willing to do everything we can at this end to provide a structure. But if we are going to attempt to reinvent HCFA on a private sector model in the timeframe that we need to do it, we can't do it, in my opinion.

So I am looking for yardsticks, measurements, formulas that you folks have found to be successful that will attempt to incorporate

into a model to provide for the opportunity to allow people to walk over into that private sector by choice.

And I don't understand why, and I would like to see the letter that HCFA has been putting out or even the modified letter that HCFA has put out, why we aren't creating at least an umbrella of understanding that this is an option and a reasonable one available.

The gentleman from Nebraska.

Mr. CHRISTENSEN. I am going to pass.

Chairman THOMAS. The gentleman from Washington.

Mr. MCDERMOTT. Mr. Wiggins, I was looking at some data that is provided to us, companies providing managed care, this Oxford bunch. Last year you spent 69 cents of every dollar on patients.

Mr. WIGGINS. That is incorrect. That is the percentage of our total revenues that went to health services, included in revenues is what is called the administrative services only premium. You have to gross up what is our self-funded business to a fully insured equivalent to derive a loss ratio, which is meaningfully higher. The number you use is not a loss ratio and probably comes out of a proxy or something.

Mr. MCDERMOTT. Are you an economist or what are you? If it says 69 percent——

Mr. WIGGINS. Yes, I am the economist for Oxford Health Plans.

Mr. MCDERMOTT [continuing]. What are you doing with the rest of it?

Mr. WIGGINS. Our medical loss ratio varies by line of business. We generally develop products that deliver comprehensive health benefits for the commercial market. It might be anywhere from 10 to 25 percent below the cost of a fee-for-service plan. And for that much reduced premium relative to the commercial market, we are able to deliver, as I said, a much more comprehensive program.

Of my commercial employer customers, 98.6 percent stayed with the program in the last 2 years. That is our annual retention rate of commercial customers. So nobody seems to be complaining about the composition of the cost structure in our program.

And, in fact, now that we are going into another year of zero premium increase year over year, which was our 1994–95 adjustment, I anticipate that they will continue to not have a great difficulty with the composition. I would like to address your Medicaid point earlier, because we are also one of the fastest growing providers of services to the Medicaid population in New York and probably the only company making major investments in developing provider sites to serve the poor in inner-city neighborhoods. For instance, we are developing clinics in East New York, which is the highest crime area of Brooklyn.

And what you find in Medicaid is that it is not at all like a commercial employment group. We have to hire outreach socialworkers that go into the homes to do what I have called a VP. We do a visual preview, because most of who we cover, the ADC population, which is the mothers——

Mr. MCDERMOTT. Why do you have to go in and look at their house? You deliver health care; what the heck does the house have to do with it?

Mr. WIGGINS. We are trying to lower the infant mortality rate and we have successfully done that in the Medicaid program. It takes a significant amount of money——

Mr. MCDERMOTT. What factors in infant mortality do you get from looking at the house?

Mr. WIGGINS. You try to assess as best you can how "at-risk" a pregnancy might be.

Mr. MCDERMOTT. So it is at-risk. What do you do?

Mr. WIGGINS. You put caseworkers on it and try very hard to make sure you bring that pregnancy to full term.

Mr. MCDERMOTT. What does that caseworker do?

Mr. WIGGINS. You are in the face of the mother. You are there often. You are trying to teach them about proper nutrition. When possible, you are trying to make sure they get to the providers most appropriate for their needs. Making sure they are getting in for their examinations in a timely manner to assure that they don't have a high-risk situation.

Many of the mothers on Medicaid happen to be high risk. And it is important to identify those situations early.

Mr. MCDERMOTT. Can you terminate them?

Mr. WIGGINS. No.

Mr. MCDERMOTT. So once you got them, you are stuck with them, no matter what they do?

Mr. WIGGINS. That is right.

Mr. MCDERMOTT. And——

Mr. WIGGINS. By the way, in New York, as I mentioned, you weren't here, we take everybody without question. We take individuals enrolling in the plan, Medicare, Medicaid, anybody that wants into Oxford Health Plans can join any day of the week.

Mr. MCDERMOTT. Under Medicare, if HCFA would risk adjust, would you still take people?

Mr. WIGGINS. Sure, we would. I think risk adjusters are a mistake. I am aware of the three computer tools that are available right now to risk adjust. You could use ambulatory groups, you could use the Peer-a-Med system or the Symmetry system. Those would be the three most valid ways to risk adjust. Those are tools we use right now. I am familiar with their advantages and disadvantages.

You will find that in risk adjusting populations, that demographics explain most of the variance. There is very little variance that is explained beyond demographics by these severity adjusting tools. And so it is a little bit folly, because it is like the fly on the elephant. It is just not going to help you much to know what the risk ad——

Mr. MCDERMOTT. Explain that in C–SPAN language for people who don't know all the medical terms. What do you mean by risk adjustment?

Mr. WIGGINS. Risk adjustment is a way to determine how sick somebody is and then vary the payment to an HMO based on your assessment of how healthy or sick they are. Of course, as you know, people can change quickly. And so you might have somebody that has an assessment coming in that is very different 2 months in.

In addition, much like the Federal DRG program which has led to terrible fraud and abuse out in the marketplace, where doctors, as I know you are a physician, are trained now in our Nation's hospitals how to get the coding right to get the reimbursement higher at the hospital. Risk adjusters will lend themselves to the same type of gaming, and for that reason—I think that is one of the reasons I think they would be a very bad tool to use.

Mr. MCDERMOTT. Your basic view is that you should not use a risk adjustment, you should give a flat fee for everybody, and that is it, not even for age?

Mr. WIGGINS. Age is valid. Once you get above 30 or more percent of the population in HMOs, you have already spread the risk meaningfully enough that you no longer need to worry about risk adjusters. There is an even spread in the HMOs and there is an even spread outside the HMOs.

Mr. MCDERMOTT. You are basically for community rating?

Mr. WIGGINS. I am very much in favor of community rating. And I think you could solve the problems that you addressed earlier here by having a community rating structure that forces me to take any Medicare comer. It is conceivable you could even include end-stage renal disease.

Mr. MCDERMOTT. Did you hear that, Mr. Gradison?

Mr. WIGGINS. I am talking for myself now.

Mr. MCDERMOTT. I understand that. That is why——

Mr. WIGGINS. I have lost the Health Care Leadership Council reservation.

Mr. MCDERMOTT. I had a feeling you were wandering off the text.

Would you agree to that, take all comers?

Mr. GRADISON. That is exactly the way Medigap works today. At 65, when you become eligible, it is guaranteed issue. It is only people who wait until later who don't want to keep up their premiums, that the ratings and the preexisting condition limitations are happening. So that with regard to——

Mr. MCDERMOTT. You mean if they bought it at 65—and never drop a payment?

Mr. GRADISON. I am saying there is guaranteed issue at 65. Today, that is the standard approach to Medigap insurance. That is the way it works.

Chairman THOMAS. Ostensibly the gentleman's time has expired, but he is scoring so many points for us I want him to just keep going.

Mr. MCDERMOTT. I want it on the record so that we can ultimately discuss it, because not everybody believes what Mr. Wiggins said.

Chairman THOMAS. The gentleman understands the framework.

Mr. MCDERMOTT. If you want me to go on, I would love to.

Chairman THOMAS. Your line of questioning is more beneficial to our coming to a conclusion than ours, because when you agree, you don't really try——

Mr. MCDERMOTT. That is because you have got the votes.

Chairman THOMAS. I will tell the gentleman, I have been sitting here since 10 a.m. not because I have the votes. I have been sitting

here because I want to listen to people who I think have answers. That is why I am sitting here.

The gentleman from Nebraska will question.

Mr. CHRISTENSEN. I just wanted to make a couple comments. First I wanted to thank the panel. I am sorry that I didn't get a chance to hear your entire testimony but I am going to read it because I am very intrigued as to the options and ideas that you have.

I also want to say my hat is off to the young man in this crowd who can't be more than 12 or 13 years old, who has been enduring this for a long time. You are to be——

Ms. IGNAGNI. It is Mr. Wiggins' son.

Mr. CHRISTENSEN. You are a fine young man.

Mr. WIGGINS. He has Sonny Bono's signature here.

Mr. CHRISTENSEN. I want to ask the panel if they have any ideas on why the administration "punted" on their responsibility as far as the budget goes this year with reform in terms of Medicare. Have you heard anything as far as the administration's viewpoints toward addressing this area, anything in general?

Ms. Ignagni.

Ms. IGNAGNI. I was hoping you wouldn't turn to me first, frankly. What comes to mind is one has enough trouble explaining one's own actions, it is very difficult to explain somebody else's, but I suspect that what needs to be said is that some of the discussion is quite new with respect to a full look at the Medicare program.

I think several months ago no one would have predicted that we would have been here talking about a fundamental change in direction potentially for Medicare, while assuring the promise that was made back in 1965, and I would suspect that many individuals from across the political perspective and spectrum, as I know within our organizations and probably many others are beginning to just now get their hands around what that means and the potential for moving forward in a variety of directions.

I think the Chairman's notion and challenge for the witnesses which we have tried to take very seriously is to think broad, think bold, and try to be as helpful as we can in pointing a direction.

What also needs to be said is I am not sure everyone has thought fully about the steps that would be necessary seriatim to move from A to B, and we want to be very helpful in that, but I want to be quite frank in saying that we are going to have quite a lot of additional discussion within our own ranks.

Mr. CHRISTENSEN. Congressman Gradison, is there any doubt in your mind at all—you have been here on the Hill for several years of your life, been involved in public service, and now you are on the other side in terms of the private sector—is there any doubt in your mind who can help solve this problem? Is it the government or can it be better solved and better managed through private sector options, private sector ideas like Mr. Wiggins talked about a little bit ago? Not that I agree with everything that he said because I am opposed to community rating, but I liked what he said in terms of addressing Medicare.

Mr. GRADISON. First off, the last major changes of any consequence in national health care legislation occurred almost 30

years ago. That tells you how hard it is to bring about changes. That was Medicare and Medicaid, 1965. That I think is interesting.

I think that what is happening, and this has been true with administrations of both parties, and Congress, as it turns out, of both parties now as well, is that the promises made in 1965 are turning out to be difficult to fulfill. They are just very expensive, more expensive, far more expensive than was anticipated, and that creates a real problem of what do you do about it, pony up more money or somehow cut back on the programs or some combination of the two.

The third thing that has happened is that there has been a tremendous change in the way health care is delivered and financed in this country over recent years, and the pace seems to be accelerating.

Now, to come directly to your question, what runs through my mind, this isn't a direct but it is intended to be a very significant, I mean meaningful response to you, what comes to my mind was the experience we had with Medicare catastrophic. It blew up on us. I was one of a handful that went down with the ship and voted against repeal, but what it turned out was that—there are a lot of ways to interpret what happened, but one way to interpret it is that most Medicare beneficiaries like the program the way it is, and therefore it is hard to change it. That I think is a simple-minded but accurate way to say it.

We thought we were at the time—I am not trying to beat a dead horse—but we thought we were improving it for the vast majority of the beneficiaries, but that didn't seem to be the message that came through in the end, so I guess that there is just a warning flag out there.

For those of you who didn't live through that experience, it was traumatic. I carry it around with me, I actually have it in my desk—a photograph of the signing ceremony. Here is Ronald Reagan, he signed it, and here are a number of people, some of whom would be here today if the full committee or subcommittee were here, including this guy, beaming with pride.

Within 1 year later it was repealed, the first and I think only social program in the history of this country that was repealed before it took full effect. So it is just a sensitive program. It is hard to work with it, hard to change it.

Mr. CHRISTENSEN. I have got a quick question before my time runs out. On the Oxford Health Plan, did you start that company?

Mr. WIGGINS. Yes.

Mr. CHRISTENSEN. How many employees do you have now?

Mr. WIGGINS. I have got about 2,100.

Mr. CHRISTENSEN. 2,100, and you started this company from scratch?

Mr. WIGGINS. Yes, about a billion and a half, billion three or four this year.

Mr. CHRISTENSEN. I would just say hats off to you, Mr. Wiggins, because you are a prime example of what made this country great in terms of entrepreneurial capitalism, entrepreneurial activity, creating jobs, expanding the tax base, and you are much more than just an economist, you are the envy of America, and I appreciate your testimony here today.

Mr. WIGGINS. Thank you.

Mr. ENSIGN. He wants a job afterward.

Chairman THOMAS. No, you are going to be here for a long time, Mr. Christensen.

As one who did not vote for catastrophic, in trying to follow it, who was relatively new to the whole process, I mean, what I thought was going on was a relatively clear disconnect from people who wanted to provide something which in terms of the larger parameters, responsibility, copays made sense. But who was going to react were people who already had what we were trying to give them, by virtue of being relatively sophisticated and purchased it in the marketplace.

Mr. GRADISON. Right.

Chairman THOMAS. What they were looking for was something they didn't have, long-term care and some other areas that we should have moved. So, to me, I just saw the train wreck coming from the beginning because not that it wasn't going to be a benefit for the entire universe, the universe that was going to react, react quickly, and react negatively. The ones who ultimately tipped the balance were those who really didn't see that they were getting anything for the additional payments. That was my analysis.

Mr. GRADISON. You are absolutely right. There were large numbers of people out there who had generous health benefit plans in retirement from the Federal service and from private industry as well who felt they wouldn't get anything out of it. I think that is part of it.

If that is so, and I am inclined to agree that was one of the elements, then it calls into question the notion of a one-size-fits-all package, and my impression is that the program in the long run would be a lot better off if it offered—I mean the Federal Government should figure out what it is willing to spend, but I think the notion of offering actuarially equivalent packages and giving people some choice makes sense.

What a lot of people, I think, were saying is, We are willing to pay a higher deductible on the present benefit package if you add some outpatient prescription drugs, as an example. They can't do that today.

Chairman THOMAS. See, that is my problem. My problem is that we can't even play the game of building up the package that we now have under the old fee-for-service to continue to try to profile what is going on out there because the change is so rapid.

What I got out of catastrophic was that we ought to get out of the business as government either bureaucrats or elected officials in trying to guess what people want. Our job is to create some kind of a clear, as the best we are able with all the techniques we have, equivalency in which people vote with their feet. The Medicare check will let them vote where they want the money to go. Our job is to make sure that you have got minimum standards out there.

This is a slightly different profile group than most, but the program that will work best is the one that they choose, not the one that we choose, and that is where I think we will be able to make changes and not have it blow up on us like catastrophic did.

Are there any more questions?

I want to thank this panel very much. You obviously are very, very knowledgeable. Let me say that you are going to be relied on very heavily and others like you in shaping this program. You are out there doing it, and we need you.

Mrs. JOHNSON. Mr. Wiggins, would you reply to Mr. McDermott's question in writing for us regarding the 69-percent figure he used, and we can get that, the staff on that side, to clarify those figures, because those kinds of figures were used throughout the hearing in a number of circumstances and this committee needs to understand that when 69 percent is spent on services, that does not mean that 31 percent is spent on administrative costs or profit. So we need to get clear what dollars get spent on services, what are administration, what are costs, and what are other kinds of expenditures like those you described that were more complicated.

Thank you.

Mr. WIGGINS. I would be happy to.

Chairman THOMAS. My assumption is it won't be on Health Care Leadership Council letterhead.

[No information was received at the time of printing.]

Chairman THOMAS. We will ask for our last panel to come forward, please. Ms. Musser, Ms. Shearer, and Mr. Gauthier, we want to thank you for your patience. Any written testimony that you may have for the subcommittee will be made a part of the record, without objection, and you may proceed in any way you wish to inform the subcommittee. And we will begin with Dr. Musser.

STATEMENT OF JOSEPHINE W. MUSSER, RECORDING SECRETARY, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; AND COMMISSIONER OF INSURANCE, STATE OF WISCONSIN

Ms. MUSSER. Thank you, Mr. Chairman. There is an error, it is Commissioner Musser. I am not a physician or a Ph.D., but I would like to take credit for a number of those things.

Chairman THOMAS. We will leave it up there anyway.

Ms. MUSSER. Thank you.

There are advantages and disadvantages to going on the last panel. I have pages after pages of purple ink and comments, wonderful ideas and difficult issues that were deliberated today and many very worthwhile suggestions and comments that I have written all over.

I wanted to say how impressed I am as well with the deliberation that has gone on on this very serious issue.

My name is Josephine Musser. I am the recording secretary of the NAIC, the National Association of Insurance Commissioners, and I am the Commissioner of Insurance for the State of Wisconsin.

The NAIC is the Nation's oldest association of State government officials. Our members are the chief insurance regulators of 50 States, the District of Columbia, and 4 U.S. territories. On behalf of the NAIC, I want to thank you for the opportunity to discuss the Medicare Select program today.

Mr. Chairman, I am pleased to be here today to testify in support of our position. I am also pleased to report to you that two of our sister State organizations, the National Governors Association and

the National Conference of State Legislatures, join the NAIC in our position before you today.

The NAIC supports the extension of Medicare Select to all 50 States and the elimination of the sunset provision. Why? Because it is a good deal for customers. Medicare Select offers choice, it offers savings, it offers consumer satisfaction. Unfortunately, only a relatively few of our Nation's Medicare supplement customers now have this option available to them. We would like it to be available to all.

The concept of Medicare Select, of course, is quite simple. These policies are just like standardized Medicare supplement policies except that they utilize the concepts of managed care. In order to receive full benefits, Medicare Select policyholders use network providers. The policyholder's out-of-pocket expenses are larger if he or she goes outside the network for care.

Under the leadership of Governor Tommy G. Thompson, Wisconsin already had a well-established and successful managed care Medicare supplemental insurance market. With the enactment of OBRA 1990 and the Medicare Select program, we recognized that in order to maintain that market we needed to become one of the 15 States chosen to participate in the Medicare Select demonstration project. Among the others, of course, are California, Illinois, Texas, and Washington.

In Wisconsin, Governor Thompson and I are very pleased with the program. We know that the program works. We have seen the savings, and the high level of customer satisfaction Medicare Select policyholders enjoy.

During the break many of the HCFA staff members today—during the many breaks today, many of the HCFA staff members came up to me and said, We know it works in Wisconsin. If all the States would do it like Wisconsin, we wouldn't be having this discussion.

The 3-year demonstration period in the 15 States expired at the end of last year, but as you know, we have the extension for another 6 months, and so the clock is once again ticking for the Medicare supplement customers. It is time to make the program permanent and time to make it available in all States now.

When Congress instructed the NAIC to develop Medicare Select standards in 1990, we built in important customer protections. In order to sell Medicare Select policies, insurers must file a plan of operation with the insurance commissioner, demonstrating that the network provides sufficient access to care, an ongoing quality assurance program, disclosure of all network restrictions at the time of enrollment, provisions for out-of-area and emergency coverage, and the availability and cost of all Medicare supplement policies without network restrictions that are offered by that insurer.

Additionally, through 1994 and 1995, the NAIC has begun developing what has been called health plan accountability standards and model regulations, to enable State insurance departments to strengthen their quality assurance standards in the insured marketplace.

I would like to discuss that further with you, if you have questions, and also what the NAIC is doing with regards to quality assurance and especially data collection.

Our experience with Select policies in Wisconsin has been most positive. Twelve percent of our Medicare supplement market consists of Select plans. As you can see, this innovation is a substantial part of the Wisconsin market affecting thousands of Wisconsin citizens.

The consumers of my State are satisfied with their managed care Medicare supplement coverage. Over the last 5 years, only 2.2 percent of our department's Medicare supplement complaints were lodged against HMO Medicare supplement insurers.

In addition, Medicare Select coverage is cheaper, in Wisconsin a full 20 to 30 percent cheaper than indemnity products. That can be as much as $500 per year in the pocket of the average 85-year-old beneficiary.

In Wisconsin, Medicare Select works. On the national level, let me tell you more about why the NAIC supports the expansion of Medicare Select to all 50 States and the elimination of the program's sunset provision by pointing out what Medicare Select does for policyholders.

Again, it gives consumers choice, savings, and satisfaction. Nationally, the Select program offers premiums 10 to 37 percent below those of other supplement products. That is hardly pocket change to a consumer on a fixed income.

As for consumer satisfaction nationally, let's look at the closed complaints in 10 Medicare Select States for 1994. We found 967 complaints against non-Select policies. By comparison, Select policies logged a grand total of nine. That is nine complaints.

Again, I cannot stress strongly enough the choice Select policies offer Medicare supplement consumers. Not giving consumers in all 50 States the choice of these insurance products, or worse yet, taking these products away from the consumers in the 15 demonstration States would ill serve both our consumers and our marketplace, and likely we must consider the prices of the indemnity Medicare supplement products, would also increase if this product was removed from the market.

Mr. Chairman, I also ask you to consider the effects on current Select policyholders. If the program is not extended with no new enrollees, premiums will increase for current Select policyholders.

While they will be allowed to remain in the program without infusion of new members, premiums will increase as the policyholders grow older, resulting in premiums that would be well beyond the reach of consumers left stranded in the program. But if the program is expanded to all 50 States, we believe more carriers will be persuaded to enter the Select market.

Mr. Chairman, the NAIC supports the extension and expansion of Select to all 50 States. The Wisconsin experience has been a success, and we have high hopes for an expanded program on a permanent basis.

We look forward to working with you.

Thank you.

[The prepared statement follows:]

TESTIMONY OF JOSEPHINE W. MUSSER
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mr. Chairman and Members of the Subcommittee, my name is Josephine Musser. I am the Recording Secretary of the National Association of Insurance Commissioners (NAIC), and the Commissioner of Insurance for the State of Wisconsin.

The NAIC is the nation's oldest association of state public officials, composed of the chief insurance regulators of the fifty states, the District of Columbia, and four U.S. territories. On behalf of the NAIC, I want to thank you for the opportunity to appear before the Subcommittee on Health to discuss the Medicare SELECT program.

NAIC supports the extension of Medicare SELECT to all 50 states and elimination of the sunset provision. I am pleased to be here today to testify in support of our position. I am also pleased to report to you that the National Governors Association (NGA) and the National Conference of State Legislatures (NCSL) joins the NAIC in our position before you today.

Today I will discuss the Medicare SELECT program generally; the experience of the State of Wisconsin as one of the states participating in the Medicare SELECT demonstration project; the savings accruing to beneficiaries with Medicare SELECT policies; the high level of consumer satisfaction with Medicare SELECT policies; the added choice the existence of these policies gives to Medicare beneficiaries; and the adverse effect the sunset of the program would have on Medicare beneficiaries. I will also discuss the fact that Medicare SELECT policies are supplemental insurance products and cannot be compared to Medicare Risk contracts.

Medicare SELECT

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) limited the sale of Medicare Supplement, or Medigap, insurance policies with managed care or preferred provider component to 15 states for a three year demonstration period. (The three year period expired on December 31, 1994, and, in the fall of 1994, Congress extended the program for another six months through the Social Security Act Amendments of 1994). OBRA 1990 also provided for standardization of Medigap policies. Pursuant to that legislation, the NAIC adopted the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (NAIC Model) that was incorporated into federal law when the Secretary of the Department of Health and Human Services (Secretary) published this model. This model developed 10 standard Medigap policies, A through J, and set forth the Medicare SELECT standards. Medicare SELECT policies are just like standardized Medigap policies, except that full benefits are paid only when network providers are used.

The Secretary established guidelines for states to request to participate in this demonstration project. The Secretary initially chose the following states for the demonstration project. Alabama; Arizona; California; Florida; Indiana; Kentucky; Michigan; Minnesota; Missouri; North Dakota; Ohio; Oregon; Texas; Washington; and Wisconsin. Oregon and Michigan ultimately withdrew from the project due to lack of interest by insurers, and were replaced by Illinois and Massachusetts.

OBRA 1990 established the minimum requirements for Medicare SELECT policies and the NAIC Model served as the vehicle to implement these requirements. In order to sell Medicare SELECT policies, insurers must file a plan of operation with the insurance Commissioner demonstrating that: 1) the network offers sufficient access to care; 2) the network has an ongoing quality assurance program; and 3) the insurer provides disclosure, at the time of enrollment, of the network restrictions, provisions for out-of-area and emergency coverage and the availability and cost of all Medicare supplement policies without network restrictions offered by the insurer. The plan of operation must also outline certain required disclosures to consumers including descriptions of the network restrictions, the grievance procedure and quality assurance.

As stated above, Medicare SELECT policyholders must avail themselves of network providers designated by the insurer (except for emergency services) in order to obtain full benefits under the policies. This is the main characteristic differentiating SELECT from non-SELECT Medicare supplement policies, whose policyholders have no such provider restrictions. Under both types of policies, Medicare pays a significant portion of a bill irrespective of the provider chosen by the policyholder, but the

policyholder's cost-sharing portion will be larger if a SELECT policyholder obtains services outside the network.

A Congressional Research Service Report for Congress on this program estimates that as of October, 1994, 450,000 persons were enrolled in Medicare SELECT.

In all states except Massachusetts, Minnesota and Wisconsin, the Medicare supplement policies conform to the standardized A through J NAIC model plans. This is also true for SELECT policies. Massachusetts, Minnesota and Wisconsin were granted a waiver from the standardization requirement because they had standardized programs in place prior to the NAIC models. In those states, the SELECT policies must conform to the existing state standardization requirements.

The Wisconsin Experience

Managed care medicare supplement coverage has not been a stranger to Wisconsin. Well before the enactment of OBRA 1990 and the establishment of the Medicare SELECT demonstration project, Wisconsin already had a good portion of its Medicare supplement insurance market in private managed care (HMO) insurers. Since OBRA 1990 prohibited the sale of private managed care Medicare supplement insurance, except as Medicare SELECT, it was vital that Wisconsin be one of the 15 states in the Medicare SELECT demonstration project.

At the end of 1993, there were 321,336 Medicare supplement insurance policies in force in Wisconsin. The number of HMO Medicare supplement insurance policies (SELECT) in force at the end of 1993 was 41,016, or 12% of the total market. This figure includes 12,430 enrollees in Health Care Prepayment Plans. As you can see, managed care Medicare supplement coverage is a substantial part of Wisconsin's Medicare supplement market and affects many thousands of Wisconsin citizens.

Wisconsin consumers are satisfied with their managed care Medicare supplement coverage. The Wisconsin Office of the Commissioner of Insurance receives about 9,500 written consumer complaints annually for all lines of business. In the last five years, the office received a total of 1,984 medicare supplement insurance complaints, of which only 45 or 2.2% were complaints against HMO Medicare supplement insurers. Clearly, managed care Medicare supplement insurance has been a well-received, successful product in Wisconsin.

In Wisconsin, HMO Medicare supplement insurance or Medicare SELECT coverage is cheaper than indemnity Medicare supplement coverage. Depending on age and geographic location, Medicare SELECT policies are 20% to 30% cheaper than indemnity Medicare supplement policies. That can be a savings of as much as $500 per year, on average, for an 85 year old beneficiary,.

As I mentioned earlier, Wisconsin had an active HMO Medicare supplement market well before OBRA 1990 and its Medicare SELECT demonstration project. Wisconsin's market was comprised of federally sponsored programs such as Health Care Prepayment Plans and Medicare Risk policies, and private HMO Medicare supplement plans. We have actively regulated the private HMO Medicare supplement plans and the supplement portion of the federal programs. In fact, many of the provisions currently a part of the Medicare SELECT requirements were already in place as part of Wisconsin's regulatory framework for managed care Medicare supplement coverage. From Wisconsin's standpoint, we would hope that Congress would at least see fit to extend Medicare SELECT to all 50 states and eliminate the sunset provision. Without such action, more than 28,000 Wisconsin citizens would be placed in a very costly position.

Extension of Medicare SELECT to all 50 States

NAIC supports the expansion of Medicare SELECT to all 50 states, and the elimination of the program sunset provision. As you know, Representatives Johnson and Pomeroy and Senator Chafee have introduced legislation which would do just that. For a number of reasons, we strongly support these efforts.

I would like to point out what Medicare SELECT does for SELECT policyholders. The primary reason the NAIC supports the extension and expansion of the Medicare SELECT program is due to the savings it offers to the beneficiary. As stated earlier for Wisconsin, and now nationally, various sources have indicated that across the demonstration states the SELECT program offers premium savings to Medicare

beneficiaries ranging from 10% to 37% off of the cost of premiums for other supplemental products. That is a significant amount of money to persons on a fixed income.

Second, there is a high degree of consumer satisfaction among SELECT policyholders. The statistics I proffered earlier regarding the extremely low occurrence of consumer complaints regarding the SELECT product in Wisconsin have been replicated among the demonstration project states. In fact, ten Medicare SELECT states, Arizona, California, Florida, Illinois, Indiana, Kentucky, Missouri, North Dakota, Texas, and Wisconsin report Medicare supplement complaints to the NAIC's Complaint Data System. Of the records received so far for closed complaints in 1994, only nine are against Medicare SELECT policies and 967 are against non-SELECT Medicare supplement policies.

Third, the existence of the SELECT product offers Medicare beneficiaries a choice among the array of Medicare coverage options, particularly since it is the only Medicare supplemental product that incorporates elements of managed care. Options currently available to Medicare beneficiaries include Medicare Risk and Cost Contracting programs, which provide non-supplemental and supplemental benefits. For supplemental coverage, beneficiaries can choose between standardized Medicare SELECT and nonrestrictive Medigap policies. Thus, Medicare SELECT creates an additional option among the entire spectrum of available options relating to Medicare and Medicare supplemental coverage.

There are also several points that need to be made about the effect on current SELECT policyholders of not extending the program. If the program sunsets, no new enrollees will be allowed in the program and premiums will increase for current SELECT enrollees. While current policyholders will be allowed to remain in the Medicare SELECT program, without the infusion of new members, premiums will increase as the policyholders age, reflecting the increased adverse experience of the aging policyholder base. It is likely that ultimately the premium will become unaffordable for persons stranded in the program (the premium "death spiral"), and policyholders could be forced into the indemnity Medigap insurance market, and be otherwise uninsurable.

Another problem which could occur if the Medicare SELECT program is not extended is that the SELECT provider networks would likely deteriorate. If there are no new members in the SELECT program, providers who decide that it is not worth the administrative burden to participate in a program which is not enrolling new members could drop out of the SELECT network. This could result in a collapse of the network and immediate loss of services to beneficiaries if there are no contracted providers to deliver care.

Some have expressed disappointment that more insurance carriers are not participating in the Medicare SELECT program. However, the lack of insurer participation may be attributed to the finite nature of the demonstration project. Many carriers were reluctant to enter the market with a new product when the market was limited to 15 states and the product might be terminated after three years. Most carriers believe that it takes two to three years to develop a product, price it, and obtain regulatory approval, and four to five years to obtain good data on the new product. It is entirely possible that with the extension and expansion of Medicare SELECT to all 50 states and the elimination of the sunset provision, more carriers will enter the SELECT market.

Now I would like to talk briefly about what Medicare SELECT is not. It is not the Medicare Risk program. Medicare SELECT is a Medigap policy - a supplemental insurance product. That fact needs to be underscored to prevent inappropriate comparisons with other managed care options available to Medicare beneficiaries. For example, standards and expectations applicable to Medicare Risk contracts, which affect the full spectrum of services received by Medicare beneficiaries, are not necessarily transferable to the Medicare SELECT program, a supplemental insurance product designed to pay benefits relating to gaps in Medicare coverage.

One of the goals of the Medicare SELECT program is to introduce the Medicare beneficiary portion of the population to concepts of managed care. It is important to note that managed care is in different developmental stages throughout the states, and is not as developed elsewhere as it is in states like Wisconsin and California. However, the introduction of the concept of managed care to Medicare beneficiaries is being achieved in the SELECT population by use of HMOs, such as in Wisconsin, and by the use of preferred provider organizations with contracted networks of providers in other states. In many areas of the country, a Medicare Risk contract is not an option for a Medicare beneficiary. If the intent in the long run is to make a transition of all Medicare

beneficiaries into the Medicare Risk or similar Medicare managed care program, it well serves that purpose to have Medicare SELECT available to those portions of the Medicare population where Medicare Risk is currently unavailable to introduce them to elements of managed care.

Conclusion

The NAIC supports the extension and expansion of Medicare SELECT to all 50 states. Certainly, Wisconsin considers managed care Medicare supplement coverage and its Medicare SELECT demonstration project to be a success, and has high hopes for the program as a whole. The task of introducing the Medicare population to managed care is certainly worthwhile but will take time. Medicare SELECT is a product which we believe provides meaningful Medicare supplement coverage, helps in introducing Medicare beneficiaries to managed care and saves beneficiaries money.

We look forward to working with you on this issue. Again, thank you for the opportunity to testify.

Chairman THOMAS. Thank you, Ms. Musser.

I will ask members of the panel, do you want to try to vote and come back or get another witness in?

Ms. Shearer, you are under the gun.

STATEMENT OF GAIL SHEARER, DIRECTOR, HEALTH POLICY ANALYSIS, WASHINGTON OFFICE, CONSUMERS UNION

Ms. SHEARER. I will be very quick.

Consumers Union appreciates the opportunity to present our views on the issue of Medicare Select. We have spent many years monitoring the Medigap market and working to improve protections for seniors who buy Medigap policies. We worked in support of this subcommittee's efforts to fix the problems in this marketplace, efforts that culminated in the historic enactment of OBRA 1990 Medigap reforms. These reforms made it much easier for consumers to comparison shop among so-called Medigap policies which are designed, of course, to fill in the gaps left by Medicare.

This testimony addresses one aspect of the Medicare supplement insurance market: Medicare Select. We believe there are several major problems with the Medicare Select market, and we urge caution when it comes to making it a permanent program.

The first problem is pricing games. Medicare Select policies offer cheaper premiums to begin with, but because of a system of so-called attained age pricing that many policies use, the premiums will rise steeply as the policyholder gets older. Most of the top-rated Medicare Select policies rated by Consumer Reports were attained age rated products. Congress should not lock in or expand a program which perpetuates this deceptive pricing practice.

Second, illusory cost savings. Medicare Select premiums are often low but at a cost to other Americans. Insurance companies that write Medicare Select policies typically don't pay the deductible to the hospital that other Medigap policies are designed to pay, but the hospital still has to cover its costs. The result? It shifts costs to other patients and their insurers. To paraphrase Congressman Gradison who addressed cost shifting in the Medicare market, Medicare Select, by cost shifting, represents a tax on non-Medicare Select consumers.

Third, the Medigap maze. The whole idea behind OBRA 1990 Medigap reforms was to allow consumers to make kitchen-table comparison among plans, but the Medicare Select program doesn't forward this goal. Medicare Select adds a layer of confusion by forcing consumers to balance initially lower premiums against restricted freedom of choice of doctor or hospital.

We believe that it is premature to expand or make permanent the Medicare Select program. The preliminary analysis of this program indicates that so far it has not been successful in reducing costs or even attracting substantial interest from insurers or consumers.

Therefore, we recommend, quickly, that Congress require all States to do what several States have done already—community rate their Medigap market to eliminate this hazardous pricing structure used by many Medicare Select plans and thereby level the playingfield among insurers. Alternatively, condition a State's

ability to participate in Medicare Select to a statewide requirement of community rating for the Medigap market.

Second, require a 6-month open enrollment period for all consumers who were previously enrolled in Medicare Select who want to switch to a fee-for-service plan.

And third, limit the extension of Medicare Select to a 2-year time period that would allow for study and analysis of cost savings and quality control.

Postpone expansion of the program to additional States until the studies are complete and regulatory adjustments can be put in place. We were pleased to hear that Congressman Pomeroy spoke in support of this possibility to allow for fine tuning.

In conclusion, research done to date indicates that the Medicare Select demonstration program has not achieved its goals. It has resulted in a marketplace in which premium pricing games distort the true cost of the policy. It has not achieved cost savings but merely shifts the costs to other consumers. Few insurers and few consumers have participated.

In many States' regulation of this product, Medicare Select has fallen between the cracks of different regulatory agencies, leaving consumers without the protections that they need.

Congress should not expand the program and make it permanent, but should take steps now to fix what is broken, specifically the pricing structure and the need for open enrollment, and await further study results before locking the program into place.

With respect to Medicare Select, we urge you to proceed with caution.

Thank you very much for considering our views.

[The prepared statement and attachment follow:]

TESTIMONY OF GAIL SHEARER
CONSUMERS UNION

Consumers Union[1] appreciates the opportunity to present our views on the issue of Medicare Select. We have spent several years monitoring the medigap market and working to improve protections for seniors who buy medigap policies. We worked in support of this Subcommittee's efforts to fix the problems in this marketplace, efforts that culminated in the historic enactment of OBRA-90 medigap reforms. These reforms made it much easier for consumers to comparison-shop among so-called medigap policies, which are designed to fill in the gaps in coverage left by Medicare. We continue to believe that these reforms serve as a valuable model for future legislation in areas such as long-term care insurance and regulation of a supplemental market in future health reform.

This testimony addresses one aspect of the Medicare supplement insurance market -- Medicare Select. Medicare Select is a cross between traditional Medicare supplement (or medigap) policies and HMO's. In return for initially cheaper premiums, consumers agree to obtain care within a designated network of doctors -- in order to be reimbursed for the costs covered by the policy. (Medicare still provides coverage, regardless of whether the provider is in the Select network.)

We believe that there are several problems with Medicare Select. In the big picture, Medicare Select represents a diversion from the tough issue of reining in Medicare costs -- through managed care or other steps. Pressing questions that this Subcommittee must address include: to what extent do HMO's -- which limit seniors freedom of choice of doctor -- truly save costs (or merely select the healthy risks)? Is there adequate quality assurance in Medicare risk contracts? Is there sufficient ability for consumers who do not feel well-served by Medicare HMO's to pick up traditional Medicare/medigap coverage? Is it possible -- and fair to seniors -- to ratchet down the Medicare budget without achieving cost control in the private insurance sector (in the context of overall health care reform)?

There are several major problems with the Medicare Select market and we urge caution when it comes to making Medicare Select a permanent program:

- **Pricing games**: Medicare Select policies often offer cheaper premiums to begin with. But because of a system of so-called "attained age" pricing that many policies use, premiums will rise steeply as the policyholder gets older. Congress should not lock-in or expand a program which perpetuates this deceptive pricing practice.

- **Illusory Cost Savings:** Medicare Select premiums are often low, but at a cost to other Americans. Insurance companies that write Medicare Select

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[1]Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 5 million paid circulation, regularly, carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

policies typically don't pay the deductible to the hospital that other medigap policies are designed to pay. But the hospital still has to cover its costs. The result: it shifts the cost to other patients -- and their insurers.

- **The Medigap Maze:** The whole idea behind the OBRA-90 medigap reforms was to allow consumers to make kitchen table comparisons among plans. But the Medicare Select program doesn't forward that goal. Medicare Select adds a layer of confusion by forcing consumers to balance initially lower premiums against restricted freedom of choice of doctor or hospital.

SUMMARY OF RECOMMENDATIONS

We believe that it is premature to expand or make permanent the Medicare Select program because of these problems and others described below. Preliminary analysis of the program indicates that so far it has not been successful in reducing costs or even attracting substantial interest from insurers or consumers. We recommend that Congress:

- Require ALL states to do what several states have already done: community rate their medigap market to eliminate the hazardous pricing structure used by many Medicare Select plans (and level the playing field among all insurers). Alternatively, condition a state's ability to participate in Medicare Select to a state-wide requirement of community rating for the medigap market.

- Require a six-month open enrollment period for all consumers who were previously enrolled in Medicare Select.

- Limit the extension of Medicare Select to a two-year time period that would allow for study and analysis (that is currently underway by HCFA) of cost savings (vs. cost shifting) and quality control. Postpone expansion of the program to additional states until the studies are complete and regulatory adjustments can be put in place.

We elaborate on our concerns and recommendations below.

ANALYSIS OF THE MEDICARE SELECT MARKET

Pricing Games

Medicare Select policies often use an "attained age" pricing structure, which Consumer Reports says is "hazardous to policyholders." Various letters and comments regarding Medicare Select have noted that Consumer Reports found that eight of the top 15 Medigap products were Medicare Select. But this tells only part of the story. Five of the eight policies mentioned use an attained-age pricing structure. Consumer Reports stated that:

> Attained-age policies are hazardous to policyholders. By age 75, 80, or 85, a policyholder may find that coverage has become unaffordable--just when the onset of poor health could make it impossible to buy a new, less expensive policy. Take, for example, an attained-age Plan F offered by New York Life and an issue-age Plan F offered by United American. For someone age 65, the New York Life policy is about $114 a year cheaper. But by age 80, the buyer of the New York Life policy would have spent a total of $5000 more than the buyer of the United American policy.[2]

The attained-age pricing structure allows companies to bait consumers with low premiums in early years, and then trap them with high increases in later years. Standardization of the medigap market resulted in price conscious consumers, with the effect of facilitating a trend away from community-rated policies and toward attained-age rated policies. The percent of Blue Cross-Blue Shield affiliates, for example, that sell attained-age policies grew from 31 percent in 1990 to 55 percent in 1993.

Ten states have recognized this market dynamic and have taken steps to protect consumer either by requiring community rating for this market or by banning attained-age rating. These are Arkansas, Connecticut, Florida, Georgia, Idaho, Maine, Massachusetts, Minnesota, New York, and Washington. Four of these states -- Florida, Massachusetts, Minnesota and Washington -- are part of the Medicare Select demonstration program.[3]

Recommendation: Require ALL states to do what several states have already done: community rate their medigap market to eliminate the hazardous pricing structure used by many Medicare Select plans (and level the playing field among all insurers). Alternatively, condition a state's ability to participate in Medicare Select to a state-wide requirement of community rating for the medigap market.

Illusory Cost Savings

The purpose of Medicare Select was to cut health care costs through coordinated care networks that increase the use of utilization review and management controls, often through PPO's. It was expected that enrollees would be restricted to a subset of providers. But the experience shows that often there is no restriction of providers. There is little coordination or management of care in Select plans.[4]

Medicare Select premiums may be low for the wrong reasons -- because these policies shift costs to others by not covering all the costs that traditional medigap policies must cover. Medicare Select companies often negotiate with providers to eliminate the payment of Part A deductibles. Insurers have indicated that the discounts of the Part A deductible by participating hospitals is the most significant source of premium savings available in Medicare supplements.[5] This means that hospitals get less reimbursement

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[2]"Filling the Gaps in Medicare," Consumer Reports, August 1994, p. 526.

[3]It is premature to evaluate the impact of the combination of Medicare Select and community rating, since two states (Massachusetts and Washington) are new to Medicare Select and since community rating requirements are fairly recent.

[4]"Evaluation of the Medicare SELECT Amendments -- Case Study Report, RTI Project No. 32U-5531, prepared for Office of Demonstrations and Evaluations, Health Care Financing Administration, U.S. Department of Health and Human Services, February 10, 1994, RTI, p. XX-3.

[5]RTI, p. xi.

from Medicare Select carriers. It does not mean that the hospital's costs are lower, so cost shifting to other patients (and their insurers) is inevitable.

Before extending Medicare Select to additional states (or for a substantial time period), we urge you to study further why Medicare Select premiums are often low. Are they cutting premiums for their policyholders merely by shifting costs to other payers? Another issue of concern to us is whether the Medicare Select markets in each state are truly competitive. We understand that in California, for example, there is only one key Medicare Select carrier (Blue Cross).[6] A study prepared for HCFA found that three-fourths of Medicare Select enrollees have policies from affiliates of three Blue Cross and Blue Shield plans (in Alabama, California and Minnesota), hardly an indication of a truly competitive marketplace.[7] We urge you to study the level of competition in this marketplace, recognizing of course that traditional medigap policies do compete with Medicare Select policies.

Recommendation: Limit the extension of Medicare Select to a two-year time period that would allow for study and analysis (that is currently underway by HCFA) of cost savings (vs. cost shifting) and quality control. Postpone expansion of the program to additional states until the studies are complete and regulatory adjustments can be put in place.

Medigap Maze

A key goal of the medigap reform legislation that was included in OBRA-'90 was to provide true consumer choice of medigap policy by standardizing policies, thereby simplifying the choice. In light of the minimal role the Medicare Select products have made in this marketplace, we question whether the expanded complexity offers consumers significant benefits. Consumers (in Medicare Select states) must decide between Medicare only, Medicare risk plans, Medicare cost plans, health care prepayment plans, Medicare Select plans, and traditional Medicare supplement policies. They can't even consider which of 10 standard packages to consider until they have made this choice.

Furthermore, insurers have indicated that the 10 standard medigap plans are appropriate for fee-for-service (traditional) medigap policies, but not for network Medicare Select products.[8] If Medicare Select necessitates an additional one or more standard policies, then simplicity is further undercut.

Need to Await Study Results

Medicare Select was included in OBRA-90 medigap reform legislation as a demonstration program. Medicare Select was established with the hope of achieving goals such as reducing health care costs (both for the Medicare program and consumers) and reducing the paperwork burden on consumers (since Medicare Select plans relieve consumers of the paperwork burden inherent in filing claims). It should not be made permanent until studies of its effectiveness have been completed. The preliminary report (February 1994) paints a picture of Medicare Select that is hardly complimentary. A tiny percent of people eligible have enrolled; a small fraction of insurers participate; cost savings appear to be superficial only and may be cost-shifting in disguise; the market is

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[6]Three other plans: Foundation Health Plans; National Med; and Omni Health Plan have been approved but had minimal enrollment, that totals less than 500. [RTI, p. IV-17]

[7]p. ix.

[8]RTI, p. xiii.

highly concentrated; Medicare Select regulation often falls between the cracks in state regulatory departments.

Some specific findings that should set off alarms to put on the brakes -- not rush ahead with a permanent expansion -- include:

- Some states (e.g., Arizona) have found that market response has been poor and that beneficiaries tend to migrate back to traditional plans.[9]

- Several states that were selected for the program could not get it off the ground and dropped out.[10] Others have had no applications for Select plans.[11]

- When studied by RTI, only 2.5 percent of eligible Medicare enrollees selected Medicare Select policies, and most of these "rolled over" from pre-standardization products. It appears that consumers are not, in general, attracted to Medicare Select policies.[12]

- Nor are insurers attracted to the Medicare Select product: only ten percent of HMOs and medigap insurers in Select states offer Medicare Select policies, with even interest in some states.[13]

Recommendation: Congress should delay expanding and making permanent the Medicare Select program until further study results are available. It should not be made permanent without fixing the elements that are broken.

Regulatory Gaps

Medicare Select is fraught with questions about regulatory authority. It is not unusual for a state's insurance department to regulate fee-for-service medigap coverage, but another state department (e.g., Department of Public Health or Department of Corporations) to regulate Select products. It is very possible that Medicare Select policies get lost in the regulatory cracks where authority for traditional insurance and HMO's is split. This confusion has even led to approval of plans (as Select) that deviate from the OBRA '90 standard plan designs.[14]

Medicare Select consumers need regulatory protection. For example, consumers switching out of Medicare Select need protection. Consumers who choose a Medicare Select option must use providers in the designated network in order to get medigap coverage. The NAIC model regulation provided protection to consumers who elect Medicare Select but then wish to change to traditional medigap policy. Companies were required to offer such consumers a policy with similar benefits, without underwriting. **But this provision has a loophole** -- consumers have no assurance of such an offer if the

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[9]RTI, p. III-6.

[10]E.g., Oregon and Michigan. RTI, p. XV-1.

[11]E.g., Illinois. RTI, p. XV-3.

[12]RTI, p. ix.

[13]RTI, p. ix.

[14]See, for example, RTI, p. IV-9, IV-10.

Medicare Select company does not offer a traditional ("fee-for-service") medigap policy.

In the event that Congress decides to end the Medicare Select program, either now or in the future, then consumers who have Select policies when the program is ended will need protection. Without new entrants in their pool, their premiums (in closed blocks of business) would spiral upwards. They will need the protection from such an open enrollment period.

Recommendation: Congress should require that all policyholders who wish to switch out of Medicare Select be eligible for an open enrollment period (regardless of which company they select) in order to protect them against being locked into a Medicare Select plan that they do not like.[15] This protection would actually help to promote the Medicare Select option because consumers would have a safety valve if they are dissatisfied. If Congress chooses to end the Medicare Select program, insurers should be required to extend an open enrollment period to Medicare Select policyholders. We urge the Congress to study carefully the regulatory experience and analyze where regulatory authority for Medicare Select is best housed.

Does Medicare Select Compromise Quality?

Medicare Select policies keep premiums low by negotiating lower reimbursement schedules with providers (mostly hospital), providing discounts to policyholders. On average Medicare pays doctors and hospitals about 59 percent of what private insurers pay for the same services. If (in the future) Medicare Select coverage is negotiated downward (e.g., providing Select policies with Part B discounts also), providers will get even less. At some point, the cumulative impact of lower reimbursement has got to have an impact on quality of care that patients receive. This could occur when providers withdraw from providing services to consumers, or when they cut corners (such as patient time) due to the lower reimbursement levels.

Recommendation: Congress should study the impact of further negotiated discounts for providers before rushing to extend the Medicare Select program.

In conclusion, research done to date indicates that the Medicare Select demonstration program has not achieved its goals. It has resulted in a marketplace in which premium pricing games distort the true cost of the policy. It has not achieved cost savings, but merely shifts costs to other consumers. Few insurers and few consumers have participated. In many states, regulation of this product has fallen between the cracks of different regulatory agencies (is it insurance or managed care?), leaving consumers without the protections they need. Congress should not expand the program and make it permanent, but should take steps now to fix what is broken (the pricing structure, the need for open enrollment) and await further study results before locking the program into place. With respect to Medicare Select, we urge you to proceed with caution.

Thank you for considering our views.

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[15]In Florida, Select insurers are required to offer at least a basic Plan A in a non-Select form, providing partial protection for people who wish to switch out of Select plans. One side-effect: this provision makes it infeasible for HMO's to offer SELECt plans.

Photos by Tracey Kroll

FILLING THE GAPS IN MEDICARE

How to buy the right Medicare-supplement policy at the right price.

Some 2 million Americans will turn 65 this year and become eligible for Medicare. If you or someone close to you are among them, this report will help you understand the jargon and get the best coverage for your needs.

Since its introduction in 1967, Medicare has been a lifeline for older Americans, paying about 90 percent of their hospital and doctor bills. To handle the remainder and some other expenses Medicare doesn't cover, many people buy Medicare-supplement insurance, sometimes referred to as a "Medigap" policy.

As important as the Medicare program has become, many recipients still don't understand how it and Medicare-supplement insurance work. That ignorance has allowed some insurance companies and some doctors to take advantage of Medicare beneficiaries and the system itself.

In this report, we rate 181 Medicare-supplement policies. Next month, we'll look at the future of the Medicare program, at the managed-care options available for beneficiaries, and at policies for people with disabilities.

Five years ago, when CONSUMER REPORTS investigated the Medicare-supplement market, we found many problems, particularly in the way policies were being sold. A year after that report was published, Congress passed reforms designed to make shopping for a Medicare-supplement policy easier and to stop agents from selling duplicate policies that consumers didn't need.

What reform accomplished

The reforms resulted in 10 standard policies that were identical from company to company. The idea was to create a fairer marketplace and to make policies easier to compare. In theory, insurers would then compete

to offer the lowest price for each of the 10 options.

The law has had positive effects. It eliminated the bewildering variety of benefits that insurance companies had been selling. It made agents wary of selling a prospect more than one Medicare-supplement policy, a useless and costly duplication of coverage. And it led to the creation of shopping guides in two-thirds of the states.

But a recent, seven-month investigation by CONSUMER REPORTS reveals that insurance companies and agents have in many instances thwarted the best intentions of Congress.

■ Instead of offering a choice of 10 policies, agents and insurance companies are steering consumers to only one or two plans, while strongly disparaging the others.

■ Agents are failing to give their sales prospects the price information they're required by law to provide.

■ Agents are still urging consumers to buy benefits they don't need, and their sales pitches are as misleading as ever. One California woman who counsels seniors about Medicare sat through several agents' sales presentations with our reporter and left shaking her head. "Now I understand why they come into my office so confused," she said.

■ Insurance companies are still playing pricing games that will mean nasty surprises for policyholders later on. Different insurance companies charge premiums that vary by hundreds of dollars for the same set of benefits in the same city. Our analysis of their premiums shows that many insurers charge substantially more for their policies than appears warranted.

The 10 plans

In 1992, the National Association of Insurance Commissioners created the 10 standardized plans. It is illegal for a carrier to sell anything other than those 10 plans, except in Massachusetts, Minnesota, and Wisconsin. Those states already had similar laws on the books when the Federal standards were passed.

All 10 plans, designated by the letters A through J, provide certain "core" benefits: They pay the patient's share of the cost for long hospital stays, the patient's share of the cost for physicians' services, and the cost of up to three pints of blood. (Medicare covers transfusions above that amount.) Plan A offers only the core coverage. The others provide the core plus a combination of other benefits. The chart below shows what each plan provides and explains the basic mechanics of Medicare.

State regulations require insurance agents, as well as companies that sell policies through the mail, to present an outline of the benefits in each of the 10 plans, along with price information for each plan they sell. (Insurers are not required to sell any specific plan except Plan A.) But even those fairly lenient measures are being stymied.

We sat in on agents' sales pitches in California, Florida, Maryland, and New York. Sometimes the agents didn't give their prospects the required outline—or if they did, they used it as a sales tool to disparage the plans they didn't want to sell. Half of the agents whose pitches we heard didn't leave the required price information.

Companies selling through the mail may not do much better. For example, a Physicians Mutual mailing to a consumer in Nebraska gave price information only for Plans A and F, omitting prices for the other two plans the company can sell in that state.

The goal of standardization was to allow consumers to pick the plan most suitable to their needs. But judging by the sales pitches we heard and by the sales data provided by the insurance companies, it seems that consumers are being steered primarily to only two of the 10 plans: Plan C and Plan F. About two-thirds of Medicare-supplement sales for the companies in our study come from those two plans.

Why Plan F?

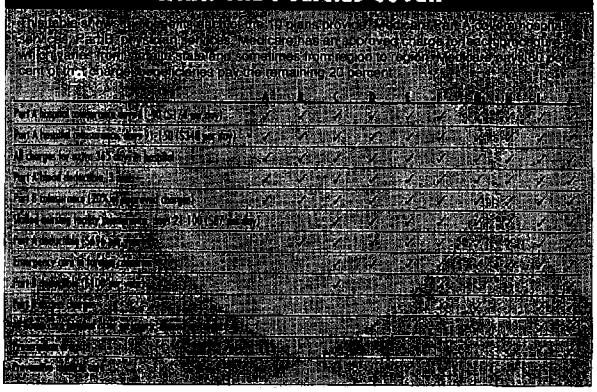
Plans C and F, the darlings of the insurance industry, are nearly identical, but Plan F is particularly attractive to insurers. It differs from Plan C in that it covers excess physicians' charges—the amounts doctors can bill patients above Medicare's approved charge.

Until recently, doctors had carte blanche to sock patients with high excess charges, a practice known as "balance billing." Horror stories about balance billing have made Plan F an easy sell to consumers. But excess charges are increasingly a thing of the past.

Most patients don't encounter excess charges today, and insurers seldom have to pay off on that benefit—making Plan F a no-lose proposition for them. The average premium for Plan F runs about $160 more—in some cases $500 more—than Plan C. Yet we estimate the average value of the extra benefit at only $53.

In 1989, we did find that excess charges were a significant problem, and we recommended that people buy insurance to cover them. But since 1991, Congress has steadily reduced the amount that doctors may legally bill above Medicare's approved charge. Today they can charge their patients a maximum of 15 percent more than the approved amount. For instance, a doctor in Manhattan who balance bills for an

WHAT THE POLICIES COVER



"intermediate office visit" (longer than a brief visit but shorter than a comprehensive one) can charge a maximum of $44.08—$38.33 plus an excess charge of $5.75 billed to the patient.

Some 65 percent of all doctors have signed "participation" agreements, meaning they will take Medicare's approved charge as payment in full for every patient. In Medicare-speak, they "take assignment." In return, they are entitled to receive 100 percent of the approved charge as their fee. (Medicare pays 80 percent; the beneficiary pays 20 percent.) For nonparticipating doctors, Medicare pays only 95 percent of the approved amount. The mathematics of balance billing give them a little over 9 percent more than the approved charge.

Increasing numbers of physicians are finding it's hardly worth the trouble to balance bill. Even doctors who don't "participate" completely often take assignment on a case-by-case basis. In 1993, about 91 percent of all approved charges were taken on assignment, and that number is rising each year. (The map at right shows the risk of facing excess charges in each state.)

Even so, in state after state, people are needlessly buying Plan F. One company shared its sales strategy with us. Its agents are to present Plan F, but if there's price resistance or if competing agents have shown policies with lower prices, they are to switch to the less costly Plan C and push a long-term-care policy as well.

At a Florida sales call, our reporter witnessed an AFLAC agent urge his prospect to avoid Plan E, which offers a $120 annual benefit for some preventive care that Medicare normally doesn't cover. The agent boasted, "I know how you can go to the doctor and still have preventive care covered. If you want to go to an ophthalmologist, complain of itchy eyes." The agent also disparaged Plan D, which covers at-home recovery, steering the consumer smoothly to Plan F instead.

"Plan F buys peace of mind," an official for South Carolina Blue Cross-Blue Shield told us. The plan also buys coverage that most South Carolinians on Medicare don't need. Last year, only about 8 percent of all approved charges were *not* accepted as payment in full. To protect themselves from this low risk, South Carolinians might spend as much as $250 more a year to buy Plan F rather than Plan C. For a couple on Medicare, that means an extra $500 in annual premiums for coverage they're not likely to need. To make that $500 expense pay for itself, they would have to buy some $3800 in services from physicians who balance bill.

Scare tactics

Some agents lie outright to scare their prospects into buying Plan F. "If I could make an impression here, it's that the gap is getting bigger and bigger between what's approved and what's charged," we heard a Maryland agent tell his prospect. In fact, the gap is narrowing. In Maryland today, only about 5 percent of approved charges are not accepted by doctors as payment in full, down from about 8 percent in 1991.

If you know your own doctor will take assignment, you may have nothing to fear. So agents warn their prospects about the excess charges billed by specialists—the ultimate sales pitch for Plan F. A Maryland agent flatly said, "If you're seeking out a specialist, you can forget about them accepting what Medicare pays." And in Florida, one insurance agent told us that "a lot of doctors take assignment, but cardiologists, anesthesiologists, and radiologists won't waive the 15 percent."

According to data supplied exclusively to CONSUMER REPORTS by the Health Care Financing Administration, which administers Medicare, that agent was far off the mark. In Florida, only 4.6 percent of approved charges from cardiologists, 1.8 percent from anesthesiologists, and 3.5 percent from radiologists were not taken on assignment, a low risk by any measure.

Nationally, most specialists, especially those who perform high-cost procedures, accept Medicare's payment as payment in full. Last year, for example, only 6 percent of all approved charges billed by cardiologists were subject to excess charges.

For anesthesiologists, the figure is somewhat higher: 10.5 percent. The risk of running into an anesthesiologist who does not take assignment is greatest in California, Colorado, Idaho, Iowa, Minnesota, Montana, Nebraska, New Jersey, New York, North Dakota, Oklahoma, Oregon, South Dakota, Washington, and Wyoming.

The doctors most likely to bill more than Medicare pays are family practitioners and internists. Nationally, about 14.5 percent of approved charges billed by doctors in family practice and a little more than 13 percent of those billed by internists were not accepted as full payment last year. But it's easy to choose a family doctor who doesn't engage in balance billing. Medicare publishes directories of participating physicians; those directories are available at local Social Security offices and from Medicare carriers listed in the Medicare Handbook sent to beneficiaries when they enroll. It's better to pick a participating doctor than to spend money for extra insurance.

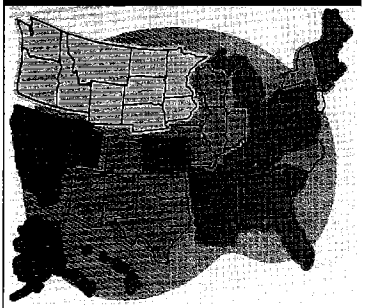
Although most Medicare services are now subject to the balance-billing limits, durable medical equipment (such as oxygen tanks and wheelchairs), prosthetic devices, and ambulance services are not. Providers of those items and services can charge Medicare patients whatever they wish. Such expenses would be covered by Plan F.

The pricey drug plans

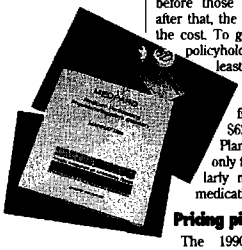
If Plan F is oversold, Plans H, I, and J, which offer limited benefits for prescription drugs and command sky-high premiums, are hardly pushed at all. That may be a good thing. To get the $1250 maximum benefit on Plans H and I or the $3000 maximum benefit on Plan J, consumers often have to spend as much as that or more in premiums. We found annual premiums for Plan H as high as $2160; for Plan I, as high as $3088; and for Plan J, as high as $3312.

Even after shelling out such a

WHERE THE EXCESSES ARE



Low, moderate, high If you live in one of the states colored ■, you face a low risk of running into an unassigned claim and having to pay excess charges. In those states, the percentage of such charges is below the national average of 8.9 percent. In states colored ■, your risk is moderate. In states colored ■, your risk of facing excess charges is higher—at least twice the national average.



large premium, a policyholder must satisfy a $250 deductible for drugs before those benefits begin—and after that, the policy pays only half the cost. To get $1250 in benefits, policyholders must incur at least $2750 in prescription drug expenses, and to get $3000 in benefits, they must spend $6250. Such costs make Plan J a realistic option only for patients who regularly need very expensive medications.

Finding a doctor
To locate a doctor who participates in Medicare, check the directory found at local Social Security offices and available from the insurers that process Medicare claims.

Pricing pitfalls

The 1990 reforms of the Medicare-supplement market had another unintended effect. Many companies have changed the way they price policies so they can bait consumers with low premiums at the outset and trap them with very high increases later on.

In 1989, most carriers used either "community rates" or "issue-age rates" to price their policies. With community rates, all policyholders, young or old, pay the same premium. With issue-age rates, premiums will vary depending on the age of the buyer. But in either case, the annual premium will go up only to reflect inflation in the cost of benefits; it will not rise because you get older. Both community and issue-age rates protect policyholders from steep annual increases.

Now, however, more and more insurance companies are resorting to a less benign strategy known as "attained age" pricing. It allows companies to gain a competitive advantage by selling cheap policies to 65-year-olds when they enter the Medicare-supplement market. With attained-age pricing, the initial premiums, especially for those between 65 and 69, are usually lower than for issue-age or community-rated policies. But there's a catch: Premiums will rise steeply as the policyholder gets older.

In 1990, 31 percent of all Blue Cross-Blue Shield affiliates sold policies with attained-age rates. In 1993, 55 percent did. At the same time, the proportion of Blue Cross-Blue Shield plans offering community rates has dropped from 51 percent to 21 percent. AARP/Prudential still offers community rates but finds its initial premiums have become less competitive for policyholders age 65 to 69.

Attained-age policies are hazardous to policyholders. By age 75, 80, or 85, a policyholder may find that coverage has become unaffordable—just when the onset of poor health could make it impossible to buy a new, less expensive policy. Take, for example, an attained-age Plan F offered by New York Life and an issue-age Plan F offered by United American. For someone age 65, the New York Life policy is about $114 a year cheaper. But by age 80, the buyer of the New York Life policy would have spent a total of $5000 more than the buyer of the United American policy.

Buyers are rarely warned of these consequences. Neither insurers nor agents are required to tell consumers how expensive attained-age policies will become over time. A sales brochure from California Blue Cross, which boasts one of the state's hottest-selling Medicare supplements, says nothing about rate increases; it doesn't even mention that rates are calculated on an attained-age basis. Of the 17 agents our reporter heard, only one discussed the way his company's rates were set—and he thoroughly confused the three methods. "The vast majority of agents don't understand attained-age pricing, so they can't possibly explain it to their customers," says Mark McAndrew, president of United American.

Only 10 states—Arkansas, Connecticut, Florida, Georgia, Idaho, Maine, Massachusetts, Minnesota, New York, and Washington—either require that insurers use community rates or specifically ban attained-age policies. In most other states, insurers are shifting to attained-age policies. United American, a large seller of Medicare-supplement policies, has just notified state insurance regulators that it plans to switch from issue-age to attained-age rates. "We think attained-age rates are a bad thing, but our agents had to eat," explains Joyce Lane, a United American vice president.

Rating the policies

To obtain the prices we show in the Ratings, we asked the Blue Cross-Blue Shield organizations and the commercial carriers that do most of the Medicare-supplement business to supply us with premiums for all the plans they sell. Most cooperated; those that didn't are marked with an asterisk. If a company didn't give us its rates, we did our best to obtain them from state insurance departments. In all, we obtained more than 10,000 prices.

To judge policies, we estimated the value of benefits provided by each of the 10 plans for policyholders in 64 cities at age 65, 70, and 75. We then computed a price index for the benefits in each policy. The higher the index, the more expensive the policy.

Policyholders, of course, should expect to pay something more than the value they receive, to cover the company's expenses and provide a reasonable profit. National Association of Insurance Commissioners guidelines suggest that the extra cost for expenses and profits should not exceed 54 percent of the value of the benefits. But our analysis showed that two-thirds of the 65 companies in our survey are apparently charging more than that. Some premiums amount to nearly 150 percent of the estimated value of the benefits.

The 1990 reforms will in the future require insurers to refund money to policyholders whenever they have paid out too few benefits for the premiums they charged. If the law is enforced, many companies will be busy writing refund checks. But when we asked state regulators if they expected refunds, about half told us they did not.

Can you get a policy?

During the first six months after signing up for Medicare Part B, which covers physicians' services and hospital outpatient care, anyone can buy Medicare-supplement insurance, regardless of health, from any company. After that open window closes, companies in most states can deny coverage based on medical history. AARP/Prudential and the Blue Cross plans in some states offer "guaranteed issue" policies that provide coverage regardless of health status.

When insurers do inquire about an applicant's health after the six-month open window, they can be strict. Most ask prospective policyholders whether they've had certain health problems. A "yes" answer to any question usually triggers a rejection. Even fairly common conditions, such as having cataracts or facing surgery, can disqualify an applicant. Only a few insurers told us they would reconsider if more information were provided.

Insurance companies, including those that sell guaranteed-issue policies, are very strict when it comes to offering drug coverage. Applicants are asked to list the drugs they take and to estimate how much they spend each month. Applicants who spend more than a certain amount

OVERCHARGES, RETAINERS, WAIVERS

HOW MEDICARE PATIENTS ARE BILKED

To extract more money from Medicare patients, some physicians engage in questionable, if not illegal, practices that make patients pay more than they should. Three to watch out for are overcharges, retainers, and waivers.

Overcharges. Two years ago, James McGlynn, a 70-year-old retired truck driver from College Point, N.Y., underwent hand surgery. As a condition for performing the operation, a surgeon at a New York City hospital made him sign a contract agreeing to pay $2601.

Medicare's "approved charge" was $1243. It paid $994, its 80 percent share. McGlynn's supplemental insurer, Empire Blue Cross-Blue Shield, made the 20 percent copayment of $249. That left McGlynn with an out-of-pocket expense of $1358—$1172 of which represented an illegal overcharge. Under New York law in 1992, a doctor could charge a patient no more than an additional 15 percent of Medicare's approved charge. But McGlynn paid the bill; to him, a contract was a contract.

Last year nearly 1.5 million Medicare beneficiaries were illegally overcharged by their doctors. The overcharges totaled some $101-million.

Until mid-1992, the Health Care Financing Administration, which administers Medicare on the Federal level, had done practically nothing to enforce the laws on overcharging. In fact, it was telling beneficiaries they had to pay the illegal amounts. New York state was doing even less. Later that year, the HCFA began "looking at" excess charges doctors billed and advising them they were overcharging. In 1993, it began notifying beneficiaries they had been overcharged.

This year, the HCFA is trying to make doctors refund illegal charges to patients and show proof that they did. It's too early to judge the effectiveness of this latest activity. Though the law provides civil penalties for doctors who repeatedly overcharge and doctors can be thrown out of the program, the HCFA is just beginning to look for repeat offenders. So far, no doctors have been punished.

Medicare-supplement carriers are not required to cover any excess charges above the legal limits. However, some insurers apparently will pay even illegal charges. That often tempts doctors to see what they can get away with.

Retainers. In late May, our reporter obtained from an Atlanta physicians' office a retainer agreement obligating new Medicare patients to pay $400 for a package of services ostensibly not covered by Medicare. Those doctors require that new patients sign the agreement in order to be treated. Services include a comprehensive physical examination, an annual fin shot, a sigmoidoscopy (to examine the colon), and unlimited office and hospital visits. The package also covers the patient's Medicare Part B deductible of $100 and 20 percent coinsurance. Doctors in several states have been selling this package, called "Primary Physician Care." Similar packages have been marketed elsewhere.

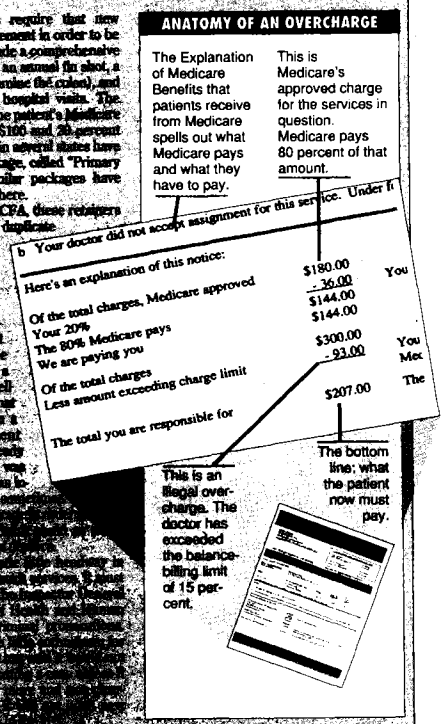
According to the HCFA, these retainers may be illegal. They duplicate provisions in a traditional Medicare-supplement policy; at the very least, they duplicate coverage for the Part B deductible and the Part B coinsurance. The 1990 reforms make it a crime to knowingly sell someone a policy that duplicates benefits in a Medicare-supplement policy that person already owns. That provision was aimed at unscrupulous insurance agents who [illegible] [illegible] their [illegible] apply to [illegible]

The HCFA [illegible] in [illegible] rely on the [illegible] in the Department of [illegible] Services to [illegible] That office has [illegible] upholding the [illegible] even [illegible] involved [illegible] out. [illegible]

[illegible] patients to [illegible] doctor [illegible] services [illegible] separately for [illegible] ferences, and [illegible] vices Medicare [illegible] pays physicians.

In what's called a [illegible] for lists a number of [illegible] asks patients to [illegible] fit into those [illegible] "Medicare does not [illegible] injection or [illegible] "Medicare does not [illegible] extensive procedure."

The only type of [illegible]


ANATOMY OF AN OVERCHARGE

The Explanation of Medicare Benefits that patients receive from Medicare spells out what Medicare pays and what they have to pay.

This is Medicare's approved charge for the services in question. Medicare pays 80 percent of that amount.

b Your doctor did not accept assignment for this service. Under f

Here's an explanation of this notice:

Of the total charges, Medicare approved	$180.00	You
Your 20%	- 36.00	
The 80% Medicare pays	$144.00	
We are paying you	$144.00	
Of the total charges	$300.00	You
Less amount exceeding charge limit	- 93.00	Mec
The total you are responsible for	$207.00	The

This is an illegal overcharge. The doctor has exceeded the balance-billing limit of 15 percent.

The bottom line: what the patient now must pay.

[illegible] that [illegible] a specific uncovered procedure [illegible] surgery. All others have [illegible] the excess charge [illegible] However, didn't stop a Man[illegible] from telling our reporter [illegible] that such a waiver would be [illegible] he would provide services. [illegible] earlier, a patient had given the [illegible] waiver from the same doctor to the [illegible] Beneficiaries Defense Fund, a [illegible] advocacy group. Last [illegible] the defense fund sent the waiver on [illegible] HCFA, and a few months later the [illegible] insurance companies that pay [illegible] claims to notify doctors that [illegible] could be illegal. The practice [illegible] nevertheless.

are out of luck. That threshold can be low. New York Life, for instance, refuses to sell drug benefits to anyone whose monthly prescription bill exceeds $100.

What to buy

For most people, the important benefits beyond the core are coverage for Medicare's hospital deductible, this year $696; the coinsurance required for a stay in a skilled nursing-care facility; and at-home recovery services, a potentially useful although limited benefit.

Plans B, C, and D cover most of the basics with the fewest frills. Unless you live in a state where you face a high risk of running into unassigned claims, you'll save money if you skip Plan F and its higher-priced cousins—Plans G, I, and J. The plans with drug coverage (H, I, and J) don't appear to be worth the added cost.

We have based our comparisons on Plan C—not because it's the ideal plan, but because it is one of the most widely available. Plan B is a better choice, if you can find it. It covers most of the important gaps and is about 16 percent cheaper on average than Plan C. The average annual premium runs about $722 for Plan B, compared with $856 for Plan C.

Plan D is also a better value than Plan C but unfortunately just as hard to find as Plan B. Unlike Plan C, it doesn't cover the $100 deductible for Medicare physicians and outpatient services—a benefit that sometimes adds more than $100 to the premium. Instead, Plan D covers some at-home recovery services that could be useful. A few Blue Cross organizations do sell Plan D.

The section of the Ratings titled "How the Insurers Rank Nationally" lists companies that generally have lower-than-average prices. Because our national rankings are based on all plans across all cities and all ages, they are only a rough guide. A company may sell cheaper policies in one location and very expensive policies in another.

The "Best Policies" table on the following page is specific to 64 cities. It lists the two best community-rated or issue-age policies and the best attained-age policy for each locality. Though we include attained-age policies, we don't recommend them for most people. They should be considered only by people who have reason to believe they won't live very long or who know they will have enough money to cover the steeply increasing premiums in old age. Note that, in some locations, a community-rated or issue-age policy may have a lower rate than an attained-age policy.

AARP/Prudential's community-rated policies are clearly the best buys for people 75 or older. And with the exception of the drug plans, the AARP policies have the added advantage of being available to everyone at any time. Even the AARP policies for 65-year-olds show up among the best values for some locations.

A word of caution, however. To continue community rating with competitive prices, AARP/Prudential must continue to attract its share of younger applicants. If it doesn't, it may later have to raise rates or stop offering community-rated policies.

If you have an old plan that you bought before standardization, and it covers private rooms and private duty nurses, you might want to keep it, since those benefits are no longer available. But if you can buy a cheaper plan that gives you the coverage you want, you may want to switch. If you do switch, remember the attained-age pricing trap.

You may also want to consider company stability. If your carrier got

TOUGH DECISION

EMPLOYER COVERAGE OR YOUR OWN?

When Milton Stern retired nine years ago from Smith International, a maker of oil-well valves, the company provided health insurance that cost Stern and his wife $300 a year. The policy required a small deductible—a total of $100 for both. But the Sterns' good fortune didn't last. When the company got into financial trouble, it switched its retirees to another type of plan.

Stern's premium climbed to $1500 a year, and he and his wife had to satisfy a $400 deductible. That sent Stern into the market for traditional Medicare-supplement insurance. Stern, who is 84, eventually bought coverage from AARP/Prudential, the best choice we've found for people at older ages. Its policies are community-rated and don't have medical requirements.

Stern's dilemma illustrates what thousands of retirees are facing—the loss of good supplemental coverage paid by their former employers. Hundreds of employers are cutting retiree benefits or dropping their coverage altogether.

Judging ex-employer coverage. The 1990 reforms that led to standardized Medicare-supplement policies did not apply to the coverage offered by employers. If the coverage offered by an employer is clearly inadequate and far too expensive, a retiree may want to drop it and buy a traditional Medicare supplement, as Stern did. However, if the employer's coverage provides prescription-drug benefits but is otherwise inadequate, or if a younger spouse not yet eligible for Medicare is involved, the decision is harder. In these situations, a retiree may have little choice but to keep the employer's coverage, especially if the premium is fairly low.

Can you have both? It's technically illegal for an insurer to sell a policy that duplicates benefits provided by an employer. (The 1990 reforms outlawed duplicate coverage because some unscrupulous insurers were selling consumers multiple policies.) Our survey shows that state regulators do not agree on whether this is, in fact, duplication. They need guidance from Congress. But Congress has yet to pass "technical" corrections to the reform laws that would allow employees to have both types of coverage.

If you work past 65. People who continue to work after age 65 face different choices. If you work for a company with 20 or more employees, your employer must offer you the same coverage it offers younger workers. You can take that coverage, which may be broader than Medicare's.

If you do choose your employer's coverage, you may want to delay signing up for Medicare Part B. That's because the six-month open-enrollment window (during which you do not have to meet an insurer's medical requirements) doesn't begin until you first sign up. If you sign up and don't buy a policy within the next six months, you could be out of luck. Your employer's coverage is primary in this situation anyway, and it's probably not worth the trouble to get Medicare to pay for small amounts not covered by your employer's insurance. That is especially true if your health coverage is provided through a managed-care plan, for which the copayments are likely to be small.

If you choose to sign up for Medicare instead of the employer plan, your employer is not allowed to offer a Medicare-supplement policy. You will have to buy one on your own.

If you continue to work for a company with fewer than 20 employees, the rules are different. Medicare becomes your primary insurer, and your company is allowed to provide you with a supplemental policy. But many small firms don't, and most likely you'll have to buy your own. Be sure to do so before the six-month window closes.

into financial trouble, you could look to the guaranty fund in your state to protect your benefits. Or more likely, the state insurance department would arrange for another company to take over your coverage. However, you might be inconvenienced in the meantime. For a discussion of company financial strength, see "When It's Time to Buy Life Insurance," CONSUMER REPORTS, July 1993.

Needed: Further reform

Many of the problems still afflicting the Medicare-supplement market mirror those in the larger health-insurance market. There are disturbing parallels between the disappearance of community- and issue-age rating in Medicare supplements and the demise of community rating for other types of health coverage. That trend has made insurance unavailable or unaffordable for many employees of small firms, a problem that helped create the current health-care crisis. Unless state regulators outlaw attained-age pricing or national health reform makes community rating mandatory for Medicare-supplement policies (as it would be under the Clinton health-care plan), attained-age pricing will take over the marketplace, with serious consequences to the oldest policyholders.

Some health-care reform proposals are based on the theory that market competition and the availability of information about providers and health-care plans will enable consumers to select the right coverage at the best price. Our investigation of the Medicare-supplement market indicates that those assumptions haven't been borne out. Market competition is of little help if it doesn't result in better products, better prices, or both. And information is all but useless if it never reaches the consumer it was intended to help. ■

For information on reprints and prices, please write: CU/Reprints, 101 Truman Ave., Yonkers, N.Y. 10703.

Best policies for 64 cities

Notes on the table This table lists the best community- or issue-age-rated policy for Plan C, a widely available plan that covers the essential gaps in Medicare. The table also shows the best attained-age policy, although such policies are inappropriate for many people, as we explain on page 526. **Premium** reflects annual premiums for community- or issue-age-rated policies at age 65; such premiums are subject to annual increases based on increases in Medicare deductibles and coinsurance, but not on the policyholder's age. Attained-age premiums are the initial premiums paid by someone at age 65; they are subject to substantial increases as the policyholder ages, as well as to increases due to higher deductibles and coinsurance. "Select" policies are a combination of traditional insurance and managed-care plans, such as health-maintenance organizations. We will discuss how they work next month.

	Best community or issue-age policies				Best attained-age policy	
Location	First company	Premium	Second company	Premium	Company	Premium
Ala. (Birmingham)	Continental General	$834	AARP/Prudential	$945	Union Bankers	$586
Alas. (Anchorage)	AARP/Prudential	744	AFLAC	877	Bankers United Life	800
Ariz. (Phoenix)	Physicians Mutual	843	AARP/Prudential	846	Samaritan Group (Select)	716
Ark. (Little Rock)	AARP/Prudential	804	Pyramid Life	867	1	
Calif. (Los Angeles)	AARP/Prudential	953	Continental General	969	Central States Health & Life	908
Calif. (San Diego)	Continental General	862	AARP/Prudential	963	Bankers Life & Casualty	756
Calif. (San Francisco)	Continental General	862	AARP/Prudential	885	Bankers Life & Casualty	756
Colo. (Denver)	Physicians Mutual	773	First National Life	792	Union Bankers	683
Conn. (Bridgeport)	Central States Health & Life	786	Bankers Life & Casualty	885	1	
Del. (Wilmington) 2	AARP/Prudential	831	Union Labor Life 3	847	Union Bankers	384
Wash., D.C.	AARP/Prudential	717	AFLAC	888	Bankers Life & Casualty	596
Fla. (Jacksonville)	Continental Life Insurance	841	AARP/Prudential	858	1	
Fla. (Miami)	Continental General	999	Mutual of Omaha	1050	1	
Fla. (Tampa)	AARP/Prudential	858	Medico/Mutual Protective	897	1	
Ga. (Atlanta)	Physicians Mutual	805	Integrity National Life	818	1	
Hawaii (Honolulu)	AARP/Prudential	501	Continental General	842	Bankers United Life	724
Idaho (Boise) 4	AARP/Prudential	702	First National Life	732	Pioneer Life	643
Ill. (Chicago)	AARP/Prudential	852	United American	968	Central States Health & Life	699
Ind. (Indianapolis)	First National Life	550	AARP/Prudential	693	Integrity National Life	556
Iowa (Des Moines)	AARP/Prudential	711	Continental General	742	American Republic	611
Kan. (Wichita)	Mutual of Omaha	756	AARP/Prudential	780	Hartford Life 3	557
Ky. (Louisville)	Humana (Select)	684	Blue Cross Blue Shield of Ky. (Select)	694	Central States Health & Life	629

1 *State does not allow attained-age rating, or no company provided attained-age rates.*
2 *State does not allow Plan C; rates are for Plan D.*
3 *Policies unavailable to general public; sales restricted to members of particular groups.*
4 *Passed laws prohibiting attained-age rating; not yet implemented.*

Location	Best community or issue-age policies				Best attained-age policy	
	First company	Premium	Second company	Premium	Company	Premium
La. (New Orleans)	Continental General	$890	Physicians Mutual	$945	Central States Health & Life	$768
Me. (Portland)	Blue Cross Blue Shield of Maine	548	AARP/Prudential	606	[1]	
Md. (Baltimore)	First National Life	792	Union Labor Life [3]	809	Union Bankers	651
Mich. (Detroit)	United American	867	Medico/Mutual Protective	889	Union Bankers	683
Miss. (Jackson)	Continental General	801	AFLAC	877	Celtic Life	654
Mo. (Kansas City)	Continental General	810	AARP/Prudential, Equitable Life & Casualty	852	Bankers Life & Casualty (Select)	573
Mo. (St Louis)	Continental General	810	AARP/Prudential, Equitable Life & Casualty	852	Bankers Life & Casualty (Select)	573
Mont. (Billings)	AARP/Prudential	711	First National Life	732	Bankers United Life, Bankers Life & Casualty	724
Neb. (Omaha)	Continental General	732	AARP/Prudential	780	Celtic Life	594
Nev. (Las Vegas)	Standard Life & Accident	963	AARP/Prudential	969	Union Bankers	779
N.H. (Manchester)	AARP/Prudential	675	Physicians Mutual	844	Bankers Life & Casualty	596
N.J. (Newark)	AARP/Prudential	753	Blue Cross Blue Shield of N.J.	1010	Bankers Life & Casualty	756
N.J. (Jersey City)	AARP/Prudential	753	Blue Cross Blue Shield of N.J.	1010	Bankers Life & Casualty	756
N.M. (Albuquerque)	AARP/Prudential	732	American Republic	749	Bankers Life & Casualty	660
N.Y. (Brooklyn)	AARP/Prudential	936	First United American	1182	[1]	
N.Y. (White Plains)	AARP/Prudential	936	First United American	1182	[1]	
N.C. (Charlotte)	Blue Cross Blue Shield of N.C.	599	AARP/Prudential	681	Integrity National Life	618
N.C. (Raleigh)	Blue Cross Blue Shield of N.C.	599	AARP/Prudential	681	Integrity National Life	618
N.D. (Fargo)	AARP/Prudential	657	Continental General, Equitable Life & Casualty	810	Hartford Life [2]	592
Ohio (Columbus)	AARP/Prudential	783	Continental General	855	Bankers Life & Casualty (Select)	570
Ohio (Cleveland)	AARP/Prudential	783	Continental General	855	Bankers Life & Casualty (Select)	570
Ohio (Cincinnati)	AARP/Prudential	783	Continental General	855	Bankers Life & Casualty (Select)	570
Okla. (Oklahoma City)	Hartford Life [2]	690	Continental General	788	Central States Health & Life	629
Ore. (Portland)	AARP/Prudential	696	First National Life	792	American Republic	698
Pa. (Philadelphia)	AARP/Prudential	861	Physicians Mutual	959	Union Bankers	671
Pa. (Pittsburgh)	AARP/Prudential	861	Physicians Mutual	874	Union Bankers	671
R.I. (Providence)	AARP/Prudential	657	Blue Cross Blue Shield of R.I.	808	Bankers Life & Casualty	532
S.C. (Columbia)	Union Labor Life [3]	727	Continental General	766	Central States Health & Life	641
S.D. (Sioux Falls)	AARP/Prudential	762	Continental General	767	Hartford Life [3]	528
Tenn. (Memphis)	AFLAC	820	Continental General	834	Pyramid Life	662
Tex. (Dallas)	Continental General	877	Continental General	888	Bankers Life & Casualty (Select)	613
Tex. (Houston)	Continental General	877	AARP/Prudential	924	Bankers Life & Casualty (Select)	613
Tex. (San Antonio)	First National Life	792	Continental General	877	Sierra Health & Life (Select)	432
Utah (Salt Lake City)	AARP/Prudential	624	Equitable Life & Casualty	810	Bankers Life & Casualty	592
Va. (Richmond)	Blue Cross Blue Shield of Va.	744	AARP/Prudential	768	Integrity National Life	503
Vt. (Burlington)	AARP/Prudential	579	Physicians Mutual	689	New York Life	526
Wash. (Seattle)	AARP/Prudential	690	Physicians Mutual	705	[1]	
W.Va. (Charleston)	AARP/Prudential	783	Continental General	845	Pioneer Life	676
Wyo. (Cheyenne)	AARP/Prudential	642	Continental General	734	Pioneer Life	643
NONSTANDARD STATES' BASIC PLAN						
Mass. (Boston) [4]	AARP/Prudential	396	Blue Cross Blue Shield of Mass.	577	Bankers Life & Casualty	385
Minn. (Minneapolis)	Blue Cross Blue Shield of Minnesota	311	New York Life	483	[1]	
Wisc. (Milwaukee)	Continental General	458	AARP/Prudential	522	Central States Health & Life	431

How the insurers rank nationally

Notes on the table This table ranks the insurance companies in our study from least expensive to most expensive. For each company, we averaged the price indexes we calculated for all the plans it offers to three different age groups in 64 large cities. The "Best Policies" table on page 529 shows the policies we recommend for each of the 64 cities. If you do not live in or near one of those cities, use this table to shop for a low-cost insurer. **Value index** is based on a price index that measured the value of a package of benefits in relation to each plan's cost. **Underwriting** is our judgment of how tough a company's medical requirements are for obtaining a policy without drug coverage after the six-month "open window" has closed. **Pre-existing conditions** shows the waiting period before policyholders are covered for an existing medical problem. **Rating method** shows which of three methods the insurer primarily uses. Most policyholders are better off with a community- or issue-age rated policy. Dashes indicate information was unavailable.

Company	Value index (0 Poor—Excellent 100; P F G VG E)	Underwriting	Pre-existing conditions	Rating method	Telephone
Blue Cross Blue Shield of Mich.		Guaranteed	None	Community	800 848-5101
Blue Cross Blue Shield of Minn.		Strict	None	Community	612 456-5050
Blue Cross Blue Shield of Ky., Southeastern Group (Select)		Strict	6 mo.	Community	502 423-1316
Sierra Health and Life (Select)		Strict	None	Attained age	800 688-0010
Bankers Life & Casualty (Select)		Easy	None	Attained age	800 621-3724
Mennonite Mutual Aid Assn. (1)		Moderate	2 mo.	Issue age	800 348-7468
Blue Cross Blue Shield of Fla. (Select)		Guaranteed	None	Issue age	800 876-2227
Arkansas Blue Cross Blue Shield		Strict	None	Community	800 338-2312
Samaritan Group (Select)		Strict	6 mo.	Attained age	602 491-1888
Blue Cross Blue Shield Mass.		Guaranteed	None	Community	800 258-2226
AARP/Prudential		Guaranteed	3 mo.	Community	800 523-5800
Independence Blue Cross *		—	—	Community	215 241-2400
Blue Cross of Calif. (Select) *		—	—	Attained age	800 747-0548
Blue Cross Blue Shield of Ariz. (Select)		Guaranteed	None	Attained age	800 543-2944
First Health of Ariz. (Select)		Guaranteed	None	Community	602 933-1344
Hartford Life * (1)		—	—	Attained age	203 547-5000
Blue Cross Blue Shield of Tex.		Guaranteed	6 mo.	Attained age	800 654-9390
National Home Life (Select)		Strict	None	Issue age	800 356-6271
Humana (Select) *		—	—	Community	800 245-4446
Integrity National Life		Strict	6 mo.	Attained age	800 999-1843
Blue Cross Blue Shield of Va.		Strict	6 mo.	Issue age	800 443-6646
Blue Cross Blue Shield of Conn.		Guaranteed	6 mo.	Community	800 238-1143
Anthem Life		—	—	Attained age	214 732-2000
Blue Cross Blue Shield Illinois		Guaranteed	None	Attained age	800 624-1723
First United American		Guaranteed	2 mo.	Community	214 328-2641
Blue Cross & Blue Shield of Me.		Guaranteed	Varies	Community	800 585-0099
Central States Health & Life		Strict	3 mo.	Attained age	800 541-2363
Aid Association for Lutherans (1)		Strict	6 mo.	Community	800 225-5225 x5913
Blue Cross Blue Shield of N.C.		Moderate	6 mo.	Issue age	800 672-6584
Blue Cross Blue Shield of Ky., Southeastern Group		Strict	6 mo.	Community	502 423-1316
Blue Cross Blue Shield of La.		Guaranteed	None	Attained age	504 832-5800
Empire Blue Cross Blue Shield *		—	—	Community	212 476-1000
Blue Cross Blue Shield of Md.		Guaranteed	3 mo.	Attained age	800 544-8703
Blue Cross Blue Shield of N.J. *		—	—	Community	201 466-4000
Blue Cross Blue Shield of Ariz.		Guaranteed	None	Attained age	800 543-2944

(1) *Policies unavailable to the general public; sales limited to members of particular groups.*
* *Company refused to participate. Rates obtained from state insurance departments and other sources.*

Company	Value index	Underwriting	Pre-existing conditions	Rating method	Telephone
	0 Poor—Excellent 100 P F G VG E				
Physicians Mutual *		—	—	Issue age	800 228-9100
Blue Cross of Western Pa. *		—	—	Community	800 345-7806
USAA Life *		—	—	Attained age	800 531-8000
Blue Cross Blue Shield of Fla.		Guaranteed	None	Issue age	800 876-2227
Continental General		Strict	None	Issue age	402 397-3200
Union Labor Life * [1]		—	—	Issue age	800 637-7947
Pioneer Life		Strict	3 mo.	Attained age	800 759-7007
Pyramid Life		Strict	6 mo.	Attained age	913 722-1110
Blue Cross Blue Shield of Mo.		Guaranteed under 70	None	Attained age	800 366-2563
Blue Cross Blue Shield of R.I.		Guaranteed	Varies	Issue age	800 527-7290
Blue Shield of Calif.		Strict	6 mo	Attained age	800 248-2341
Mutual of Omaha *		—	—	Attained age	402 342-7600
Blue Cross Blue Shield of Ala.		Guaranteed	6 mo.	Community	800 292-8855
Community Mutual *		—	—	Attained age	513 872-8100
Blue Cross Blue Shield of N.D. (Select)		Strict	6 mo.	Attained age	701 282-1100
Bankers United Life		Strict	6 mo	Attained age	800 538-1019
Standard Life & Accident		Moderate	None	Issue age	405 232-5281
Union Bankers		Strict	None	Attained age	800 542-6034
New York Life		Strict	Varies	Attained age	800 995-7445
AFLAC		Strict	2 mo	Issue age	800 992-3522
Continental Life Insurance *		—	—	Issue age	615 377-1300
Bankers Life & Casualty		Easy	None	Attained age	800 621-3724
PFL		Strict	6 mo	Attained age	800 538-1018
Blue Cross Blue Shield of Ala. (Select)		Guaranteed	None	Issue age	800 292-8855
American Republic *		—	—	Attained age	800 247-2190
First National Life		Strict	6 mo.	Issue age	800 289-3654
United American		Strict	2 mo	Issue age	214 328-2841
Colonial Life		Strict	6 mo.	Attained age	800 766-2525
Gerber Life *		—	—	Issue age	914 761-4404
Allianz Life of North America *		—	—	Attained age	612 347-6500
Blue Cross Blue Shield of S.C.		Strict	6 mo.	Attained age	800 444-0030
Medico Life/Mutual Protective *		—	—	Issue age	800 228-6080
Blue Cross Blue Shield of N.D.		Strict	6 mo.	Attained age	701 282-1100
Life Investors		Guaranteed	6 mo	Attained age	800 752-9797
Medical Service Bureau of Idaho		Moderate	None	Attained age	800 632-2022
Humana *		—	—	Community	800 245-4446
Equitable Life & Casualty		Strict	Varies	Issue age	800 352-5150
Companies cooperating with survey but not selling in the areas surveyed					
Capital Blue Cross	N/A	Guaranteed	6 mo.	Community	717 255-0820
Blue Cross Blue Shield of Utica Watertown	N/A	Guaranteed	6 mo.	Community	315 798-4231
Security Health Plan	N/A	Strict	None	Attained age	800 472-2363

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

Mr. Gauthier, if you will wait until we come back, just hold your fire. We will be back as soon as we can.

Thank you very much. The committee stands in recess until we get back from the vote.

[Recess.]

Chairman THOMAS. Mr. Gauthier, if you would begin I would appreciate it.

STATEMENT OF C. PAUL GAUTHIER, C.P.A., PRESIDENT, OLYMPIC HEALTH MANAGEMENT SYSTEMS, INC.

Mr. GAUTHIER. OK. First of all, I would like to comment that we are in support of expansion and making Medicare Select permanent in all States. And so all of the positive comments that were made before we certainly support, and I will eliminate a lot of the comments that I would have previously made because they have been so often reiterated.

First of all, I would like to tell you that Olympic Health Management Systems, Inc. is a hospital consulting company specializing in managed care products. We also act as a third-party administrator, manage insurance agencies and oftentimes we are a broker for insurance products. We have roughly 180 hospitals participating in Medicare Select products running around the country with a file of the products which we assisted our insurers filing in the States of Illinois, Indiana, Texas, Missouri, Wisconsin, Alabama, and Ohio. We have other hospitals that have supported the expansion in their States and we have three other additional States that we will be bringing on in the course of the next few months.

There are several comments that I would like to be able to make in favor of the hospitals which we represent. One thing that I think is important to recognize is that our 180 hospitals very much favor the expansion of Select. Indeed, if you look at the 180-hospital composition, we have hospitals ranging anywhere from 40-bed size to major tertiary facilities. All inclusive, our 180 hospitals represent operating expenses in their budgets of in excess of $10 billion. The combined employees for our facilities are well in excess of 140,000.

Although I don't represent the hospital industry as a whole, I think for the most part I represent our hospitals. Hospitals need this Medicare Select program because they view this as an integral part of their expanding into the Medicare risk contracts or potentially voucher systems. They embrace the concept of capitation, they are not at all concerned about being at-risk, and believe that they can help manage costs more efficiently than the way the system currently is managed under the Medicare system.

Some of the issues that I think might help to expand the Select product properly in the future is, we would like to see some provision for safe harbor for physicians. Physicians today are terrified to enter into any kind of joint venture managed care programs with or without hospitals' involvement because of the threat of losing their Medicare provider status.

The current Medicare Select statutes allow for Federal review for all Medicare Select products, and this should be sufficient to protect Medicare's interest. Physicians must be allowed to participate without the threat of losing their livelihood.

In the area of community rating, community rating a product is fine if in fact you are enrolling roughly 15 percent of new business a year. Otherwise, your business begins to age in place. What that will basically spell out in a global community rating situation without permanent adoption of Select in all the States is more and more insurers will shy away from supporting the Select product.

In the area of open enrollment, if there is ever any consideration to having an open enrollment during a 1-month period, this would probably be suicide for a Medicare Select product. A Select product needs to enroll its population month by month over time.

The problem here is that it takes well in excess of 90 days to train, supervise agents to sell this product on a one-to-one sale. You simply can't expect to have any kind of critical mass with Select if that open enrollment period is contained.

I would also like to make a case for the issue of allowing office copay visits in Medicare supplement insurance but specifically Medicare Select. Insurers must be allowed to offer small copays per visit, just like HMOs. Not only does this reduce premium, but it is critical to remind the policyholder of the per incident cost implications of office visits.

Currently, there is an innovative benefits clause in all of the Medicare Select regulations which we believe should allow for small copays per office visit, but State insurance departments do not want to interpret this regulation without Federal guidance.

I would also like to make one more case in terms of expansion of Select to all States. You really need to send a clear message to providers and insurers that managed care is endorsed by the Federal Government, and I believe that if you allow the Select to stay where it is or not give it permanent status, the message that you would be giving to providers out there, in essence, is that the Federal Government supports managed care but only on a demonstration or on a test basis, and representing the hospitals that support capitation, support the issue of case management and managing the Medicare system in a different way, I think you would do well for the hospital industry and probably the physicians as well to expand the product line.

Thank you.

[The prepared statement follows:]

C. Paul Gauthier, CPA, President
Olympic Health Management Systems, Inc.
Bellingham, Washington
February 10, 1995

Hospitals' Perspective of Medicare Select

When the Medicare program was proposed in 1966, the AMA opposed this movement on the basis that it would result in nationalized medicine. Congress softened this argument by proclaiming that reasonable fees would be paid based upon area norms and that the physician would be responsible for the direction of the quality of care provided. These promises are no longer manageable. The Medicare system was designed to insure access to healthcare for a population on fixed or limited incomes, however, in 1966, there was simply no recognition that the healthcare delivery system would be so successful at extending human life through access of technology and services. The financing problems of access and technology are now greatly compounded by the impact of the aging "baby boomer" population.

The political and social issues associated with controlling costs through access, utilization, and reimbursement will require years to retool the healthcare delivery system. Healthcare providers are genuinely concerned that the rules historically defined by government and insurers will dramatically change and, therefore, would negatively impact the quality of care. Healthcare providers are willing to assume increased responsibility on issues of access, utilization, and reimbursement, however, they have not always been provided the tools to manage the process.

HMO Medicare Risk programs have provided an opportunity for healthcare providers to influence or control issues on access, utilization, and reimbursement. HMO Medicare Risk programs have, to date, generally been limited to high cost, densely populated areas where managed care commercial programs have been in existence for several years. Medicare Select has now provided the opportunity for hospitals to assume similar leadership roles in their community without the harsh financial implications involved in a Medicare Risk program. From the perspective of hospitals, Medicare Select has provided the following critical advantages:

- Because deductibles and coinsurance represent by definition a small percentage of the overall cost of providing care to Medicare beneficiaries, hospitals are not as concerned about the overall risk of this managed care program. Accordingly, healthcare providers are much more willing to assume risk, work with their medical staff to optimize health care, support insurer marketing efforts, and provide innovative managed care programs.

- Hospitals generally do not have access to detailed utilization data to influence provider behavioral modification. Insurers who may have access to useful utilization data may not make such data available because of the proprietary nature of the data, confidentiality requirements, or the inability of extracting the data in meaningful reports. Because hospitals have formed financial relationships with insurers, they now have proprietary access to all claims information. Medicare Select allows for the opportunity of extracting data on policyholders for not only the deductibles and coinsurance, but all of the data elements extracted and adjudicated by the Medicare system. Access to such clinical information is absolutely paramount in developing optimally managed care system. Over 150 hospitals are now accessing clinical information for Part A and Part B services by engaging in crossover claims exchange with the Medicare Part A and Part B Intermediaries.

- During the past decade, hospitals have attempted to provide educational forums, senior membership clubs, health screening and wellness programs, in an attempt to improve the continuum of care offered to Medicare beneficiaries in their service area. A Medicare Select program interlocks the various financial components of the delivery system into a coordinated continuum of care process. All of these basic elements are necessary to execute a successful Medicare Risk program and achieve savings in the delivery system.

Medicare Managed Care Achieves Savings

The table on the following page represents an example of the potential savings in per capita monthly claims costs as Medicare beneficiaries move from an unmanaged Medicare system to an optimally managed care system.

The unmanaged system data represents an example of current utilization for a mid-west county. The optimally managed system represents the highest degree of healthcare management or the most cost efficient system. The degree of total healthcare management based on current standards is assumed to be 100% efficient for an optimally managed system. The moderately managed system represents a mid-point between the unmanaged and the optimally managed system.

The optimally managed system provides the most appropriate care at the most appropriate level of service. To achieve an optimal managed system, substantive changes must be made to the behavioral pattern of healthcare providers as it relates to access, utilization and reimbursement. These changes cannot occur without substantial management involvement from healthcare providers, otherwise unsatisfactory outcomes occur from the perspective of the insurer, providers, and the consumer. A Medicare Select program can assist in the transition process from an unmanaged care system to an optimally managed system.

Olympic Health Management Systems, Inc.

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Example of Changes in Medicare Health Care Consumption

	Unmanaged System			Moderately Managed System			Optimally Managed System		
Type of Service	Annual Util Per 1000	Average Cost Per Services	Per Capita Monthly Claim Cost	Annual Util Per 1000	Average Cost Per Services	Per Capita Monthly Claim Cost	Annual Util Per 1000	Average Cost Per Services	Per Capita Monthly Claim Cost
INPATIENT HOSPITAL									
Non-Mat. Medical	1,543.8	937.72	120.64	1,071.0	1,139.31	101.69	598.2	1,659.41	82.73
Surgical	920.1	1,119.71	85.85	668.1	1,382.11	76.95	416.0	1,962.44	68.03
Psychiatric	36.6	430.66	1.37	25.7	477.19	1.02	14.7	542.93	0.67
Alcohol/Drug	15.1	331.23	0.42	9.6	376.96	0.30	4.0	535.88	0.18
SNF/ICF	933.6	156.60	12.18	747.9	156.60	9.76	562.2	156.60	7.34
Subtotal			220.46			189.71			158.96
OUTPATIENT HOSPITAL									
Emergency Hospital	321.5	186.32	4.99	229.2	198.89	3.65	118.8	232.91	2.31
Outpatient Surgery	63.4	1,304.51	6.89	58.7	1,334.51	6.53	54.0	1,369.74	6.16
Radiology	689.5	321.56	18.48	567.6	327.87	15.51	445.6	337.64	12.54
Pathology	741.4	105.37	6.51	610.3	107.44	5.46	479.2	110.63	4.42
Other	883.4	98.38	7.24	706.8	100.23	5.90	530.2	103.30	4.56
Subtotal			44.11			37.05			29.99
PHYSICIAN									
Inpatient Surgery									
Primary Surgeon	148.4	1,552.56	19.20	130.1	1,611.89	17.49	111.7	1,675.19	15.59
Assistant	29.9	713.75	1.78	28.4	729.59	1.71	26.9	727.45	1.63
Anesthesia	118.5	336.00	3.32	106.1	345.76	3.06	93.7	355.53	2.78
Outpatient Surgery									
O/P Facility	319.1	556.10	14.79	280.2	657.24	15.34	241.2	758.33	15.24
Office	720.2	111.48	6.69	642.3	115.25	6.18	564.3	119.05	5.60
Anesthesia	169.3	167.93	2.37	168.2	218.24	3.06	167.1	268.54	3.74
Hospital Visits	2,318.4	51.38	9.93	1,658.2	52.94	7.32	997.9	54.50	4.53
Extended Care Visits	122.8	57.13	0.58	108.6	59.17	0.54	94.3	61.20	0.48
Critical Care Visits	228.0	78.76	1.50	230.7	78.76	1.51	233.4	78.76	1.53
Office Visits	6,322.7	19.83	10.45	6,098.0	19.88	10.10	5,873.2	19.94	9.76
Home Visits	99.8	48.64	0.40	107.2	48.93	0.44	114.6	49.21	0.47
Therapeutic Injections	221.9	8.58	0.16	199.6	8.58	0.14	177.2	8.58	0.13
Allergy Testing	46.3	30.89	0.12	41.6	30.89	0.11	36.8	30.89	0.09
Allergy Immunotherapy	432.5	9.65	0.35	389.3	9.65	0.31	346.0	9.65	0.28
Diagnostic Testing	142.6	47.88	0.57	128.0	47.88	0.51	113.3	47.88	0.45
Emergency Room Visits	317.2	41.81	1.11	215.9	41.81	0.75	114.6	41.81	0.40
Consults	458.1	75.76	2.89	411.9	75.76	2.60	365.6	75.76	2.31
Physical Medicine	601.6	17.34	0.87	540.7	17.34	0.78	479.7	17.34	0.69
Cardiovascular	688.1	57.75	3.31	618.6	57.75	2.98	549.1	57.75	2.64
Dialysis	74.2	67.80	0.42	66.7	67.80	0.38	59.1	67.80	0.33
Chiropractor	503.4	23.89	1.00	452.4	23.88	0.90	401.3	23.89	0.80
Radiology	2,105.8	68.58	12.03	1,829.0	68.57	10.40	1,534.1	68.58	8.77
Pathology	8,689.9	23.65	17.13	7,353.3	23.65	14.50	6,017.1	23.65	11.86
Podiatrist	28.9	40.37	0.10	25.9	41.01	0.09	22.8	40.37	0.08
Outpatient Psychiatric	263.8	50.33	1.11	230.7	50.33	0.97	197.6	50.33	0.83
Outpatient Alcohol/Drug	121.8	46.91	0.48	106.5	47.32	0.42	91.2	46.91	0.36
Subtotal			112.66			102.59			91.37
OTHER									
Home Health	5,697.4	62.93	29.88	5,233.0	62.93	27.44	4,768.6	62.93	25.01
Ambulance	132.4	221.95	2.45	125.2	222.01	2.32	118.0	221.95	2.18
Durable Medical Equip.	991.6	38.10	3.15	901.3	38.11	2.86	810.9	38.10	2.57
Prosthetics	264.4	115.21	2.54	233.6	115.23	2.24	202.7	115.21	1.95
Subtotal			38.02			34.86			31.71
Total Claims/Benefit Cost			415.25			364.21			312.04

Problems Encountered with Medicare Select

The most significant problems associated with the implementation of Medicare Select include the following:

◊ **Fraud and Abuse.** Physicians generally are terrified of becoming involved in any Medicare managed care programs. Few attorneys are willing to provide positive counsel to physicians regarding their participation in a Medicare Select program because of the lack of Safe Harbors guidelines.

◊ **Lack of Insurer Participation.** There are relatively few insurers involved in Medicare Select programs. Most insurers have been skeptical due to the three year demonstration timelines and the potential negative impact on their policyholders in the event that Medicare Select was discontinued. Three years was never adequate considering the timeline associated with: insurance department regulatory adoption; the filing process; training and orientating personnel managing the programs; organizing providers; and implementing the marketing process. Indeed, a number of insurers would have been willing to promote a Medicare Select policy in the state of Massachusetts, but the Massachusetts Insurance Department has refused to act on Medicare Select until the issue of the demonstration status has been resolved.

◊ **Existing Managed Care Programs Were Eliminated.** The intent of Congress with Medicare Select was to encouraged managed care applications to otherwise standardized Medicare supplement insurance products. Ironically, the limitations of the pilot program actually SHUT DOWN operational PPO and HMO Medigap products in the other 35 states.

Medicare Select is Consistent With Insurance Reform.

Medicare Select policies are already governed by the type of reform measures Congress is seeking to impose on commercial insurance plans. As a subset of standard Medicare supplement regulations, Medicare Select includes regulations on: pre-existing conditions; portability; guaranteed renewal; open enrollment for individuals just turning 65; and agent compensation measures.

Medicare Select is a transitional product, representing an incremental step towards greater market reform. Medicare Select offers Medicare beneficiaries a friendly bridge into greater managed care programs such as the TEFRA risk contracts and encourages providers and insurers to work cooperatively within the market in preparation for future innovative reforms such as a Medicare voucher program.

Medicare Select offers a low cost alternative to older adults. Medicare Select premiums are up to 40% less than standard Medicare supplement policies.

Systems for consumer protection are already in place. Medicare Select policies must file a Plan of Operations for approval with the state Department of Insurance. The insurer must comply with quality assurance procedures, grievance and complaint resolution process, and ensure access to care. A Medicare Select policy CANNOT restrict payment in the event of an emergency, while the senior is traveling, or if services are not available in-network. Medicare Select is NOT an HMO or risk contract.

Improvements Needed With Medicare Select

◊ **Safe Harbors.** Medicare Select should be provided with the same safe harbors as supplied to Medicare Risk Contracts. Clearly, HCFA has the opportunity of auditing for compliance and it is this vehicle that should be employed relative to quality standards and utilization monitoring.

◊ **Office Visit Co-Pays.** As in the case of HMOs, Medicare Select should be allowed to offer a small co-pay per physician office visit. Small co-pays are an integral part of conditioning utilization behavioral patterns of Medicare beneficiaries.

◊ **Expansion to All States.** A clear message should be sent to providers and insurers that managed care is endorsed by the federal government by expanding Medicare Select to all fifty states on a permanent basis.

(admin/corres/spiegel)

Chairman THOMAS. Thank you, Mr. Gauthier.

That is a point that I think we assume but it needs to be focused on, and that is people are trying to pick up signals from us and that if the signal was that this isn't even appropriate to move forward on, what else are we not going to do, I think that is very good.

On the open enrollment question, I don't know that it is necessarily a function of time. I am looking more at the need to provide education and knowledge so that decisions would be made.

My concern would be that if you had to just constantly go and have more salesmen making calls to move insurance, I would guess that that is probably where there is more of a chance for abuse. I would be looking to provide a more direct yet broader-based education and knowledge function for the seniors so they would make a choice, not so much to me the timeframe in which they make the choice, it is what they make it with.

Reaction?

Mr. GAUTHIER. Right now Medicare Select is not very well publicized, mostly because insurers are afraid to enter into the marketplace because of the demonstration status. So at this point, our only mechanism from our hospitals to promote this kind of a managed care program is to employ the traditional tools of direct mail group presentations, telecommunications, whatever is required to in essence get the message out. You can't simply do that in a 1-week period.

Chairman THOMAS. Ms. Musser, in terms of ability to communicate, what we have heard over and over again is that people just don't know about the program. Have you folks from your national perspective seen anything that looks good or any efforts that have been made that might be some models for us to see how it is that we can go about it? What have you done in Wisconsin?

Ms. MUSSER. The NAIC has a senior issues task force that works on senior counseling, bulletins, and brochures. The Wisconsin insurance department has a number of—I can think of at least four or five brochures that we send out on a regular basis.

We also have a little computer program that we have generated that the board on aging and some of the aging coalitions use. Senior citizens call us, they give us their age, gender, their riders that they want, and their location, and we generate premium comparisons and quotes for them on the telephone on a regular basis.

But you are right, the promotional, the marketing of it is restricted, and I think that is largely because it is not a permanent program. People are not investing in it the way that they might in product development if it were a permanent program.

I mentioned that Wisconsin had these programs prior to the enactment of the demonstration project. We have 40-some thousand people enrolled. The enrollments are going up and not down, but I think they would grow more rapidly if the programs were permanent.

Chairman THOMAS. Well, and if you are gearing up to provide only just a very narrow product, it takes a lot of effort, that is kind of an inverted pyramid to deliver the product on an educational basis. If you had more product available for the seniors, in terms of understanding the full panoply might be——

Ms. MUSSER. Exactly.

Chairman THOMAS. You rattled off some statistics during your testimony that apparently HCFA doesn't have. Are you in communication with HCFA and are we supplying some of this data?

It seems that it has evaded them, and I just think it is interesting that you folks are collecting data on a profile basis which HCFA either chooses not to focus on or isn't aware of. Have you had any communications with HCFA about the results?

Ms. MUSSER. I had a number of communications today about the statistics quoted in my testimony, and I think we will have ensuing conversations about them. Wisconsin collects——

Chairman THOMAS. Was it supportive or threatening? I am just curious.

Ms. MUSSER. Quite supporting.

Chairman THOMAS. Where did you get the stuff?

Ms. MUSSER. Wisconsin collects a lot of its information on this in profiles. The insurance department in the State of Wisconsin manages the HMO industry and has since its inception, including, you know, the filing of business plans and all of the financial data, and that is of course greatly helpful to us in collecting a lot of the information that we have because we know their enrollments by breakdown.

Chairman THOMAS. For the record, I believe it is the department of corporations in California that manages the HMOs and collects the information. That was a question earlier.

Ms. Shearer, in terms of your testimony, in looking at—and I have a copy of the August 1994 Consumer Reports with your value index from poor to fair to good to very good to excellent, and you have a number of products, in fact the third, the fourth, the fifth, the seventh, the ninth best-rated value products are Selects—and in looking, for example, at the second most highly and the third most highly rated Select products, the method of rating is attained age. You had some relatively critical comments to make about that kind of a profile.

Was that not used in terms of classifying it on the value index or is there a warning label placed on the product, or how did you go about taking the testimony that you gave us and giving somebody a comfort level that the highest rated, the fourth highest rated insurance program was in fact the one that had this very poor way of rating.

Ms. SHEARER. This table is, the ratings are based purely on premiums over different age groups for consumers. If you look on page 526 of the article, a column marked "Pricing Pitfalls," that is where this issue of what we consider to be the hazardous pricing structure is addressed. But the table, the ratings——

Chairman THOMAS. I have to confess, the way I read your magazine most often is that I tend to just skip over the written material and go to the little rating structures so that I don't have to waste time plowing through what you guys plowed through, and I take your judgment based upon all of that stuff because it is an index, it is a value index, it combines all of that stuff. But you are telling me that it didn't here?

Ms. SHEARER. I am telling you what we tell our readers: Read the whole article because it is really important, and this applies to

issues beyond this. And I am sorry, one of the challenges Consumer Reports has had over the years is how to make information accessible to consumers, and there is a tradeoff. I mean, you can put so much in a table.

Chairman THOMAS. Well, OK. Then I should have read it and be wary of the attained age Select packages.

Actually the highest rated Select is one with community rating, which is the third highest of all of them that you rated.

Ms. SHEARER. And what we are suggesting is, let's make all of them community rated. We are not suggesting that the Medicare Select market should compete with an unlevel playingfield against attained age or issue age rated policies, so we are suggesting that if a State wants to offer Medicare Select that they should community rate this market.

Chairman THOMAS. But even if they do that, you don't think it is a very good product?

Ms. SHEARER. I think that the jury is still out. There are many unanswered questions.

Our reading of the RTI study is that the main reason that there are cost savings at this stage is because of discounts that this product gets, but I realize that there is some research underway, there is some data from Wisconsin that I have not had access to.

I think the experience—one thing the RTI report showed very clearly is that the experience varies from State to State, and I think it is very important for Congress to have the best information before locking in a program. And I think once this program is made permanent, it is going to be very hard to change when new ideas for Medicare PPOs emerge or whatever.

Chairman THOMAS. I will tell you, not with this Congress it won't. That has been one of the problems in the past. We are into kind of a chicken-and-an-egg problem. You don't want us to go forward until we really have a picture what the world looks like, and we have had testimony all day that HCFA is almost incapable of providing useful comparative tools in a timeframe that means anything anymore, and that therefore your position is, don't go forward, versus the other position which is, well, go forward in this limited area, and we are going to continue to build tools as we see it.

So in terms of the chicken and the egg, given the timetable that we have pressure under, to me the compelling evidence is very simple: You go forward. You don't just stop and hope HCFA in the next 3 to 5 years comes up with some measuring device that will tell you that the program that they only wanted to continue for 6 more months might have had a chance to survive.

That is my problem in listening to the kinds of warnings that you are putting forward to us in not going forward in this very small modest area.

Ms. SHEARER. I would urge you to fix what is broken in the market before going forward. I tried to outline in my testimony some of the things that we think are broken. We have not recommended that you kill this program. We urge you to proceed with caution and not lock in something that isn't serving consumers well.

Chairman THOMAS. I understand. We are under tremendous pressure because we failed in the 103d Congress to do some of

those fundamental reforms in the insurance area, in the malpractice area, administrative simplification, and creating some understanding within the Justice Department Antitrust Division that people do operate on timelines other than bureaucracies and that those timelines for decisions should be shrunk to a reasonable time with safe harbors created.

Ms. MUSSER. May I just comment a bit on that.

What you see when you look at some of the success stories, and one of the things that I would certainly agree with my predecessor about is that the State variation is pretty significant and we have to look very carefully at that and we should learn some lessons from it.

Where it is working well are in mature managed care markets. Managed care is not managed care is not managed care across the Nation.

Some points that you made earlier, Mr. Chairman, about introducing managed care concepts are critical in the immature markets. As we get people from managed care in the workplace into these markets, these programs will continue to refine themselves as they did in Wisconsin, Minnesota, California, and many other States. We didn't all of a sudden just jump in and be successful with this this last year. This takes time, and it takes time to develop the products, to refine the products, to listen to the customer choice.

I think the issues of attained age are issues of product selection and disclosure and information, and I think those are the kinds of lessons we learn in States like Wisconsin where we have a more mature market.

Chairman THOMAS. The pressure I am under, Ms. Shearer, is that all the statistics that are coming in now, despite the fact that people say, "Well, we don't know if the trend is going to last a very long period of time. Given the kind of fundamental shifts that have occurred in the private sector, you are not going to reverse them. They are going to continue." So for folks to say, "Gee, we ought to wait or maybe it is a blip," I don't have much patience with those kind of folk.

What I got out of part of your testimony was that you have to be careful because there is going to be a cost shift in terms of the cost shifted over the hospitals. What the statistics are screaming back at me is that it is Medicare that is beginning to be the cost shifter into the private sector and that the folks out there have learned their lesson, they aren't going to take the shifts anymore.

And so it is exactly the opposite, and that government might be performing a kind of a useful function here if in those areas where the managed care market and the knowledge among consumers is not as great, we could be doing a great service for folks in this particular area to begin to develop the kinds of tools and the assurance. If we do it right, government believes that this is an appropriate way to go that can speed up the markets.

I was just amazed at when you look at where managed care has been successful, it is kind of like following where import cars are sold highest and American cars are not. It is the Midwest and other areas that aren't up to speed, but it is not just in this program, it is across the board in terms of managed care. So if we

were to go to 50 States, make it permanent, come up with some tools that will allow folk to make those judgments, one, we get better at what we are doing; and, two, it creates an understanding and acceptance for the private sector to continue to move forward more rapidly in areas where it wasn't.

Now why is that bad?

Ms. SHEARER. I think the cost shifting issue is certainly bigger than Medicare Select.

Chairman THOMAS. Of course. It is all Medicare now and as such, it has become an anchor, a drag on the system.

Ms. SHEARER. My concern is that with discussion of expanding the discount to Medicare Select to part B, for example, if discounts are where the cost savings are coming from, whether it be part A or part B in the future, then I don't think it is fair to hold this up as a cost saving program. I think this is the type of thing that needs more study and analysis before locking it in.

Chairman THOMAS. Who held it up as a cost saving program? See, if I can get better quality of care for the same price, that is a plus. And if I save money along the way or if the consumer saves money along the way, isn't that a plus, too?

If you have a program that—if you have a product in your magazine that really delivers on what it says and it is cheaper, don't they get a "check" in terms of a best buy, that those were "pluses," those were positives when those two things came together.

Ms. SHEARER. Well, right now the premiums appear to be lower in large part because they are not paying all the costs, so I think this is a very——

Chairman THOMAS. Based on what, 3-year-old data, 5-year-old data?

Ms. SHEARER. Based on the only objective analysis that has been available to me, which is a 1-year-old study, and what I feel is—it is the RTI study, and that is all that I have had access to.

Mrs. JOHNSON. That study is only now out as a single example, and they haven't gotten to cost yet. They haven't. That study has not reported on cost.

Mr. CHRISTENSEN. We heard witness testimony earlier that the study wasn't correct anyway.

Chairman THOMAS. You can have a judgmental about whether it is worth anything or not, but it just amazes me that someone looks in the last 12 months what has occurred in the private sector in terms of costs in significant reductions in that area and that those folks who have changed the marketplace are going to continue to be able to, you know, absorb cost shifting, to me is just a total disconnect of what is really going on out there.

So obviously another 12 months will give us a better picture. Hey, another 5 years will give us a whole lot better picture, and then, guess what? We have 1 year to solve the bankruptcy of the health insurance market.

All we are trying to do is push the envelope a little bit in an area that seems to be, at least in those States that are more mature markets for managed care, who understand what they are dealing with and have gone one step beyond nothing in terms of trying to inform the seniors, that it looks like it is kind of useful.

So, again, it is a "flying knot" versus the alternative. I guess that is the problem.

Ms. SHEARER. Mr. Chairman, I would really urge you to look not only at the States where Medicare Select appears to be very successful, but to study carefully the States where it hasn't taken off, where the States have dropped out of the program, where it has not worked as well as it has in Wisconsin.

Chairman THOMAS. I assure you we are going to, but it is not to try to find out why we stop other States who are successful, it is to find out how those States that have successful programs can be transplanted into those States that have not.

We are just coming from a completely different direction on how you solve the problem. My goal is to move forward, not to find reasons for not moving forward. I guess that is the difference.

Mr. GAUTHIER. If I could just make one comment from the provider side. Of the 180 contracts we have negotiated with 6 different insurers, the vast majority of them have a component in those contracts that basically say that if the plan performs properly, the hospitals will share in the positive plan performance. So even with a Select product there are some incentives for providers to work together in order to make this product successful in the marketplace.

Most of our hospitals firmly believe that over time 50 percent of their population will be in some form of a Medicare risk product, and that timeline is probably 5 to 10 years. They are concerned with getting involved with Medicare Select to get the experience in terms of managing the process of case management, managed care, negotiations, working with their physicians, capturing the data, and positioning themselves for what they believe to be a continuous reduction of funding for hospital services.

This issue goes beyond just writing off deductibles and coinsurance. It has everything to do with hospitals and the system's preparing itself for a much larger issue.

Hospitals are terrified that funds won't be there beyond the year 2000 to take care of Mr. McDermott's 85-year-old person. That is not the issue. The hospitals are generally concerned with that.

The deductible is irrelevant. Most of our hospitals enter into this program not to increase census, not to write off the deductible, but because they need the data. They need the data because the Federal Government simply does not provide that information to them.

Hospitals have no idea what physicians are doing, physicians have no idea what hospitals are doing, and the whole issue of getting them to work together under a low-risk product, is a darned healthy thing to do in a free marketplace.

Mrs. JOHNSON [presiding]. Thank you very much.

Let me just—the hour is late—go to Mr. Christensen, and then I have a couple questions and we will adjourn.

Mr. CHRISTENSEN. Thanks, Madam Chairwoman.

The point you just made, Mr. Gauthier, to what degree do you think it is the hospital's concern of getting into a program that is going to be eliminated because it is a demonstration project? To a great degree?

Mr. GAUTHIER. I think most hospitals, or at least we advocate that over time, and we measure this because a lot of the managed care markets we are in, think that over time you will probably see

50 to 60 percent of the population on a voucher system or a Medicare risk product, perhaps 20 percent will be in a Select product, and the rest of it will still be in some form of ERISA or indemnity product. That is our best guess from what we know today.

If the system doesn't evolve in that process, you can't possibly afford to fund Medicare with the baby boom population coming online. I think hospitals recognize this, so they look at Select as a steppingstone for them to learn the process of negotiating with physicians and all the other components with managed care to get into a risk product.

Mr. CHRISTENSEN. In your testimony on the last page you talk about offices that charge copays, and you say small copays are an integral part of the conditioning utilization behavioral patterns of Medicare beneficiaries. What would be your example of a small copay?

Mr. GAUTHIER. $5 to $10 copay. The current rules are you either pay the deductibles or you don't. It is as simple as that.

So when we structure a plan with our physicians and with the hospital, when the senior goes to a physician's office, we either pay the deductibles or we don't. There is nothing in between.

We think putting a product out there such as an HMO so that there is a $5 or $10 reminder when that senior uses the physician's office, would do a lot in terms of reducing the premium as well as encouraging that senior that nothing is for free. Right now we simply can't do that with any of the Select products.

Mr. CHRISTENSEN. From the standpoint of Wisconsin and moving away from the Medicare Select issue for just a moment to the general Medicare issue, consumption and overconsumption is something that this committee has looked at for some time now. What do you see in Wisconsin that would work as a copay type of arrangement?

Ms. MUSSER. Wisconsin has been approached very recently by an HMO who wants to begin entering into the Medicare risk contract area and has asked for our interpretation and approval of a small copay. I don't know the exact level of that, but we are moving forward to approve it.

I believe it is in the area, the range of the $10 per visit or 20 percent kind of arrangement to assist them with some kinds of office visits and some kinds of medications and situations. We are moving forward cautiously on a limited basis, but we think that the flexibility is needed to restrain the utilization.

Mr. CHRISTENSEN. That is all I have at this time, Madam Chairman.

Mrs. JOHNSON. Thank you, Mr. Christensen.

Ms. Shearer, in your comments you quote the RTI study, but you don't mention the part of that study that found that the 3-year 15-State limitation was a significant barrier to the expansion of Medicare Select.

In the RTI report it says, "Unless a firm is already offering a similar product, 3 years is not enough time to develop a product in a provider network, market it, and recover the initial investment."

In looking at this issue, why didn't you consider that part of the study as well as those parts that you included in your testimony?

Because the implication in your testimony is that it didn't spread because it wasn't any good.

Ms. SHEARER. Well, it certainly is one factor, and in limited time and limited space I didn't mention it, focusing on some of the concerns that the RTI pointed out in terms of what is most important to consumers. And I think that that is the kind of point that industry is better positioned to make, but——

Mrs. JOHNSON. Thank you.

I would just remind you that in other testimony this morning we have heard that the RTI study was done when the program was in its infancy, and the RTI study itself cautioned that the results are in many ways preliminary and the most extensive section is a single-State study and they have yet to offer the cost section of the study and the other section on beneficiary satisfaction. So we have those yet ahead of us.

I do want to ask though the time is late, but I am very interested in the issue of the States where it hasn't taken off. I think there are probably some obvious reasons why not, but, Ms. Musser, if you could help us with that and gather any information that you can about those States where it hasn't been as active. And then I am also interested in the issue of attained age because we do have consumer protection provisions in our Medigap policy law, but also we regulate these kinds of policies at both the Federal and State level, and one of the regulations specifically goes to trying to be clear with seniors about what they are and are not buying, and if we are not telling them that there is a difference between buying this and another Medigap product, then we ought to be doing so.

Now, this is not a Medicare Select unique issue. This is a Medigap policy across the board. But I think that is a reasonable thing to deal with.

Personally, in some of the testimony you have implied that seniors might be duped. That has not been my experience. My experience is that most of my seniors know more about tax law than any 40 year old I represent as a group, and that they are very sharp, and they sit with each other and they compare benefits and dollars, and they know exactly what they are getting. Would that most of us were as sharp consumers as they were in their earlier years, though that is no longer true of my 95-year-old mother.

So I think we have an opportunity here as we move forward to make sure that any knowledge we have that could improve the opportunity for this program to serve seniors well in the States where it isn't currently built into the program. To deny the overwhelming testimony, however, of how many more benefits seniors are getting through this plan and what the satisfaction level is in the better plans and the contribution it is making in the States that it really had the ability to work with is because they have the provider sector development necessary. Isn't information we can afford to look at and say, well, we will do a 6-month extension. It is too pathetic a legislative response.

So we look forward to working with you. You know now what we are going to do. You know what information could be useful to us in doing it well.

We thank you for your testimony and invite your continued involvement.

[No information was received at the time of printing.]

Mrs. JOHNSON. Thank you.

[Whereupon, at 3:44 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT

BY

CHIEF MASTER SERGEANT JAMES E. LOKOVIC, USAF (RET.)

DIRECTOR, MILITARY AND GOVERNMENT RELATIONS

AIR FORCE SERGEANTS ASSOCIATION

Mr. Chairman and distinguished members of the committee, I am here on behalf of the Air Force Sergeants Association's 160,000-plus members. AFSA represents all enlisted Air Force, Air National Guard and Air Force Reserve members, their families, and survivors. Many of our members have served their nation, have entered their retired years, and are now among those currently being served by the Medicare system. Accordingly, we appreciate this opportunity to include AFSA's views in your important deliberations.

We are well aware of the important challenge to be faced by this committee, greatly appreciate your focus on controlling costs and improving care, and are sensitive to the enormous growth in Medicare expenditures in recent years. The overall costs and fees for service become especially significant for our members because enlisted military retirees are among the lowest-paid annuitants. As you are looking at ways to control costs and improve care in the system, we would like to suggest two important money-saving possibilities.

Our first suggestion is that the committee support **Medicare subvention**: the transfer of funds from the Department of Health and Human Services (HHS) to reimburse the Department of Defense (DOD) for care received by Medicare-eligibles at Military Treatment Facilities (MTF). Representative Joel Hefley's H.R. 580, introduced during this Congress, would allow this interagency transfer of funds. His bill realizes that the question is not spending HHS dollars versus DOD dollars; the real possibility is to save *taxpayer* dollars by the non-parochial transfer of funds.

The advantage in cost-savings would be that HHS would spend fewer dollars for the care it buys at MTFs than it does from civilian providers. Savings are derived through "utilization management," which is preventive in nature. This DOD-unique system gets the right treatment in the right place at the right time. This heads off more serious treatment problems and thereby holds down costs. Also, the cost of physicians is significantly tempered by the military rank structure. Finally, MTFs already have an infrastructure in place, so the basic care components are there. The results, when comparing MTFs to civilian providers, are savings in costs, overhead and mark-up fees.

Whereas all military retirees are eligible to seek space-available care at MTFs, most are viewed differently after they are forced to transition from CHAMPUS (soon to be TRICARE) to Medicare. In practice, MTF commanders are facing smaller and smaller budgets, and our older members tell us that space-available care has been increasingly denied for Medicare-eligibles because of lack of treatment funds. Thus, AFSA feels that the practice of Medicare subvention would make on-base care more likely for our older retirees and, at the same time, save program costs by reducing the level of Medicare expenditures for military retirees.

We would also suggest that as this committee looks at ways to incorporate managed care ideas into the Medicare system, great consideration should be given to **allow Medicare-eligible military retirees the option to remain in the military health services system through the TRICARE program.** This three-part system, DOD's health care plan of the future, is currently available only to under-65 military retirees and their dependents, and active duty family members. TRICARE includes an HMO option, TRICARE Prime. TRICARE Prime's enrollment fee and cost-shares also provide lower-cost care than traditional "fee-for-service" care associated with Medicare Part B insurance.

The lower pension income of enlisted military retirees and their survivors magnifies the issue of health care costs. The TRICARE program promises to offer enrollees much lower costs than current fee-for-service insurance programs. Also, while the committee is looking at areas of private managed-care plans it can incorporate into the Medicare system, we would argue that serious consideration should be given to extend HHS reimbursement to DOD for enrollment in the TRICARE program for military retirees over 65. Again, military retirees would be allowed to stay in the military health services system for life and, at the same time, reduce the cost of care for Medicare-eligibles.

Mr. Chairman, again, thank you for this opportunity to express our ideas on ways to lower the costs associated with the Medicare system. As you are investigating the numerous facets of the problem, we would suggest that you give serious consideration to AFSA's ideas on the matter. While these primarily apply to military retirees and their families who are Medicare-eligible, the savings to be realized may well be considerable if you consider incorporating use of the military health services system. Approving ways to keep all retirees in the military health system is not only cost-effective, it also keeps a promise made to retirees, i.e., that they would have lifetime, affordable care as part of the military family.

The men and women of the Air Force Sergeants Association wish you well as you work to accomplish your important mission. As always, we are available to assist you in matters of mutual concern.

AIR FORCE SERGEANTS ASSOCIATION
AFSA
MCMLXI

STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

On behalf of the American Academy of Family Physicians, an organization representing 80,000 practicing physicians, residents, and medical students, please accept this statement for the record of the February 10, 1995, hearing on Medicare reform and innovation.

The Academy recognizes that Medicare will be targeted for substantial expenditure reductions and policy changes designed to achieve a large portion of the approximately $1.4 trillion in savings needed to achieve a balanced budget by the year 2002. This will be a difficult task involving by some estimates at least $40 billion in Medicare spending reductions annually for the next seven years. As you and your Ways and Means colleagues search for these savings, we urge you to take advantage of the **proven** savings that can be achieved by correcting anti-primary care biases and alleviating regulatory burdens in the current program. Implementing changes such as those described below will generate meaningful savings, bringing the economy nearer to a balanced federal budget, while also improving the quality of care for Medicare beneficiaries.

Congress will consider a wide range of proposals designed to reduce the rate of increase in Medicare expenditures, including higher beneficiary cost sharing, enrolling a higher proportion of Medicare beneficiaries in managed care plans, Medicare vouchers, and medical savings accounts. While each of these reform proposals holds some theoretical possibility of reducing expenditures, there is only one factor that has been consistently proven to hold down per capita Medicare expenditures, **the availability of primary care**. Your success in controlling Medicare outlays will be directly related to your success in improving beneficiary access to primary care services.

Primary Care and Medicare

Primary care physicians--defined by the Council on Graduate Medical Education as family physicians and general practitioners, general pediatricians, and general internists--deliver health care services more efficiently and in a less costly manner than subspecialists. Family doctors, for example, treat 85-90 percent of the presenting conditions of an undifferentiated patient population and take responsibility for managing the care of those patients who are referred for subspecialty services.

There is extensive literature supporting the conclusion that primary care is cost-effective, and several of these studies are specific to the Medicare population. For example:

- There is an inverse relationship between the extent to which a nation's primary care system is developed and the per capita cost of health care. (Starfield; JAMA, Oct. 23/30, 1991)

- Per capita health expenditures decrease as the proportion of family and general physicians increases. A systematic evaluation of variation in Medicare expenditures for physician services across the U.S. concluded that a higher proportion of primary care physicians in a metropolitan statistical area is associated with a significantly less expensive practice of medicine overall, for both in-hospital and out-of-hospital care. (Welch et al; NEJM, March 4, 1993)

- A study of per beneficiary Medicare expenditures for physicians services found that the most important factor explaining lower expenditures in rural areas is the mix of physician specialties. Expenditures are significantly lower when the proportion of general and family physicians is higher and expenditures are significantly higher when the proportion of subspecialists is higher. (Dor and Holahan; Inquiry, Winter 1990).

- Increased availability of primary care services for low-income populations reduces the inappropriate and expensive use of emergency departments. In one study, nearly half (45 percent) of patients waiting for emergency department care cited unavailability of primary care services as their reason for using the emergency department. Only 13 percent of those waiting had conditions clinically appropriate for the emergency department; 38 percent were willing to trade the emergency department visit for

assurances of an appointment at a primary care clinic within 3 days. (Grumbach, et al; AJPH, March, 1993)

- Given an equivalent patient population, primary care physicians provide more cost-effective care than their subspecialty colleagues. The recent Medical Outcomes Study reported that cardiologists, for example, hospitalize patients with similar levels of illness at more than twice the rate that family physicians do, and ordered more tests, etc. After adjusting for patient mix, cardiologists and endocrinologists had utilization rates that were considerably higher than those of generalists for all health care resources. (Greenfield, et al; JAMA, March 25, 1992)

These studies point to a stark reality of American medicine: it is overly specialized and overly costly and the two are directly related. No matter what other reforms Congress may consider and adopt, **the cost explosion in the Medicare program will not be brought under control until Congress improves the availability of primary care services.**

The studies cited above point to the fact that when primary care physicians in general, and family doctors in particular, are used by Medicare enrollees, the program reaps savings. However, despite these positive and encouraging findings, the Physician Payment Review Commission (PPRC) and the AAFP itself have discovered disturbing access problems centered around primary care services for Medicare beneficiaries.

In its 1994 annual report, the PPRC summarizes the results of a 1992 physician survey showing that 10 percent of primary care doctors were not accepting new Medicare patients. The AAFP found that by region 17-35 percent of its practicing members are not accepting new Medicare patients. Over one-quarter of family physicians' patients are Medicare beneficiaries; this figure is even higher in rural areas. Despite steps Congress has taken, most recently in the Omnibus Budget Reconciliation Act of 1993, to protect primary care services from fee reductions, anti-primary care biases in the fee schedule remain a sizeable problem. Just as importantly, given the disproportionately low number of family physicians in the workforce today, it should be noted that most family practices are full--another pressing reason that our membership cannot accept new Medicare patients.

Given the potential for widespread Medicare savings when primary care and family physician services are maximized, we strongly recommend that steps be taken to completely eliminate anti-primary care biases in the Medicare program. At a minimum, this shift would involve specific changes in the fee schedule and a redistribution of Medicare's graduate medical education (GME) funds to boost the number of family physicians trained.

The Fee Schedule

Given the desirable cost-saving benefits connected with the use of primary care physicians by Medicare enrollees, removing anti-primary care features from the physician fee schedule is an important part of Medicare reform. Therefore, the Academy believes the following improvements with respect to primary care payments under the Medicare fee schedule are needed to improve beneficiary access to primary care services.

First, Medicare payment for visit services, which are the type of service that primary care physicians most commonly provide, are generally inadequate. Indeed, Medicare payments are only slightly more than half of private sector payments and often are below the cost to the physician of providing the service. Inadequate payment rates are the most important reason so many family physicians no longer accept new Medicare patients.

In general, we believe the work involved in visit services is greater than the values assigned to them by the Medicare fee schedule. The intensity of these services is uniformly and inappropriately lower than the intensity values assigned to other services, such that even highly complex visits on extremely ill patients are valued lower than very minor, straightforward skin procedures.

Since the work relative values for visit services were implemented in 1992, medical practice has changed substantially enough to create a compelling rationale for believing that the work involved in visit services is currently undervalued. Specifically, patient complexity has changed as patients enter the hospital later and leave sooner. The patient population is aging. New drug treatments and more sophisticated diagnostic tests have increased the complexity of factors physicians must consider in their medical decision making. More sophisticated diagnostic tests have produced more results for physicians to explain and discuss with more people, many of whom are better informed and, therefore, more inquisitive. Considered together, these changes in medical practice have increased the mental effort, judgment, and physician stress associated with providing a service, while adding to the amount of work that a physician must perform after the face-to-face visit is concluded. This postservice work is included in the basic visit fee. Accordingly, we have requested as part of the statutorily mandated five-year review of the Medicare fee schedule a re-examination of those E/M services for which we have a compelling rationale they are undervalued. These E/M codes are: 99213, 99214, and 99215 (established patient office visits); 99231, 99232, and 99233 (subsequent hospital visits); and 99238 (hospital discharge day service).

Second, there is a well-documented anti-rural bias in the Geographic Practice Cost Index. The GPCI is intended to measure geographic differences in physician practice costs. Instead, the Academy believes there should be a single fee for the same service--regardless of where it is located.

It should be noted that the GPCI index does not actually measure physician practice costs, but, rather, is based on "proxy" data. For example, instead of measuring physician office costs, it uses a national index of residential apartment rents. The flaw in Medicare's GPCI is illustrated dramatically in its conclusion about the relative difference in urban and rural practice costs. The GPCI purports to show that rural physician practices are significantly less expensive than urban practices. In fact, multiple studies conducted over many years show conclusively that rural practices are every bit as expensive as urban practices. The GPCI systematically and unjustifiably penalizes rural physicians. The differential between urban and rural payments for the same service can be as high as thirty percent.

More than any other specialty, family physicians locate in rural communities. To reiterate the AAFP's position, we believe there should be no differential in physician fees based on practice location. Instead, there should be a single fee for the same service regardless of where it is located. We base our position on the premise that equivalent service should result in equivalent compensation. Furthermore, our position is consistent with federal policies that incorporate uniform national rates. For example, uniform national rates apply to federal income tax, social security payments, and the Medicare Part B premium. A policy of uniform payment should only be modified, in our view, to achieve explicit policy goals (e.g., targeted adjustments for demonstrated shortfalls in access to care).

Third, we continue to believe that visit services are undervalued due to the practice expense component of the Medicare physician fee schedule. Basing practice expense relative values on historical charges, as the current fee schedule does, rather than resources, unfairly impacts the value of office visit services. We recognize that the basis for these relative value units is set in law, and we are encouraged that Congress mandated resource-based practice expense relative value units as part of the Medicare technical amendments signed into law last year. We look forward to working with the Health Care Financing Administration to implement this change.

A fourth flaw in the fee schedule relates to how visit services are undervalued due to the current Medicare Volume Performance Standard and conversion factor system. Since the inception of the MVPS, surgical services have repeatedly received a higher update resulting in an ever-increasing disparity between the fees for surgical services and those for primary care services. This cumulative differential has the perverse effect of undermining the redistributive effect intended under physician payment reform. The PPRC and others have commented extensively on this problem.

We are studying the current MVPS and conversion factor system for improvements and would pleased to work with you and your committee colleagues on this matter. In particular, we believe attention should be directed at the current use of multiple MVPSs and conversion factors and the question of whether a single MVPS and conversion factor would be more appropriate. Multiple MVPSs and conversion factors disturb the relationship between surgical and primary care services by valuing the work of the former at a higher level than the latter. In this regard, we note that the PPRC has concluded "that a single target and update would best maintain the integrity of the resource-based relative value scale." (PPRC Annual Report 1994)

The Workforce Quandary

The evidence linking excess costs to the growing supply and the extreme over-specialization of the U.S. physician workforce has been corroborated in a number of recent studies. Both the specialty imbalance and aggregate surplus are steadily worsening. It is eminently clear that if Medicare is to provide access to appropriate medical care with reasonable cost constraints, the aggregate supply must be limited and the proportion of generalists must be substantially increased.

The aggregate supply and specialty mix of physicians currently produced in the U.S. medical education system are a direct reflection of the financial incentives in the federal programs supporting these activities. Specifically, the strong inpatient bias in Medicare's graduate medical education support and Medicare's traditional under-payment for primary care services have powerfully influenced the distribution of the physician workforce towards specialization. Ironically, while the market for medical care increasingly demands more primary care services, the medical education system continues to produce a surplus of physicians narrowly trained in subspecialty fields. Changing the specialty mix of the physician workforce will require a reversal in the current incentives and establishing a meaningful connection between the market for medical care and medical education.

A July, 1994, report by the Office of Inspector General of the Department of Health and Human Services reached the same conclusion as the AAFP. In that report, the Inspector General recommended that the "Health Care Financing Administration (HCFA) reevaluate Medicare's current policy of paying GME costs for all physician specialties. In its reevaluation, HCFA should consider submitting legislation to reduce or even possibly eliminate Medicare's investment in GME costs for specialties with a surplus of physicians." We concur and urge you and your Ways and Means colleagues to include such language in the Medicare reform legislation produced by this committee.

In order to make primary care services available to Medicare beneficiaries, Medicare GME funding must support primary care training. Primary care training is based in ambulatory care. The AAFP believes any serious Medicare reform proposal should, at a minimum, include the following GME changes:

- an elimination of the penalty that teaching hospitals incur for the time that residents spend training in non-hospital owned ambulatory facilities;
- an extension of eligibility for direct GME payments to non-hospital entities that operate approved residency programs; and
- an up-weighting in direct and indirect GME payments for residents in the primary care specialties.

In addition, the AAFP has very strong concerns about the future viability of family medicine residency programs if Medicare Indirect Medical Education (IME) funds are reduced by 3 percent--as proposed by some lawmakers. Current medical education policies favor non-generalist training programs at the expense of family medicine, making them more lucrative than family medicine. If IME reductions are enacted, we have strong reasons to fear the family medicine programs will be targeted for severe cutbacks or even elimination in some

hospitals. Further hindering efforts to produce family physicians in this fashion is insupportable.

Simply stated, the savings realized by Medicare beneficiaries treated by family physicians and other primary care providers cannot be achieved without substantially more generalist physicians in the workforce. These and other recommendations would bring Medicare's training incentives into alignment with market forces to ultimately create savings for the program.

Underserved Bonus Payments

By whatever measure you might employ, this nation suffers from a severe shortage of primary care physicians, and some geographic areas are particularly underserved. Since 1986, the number of federally designated primary care health professions shortage areas has increased from 1949 to 2492, and the number of primary care physicians needed to eliminate these shortages has grown from 4314 to 4677.

Since 1989, physicians who treat Medicare patients in HPSAs have been entitled to bonus payments equal to 10 percent of the amount Medicare pays for services. In theory, the bonus payments act as incentives to attract new physicians to underserved areas and to discourage physicians in those areas from leaving. However, as recent reports by the Physician Payment Review Commission, the Council on Graduate Medical Education, and the HHS Inspector General's Office confirm, the Medicare bonus payment program is not well structured for this purpose.

Almost half of the money distributed by Medicare in the form of bonus payments accrues to physicians who provide little or no primary care. In addition, almost 15 percent of bonus payments go to urban, hospital-based subspecialists.

Congress should modify the Medicare incentive payment program to target it more effectively to primary care. We support the Inspector General's recommendation that the program be changed to provide 20 percent bonuses to physicians providing services in HPSAs and eliminate bonuses for specialty services in urban areas.

Inflexible and Clinically Inappropriate Medicare Rules

Removing anti-primary care biases from the Medicare fee schedule will make a significant contribution toward the savings needed to achieve a balanced budget. Lifting rigid and clinically unsound regulations could take us even closer. Medical regulations have a disproportionately large impact on primary care practices and serve as a strong disincentive for medical students to select primary care careers.

As you know, Medicare is one of the most complicated and confusing programs administered by the federal government. Each year, physicians are faced with increased layers of requirements and inconsistent instructions. Not only are these regulations cumbersome and expensive, they are often badly conceived from the perspective of patient care. Exceptions from Medicare's rigid rules, even for reasons of medical necessity, are hard won, and must in every case be justified with exhaustive, often redundant, documentation. The cumulative expense and frustration is such that many physicians are reluctant to accept new Medicare patients into their practices.

The PPRC noted in its 1994 Report to Congress that increased paperwork was the second most frequent complaint registered by physicians with respect to the Medicare program. Similarly, a 1993 study of family physicians' satisfaction with their practices concluded that "The number of physicians considering external regulations and paperwork as problematic has increased from a bare majority [in 1983] to almost unanimity [in 1993]." According to this study, regulations by government agencies and the amount of paperwork involved in medical practice are now felt to be moderate to large problems by 90 percent of practicing family physicians. It is telling that a survey done by the Academy found that family

physicians spend an average of 20 percent of working hours attending meetings or doing administrative tasks often the direct result of federal regulations. This is simply misdirected and wrong--physicians are trained to serve people, not push paper.

CLIA - The Clinical Laboratory Improvement Amendments (CLIA) is a particularly onerous and misguided law. CLIA was created in response to highly-publicized problems with cytology testing in commercial labs, and now regulates the full scope of medical testing, including testing done in physician office labs (POLs). The net effect of this statute and its implementing regulations has been decreased access to care for Medicare beneficiaries and an increased cost of tests. The AAFP urges Congress to exempt physician office labs from CLIA.

The requirements imposed on any physician office that maintains a laboratory for the benefit and convenience of patients are extraordinary. Under CLIA, physician office labs which perform only simply tests are waived from the law's proficiency testing requirements. However, "waived" labs are required to pay a $100 fee each year to register their waived status with the federal government. Physicians have never understood why a waived lab doing waived tests and therefore exempted from lab testing requirements must register with HCFA.

CLIA certification and documentation requirements for non-waived physician office laboratories are even more formidable. For example, as a matter of sound medical practice, physicians always record patient tests and results in the medical record. However, CLIA requires physicians to maintain a separate office record in which all laboratory tests and associated information are to be logged in chronological order. Such a requirement may be necessary in a centralized lab that has no other record of the patient, but for the physician's office, it simply represents extra, duplicative paperwork with no practical or clinical utility.

In a 1992 fiscal impact study of CLIA, Levine Associates estimated the administrative costs of recording data, maintaining files, producing manuals, hiring additional personnel to handle additional administrative tasks, time of existing personnel, and so forth and so on, to approach 25 percent of the total costs of CLIA implementation. These kinds of requirements render physician office lab financially non-viable, resulting in closure of such labs.

As a direct result of CLIA regulations, a 1993 family practice survey found that a large number of family physicians no longer provide the level of in-office testing they believe is necessary to serve their patient populations. The number one reason cited was "too much government red tape." Instead, many physicians now send their Medicare patients across town (or out of small rural towns) to large hospital or commercial labs for any testing, at a substantial increase in cost and inconvenience to the beneficiary.

Physicians are particularly bitter about CLIA. The reason is that there is not a shred of evidence that CLIA improves the quality or safety of laboratory services in physician offices.

Laboratory service payments - Medical necessity documentation for laboratory services is another area where Medicare could realize substantial savings by lifting much of the regulatory burden. HCFA is currently considering a new requirement for physicians to supply documentation of medical necessity when ordering more than 12 automated lab tests. As the AAFP stated in its comments on this proposed requirement, it is a misguided approach to a recent fraud case of labs billing for more tests than the physicians ordered. As you may know, HCFA claims Medicare could save $60 million by implementing medical necessity documentation requirements for laboratory services. However, we believe that the administrative costs associated with the change are likely to far exceed the costs of any unnecessary testing. It is clear to us that HCFA's proposed "solution" is to penalize physicians rather than the few labs who were the real culprits.

Automated lab tests are frequently conducted in panels or packages in which several tests are performed concurrently. It is cheaper and more efficient to order a multi-panel test than to order individual tests a la carte.

Some time ago, several reference labs were accused of billing for tests that were not ordered. There were instances when a physician ordered a panel of tests, and the lab unbundled the services, submitting the charges to HCFA as many different tests.

The Practicing Physicians' Advisory Council (PPAC) explored this problem and recommended that HCFA establish panels that would be uniform for HCFA, uniform for the doctors ordering the tests, and uniform for the laboratories billing for them. This recommendation would have addressed the problem in a relatively straightforward manner.

However, under the new rules, physicians and laboratories must document the "medical necessity" of each lab test ordered. This requirement will impose massive new record-keeping requirements on the physician community. It is also unreasonable from the perspective of clinical medicine. Laboratory testing is often a tool to provide a missing piece of the medical puzzle. Our patients do not always arrive on our doorsteps with a known diagnosis. A patient does not usually come into an office and say, "Doctor, test me because I have lymphoma." But, she might complain of fatigue. How is the physician to prove medical necessity when ordering tests on a patient who says she's tired? Moreover, patients often have multiple disease processes occurring simultaneously or are borderline for one or more diseases. It is simply not appropriate for the Medicare program and its carriers to second-guess a physician's professional judgement. If physicians are required to reduce the number of tests ordered, or confine the tests ordered to a specific disease process, the opportunity for early detection will be diminished.

As with CLIA and so many other standards in the Medicare program, these regulations were inspired by isolated, outlier problems and subsequently expanded by into massive, costly burdens that punish the entire medical community. The waste, cost shifting, and lost patient time resulting from these burdensome regulations should be reined in to create savings in Medicare and for beneficiaries.

Medicare and Malpractice

Medical liability should also be included as part of comprehensive Medicare reform, for it is one of the more pressing health care problems confronting physicians today. The malpractice crisis contributes significantly to cost and quality problems that plague our health care system. Malpractice also figures directly into Medicare expenditures as a factor in determining physician payments under the fee schedule. In a recent survey of our membership, members ranked meaningful malpractice reform as their number one legislative priority.

The Academy supports federal tort reforms including:

- a $250,000 limit on non-economic damages;
- reducing awards by the amount of compensation from collateral sources;
- allowing periodic payment of awards of $100,000;
- limiting attorneys' contingency fees;
- replacing joint and several liability with proportionate liability among the defendants in a case ;
- a modified statute of limitations;
- mandatory and binding alternative dispute resolution (AD) systems;
- requiring an expert affidavit signed by a specialist who practices in the same medical specialty as the defendant; and
- the use of approved clinical guidelines as an affirmative defense.

Conclusion

Improving the Medicare fee schedule, reforming Medicare GME support, retargeting underserved bonus payments, easing regulatory burdens and paperwork, and imposing rationality and limits on the medical liability system, perfecting the Medicare risk contract

program may not, at first glance, seem to be comprehensive Medicare reforms or obvious paths towards federal deficit reduction. But, taken separately or jointly, each of these recommendations will enhance the availability of primary care, and enhancing the availability of primary care is the **only** factor that has been shown to produce savings in the Medicare program. We urge you and your Ways and Means colleagues to give these programmatic changes equal consideration with spending reductions. Above all else, we urge you to consider Medicare reform through the prism of a rapidly changing medical marketplace and populace--an environment that requires greater support for primary care training and services.

Thank you for your consideration of our views. The Academy would be delighted to work with you on any of these issues.

Statement of the

American Academy of Ophthalmology

for the

House Ways and Means Committee

Health Subcommittee

hearing on

Medicare Reform and Innovation

Mr. Chairman and members of the Committee:

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

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

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

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

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

MEDICARE TRENDS

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

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

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

"CENTERS OF EXCELLENCE"

Along with the Medicare reductions, the Academy is concerned about the creation of HCFA-administered schemes to achieve additional budgetary savings. To date, many of these schemes have been thwarted by Congress. The Academy is concerned about one proposal, in particular, the so-called "centers of excellence."

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

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

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

Quality Problems

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

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

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

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

Competition and Access Problems

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

Moreover, by locating these "centers" only in urban areas, the Federal government would create access problems for patients in rural and other underserved areas. Through the marketing of a facility as a "center of excellence" and the Federal government's "rebate" payment, patients would be encouraged and, in effect, paid to leave their community-based providers in rural and

underserved areas and travel to an urban "center" for care. This exodus of patients from providers in rural and underserved areas could force many providers to relocate in order to maintain their practices. Patients remaining in the underserved areas could be left with limited access to providers.

Necessity of Care Problems

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

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

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

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

Ethical Problems

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

REFORM OF MEDICARE

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

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

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

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

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

STATEMENT OF THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE

The American Association for Respiratory Care (AARC), a 37,000 member professional association of respiratory care practitioners, welcomes the opportunity to submit written testimony on the House Ways and Means Committee's February 6, 1995 hearing on *"Controlling Costs and Improving Care of the Medicare Program"*.

Respiratory care is an allied health specialty performed under medical direction for the assessment, treatment, management, diagnostic evaluation, and care of patients with deficiencies, abnormalities, and diseases of the cardiopulmonary system. Respiratory care practitioners care for patients ranging from the premature infant whose lungs are underdeveloped to the elderly patient whose lungs are diseased. Individuals who suffer from such diseases as emphysema, bronchitis and lung cancer; children who suffer from asthma or are afflicted with cystic fibrosis; and patients of all ages who require the use of a ventilator to breathe---all often cared for by the respiratory care practitioner.

The AARC shares the Congress' concern at the increasing costs of the Medicare program. We believe that, unless fundamental changes are made to the Medicare program, the cost escalation will continue until the entire system reaches crisis proportions. We believe, however, that an in-depth analysis as to the underlying causes of the increases must be made prior to implementing changes that might inappropriately curtail the use of alternate care site services as provided by nursing homes, rehabilitation facilities, and home health care entities. The demographics of the elderly population, the advances in medicine and technology, and the increasing financial pressures from institutions to discharge patients into other less costly care sites must be considered when determining the causes of the increases in the use of alternate care services.

As advocates of the respiratory care community, the AARC and its members are acutely aware of the medical and clinical advances in the provision of respiratory care medicine, which now permits the pulmonary-restricted patient other pathways to receive the necessary evaluation care and treatment of their illnesses and diseases. For example, outpatient pulmonary rehabilitation has given many chronic lung diseased patients the ability to continue to lead productive lives at home. Pulmonary rehabilitation programs have greatly reduced hospital admissions, readmissions, and emergency room visits for asthmatics.

As another example, ventilator-dependent patients who, twenty years ago, may never have survived or, at very best, be left totally hospitalized can be cared for in a less acute care site such as a nursing home or even in the home. Many of these patients can be fully or partially weaned from the ventilator and lead productive lives provided they have access to respiratory therapy. Furthermore, the cost-effectiveness of respiratory therapy in the alternate care site has been demonstrated through study after study. Attachment No. 1 provides a summary of this cost information. If these patients who medically must have respiratory therapy services can find the services provided in a less expensive care site, then hospital care can be curtailed and costs reduced.

A 1993 Perspective Payment Assessment Commission report states the following (page 120):

> **"Taking one DRG, No. 483, tracheostomy, the most costly DRG which is most often performed to supply ventilator support, cost the Medicare program $2.6 billion per year or $76,522 per patient."**

If only a small percentage of these patients were to be transferred to a less-intensive care site, such as the nursing home, then cost savings to the Medicare program would be significantly reduced. Unfortunately, many of these patients are unable to be discharged to the nursing home because of outdated Medicare rules that were implemented well over twenty years ago when few respiratory-impaired patients left the hospital.

For the last two decades, the Medicare program has strictly interpreted a regulation that permits only respiratory therapists employed in a hospital, with which there is a transfer agreement in place, to provide Medicare-covered extended care respiratory therapy services in the nursing home. The restricted nature of the rule ties the hands of a nursing home facility in its ability to seek out other qualified respiratory therapy practitioners.

Even respiratory care practitioners who could be employed directly within the nursing home would be considered unreimbursable under the Medicare program.

This antiquated ruling must be lifted for several reasons. Nursing homes are unable to avail themselves of the competitive market place by having the ability to negotiate the best price for professional respiratory care services. The transfer hospital provides the only avenue from which nursing homes may find Medicare-covered respiratory therapy services. Skilled nursing facilities (SNFs) wishing to hire a respiratory therapist directly or under arrangements will find their services unreimbursable. With no competitive market place from which to negotiate the best and lowest cost of the RCP services, the Medicare program may be reimbursing at an inappropriately high cost for these services.

Secondly, some nursing homes may be geographically located a great distance away from the transfer hospital, and respiratory care personnel may be unavailable to travel the distances necessary to make the required visits (this is particularly true in rural areas). Under these circumstances, pulmonary patients may simply be readmitted to the hospital for lack of access to the appropriate care. Another consideration is that physicians are reluctant to discharge their respiratory patients into a facility if the necessary respiratory care is not provided or covered in the nursing home by qualified respiratory personnel; thus requiring the patient to remain in the costly hospital setting.

We would urge Congress to lift the restrictive hospital transfer agreement requirement and permit skilled nursing facilities to find the most appropriate and cost-effective way to provide medically-appropriate and prescribed respiratory care services to the Medicare nursing home patient. We would also request that, as Congress scrutinizes the Medicare home health benefit and Medicare-covered rehabilitation services, they bear in mind that respiratory care provided in these settings are cost-effective alternatives to hospital care.

COST-EFFECTIVENESS OF RESPIRATORY CARE

Increased Need for Respiratory Care Outside of the Acute Care Hospital

Respiratory care is an allied health specialty performed under medical direction for the assessment, treatment, management, diagnostic evaluation, and care of patients with deficiencies, abnormalities, and diseases of the cardiopulmonary system. Respiratory care practitioners care for patients ranging from the premature infant whose lungs are underdeveloped to the elderly patient whose lungs are diseased. Individuals who suffer from such diseases as emphysema, bronchitis and lung cancer; children who suffer from asthma or are afflicted with cystic fibrosis; and patients of all ages who require the use of a ventilator to breathe—they are all often cared for by the respiratory care practitioner.

Home care services have proven to be an integral part of the health care delivery system and a cost-effective alternative to expensive acute care hospital stays. The aging population, the spread of AIDS and tuberculosis, the increasing incidence of asthma, and advances in medical technology allowing technology-dependent patients to lead more productive lives outside the hospital, will increase the need for the services of trained and educated respiratory care practitioners. Respiratory patients will continue to be discharged from the hospital still requiring care, thereby increasing the demand for respiratory care services in alternate sites.

Overall, government health care policy has not kept pace with the advancement of medical technology and procedures. In particular, this has been the case for respiratory care services. When the Medicare/Medicaid program was first developed, respiratory care was fully recognized as a viable component of hospital services. Coverage and reimbursement for this service in the hospital have never been in question. However, Medicare/Medicaid policy has barely advanced in the past 25 years for respiratory care services rendered outside acute care settings. The scope of respiratory care services has developed significantly beyond the hospital setting. Where respiratory patients were once confined to a hospital bed, the same patients may now be cared for in a skilled nursing facility or in the patient's own home. It is the respiratory care community's recommendation that Congress recognize the role that respiratory care plays in the provision of cost-effective health care in alternate sites.

Respiratory Rehabilitation: A Cost-Effective Alternative

The purpose of rehabilitation is to ameliorate physical and cognitive impairments resulting from illness or injury, and to restore or improve functional ability so that individuals can return to work and lead independent and fulfilling lives. Pulmonary rehabilitation is designed to stabilize or reverse the effects of pulmonary diseases, such as emphysema, bronchitis, or chronic obstructive pulmonary disease (COPD) (i.e. those suffering from a degenerative disease of the lungs). One federal program, the Black Lung Program, has, since 1978, recognized the importance of structured outpatient pulmonary rehabilitation programs. The Coal Mine Procedure Manual states:

> "Further, DCMWC (Division of Coal Mine Workers Compensation) believes that properly administered pulmonary rehabilitation will reduce the need for future medical treatment, which would eventually prove more costly to the program."

Respiratory Care Saves Money

The scientific evidence on the cost-effectiveness and efficacy of providing respiratory care in alternate care sites continues to grow. The studies documenting cost-effectiveness of respiratory care have varied in methodology, scope, and time frame. The conclusion, however, is still the same: **respiratory care saves money.**

- A 1991 Lewin/ICF economic analysis focused on the effect of the availability of home medical equipment services on the cost of care for patients in three separate diagnostic categories. One of the categories studied was patients suffering from COPD. Lewin/ICF determined that $520 per patient per episode would be saved if a COPD patient was to receive care in the home rather than in the hospital. With an estimated patient population of 93,000 COPD patients per year, savings to the health care system amount to over <u>$48 million per year</u>.

- A recent Gallup survey studied the cost of providing hospital care to chronic ventilator patients. The survey estimates that there are over 11,500 chronic ventilator patients currently in U.S. hospitals costing an estimated $789 per patient per day. This totals over $9 million a day! Once a patient is medically able to be discharged, it takes an average of 35 days to place a chronic ventilator-dependent patient in an alternative care site such as the home or skilled nursing facility. That translates to an excess of $27,000 per patient in unnecessary hospital costs. Outdated reimbursement policies, which limit patients' access to respiratory care services outside the hospital, contribute to discharge delays and their subsequent excess cost.

- In the early 1980s, the Department of Health, Education and Welfare (HEW) sponsored a study that tracked 775 COPD patients, who received home respiratory services from a qualified respiratory therapist. The results of the study shows that hospital re-admissions for these patients were reduced from 1.28 per year to .55 per year. Furthermore, for those patients who were re-admitted to the hospital, the length of stay was decreased from 18.2 days to 5.7 days. The savings estimated for these 775 patients totaled $1,097,250 (1980 dollars).

- A 1982 conference headed by former Surgeon General C. Everett Koop on home care alternatives resulted in the initiation of three pilot home care studies. One pilot program in Maryland provided home care to respirator-dependent children and compared hospital costs and home care costs. The savings provided by home respiratory care were more than $15,000 per patient per month. Over the 34 month period of the pilot program, $3.1 million in savings were realized due to the availability of home care for these children.

- A 1991 Illinois-based study on ventilator-dependent infants receiving home respiratory care versus hospital-based care saved the state over $4 million during the four-year course of the program.

- A 1989 consensus conference co-sponsored by the AARC, the Food and Drug Administration (FDA), and the Health Resource Services Administration (HRSA) (attended by representatives from more than 60 national organizations and associations) studied the problems associated with the introduction of respiratory care equipment into the home. Practitioners, consumers, and representatives of the federal government that recommended that third-party reimbursement policies should allow home-bound respiratory patients to receive, when necessary, care from respiratory professionals.

- Aetna Life & Casualty developed an Individual Care Management Program for patients suffering from catastrophic illness. The following chart summarizes cost-effectiveness data for home care for these individuals:

Cost Per Month of Hospital Care Compared to Home Care, Selected Conditions

Condition	Cost of Hospital Care	Cost of Home Care	Dollar Savings	Difference
Infant born w/breathing & feeding problems	$60,970	$20,209	$40,761	66.8%
Respiratory distress/oxygen dependency	$36,000	$11,500	$24,500	68.0%
Ventilator-dependent children	$15,742	$ 9,153	$ 6,589	41.9%
Patient requiring respiratory support	$24,715	$ 9,267	$15,448	62.5%
Oxygen-dependent children with a tracheostomy	$12,236	$ 5,304	$ 6,932	56.7%
AIDS patient care	$23,190	$ 2,820	$20,370	87.8%
Pediatric AIDS	$70,153	$16,461	$53,692	76.5%

- Norwalk Hospital in Connecticut conducted a four year study to evaluate the effectiveness of a hospital-based home care program for patients with severe COPD. A comprehensive home care service program was provided to 17 pulmonary patients who previously required frequent hospitalization. The COPD patients participated in a comprehensive respiratory home care program and showed significant decreases in the following:

Hospitalization Admissions	88 pre-program	53 on-program
Hospital Days	1,181 pre-program	667 on-program
Emergency Room Visit	105 pre-program	64 on-program

Costs for hospitalization, emergency room visits, and home care fell from $908,031 to $802,999 resulting in a savings of $105,032 or $328 per patient per month over the course of 48 months.

- Several research studies conducted in the past several years have compared inpatient care to home care costs for a specific group of patients. The cost savings data for these studies is summarized in the chart below. The information has been aggregated at a monthly level for purposes of comparison.

Conditions	Per Month Hospital Costs	Per Month Home Care Costs	Per Month Dollar Savings
a. Ventilator dependent adults	$21,570	$ 7,050	$14,520
b. Oxygen dependent children	$12,090	$ 5,250	$ 6,810

(a) Bach, J.R., Intinola, P., Alba, A.S., & Holland, I.E., (1992). The ventilator-assisted individual: cost analysis of institutionalization vs. rehabilitation and in-home management. *Chest, 101* (2), 26-30.

(b) Fields, A.I., Rosenblatt, A., Pollack, M.M. & Kaufman, J. (1991). Home care cost-effectiveness for respiratory technology-dependent children. *American Journal of Diseases of Children, 145*, 729-733.

STATEMENT OF
AMERICAN ASSOCIATION OF COLLEGES OF NURSING
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS
AMERICAN ORGANIZATION OF NURSE EXECUTIVES

The American Association of Colleges of Nursing (AACN), representing 464 baccalaureate and graduate nursing institutions, the American Association of Nurse Anesthetists (AANA), representing 26,000 certified registered nurse anesthetists, and the American Organization of Nurse Executives, representing 6,000 practice executives, urge that Medicare Graduate Medical Education (GME) funds presently going mostly to undergraduate nursing education be redirected for graduate nurse education. This innovation would provide a stable, on-going revenue source to expand the production of advanced practice nurses (APNs), a vital resource for meeting future Medicare population needs. A graduate nurse education (GNE) program is one that educates nurse practitioners, nurse midwives, nurse anesthetists, or clinical nurse specialists. These APNs are prepared as expert clinicians to deliver primary care and services supportive to primary care They also manage chronic medical conditions and other concerns typical of Medicare beneficiaries GNE programs are post - baccalaureate, advanced practice nursing programs accredited by a national accrediting body and linked by a written agreement to an academic institution that is accredited by a national, state and/or regional accrediting body, and award a graduate degree.

In order to educate adequate numbers of skilled APNs who provide high quality and cost-effective services to Medicare recipients and others, there must be a reliable revenue stream that is not subject to the uncertainties of the annual appropriations process. Medicare uses GME monies for support of provider operated nursing and allied health programs. AACN urges that these nursing education GME monies be redirected to educate APNs.

We suggest the following Medicare changes regarding support for professional education at Medicare facilities:

1. Changing eligibility to include jointly operated programs.

Medicare reimburses hospitals for a portion of the costs of eligible hospital-owned or operated nurse education programs. In fiscal 1991, hospital operated undergraduate programs received $174 million in GME, according to Health Care Financing Administration data. Since the inception of Medicare, nursing education has shifted almost entirely to community colleges, senior colleges, and universities. Most APNs represent categories of providers not in existence when Medicare educational payment policies were designed; educational cost of these new providers are, with one exception (nurse anesthetists), not covered by Medicare. **Consequently, eligibility requirements should be changed to those "jointly-operated" (provider-academic) programs incurring costs for support of APN education.** Providers eligible to receive reimbursement would have to meet all of the following criteria: must be eligible to receive Medicare Part A, incur clinical costs for the support of graduate nurse education programs, and have a written contractual agreement with the program's academic institution. Cost allocations for determination of Medicare's share of reimbursement would include student stipends, costs of nursing clinical faculty and supervision at the clinical site, and program expenses, all limited to that portion of the education taking place at the Medicare provider facility. Determination of the specific cost of education would be based on an appropriate ratio of faculty to students, and faculty and supervisory salaries. In part, that agreement will require the provider to issue both a voucher for clinical education costs and a clinical stipend to the APN student.

2. Clarifying of "provider" definition to include out - patient facilities.

Medicare defines "provider" as "hospitals, skilled nursing facilities, home health agencies, and other facilities." With health care delivery evolving beyond acute care to community based sites, ambulatory care facilities as well as tertiary care sites, should be reimbursed for costs incurred for clinical training of APNs. It is critical to support these settings, because students must be exposed to a variety of places where people are getting care.

The Medicare definition of "other facilities" should be clarified to include those facilities that provide health care to Medicare recipients, with or without links to acute care settings, including, but not limited to, nurse managed centers, ambulatory care facilities, health maintenance organizations, and public health departments. A broad definition of eligible training facilities is necessary to facilitate clinical training of the largest number of APNs in those sites that have the greatest need for these practitioners.

Most nursing programs pay their own clinical training faculty or make arrangements with preceptors at clinical sites to provide clinical training at patient care sites outside the schools' academic facilities. The cost of faculty at the clinical site and cost of preceptorships for advanced nursing students, however, are part of the cost of providing patient care because patients receive the benefit of the care delivered by graduate students and their faculty.

Under this proposal, all entities that incur clinical costs for support of APN education would have access to GNE funding for the portion of the cost attributable to the Medicare patient population. GNE funding would allow the allocation of resources for added clinical faculty to expand the number of APNs in training. APNs are precisely the type of health professional the Medicare populations will need for primary care, management of chronic medical conditions affecting older people, and patient education to help this population avoid injury and expensive hospitalization or nursing home care. This would help eliminate the waiting lists which all graduate nursing programs are experiencing. Support of preceptors in the clinical sites would allow them to provide teaching and direct clinical supervision to the APN students as a planned component of their job responsibilities, rather than as an additional responsibility to their current workload. GNE support would also provide incentive to the practice sites to agree to take on students for clinical training.

Due to limited resources in many of these settings where patients are receiving care, most can only take on one or two APN students at any one time. This forces programs of nursing to contract with numerous sites in order to provide clinical training for students. Reimbursement to clinical sites for clinical faculty would allow the concentration of groups of APN students, providing economies of scale and improving efficiency of the training process. In addition, reimbursing clinical sites for training APN students recognizes the value of their services to patient care. With the number of specialty resident physicians likely to be reduced, these APNs will be delivering many of the services formerly performed by resident physicians, as well as nursing care. Acute care nurse practitioners who have graduated from programs such as these, are already assuming roles in a number of clinical sites.

The APN can be a vital component in increasing access to quality health care services for Medicare patients in a rapidly changing health care environment. Presently, costs of preparing the APN are borne almost entirely by programs of nursing and the students themselves, each with very limited resources. The Nurse Education Act (T. VIII of the Public Health Service Act), among other things, provides modest support (FY 95 = $45 million) for the didactic (non-clinical) part of the APN programs, but would not be redundant to the GME support.

At present, Medicare reimbursement for nursing education programs is limited by the "provider - operated rule," which directs most of the funding to diploma programs that produce entry level nurses. There are data indicating that the number of entry level nurses is adequate. There is a large gap, however, in the supply of advanced practice nurses. There have been five demonstration projects funded by Medicare to educate various types of advanced practice nurses. These projects ended in July 1994 and a report on the demonstration projects will be sent to Congress this summer. These projects show that Medicare dollars increased the recruitment and retention of advanced practice nurses at the facilities running the programs, created a skilled nursing facility, and improved the provision of nursing care. These programs suggest that more Medicare support for advanced practice nurses will greatly benefit the Medicare population and could help reduce Medicare costs through replacement of more costly professionals.

This is the time to shift GME funding toward the recognized great need for advanced practice nurses. Redirection of the current Medicare monies for nursing education to APN education will increase the numbers of APNs and will ensure that Medicare patients will have the benefit of their skills in the future. Though the redirection of these funds for support to APN education requires no new Medicare expenditures, it is imperative that funding levels should not be reduced for those APN programs currently receiving Medicare support . Redirection of funds would focus Medicare support on the preparation of the nurse in great demand by the Medicare beneficiary population, and help meet the needs of the changing health care workforce.

In order to quickly expand the numbers of these expert nurse clinicians, we need your help. We ask for your support.

GMEGNE.WM

AMERICAN ASSOCIATION OF PPOs

February 16, 1995

The Honorable Bill Thomas
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The American Association of Preferred Provider Organization (AAPPO) appreciates the opportunity to comment on the issue of Medicare reform and innovation, the subject of your February 10 hearing. We respectfully request that this letter be made part of the official hearing record, as provided for in your January 30 announcement.

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

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

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

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

AAPPO supports efforts to extend the Medicare Select program to all 50 states, and to make it permanent. Medicare Select allows beneficiaries to enroll in private health plans that compete to provide low-cost, high-quality care. It offers a low-commitment, low-threat

introduction to managed care for beneficiaries without previous experience, and in time may provide a comfortable transition to choosing managed care for basic as well as supplemental Medicare benefits. Medicare Select can deliver high quality care at a lower premium cost to beneficiaries, and produce savings to the government at the same time.

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

Sincerely,

Gordon B. Wheeler
President & Chief Operating Officer

cc: Members of the Subcommittee
Charles N. Kahn
David Abernethy

STATEMENT SUBMITTED TO
THE COMMITTEE ON WAYS AND MEANS, SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES
ON
"MEDICARE REFORM AND INNOVATION"
FEBRUARY 10, 1995

Introduction

The American Chiropractic Association (ACA) is pleased to submit this statement to the subcommittee on the issue of reforming the Medicare system. As the world's largest chiropractic organization, ACA has long spoken for the profession on a range of issues before Congress, and have in fact frequently testified before this subcommittee on issues related to Medicare and health care reform. Our over-arching goal in our dialogue with the subcommittee and the Congress has always been to advance Americans' freedom to choose the high quality health care services lawfully performed by doctors of chiropractic (D.C.s) under the authority of State law. It is that same goal which brings us to deliver this statement today.

We are pleased that the subcommittee has chosen to explore possible methods to reform and improve the Medicare system. We have noted with enthusiasm the statements of Speaker Gingrich and others in Congress about the need to offer greater choices to senior citizens in Medicare and look forward to being constructively engaged in the process by which those choices are expanded. Reforming the system to expand beneficiary choice and increase competition among health care providers will surely benefit the system, and advocacy of such improvements is an extremely high priority for the ACA. We are confident that, if given the genuine freedom to choose their health care provider, Medicare beneficiaries will freely avail themselves of the services of doctors of chiropractic, just as over 18 million regular chiropractic patients do every year.

Unfortunately, with the exception of a single narrowly defined service, Medicare beneficiaries are denied any real ability to choose a chiropractor. As a result, both beneficiaries and the program itself have been deprived of the potential health benefits and cost savings that full coverage of chiropractic services could produce. The program also forgoes any savings that might result from full and open competition between chiropractors and other Medicare providers.

While we do not suggest that resolving the specific problems related to the chiropractic portion of the program will solve all the problems plaguing Medicare, the issues we raise are symptomatic of a system needing to reaffirm its commitment to patient freedom of choice. Therefore, we hope that the subcommittee, and Congress as a whole, will address the issues that we raise within the context of overall Medicare reform.

Patient Freedom of Choice Guaranteed

The denial of patient choice that is manifest in Medicare's limited chiropractic benefit flies in the face of the "freedom of choice of provider" guarantees established at the inception of the Medicare program in 1965. The Social Security Act, which authorizes Medicare, clearly states that:

> "Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate in this title if such institution, agency, or person

undertakes to provide him such services."[1]

Unfortunately, as it pertains to the services of D.C.s, limitations on Medicare coverage frustrate the freedom of choice goal that is explicit in the statute. Non-coverage of chiropractic services establishes an economic barrier which dilutes beneficiaries' real freedom to choose and negatively governs patients' actions in seeking health care services. Any legislative effort to improve the current system should, in our view, reassert Medicare's fundamental guarantee of a patient's right to select the health care provider of their choice, including a chiropractor.

Medicare's Treatment of Chiropractic Services

Despite Medicare's clear promise of patient "freedom of choice," in 1973 Congress approved an extremely limited chiropractic benefit that, for all practical purposes, restricts patient access to chiropractors. As many senior members of the subcommittee are aware, Medicare does not cover the full range of services that D.C.s are licensed to provide. In fact, only a single service performed by a chiropractor -- manual manipulation of the spine -- is covered. However, due to an overly-narrow construction of the statute by HCFA and its predecessor agency, it is difficult for beneficiaries to obtain even this extremely limited benefit.

As currently drafted, the Medicare statute defines doctors of chiropractic as 'physicians', but only for the purposes of "manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist)..."[2] This definition defines the parameters of covered chiropractic services under the program. As prescribed under the definition, Medicare also *requires* that a diagnostic x-ray be performed prior to initiation of the manual manipulation service. However, while the x-ray is mandatory, if performed or ordered by a D.C., it is not deemed to be a covered service. This restrictive interpretation of the benefit was rendered over twenty years ago and has not been liberalized since.[3]

The practical result of this outdated definition is to deny Medicare beneficiaries any real choice of most of the services chiropractors are licensed to perform. It offers them an extremely limited benefit that is both insufficient for the delivery of proper care and difficult to obtain.

These restrictions on Medciare's chiropractic benefit limit patient choice in two ways. First, with the exception of manipulation of the spine, no services that D.C.s are licensed to provide under state law are available to beneficiaries. The vast majority of services that D.C.s normally provide simply are not covered. Second, the requirement of a non-covered x-ray means that chiropractic patients are either forced to pay for the x-ray themselves -- a cost that many cannot afford -- or are inconvenienced by having to seek the x-ray service from some type of provider other than their D.C. Either way, the non-covered x-ray constitutes an additional layer of bureaucracy that discourages beneficiaries' real choice of provider.

ACA's "Chiropractic Patient Freedom of Choice" Proposal

ACA would urge Congress to lend a measure of common sense to this arcane and outdated portion of the program by granting Medicare beneficiaries equitable access to health care services provided by doctors of chiropractic. *Therefore, we call for enactment of a "chiropractic patient freedom of choice provision" that would grant Medicare beneficiaries access to any service presently covered under Medicare that chiropractors are licensed to perform under state law.*

In recognition of the need to control Medicare costs, our proposal *would not add or require coverage of a single new service under the program*. Rather, it would simply provide beneficiaries access to *currently covered* Medicare services when performed by D.C.s. For example, Medicare currently covers diagnostic x-ray services when performed by medical radiologists. Under the ACA plan, patients would receive coverage for that same service when

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[1] Section 1802 of the Social Security Act.

[2] Section 1861(r)(5) of the Social Security Act.

[3] 39 Federal Register, No. 155, August 9, 1974.

furnished by a D.C., since the performance of x-rays falls within a D.C.'s legal scope of practice. Wherever there is overlap between the services Medicare covers and the services D.C.s are licensed to perform, beneficiaries would enjoy the ability to obtain care from a chiropractor. The proposal would expand beneficary access to cover services while at the same time significantly improving their choice of licensed health care providers.

The concept embodied in this proposal is nothing new. A majority of the states have adopted similar "health provider freedom of choice" laws where they have expanded access to care and spurred the competition among providers that helps hold down costs. It is time for Medicare to "get in step" with the health care innovations taking place in the States by adopting a similar patient freedom of choice proposal.

Cost Benefits of Chiropractic Care

It has been known for years that D.C.s provide cost effective health care services. By granting Medicare enrollees access to these services, the program stands to reap significant savings from lower costs of treating many common health care conditions. The majority of the care that D.C.s provide involves treatment of neuromusculoskeltal (NMS) disorders -- over 88% according to ACA's 1994 Annual Membership Survey. Research shows that chiropractors typically treat these conditions much more cost effectively than do other providers. For example, a recent study of found that, for treatment of common NMS conditions treated by all types of health providers, "chiropractic users tend to have *substantially lower* total health care costs."[4] (emphasis added.) Follow-up research has substantiated these initial findings.[5]

These findings should come as no surprise. D.C.s treat patients in a conservative manner without the use of expensive drugs of surgery and have historically helped patients avoid the expensive hospital setting.

ACA has shared numerous other studies demonstrating chiropractic cost effectiveness with the subcommittee in the past, and would be delighted to do so again at your request. However, it is important to emphasize that the cost savings attributable to chiropractic care are especially notable in the treatment of low-back pain -- a health care condition that will afflict most of the population at some time in their lives and for which costs to society range from $20 to $50 billion a year.[6]

Independent empirical research indicates that chiropractic is by far one of the best forms of care available for low back pain. According to a recent study commissioned by the Ontario Ministry of Health, "there is an *overwhelming* body of evidence indicating that chiropractic management of low-back pain is *more cost effective* than medical management."[7] (emphasis added.) In fact, the researchers involved in this study were so impressed with the effectiveness of chiropractic, that they recommended government policies actively encourage patients with low-back pain to visit D.C.s as the first course of treatment.

While these and similar findings have been available for a number of years, one of the strongest endorsements for treatment of low-back pain through chiropractic methods has been provided by the U.S. Agency for Health Care Policy and Research (AHCPR). In the agency's recently released guideline on the treatment of low-back pain, spinal manipulation was found to be a *recommended and effective* form of care. While the guideline did not specify a preference for any particular provider of spinal manipulation, it is well known that doctors of chiropractic are the leading experts in this particular treatment modality. In fact, they are virtually the sole

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[4] Stano, M, et al., Journal of American Health Policy, Nov./Dec. 1992, Vol.2, No.6.

[5] Stano, M., Journal of Manipulative and Physiological Therapeutics, Vol.17, No.7, September 1994.

[6] U.S. Department of Health and Human Services, "Acute Low Back Problems in Adults," Clinical Practice Guideline, Number 14, AHCPR Publication No. 95-0642, December 1994.

[7] Manga, P., et al, The Effectiveness And Cost Effectiveness of Chiropractic Management of Low-back Pain, Pran Manga & Associates, Inc., Ottawa, Ontario, August 1993.

practitioners of this care, delivering 94% of all the spinal manipulation services rendered in this country.[8]

Undoubtedly, low-back pain is a problem that has a huge impact on the health and quality of life of many elderly Americans. In light of all the evidence, including the AHCPR's new clinical guideline, there is more reason than ever to revise Medicare's antiquated and biased policies that hinder the elderly's ability to obtain health care services from D.C.s. Under ACA's "chiropractic patient freedom of choice provision," Medicare beneficiaries could once and for all freely avail themselves of this cost effective form of care.

Managed Care

We are aware that much of the debate on Medicare reform thus far has focused on expanding the delivery of covered benefits through managed care organizations (MCOs). Because our commitment to patient freedom of choice extends to a patient's ability to choose types of plans, we believe that health maintenance organizations and other MCOs should remain an option for the elderly. However, we feel it is unfair to present beneficiaries with undue disincentives for electing to remain in the traditional fee-for-service portion of the program. Many elderly wish to retain the freedom-of-choice that is the underpinning of fee-for-service health care and financial arrangements should not discourage them from exercising this option. However, if a beneficiary elects to enroll in a Medicare HMO, we believe that Medicare has an obligation to fully inform them about what that choice means, especially as it relates to the inability to freely choose one's health care provider. If beneficiaries wish to accept limited provider choice, then that is their right. However, they should not be deluded about the fact that they will relinquish their ability to select a health care provider from outside of a narrowly drawn list.

As managed care's emphasis on containing costs has grown, the ACA and many other health care organizations have become increasingly concerned about fundamental issues of consumer choice, access and quality. Health care consumers, including Medicare beneficaries, expect and deserve a certain minimum level of protection against the managed care industry's shortcomings in these areas. The public desire for these protections was especially in evidence during last year's health care reform debate when several health reform bills contained important provisions designed to address these concerns.

The ACA's interest in this area has not abated. As a result, over the last several months, we have spearheaded a coalition of health care provider and consumer organizations in developing a legislative package designed to improve consumer choice and health care quality under managed care settings. Almost complete, the package seeks to improve the current system by ensuring that health plans have an adequate choice and mix of providers; by establishing quality assurance mechanisms; by improving the quality and availability of consumer information; and by creating 'due process' procedures for both providers and consumers. Similar provisions received considerable bipartisan support in the last Congress and we have attempted to 'bundle' these concepts into a single legislative package that we hope will receive serious consideration this year. We will transmit this proposal, along with a list of supporting organizations, to the subcommittee once it is finalized in the near future.

In our view, these protections should be extended to enrollees in all managed care health plans, including those enrolled in Medicare HMOs. We hope that the subcommittee will give serious consideration to this package of consumer and provider friendly provisions as part of any effort to encourage further beneficiary enrollment in managed care plans.

Lastly, before further encouraging the elderly to enroll in managed care, Congress should revise the rate setting methodology utilized in the risk contract program to ensure that cost savings are being realized. As the committee is all too aware, current policies under which

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[8] Shekelle, PG., et al., The Appropriateness of Spinal Manipulation for Low Back Pain: Project Overview and Literature Review, RAND Corporation, Santa Monica CA, 1991.

Medicare HMOs are paid result in overpayment of between 6 and 28 percent.[9] This means that Medicare is actually losing money by enrolling beneficiaries in managed care plans. It makes little sense to encourage the elderly to enroll in these plans if doing so consistently costs the program more than if these patients remained in fee-for-service Medicare. Clearly, these glitches should be corrected prior to moving more rapidly in this direction.

Conclusion

The current chiropractic benefit under Medicare was enacted over twenty years ago and reflects an antiquated and ill-informed view of the role of doctors of chiropractic (D.C.s). It is an outdated vestige of an era when patient choice was subordinated to other less lofty interests. It is time to discard old policies which serve only to impede beneficiary choices. ACA's "patient freedom of choice" proposal seeks to expand the beneficiaries' choice -- a goal we believe that this subcommittee shares with us. We urge the subcommittee to adopt our proposal as part of any Medicare reform it pursues.

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[9] U.S. General Accounting Office, Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs, September 1994.

STATEMENT OF THE AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS TAX DIVISION

The American Institute of Certified Public Accountants (AICPA) is the national, professional organization of CPAs comprised of more than 320,000 members who advise clients on federal, state and international tax matters as well as prepare income and other tax returns for millions of Americans. Our members provide services to individuals, not-for-profit organizations, small and medium-size businesses, as well as America's major businesses, including multi-national corporations. Many serve businesses as employees. It is from this base of experience that we offer our comments on the tax treatment of health insurance costs of self-employed individuals.

The decision in 1994 to postpone consideration of health care reform legislation has resulted, among other things, in the loss of a deduction by self-employed individuals for any health insurance premiums they have paid in that year. As part of the 1993 Omnibus Budget Reconciliation Act, when a number of other "expired provisions" were retroactively re-enacted (targeted jobs tax credit, low-income housing credit, employer-provided education and training expenses, etc.) and allowed to remain in the law past the end of 1993, the deduction for 25 percent of self-employed insurance premiums was terminated at the end of the calendar 1993. The committee reports noted that this provision should be considered in conjunction with forthcoming health care reform (as indeed it was, in virtually all the health care bills proposed during 1994).

Since, however, there were no health care changes in 1994, there was also no extension of the deduction for self-employed health insurance. This is a highly unfortunate result, and puts a significant penalty on the health costs of those who operate as proprietors, partners, or S corporation shareholder/employees, vis-a-vis those who are employees of C corporations.

Pending whatever changes are made to health care legislation in the future, we think it critical that Congress re-establish the right of self-employed persons to receive even that limited deductibility for health insurance costs that they enjoyed before 1994. We do recognize that this provision, on a stand-alone basis, is a revenue loser for the government. Nonetheless, there remains a major issue of fairness for a significant part of the business community, and we would urge your attention to this matter.

As an organization that values simpler approaches to tax legislation, we would greatly prefer to see action taken immediately, before the bulk of 1994 returns have been filed, rather than the added complexity of amended 1994 returns and refund claims that even a minor delay will cause. Still, we believe the self-employed business person has now – even with the best of congressional intentions – been further disadvantaged with respect to the cost of health care, and is entitled to a restoration of the deduction for the current year.

We appreciate your consideration of our views.

STATEMENT OF THE AMERICAN REHABILITATION ASSOCIATION

Mr. Chairman:

This statement is submitted on behalf of the American Rehabilitation Association for inclusion in the record of your subcommittee's hearing on the growth of cost under Medicare.

Our association is a national membership organization of rehabilitation facilities providing medical, vocational and/or residential services. Our membership includes over 300 rehabilitation hospitals and rehabilitation units in general hospitals. All of these are providers of inpatient rehabilitation services.

There is a critical need for reform of the current Medicare payment policy for PPS exempt rehabilitation hospitals and units. The present system is harmful to patients and providers alike and is wasteful for the Medicare program. No one - not HCFA, ProPAC, providers or consumers - defends the status quo. We urge reform of this payment system, and that it be thorough and immediate.

Defects of the Present System.

When the Medicare Prospective Payment System (PPS) was enacted in 1983 rehabilitation hospitals and units were excluded because the data used to develop that system did not account for cases with longer lengths of stay, including rehabilitation cases. Such facilities continued to be paid through cost reimbursement, subject to per-discharge rate-of-increase limits imposed by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA limits were intended to be a temporary means of controlling costs pending adoption of a PPS. They are still in place 12 years later and have produced serious, and unintended, distortions in the delivery of rehabilitation services for the following reasons:

- TEFRA limits do not adjust for change in case mix and/or increased acuity of patients. This means that any increase in intensity of services or length of stay is likely to cause a hospital or unit to exceed its TEFRA limit.

- TEFRA limits place pressure on rehabilitation hospitals and units to cut average length of stay as a means of reducing per-discharge cost. By treating all rehabilitation discharges as having the same value, the system provides a strong incentive to treat short stay, less complex cases and avoid more severely disabled patients.

- New hospitals and units can establish limits based on contemporary wage levels and other costs, thereby achieving much higher limits than older hospitals. Accordingly, hospitals in the same service area may have widely differing TEFRA limits and reimbursement for similar services. This encourages the development of new providers, which are reimbursed at much higher levels, and seriously distorts the positions of competitive providers.

- This system virtually prohibits the development of programs by existing providers, because any change in services that increases average length of stay or intensity of services will likely result in costs over a TEFRA limit, while encouraging the development of new rehabilitation hospitals and units. This adds unnecessary cost while eroding the service capacity of established institutions.

- The administrative process for adjustment of TEFRA limits does not provide a remedy because it does not produce timely decisions and does not recognize many legitimate costs.

How is the government hurt by these effects? First, because new hospitals are paid more, the system encourages capital spending. Second, the Medicare program is paying many new hospitals and units considerable amounts in incentive payments while not covering cost of service to many older facilities. This is a disservice to beneficiaries. Any system that so seriously distorts the allocation of payment with no regard for patients needs or services delivered will distort quality and availability of services.

Data available from HCFA for Medicare reporting years ending between October 1, 1992 and August 31, 1993 contained cost report information for 128 rehabilitation hospitals. Of these 67 were under their limit, 23 were over their limits and 38 had no limits (because they were new). Those facilities over their limits had an average cost per day of $562. Those under their limits had a cost per day of $559. Thus, presuming cost per day reflects intensity, there is no evidence of differing intensity of services. The average TEFRA limits for those with costs over their TEFRA limits was $11,122. The average for those under their limits was $15,267.

The difference in payment between these groups does not reflect a difference in services provided, but rather the vagaries of the Medicare system. The picture for rehabilitation units is similar.

Cost Reimbursement/TEFRA Should be Replaced by a PPS for Rehabilitation.

Prudent use of scarce resources and the interests of patients dictate that this system be replaced as soon as possible. Marginal changes in the TEFRA system will not, at least as it affects providers of rehabilitation services, eliminate its basic defects.

It should be replaced with a prospective payment system for PPS exempt rehabilitation hospital and rehabilitation unit services that makes payment based on patients' needs for services. By doing so Medicare payment will eliminate the bias in the present system against more complicated diagnoses (or cases) and treat all providers equally, thus removing the preferential treatment and incentives for new facilities.

Our association has sponsored research to fashion such a system. A research team at the University of Pennsylvania developed a patient classification system based on Functional Related Groups (FRG). This classification system includes age, diagnosis and functional ability on admission to rehabilitation. It predicts duration and intensity of rehabilitation services. The Health Care Financing Administration has issued a request for proposals to evaluate this system and to design a payment system based on it. We are encouraging and supporting this effort in every way possible.

The first law of governmental action is that research and analysis will expand to fill the time available. This is a major concern for us. The best evidence of this reality is the fact that in the Omnibus Budget Reconciliation Act of 1990 the Congress directed the Secretary of HHS to submit recommendations on reform or replacement of TEFRA by April 1, 1992. Almost three years after that deadline no such recommendations have been forthcoming. Hence, we believe that a statutory deadline for implementation of a PPS for rehabilitation is badly needed to force this matter to a conclusion.

Therefore, **we recommend** that any Medicare legislation considered this year include a provision setting such a deadline. We suggest that this be for cost reporting periods beginning on and after October 1, 1996.

Modification of Criteria for Definition of Rehabilitation Hospitals and Units.

Rehabilitation hospitals and units must meeting certain criteria established by regulation for exclusion from the Medicare Prospective Payment System. These are contained in 42 CFR 412.23. Among these is a requirement that not less than 75% of a provider's patients be in one or more of 10 diagnostic categories. These are:

* stroke;
* spinal cord injury
* amputation:
* major multiple trauma;
* fracture of femur (hip fracture):
* brain injury:
* polyarthritis, including rheumatoid arthritis;
* neurological disorders, including multiple sclerosis; motor neuron disease, polyneuropathy, muscular dystrophy and Parkinson's disease ; and
* burns.

This list was adopted from the practice of rehabilitation facilities in the 1970s. Over the past 20 years it has become increasingly common for rehabilitation hospitals and units to treat other patients with other diagnoses, including particularly those with pulmonary conditions, chronic pain, cancer and cardiac problems. The functional limitations of each of these, often post-surgery, can be improved through rehabilitation.

The present criteria for exclusion of rehabilitation hospitals and units from the Medicare PPS are established by regulations, not statute. For several years the rehabilitation community, through this association and otherwise, has urged HCFA to revise the pertinent regulations, to no avail.

We recommend that this subcommittee correct this problem by legislation by adding the above referenced four conditions to the criteria for exclusion.

We advocate this change for two reasons. First, it is important to a number of hospitals now excluded from PPS as long term care hospitals. Many of these function as rehabilitation hospitals, but are precluded from qualifying for exclusion from the PPS as such because they have significant numbers of patients in one or more of the four diagnostic categories we seek to have added to the exclusion criteria. The matter is increasingly critical for institutions that have reduced lengths of stay to try to mitigate financial damage from TEFRA limits.

ProPAC recently released figures showing that, on average, long term hospitals are reimbursed on about 75% of cost because of TEFRA limits. Enclosed is a schedule we prepared from HCFA data that indicates large TEFRA penalties for this group. As a practical matter the only way to reduce per discharge cost significantly is to reduce lengths of stay. But, long term hospitals have a floor of 25 days, beyond which is loss of exclusion. (The need for rebasing of TEFRA limits of long term hospitals is discussed below).

The logical course for such facilities is to be excluded from the PPS as rehabilitation hospital, but the provision of significant services to pulmonary, cancer, pain and/or cardiac patients is a barrier to doing so.

The second these conditions is important is the effect of current rules on institutions now excluded as rehabilitation hospitals and units. Those that operate programs for patients in the four conditions must constantly monitor their admissions in these categories to avoid going over 25%. Admissions should reflect the needs of patients and the current practice of rehabilitation in the field rather than such artificial regulatory considerations.

Need for Oversight of TEFRA Adjustment Process.

Section 1886(b) of the Medicare Act provides that a provider with operating cost over a TEFRA ceiling may seek administrative adjustment of its TEFRA limit by HCFA. The law requires that HCFA issue the provider a decision on a complete application within 180 days of its receipt and that a full explanation of the decision be provided to the applicant. The law also provides for assignment of a new base year for determination of TEFRA limits "which is more representative" of the reasonable and necessary cost to a hospital of providing inpatient services."

While the authority vested in the Secretary is sufficient to permit proper adjustment of limits to recognize changes in services and inequities between new and old providers, the adjustment process is flawed in its implementation.

It is beyond the scope of this statement to critique the administration of these provisions by HCFA. However, **we recommend that** the subcommittee examine this matter through oversight hearings, GAO inquiry or otherwise with respect to the following points:

- Timeliness of decisions. The statutory requirement for issuance of decisions within 180 days is routinely violated by HCFA, while filing requirements are strictly enforced against providers.

- Failure to use rebasing authority. HCFA has refused to use the authority to rebase providers, while acknowledging the disparity of treatment between newer and older providers.

- Inconsistency. Standards for adjustment are not applied uniformly, without explanation.

- Absence of explanations. While the law requires that a provider receive a "detailed explanation of the grounds" on which its application is approved or denied decisions often do not address issues raised and do not explain actions taken.

Interim Modifications of the TEFRA System Pending A PPS for Rehabilitation.

We recommend enactment of legislation to set October 1, 1996 for implementation of a PPS for rehabilitation hospitals and units. If a later deadline is adopted we recommend certain modifications to the TEFRA system as it is applied to such providers.

First, we recommend that there be an floor on TEFRA limits, set at 70% of the national average. Presently there are some rehabilitation hospitals and units with limits as low as $3,000, while the national average is over $12,000. These providers are required by Medicare coverage guidelines to provide the same levels of nursing and therapy services as other hospitals and units. Because Medicare coverage guidelines require similar services there should be some comparability of caps on payment. We suggest 70% of the national average TEFRA limit as a floor to provide relief to hospitals and units saddled with extremely low limits.

Second, we suggest that any new rehabilitation hospital or unit certified after date of enactment receive a TEFRA limit no greater than 150% of the national average. It is completely inequitable for the Medicare program to continue to reimburse new facilities at far higher rates than older ones - while both compete for staff and patients. The inequities presented by the widely varying limits of current providers will be eliminated only through adoption of a PPS. In the meantime, some small measure of sanity can be introduced into the system by capping limits for new facilities.

TEFRA Limits Should Be Recalculated on Contemporary Cost for Long Term Care Hospitals.

The serious distortions and inequities of the TEFRA system for rehabilitation providers can and should be solved by the adoption of a PPS for rehabilitation hospitals and units. We believe that the patient classification system discussed above provides a sound basis for doing so. Well over 90% of patients treated in rehabilitation hospitals and units fall into the classification categories represented by FRGs and payment for the balance can be easily computed through averaging and/or provision for outliers.

A PPS for rehabilitation will not, however, remedy the impact of TEFRA limits on long term care hospitals, except for those facilities that are recognized by the Medicare program as rehabilitation facilities. The sole criterion for exclusion of a long term care hospital from the PPS is maintenance of an average length of stay of over 25 days. The types of patients treated in this group of facilities vary widely and the patient classification system developed for rehabilitation does not apply to most of them.

The adverse effect of TEFRA on long term care hospitals has been profound. ProPAC reports that in fiscal years ending 1989 long term care hospitals as a class were reimbursed only 75% of cost by the Medicare program and in FY 1991 75% were over their TEFRA limits. This is because many such facilities were Medicare providers when the TEFRA system was adopted in 1982 and have limits based on base years that are not representative of current costs.

Exhibit A shows the position 75 long term care hospitals. These data are drawn from the HCFA PPS-IX Minimum Dataset and are the most current data so reported by HCFA. The cost reports contained in this data base are for fiscal reporting periods ending in the period 10/1/92-8/31/93.

In 1994 HCFA separately reported that there were 115 long term hospitals excluded from the PPS. This absence of 40 hospitals from the Minimum Dataset cannot be conclusively explained. It is likely that many are new facilities. To the extent that this is the case, they were not subject to TEFRA limits and would not be affected by rebasing of limits. Similarly, there would be no increased Medicare payment to these hospitals from rebasing.

These data show that the average TEFRA limit for facilities over their limits was only $11,181. For those under limits the average was $21,740. This is a huge difference, for which there is no sound public policy.

Since a PPS is not a prospect for this group of facilities **we recommend** rebasing of TEFRA limits to current cost. In the process incentive payment of providers under their TEFRA limits should be protected.

Future Initiatives.

The subcommittee's announced intention to consider alternatives to the present structure of the Medicare program is to be applauded. We are particularly concerned with the fragmentation of rehabilitation services due to current institutional definitions, coverage guidelines and division of services between Part A and Part B. Our association has several committees working to fashion proposals to address these matters and hope to submit further recommendations to your in the near term.

Our guide in this undertaking is continuity of care for patients and provision of services in the least restrictive and most cost beneficial environment, subject to the ultimate goal of maximum recovery of function and ability to live independently and productively.

Thank you for your consideration of the recommendations set forth above.

Attachment: Long Term Hospitals Status Sheet

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ATTACHMENT
11/23/94

MEDICARE COSTS VS. TEFRA LIMITS
LONG TERM HOSPITALS

Total Hospitals Reporting	75
Under Limits	19
Over Limits	40
No Limits	16
Average Length of Stay (Total)	28.46
Average Length of Stay (Under)	27.68
Average Length of Stay (Over)	28.60
Average Length of Stay (No Limit)	30.18
Average No. Medicare Days (Total)	7,538
Average No. Medicare Days (Under)	11,813
Average No. Medicare Days (Over)	6,270
Average No. Medicare Days (No Limit)	5,631
Average No. Medicare Discharges (Total)	265
Average No. Medicare Discharges (Under)	427
Average No. Medicare Discharges (Over)	219
Average No. Medicare Discharges (No Limit)	187
Average Cost Per Discharge (Total)	$15,877
Average Cost Per Discharge (Under)	$13,004
Average Cost Per Discharge (Over)	$16,050
Average Cost Per Discharge (No Limit)	$23,176
Average TEFRA Limit - All Discharges (Under)	$16,308
Average TEFRA Limit - All Discharges (Over)	$11,831
Average TEFRA Limit - per Hospital (Under)	$21,740
Average TEFRA Limit - per Hospital (Over)	$11,181
Average Cost Per Day (Total)	$558
Average Cost Per Day (Under)	$470
Average Cost Per Day (Over)	$561
Average Cost Per Day (No Limit)	$768
Average Medicare Cost Under Limits	$1,410,101
Average Medicare Cost Over Limits	$925,145
Total Medicare Cost Under Limits	$26,791,922
Total Medicare Cost Over Limts	$37,005,813
Total Incentive Payments (Under Limits)	$4,740,793
Total Cost Sharing (Over Limits)	$6,388,328

Data Source: PPS-IX Minimum Dataset
For fiscal periods beginning on or after 10/01/91 and ending by 8/31/93

STATEMENT OF THE AMERICAN REHABILITATION ASSOCIATION

SUBMITTED TO THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

FOR THE RECORD OF THE HEARING ON MEDICARE ISSUES
-FOCUS ON CONTROLLING COSTS AND IMPROVING CARE-
ISSUES RELATED TO MEDICARE MANAGED CARE ALTERNATIVES

FEBRUARY 10, 1995

Mr. Chairman:

This testimony is being submitted on behalf of the American Rehabilitation Association for inclusion in the record of your subcommittee's hearing on managed care and the Medicare system.

American Rehab is a national organization representing over 900 members who provide inpatient, outpatient, vocational and community based rehabilitation programs and services to over 4 million people annually.

All of us will probably need at least one rehabilitation service sometime in our life. As we go about our daily lives none of us contemplate if we will have a stroke, break a hip, hit our head, have a spinal cord injury, be shot or stabbed or have a child born with a congenital problem. We do not think about this as our future. But for many Americans, unexpectedly and unfortunately these things happen. These types of illnesses or injuries require rehabilitation services to help return people to home, to work, to school and ideally to an active life. For a child born with a congenital or genetic disorder, rehabilitation services can help them walk, move, write, feed themselves, and therefor attend school, participate in social events and enjoy the kind of life that most of us think is what life is all about.

AGING OF AMERICANS

Demographic trends in the population at large suggest that the prevalence of disabling conditions will increase in the future as more individuals live longer. Table 1 shows the expected growth of the number of persons over 65 in the U.S. (see Attachment I) It can be seen that dramatic growth will occur between the years 2000 and 2025 when the aged population will nearly double. Table 2 shows the percentage of persons in each age group that have a functional limitation. (see Attachment I) From this table it can be seen that 58.5% of persons 65 years and older have a functional limitation. Thus, in the future, as more individuals live past 65 years of age, the U.S. will be faced with a larger population of persons with functional limitations, challenging the medical rehabilitation field to provide effective care and services.

Age of Rehabilitation Patients

Data presented in Table 3 provide estimates of the average age of patients admitted for inpatient rehabilitation by impairment condition. (see Attachment I)

The average age of patients admitted for stroke, orthopedic condition, non-traumatic spinal cord dysfunction, and neurologic condition are all greater than or equal to 60 years of age, which reinforces the impact that the "greying of America" will have on the utilization of rehabilitation services in the future. By contrast, lower average ages for traumatically impaired brain and spinal cord patients is indicative of the prevalence of injury, accident, and violent crime, and related medical impairments, for relatively young patients. The UDS_{MR} data suggest a general trend of an increase in the average age of rehabilitation patients (1990: 67 years; 1992; 69 years). Again, as the life span of Americans increases the demands for rehabilitation services will also increase.

BACKGROUND ON REHABILITATION

Rehabilitation services are an integral part of our American health care system. They are very cost effective. For example a Northwestern National Life study shows an average savings of $35 in disability reserves for every $1 spent on rehabilitation services to return injured workers to work.

Rehabilitation involves specialized physicians, rehabilitation nurses, physical and occupational therapists, speech language pathologists, respiratory therapists, social workers, psychologists, and other therapists who work as a team with patients to restore their functional ability and help them be independent. This interdisciplinary team concept is central to rehabilitation and the sum of these efforts is greater than the parts. The team establishes an individual rehabilitation plan which sets forth that person's goals in rehabilitation. For example, a person has had a stroke which impairs the ability to walk, see, swallow and creates weakness on the left side. The goals include walking again independently, swallowing without aid, seeing well enough to read, strengthening the left side so the arm and leg can be used, and being able to dress independently again. Over 80% of the 4 million people receiving rehabilitation services return to their homes, work, schools or an active retirement. Common conditions usually requiring rehabilitation include: heart attack, stroke, arthritis, cancer, neurological disorders, joint fractures and replacements, amputation, head injury, spinal cord injury, chronic pain, pulmonary disorders, burns, multiple trauma and congenital or developmental disorders.

Rehabilitation is delivered in freestanding rehabilitation hospitals, rehabilitation units of general hospitals, comprehensive outpatient rehabilitation facilities, rehabilitation agencies and other outpatient settings, skilled nursing facilities and in people's homes. Determining which setting is appropriate is a function of medical judgement. These settings provide a full continuum of rehabilitation care.

The rehabilitation field is responding to the changes in the health care field. It is becoming more cost effective through the use of critical pathways, decision rules and constant examination of the use of resources and outcomes. All of these practices help make decisions about the appropriate use of resources and help cut costs.

EFFECTIVENESS OF REHABILITATION

If rehabilitation services are delivered, they are most effective if delivered early after trauma or illness. For example, rehabilitation is one of the evaluations done right in the trauma center. If an appropriate referral is not made the person remains dependent, the family suffers and society, the individual and the family pay more than just financially. In a study of the cost benefits of stroke, the investigators found that for each stroke patient who, through rehabilitation, was able to live at home, the expense of living at home versus in a nursing home setting saved $13,248 per year in 1981 dollars, or $21,599.54 in 1994 dollars per year. Given that the average stroke patient lives over 5 years this is a savings of $107,997.70 in 1994 dollars.

An article in the 1994 October/November/December issue of TQM magazine, "Judging the Cost-Effectiveness of Rehabilitation", discussed the cost effectiveness of rehabilitation. Pulmonary rehabilitation improves patient function and reduces the use of medical services. Early rehabilitation in a rehabilitation unit for stroke patients is more effective than for patients treated on general medical wards. Twice as many of the patients who did not receive rehabilitation went to nursing homes and the mean time in an institution in the first year, including nursing homes was 75 days for the rehabilitation patients and 123 days for the patients who did not get the rehab program.

For traumatic brain injury (TBI) early initiation of rehabilitation can save costs. A recent study compared patients from one hospital with an aggressive early rehabilitation program for TBI with those from 11 other hospitals without organized programs. Patients from the formal program experienced one third the time in a coma. Also the rehabilitation length of stay averaged 54 days vs. 106 days for those coming from routine care. Ninety-four percent (94%) were discharged home in the early intervention program compared to 57% of the others. Again, there is an

enormous amount of money saved simply by calculating the cost of days **not** spent in the hospital.

MEDICARE, REHABILITATION AND HMOs

As noted previously, the Medicare program impacts the medical rehabilitation industry significantly in accounting for over 60% of inpatient days, and the Medicare program has not been immune to the managed care movement. Medicare HMO volume in the form of Medicare risk contracts has grown since the 1980s. In 1993, there were nearly 1.7 million enrollees under Medicare risk contracts, which is more than three times greater that the 467,000 enrollees in 1986 (McMillan, 1993). However, as McMillan notes, through 1993 there has been moderate growth in Medicare HMOs. A recent study by the GAO predicted an increase of 20% in enrollment in risk contract HMOs in 1994. This is 2.3 million beneficiaries or 6.5% of total Medicare beneficiaries. Medicare HMO activity is also concentrated geographically in a few large plans. For example, California and Florida account for over one-third of Medicare HMO enrollees, and one-half of the states have no Medicare HMO enrollment.

Nonetheless, the result of the continued overall growth of managed care is that rehabilitation providers are and will continue to be compelled to accommodate to HMO-type plans and document the cost-effectiveness/cost-benefits of their services in response to case management and utilization review pressures. Managed care requires that health systems provide a vertically integrated continuum of care which allows patients to receive quality in the lowest cost environment. The rehabilitation industry will be compelled to meet this requirement in order to gain managed care contracts. Managed care has essentially altered the relationship between provider and insurer, and providers will assume more financial risk under a fixed payment system.

The managed care movement has also provided strong impetus for the development of outcomes-based health care, in which providers are asked to objectively document the clinical outcomes of care relative to expenditures. The ability of rehabilitation facilities to provide outcomes data is a crucial issue as patients, payors, and businesses are all becoming increasingly involved in outcome measurement. Rehabilitation hospitals and clinics will be held increasingly accountable by payors for effective rehabilitation programs. Payors often request information on functional assessment, cost data, and patient satisfaction. The future of rehabilitation programs appears to depend on whether or not the program can document the success of their treatment's outcomes.

Medical rehabilitation, relative to other health care professions and industries, has made significant progress in implementing systematic outcomes assessment systems. For example, several outcome assessment systems are currently being used by rehabilitation facilities to document outcomes. Examples of these systems include: Functional Independence measure managed by UDS_{MR}; Restore and Level of Rehabilitation Scale (LORS) managed by Formations in Healthcare; Patient Evaluation & Conference System (PECS) managed by Marianjoy Rehabilitation Hospital and Clinics; and Total Outcome Prediction Program (TOPP) managed by Continental Medical Systems, Inc.

ISSUES

As this committee looks for ways to bring Medicare into the next century, ensure its financial viability and examine current managed care practices as possible models for the Medicare program, we want to highlight several issues we have encountered. They are:

* coverage of rehabilitation services and providers;
* incentives, or not, to refer for specialty services;
* the quality of rehabilitation services provided.

I. Coverage

Medicare covers a broad range of health care services for its eligible beneficiaries and is the single largest payor of medical rehabilitation services in the United States accounting five years

ago, for an average of 40% of revenues in rehabilitation hospitals and more than 50% in rehabilitation units (Langenbrunner, Willis, Jencks, Dobson, & Lezzoni, 1989). More current estimates indicate that Medicare "days" account for between 60-70% of total inpatient days in rehabilitation hospitals and units. It is estimated that in 1994, 37 million persons will be enrolled in Medicare - 32.8 million aged persons and 4.2 million disabled persons. For eligible beneficiaries, Medicare covers certain inpatient and outpatient rehabilitation services provided at a rehabilitation hospital or unit of an acute care hospital, skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), rehabilitation agency, therapist's office, or at a patient's home through the services of a home care agency.

Medicare Beneficiaries in HMOs

An American Rehab survey found that of those HMOs that referred enrollees to rehabilitation hospitals and units and limited the number of days, the average number of covered days was 58. Sixty nine percent (69%) of the rehabilitation hospitals and units to which HMOs referred Medicare patients reported that the HMO limits the numbers of days of therapy, with an average limit of 51 days. We find this information about Medicare beneficiaries particularly disconcerting because it is our understanding that the Medicare package of benefits is to be available to Medicare rehabilitation patients. Under Medicare there are no day limits on therapies or programs. Medical necessity is determined by the Medicare inpatient rehabilitation hospital guidelines.

Recommendations:

(1) There are rational coverage guidelines for inpatient rehabilitation hospital and unit services and outpatient services. To determine medical necessity of rehabilitation for Medicare beneficiaries they are based on the patient's need and progress, not an arbitrary limit. The current Medicare inpatient and outpatient guidelines should be used by HMOs while options are examined.

II. Incentives for Referrals

Managed care plans frequently place physicians at financial risk when they serve people who need intensive, on going services. This is particularly true for nonsalaried physicians who receive a capitated payment for each enrollee. Other plans attempt to pass on risk to providers in the form of financial incentives that lead to under service. These include bonuses or penalties to providers related to meeting, or exceeding, utilization limits and policies requiring physicians to assume the cost of out of plan specialty care. Other plans withhold a percentage of a providers' income if they exceed a targeted number of referrals to specialists and/or hospitalizations. These financial incentives coupled with any lack of awareness of the value of rehabilitation result in many people who need rehabilitation services and many people with disabilities not receiving needed care and remaining needlessly dependent at great cost to them and society. Or, they go out of plan and have to pay for the specialty care at great cost.

The American Rehab study found that 27% of the facilities that have contracts with HMOs for non Medicare enrollees said that the HMO does not refer enrollees to rehabilitation hospitals/ units. One-half of the facilities that have Medicare contracts reported that the HMO does not refer to rehabilitation hospitals/ units. Of those that do not refer Medicare enrollees, 57% said that the HMO states that it is not medically necessary; 25% said the HMO says care can be provided at a skilled nursing facility and 13% said that the HMO states that cost is the reason for not referring to rehabilitation hospitals and units.

Several studies raise concerns about HMO treatment of Medicare beneficiaries as well. The Medicare Advocacy Project, Los Angeles, California in its January 1993 report, "Medicare Risk-Contract HMOs in California: A Study of Marketing, Quality, and Due Process Rights" noted the following problems:

* Failure to refer for needed specialty care. The decision may not be made by the gatekeeper physician but by the medical group manager, utilization review coordinator or medical director. They also cited the physician financial incentive issues mentioned above.

* Not having enough contracting specialty physicians available or when the financial incentives delay referrals to specialty physicians.

* Failure to refer for rehabilitation. The frequency with which HMOs deny access to home health care and inpatient rehabilitation services... "raises questions about the financial incentives under which HMOs and their subcontracting provider groups operate." The report questions the HMOs determinations that cases that appear to meet the Medicare coverage guidelines were denied the care as not medically necessary.

Recommendations:

(1) Establish criteria for HMO Medicare plans to assure that an individual a) with one of the conditions usually requiring rehabilitation services, b) with a congenital disability, and/or c) with a specific functional status based on a functional assessment, receive a rehabilitation evaluation within 72 hours upon seeing a primary care provider or other gatekeeper. The conditions in question include, but are not limited to, stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, all forms of arthritis, neurological disorders, burns, cancer, cardiac and pulmonary diseases and pain.

(2) Assure that physician referrals to physician and non-physician specialists are based solely on the needs of the patient. Financial incentives for referrals and/or for denying referrals should be prohibited.

(3) Assure that persons requiring rehabilitation services and persons with disabilities in particular can select a primary care provider or gatekeeper who is a physiatrist, an otherwise qualified rehabilitation physician or a specialist in the medical management of their particular condition.

(4) Assure that rehabilitation services are provided for as long as a patient is making progress and achieving rehabilitation goals.

III. Quality Concerns

We are also concerned about the quality of care given to many HMO Medicare enrollees. This is a difficult issue to quantify. As noted, above we have heard about problems with people either not being referred at all for rehabilitation or being referred but with a limit on the number of days. Quality goes to the setting to which the patient is referred for services and the duration, frequency and type of treatment they receive. Our members have told us about enrollees, both Medicare and non-Medicare, being sent to what we characterize as a custodial institutional setting that provides either no or periodic skilled nursing and rehabilitation therapies as required under OBRA '90, but not a comprehensive rehabilitation program. Our members do not believe many of these patients obtain their maximum outcomes and the rates of return to home, work, school and an active retirement are not as high as possible. This is a tragic personal, professional, familial, social and financial loss and burden.

The Medicare Advocacy Project Report cited above noted several cases where the HMOs approved less care than needed. The report states the "survey also points to possible systemic bias by some HMOs against referrals for in-patient rehabilitation services. All five of the southern California in-patient rehabilitation hospitals responding to MAP's survey felt that some Medicare HMOs denied medically necessary rehabilitation services to a greater extent than occurred in FFS [fee for service]. " The report further states "some HMOs appear to use arbitrary standards to deny or discontinue rehabilitation care." These standards include the patient's age even when a patient was improving.

The Mathematica study released in December, 1993 also raised concerns about quality of care. Mathematica looked at rates of death, hospital readmission and post admission complications as

gross outcomes" measures but did not make any adverse findings. However it did state," ...a few differences do indicate that HMOs may be providing less adequate care in some situations. ...HMO stroke patients received significantly less physical therapy while in the hospital and had greater motor and speech deficits at discharge, yet were not more likely to have a post discharge speech or physical therapy plan. This pattern suggests that HMOs may economize on rehabilitation care...Although there is no evidence that these differences in care led to poorer patient outcomes, they cause some concern because of their potential adverse effect on outcomes."

The study noted that HMOs discharge a higher proportion of stroke patients to nursing homes and a lower proportion to rehabilitation hospitals. While it did not have follow up data, this practice raised concerns about whether this pattern was leading to poorer care.

Outcomes as a measure of quality are well accepted in the rehabilitation field because of its focus on the functional status of the patient. Rehabilitation concentrates on the changes in function which occur during the course of treatment, as revealed by comparing patient status at the time of admission to the time of discharge. The continuation of these gains is monitored through follow up functional assessment after discharge. Several functional assessment measures in the rehabilitation field have been developed and may be adapted to measuring outcomes. The majority were developed for use in inpatient services. One is being adapted so that it can be used in a skilled nursing setting as well as an hospital inpatient setting. A patient classification system has also been developed for rehabilitation by American Rehab and the University of Pennsylvania. It is based on functional status at admission, age and impairment category. It uses 55 functionally related groups (FRG's) which classify patients and predicts length of stay. With future research it may be adapted to predict outcomes as well.

However as these predictive tools are being developed and implemented we remain concerned that both Medicare and non Medicare enrollees continue to be sent to less intense rehabilitation service settings where they achieve less than maximum outcomes. They simply are not being allowed to function at the level at which they are able with appropriate therapies.

Recommendations:

1. HCFA should direct Medicare HMOs that they cannot use arbitrary rules of thumb to deny rehabilitation care to Medicare beneficiaries, e.g. age or deny any Medicare benefits to beneficiaries. If an enrollee is a candidate for rehabilitation and meets the existing Medicare inpatient rehabilitation hospital or outpatient guidelines he or she should be referred for those services.

2. HCFA should increase its review of Medicare risk contractors' practices in referring patients who require rehabilitation to less intense levels of services which may result in decreased positive functional outcomes.

3. Quality criteria by which to determine HMO approval of rehabilitation services to Medicare beneficiaries should include patient outcomes including, but not limited to, death, pressure sores, discharge status, and change in functional motor and cognitive function, and others.

We would be pleased to discuss these critical issues with you Mr. Chairman

ATTACHMENT I

Table 1. Projected Growth of the Number of Persons 65 Years and Older in the U.S.: 1995-2075

Aged Population /Projected	1995	2000	2025 (in millions)	2050	2075
65 years and older	34.0	35.2	60.6	73.7	83.3
75 years and older	15.0	16.7	25.0	38.9	45.7
85 years and older	3.8	4.4	6.3	14.6	16.9

Source: HCFA Statistics, Baltimore, MD

Table 2. Percentage of Persons by Age Group that Have a Functional Limitation

Age	Total (in 1,000s)	Percent With a Functional Limitation	Percent With A Severe Functional Limitation
15-24 years	39,297	5.2	0.9
25-34 years	40,464	7.5	1.5
35-44 years	30,480	13.4	2.9
45-54 years	22,264	23.0	6.4
55-64 years	22,060	34.2	12.4
65 years & over	26,422	58.5	28.5
65-69 years	8,928	45.4	18.8
70-74 years	7,378	55.3	22.9
≥ 75 years	10,116	72.5	41.2

Source: U.S. Bureau of the Census, 1984 Survey of Income and Program Participation, Current Populations Report, Series P-70, No. 8, Table C.

Table 3. Average Age of Patients Admitted for Inpatient Rehabilitation by Condition: 1990-1992

	1990	1991	1992
Condition	Avg. Age (in years)	Avg. Age (in years)	Avg. Age (in years)
Stroke	70	71	71
Orthopedic Conditions	74	75	75
Brain Dysfunction-Nontraumatic	58	60	59
Brain Dysfunction-Traumatic	38	39	40
Spinal Cord Dysfunction-Nontraumatic	64	63	64
Spinal Cord Dysfunction-Traumatic	43	40	42
Neurologic Conditions	60	60	62
All Patients	67 (N=33,427 patients)	68 (N=44,997 patients)	69 (N=83,571 patients)

Source:(data from UDS_{MR}); American Journal of Physical Medicine & Rehabilitation, vol 73, no. 1, February 1994, 51-55.

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SUSAN J. SMITH
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SUBMITTED STATEMENT OF
SUSAN J. SMITH
VICE PRESIDENT OF GOVERNMENT RELATIONS
THE ASSOCIATED GROUP
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

IN SUPPORT OF H.R. 483,
THE MEDICARE SELECT EXPANSION ACT OF 1995

FEBRUARY 10, 1995

Mr. Chairman and members of the Subcommittee, The Associated Group appreciates this opportunity to discuss its support of H.R. 483, a bill to amend Title XVIII of the Social Security Act to permit Medicare Select policies to be offered in all States. This bill was introduced on January 11, 1995 and earlier this week had a bipartisan group of 77 cosponsors who we are pleased to note include you Mr. Chairman and Chairman Bill Archer.

The Associated Group is a national diversified insurance and financial services company doing business in 49 states, based in Indianapolis, Indiana. As a $3.4 billion (revenues) company, The Associated Group offers a variety of products, including:

- health, life, and property and casualty insurance;
- managed care and integrated delivery networks;
- asset management, equipment leasing, and receivables management; and
- market research.

The Associated Group is a for-profit mutual insurance company and the Blue Cross Blue Shield licensee in Indiana and Kentucky. In 1993, The Associated Group merged with Southeastern Mutual Insurance Company in Louisville, Kentucky (then the licensee for Blue Cross Blue Shield products in Kentucky). The Associated Group now employs more than 13,000 people with major concentrations in Indiana, Kentucky, Ohio, West Virginia, Florida, Texas and California.

The Associated Group supports the use of managed care as a tool to reduce the cost of health care in the United States. We believe that the development of high quality managed care networks for seniors is a critical part of our efforts to lower the cost of health care while offering our enrollees the highest quality of care. The Associated Group recruits network providers that have expertise in responding to the health care needs of seniors. This ensures that our enrollees are receiving the best possible care.

The Associated Group supports H.R. 483, introduced by Representative Nancy Johnson, a member of this Subcommittee. Over 400,000 Medicare beneficiaries are currently enrolled in Medicare Select. H.R. 483 will make this program permanent and available in all fifty states. We also take this opportunity to thank Representative Pete Stark and Representative Johnson for their bipartisan efforts at the end of the 103rd Congress to secure enactment of H.R. 5252, which extended the Medicare Select program until June 1995.

The Associated Group currently has over 14,500 enrollees in the Medicare Select program in Kentucky and Indiana. The Associated Group is developing additional Medicare Select networks in Texas and Indiana. Moreover, our current Indiana and Kentucky Medicare Select networks continue to attract new enrollees. Our Medicare Select enrollees enjoy an average premium savings of 27 percent from traditional fee-for-service Medigap insurance offered by our company. For individuals on fixed incomes, this represents very real, tangible savings. We believe that it is important that consumers continue to have this lower cost managed care option available.

We realize there is an ongoing dialogue about improving this program, and The Associated Group will continue to participate in these discussions. However, H.R. 483 needs to be enacted by this April to avoid any disruption in the program. If this program ends in June 1995, hundreds of thousands of seniors will be forced to pay higher premiums for Medigap insurance. In addition, managed care networks specifically developed to provide quality care to seniors at a lower cost will dissolve, limiting access to managed care for this segment of the population.

Critics of the Medicare Select program have raised questions about consumer protection provisions. Federal and NAIC standards for Medigap and Medicare Select require the Select products to provide the same consumer protections that are required of Medicare At-Risk HMO offerings.

Before enrolling in our Medicare Select program, an applicant receives the following information about our program:

- an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy with traditional Medigap policies and other Medicare Select policies;
- a description including address, phone number and hours of operation of network providers;
- a description of the network restrictions, including payments for coinsurance and deductibles when providers other than network providers are utilized;
- a description of coverage for emergency and urgently needed care and other out-of-service area coverage;
- a description of limitations on referrals to restricted network providers and to other providers;
- a description of the policyholder's rights to purchase any other traditional Medigap policy offered by our company; and
- a description of our quality assurance program and grievance procedures.

These consumer protections are designed to ensure that the consumer has knowledge of and fully understands the program in which he is enrolling including any restrictions or limitations on providers or coverages. State departments of insurance review and approve the descriptions noted above prior to their use. The regulation of these consumer protections as well as those placed on traditional Medigap insurance is done by state departments of insurance at no cost to the federal government.

Under the Medicare Select program, Medicare beneficiaries have the option to purchase lower cost supplemental insurance through managed care networks. The Associated Group urges Congress to make this program permanent and available to seniors in all fifty states. Mr. Chairman and Members of the Subcommittee, The Associated Group urges your support of H.R. 483.

Statement of the College of American Pathologists for the record of the House Ways and Means Subcommittee on Health hearing regarding "Extraordinary Growth in Certain Medicare Costs," February 6, 1995

The College of American Pathologists (CAP) appreciates the opportunity to present its views to the Ways and Means Subcommittee on Health regarding growth in certain areas of Medicare costs. The College is a national medical society representing more than 14,800 physicians who are board certified in clinical and/or anatomic pathology. College members practice their specialty in community hospitals, independent clinical laboratories, academic medical centers, and federal and state health facilities.

Pathologists are responsible for the overall operation and administration of the laboratory and for ensuring that quality laboratory services are available. The College believes that pathologists must be involved in the determination of coverage and utilization of clinical and anatomic pathology services. Adequate resources must be allocated for the provision of laboratory direction, quality assurance, and other services provided by pathologists.

The College is grateful to the Subcommittee chair, Mr. Thomas, and the chair of the full Committee, Mr. Archer, for their leadership and foresight in holding hearings at an early date to examine the causes of unusual growth in Medicare costs and to consider how the program can be made more cost-efficient. Ideally, Medicare should be a model of efficient interaction between the public and private sectors in serving patients. While it has succeeded in improving the health of the elderly and disabled, the program is failing from a budgetary standpoint due to a flawed financial structure and unrealistic budget projections. Rather than deal with these underlying structural problems, Congress and the Executive Branch have historically attempted to deal with the program's financial problems by cutting provider payments and making numerous operational changes that have increased the burden and confusion for everyone involved with the program. The result has been cost-shifting to the private insurance market, where premiums and prices have increased dramatically. Now, as private payers intensify their bargaining with providers, the ability to cross-subsidize Medicare with private dollars is shrinking.

With the passage of the balanced budget constitutional amendment, the College is concerned that Congress will once again be under pressure to resort to short-sighted budget cuts to meet deficit reduction targets rather than taking a careful, comprehensive look at how the Medicare program could be financed more equitably. Medicare physician and laboratory payments cannot continue to be driven lower and lower in comparison to private market levels without soon affecting the availability and quality of medical services.

Physicians and laboratories have already sustained disproportionately deep reductions in Medicare payments during the past 13 years (see attached chart). Physicians, who account for 23 percent of Medicare outlays, have borne 32 percent of the Medicare provider cuts over the last decade. Of the $98 billion in Medicare cuts from 1981 to 1993, payment cuts to physicians accounted for $39 billion. Laboratory services, which account for less that eight percent of Medicare Part B expenditures, sustained $6.8 billion in Medicare payment cuts between 1984 and 1993.

Clinical laboratory payments have been a consistent target for cuts over the last eight years and are currently in the midst of a three-year phased-in 12 percent reduction in the national limitation amounts approved as part of the 1993 Omnibus Budget Reconciliation Act. That measure also included elimination of the CPI update for laboratories in 1994 and 1995, for a total five-year cut in laboratory payments of $3.3 billion.

While the College is pleased that the President's budget proposal for fiscal year 1996 does not include any additional reduction in Medicare payments to physicians and laboratories, we are concerned that Congress, in its effort to achieve greater deficit reduction, will once again turn to Medicare providers for significant savings.

We would like to take this opportunity to comment on several policies proposed during the 103rd Congress that we believe may be considered again this year in the context of deficit reduction.

Competitive Bidding for Clinical Laboratory Services

The ill-conceived idea of instituting a competitive bidding process for Medicare clinical laboratory services was considered last year, despite the fact that Congress has repeatedly rejected it. The College was pleased that the Ways and Means Committee did not include this proposal in the comprehensive health reform legislation it adopted last year.

Competitive bidding contracts, particularly exclusive "winner-take-all" contracts, have proven to be unworkable because they create a strong incentive for laboratories to submit "low-ball" bids to become the exclusive supplier. These bids can result in below-cost contract prices which ultimately prevent the laboratory from having the resources necessary to assure high quality testing. For example, the Air Force selected a laboratory to screen Pap smears under such a process and found that the laboratory performed so poorly that women's lives were placed at risk. The Air Force had to impound more than 700,000 Pap smear specimens for retesting.

Access to the full range of laboratory services in rural areas could be adversely affected by a competitive bidding process, even if rural areas are exempted from the process. Because of the severe cost constraints imposed on the winning bidder under competitive bidding, laboratories might no longer be able to provide daily courier pick-ups, 24-hour turnaround for test results, and other services.

While competitive bidding is poor policy for all clinical laboratory services, it is particularly inappropriate for surgical pathology and cytology services. These services require the involvement of highly trained physician specialists with the personal knowledge of and accessability to the referring physician in making the appropriate diagnosis. Laboratory testing is a service, not a product or a commodity. Physicians choose one laboratory over another in part because of the mix of quality and service attributes of their selected facility. A competitive bidding process would ignore these other equally important factors and would prevent the physician from playing any role in selecting the best laboratory for his or her patient's needs.

Medicare Relative Value Scale Policies

The current Medicare Relative Value Scale (RVS) payment system for physicians is the result of lengthy, complex deliberations. Enacted in 1989, it is just beginning the fourth year of its five-year implementation. The College strongly believes that Congress should exercise great caution in considering any changes to the Medicare RVS system.

Medicare RVS fee schedule amounts are already too low in many instances. Continued erosion of the Medicare RVS payments and changes in methodology could exacerbate this problem and ultimately lead to reductions in quality of medical care. A recent CBO analysis of Medicare cuts stated that "growing disparities in rates between Medicare and the private sector that would result from these cuts could impair access of Medicare beneficiaries to health care." In 1994, on average, Medicare paid only 59 percent of the amount paid by private insurers. Under current law, Medicare payments are projected to fall to 56 percent of private insurance payments by the year 2000. Practice overhead costs are generally rising much faster than annual Medicare updates. Additional cuts will result in cost-shifting to private payers, forcing businesses and employers to face higher costs.

In particular, the College is concerned about several proposals consider by the previous Congress:

- Changing the Medicare Volume Performance Standard. The Medicare Volume Performance Standard is an integral component of the Medicare RVS update methodology and should not be manipulated to produce overall budget savings. If the MVPS is to be meaningful it must be based on changes in expenditures for Medicare services not on changes in the general economy and should not be so changed that inflation updates in subsequent years are unrealistic.

Use of a cumulative MVPS, tying Medicare spending updates to growth in the overall economy rather than in the Medicare sector, and other proposed changes in the MVPS methodology would likely result in establishing MVPSs that would be so low that physicians would not be able to meet them, leading to arbitrary and real cuts in payments. Further, the changes would result in lower conversion factor updates that would cause further reductions in payments in the future.

- Reducing Medicare relative values for non-primary care services. The College appreciates the need to ensure an adequate supply of primary care physicians. However, reductions in non-primary care services relative values or development of "outlier intensity" relative value adjustments to increase payment for primary care services undermine the resource-based methodology on which the RVS is predicated. Congress should not consider arbitrary adjustments proposed outside the formal RVS update and refinement process.

- Reducing payment to so-called "high-cost" hospital medical staff. The College opposes efforts to create another layer of Medicare Volume Performance Standards at the individual hospital staff level — the proposed reduction in payments for so-called "high-cost" medical staffs. If adopted and implemented, this policy would be divisive to hospital medical staffs, administratively complex, difficult to implement and maintain, ineffective in cost containment, and could threaten the delivery of quality health care. It is inappropriate to punish an entire medical staff for so-called excess relative values generated perhaps by only a portion of the medical staff. Further, the policy would distort the relationship of relative values among services and undermine the reasonableness of the Medicare RVS.

- Establishing "Centers of Excellence" contracting. Congress should use extreme caution in considering the concept of so-called "Centers of Excellence" contracting, where an all-inclusive rate, including the physicians' professional services, is paid by the Medicare program to the facility in which a surgical procedure is provided. It is essential that a requirement for payment to the *physician* for services provided be a part of the contracting process. Payment to a hospital or other facility for physician services does not ensure the facility will appropriately compensate the physicians for their services. Further, while "Centers of Excellence" naturally develop, it is important that aggressive contracting not stifle competition and decrease access to care through over-centralization.

Coinsurance for Medicare Laboratory Services

While the College understands and generally agrees with the need to make Medicare beneficiaries more aware of the cost of the medical care they receive, we urge Congress to reject the idea of reimposing a 20 percent coinsurance payment for Medicare clinical laboratory services, as it did during consideration of comprehensive health reform legislation last year. Since eliminating the coinsurance requirement for these services in 1984 Congress has repeatedly rejected proposals to restore it, with good reason. Reimposing coinsurance would place a significant administrative burden on laboratories and a new cost on beneficiaries while doing little to affect utilization of laboratory services; in many instances the cost of billing for coinsurance will exceed the amount collected from the beneficiary.

If coinsurance were reimposed, laboratories presumably would have to produce two claims — one to the Medicare Program and one to the patient. On average, laboratories estimate it would cost between $3 and $5 just to produce the additional invoice covering the coinsurance. In many instances, this cost would be a substantial percentage of the amount collected from the patient and could easily exceed collected amounts. The table below illustrates the approximate coinsurance amount for several commonly ordered tests once the OBRA '93 reductions are fully phased in. For these common tests, the collection costs exceed the coinsurance payments:

	Cap	Coinsurance
Multichannel Chemistry Test	$14.86	$2.98
CBC, with differential	$10.36	$2.02
Urinalysis	$ 4.24	$0.85

Past experience with coinsurance suggests that many laboratories will have to write off from 20 to 50 percent of the billed amounts as uncollectible. These collection problems are the very reason that coinsurance was eliminated by Congress as part of DEFRA '84, with the support of the Health Care Financing Administration and the laboratory industry. In exchange for eliminating the copayment, Congress mandated the current fee schedule methodology, which set the fee schedules at 60 percent of then-prevailing charges.

Imposition of coinsurance would shift the costs of the Medicare program to beneficiaries and force them to incur an additional $7 billion in out-of-pocket expenses, a burden that Congress specifically relieved them of in 1984. However, it is unlikely that coinsurance would have any impact on the volume of clinical laboratory services performed. Patients do not decide when to order testing nor do they select the testing laboratory. These decisions are made by the physician. Thus, imposition of copayment obligations on Medicare beneficiaries will not curtail utilization. As the Congressional Budget Office noted in a 1990 Report, "Cost-sharing probably would not affect enrollees' use of laboratory services substantially...because decisions about what tests are appropriate are generally left to physicians, whose decisions do not appear to depend on enrollees' cost sharing."

Medical Liability Reform

The College appreciates the strong support that many members of this Subcommittee have shown for federal legislation to reform the current medical liability system. As members are well aware, the cost of the current liability system is unacceptable. The American Medical Association estimates that more than $9 billion will be paid in premiums this year by physicians and hospitals for medical malpractice insurance. In addition, conservative estimates of the cost of "defensive medicine," tests and procedures performed solely to avoid suit, will be between $4 billion and $25 billion this year.

We believe the evidence is clear that comprehensive medical liability reform can be effective in reducing costs and assuring access to the liability system. Twenty years ago, insurance premiums in California were among the highest in the nation. State legislators adopted the Medical Injury Compensation Reform Act, known as MICRA, in 1975. Today, California's insurance premiums are below average for all states and one-half to one-third of those in high population states that have not adopted MICRA reforms. The difference has been the reduction in windfall awards and excessive legal fees.

The College strongly supports enactment of medical liability reform to promote the basic goal of providing access to all necessary health services, deter substandard or unethical practices and encourage improvements in the safety and quality of medical care. Based on California's MICRA, these reforms should include:

- a $250,000 limit on the total amount of non-economic damages;
- binding mandatory alternative dispute resolution systems administered by the state to resolve medical liability claims;
- reduction of the total amount of damages by the amount of payments from collateral sources;
- mandatory periodic payment of awards;
- a sliding scale limit on attorneys contingency fees; and
- the use of practice guidelines developed by professional associations as an affirmative defense in liability actions.

Graduate Medical Education

While the College recognizes the appropriateness of increasing the nation's supply of primary care physicians under a reformed health care delivery system, several proposals under recent consideration raise serious concerns. Of greatest concern are proposals that would authorize the federal government to restrict the number and types of medical residencies. The College believes that the extent of federal involvement in medical residency training should be limited and opposes federal restrictions on the numbers and specialty mix of medical residencies. Residency choices of medical students are based on a complex set of variables. Federally imposed restrictions or distortion in the Medicare Relative Value Scale (RVS) to provide incentives to enter primary care residencies are ill-concieved and inappropriate. We believe that

the objective of achieving an appropriate balance of primary care and specialty residency positions can be better achieved in other ways.

Any changes in funding for graduate medical education must ensure that an adequate supply of specialists is trained to meet the nation's during the upcoming century. Pathologists are uniquely trained to provide a range of medical services that are critical to the prevention, detection, and treatment of disease. These services will be equally important to providing high-quality health care under any reformed delivery system. Through attrition, pathology is losing an average of 1.87 pathologists per day with only .96 newly trained pathologists per day entering the specialty. Any changes in funding for graduate medical education must ensure that an adequate supply of pathologists is trained to meet future health care needs.

Direct Billing for Clinical Laboratory Services

In order to provide clinical laboratory services as efficiently and cost effectively as possible, the College urges Congress to require that laboratories seek payment directly from the patient or a financially responsible third party, such as the patient's insurer. Medicare already requires laboratories to bill the program directly for clinical diagnostic laboratory testing provided to its beneficiaries. In addition, California, New York and Rhode Island have each enacted some form of direct billing. Payors in other jurisdictions, such as Michigan, Connecticut and Pennsylvania, require direct billing as a matter of payment policy. A national direct billing requirement was included in virtually every major health reform proposal considered by Congress last year.

The Center for Health Policy Studies (CHPS) recently completed an analysis that found that the number of services per person is *28 percent greater in non-direct billing states* than in states where direct billing is required and that *total lab charges per person are 41 percent higher* in non-direct billing states. CHPS concluded that if a direct billing requirement were adopted nationwide, *the annual private sector cost savings* attributable to this change would fall in the range of *$2.4 to $3.2 billion*, or *between $12 billion and $16 billion over five years.*

In addition, CHPS suggested that Medicare expenditures could also be reduced by enactment of a national direct billing requirement, even though such a policy already exists for Medicare. CHPS found that Medicare utilization declined in states that required direct billing, indicating that physicians changed their pattern of ordering clinical laboratory services for both Medicare and non-Medicare patients when direct billing was required.

Due Process Protection in Managed Care Plans

As the Subcommittee is well aware, competition for patients in the private marketplace is increasing dramatically. The College believes that appropriate safeguards must be established to respond to these changes. Patients and providers alike are concerned about denials of necessary services and restrictions in choice of physicians and other health professionals and facilities that are becoming more and more common as large insurers exercise greater control over medical treatment decisions. We are concerned about health plans that discriminate against people with health conditions that require expensive care by dropping their caregivers from health plan networks.

The College supports enactment of federal legislation to control these abusive practices through the same reasonable methods commonly used by high quality insurance plans. These include establishing standards of operation, full disclosure of those standards to patients and providers, and effective options for recourse when problems arise. These protections were introduced last year as the Patient Protection Act of 1994, and we encourage the Subcommittee to include similar provisions in legislation this year.

Specifically, Congress should enact protections to require that consumers receive easily understood information about covered and excluded procedures and requirement for prior authorization, to assure that plans do not deny access to physicians and providers unreasonably because of utilization review practices. Standards should be required for the hiring and firing of physicians and other providers, and the right of timely notice and appeals when previously-accepted contracts are adversely modified. Certification processes for managed care plans and

utilization review programs that include periodic review and the opportunity to remedy deficiencies.

In conclusion, the College of American Pathologists appreciates the difficult task that the Subcommittee must confront. The necessity of addressing the long-term cost growth in the Medicare program means that hard choices must be made. We hope that you will resist the temptation to simply cut Medicare payments to health care providers and address the serious problems with the program's underlying financial structure. As you consider specific proposals this year, the College hopes that you will look on pathologists as an information resource on how patients will be affected. We look forward to working with you to achieve reasonable Medicare payment policies.

SUMMARY OF MAJOR REDUCTIONS IN PAYMENT FOR PATHOLOGY AND LABORATORY SERVICES

DEFRA '84

- Established Medicare Clinical Laboratory Fee Schedule (CLFS) at 60-62 percent of the then-prevailing charges
- Eliminated 20 percent coinsurance for Medicare clinical laboratory services

COBRA '86

- Established Medicare laboratory fee caps at 115 percent of the fee schedule medians

OBRA '87

- Reduced Medicare laboratory fee caps to 100 percent and limited the CPI update
- Reduced Medicare payment for certain automated tests by 8.3 percent

OBRA '89

- Reduced Medicare laboratory fee caps to 93 percent
- Established Medicare Resource Based Relative Value Scale (RVS) for physician services, reducing pathology services 23 percent from 1992 — 1996

OBRA '90

- Reduced Medicare laboratory fee caps to 88 percent and limited the CPI update
- Reduced Medicare payment for physician pathology services by 7 percent for 1991

OBRA '93

- Reduced Medicare laboratory fee caps to 76 percent over three years
- Eliminated Medicare laboratory fee schedule CPI update for 1994 and 1995
- Reduced Medicare RVS update for pathology and other non-surgical, non-primary care services by 2.6 percent for 1994 and 2.7 percent for 1995

College of American Pathologists

STATEMENT OF JAMES R. PATTON
EXECUTIVE VICE PRESIDENT AND CHIEF EXECUTIVE OFFICER
THE WELLNESS PLAN
COMPREHENSIVE HEALTH SERVICES OF DETROIT

Background

Comprehensive Health Services of Detroit, known as The Wellness Plan (TWP), is a 501(c)(3) federally qualified health maintenance organization ("HMO") operating since 1972 and serving the Detroit metropolitan area. Currently, TWP has over 100,000 enrollees, approximately 90 percent of whom are enrolled through the state of Michigan Medicaid program. TWP is a well established HMO that has been recognized as a model quality Medicaid managed care program by such national leaders as Dr. Otis Bowen, former secretary of the Department of Health and Human Services. Although it has over 200 commercial accounts with medium and small businesses, enrolls nearly 10 percent of the federal employee health benefit plan participants in Detroit, and has accounts with major companies, TWP has a disproportionate percentage of Medicaid members from sectors of the city of Detroit the greatest preponderance of minority and low income populations. Based on its stellar performance, TWP is as qualified as any other HMO in serving Medicare patients. Indeed, despite the fact that it often serves the sickest and most vulnerable population in the city of Detroit, including many dual eligible persons (with Medicare and Medicaid coverage), its costs to the Medicare program are far below the average adjusted per capita cost rates paid to Medicare Risk Contractors.

In 1989, TWP applied to HCFA for a Medicare health care prepayment plan (HCPP) contract. While TWP would have preferred to have a contract authorized by section 1876 of the Social Security Act (a Cost or Risk Contract), it was and remains ineligible to participate in these contracts because of the enrollment composition rule. This rule requires that in order for a federally qualified HMO to be eligible at least 50 percent of its members must have coverage other than through Medicare or Medicaid. 42 U.S.C. § 1395mm(f)(1) and (2).

Technical Corrections Act of 1994

At the end of the last session, Congress enacted a bill known as the Social Security and Technical Corrections Act of 1994, H.R. 5252 (dated October 7, 1994). Section 171(f) would subject an HCPP contractor to Medigap laws and regulations as of January 1, 1996. (The full text of this provision is included as Appendix A.) Because these provisions are inherently contrary to the operations of HCPPs, Section 171(f) would make it impossible for an HCPP contractor to offer a "gap policy" to any of its individually enrolled Medicare members. This is critical because, without a gap policy Medicare beneficiaries would have no reason to enroll or remain enrolled in an HCPP contractor. Rather, HCPPs would have to limit offers of gap policies to persons enrolled in a group contract (e.g. Medicaid dually enrolled Medicare beneficiaries, retirees of union trust plans and employer group retiree plans), who do not fall under the scope of Section 171(f).

Historically, HCPP contractors generally, and all federally qualified HMOs, were exempt from the federal Medigap laws. HCFA apparently interprets Section 171(f) as restricting an HCPP contractor from offering a gap policy unless it is in conformance with requirements for a Medicare Supplement Policy ("Medigap policy"). Because Medigap policies are indemnity policies and because most federally qualified HMOs and most other state licensed HMOs are not licensed insurers, it is impossible for them to offer such policies solely through an HCPP.

Moreover, under federal law, a Medigap policy must reimburse benefits regardless of which provider or physician offers the care. In a few states, Congress provided an exception to the Medigap requirements enabling insurers and Blue Cross Blue Shield plans to offer Medicare Select, a Medicare PPO product. Even though Medicare Select allows for differences in

reimbursement between in-network and out-of-network providers, it does not address most of the conflicts for HCPPs attempting to comply with Section 171(f). Specifically, by requiring an HCPP contractor to conform to Medicare Select, Section 171(f) would preclude an HCPP from offering its own unique version of covered benefits and require instead that the HCPP gap policy conform to 1 of 10 standard Medigap policies. None of these policies permit an HCPP contractor to use modest copayments (i.e., $5 to $10 for office visits and $25 to $50 for use of a hospital emergency room) to help manage usage of services by Medicare enrolled members of the HCPP. Nor does Medicare Select allow an HCPP to offer more comprehensive or more generous benefits, including extensive preventative care services that are not covered by Medicare or by Medigap policies.

Moreover, even for provisions that do not directly conflict with the obligations of an HCPP contractor, some requirements of Medicare Select, if implemented, could increase dramatically the administrative costs of operating an HCPP program. For example, even though the HCPP is paid its costs in lieu of the billed fees from a Medicare carrier, Section 171(f) would require an HCPP to submit bills to a Medicare carrier. Accordingly, the framework created by Section 171(f) is contrary to the framework of operating as an HCPP. (For additional details on the differences between Medicare Select and HCPP or HMO requirements see Appendix B.)

Comparison of HCPPs to Medicare Cost Contractors

In contrast with Section 171(f), Medicare Cost and Risk Contractors would continue to be exempt from Medigap requirements. All but a few Cost Contractors operate in exactly the same manner as TWP operates an HCPP. Indeed, HCPP contractors are held to the same standards as Cost Contractors for virtually all major financial and management aspects of their plans:

- Coverage -- Both must comply with Medicare coverage and reimbursement regulations and guidelines for non-provider services;
- Reimbursement -- Both are reimbursed on the basis of reasonable and allowable costs;
- Accountability -- Both must meet Medicare record keeping and reporting standards;
- Lock-in -- Both allow the Medicare enrolled member to elect out of plan services from Medicare on a fee-for-service basis, in the same fashion as a point of service plan or preferred provider organization, so that the patient never loses Medicare benefits;
- Marketing -- Both must comply with HCFA approval for marketing benefits;
- Quality of Care/Network Providers -- Both must utilize only Medicare approved health care practitioners;
- Quality Assurance -- Both must maintain adequate systems of quality assurance;
- Financial Risk -- Both have the same financial risk and flexibility to offer a gap policy to cover Medicare deductibles, copayments, and non-Medicare benefits and to charge no more than the actuarial value of Medicare deductibles and coinsurance.

There are only relatively minor differences between an HCPP and a Cost Contractor:

- Payment And Coverage Of Part A Provider Services -- while only Cost Contractors have the option of paying for these services directly, more than 90 percent of current Cost Contractors elect to have the Medicare fiscal intermediary pay providers directly. TWP arranges for such care with its network hospitals (through the Detroit Medical Center) and pays Medicare deductibles and copayments, in the same manner as Cost Contractors.

- Health Screening -- HCPPs are permitted to health screen while Cost Contractors are prohibited from health screening. In practice this is not followed by TWP or other HCPPs of which we are aware.

- Grievance And Appeals -- No specific regulation governs grievances and appeals within an HCPP, but TWP follows the same grievance and appeals procedures as a Cost Contractor. Other HCPP contractors that are licensed HMOs must follow at least the applicable state grievance and appeals process.

Impact and Recommendations

It is ironic that Congress, by adopting Section 171(f), could undermine the HCPP program when it has been a source of long term stable participation of HMOs with Medicare. Unlike the HMO Risk Program, HCPPs have not been criticized for having financial incentives to favorably select only healthy patients. Yet, HCPPs have served as an important feeder program that enables HMOs to shift to Risk Contracts once they gain experience in managing Medicare population. Few HCPPs have dropped out of the Medicare program and since the inception of the Risk Contract program 14 of the largest and most successful Risk Contractors were previously HCPPs. By contrast, in the first eight years of the Risk Contract program approximately 300 out of 400 contracts (or 75 percent) were terminated or non-renewed. **Accordingly, Congress should repeal Section 171(f) of the Social Security and Technical Corrections Amendments of 1994, otherwise it will be practically impossible for HCPP contractors such as TWP to continue to serve Medicare patients.**

Additional Recommendations

TWP believes that managed care can offer a more efficient and effective means of serving Medicare beneficiaries than traditional Medicare. Because of the wide variety of circumstances and obstacles affecting the availability of managed care plans for Medicare beneficiaries, Congress should approach the issue of Medicare managed care options by encouraging the offering of a variety of programs. Competition among plans will eventually force HMOs to whatever the Medicare beneficiaries seek in a plan. It is obvious, however, that no single type of managed care plan dominates throughout the country. In addition to repealing Section 171(f), TWP urges Congress to adopt changes to the Medicare managed care program and eliminate barriers to new managed care plans and to those plans that have specialized in serving the Medicaid population. Accodingly, Congress should consider the following recommendations:

> **Congress should amend 42 U.S.C. §1395()()() to allow a federally qualified HMO that is in full compliance with federal HMO Act requirements to obtain a waiver of the 50 percent enrollment composition requirements to obtain at least a Cost Contract. It should also allow such federally qualified HMO to obtain a Risk Contract subject to HCFA's judgement on the quality and fiscal soundness of the plan.**

Congress should encourage HCFA to adopt more flexible rules and regulations to reduce the paperwork burden of Medicare Cost Contracts, especially for provider services.

Congress should require HCFA to survey Cost, Risk and HCPP Contractors to get better information on the scope of benefits, types of copayments or fees, deductibles, or other limits so that more rationale policies on gap policies for Risk, Cost, and HCPP Contracts might be developed.

* * *

If you have any questions or wish to obtain additional information regarding this statement, please call our Washington Counsel, Jerrold Hercenberg at 202-778-8083 or Wendy Krasner at 202-778-8064 of the firm of McDermott, Will & Emery in Washington, D.C.

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APPENDIX A

Section 171(f) of H.R. 5252

For purposes of this section, a Medicare supplement policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed under this title; but does not include any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employers or former employees(or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of ~~a health maintenance organization or other direct service organization which offers benefits under this title, including such services under a contract under section 1876 or an agreement under section 1833.~~ an eligible organization (as defined in section 1876(b) if the policy or plan provides benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Acto of 1986, or during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1995, a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A).[1/]

[1/] The time period for this amendment is linked to the time period in each state when the Medigap law became effective. § 1882(p)(1)(C) sets the effective date for Medigap in each state as the date that a state adopts the NAIC model standards for Medigap policies (or if the state fails to adopt the model standards than the date that Federal standards are effective) beginning after January 1, 1992. In any event, the language of H.R. 5252 provides a grace period through December 31, 1995.

APPENDIX B

COMPARISON BETWEEN MEDICARE SELECT REQUIREMENTS

AND FEDERAL HMO REQUIREMENTS

1. Quality Assurance

- Medicare Select policies require submission to a state by an issuer of a description of its quality assurance program setting forth its formal organizational structure, written criteria for selection, retention, and removal of network providers, the methods for developing such criteria, and the procedures for evaluating quality of care provided by network providers and taking corrective action when warranted. See NAIC § 10.E.4.

- Federally qualified HMOs (HMOs) must have a quality assurance program. The program must: stress health outcomes, provide review by physicians and health practitioners of health services, use systematic data collection of performance and patient results to evaluate services, provide interpretation of data on performance to its physicians and practitioners, and provide corrective action based upon the HMO's evaluation. See 42 C.F.R. § 417.107(h).

2. Preventive Services

- One option that a Medicare Select policy may offer is coverage of preventive services including: tetanus and diphtheria boosters, dipstick urinalysis, thyroid function tests, fecal occult blood tests, cholesterol screening, and influenza vaccines. "Reimbursement shall be for the actual charges up to 100 percent of the Medicare approved amount for each service . . . to a maximum of $120 annually." See NAIC § 8.C.9.

- HMOs must provide preventive services (without limitation) including periodic health evaluations and immunizations. See 42 C.F.R. § 417.101(a)(8). Conventional practice among HMOs is to provide all of the preventive services allowed by a Medicare Select policy without limiting the amount that may be spent on such services.

3. Minimum Benefits

- Medicare Select policies are required to provide at least core benefits which include coverage of Part B coinsurance except for the $100 Medicare Part B deductible. See NAIC Model Act § 6.A, § 7.B. Medigap policies are required to cover the reasonable cost of the first 3 pints of blood. See NAIC Model Act § 7.B.5.

- HMOs must provide basic benefits, many of which do not correspond to Medicare or are subject to coverage limitations. For example, HMOs are required to provide 20 outpatient mental health visits per member per year. See 42 C.F.R. § 417.101(a)(4). HMOs are not required to provide long term physical therapy or rehabilitation services (e.g. physical therapy, occupational therapy, dialysis services), whole blood, corrective appliances, durable medical equipment at home, or certain transplantation services. See 42 C.F.R. § 417.100(d).

4. Nominal Copayments

- Medicare Select policies must pay for Medicare Part A and B deductibles and coinsurance by filling 100% of the gaps in Medicare coverage for the NAIC model core benefits package and 100% of the deductible or coinsurance amounts payable for each of the additional benefits offered. If a Medicare Select policy offers to cover additional benefits such as the coinsurance for skilled nursing facility services, or the Part B deductible covering a range of physician, outpatient and other medical services and items, no copayments may be charged by the issuer of Medicare Select against the Medicare beneficiary. See NAIC § 6.B.

- HMOs are authorized to charge nominal copayments. Copayments may not exceed 50% of the total cost of providing any single service offered to the HMO member or 20% of the annual aggregate costs incurred by the member. To insure that copayments are not a barrier to utilizing services, an HMO may not impose copayments in excess of 200% of the annual premium costs which a subscriber would be required to pay for an HMO policy with no copayments. 42 C.F.R. §417.104(a)(4). Conventional practice by HMOs is to provide nominal copayments of between $5 to $25 for selected outpatient services such as physician, diagnostic, hospital outpatient or emergency, mental health, or special therapy services.

5. Medical Necessity

- o Medicare Select policies must cover "Medicare eligible expenses" which are defined as expenses of the kinds covered by Medicare to the extent recognized as reasonable and medically necessary by Medicare. See NAIC § 5.G.

- o HMOs must provide or arrange for all covered medically necessary services. Because HMOs determine the medical necessity of services independently of Medicare carriers, they may disagree with approval by such carrier. For example, HMOs are sometimes more restrictive in approving DME. In addition, Medicare carriers will approve routine services furnished by non-HMO providers even if the HMO has not given authorization for such services. Whenever an HMO denies coverage, a member is entitled to appeal through the HMO's grievance procedures. See 42 C.F.R. §§ 417.100 and 417.107(g).

6. Enrollment and Underwriting

- o Medicare Select requires open enrollment for any Medicare beneficiary age 65 or older who resides in the state without discriminating against individuals with adverse health conditions either in the pricing of the premium or in accepting new subscribers. See NAIC § 11.

- o HMOs are permitted to enroll only persons who live within the service area it serves. See § 1301(c)(3)(A) of the HMO Act. HMOs are prohibited from discriminating in enrollment on the basis of health status and must rate premiums based upon community rating requirements which do not take into account the individual health status of the member. See 42 C.F.R. §§ 417.107(d) and 417.104(b).

7. Indemnity and Out-Of-Network Option

- o The issuer of a Medicare Select policy is obligated to make available to each applicant the opportunity to purchase a Medicare supplement policy (an indemnity policy it offers without network restrictions) which has comparable or lesser benefits and does not contain a restrictive network provision. See NAIC §10 L. and M. Medicare Select policies also must provide payment for full coverage for services that are not available through network providers. NAIC § 10.H.

- An HMO must provide at least 90% of physician services through its staff, medical group, IPA, contracted physicians or combination of these. See HMO Act § 1301(b)(3)(A). HMOs are not authorized to pay for non-emergency routine services of non-participating providers. See HMO Act § 1301(b)(4).

8. Conversion

- Medicare Select requires the issuer to allow the subscriber to convert to continuation coverage under a traditional Medigap policy if HHS determines that the Medicare Select policy must be discontinued. See NAIC § 10.N.

- HMOs would need an exemption from this requirement because HMOs do not offer traditional Medigap policies and would be unable to convert their members to a traditional Medigap policy.

9. Termination of Membership

- Medicare Select issuers are prohibited from terminating or cancelling a policy or certificate except for non-payment of premium. See NAIC § 7.A.4. In addition, Medicare Select policies are required to provide protection against continuous loss after cancellation of the policy. See NAIC § 7.A.6.

- Even though HMOs may not discriminate against a member on the basis of health status in terminating or refusing re-enrollment, HMOs may terminate a member for reasons other than non-payment of premiums, including (i) the member's relocation out of the service area; (ii) the inability of the member to maintain satisfactory relations with HMO physicians; (iii) the non-cooperation of the member in following HMO policies and procedures; (iv) the fraudulent use of membership privileges. See 42 C.F.R. §417.107(d). HMOs can provide protection from continuous loss following termination of a member only through participating providers.

10. Emergency and Urgently Needed Services

- Medicare Select issuers are required to reimburse for emergency care obtained 24 hours per day 7 days per week. In addition, such issuer must disclose to subscribers on what basis it will pay for emergency, urgently need, and out of area coverage. See NAIC § 10.E.1.d., G, and I.4.

- A member of an HMO is entitled to be reimbursed for medically necessary services rendered in emergencies or when urgently needed and where the member is unable to obtain services from a participating HMO provider. Such services must be due to unforeseen illness, injury, or condition. See § 1301 (b)(4) of the HMO Act.

11. Free Look Period

- Medicare Select policies must offer a subscriber at least 30 days to reject coverage after enrolling. See NAIC § 15.

- HMOs would need authority under this requirement to recover the cost of services furnished during the free-look period if a member, who has received services, elects to cancel membership retroactively.

12. Member Protection From Provider Claims

- Medicare Select has no provision.

- HMOs are required to protect their members in case of insolvency. See 42 C.F.R. § 417.107(a)(3). It is conventional practice for HMOs to require "hold harmless" agreements with participating providers, in which providers agree not to charge an HMO's members if the HMO fails to pay the provider. Hold harmless provisions protect members in the event of insolvency and during any disagreement over the medical necessity of a claim.

Statement of the

HOME CARE COALITION

submitted to

House Ways and Means Committee Subcommittee on Health
U.S. House of Representatives

Hearing On
"Growth in Medicare Costs"

Monday, February 6, 1995
Washington, D.C.

I. Introduction

The Home Care Coalition is pleased to submit a statement for the record of the February 6, 1995 House Ways and Means Health Subcommittee hearing on "Growth in Medicare Costs." This statement is submitted on behalf of our more than one hundred organizations on the growth of Medicare Part B costs and the need to improve the overall Medicare program.

The Home Care Coalition, founded in January of 1991, is a diverse group of organizations representing consumers and patients, family caregivers, health care professionals, providers, and manufacturers dedicated to serving people in their homes. The mission of the Coalition is to enhance consumer access to quality home care services, supplies, and equipment, and it focuses attention on providing education and communications advocating the benefits of home care to policymakers and the public.

II. Medicare Should Capitalize on the Cost-effectiveness of Home Care

The Home Care Coalition is pleased that the House Ways and Means Committee Health Subcommittee is carefully examining the overall Medicare program to find ways to improve its cost-effectiveness and its quality of service. The Home Care Coalition has long advocated that Medicare, while a base for coverage of home health services, supplies and equipment, should be revised to include therapies, treatments, and equipment which enhance clinical outcomes and quality of life for individuals with both acute and long term care needs. Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) coverage does not cover many cost-effective home medical services, supplies, and equipment which utilize cost-effective technology. For example, the 1965 Medicare

statute's restrictive language prevents beneficiaries from taking advantage of cost-effective home care, such as home infusion therapy and respiratory therapy. These therapies should be covered but currently are not because of the language of the outdated 1965 Medicare statute. As the 104th Congress examines the rise in Medicare and other health care costs, it should look to home care as a solution.

III. Factors Contributing to Medicare Part B Growth

We caution the Health Subcommittee not to look at the growth of Medicare Part B in a vacuum but rather to consider the demographic and historical factors which have increased the use of home care versus institutional care. These factors include (1) the aging of the elderly population which is likely to continue to dramatically increase the use of home care, (2) advancements in sophisticated technology which now enable patients to receive high technology care (*e.g.* home infusion therapy, oxygen therapy) in their homes rather than in the hospital, and (3) the 1983 implementation of the Medicare hospital prospective payment system which has led to patients being released from the hospital "quicker and sicker." These factors, coupled with patients' increasing preference for care at home, have contributed enormously to the growth of home care and the shift from Medicare Part A hospital care.

Reasons For Growth

- Increased number of beneficiaries
- Increased number of elderly beneficiaries
- Increased support for home care by physicians
- Increased support for home care by consumer and beneficiaries (recognition of the value in returning workers to work, such as the Americans With Disabilities Act)
- Increased home care utilization to reduce more costly institutional utilization (DRGs)

Not Reasons For Growth

- Medicare fee schedules have not increased, in fact, the have decreased
- Medicare coverage guidelines under new DMERCs are focused and tight
- Carrier consolidation has focussed carriers' administration of the DMEPOS benefit

IV. Home Care Is Cost-Effective

The growth of Medicare Part B expenditures, however, is not attributable to inappropriate utilization. Appropriate home care services decrease costly stays in hospitals and nursing homes, and increase patients' potential to become productive and participatory members of society. As the following summary chart shows, a number of studies show that home care is more cost-effective than hospital care:

Monthly Cost of Hospital Versus Home Care Under Selected Conditions

CONDITION	COST OF HOSPITAL CARE	COST OF HOME CARE	DOLLAR SAVINGS	DIFFERENCE
Infant with breathing and feeding problems	$60,970	$20,209	$40,761	66.8%
Nutrition infusions	$23,670	$9,000	$14,670	62%
Antibiotic infusions	$7,290	$2,070	$5,220	71.6%
ALS Patient on mechanical ventilation	$366,852	$136,560	$230,292	62.8%
Patient requiring respiratory support	$24,715	$9,267	$15,488	62.5%
Quadriplegic w/spinal chord injury	$23,862	$13,931	$9,931	41.6%
Person with cerebral palsy	$8,425	$4,867	$3,568	42.3%
Bone Marrow infection	$16,000	$5,000	$11,000	68.6%
Respiratory distress/oxygen dependency	$36,000	$11,500	$24,500	68.0%
Ventilator-dependent children	$15,742	$9,153	$6,589	41.9%
Oxygen-dependent children with a tracheostomy	$12,236	$5,304	$6,932	56.7%
AIDS care	$23,190	$2,820	$20,370	87.8%
Pediatric AIDS	$70,153	$16,461	$53,692	76.5%
Cancer chemotherapy	$10,500	$3,500	$7,000	66.8%
Kidney dialysis	$2,000	$1,200	$800	40.0%

Sources: from Olsten HealthCare, Aetna Life & Casualty Co., National Association for Home Care, 1993, 5th International Conference on Pulmonary Rehabilitation and Home Ventilation, Denver, Colorado, 1995.

As this chart shows, home care is considerably more cost-effective than hospital care for a number of different medical conditions. The information in the chart is a compilation of published reports and studies from a number of sources, including those listed above. Clearly, the percentage of the difference in costs between the home care and hospital setting -- as high as 87.8 percent -- indicates that home care should receive the highest consideration in efforts to lower costs in the health care delivery system.

The following chart shows the cost-effectiveness of home care per episode in comparison to hospital inpatient treatment:

COST COMPARISON OF TREATMENT OF HIP FRACTURE, COPD AND PNEUMONIA IN ALS

CONDITION	HOSPITAL INPATIENT TREATMENT	HOME TREATMENT	COST SAVINGS
Hip Fracture Patients	$6,708.14	$4,692.05	$2,016.09 per episode
COPD	$3,547.87	$3097.75	$450.12 per episode
ALS Patient	$3,751.26	$3,491.98	$259.28 per episode

Source: Lewin ICF, "Economic Analysis of Home Medical Equipment Services," May 29, 1991.

There are also a number of studies which have showed states' effectiveness in moving to cost-effective home care, including the following:

- **GAO Report on Home Care Cost-Effectiveness**

The General Accounting Office's (GAO) August 1994 report, *Medicaid Long Term Care: Successful State Efforts to Expand Home Services While Limiting Costs* (GAO-HEHS 94 167) shows the cost-effectiveness of home and community-based long term care programs implemented in Washington, Oregon and Wisconsin. The GAO study reports that as a result of their shift to home and community-based care, these states have been able to serve more beneficiaries with the Medicaid and state dollars they have available. The study states, "On a per-beneficiary basis, home and community-based care is considerably less expensive than nursing facility care." The report also states that per-user spending for nursing facility care has been rising faster than for home and community-based care.

Washington
The report found that Washington's average monthly expenditure per user for nursing facility care for the aged and disabled averaged $2,023 in 1993 compared with $419 for home and community-based users.

Wisconsin
Wisconsin had a net savings in per-person public expenditures associated with home and community-based care of 16 percent.

Oregon
Oregon saved $227 million between 1981 and 1991 by using home and community-based care and reduced the number of nursing facility beds significantly. Oregon's average monthly expenditure per user for nursing facility care for the aged and disabled averaged $1,657 in 1993 compared with $420 for home and community-based users.

Other Reports

- **New York's "Nursing Home Without Walls" State Senate Report**

New York's "Nursing Home Without Walls" program takes individuals who are eligible for Medicaid and allows them to be cared for at home if the costs so incurred are 75 percent or less than the cost of comparable nursing home care. New York's State Senate studies show the state saved 50% of the cost for these patients which would have been incurred had they been placed in a nursing home.

- **New Mexico Waiver Program**

New Mexico's waiver program for people with AIDS estimates a savings of $1100 a month for patients who use home care rather than skilled nursing facility care. The average patient plan of care costs $1000 a month for home care compared to $2,100 a month for skilled nursing facility care. New Mexico reports that only about 47% of patients receiving waiver services are hospitalized in a given year compared to 70% of those not under waiver.

- **National Governors Association 1992 Resolution**

The National Governors Association's 1992 resolution recommended the elimination of the current institutional bias in public programs such as Medicaid. The governors are asking for more flexibility to make greater use of home care as the more preferred and cost-effective method of meeting the growing need for long-term care.

V. Home Care Coalition Recommendations

The Home Care Coalition has identified specific ways to improve access to home care. These legislative initiatives recognize and support home care as a cost-effective and patient-preferred alternative to institutional care. Legislative initiatives to encourage home care that the Coalition supports include patient choice of provider, caregiver issues,

coverage of home IV and respiratory therapy services, reimbursement issues, and quality assurance mechanisms for the patient receiving home care services, supplies and equipment.

Home Care Coalition Recommendations Address Fraud and Abuse

The Home Care Coalition agrees with the Ways and Means Health Subcommittee that the Medicare program should be revised to safeguard against fraud and abuse and to ensure that beneficiaries receive high quality service. For example, the Home Care Coalition supports home infusion and respiratory therapy quality standards in home care. The Home Care Coalition strongly supports more rigorous supplier service standards to ensure that Medicare beneficiaries receive a consistent level of quality service. In addition, the Home Care Coalition supports a home care data system to improve data management, including administrative simplification, standard claims processing forms (paper and electronic) for all public and private payors, and standardized home care data management to facilitate communications among providers and payors. These are just some of our proposals to improve Medicare Part B to prevent fraud and abuse and to improve quality.

Specifically, the Home Care Coalition supports the following legislative initiatives:

Caregiver Issues

Caregiver Tax Credit - Provide $500 refundable tax credit for individuals caring for a chronically disabled grandparent, parent, spouse or child in their home.

Personal Assistant Services/Attendant Care Demonstration - On a demonstration or pilot project basis, require all payors (Medicare, Medicaid and private payors) to provide defined period of personal assistant services/attendant care services to persons with disabilities requiring assistance with activities of daily living.

Caregiver Safety and Well-Being - Require all payors to take into consideration the safety, health and well-being of the primary caregiver when determining the medical necessity of, and prescribing, appropriate home health services and home medical equipment (HME). Authorize payors, including Medicare, to pay for specific items and upgrades of otherwise medically necessary HME when, in the clear and documented clinical judgment of the prescribing health care professional, the HME recommended will significantly reduce the risk of injury to the unpaid primary caregiver.

Patient Choice

Patient Choice of Provider - Require health plans to allow a patient to go to a provider of their choice outside of their health plan's network at no more than a reasonable charge to the patient.

Patient Choice/Upgrade - Amend the Medicare law to authorize beneficiaries to pay suppliers who agree to take assignment on their claims the balance above the Medicare allowable for the equipment which has functional or other features exceeding those of the item determined by Medicare to be covered. Further amend the Medicare statute to clearly continue to allow a supplier to submit any claim for payment under assignment for an item the beneficiary chooses to upgrade.

Coverage and Reimbursement Issues

Home Care Benefit Package - Include legislatively defined comprehensive home care services, supplies and equipment in any standard health benefit package.

Medicare Coverage for respiratory therapy services - Cover respiratory therapy services under Medicare.

Medicare Coverage for home intravenous (IV) therapy - Cover home IV therapy services under Medicare.

Medicare Coverage for occupational therapy - Include occupational therapy as a qualifying service for Medicare Part A home health services.

Non-Discrimination against home care - Provision would eliminate any financial or other disincentives for utilization of home care under Medicare or private payor systems. (Requiring home care beneficiaries to pay a co-payment for care is a disincentive to use home care when there is no co-payment required for institutional care.)

Reimbursement for physician home care visits - Medicare and other payors should reimburse the physician at a reasonable fee for medically necessary home care visits to a patient in the home.

Quality Assurance

Certification of Suppliers; Quality Standards - Establish Medicare supplier standards based on the complexity of the services provided for suppliers to be able to bill Medicare for durable medical equipment, prosthetics and orthotics (DMEPOS). For example, suppliers providing respiratory equipment and related services would have to meet more rigorous standards than suppliers providing only "traditional" HME such as

hospital beds and canes. Further, suppliers providing certain "life-supporting" equipment and related services would be required to meet even higher standards.

Miscellaneous

Home Care Data System - Provide for a series of data management improvements, including administrative simplification, standard claims processing forms (paper and electronic) for all public and private payors, and standardized home care data management to facilitate communications among providers, payors, *etc.*

Home Care Council - Establish a national council on home care to make recommendations to Congress, and to develop proposed changes in regulations and policy related to the provision of home care. The national council would make recommendations on simplifying consumer understanding of home care benefits and payments. The Council would include consumers, providers and fiscal intermediaries. The Council would make recommendations to the Secretary on streamlining procedures for approving coverage criteria and appropriate reimbursement for new technology products.

VI. Conclusion

The Home Care Coalition commends the Ways and Means Health Subcommittee for its efforts to explore ways to improve the Medicare program. The Home Care Coalition believes that the answer is not to cut Medicare Part B, which is a cost-effective alternative to institutional care, but rather to revise the Medicare statute to consider cost-effective technologies which Medicare currently does not cover. For example, the 1965 Medicare statute's restrictive language prevents beneficiaries from taking advantage of cost-effective home care, such as home infusion therapy and respiratory therapy. These therapies should be covered but currently are not because of the language of the 1965 Medicare statute.

As our population ages and there is more utilization of home care because patients prefer home care and sophisticated technology allows for home care treatment, Medicare must accommodate advances in medical technology to continue the cost-effective use of home care versus expensive care in a hospital setting. If access to more home care services were provided to patients hospital costs could be reduced. There is no question that savings could be realized, provided that utilization controls based on medical necessity were also in place. The Coalition is concerned that Congress not seek to solve the cost problems by simply limiting the benefits offered to patients without a more global consideration of the most appropriate and cost-effective site of care.

The Home Care Coalition

Advocate for Elderly and Disabled
The ALS Association
American Association for Continuity of Care
American Association for Respiratory Therapy
Cystic Fibrosis Services, Inc.
Daughters of Charity National Health System
HIDA Home Care
Health Industry Manufacturers Association
Home Health Care Dealers Co-op
Invacare Corporation
National Association of Retail Druggists
United Ostomy Association

STATEMENT OF THE NATIONAL ALLIANCE FOR INFUSION THERAPY

The National Alliance for Infusion Therapy ("NAIT"), an association of health care providers and manufacturers involved in the provision of home and alternate-site infusion therapy, submits the following comments to the Subcommittee on Health of the House Ways and Means Committee for its hearing on extraordinary growth in Medicare costs. NAIT members serve much of the infusion therapy patient population, providing nursing and pharmacy services, equipment, drugs, nutrients, and supplies.

Infusion therapy involves the administration of drugs or liquid nutrients to patients with cancer, infections, severe pain, gastrointestinal disorders, and a wide variety of other illnesses and conditions. NAIT members share the concerns of the Subcommittee about rising Medicare costs and increasing fraud and abuse, and are pleased to contribute to the discussion on how to address these problems with respect to home infusion therapy services. We will discuss each issue separately and will propose a possible course of action that we believe addresses both.

Compared to other home care services, home infusion therapy is relatively new in terms of its utilization. Only in the last fifteen years has infusion therapy become widely available in the home, as advances in technology and changing nursing and pharmacy practice have made it possible to deliver complex treatments outside the hospital. The cost savings associated with home infusion therapy as compared to inpatient care have prompted both private insurers and the Medicare program to provide coverage for home infusion therapy. Medicare began to cover the nutritional therapies (parenteral and enteral nutrition) in 1981. The enactment of a Medicare prospective payment system for hospitals in 1983 further fueled the demand for home care

services, including home infusion therapy, as patients were discharged from the hospital at earlier stages of recovery.

As the demand for home infusion therapy services has grown, so has the universe of providers serving patients in their homes. NAIT was formed in large part to provide leadership in the area of quality and to responsibly address home care policy as it pertains to home infusion therapy.

Medicare Home Infusion Therapy Costs

We have long been concerned about Medicare policy in the area of home infusion and its effect on rising Medicare expenditures. While the portion of Medicare costs attributable to home infusion therapy is actually small in relation to the full spectrum of home care, this is still an area that warrants serious change. Currently, the Medicare program cannot determine what it is "buying," in effect, with the dollars it pays for the various infusion therapies, or whether its beneficiaries are being served by qualified providers.

This situation is largely due to how Medicare covers home infusion therapy. To explain briefly, Medicare treats the nutritional therapies as prosthetic devices under Part B of the program. Certain other infusion therapies are covered under the durable medical equipment benefit, also under Part B, at the discretion of the regional carriers. In both instances, the

"trigger" for coverage is the patient's need for a device or piece of equipment. Neither the prosthetic device benefit nor the durable medical equipment benefit was designed to accommodate a multidisciplinary therapy that involves services as well as products, as home infusion therapy certainly does. From the perspective of the program, all that is officially covered under these two benefits are the tangible items, such as tubes, catheters, pumps, nutrients, or drugs. Professional services, which are critical to ensure patient safety (especially for the frail elderly), are not explicitly covered.

Over the years, this has created a situation where patients must qualify for coverage based on illogical, and sometimes irrelevant, criteria. Instead of determining coverage based on the medical necessity for the treatment, Medicare instead requires patients to demonstrate a medical need that fits into the narrow definitions of the prosthetic device benefit or the durable medical equipment benefit. This has had ramifications in terms of Medicare costs, in that it discourages cost-effective use of resources based on patient need. For example, many patients may not need a pump to deliver their prescribed antibiotic therapy, yet Medicare will not cover the therapy unless a pump is used in the treatment (since the coverage is based on the use of an item of durable medical equipment). This needlessly creates an incentive to use a pump, which is more costly than other alternatives such as a traditional gravity-drip mechanism, or worse, to keep the patient in the hospital at a significantly greater cost than home care.

These illogical rules can also cut the other way. Because the program only explicitly covers items and not professional services, officials at the Health Care Financing Administration

(HCFA) are constantly looking for ways to reduce payment for infusion by basing it only on the provider's acquisition cost of products. This is disingenuous, in our view, because HCFA is well aware that most beneficiaries need the services of nurses and pharmacists to ensure safety and efficacy. HCFA knows, for example, that these therapies are invasive and present the possibility for severe, sometimes life-threatening, complications if they are not administered and monitored properly. Yet program officials persist in suggesting budget cuts that would seriously undermine providers' ability to ensure patient safety.

One such proposal was put forth late last year in the health reform debate, which NAIT strenuously opposed on the grounds that it was completely inconsistent with other provisions in the bill and, if implemented, would severely hamper providers' ability to deliver quality service. The proposal would have allowed HCFA to competitively bid for parenteral and enteral nutrition (PEN) services. Under the proposal, providers would submit bids based on the cost of supplying only PEN nutrients and supplies, not professional services. Medicare would be allowed to contract with one PEN provider per geographic area. The obvious incentive for providers would be to submit bids that do not reflect the costs of employing nurses and pharmacists. This would effectively drive many quality PEN providers out of the Medicare program and reduce payment to an unreasonably low level. Or, it would force a national redefinition of PEN therapy, so that in the future all services would simply disappear from policymakers' and payers' perception of these therapies. That would be a genuine tragedy, and one clearly inconsistent with the patients' interests.

We want to make it clear that we intend to cooperate with Congress to develop budget policies in the area of home infusion therapy that make sense for both the program and patients. Over the past eight years, PEN has contributed substantially to deficit reduction efforts, with payment rates being frozen several times over that period. However, we intend to oppose any cuts that would have a negative effect on quality for Medicare beneficiaries and which would make it impossible for responsible providers to compete for Medicare patients.

Potential for Fraud and Abuse in Home Infusion Therapy

As mentioned earlier, one of the primary reasons for forming NAIT was to promote sound public policy and responsible behavior on the part of providers and manufacturers. We continue to seek reforms designed to protect patients from unscrupulous providers and to clarify the rules under which providers and manufacturers operate.

For example, while NAIT has always supported and continues to support the critical role of physicians in the provision of therapy, we believe that third party payers, not providers, should be paying them for the clinical management services they provide. We supported the Stark ban on physician self-referral that was enacted as part of OBRA-93, as well as the extension of the ban to all payers that was part of virtually every major health reform bill last year. As show of their support for this policy, all NAIT providers, which comprise most of the

national providers in the industry, recently decided to divest themselves of any existing private-sector financial relationships with physicians.

NAIT has always pushed for greater oversight of home infusion therapy providers to ensure quality and patient safety. We believe that the current environment does not offer patients, either in the private or public sectors, sufficient assurance that they are receiving care from a qualified provider. While state licensure laws and voluntary accreditation offer some measure of protection, we believe a more comprehensive approach is needed. We have proposed that home infusion therapy providers be given "provider" status under Medicare and be required to meet conditions of participation in order to provide care to beneficiaries. These same standards could easily be adapted to the private sector. Most of the major health reform bills last year included NAIT's suggested language on these requirements, as did a bill introduced last year by Congressman Sherrod Brown (D-OH).

Clearly, the absence of Medicare standards in the area of home infusion contributes to the potential for poor quality care. Currently, providers of home infusion therapy have only to acquire a "supplier" number and meet very minimal requirements in order to provide care to Medicare beneficiaries. As mentioned earlier, infusion therapy is an invasive treatment involving the administration of drugs and nutrient solutions directly into a patient's bloodstream or digestive tract. The potential for infection and adverse reactions to the solutions infused is very real, and patients must be monitored closely. Nurses must know how to spot complications and respond immediately to prevent injury to the patient. Pharmacists must be trained in how

to compound sterile solutions according to precise prescriptions. The Medicare program, in our view, simply takes for granted that its beneficiaries are getting the benefit of such expertise; that may well be true, at the moment. However, HCFA's efforts to simply reduce provider payments while maintaining coverage only in the context of the prosthetic device benefit and the durable medical equipment benefit will guarantee that quality care may not be presumed in the future. It is clear that Medicare will neither recognize nor explicitly pay for professional services until change is mandated by Congress.

A Possible Solution to Rising Costs and Current Regulatory Problems

As stated earlier, NAIT is concerned about how to promote efficient use of Medicare dollars for infusion therapy and better quality of care for beneficiaries, and we believe that we have a solution that will address our concerns as well as those of Congress and the Medicare program. We have long supported a reengineering of Medicare coverage of home infusion therapy that would change the way Medicare defines infusion therapy, as well as the way Medicare pays for it. It would involve the creation of provider quality standards so that patients would have some assurance that they are receiving good care. Put simply, it would deal with infusion therapy in a straightforward, patient-centered manner and instill some accountability where there has traditionally been little or none.

Such changes have been considered by Congress several times, starting in 1988 with the Medicare Catastrophic Coverage Act, and most recently in the comprehensive health reform proposals advanced during the last two years. We would like to work with Congress this session to ensure they are enacted.

Congress must make these changes if the Medicare program is to have any hope of instilling accountability in its administration of home infusion therapy benefits. The current system simply does not encourage it, as HCFA is aware. In fact, HCFA officials testified before Congress in September of 1993 on the inadequacy of current coverage policies for home infusion therapy. However, instead of actively working for change, HCFA instead persists in making budget and other decisions that only exacerbate the problems and potentially endanger beneficiaries.

We suggest one of two possible courses of action. One would be to create a freestanding home infusion benefit within the Medicare program. Home infusion therapy providers would be given "provider" status, and HCFA would develop quality standards in the form of conditions of participation. Services and products to be covered could be clearly spelled out, and HCFA could develop a fee schedule based on what a patient actually needs and what is actually provided to that patient.

The other possibility is to allow Medicare beneficiaries to receive infusion therapy services as part of private-sector insurance coverage that is funded by the Medicare program

through a voucher system. For example, Medicare could determine a baseline payment for home infusion therapy benefits and require that private payers meet certain requirements in order to participate. The advantage it offers is that it puts the administration of infusion benefits in the hands of the private sector, which for the most part has become much more adept in this area than the Medicare program. There are a variety of ways such a system could be structured, and we would be pleased to work with Congress on this proposal.

Either of the above proposals would vastly improve the ability of the Medicare program to determine the true cost and quality of home infusion therapy services its beneficiaries are receiving, and would assure providers that payment will be based on all elements of therapy, not simply the product components. Most importantly, beneficiaries would have some comfort that they are receiving care from qualified providers. We believe that these proposals are truly in the interest of all parties, and we look forward to working with Congress to achieve our mutual goals.

Thank you for the opportunity to submit these comments for the record to the Subcommittee. If Subcommittee members or staff have any questions about our testimony, please contact Alan Parver or Jana Sansbury at (202) 347-0066.

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STATEMENT OF THE NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF ORTHOTICS AND PROSTHETICS

INTRODUCTION

The National Association for the Advancement of Orthotics and Prosthetics (NAAOP) is a national, non-profit organization comprised of orthotic and prosthetic health care practitioners (orthotists and prosthetists) who clinically and technically design, fit, and fabricate orthopedic braces and artificial limbs (orthotics and prosthetics) for this nation's two million amputees and other people with physical disabilities requiring orthotic and prosthetic care. Quality orthotic and prosthetic care can be extremely cost-effective by enabling people with disabilities to achieve high levels of independence and function in the workplace, in the home, and in all aspects of community life. Appropriate orthotic and prosthetic care also helps prevent secondary disabilities and decreases long term health and welfare costs to society

Orthotic and prosthetic services are reimbursed under Part B of the Medicare program through a fee schedule known as the "L-codes." Although the four recently-created Durable Medical Equipment Regional Carriers (DMERCs) currently administer reimbursements for orthotics and prosthetics under the Medicare program, there is a major distinction between durable medical equipment (DME) and orthotic and prosthetic (O&P) services that justifies separate consideration and treatment when regulating these sectors of the health care field.

ENSURING QUALITY ORTHOTIC AND PROSTHETIC CARE

Practitioner Education

A critical distinction between the provision of durable medical equipment and the provision of orthotic and prosthetic services entails the level of education and training necessary to provide comprehensive O&P services. Comprehensive orthotic and prosthetic care requires highly specialized and trained practitioners in order to design, fit and fabricate a customized artificial limb or orthopedic brace for the particular needs of each patient. These highly specialized services combine the disciplines of medicine and engineering like almost no other area of health care. The successful custom replication and restoration of functional human body parts, which are in a multitude of shapes, sizes and complex contours, is fundamentally different from most types of durable medical equipment which tend to be more generic, pre-fabricated, and less clinically intensive to provide.

In addition, significant variation exists in the delivery of quality orthotic and prosthetic services, primarily due to the range of physical disabilities orthotic and prosthetic care can benefit and the explosion of technology over the past decade. To keep abreast of clinical and technological developments, individual practitioners participate in continuing education, research, and the frequent exchange of information among professionals. The orthotic and prosthetic profession has a defined body of clinical and technical knowledge and a core of over 3,000 specially credentialed practitioners with formalized education provided by well-established baccalaureate and post-baccalaureate education programs offered at eight major American universities.

Certification and Accreditation

Currently, the American Board for Certification in Orthotics and Prosthetics (ABC) offers the highest level of credentialing standards for orthotists and prosthetists and is the most widely recognized credentialing organization for orthotic and prosthetic services. ABC was founded in 1948 and conducts a comprehensive credentialing process for both orthotic and prosthetic practitioners as well as facilities in which they provide their clinical and technical services.

ABC-certified orthotists and prosthetists are the only orthotic and prosthetic practitioners recognized by the American Medical Association (AMA) as true orthotic and prosthetic allied health professionals. The education requirements for ABC certification are the only educational pathways recognized by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the U.S. Department of Education.

The ABC awards practitioner accreditation in three categories, Certified Orthotist (C.O.), Certified Prosthetist (C.P.), and Certified Prosthetist/Orthotist (C.P.O.). The minimum entry level requirements for practitioner education and certification are:

(a) a bachelor of science degree in orthotics and prosthetics or a bachelor of science degree in a related allied health or engineering field along with successful completion of specific undergraduate courses in orthotics and prosthetics at accredited schools,

(b) one year of clinical residency in each discipline, and

(c) successful completion of a comprehensive written, oral, and clinical examination for practitioners administered by the American Board for Certification in Orthotics and Prosthetics.

These stringent standards help ensure that ABC-certified orthotic and prosthetic practitioners are competent to provide the full range of comprehensive O&P care to patients with a multitude of varying disabilities. This high level of education and training helps assure quality in the clinical service element inherent in the delivery of these highly technical customized devices.

The Service Element of Orthotic and Prosthetic Care

Quality orthotic and prosthetic care is as much a professional service as it is a device that results from this service. While there is a service component in the delivery of some types of durable medical equipment, such as the design of customized wheelchairs and the delivery of certain home health services, orthotic and prosthetic care is generally far more service-oriented and specialized to the needs of each patient. Yet, when Congress and the Health Care Financing Administration (HCFA) have regulated durable medical equipment in the past, through fraud and abuse and reimbursement reforms for instance, they have tended to blindly cast the same net over the very different fields of orthotics and prosthetics.

The lack of separate treatment between DME and O&P has resulted in widespread confusion and limited understanding of this small but critical component of rehabilitation in our health care delivery system. This failure to separately address DME and O&P often creates unintended consequences and unfairly punishes the orthotic and prosthetic fields for problems in other areas of the health care delivery system. Two recent examples of this is the inappropriate reclassification by HCFA of custom orthotic seating systems as "inexpensive/routinely purchased" DME and the fraud and abuse orthotic body jacket investigation conducted by the Office of Inspector General.

HCFA'S RECLASSIFICATION OF ORTHOTIC SEATING SYSTEMS AS DME

Custom orthotic seating systems are designed and fabricated to meet the unique needs of people with severe physical disabilities requiring seating support usually associated with long term wheelchair use. Custom orthotic seating systems are needed in this instance to avoid serious health complications--such as decubitus ulcers and spinal collapse--and to maintain functional activities of daily living. Depending upon the severity of the patient, these customized orthoses range in cost from a few hundred to several thousand dollars. Until recently, HCFA reimbursed these orthoses using an orthotic L-code and individually considered each device to determine a reasonable fee.

With the creation of Medicare's Durable Medical Equipment Regional Carriers, these custom seating orthoses were inappropriately reclassified as "inexpensive/routinely purchased" durable medical equipment and assigned three different "K-codes," obviously not part of the orthotic and prosthetic L-code system. Instead of individually considering the fee for each custom seating orthosis claim, HCFA and the DMERCs now reimburse claims for these devices at a fixed allowable fee, regardless of the level of complexity involved in designing and developing the individual orthosis. Despite the fact that the descriptions for these three new K-codes include the

words, "orthotic" and "custom fabricated,"--which clearly demonstrate the propriety of reimbursing these devices under the L-code system--they continue to be treated as "one size fits all" durable medical equipment.

The DMERCs have recently stated that this action was taken because these custom orthotic seating systems are merely permanent accessories to wheelchairs and are not transferable. While custom orthotic seating systems are often fabricated to mount onto a wheelchair, the DMERC's rationale fails to consider the frequent use of these devices, particularly among children, as transferable between wheelchairs, as car seats, and in a variety of other situations, including allowing one to sit independently supported at a table to eat a meal.

HCFA and the DMERCs have been fully informed of this problem throughout the past several months, but have failed to remedy the situation to date. As a result, some of the very specialized orthotists who fit and fabricate these orthoses have begun to deny these services to Medicare beneficiaries. We point to this situation as an example of the problem of not recognizing the separate treatment of DME from orthotics and prosthetics. We request this Subcommittee, HCFA, and the DMERCs to consider reincorporating these newly-created K-codes into the L-code system where custom orthotic seating systems truly belong and determining fees for these orthoses based on individual consideration of each claim.

THE OFFICE OF INSPECTOR GENERAL'S TESTIMONY

The Office of Inspector General (OIG) testified today on the issues of fraud and abuse in the area of durable medical equipment generally, and specifically as to the investigation of "orthotic body jackets." The OIG testified that "payments for [orthotic body jackets] went from $217,000 in 1990 to $18 million in 1992. We estimated that 95% of those payments were for devices more properly categorized as [prefabricated wheelchair] seat cushions, rather than body jackets." Seat cushions are items of durable medical equipment that cost Medicare $200 to $300 per unit. An "orthotic body jacket" is a thoracic-lumbar-sacral orthosis (TLSO) designed for the treatment of spine or trunk musculoskeletal disorders such as fractures, spinal cord injuries, post surgical stabilization, scoliosis, congenital deformities, etc. The custom design and fitting of a TLSO requires sufficient medical knowledge of these complex disorders for one to possess the clinical and technical skills necessary to provide this complex and comprehensive orthotic service.

This type of orthotic body jacket is identified as L-0430 in the Medicare O&P reimbursement system and has a reimbursement value of approximately $1,000 to $1,200. According to the OIG report, unscrupulous providers began submitting claims for simple seat cushions using the L-0430 reimbursement code in 1990. By the time HCFA identified this fraud and abuse, nearly $18 million in fraudulent claims had been reimbursed under this L-code in 1992 alone.

What the Inspector General did not mention was that the 5% of "orthotic body jackets" that were deemed by the OIG report to be "legitimate" claims were, in almost every instance, provided by certified orthotists "whose primary occupation is supplying orthotic and prosthetic devices to patients. The non-legitimate body jackets in our sample were supplied by Durable Medical Equipment (DME) suppliers that primarily supply DME equipment and supplies, not orthotics." OIG Report , p.4.

THE IMPORTANCE OF CONDITIONS OF COVERAGE

Recognition of provider credentials in the delivery of quality orthotic and prosthetic care is a critical point that we strongly request this Subcommittee consider when attempting to legislatively ferret out health care fraud and abuse in the Medicare program. NAAOP believes that an effective way to curb the type of fraud and abuse that occurred with orthotic body jackets would be to establish conditions of coverage for reimbursement under the orthotic and prosthetic L-codes. By limiting reimbursement of orthotic and prosthetic services to qualified orthotists and prosthetists who are certified to provide these services, HCFA could dramatically reduce the likelihood of this type of fraud and abuse in the future, as well as, the additional costs of adjudicating these fraudulent claims.

Currently, as a practical matter, any provider who obtains a Medicare billing number can submit a claim for orthotic and prosthetic reimbursement. Until 1992, HCFA's Medicare policy carriers manual on orthotic and prosthetic coverage restricted reimbursement to ABC-certified orthotists and prosthetists. HCFA changed its policy to allow O&P reimbursement to any provider credentialed by a membership organization of the National Organization for Competency Assurance (NOCA). NOCA is not a credentialing organization, but rather a membership organization open to all organizations interested in credentialing issues.

Realizing this error in recognizing the NOCA and instead of limiting reimbursement to practitioners qualified to provide comprehensive orthotic and prosthetic care, HCFA further expanded the range of providers eligible to provide O&P services reimbursable under the Medicare L-codes in September 1994. HCFA, therefore, currently has no substantive restrictions or apparent monitoring procedures as to who is qualified to submit orthotic and prosthetic claims under the Medicare program.

HCFA, has potentially exacerbated the likelihood for the type of fraud and abuse that occurred with orthotic body jackets by recognizing and allowing "anyone credentialed by any certification organization in orthotics and prosthetics" to acquire an O&P provider specialty code and use the L-code designations in submitting orthotic and prosthetic reimbursement claims. This HCFA Medicare carriers manual policy change only increases the likelihood for fraud and abuse and provides virtually no control over the use of the O&P L-codes. Further, HCFA's relaxation of its conditions for orthotic and prosthetic coverage may lead to further proliferation of "new" orthotic and prosthetic credentialing organizations wishing to meet the relaxed requirements for orthotic and prosthetic reimbursements.

The creation of orthotic and prosthetic conditions of coverage under the Medicare program, therefore, would serve to promote quality control of orthotic and prosthetic health care services provided to Medicare beneficiaries and would lead to easy identification of fraudulent and abusive activities by unqualified providers. HCFA should consider reincorporating the ABC practitioner certification and facility accreditation standards into its conditions for O&P coverage. These certification and accreditation standards include physical facility requirements and the prerequisite that an ABC-certified practitioner be employed full-time in an O&P facility.

CONCLUSION

NAAOP welcomes the opportunity to work with this Subcommittee, the Health Care Financing Administration, and the Durable Medical Equipment Regional Carriers to eliminate fraud and abuse in the Medicare program, to appropriately regulate orthotics and prosthetics separately from durable medical equipment, and to ensure the provision of the highest quality orthotic and prosthetic care to Medicare beneficiaries. Thank you.

National Association of Long Term Hospitals

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February 16, 1995

BY OVERNIGHT MAIL

Philip D. Moseley
Chief of Staff
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Washington, D.C. 20515

Re: Hearings on Medicare Issues

Dear Mr. Moseley:

These comments are being submitted on behalf of the National Association of Long Term Hospitals ("NALTH") for inclusion in the printed record of the Subcommittee on Health's hearings on Medicare issues. The hearings were held on February 6, 7, and 10, 1995. We welcome the opportunity to submit these written comments. NALTH invites participation in future hearings which the Subcommittee on Health may hold on Medicare issues related to long term care hospitals and the patient population they serve. These comments address three issues which NALTH believes are important to the future of the Medicare program.

1. Selective rebasing for long term hospitals which meet a disproportionate share test;

2. Issues related to Medicare patients who "crossover" to Medicaid status; and

3. Opposition to a moratorium on new long term hospitals.

BACKGROUND ON NALTH

NALTH's member hospitals are typically not for profit and have participated in the Medicare program for many years. Most of NALTH's members have participated in Medicare from the inception of the program. NALTH member hospitals are long term hospitals as that term is defined in the Social Security Act and implementing regulations. Long term hospitals have a variety of programs to serve the a diverse, catastrophically ill and disabled population. In areas where long term hospitals do not exist, these patients remain in PPS hospitals as "extreme outliers" or, in some instances, experience repeat admissions between PPS hospitals and nursing facilities.

ISSUES

I. Selective Rebasing of Disproportionate Share Long Term Hospitals.

A. The Problem.

Medicare currently pays long term care hospitals amounts which in many cases are well below actual costs. The target amount for most NALTH member hospitals is based on costs incurred in 1982 or 1983 or later years for a hospital which joined the Medicare program after 1983. These base year costs are increased by update factors, however, the update factors are below established hospital market basket indices and fail to reflect changes in treatment methods, technology, labor and other costs which increased at rates in excess of the update factors.

B. Proposal.

NALTH proposes selective rebasing of long term care hospitals to a more current year. To qualify for rebasing, hospitals would be required to satisfy two criteria. First, the hospital must establish that it has two consecutive years of losses (i.e., Medicare costs were greater than the TEFRA target amount). Second, the hospital must meet a low income patient load test. The low income patient load test would require that the hospital's Medicaid and Medicare SSI population equal 25% or more of its patient population, or that the hospital had been certified as a long term care hospital on or before fiscal year 1989 and was located in a state which provides no coverage under its Medicaid program for patients who have exhausted the Medicare day limit, i.e., 150 days, and become Medicaid eligible.

The Congressional Budget Office has previously scored this proposal to cost $4 million in 1994 and $5 million each year thereafter. A copy is attached as Attachment "A".

II. Medicaid Issues Related to Medicare Beneficiaries Who Exhaust Their Medicare Hospital Day Limit Benefit.

A. The Problem.

The Medicare program provides ninety (90) days of inpatient hospital coverage in any given spell of illness and a one time use of sixty (60) additional days which constitute so-called life time reserve days. A spell of illness begins with the first day a Medicare Part A beneficiary benefits is provided inpatient hospital services or extended care services and ends on the sixtieth consecutive day in which the patient is neither hospitalized nor an inpatient in a skilled nursing facility. Social Security Act, §1861(a). The chronically ill patients served by long term care hospitals typically exhaust their Medicare coverage. This is in part the reason why the average length of stay of long term hospitals exceeds twenty-five days. Often times patients come to long term care hospitals only after having experienced recurrent hospitalizations in PPS hospitals during the same "spell of illness". As a result, these patients often have exhausted or greatly reduced the number of Medicare

covered days available to them prior to admission to a long term hospital. Patients who do not have Medigap coverage and who exhaust their Medicare coverage must "spend-down" their assets in order to qualify for Medicaid coverage. However, Medicaid coverage varies greatly from state to state. Some states have extremely short Medicaid day limits for hospital stays. At least one state provides no hospital coverage for patients (sick, elderly and SSI) who exhaust their Medicare hospitalization benefits. These hospital limits may be adequate for the younger Medicaid populations. (The Medicaid Program typically covers families on aid to families with dependent children.) However, these limits are grossly inadequate for the severely ill elderly population. NALTH believes that the legitimate needs of the Medicare "crossover" population are different than the vast majority of Medicaid recipients who are predominantly young women and children. NALTH believes the elderly population could be adversely affected by a block grant type of program aimed at the AFDC population.

B. **NALTH's Suggestion to Finance Removal of the Medicare Day Limit for Most Beneficiaries.**

1. The day limit on inpatient hospitalization would not apply to Medicare beneficiaries, except as provided in Number 7, below.

2. All coinsurance and deductibles would remain in effect and be subject to current financing mechanisms, e.g., Medigap, etc.

3. HCFA would annually determine and publish the incremental costs (premium) for beneficiaries to "buy in" to the unlimited hospital Medicare inpatient day coverage.

4. Uniform federal standards for certification of Medicare supplemental policies under Section 1882 of the Act would require that Medigap insurance separately price components of offered supplementary insurance so that Medicare eligible individuals are able to compare, on a timely basis, the price of purchasing insurance for supplemental inpatient hospital benefits from a Medigap insurer or from the Medicare program.

5. Medicare-eligible persons with resources who purchase unlimited Medicare hospital coverage would choose between the government and Medigap plans. Where the government price is lower, and the beneficiary elected government coverage, the insurer would be required to grant a full credit for the higher insurance cost when selling the remainder of the Medigap package to the insureds. For example, if the Medigap premium is $300 and the government's "stay in place" insurance costs $15, while private Medigap coverage costs $25, a beneficiary who elected government coverage would pay $275 for Medigap coverage, $15 for "stay in place" coverage Medicare insurance and would save $10.

6. States would maintain effort and "buy in" to the new

Medicare hospital benefit for individuals who would, under current rules be Medicaid eligible.

7. Individuals who could not afford to purchase Medigap or the new federal "buy in" insurance as determined by the Secretary due to the unavailability of resources or income at a specified percentage of, or above the national poverty level, would be entitled to the federal "stay in place" coverage. Individuals who have resources or income which exceed the poverty level established by the Secretary and who voluntarily choose not to purchase Medigap or the federal "buy in" coverage would spend-down until they meet Medicaid eligibility standards and then would be included in the Program.

As noted above, many NALTH member hospitals currently are reimbursed at rates which are significantly below the cost of caring for Medicare beneficiaries. Repeal of the day limit will increase the losses suffered by these hospitals. For this reason NALTH recommends that the repeal of the day limit and selective rebasing of long term care hospitals be enacted together.

The Congressional Budget Office had previously scored the repeal of the day limit in connection with the Medicare Catastrophic Coverage Act. The cost estimate for fiscal year 1992 was $420 million. A copy is attached as Attachment "B". This is approximately $11 - $12 per beneficiary per year. We are unable to determine whether this includes savings which would be realized from the Medicaid program as a result of repeal of the Medicare hospital day limit. The Medicaid program generally pays for additional care for Medicare individuals who exhaust their inpatient hospitalization benefits. These funds could be redirected to pay for the repeal of the day limit.

III. Opposition to Moratorium on New Long Term Hospitals.

NALTH is aware of suggestions by HCFA for a moratorium on new long term hospitals. NALTH believes a moratorium on new long term hospitals is unwarranted and counter-productive. Data available to NALTH indicates that payment on a per diem basis to long term hospitals is less than outlier payments to PPS hospitals. NALTH also believes, but cannot demonstrate that in undeserved areas a spectrum of patients experience repeat PPS admissions from nursing facilities which would not occur if the patient received services in a long term hospital. Also, it should not be forgotten that long term hospitals have programs of care such as rehabilitation for the medically frail patient which may not be duplicated in a PPS hospital setting. The clinical goal for these patients is to regain a health status which does not require continued inpatient care and results in discharge to the patients' homes. Also, classes of patients with specialized program needs such as those with AIDs (who are Medicare eligible due to SSI), the elderly who experience unexpected behavioral changes and require comprehensive medical and psychiatric testing are best served in long term hospitals who specialize in caring for these patients.

NALTH would be pleased to further address these issues should the Committee desire further information.

Sincerely,

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ATTACHMENT "A"

Proposed Policy for Rebasing Long Term Hospitals

- Participating as a long term hospital
- Has disproportionate share patient percentage of at least 25 percent
- Sustained a Medicare operating loss (after any adjustments) for two immediately preceding cost reporting periods
- Eligible for rebasing using FY 1992 cost report

Rebasing cost estimate should be net of any amounts that would be likely to be recognized through adjustment process, as well as the 50 percent cost-sharing for costs between the target and 120 percent of the target.

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d) Rebase long-term hospitals as described:

	FY94	FY95	FY96	FY97	FY98	TOTAL
Outlays	$4	$5	$5	$5	$6	$25

ATTACHMENT "B"

MEDICARE CAT. COVERAGE ACT
P.L. 100-360
[page 35]

2. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES

In compliance with clause 2(l)(3)(B) of Rule XI of the Rules of the House of Representatives, the Committee states that the letter from the Congressional Budget Office indicates that there is a change in budget authority and that there are no new or increased tax expenditures as a result of the bill.

3. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 2(l)(3)(C) of Rule XI of the Rules of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office, the following report prepared by CBO is provided.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 2470.
2. Bill title: The Medicare Catastrophic Protection Act of 1987.
3. Bill status: As ordered reported by the Committee on Ways and Means on May 19, 1987.
4. Bill purpose: To amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the Medicare program, and for other purposes.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Direct spending/offsetting receipts:					
Section 101 provisions:					
Eliminating the limit on covered hospital days:					
Budget authority	−10	−30	−60	−90	−130
Outlays	180	300	345	380	420
Eliminating enrollees' copayments for hospital coinsurance and reserve days:					
Budget authority	−15	−50	−95	−150	−210
Outlays	295	485	560	615	680
Limiting payment of the hospital deductible to the first stay each year:					
Budget authority	−20	−60	−110	−160	−220
Outlays	395	630	550	595	655
Indexing the first-stay hospital deductible amount to the COLA:					
Budget authority	(1)	−5	−15	−35	−65
Outlays	10	75	175	290	410
Changing the calculation of the part A premium:					
Budget authority	15	25	25	25	25
Outlays	15	25	25	25	25
Effect on trust fund from change in part A premium:					
Budget authority	−16	−27	−30	−30	−35
Outlays	0	0	0	0	0
Section 102 provisions:					
Changing the requirements for coinsurance on SNF stays, and covering up to 150 days a year:					
Budget authority	−10	−30	−55	−85	−120
Outlays	170	275	315	350	385
Eliminating the prior hospitalization requirement of coverage of SNF stays:					
Budget authority	(1)	−2	−5	−10	−15
Outlays	0	40	55	65	75

STATEMENT OF THE NATIONAL ASSOCIATION OF MEDICAL DIRECTORS OF RESPIRATORY CARE

The National Association of Medical Directors of Respiratory Care is a membership association whose members serve as medical directors in just under 2,000 hospitals nationwide. Our members generally are board certified pulmonologists with a small minority of anesthesiologists. In our capacity as medical directors of respiratory care we are extremely familiar with virtually all aspects of the facet of the Medicare durable medical equipment company (DME) benefit that authorizes coverage and payment for home oxygen. That component of the Medicare program has received a fair amount of attention in recent months, particularly related to a report of the Office of the HHS Inspector General, "Oxygen Concentrator Services."

As background, it is important to emphasize the objective, clinical focus of our comments. We believe that we speak authoritatively on behalf of pulmonary medicine in this country and have provided input time and time again to the OIG and the Health Care Financing Administration on issues related to the DME oxygen benefit. In fact it was our organization that condensed the HCFA Certificate of Medical Necessity for home oxygen (HCFA Form 484) into a workable, well accepted one page check-off form.

It is our understanding that the Congress may be considering, in response to the OIG study, a shift to competitive bidding for oxygen, modeled after the approach of the Department of Veterans Affairs. We strongly urge the Congress not to adopt that approach because we believe it will adversely affect the care Medicare beneficiaries who suffer from chronic obstructive pulmonary disease (COPD) currently receive. We do have

an alternative recommendation that will address directly the problem of payment levels for oxygen concentrators and simultaneously, we believe, address other related problems inherent with the current statutory limitations for payment of oxygen.

THE PROBLEM: Simply stated, the current statute is supposed to recognize all oxygen therapy modalities equally. Whether a physician orders a concentrator, a liquid system, or a gaseous system, the supplier receives the same payment. The statute was designed this way to eliminate cost based reimbursement that had rewarded the use of liquid systems. In a short time after the passage of the "six point plan" the use of concentrators shot upward and the use of the more costly liquid systems dropped. There was no clinical reason for this shift. It occurred, regardless of what the physician had prescribed. "We only do concentrators" became a popular refrain of suppliers when queried by physicians or patients who suddenly found the concentrator replacing the previous system.

It does not take a strong background in mathematics to determine that the profit margins for a concentrator are very attractive to suppliers. And, for understandable, **BUT WRONG REASONS**, the VA also noted the relatively low cost of concentrators. The VA began a competitive bidding process for providing their constituency with concentrators, regardless of the medical need of the patient. A single concentrator with a maximum 50 foot tether meets the medical needs of no more than 15 - 20% of the Medicare beneficiary population. We seriously question whether it meets the medical needs of the VA population.

The COPD population is increasingly mobile, thanks to innovations in oxygen delivery systems. A portable oxygen system that allows the COPD patient to leave his/her house and visit friends, do grocery shopping, and numerous other activities of daily living outside the home is an integral part of the Medicare home oxygen benefit. Not so with the VA. The typical VA contract that we are familiar with, again, meets the medical needs of a very small portion of the truly homebound, probably bed bound COPD population.

Furthermore, a strong inference of the OIG report focuses on sheer overutilization of oxygen therapy. NAMDRC pushed HCFA to adopt specific objective medical criteria for a Medicare beneficiary, documented on the Certificate of Medical Necessity, in order for oxygen to be a covered supply. The criteria are well documented in the medical literature. Therefore, overutilization can occur only when fraudulent 484s are submitted by a supplier, and all parties to such a fraudulent submission, including physicians, should be prosecuted vigorously.

While there may be a tendency to note the significantly higher rates of oxygen consumption in the United States as compared to other countries, we would cite the following: "Patients who qualify for long term oxygen therapy are being identified earlier before advanced stages of lung disease occur. There is greater awareness of the indications for long term oxygen therapy among physicians and allied health professionals and a wide availability of suppliers to provide the service and equipment. Mechanisms for reimbursement are readily available for most patients who qualify for home oxygen therapy.

Since the indications for long term oxygen therapy and requirements for reimbursement have been well defined in the United States, it is increasingly unlikely that home oxygen therapy is prescribed unnecessarily, and more patients who would benefit from oxygen therapy are able to receive it. Failure to identify patients who might qualify for therapy and the lack of financial resources, equipment and suppliers are reasons for less use of home oxygen therapy in many other countries."[1]

NAMDRC fully acknowledges there is little question regarding Medicare payment for concentrators. It is too high. With the actual acquisition cost to a supplier for a concentrator in the $800 - $1100 range, the current monthly payment is inflated. Liquid systems, on the other hand, are less attractive to suppliers because of higher maintenance/service costs. Regardless of the clinical appropriateness, concentrators are the modality of choice for many suppliers, a decision driven by dollars, not medical appropriateness.

THE SOLUTION: As much as we believe that the Medicare program has absorbed an inordinate portion of cuts the past 15 years as the Congress has reckoned with budget matters, it seems truly fruitless to attempt to convince Congress to find other sources of cuts. We genuinely believe that we have absorbed more than our fair share of cuts since 1981 and believe that additional cuts, regardless of the political popularity, eventually reduce the care, the quality and access of Medicare beneficiaries.

[1] O'Donohue WJ. Jr., Plummer AL Magnitude of Use and Cost of Home Oxygen Therapy in the United States, Chest 1995; 107: 301-302

So, for the sake of discussion, let's assume that the Congress, in its infinite wisdom, reduces all oxygen payments 3%. Based on current law, that still leaves a definable pot of money for home oxygen therapy. We believe that pot of money ought to be redistributed *within the various oxygen modalities*, reducing payments for concentrators and raising payments for liquid systems, *maintaining budget neutrality based upon the reduced pot of money*. Because concentrators account for the vast majority of the Medicare home oxygen therapy benefit (see attached data from HCFA), a 20% reduction in concentrator payments can be used to boost liquid payments approximately 50%. Our rationale for this approach is both medically and fiscally sound. Based upon preliminary conversations with the Health Care Financing Administration, together we believe that this is a workable cost saving solution.

One important issue raised by the OIG study, however, should be addressed by the Congress, particularly if the Congress is serious about saving money while continuing to provide home oxygen therapy for approximately 500,000 Medicare beneficiaries. That issue is the question of service and the total absence of standards in the area of home oxygen therapy. Congress must mandate appropriate standards for suppliers to assure that a supplier complies with the specific modality of oxygen cited on a physician prescription. As with any prospective payment system, there must be safeguards to

For 1993 HCFA paid (i.e., allowed charges) the following amounts of oxygen:

Stationary-Rental-Gaseous O_2-1 unit = 50 cu. ft.	$	15,319,055
Stationary-Purchase-Gaseous O_2		15,351
Portable-Purchase-Gaseous O_2		5,411,404
Portable-Rental-Gaseous O_2		80,707,053
Portable-Rental-Liquid O_2		28,358,944
Portable-Purchase-Liquid O_2		253,487
Stationary-Rental-Liquid O_2-1 unit = 10 lbs.		170,081,107
Stationary-Purchase-Liquid O_2		46,489
Gaseous O_2-Owned system-1 unit = 50 cu. ft.		608,990
Liquid O_2-Owned system-1 unit = 10 lbs.		755,999
Portable-Gaseous O_2-1 unit = 5 cu. ft.		442,986
Portable Liquid O_2-1 unit = 1 lb.		31,573
O_2 Concentrator-High Humidity-244 cu. ft.		1,927,844
O_2 Concentrator-High Humidity-488 cu. ft.		39,318
O_2 Concentrator-High Humidity-over 1952 cu. ft.		8,974
O_2 Concentrator-$\leq$ 2 L/Min.		269,038,396
O_2 Concentrator-2-3 L/Min.		209,048,031
O_2 Concentrator-3-4 L/Min.		118,447,124
O_2 Concentrator-4-5 L/Min.		214,632,398
O_2 Concentrator-$\geq$ 5 L/Min.		62,821,678
O_2 and H_2O Vapor Enriching with Heater		3,159,829
O_2 and H_2O Vapor Enriching without Heater		3,475,578
TOTAL		**$1,169,312,553.00**

STATEMENT OF PETER J. FERRARA
SENIOR FELLOW
NATIONAL CENTER FOR POLICY ANALYSIS

Medicare faces an overwhelming financial crisis. The latest annual trustees' report for the Hospital Insurance (HI) portion of the program shows that it will likely fall short of funds to pay promised benefits within 5 or 6 years. Moreover, even before then, rapidly growing annual deficits in the HI program will begin adding large amounts to the total Federal deficit. By 2000, the annual deficit in HI will be over $40 billion, increasing the total Federal deficit by that amount.

The Federal government's general revenue contributions to the Supplementary Medical Insurance (SMI) portion of the program will also have to soar rapidly in order to pay all promised benefits. By 2000, the annual general revenue contribution to SMI will climb to about $100 billion. Counting this along with the deficit in HI, Medicare will be adding almost $150 billion to the total Federal deficit in 2000, about three-fourths of the total Federal deficit today.

Over the long run, the financial gaps in Medicare just grow ever wider. By the time those entering the work force today retire, payroll tax revenues under the government's intermediate projections will be sufficient to pay only about 30% of promised HI benefits. Paying all promised benefits to these workers would require an increase of over 3 times on the total HI payroll tax rate, from 2.9% today to almost 10% in 2040 and beyond. By comparison, the total payroll tax rate for Social Security, including retirement, survivors, and disability benefits, is 12.4% today.

Under so-called pessimistic projections in the latest annual trustees' report, current payroll tax rates would be sufficient to pay only about 16% of promised HI benefits when today's young workers retire. Paying all promised benefits to these workers would require an increase of almost 7 times in the current HI payroll tax rate, from 2.9% today to 20.26% in 2040. The HI payroll tax rate alone would then be over 50% higher than the total payroll tax rate for Social Security today.

The general revenue financing burden for SMI would similarly skyrocket. By the time today's young workers retire, this annual contribution would be $340 billion to $485 billion in constant 1995 dollars, under the intermediate to pessimistic projections.

Moreover, financing all promised Medicare benefits would require an equivalent increase in the monthly premiums paid by the elderly for SMI. Under the intermediate assumptions, by the time today's young workers retire, premiums in constant U.S. dollars would have to increase more than 9 times over today's level. Even if we account for higher incomes in the future, the premiums would have to be more than 4 times as large relative to income as today. In other words, the premiums would be of the same relative magnitude to incomes of the future as monthly premiums today of $185 per beneficiary, or $370 dollars per couple, amounting to $2,200 per year per individual, or $4,440 per year per couple.

Under the "pessimistic" projections, premiums would have to increase more than 13 times in constant 1995 dollars by the time today's young workers retire. Or, accounting for higher incomes, the premiums would have to be almost 9 times as large relative to income as today. In other words, the premiums would be at the same relative magnitude to incomes of the future as monthly premiums today of $360 per beneficiary, or $720 per couple, amounting to $4,320 per year per individual or $8,640 per year per couple.

Bad Solutions

Means Testing. Some would attempt to solve these problems by means-testing Medicare. Benefits would then be reduced, or possibly eliminated altogether, as income rises. But such means-testing would effectively constitute a tax on savings, investment and work. Those who save and invest more during working years to have a higher income in retirement would find that higher income causing a reduction in Medicare benefits. Those who work and earn more during retirement years would be similarly penalized. This effective tax burden would result in less savings, investment, work, and economic growth.

Forcing all the reductions on only one small part of the population would also be unfair. In addition, this approach would never produce enough savings to completely solve the long term problems of the program.

HMOs for Medicare. Another approach is to push the elderly into HMOs to receive their Medicare benefits. At a minimum, the elderly would be offered some incentive that would be available only if they choose to receive their Medicare benefits

through an HMO. The HMOs would then be expected to produce cost savings for Medicare.

This amounts to a policy to utilize HMOs to effectively ration health care for the elderly. President Clinton's health care reform plan last year attempted to adopt the same policy, which proved to be highly unpopular with the general public. Such rationing is wrong because the government would be restricting the essential freedom of citizens to choose and control their own health care. Any choice of HMOs for Medicare benefits must be on a level playing field with all other options.

Increased Medicare Premiums. About 25% of the costs for SMI, also known as Medicare Part B, come from premiums paid by the elderly. These premiums have already increased to stiff levels, amounting to about $500 per year per retiree, or about $1,000 annually per elderly couple.

Some now propose to raise these premiums two times for higher income retirees. But this is just another way for the government to grab even more money for a failed program, without addressing its fundamental problems. It would discourage savings, work and economic growth the same as described above for means testing. It would also again unfairly force the burden on just one small group. Nor could this approach ever remotely produce enough revenue to solve the program's problems. Indeed, the premiums under current policy would already grow to unmanageable levels for the elderly, as described above.

In the late 1980's, the government increased Medicare premiums mostly for the higher income elderly to fund new catastrophic benefits under the program. The elderly responded with a political firestorm that forced repeal of the taxes and the benefits. What will the elderly say when the premiums are similarly raised, but without the new benefits?

A Proposal for Reform. There is a better way. Medicare benefits can be reformed to ensure that the program spends no more than the amount of revenue coming in each year. Moreover, the program's revenues can be reformed to ensure that they impose no more than a reasonable manageable burden.

The first component of such reform would be a commitment to hold the Medicare payroll tax to its current rate of 2.9%, without any increases to address the program's long term financial deficit. The payroll tax is already far too high, excessively burdening employment with a discouraging levy.

Along with this, the annual general revenue contribution to Medicare Part B would be capped to grow no faster than the rate of economic growth. The monthly Medicare premiums for the elderly would also be capped to grow no faster than income growth. This would ensure that Medicare financing would not become a greater relative burden over time.

The Medicare benefit structure would then be changed by adding a front end deductible automatically adjusted each year to be large enough to equalize expenditures with the program's revenues. Beneficiaries would have to bear initial expenditures each year up to this deductible amount before receiving any Medicare benefits. Retirees could pay for such expenses directly, or purchase private insurance to cover some or all of the added deductible.

This deductible amount would start small and grow slowly over time, perhaps amounting to a few hundred dollars after the first 10 years or so. By the time today's young workers retired, the amount would likely have grown to a few thousand dollars per year in today's terms. But these workers would have many years to prepare for this development, through increased IRA savings, for example, or other means of providing for additional retirement income.

The key to this proposal is to recognize that Medicare revenues and benefits would still increase in real terms at the rate of real economic growth over time. They would just grow no faster than such real growth. Surely, given the persistent Federal deficit, and the overwhelming long term Medicare financial crisis, we cannot increase benefits even faster than that. If the economy grows faster, or health costs grow more slowly, the added deductible would automatically grow more slowly over time.

Several additional features would make such reform more appealing. IRAs should be expanded so that long term savings to pay for the added deductible would be more feasible. Vouchers could be provided to the poor sufficient to enable them to purchase private insurance to cover the added deductible. Medicare benefits could be provided without the current limits that leave the elderly exposed to the most catastrophic expenses. This would cost very little overall, but would allow the elderly to focus on financing only the more routine front-end expenses. If the Medicare retirement age were expanded slowly over time to age 70, then the amount of the increased deductible would be substantially reduced. In addition, under the reform, the elderly would avoid the burden of higher Medicare premiums relative to income over time.

Perhaps most importantly, the elderly should be allowed to take their per capita share of Medicare funds and use it to contribute to a Medical Savings Account combined with high deductible catastrophic insurance, or buy any other private insurance or HMO coverage of their choice. This would allow the elderly to each choose the benefits and other features they prefer. The cost control incentives of MSAs would substantially reduce

Medicare expenses over time, reducing the level of the added front-end deductible. Moreover, through this option, the elderly could escape the rationing and reduced quality of care that is increasingly being imposed on them under Medicare.

Under this reform, Medicare would add no more to the Federal deficit in the future than today, because future benefit growth would be tied to revenue growth. Indeed, the reform would produce enormous budget savings over time. Remarkably, the long-term Medicare financing crisis would be solved as well, as Medicare would spend no more each year than it takes in. Over time, Medicare would be reformed into a more rational program protecting the elderly against high medical expenses, but not attempting to pay for all routine expenses. In addition, the higher deductibles and MSAs are the best possible means of controlling rising health costs under Medicare.

Such reform would admittedly be highly controversial politically. But in the context of the Federal deficit and the overwhelming long term Medicare financial crisis that requires fundamental reform, in any event, this proposal is the best of the alternatives, politically as well as economically. It protects workers from increased taxes while still allowing real benefits to grow with the economy, and providing maximum freedom of choice, and other important highly appealing advantages for the elderly. Opponents would have to argue that taxes must be increased so that real benefits can grow more rapidly than the economy, not a generally appealing proposition.

National Committee to Preserve Social Security and Medicare

Statement of

The National Committee to Preserve Social Security and Medicare

The National Committee to Preserve Social Security and Medicare, a grassroots education and advocacy organization representing millions of senior Americans, submits this statement for The Subcommittee on Health of the Ways and Means Committee hearing on the subject of "Controlling Growth in Medicare Costs" and "Medicare Reform and Innovation." The National Committee's mission is to protect, preserve, promote and ensure the financial security, health, and the well being of maturing Americans of current and future generations.

Before Medicare, health care for a retired or disabled person depended on individual wealth or the generosity of family, friends, physicians or local health care institutions. When this wealth and generosity were not available, retired and disabled people often went without care when they needed it most.

Medicare has enhanced life for millions of Americans and their families. While increasing productive years of life for beneficiaries, Medicare has also helped support the development of health care facilities and medical education. In the years since 1966, when Medicare was implemented, much has been learned about reversing life-threatening illness, relieving pain and recovering lost functional capacity. Americans of all ages and degrees of health are benefitting from this program, because it protects whole families from much of the cost of acute health care for senior or disabled family members.

Medicare is working very well. To access to quality care and choice of provider, "Do no harm!" should be the guiding principle as we consider possible Medicare "reforms". Citizens want prudent spending but we also want the insurance we pay for to be in place when we need it. In general, large systems require continuous evaluation and refinement, and Medicare is no exception. "Innovations" may be found that will increase efficiency, hold down cost and eliminate waste, but let us not jump at just any strategy that is advertised as cutting cost. We must ask "whose cost is being cut?" and "who benefits from these cuts?" Will Medicare really pay out less? Will individual beneficiaries get less choice, coverage and quality of care?

In seeking ways to improve Medicare this nation must always keep the individual beneficiary in focus. Medicare's 36 million beneficiaries are overwhelmingly satisfied with this insurance which assures portability, renewability, wide choice of providers, does not exclude preexisting conditions, does not change the ground rules of coverage when people are sick and need care and gives the individual standing to dispute decisions about coverage. Some of the changes being promoted as Medicare reforms would diminish these protections.

Preserve the integrity of the system

Subsidies for low income beneficiaries make sense, but income-based premiums do not. Medicare is not a welfare program. The general fund, which partially subsidizes Part B, has already been progressively financed by individual income taxes. Beneficiaries pay a premium in addition. If premiums are to be income-based, the value of the insurance will undoubtedly diminish in the public eye and Medicare may lose its broad support.

We should avoid new co-pays that will involve new administrative costs and erect further barriers to seeking needed medical care. Medicare beneficiaries already pay much of their health care out-of-pocket and existing co-pays keep some from getting care. If new co-pays are imposed, fewer low income people will seek care and medigap premiums will increase. Please look instead at the prices of services, and ask what a fair price should be.

Control inflation in private sector health care

Increased Medicare expenditures reflect the desired outcomes of the program: longer lives and more beneficiaries. But they also reflect the inflation in private sector expenditures driven by entrepreneurial pricing of services. Medicare accounts for only 17% of the nation's health care expenditures, but is serving the populations that need the most health care. Medicare may pay less than private insurers because of its large volume of

claims and careful reimbursement policies, but prices in the private market are continually driving up charges.

If private sector health care inflation can be checked, Medicare will be able to serve its beneficiaries more economically and other people will be better able to afford private insurance. Many complicating factors can interfere. One new concern is that mergers of health care corporations may place monopolistic control of provider rates in the hands of a few companies. Anti-trust action is needed to prevent this.

Health care consumers do not have the expertise to judge their own health care requirements and the relative risks of cost saving choices. Health care is not a typical market commodity because it involves specialized knowledge beyond that of most consumers. Often medical care is not optional because basic survival is at stake and as a result people do not have the luxury of shopping around for care. Citizens need the protection of some basic cost and quality controls, as they do with necessary utilities.

Reduce cost within the Medicare program

Controlling fraud can save much more than it costs. Strategies to reduce fraud have been developed by the HHS Office of the Inspector General (OIG), and strides are constantly being made, with a reported $80 savings for every dollar invested. The Semi-annual Report of the Inspector General April 1, 1994 to September 30, 1994 lists hundreds of millions of dollars of unnecessary Medicare expenditures, including an estimated $85 million that private insurers should have paid, and an estimated $47 million paid for physical therapy that was not medically necessary. However, greater funding is needed for more OIG investigations as well as routine audits to compare services or equipment billed with those received, to examine excessive utilization of services, variations in quality, and unreasonable pricing. Carriers and intermediaries must be held responsible for much of this. We hope that unwarranted charges for supplies now are more likely to be intercepted with reimbursement authority consolidated in four regional carriers, but inconsistencies and abuses are still a problem. Providers and health care professionals should also be expected to report questions of inappropriate pricing, and billing.

Other suggestions for Medicare Savings

Merging Medicare Part A and Medicare Part B could reduce administrative costs and perhaps eliminate double charges. Part B billing for services and supplies that should be covered by Part A reimbursement should be examined in nursing homes certified under Medicare and Medicaid.

Continuous evaluation of pricing of services is needed to appropriately control Medicare reimbursement rates for providers. Particularly in the areas where reimbursements are cost based

Stricter criteria for utilization of covered services may be needed and justification required for frequency of visits. Medicare subsidies for institutional capital investments and professional education should be reevaluated.

Skilled Nursing Facility (SNF) increased utilization and growing exceptions to the SNF cost limits should be evaluated in light of the care actually delivered. Where exceptions are warranted, a mechanism is needed to assure reimbursements are appropriately used for direct patient care. If prospective payment is instituted for Skilled Nursing Facilities this mechanism will also be needed. Transferring patients from hospitals to nursing homes to save Medicare dollars is not justified unless the care provided is excellent.

Hospital out-patient increased utilization is the area of greatest growth in Part B expenditures. This is an area requiring greater scrutiny. Medicare's basis for reimbursment should be reevaluated and beneficiary co-payments should be based on Medicare reimbursments, rather than the hospital charges.

Home Health Agency growth in utilization and Medicare expenditures should be evaluated. More acutely ill patients are being cared

for at home to save hospital costs. This health care market is an area of greatly increased entrepreneurial activity. Quality of care, acceptability to beneficiaries and family caregivers and pricing of services should be examined.

"Managed care" for Medicare beneficiaries

Managed care companies prosper by enrolling healthier and younger people, emphasizing preventive care, and limiting utilization of acute care services. They have little experience in caring for the populations that need most acute and post-acute care - older seniors and the disabled.

Medicare savings anticipated by managed care may be exaggerated. Currently Medicare does not save money according to recent evaluations. Some adjustment to the reimbursement rates may change that but might also reduce the incentive for HMOs to sign up Medicare beneficiaries. It is hard to compete with Medicare which pays providers less than most HMOs.

Managed care options should be made available to Medicare beneficiaries who might want them for greater benefits or lower out-of-pocket cost, as long as federal standards, safeguards and appeals rights are assured. There should also be an assured option for seeking care outside the plan when special expertise is needed to treat a life or occupational threatening situation. Perhaps Medicare could establish a financing pool for covering this.

Beneficiaries should not be required to join managed care plans. Medicare's pre-payment for care per person is based on average costs in a geographic area. How can a managed care plan survive under such an financial arrangement other than by limiting needed services to the more costly patients? Elderly, frail people should not be subjected to prolongued waiting for services. They should not have to give up Medicare full acute care, Skilled Nursing Facility or Home Health coverage because they joined a managed care plan. Reportedly some HMOs set arbitrary limits on days of service, that significantly cut needed rehabilitation services that are well justified under Medicare's criteria.

If beneficiaries are going to be involved in managed care programs the plans must be required to meet federal standards of access, structural components, quality of care, patient information and marketing.

Information about all providers in a plan must be given to prospective enrollees, including in-patient and out-patient institutional facilities, primary and specialist physicians and other health care professionals. A beneficiary should have the option to choose a plan that serves his special needs (a person with diabetes should be able to choose a plan with diabetes experts; a heart patient might want a plan with experienced cardiologists and heart surgeons). Also, prompt notice to beneficiaries of changes in participating providers must be given in advance of a provider's change of status or leaving a plan.

Information about geographic location and hours of availability of all provider institutions, emergency facilities, participating physicians and other health care professionals must be made clear.

Information about out-of-pocket costs must be clearly spelled out to prospective and new enrollees as well as information about a plan's procedures and policies for holding down costs (e.g., incentives for physicians re limiting utilization, referrals to specialists, tests) must be explained to beneficiaries.

Choice of primary provider and the ability to change primary providers must be assured.

Provision must be assured for retirees to be able to receive care in different parts of the country, as many retirees change residence with the seasons.

Grievance and appeals processes must assure review within a few hours for denials of requested urgent care. Information about how to use grievance and appeals steps must be provided to all enrollees. Access to HHS hearings and federal court review appeals must be assured for Medicare beneficiaries.

Medicare Select, a lower-cost Medigap program, was designed to increase participation in managed care. Enrollees in this 15 state demonstration program agree to receive care within preferred provider

networks. They may use other Medicare providers, but sacrifice Medigap coverage when they do. Medicare Select preferred provider networks are not governed by federal standards and appeal rights that offer some protection to Medicare beneficiaries in other managed care arrangements. It would be adviseable to require federal protections of beneficiaries as required with other managed care arrangements. Safe harbor legislation has allowed discount deals waiving collection of co-payments. It is not clear that care is being managed in any way that cuts Medicare expenditures. Medicare Select providers should also bear some risk if beneficiaries are dissatisfied and want to enroll in a traditional Medigap plan. Congressman Stark's proposed Medicare Beneficiary Protection Act of 1995 will institute needed protections in the Medicare Select program and wisely extend the demonstration period to permit further evaluation. It also strengthens protections for Medicare beneficiaries in other managed care options.

The National Committee supports all efforts to assure the solvency and integrity of Medicare to best serve beneficiaries.

We are concerned that in the rush to transform and restructure Medicare senior citizens will wind up with less choice and higher costs. In the future, further expansion of Medicare coverage will be needed as new knowledge and technology improves health care capability. Eventually, Medicare coverage should include an out-patient prescription drug benefit and certain preventive screening measures.

STATEMENT TO THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

Subject: Hearing held on February 7th on Medicare premiums

Person submitting statement
Gerald S. Parker
11 Shore Acre Drive
Old Greenwich, CT 06870

Capacity
Retired citizen, age 78, with 30 years experience in health insurance management with The Guardian Life Insurance Company of America

Representing
Himself only

The objective of the hearings should be to reduce the rate of growth of the cost of Medicare to the taxpayers. The need to do this does not seem to penetrate the consciousness of the several organizations purporting to represent senior citizens. However, all seniors are not ignorant of the need to avoid bankrupting the country.

One obvious place to start is the Part B deductible. Raising that is, in effect, increasing the premium. It must be close to 15 years since it was raised to $100 from the $50 that had then been in effect since 1966. It should be raised to $200 or $300 now and probably indexed every few years thereafter.

With respect to Part A, it's already indexed annually, and I see no benefit pattern modification that would be helpful in saving money and practical to administer. That leaves means testing.

The professional advocates for the elderly keep trumpeting the fallacy that " You paid for these benefits and earned them. Don't let the Congress take them away from you." To be fair, much of the blame for that misunderstanding lies at the door of Congress, which made that sort of assertion for years in its determination to capture the elderly vote. But it was never true, never intended to be true, and is now a complete falsehood of which the organized advocates should be ashamed. I am sure they know the truth!

It seems to me that a reasonable approach would be to make a charge, deductible from Social Security monthly pension benefits, to people who can afford it. It could be levied on taxable incomes of, for example, $50,000 or more and perhaps graded up somewhat for those with taxable incomes exceeding $100,000, $150,000 and $200,000. Charges could be made for Part A, and perhaps for Part B also if it is needed. And at that level, impoverished elderly and the lower income half of the "middle class" would escape most of it. If taxable incomes would be too difficult to keep track of, adjusted gross incomes could be used, beginning at somewhat higher levels.

Miriam J.Ramirez de Ferrer MD
President, Puerto Ricans in Civic Action

Statement: Contract With America
Sub-Commitee on Health
Hearings on the " Medicare Reform "
February 10, 1995

Mr. Chairman and Honorable members of this Committee:

We respectfully request to have the following testimony introduced in the written record for the February 10m 1995 Medicare Reform hearing.

This testimony, which was presented to the Sub-Committee on Welfare of the Ways and Means Committee during the February 2, 1995 hearings on Welfare Reform, are our our views regarding what should be the impact of the Contract with America on Medicare for Puerto Rico.

As a physician, I have devoted my medical career to give medical services to the needy in Puerto Rico as an Ob-Gyn for the Health Department. The great majority of my patients are poor people, whose incomes fall below the poverty line, and whose means of support come from welfare programs. These 26 years have given me the opportunity to feel first hand the needs of the people who will be affected by the proposals in the Contract with America.

- **But, you are right ! ....The American Welfare system is broken.**

Puerto Rico endures the same sad story as every other state. It is sad that $14.6 billion dollars in federal funding and tax credits have not markedly changed the quality of life for those it intended to.

Federal programs have created a welfare culture in major United States cities. These have held hostage generations of families in a web of overlapping federal handouts which promote dependency, illegitimacy, unemployment and anti-ethical values.

The hopes of many are with this new Congress. We encourage you to practice radical surgery to stop the billion dollar hemorrhage of federal funds throughout the Nation. State and territorial governments are hammered by the myriad of bureaucratic rules for over 300 federal assistance programs. What a waste ! It would be vastly more efficient to consolidate these into five or seven block-grants with clear guidelines.

Miriam J.Ramirez de Ferrer MD
President, Puerto Ricans in Civic Action

Remember the conservative revolution of the Reagan years, with the President's "state's rights agenda" ? This Congress should learn from the block grant that replaced the Food Stamp Program. It was the outcome of the Reagan conservative agenda.

The block-grant did not work because it was the only assistance program. Partial welfare reform, without the extension of all other programs, failed to give Puerto Rico the edge to produce the shining results of President Reagan's vision of empowering local government. We endorse block grants, but with clear federal guidelines

In order to eradicate the conditions which trap welfare recipients in a state of cultural and economic poverty, we urge Congress to establish clear guidelines to expand the JOBS programs, and to limit cash benefits to a specific number of years. We support the creation of empowerment or enterprise zones to help our major cities generate more jobs.

We support a complete restructuring of the American Welfare system. Put in place a system that promotes work, education, self sufficiency and family values in all the Nation. including Puerto Rico. Include the 3.6 million United States citizens in Puerto Rico, because we suffer doubly under the ill-focused federal assistance programs that are underfinanced.

- **The Federal "Safety Net "for United States citizens in Puerto Rico is incomplete.**

Unequal federal funding limits the benefits of former President Reagan's "Safety Net" for United States citizens, as more than 200,000 senior Americans in Puerto Rico live in substandard conditions. Congress established the Supplemental Security Income program (SSI) in 1972 to guarantee a minimum level of income to needy aged, blind, and disabled persons, which should include all U.S. citizens, and exclude aliens without established legal residence.

However Congress did not expand SSI to Puerto Rico, since the program is funded from the general US Treasury Fund and we do not pay full Federal Taxes. In contrast, we qualify for all other Social Security entitlements, as we have been paying Social Security contributions.

Miriam J.Ramirez de Ferrer MD
President, Puerto Ricans in Civic Action

We urge Congress to rectify this unequal treatment, and to finance the extension of the Supplemental Security Income by extending the Federal Income Tax to Puerto Rico, and phasing out the archaic practice of "cover overs" of Federal custom duties and excise taxes to the Puerto Rico Treasury.

- **We are ready to assume equal responsibilities.**

The United States citizens in Puerto Rico are ready to assume increased responsibilities. We already contribute **$2.2 billion** in Social Security taxes. We should not be treated different than the residents in any other states. In addition to unequal treatment under the Supplemental Security Income, the United States citizens in Puerto Rico are treated unequally in the Medicaid, Medicare, Aid to Families with Dependent Children and Food Stamp programs.

We want equal treatment through the Contract Proposal Welfare Reform, re-focusing our goals on self - sufficiency, work fare and family values.

WE PROPOSE THAT CONGRESS:

1. **Gradually extend the federal tax system to Puerto Rico over a 5 year period, while during the same time, phase in all federal programs, in order to shift some of the burden of operating our great Nation to the United States citizens in Puerto Rico.**

2. **Phase out the cover- overs of Federal custom duties, fees, and excise taxes and the Possessions Tax Credit over a five (5) year period.**

3. **Establish economic incentives such as President Reagan's Enterprise zones to help reduce unemployment in all affected areas. (Empowerment zones.)**

Miriam J.Ramirez de Ferrer MD
President, Puerto Ricans in Civic Action

THE UNITED STATES WILL BENEFIT FROM THE POSITIVE EFFECTS OF EXTENDING THE FEDERAL INCOME TAX SYSTEM TO PUERTO RICO.

1. It will help to balance the budget:

With the proposal for a Balanced Budget Amendment, the U.S. taxpayer will find some relief when we share the fiscal burdens through our contributions. As it stands presently, there is no relief in sight for the US taxpayer, but with the Contract with America, all U.S. citizens can help carry the load and realize the benefits of a sound fiscal future.

According to the Congressional Budget Office, extending the federal tax code to Puerto Rico would result in more than **$2 billion** in annual federal revenues. Additionally, the complete phase out of Section 936 tax credit would produce and additional **$2 billion**, according to the latest tax expenditure estimates of the Joint Committee on Taxation. This would result in a total of approximately **$4 billion** annually.

The next table shows the amount of federal revenues that will be collected in Puerto Rico in the years 1999 and 2000, after the extension of the federal tax system:

	1999	2000
Total change in Federal revenues from Puerto Rico sources (**millions**)	$2,251	$2,244
New excise taxes	$395	$414
Custom duties	103	171
Rum excise tax	265	268
Individual income tax	809	846
Tax on Puerto Rico Corporations	519	545

(Source: Congressional Budget Office, April 1990)

Miriam J.Ramirez de Ferrer MD
President, Puerto Ricans in Civic Action

2. Working families in Puerto Rico, who earn mostly wages would pay lower federal income taxes than their current local tax burden.

The Puerto Rico taxpayer pays more state income tax than their fellow citizens in most of the other States of the Union. We are not equally treated in the U.S. Budget, so the government of Puerto Rico must levy high local income taxes in order to give services to the people.

Since federal income tax has not been extended to Puerto Rico, the middle class will not benefit from those changes to the tax return proposed by the Contract with America. The extension of the federal income tax system will allow our working families to enjoy the benefits of higher tax credits for children, personal exemptions, and lower tax rates. The Contract's capital gains tax cut would also help spur investments and the economy in the island.

It would also allow Congress to extend the Family Reinforcement Act provisions in the Contract with America to Puerto Rico.

3. Thousands of high income individuals who now escape taxes legally through tax loopholes in the local tax system would have to pay federal income taxes.

For example, interest on mortgage backed securities, known as Ginnie Maes, and interest on U.S. Treasury bonds are exempted from local income tax, but not federal income tax. Investors in Puerto Rico earned about $100 million in interest income on these instruments, and nearly $1 billion in manufacturing and tourist enterprises which receive partial tax exemption under local income tax laws.

Miriam J.Ramirez de Ferrer MD
President, Puerto Ricans in Civic Action

4. United States taxpayers will be pleased to know that all who benefit from the United States budget, will have to pay their share. " If you play, you pay."

5. Puerto Rico's "burden sharing" will restore the dignity of the United States citizens in Puerto Rico.

6. It would bring justice to the hard working families who live on wages which are subject to withholding source and who carry the burden of paying for the Puerto Rico budget.

The burden will be shared by all, as the Internal Revenue Service extends its enforcement power and uncovers the extensive underground economy in Puerto Rico. As loyal American citizens, people will recognize the importance of filing returns. (Read: Federal liability)

7. Both the Governor of Puerto Rico, Dr.Pedro Rossello and the Resident Commissioner, Carlos Romero Barcelo Esq., have publicly endorsed this concept. (See newspaper clipping)

President Reagan's state's rights conservative agenda got its start in a model block-grant program to Puerto Rico; let's complete the Reagan revolution with full application of the provisions of the Contract with America in Puerto Rico.

POSITION PAPER OF
HONORABLE CARMEN L. FELICIANO DE MELECIO
SECRETARY OF HEALTH
OF THE COMMONWEALTH OF PUERTO RICO
BEFORE THE SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS

INTRODUCTION

Health care is the second largest service sector within the Puerto Rican economy, the first being education services. The salary contribution generated by this sector amounted to $359.6 million in 1993. The health care industry comprises over 25% of the jobs and compensation of the service sector. During 1992, the health care industry accounted for 41,460 jobs in the hospital sector, or 70% of the labor force of this industry. Furthermore, this sector represents about 20% of the labor force of the entire Puerto Rican service industry.

During 1991, the federal minimum wage went into effect in the health care industry. In addition, the local mandatory decree applicable to the professional services industry raised the minimum wage to $5.00 per hour. These changes had a significant impact on the health care industry costs and is evidence of the industry's vulnerability to all changes, including changes in federal regulations as well as in other economic variables.

In conclusion, the health care industry - and especially the hospitals - have two important roles in the local economy. First, the industry generates a significant number of jobs. Secondly, it fulfills its fundamental role of promoting and maintaining the health of the Puerto Rican population.

HOSPITAL FACILITIES

Puerto Rico has 77 licensed hospitals, of which 30 are public and 47 are private. Private hospitals include profit and not-for-profit institutions. Two of the private hospitals are currently closed.

For the period of October 1, 1991, through September 30, 1992, there were 384,345 patient admissions of which 243,244 were within the private institutions. During the same period, the private hospitals generated 50 admissions per bed, while the public sector generated 46. These figures indicate the importance of private hospitals to the Puerto Rico health care system.

FEDERAL PARTICIPATION

Puerto Rico has a special relationship with the United States concerning federal assistance, especially in respect to the Medicare and Medicaid programs. *In the case of Medicaid, Puerto Rico has the third largest Medicaid-eligible population because of its poverty level, yet it receives the lowest percentage of federal contributions.* This situation has placed a tremendous burden on the local government which is responsible for providing adequate care to the indigent population.

With regard to Medicare, Puerto Rico entered the Prospective Payment System in 1987, following lobbying efforts by the Puerto Rico Hospital Association and the government of Puerto Rico. Upon approval by Congress of the Prospective Payment System for Puerto Rico, a special formula was designed by Congress that provided a standardized amount determined as follows: 75% of the Puerto Rico hospitals historic average cost per discharge and 25% national average.

This formula was fixed from the beginning, unlike U. S. hospitals which went through a three year transition before reaching the 100% national rate. At the time, the Hospital Association and the health care community called attention to the unfairness of the proposition. Furthermore, *the formula has been challenged not only on the basis of its unfairness, but on the basis that it does not accurately reflect the cost structure of hospitals in Puerto Rico,* especially when confronted with public hospitals costs.

INACCURATE PPS BASE YEAR

One of the main concerns is that *the base year selected for the formula did not accurately reflect hospitals' costs for various reasons,* among which are:

1. *Public hospitals failed to recognize all costs.* Examples of these are ownership and indirect costs, which were mostly omitted.
2. *Lack of a uniform charge structure* automatically deprived the public hospitals of 2% of their allowable costs, thus understating the costs used in determining the Puerto Rico Component.
3. *The labor component was determined from totally inadequate data* in which many contracted services were missing. In addition, labor rates were significantly lower because the minimum wage had not gone into effect in the health care industry until 1991.

In general, *the formula has built-in inequities whereby a hospital with a high salary structure is penalized, while a hospital with a low salary structure is rewarded.* This created poor incentives for the low salary structure hospital to increase salaries.

It is obvious that the information upon which the formula was constructed is inaccurate. This is evidenced by the fact that *the non-labor component of the DRG's formula is about 50% for Puerto Rico when compared to other regions in the United States.*

REGIONAL AND PUERTO RICO ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NON LABOR				
	Large urban areas		Other urban areas	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
New England	$2,840.62	$1,137.84	$2,795.63	$1,119.82
Middle Atlantic	2,592.46	1,038.44	2,551.42	1,022.00
South Atlantic	2,654.29	1,063.21	2,612.28	1,046.38
East North Central	2,892.31	1,158.55	2,846.52	1,140.20
East South Central	2,508.24	1,004.71	2,468.53	988.80
West North Central	2,711.20	1,085.99	2,668.26	1,068.80
West South Central	2,638.83	1,057.01	2,597.06	1,040.27
Mountain	2,621.88	1,050.22	2,580.37	1,033.59
Pacific	2,680.57	1,073.72	2,638.13	1,056.73
National	2,682.96	1,074.69	2,682.96	1,074.69
Puerto Rico	**2,416.27**	**503.53**	**2,378.02**	**498.56**

Puerto Rico is an island. Therefore, most of its products are imported from the U.S. mainland, which represents a tremendous source of business for U.S. enterprises. All items imported into Puerto Rico, with a few exemptions, are taxed from 6.6% up to 19%. In addition, overseas freight and incidental shipping and handling costs are significant. Consequently, it would be erroneous to assume that Puerto Rico's cost of materials, supplies and equipment to be equal or lower than similar costs in the mainland. Therefore, it would be impossible for the nonlabor related costs to be 50% lower.

PR WAGE INDEX COMPARED TO OTHER STATES

Arecibo, lowest in PR	.3798
Aguadilla, Highest in PR	.4758
Caguas	.4373
Ponce	.4518
San Juan	.4367
Mayagüez	.4533
Mississippi, lowest in US	.6577
California, Highest in US	1.4658

Another problem with the formula is the wage index applied to Puerto Rico. Puerto Rico's wage index ranges from .3798 to .4758. *If we compare Aguadilla's, Puerto Rico wage index (.4758), which is the island's highest, to Hattiesburg, Mississippi's wage index (.6577), which is the lowest in the U.S. mainland, we can observe a difference of .1819 or 38%.* If we also compare Aguadilla's wage index (.4758), with Oakland, California's wage index of 1.4658, which is the highest in the United States, we observe a difference of .99 or 208%.

FEDERAL CAPITAL PAYMENTS

We also need to emphasize another major difference between Puerto Rico and the rest of the states in regard to the payment methodology, specifically, the federal capital payments. This payment is computed by taking the DRG Relative weight multiplied by the Federal Capital rate. This factor is then multiplied by the Federal portion of Capital rate times the Geographic adjustment factor times the Large urban add-on (this last factor does not apply to Puerto Rico, at present). *The following are the major problems with the formula:*

1. The federal capital rate for Puerto Rico is $289.87 which, when compared to the national rate of $376.83, *represents a lower rate of $86.96 or 30%.*
2. The geographic adjustment factor (GAF) in Puerto Rico ranges from .5153 to .6013 as shown in following table. *These GAFs are substantially lower than that of next lowest geographic area defined by HCFA, which is Mississippi at .7506, which represents a difference of 25%.*

Geographic Adjustment Factor

Aguadilla, highest in PR	.6013
Arecibo, lowest in PR	.5153
Caguas	.5676
Ponce	.5804
Mayagüez	.5817
San Juan	.5670
Lowest in USA Mississippi	.7506
Highest in USA California	1.2994

As a result of the foregoing, the hospitals in Puerto Rico individually claim losses in their services to Medicare patients. This is demonstrated by accumulated statistics from the Medicare cost reports of the past several years. Following are some comparative statistics of Puerto Rico public and private hospitals.

GOVERNMENTAL HOSPITALS INPATIENT COST
COMPARED TO MEDICARE PAYMENT RECEIVED
FROM THE YEAR 1988 THROUGH 1992

	1988	1989	1990	1991	1992
Inpatient Cost	$31,085	$44,833	$51,934	$50,840	$53,581
Medicare Payment	$34,910	$55,074	$50,909	$62,547	$62,396

Note: 000's Omitted

PRIVATE HOSPITALS INPATIENT COST
COMPARED TO MEDICARE PAYMENT RECEIVED
FROM THE YEAR 1988 THROUGH 1992

	1988	1989	1990	1991	1992
Inpatient Cost	$84,594	$122,557	$127,875	$154,517	$175,463
Medicare Payments	$102,796	$130,017	$130,943	$153,604	$172,561

Note: 000's Omitted

As shown in the above table, during the period from 1988 through 1992 Medicare inpatient costs increased from $84,594 to $175,463 or about 200%, while Medicare Payments increased from $102,796 to $176,561, or about 167%. ***If this trend continues it will have a devastating impact on private hospitals.*** Please, refer to Exhibit I

MEDICARE PART B

The Health Care Financing Administration provides payments to physicians based on a physician fee schedule, which is determined by three factors:

1. A nationally uniform relative value (RVU).
2. A Geographic Adjustment factor (GAF) for each physician fee schedule area.
3. Nationally uniform conversion factor (CF) for surgical, nonsurgical and anesthesia services.

The Geographic Adjustment Factor (GAF) for a fee schedule area is equal to a weighted average of the individual geographic practice cost indices (GPCI), for each of the three components of a physician's service.

1. Work (estimated value of physicians time)
2. Practice expenses and overhead (office rent supplies, equipment, staff salaries and fringe benefits)
3. Malpractice expense

These indexes are combined into a Geographic Adjustment Factor which determines the proportion of payment for a service provided in a particular region. Thus, the formula is:

RVU multiplied by GAF multiplied by CF = Payment

Technically, RVU factors for each of the three resources used in providing the specific service (work, practice expenses, malpractice) are multiplied by a corresponding GAF factor for each of the resources (and then added together) before being multiplied by the conversion factor.

Example

For HCPCS code 42182, Repair Palate, performed in Des Moined, Iowa, in 1993 you would multiply
(1) the work RVU by the work GAF (3.87 x 0.997=3.86),
(2) the practice expense RVU by the practice expense GAF (3.56 x 0.966=3.44), and
(3) the malpractice RVU by the malpractice GAF (0.39 x 0.666=0.26).

These three factors would be added together (7.56) and then, multiplied by the conversion factor for surgical service ($31.962 in 1993), which equals $241.63. Every physician performing this procedure in the Des Moines, Iowa area would be paid $241. 63 in 1993.

THIS SAME EXAMPLE IN PUERTO RICO WOULD BE AS FOLLOWS:

Example

For HCPCS code 42182, Repair Palate, performed in Puerto Rico, in 1993 you would multiply
(1) the work RVU by the GAF (3.87 x .882=3.41),
(2) the practice expense RVU by the practice expense GAF (3.56 x .763=2.72), and
(3) the malpractice RVU by the malpractice GAF (0.39 x 4.66=0.18),

Add them together (6.31) and multiply the sum by the conversion factor for surgical services ($31.962), which equals $201.68. *Every physician performing this procedure would be paid $201.68 in 1993, a difference of $39.95 (20%) less than Iowa.*

During the year 1994, Puerto Rico was the geographic region with the lowest payment rates. This was due to the fact that two of the three cost component index values for Puerto Rico were the lowest. During the year 1995, Puerto Rico is the geographic region with the lowest cost component.

Puerto Rico's GPCIs Compared to Lowest Values
1994

	Work	Practice Expense	Malpractice	GAF
Puerto Rico	0.882	0.763	0.466	0.813
Lowest in US	0.942 (Vermont)	0.838 (Mississippi)	0.407 (Tennessee)	0.886 (Arkansas)

Puerto Rico's GPCIs Compared to Lowest Values
1995

	Work	Practice Expense	Malpractice	GAF
Puerto Rico	0.883	0.739	0.268	0.794
Lowest in US	0.936 (S. Dakota)	0.809 (Missouri)	0.349 (Indiana)	0.880 (S. Dakota)

According to a study prepared by Lewin - VHI, a health policy and research firm, *it was determined that the assumptions and / or proxy measures, used to determine the GPCIs, were questionable in the case of Puerto Rico* due to the significant differences between the economy of Puerto Rico and that of the United States mainland.

FOLLOWING ARE THE MAJOR FINDINGS OF THE LEWIN-VHI STUDY

1. HCFA does not estimate the value of physicians' time directly (i.e., by measuring physician wages.). Rather, it uses an index created from the average hourly earnings of a sample of "professional" workers (including engineers, lawyers, teachers, and others) to capture regional variations in the value of physicians' time. Differences between the economy of Puerto Rico and that of the typical mainland location make the relative earnings of professional workers an inappropriate proxy for the relative opportunity cost of physicians' time in Puerto Rico.

2. HCFA does not measure physician office rents directly. Rather, it uses a Housing and Urban Development (HUD) *index of residential apartment rent to capture regional variations in physician office rent expenses.* The assumptions underlying this proxy measure are not satisfied in the case of Puerto Rico because of a multi-tiered real estate market.

3. HCFA does not take into account the higher shipping and handling costs for medical supplies and equipment incurred by physicians in Puerto Rico.

4. HCFA's survey of malpractice liability insurers found that nominal malpractice premiums in Puerto Rico did not change from 1986 to 1992.

CONCLUSION

In conclusion, the lowest labor and nonlabor components, wage index, geographic adjustment factor and federal capital rate does not necessarily mean these are incorrect. Puerto Rico is and should be a region with lower figures. *However, we consider HCFA has combined incorrect data and inappropriate assumptions which have significantly reduced the rates and figures drastically in the case of Puerto Rico.*

In the case of physicians payments, for example, many of the measurements made by HCFA in the calculation of practice expense are not direct measures of actual expenses, but indirect proxy measures. The validity of these proxy measures rest, in many instances, on assumptions that are inappropriate in the case of Puerto Rico.

In connection with the DRG formula applied to Puerto Rico, the fact that it has been static since October 1, 1987 (75/25), is a factor having a substantial impact on the financial stability of the hospital reimbursed under PPS/DRG located in Puerto Rico.

Five years after the implementation of PPS/DRG, there is a general consensus in the health care industry in Puerto Rico that the frozen formula imposed by the law has resulted in an unfair reimbursement, forcing the hospitals to reevaluate their financial capacity to maintain high quality of services needed by Medicare beneficiaries. Hospitals in Puerto Rico claim that they have been under pressure to operate with less than the required funds as a result of the blended rate. However, they also have to comply with requirements similar to those on the mainland to qualify for reimbursement. The result is that a substantial number of hospitals in Puerto Rico is either under financial difficulties, or is already operating under the provisions of the Bankruptcy Act.

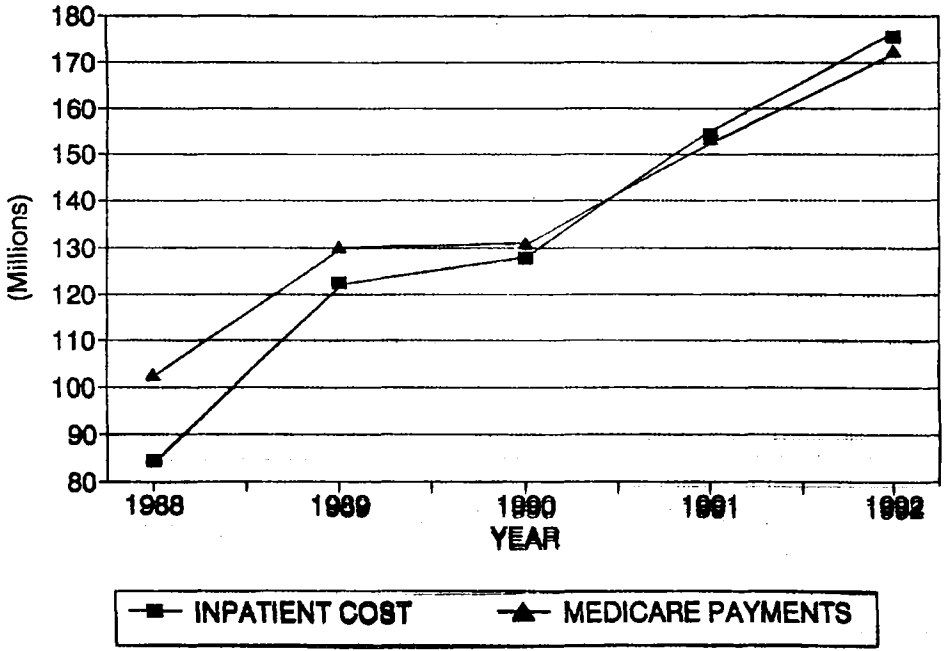
It is obvious that the overall objective of the general formula - which was to promote a strategy towards implementing cost containment measures by awarding incentives for efficiency - was not to force hospitals into a bankruptcy setting.

In Puerto Rico, the private medical plans do not take any more shifts from the Medicare program. Therefore, the continuous underpayment to hospitals may eventually affect the health care services to all patients as hospitals will be deprived of the funds necessary to maintain themselves as technically competent institutions and may not have the capacity to replace their equipment or to invest in more advanced technology. *That is why a second look at the Medicare formulas both for hospitals and physicians and its components is required.*

EXHIBIT I

PRIVATE HOSPITALS

INPATIENT COST & MEDICARE PAYMENTS



Testimony of Valeriano Alicea-Cruz, M.D.
President, Puerto Rico Medical Association

Before the Subcommittee on Health
of the
Committee on Ways and Means

February 1995

Introduction:

Thank you, Mr. Chairman, for the opportunity to testify before your committee on behalf of the physicians of the Commonwealth of Puerto Rico. As you know, the Health Care Financing Administration adjusts Medicare Part B payments to physicians across the United States and its possessions based on its estimate of the geographic variation in physician practice expenses. Those areas where practice costs are estimated to be relatively higher receive a higher payment, while those areas with costs estimated to be relatively lower receive lower Part B payments for the same services. Bureaucratic costs would be meaningfully diminish if an universal formula is applied nationwide instead off regionally. You may not know that, based on these geographic cost adjustments, physicians in Puerto Rico receive the lowest Medicare Part B payments of all physicians receiving payments. Moreover, these payments are substantially lower than those received by physicians in the next lowest geographic area defined by HCFA.

How GPCI's Are Computed:

HCFA computes indexes, called Geographic Practice Cost Indices (GPCIs), for each of the three components of physician payments: (1) the "work" GPCI, which estimates the value of the physician's time; (2) the practice expense GPCI, which includes the cost of office rent, supplies, equipment and staff; and (3) malpractice expense. HCFA combines these indexes into a "Geographic Adjustment Factor" (GAF). The GAF determines the proportion of a full Medicare payment for services that physicians in a particular geographic region are paid. The average GAF across all regions is 1.0. If the factor is 0.9 in a particular region, physician in that region receive 90% of the average Medicare Part B payment.

Discriminatory Situation:

Reduced Medicare payments adversely affect the incomes of physicians and health care workers in Puerto Rico. However, Medicare Part B reimbursements to physicians in Puerto Rico are, in the long run, not merely a matter of the incomes of physicians and the incomes of other health care workers. A policy which, in effect, consistently reimburses Puerto Rico's physicians at lower rates than physicians in other geographic regions for the same services, when those lower reimbursement rates do not properly reflect underlying cost differences, will eventually result in fewer physicians and less access to health care for the people of Puerto Rico. This will adversely affect the welfare of both Medicare and non-Medicare patients in Puerto Rico.

Comparison of 1994 and Estimated 1996 GPCI's:

In 1994, physicians in Puerto Rico received about 81% of the average payment that physician received for a given medical service. This was the lowest payment rate of all the geographic regions defined by HCFA. Physicians in the next lowest region received payments almost 9% higher than those received by physicians in Puerto Rico. Two of the three cost component index values for Puerto Rico, as estimated by HCFA, were the lowest of all regions.

Under recent HCFA revisions to GPCIs, Puerto Rico will have the lowest reported value for all three components. The 1996 GAF for Puerto Rico of 0.79 means that our physicians will receive payments that are 21% lower than the payments received by the typical physician for the same services. The next lowest region will receive payments fully 11% higher than Puerto Rico. **Table 1**, included for the record, illustrates these points.

Table 1.
Puerto Rico's GPCIs Compared to Lowest Values: 1994 and 1996.

	Work[1]	Practice Expense	Malpractice	GAF
1994 GPCIs				
Puerto Rico	0.882	0.763	0.466	0.813
Lowest (next lowest, if lowest is Puerto Rico)	0.942 (Vermont)	0.838 (rest of Mississippi)	0.407 (Tennessee)	0.886 (Arkansas)
1996 GPCIs				
Puerto Rico	0.883	0.739	0.268	0.794
Next Lowest	0.936 (S. Dakota)	0.809 (small cities in Eastern Missouri)	0.345 (urban/rest of Indiana)	0.880 (S. Dakota)

[1]The work GPCI reflects only 25% of the difference between the measured value of physicians' time and the national average. Hence, a work GPCI of 0.883 represents a measured index value of about 0.526.

We recognize that having the lowest value for the payment adjustment index does not necessarily mean that it is incorrect or that physicians in Puerto Rico are being treated unfairly. In any such calculations, some region will necessarily be the lowest.

However, many of the measurements made by HCFA in the calculation of practice costs are not direct measure of actual expenses, but indirect proxy measures. The validity of these proxy measures rests, in many instances, on assumptions that we believe are inappropriate for the case of Puerto Rico. Because of important differences between the economy of Puerto Rico and the typical mainland economy, the relationship between these proxy variables and the true practice expense is likely to be significantly different in Puerto Rico compared to the economies of regions in the U.S.

Findings and Recommendations, study by Lewin-VHI, Inc.

Lewin-VHI, Inc., a health policy and research firm, has reviewed the calculation of the GPCIs and the assumptions underlying them for Puerto Rico, at our request. Their analysis incorporates data from a variety of sources including a special survey, conducted as part of this project, of approximately 200 Puerto Rico physicians. Four areas were found in which the indexes are based on assumptions and/or proxy measures which, due to significant differences between the economy of Puerto Rico and that of the US mainland, are questionable for the case of Puerto Rico. The following are the major findings and recommendations, which we cite directly from the Lewin-VHI, Inc. study:

- Overall, the methodology used by HCFA is reasonable, given both the practical constraints on available data and the theoretical difficulties inherent in computing the indexes. However, many of the assumptions deemed reasonable for the mainland U.S. do not hold in the case of Puerto Rico.

- HCFA does not estimate the **value of physicians' time** directly (i.e., by measuring physician wages). Rather, it uses an index created from the average hourly earning of a sample of "professional" workers (including engineers, lawyers, teachers, and others) to capture regional variations in the value of physicians' time. Differences between the economy of Puerto Rico and that of the typical mainland location make the relative earnings of professional workers an inappropriate proxy for the relative opportunity cost of physicians' time in Puerto Rico. As an alternative, physician earnings are measured directly for Puerto Rico, adjusting the potential dependency of earnings on Medicare payments, and compared to that of US physicians. Based on a direct comparison of physician wages, HCFA should raise Puerto Rico's work GPCI value from 0.883 to 0.924, and increase the overall Geographic Adjustment Factor for Puerto Rico by 0.022, a 2.77 percent increase.

- HCFA does not measure **physician office rents** directly. Rather, it uses a Housing and Urban Development (HUD) index of residential apartment rent to capture regional variations in physician office rent expenses. The assumptions underlying this proxy measure are not satisfied in the case of Puerto Rico because of the degree to which rents

are subsidized in Puerto Rico, and because of a multi-tiered real estate market. Three alternative measures of rental costs indicate that, when controlling for quality, office rental prices in Puerto Rico approximate the U.S. national average. By making this adjustment, Puerto Rico's GAF will rise by approximately 3.2 percent.

- HCFA does not take into account the **higher shipping costs** for medical supplies and equipment incurred by physicians in Puerto Rico. Data from shipping companies indicate that medical supplies and equipment are more expensive to ship from the U.S. mainland to Puerto Rico than within the mainland. Estimates indicate that if HCFA adjusts Medicare reimbursement rates to account for these additional shipping costs, Puerto Rico's GAF will rise approximately 0.02 percent.

- HCFA's survey of **malpractice liability** insurers found that nominal malpractice premiums in Puerto Rico did not change from 1986 to 1992. The survey of physicians in Puerto Rico conducted for this study indicate that from 1989 to 1993, malpractice insurance premiums rose at an average annual rate of 5.9 percent. After adjusting HCFA's estimate to account for this premium growth, Puerto Rico's GAF will rise by approximately 0.2 percent due to this factor.

The effect of these recommended changes on the Geographic Adjustment Factor for Puerto Rico is summarized in the following table.

Table 2.
Proposed Index Values and Revised GAF for Puerto Rico

Index	Original Index	New Index
Physician Work GPCI	0.883	0.924
Practice Expense GPCI:		
--Nonphysician Payroll Index	0.499	0.499
--Rent Index	0.752	1.00
--Supplies, Equipment, Miscellaneous Other Index	1.00	1.01
Malpractice GPCI	0.268	0.30
GAF	**0.794**	**0.845**

Conclusion

Based on these recommended changes, the GAF for Puerto Rico would **increase by 6.4%.** The GAF computed for Puerto Rico would remain the lowest of all geographic locations, as would the individual GPCIs. The effect of these changes on the national average is negligible.

We have suggested that the assumptions underlying the lower payment rates for Puerto Rico are, in several instances, inappropriate, and have adjusted the practice cost indexes using other data sources. If we apply the revised GAF for Puerto Rico to projections of its 1995 and 1996 Medicare Part B payments, we estimate that Medicare payments to providers in Puerto Rico would increase by approximately $11 million in 1995 and $23 million in 1996, in nominal dollars, over what they would have been under the original GAF.

Adjustment of Medicare Part B payments to reflect geographic differences in practice expense is reasonable. However, the methods and data used by HCFA to make these adjustments are less than ideal. In the case of the Commonwealth of Puerto Rico, the assumptions underlying the proxy measures used to make adjustments to Medicare Part B payments, including the structure of wages among the professions and the market for office space, must be carefully evaluated. Errors that consistently understate practice expenses in Puerto Rico compared to the other localities are not only unfair to the physicians and health care workers in the Commonwealth of Puerto Rico but, in the longer run, to all the users of the health care system.

Thank you, Mr. Chairman.

STATEMENT OF COLONEL FRANK G. ROHRBOUGH, USAF RETIRED
DEPUTY DIRECTOR OF GOVERNMENT RELATIONS
THE RETIRED OFFICERS ASSOCIATION

MISTER CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE

This statement is submitted on behalf of The Retired Officers Association (TROA), which has its national headquarters at 201 North Washington Street, Alexandria, Virginia. TROA has a membership of more than 400,000 active duty, retired, and reserve officers of the seven uniformed services. Included in its membership are approximately 65,000 auxiliary members who are survivors of former members of the association.

On behalf of TROA's members, we would like to thank the Chairman and other distinguished members of the House Ways and Means Committee's Subcommittee on Health for allowing us to submit our recommendations for the enactment of an innovative concept for reducing Medicare costs.

INTRODUCTION

Health care has always been regarded as the most important benefit, after military retired pay, for our members. Based on membership surveys, we know that many TROA members prefer Department of Defense (DoD) military hospitals as their primary source of health care. Over 90 percent of TROA members who use military medical facilities (MTFs) report they were satisfied or very satisfied with the quality of the health care they received. The quality of health care in military hospitals is further documented by the Joint Commission on Accreditation of Healthcare Organizations. Its survey results indicate that military hospitals generally perform better than most of their civilian community hospital counterparts.

While quality of care in MTFs is judged as good, the availability of care has become increasingly uncertain, and inaccessible in many cases, forcing many, if not most, older retirees to seek health care in the private sector. This has imposed significant difficulties for retired families in many communities because many civilian providers already refuse to participate in the Medicare program.

We applaud the efforts underway in Congress to make Medicare more cost-effective and to constrain its growing cost. Nevertheless, TROA is gravely concerned that further cuts to Medicare providers will mean fewer providers participating in Medicare, a further shifting of the cost of care to private insurers and citizens and - inevitably - rationing of care for the elderly.

THE OBSTACLES TO COST-EFFECTIVE CARE FOR THE DEPARTMENT OF DEFENSE

Approximately 70 percent of TROA's members get their health care from civilian sources, primarily on a "fee-for-service" basis through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or Medicare. While "fee-for-service" gives individuals greater freedom to choose their own provider, it is generally more costly to them and the government. Responding to a national trend, many of our members are turning to managed care plans to assure access to comprehensive care. For example, more than 4,500 Medicare-eligible military retirees and spouses in San Antonio, Texas are enrolled in PacifiCare's "Secure Horizons" Medicare health maintenance organization (HMO) plan. Retirees are selecting such alternative plans, despite the availability of two major military medical teaching centers in town, because Secure Horizons contains two ingredients that are missing from the Military Health Services System (MHSS) -- continuity of care and assured access to quality health care services.

Although many of our members express strong interest in joining DoD's new "Tricare Prime" -- a managed care program which has been mandated by Congress and is to be fully operational by 1997-- an extremely serious obstacle exists: **Under current law, DoD cannot be reimbursed for Medicare-eligible retirees who would like to enroll, which effectively bars all older military retired beneficiaries from using it.** Lacking Medicare reimbursement, DoD has no funding or financial incentive to treat military Medicare eligibles, thus **they are being shoved out of the military health care system and onto Medicare.** If that were not bad enough, CHAMPUS-eligible beneficiaries who enroll are abruptly disenfranchised from Tricare when they become Medicare-eligible. Theoretically, Medicare-eligible retirees and their spouses could still be treated in military treatment facilities (MTFs) on a **"space-available" basis.** But, the truth is that MTF space available care will evaporate as enrollments in Tricare Prime grow and regional provider networks reach their full program capacity.

THE "MEDICARE SUBVENTION" IMPERATIVE

For some time, TROA and The Military Coalition - a consortium of 27 military and veteran organizations, representing 3.75 million members of the uniformed services (active, reserve and retired) plus their families and survivors - have advocated implementation of a reimbursement concept called "Medicare Subvention". Subvention means the Health Care Financing Administration (HCFA) would

reimburse DoD for care provided to Medicare-eligible beneficiaries in military treatment facilities (MTFs). From a fiscal viewpoint, **subvention will save money both for the government and the taxpayers.** Equally important, **it will preserve military medical readiness, and keep faith with military beneficiaries who accepted repeated government promises of lifetime health care in return for their decades of career military service.**

Fiscal Considerations

In the past, Medicare has reaped an apparent windfall for every Medicare-eligible beneficiary treated in an MTF. DoD provided over $1 billion in "space available" care in MTFs in 1994 to about 230,000 Medicare-eligible military retirees. Thus, DoD has been subsidizing the Medicare Trust Fund, even though these beneficiaries have paid payroll taxes to the Hospital Insurance (HI) Fund all through their years of government employment. Not surprisingly, HCFA has been concerned that should subvention be authorized, Medicare outlays would immediately increase.

In reality, Medicare costs are going to increase even more if subvention is not authorized. The fact is that Tricare Prime will turn thousands of Medicare-eligible retirees away from military health care and force them to use Medicare in the private sector. This is already happening as military bases and MTFs are closed or downsized. The trend will only accelerate as Tricare is implemented across the country. By the end of 1997, DoD will treat only a tiny fraction of the Medicare-eligible retirees they see today. **Subvention is a cost-effective alternative for addressing this phenomenon.** DoD acknowledges that, if subvention is authorized, its medical budget could be decreased by an amount corresponding to the reimbursement received from Medicare. Last year, when the Senate and the House Armed Service Committees favorably reported subvention in their inputs to national health care reform, the Congressional Budget Office acknowledged this fact. Thus, enactment of subvention would be cost-neutral even under a worst-case scenario. That is, the increase in Medicare expenditures could be offset by a corresponding decrease in the DoD budget.

Subvention Ultimately Saves Money for the Government

However, the more likely scenario is that subvention would reduce the cost to the government, because DoD-provided health care would cost Medicare less than the same care provided in the private sector. To illustrate, a Medicare/military treatment facility pilot project,

conducted at U.S. Naval Hospital, San Diego, between November 1988 and March 1990, demonstrated that the potential savings for HCFA are significant. Under this project, the Navy contracted with two private Medicare-certified physicians to perform inpatient and outpatient services at the military hospital for a negotiated fee. HCFA authorized the waiver of the Medicare co-payment and the Naval Hospital provided the facility at no cost to Medicare. Over the test period, 75 coronary artery bypass grafts were performed in the Naval Hospital at a conservatively estimated savings of $17,000 per procedure, generating a total savings of $1.3 million.

When such savings are possible, it is clear that maximum use should be made of MTFs. This is further supported by a 1990 GAO Study directed by the House Armed Services Committee. That report (GAO/HRD 90-131) concluded that DoD would reap substantial savings by adding staff and equipment at military hospitals to treat more patients rather than paying for their care under CHAMPUS.

Based on a review of six hospitals, GAO estimated savings ranging from $18 million to $21 million in CHAMPUS funds. If Medicare-eligible beneficiaries were included, the savings to the Government would be substantially greater. Such potential savings were further substantiated in DoD's "Section 733 Study of the Military Medical Care System" released in May 1994, which found that care could be delivered 10 to 24 percent less expensively in military treatment facilities. Thus, if MTF commanders were provided the wherewithal to compete with Medicare providers, they could expand the capability of their facilities, clinically challenge their providers, and better meet the needs of all DoD beneficiaries -- all while saving Medicare money.

It seems to us, if necessary, this Committee could lock-in these savings by stipulating in the law that the HCFA reimbursement to DoD will not exceed 95 percent of the amount Medicare would pay to a civilian Medicare HMO.

All the evidence clearly demonstrates that the current statutory constraints inhibit the system from operating at maximum efficiency. Such restrictions inhibit DoD's and HCFA's ability to cooperate in reducing government cost. It forces each into penny-wise and pound-foolish decisions that myopically subordinate the government interests to parochial budgetary considerations. Thus, DoD budget constraints force exclusion of Medicare-eligible retirees, even though that exclusion will increase overall costs to the government. At this juncture, DoD has developed legislation, pending OMB clearance, which will permit MHSS facilities to receive Medicare reimbursement so they can compete with civilian sector Medicare "At Risk" HMOs.

We believe that subvention would facilitate maximum use of federal medical facilities and at the same time reduce the Governments outlays for health care.

Retention And Readiness Concerns

While the cost issue is extremely significant, there is yet another reason why exclusion of retired personnel from the military health care system undermines the government's long-term interests. That reason is that such actions undermine the very purpose of the Department of Defense -- to ensure the Nation's military forces are prepared and ready to defend the National interest, by force if necessary.

A crucial aspect of this issue is personnel readiness, which is totally dependent on sustaining strong incentives for high quality personnel to continue to serve full military careers comprising 20 to 30 years of arduous service and sacrifice. Well-documented historical "offers of lifetime health care benefits" were one of the primary incentives that induced many current retired members to serve military careers that often spanned two or three wars. Now, they are understandably shaken at the prospect of being foreclosed from any access to the military health care system. Finding themselves left with no coverage but Medicare -- at a time when the government seems bent on drastic reductions in Medicare benefits -- many are understandably bitter at being treated as if their decades of service and all of the government's past promises have no value. Such sentiments bode extremely ill for long-term retention and readiness.

Any employer dependent on internal promotion for its mid-level and senior management must keep the promises it makes to its employees. Such credibility is doubly important when the employer is the United States government, and the employees are military members whose conditions of service include extended family separations, forfeiture of many personal liberties and repeated hazards to life and limb. To induce members to serve 20 or 30 years under such conditions, the government must offer -- and has offered -- an exceptionally attractive benefits package. **The prospect now is that, after the members have been induced to serve, and after they have attained an age when their medical benefits have assumed major importance in their lives, they are to be closed out of the military health care system and left with no employer provided health benefits at all. Just Medicare.**

Mr. Chairman, General Motors subsidizes supplemental health care for its Medicare-eligible retired employees. The Federal government provides supplemental coverage to Medicare under the Federal Employees Health Benefits Program to every Federal civilian employee. Supplemental coverage is provided to Medicare-eligible retired Members of Congress and their families. Supplemental coverage is provided to retired Congressional staffers and their families. Yet, implementation of the Tricare system under current law denies any such "employer-provided" health care benefits to those 65 and older who fought their country's battles -- or to the survivors of those who died in the Nation's defense while believing that the government would keep its promises in this matter.

The treatment of today's retirees will not be lost on today's active duty military members. Unless Congressional and Government leaders meet their commitments and responsibilities for today's retirees, military commanders' retention promises to the current force will ring hollow. The incentives to endure the well-known sacrifices inherent in a military career will be significantly diminished, and retention and readiness will inevitably suffer.

There is one final, but critical readiness consideration which deserves comment. **Ensuring Medicare-eligibles access to the military health care system will also help ensure we maintain a military medical force that will be prepared for any operational contingency.** To be prepared to accomplish DoD's wartime and contingency missions, medical personnel must be recruited, trained and retained. Their retention is contingent on professional advancement which means they must see and treat a wide range of patients and with a broad spectrum of medical problems. Medicare-eligible retirees provide that clinical experience. By having well-trained, quality physicians and allied health care providers, the medical community is better able to respond to any military contingency operation or wartime deployment which this nation may face in this very unstable world. Military deployments to Haiti, Somalia and Bosnia are excellent examples of how treating a wide range of clinical conditions prepares military medical personnel for military contingencies.

TROA'S POSITION

Mr. Chairman, the Nation has an obligation to do better. It has an obligation not only to those who have already served, but also to those who are now serving, and to the current and future generations of Americans who require a strong national defense to preserve them from the continuing threats of a dangerous world. This is a matter

not only of keeping promises and doing the right thing by those who have served; it is a matter of acting in the national interest.

TROA is convinced that military medical readiness will suffer if Medicare-eligible retirees and their spouses are denied access to care in the military health system. The system must attract, train and retain physicians and other health care personnel if it is going to be a capable and viable national resource for the defense of this great country. Medicare subvention will provide that institutional foundation which is needed to meet any contingency operation and will insure that military retirees will have the freedom of choice in health care they have earned and deserve.

Unless dramatic changes are forthcoming, Medicare-eligibles' access to health care providers will be so restricted as to deny them access to care when they increasingly need it. The use of Medicare "risk contracts" to provide health care services on a capitated basis, as now used by HCFA, has great potential, if similar risks were assumed by DoD. The bottom line is that subvention will save money for everyone -- Medicare, DoD, patients and taxpayers. **We, therefore, strongly recommend that this committee favorably report the subvention provisions contained in H.R. 580, which was introduced by Representative Joel Hefley (R-CO) on January 19, 1995.**

CLOSING

Mr. Chairman, thank you for allowing us the opportunity to present the views of The Retired Officers Association on this very important issue. Any questions that you or any other members of the Committee might have can be referred to us at the National Headquarters.

MAIN OFFICE:

February 6, 1995

Mr. Phillip D. Moseley
Chief of Staff
Committee on Ways and Means
U S House of Representatives
1102 Longworth House Office Building
Washington DC 20515

Dear Mr. Moseley:

Written Testimony for February 6, 1995, Committee on Ways and Means hearing regarding growth in Medicare.

For the last 13 plus years, I have been the Chief Financial Officer of the largest home care provider in Central Pennsylvania. I have seen and experienced first hand the significant expansion of home care services and the corresponding benefit to the community we serve.

Skilled home health services have become an integral part of our nations health care delivery system. Home health agencies have allowed the DRG payment system to work for hospitals as patients have been discharged earlier to the less expensive alternative of home care services. We, as a nation, have benefited greatly by the expansion of home care services that allows chronic and acute care patients to complete their recovery at home.

As we explore the perceived problems, let us not be hasty to undo the success of the past. The Advisory released by the Committee on Ways and Means suggests in the background that program growth "may represent significant fraud and abuse." It is clear that a small percentage of home care providers do undoubtedly act in a fraudulent way. It is also clear that the present home health reimbursement system is such that fraudulent providers are hard to identify and even harder to prosecute.

The current system not only allows two provider to get paid different prices for the same service but allows providers to get varying number of visits paid for an equal situation.

The answer is not co-payments or co-insurances. The answer is a total overhaul of the payment system to include incentives for providers to provide cost-effective quality care.

I would encourage the Congress to put away the Band-Aids and perform the surgery that is necessary. It is time to develop a fair and reasonable prospective payment system that will control costs, benefit providers and meet the needs of the millions of Americans needing home care services.

Sincerely,

Steven Richard
Chief Financial Officer

COMMISSION ACCREDITATION OF HEALTHCARE ORGANIZATIONS

MEDICARE PROVISIONS IN THE PRESIDENT'S BUDGET

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

FEBRUARY 23, 1995

Serial 104–31

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

90–502 CC WASHINGTON : 1996

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-052389-3

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MEDICARE PROVISIONS IN THE PRESIDENT'S BUDGET

THURSDAY, FEBRUARY 23, 1995

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

The subcommittee met, pursuant to notice, at 9:33 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 16, 1995
No. HL-4

CONTACT: (202) 225-3943

THOMAS ANNOUNCES HEARINGS ON MEDICARE PROVISIONS IN THE PRESIDENT'S BUDGET

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 Medicare provisions contained in the President's fiscal year 1996 budget proposal. **The hearing will take place on Thursday, February 23, 1995, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 9:30 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be heard from invited witnesses only. Invited witnesses include representatives from the Administration, budget experts and actuaries, as well as other interested parties. 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:

Medicare Part A pays for inpatient hospital care, certain inpatient care furnished in skilled nursing facilities, home health care and hospice care. Last year, the President submitted an ambitious health care plan which included significant savings in the Medicare program. This year, the President's budget does not contain proposals on Medicare-related budget issues. In addition, the budget does not address a pressing problem facing the Medicare program, the pending insolvency of the Medicare Part A trust fund. According to the Department of Health and Human Services summary of the President's budget, the fiscal year 1996 budget for Medicare benefits anticipates the enactment of legislation to extend certain current law policies that will otherwise expire. The summary states: "These are not new Medicare cuts; rather, these are policies that are currently part of the Medicare program." This hearing will review the Medicare provisions included in the President's Fiscal Year 1996 budget.

In announcing the hearing, Thomas said: "The Administration has chosen to ignore the fact that the Part A trust fund starts spending more money than it takes in during 1996 and will become insolvent in 2001. This Subcommittee will attempt to determine the Administration's rationale behind the limited provisions included in the President's budget in the face of this pending crisis for the beneficiaries and taxpayers."

FOCUS OF THE HEARING:

This hearing will focus on the Medicare proposals included in the President's fiscal year 1996 budget and their impact on the Part A trust fund.

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, March 10, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements 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 over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

* * * * *

Chairman THOMAS. Good morning. Today's subcommittee hearing will focus on the Medicare provisions contained within the President's budget. We will examine the issues that were included in his budget and those which may have been omitted.

The President's budget includes three Medicare policies. First, it permanently sets part B premiums at 25 percent of program cost. Second, it maintains the freeze on home health and skilled nursing facility payments. The final policy extends Medicare secondary payer provisions, which expire in 1998.

Today, the subcommittee will discuss the part B premium and the Medicare secondary payer. The areas of home health and skilled nursing facility payment policies were covered in an earlier hearing.

It is important to note that the administration, in recommending these policy extensions, stressed that these proposals are "not new Medicare cuts." The President chose to take a hands-off, leave-it-as-it-is approach to Medicare. The President chose not to recognize, much less plan for, the deteriorating financial condition of the Medicare part A trust fund.

According to the most recent Medicare trustees report, as early as 1996, the part A trust fund will begin to pay out more for medical care than it receives from revenue. Furthermore, the trustees report that the trust fund will not only lack funds to cover its obligations for the Medicare beneficiaries by 2001, but it will be completely exhausted sometime later that year.

Now, some may scoff and say, this is not a crisis. They will cite the possibility that the trustees report, due April 1995, will predict that the bankruptcy of the trust fund will occur a year or so later than 2001 because of the recent decrease in the growth of medical costs. They may try to trivialize the issue by pointing to the experience of the last 15 years, where predictions of bankruptcy for the trust fund, they say, were premature.

I think the subcommittee, through testimony today, will learn, however, that the past is not prelude in this instance. Increases in taxes, reductions in the growth of Medicare payment to hospitals, and generally good economic conditions did prevent insolvency in the 1990s. But more than piecemeal fixes are needed now. Rising medical costs and the aging of the baby boomers is catching up with the trust fund. When the fund finally goes bust, it will be in the red by almost $50 billion in the first year alone.

It is unfortunate the President chose not to provide leadership on this issue. The year 1996 marks the start of the spend-down of the trust fund. This action sends off warning signals that this subcommittee will not ignore. If we don't act decisively, if we continue to mortgage the future, our children will be forced to bear a heavy burden. We must summon the courage to act, gentlemen, and protect the futures of our children, as well as ensure that promises made to the elderly are, in fact, kept.

The gentleman from California, Mr. Stark.

Mr. STARK. I hardly know what to say. Facing this list of right-wing lunacy that qualifies as a witness list, I am not sure whether to be amused or cry at the thought that these folks would talk to us about keeping the trust fund solvent.

We are supposed to focus on Medicare provisions in the President's budget, and if the experience of our hearing on February 10 is evidence, we will hear from the majority criticizing the President for not proposing more cuts and, as the chairman has done, pointing with alarm to the crisis in the part A trust fund.

Let us deal with the second issue first. The insolvency of the trust fund is a serious problem and we must pay attention to it, but the last people who have any right to say anything about it are my colleagues on the Republican side. As I have pointed out repeatedly, the Republicans are the only ones who have on the table a proposal which takes money out of the part A trust fund, through a reduction in the amount of Social Security benefits subject to taxation. Some $15 billion would be removed from the trust fund over 5 years, $48.2 billion over 10 years.

It is very disingenuous to complain that the President's proposal doesn't do enough when you have a proposal on the table that takes you in the wrong direction.

The other reason my Republican colleagues' newfound concern about the trust fund is ironic is that the last year they had the chance to help us enact the largest Medicare savings proposal ever proposed, it included, in the Ways and Means Committee reported version of health reform, that which would have done more than any proposal to improve the long-range fiscal health of the trust fund.

Nevertheless, during the full committee markup, the Republicans offered an amendment to remove all of the Medicare savings out of the proposal, and every Republican member voted for this specific proposal.

So I hope, Mr. Chairman, if I report to you that your newfound concern sounds a little phony to this side of the aisle, that we have good reason to be rather skeptical.

The last point is that we have been here before. As you mentioned, I am going to mention it, that the trustees in 1977 reported that the fund would become insolvent in 1987. By my calculation, that was about 8 years ago. By the time President Carter left office, the insolvency date was extended to 1994. Today, the insolvency date is 2001. I understand the next trustees' report will push the insolvency date out a few years further, not through anything we have done.

So years of reform in Medicare, through the creation of the DRG system for hospitals, through the resource-based relative value system for physicians, has kept the trust fund solvent far longer than expected. In maintaining the program solvency, there were absolutely no magic bullets. It has been hard work, something the Republicans don't seem to know much about.

We have been successful in strengthening the Medicare program and have done so without merely shifting costs to beneficiaries. Democrats have done this for one reason. We made a contract, a contract with Americans, not a contract with people who contribute to Newt Gingrich's GOPAC, not a contract with the big insurance companies who put their hired guns on Republican staffs and who buy out elected officials to bring big profits to for-profit hospitals and insurance companies while withholding needed care to the poor and to the seniors. Over the past 30 years, we have maintained a

commitment to the American people and we plan to keep that commitment.

I would offer a word of caution, and that is, don't rely on quick fixes. You can send the beneficiaries a check. You can call it a medicheck or anything else, but that would not be in the long-term interests of the seniors nor of average Americans in this country.

I look forward to listening to a witness list that is probably picked by the CATO Institute and other right-wing think tanks. I must say, it appears to be me to be a waste of time, but I will listen.

Chairman THOMAS. I thank the gentleman for his comments. Perhaps the record should show that we asked the Director of the Office of Management and Budget if she would appear before this subcommittee of the Ways and Means Committee and her answer was, basically, she doesn't "do" subcommittees. We asked; she did not come. We asked the AARP if they would like to testify. They declined to testify.

I would tell the gentleman, in terms of bragging about his efforts in terms of health care reform last year, that a jury-rigged plan to try to salvage the President's ill-conceived proposal passed this committee. I don't recall voting for it on the floor when you controlled the Rules Committee, the floor, and both houses.

So when you talk about honesty and sincerity, let us examine who was asked and who didn't come to appear before this particular subcommittee.

The first panel consists of two individuals who formerly were in the operation of the Office of Management and Budget and, frankly, I believe, have extremely impressive credentials. Deborah Steelman is the former Director, Human Resources, Veterans and Labor, Office of Management and Budget, and she chaired the 1991 Advisory Council on Social Security. Tom Scully is the former Deputy Assistant to the President for Domestic Policy and former Associate Director of the Office of Management and Budget.

We are very pleased to have both of you in front of us. Any written testimony that you might have will be made a part of the record, without objection. You may proceed as you see fit.

Mr. Scully, why don't you begin?

STATEMENT OF THOMAS A. SCULLY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, FEDERATION OF AMERICAN HEALTH SYSTEMS; AND FORMER DEPUTY ASSISTANT TO THE PRESIDENT FOR DOMESTIC POLICY AND FORMER ASSOCIATE DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET

Mr. SCULLY. Thank you, Mr. Chairman, and members of the subcommittee for having us here today.

Obviously, I think, as my testimony states in the beginning, I am in a little bit of a strange position. I spent a lot of time working with many of you on both sides of the aisle over the years, proposing four different budgets that President Bush sent up, many of which proposed just about every way to take money out of Medicare that anybody can imagine.

I have gone from the position of being on the slash proposing side to working for the hospitals now, in which, obviously, we are usu-

ally the number one targets of Medicare cuts. So the biggest chunk and the biggest portion of Medicare is Medicare part A, which is mostly hospital payments. Obviously, any time Medicare is on the table, we are the ones who generally get operated on.

It is a little bit of an unusual position. However, I do think that, realistically, there are ways to take money out of Medicare, and I think there are ways, if it is done constructively, that we can all win, that Congress can get the savings it needs, that seniors can have a much better, much improved Medicare system, and that hospitals, which is what our hospitals are interested in, can get a rational, gradual transition to more of a market-based system that gets rid of some of the perverse incentives that are in the Medicare system right now.

The first problem which the chairman asked us to come talk about today, which is pretty obvious, is the fact that the Medicare trust fund is going broke, again, and, I think, depending on what Guy King and others will testify on this morning, the trust fund will go broke somewhere between 2001 and 2004.

Obviously, we could sit around and complain about the administration's budget not taking enough cuts out of Medicare. Clearly, hospitals would love it if you took nothing out of Medicare. I am sure my members would all be thrilled if there was nothing done to Medicare this year.

But given the public demand for deficit reduction and given the demand for straightening out the public programs in health care, I think that is fairly unrealistic, and my view is and my organization's view is that there are going to be changes in Medicare, that there are going to be cuts in the program, and that we should probably deal with that and find a way to work with you to come up with rational solutions.

I don't think the administration, obviously, did—it is not, I don't think, a particularly partisan view. Senator Exon, the Senate Budget Committee, Time Magazine, and everybody else, said the administration essentially punted on Medicare policies in their budget. I can't say that I blame them. If I had been in their shoes, politically, I might have done the same thing.

But the fact is, they have pretty much left it to the Ways and Means, and Finance Committee, obviously, to come up with major changes in the Medicare program this year. My organization, at least, has chosen, instead of saying, let us just oppose all Medicare cuts, to hopefully sit down with you and try to work out some rational ways to restructure Medicare and to save some money.

I don't think it is going to be easy. Can you take money out of Medicare? You definitely can. It is not easy; it never has been. It is not fun. It is not pleasant when you go home to your districts. It is not going to be pleasant for anybody—hospitals, physicians, labs, anybody. Is it a lot tougher than it was in the past? I think it is.

I think the fact is that cost shifting, which was pretty apparent a few years ago, has largely disappeared. In any major metropolitan area, if you go out and look at hospitals or physicians, in the past, when Medicare cut its reimbursement rate, providers essentially shifted money over to the private side and charged the private payers more. With the advent and explosive growth of man-

aged care, that cost shifting is rapidly disappearing. There is not much opportunity to do it anymore.

I think if you go and ask your physicians or hospitals what their various rates are on Medicare versus private payers, the private payer side has been pretty significantly squeezed the last few years and there just isn't any cost shifting or is not much cost shifting left to do.

So can you save? Yes, I think you probably can save some money. Can you save the $100 to $150 billion over 5 years that many on the Republican leadership have said you can save? You can try, but I think you are going to have a massive meltdown all across the health care system if you try to take that kind of money out of it.

As I mentioned in my written testimony, I think if you get that kind of level of cuts, you are going to have the same kind of reaction that we had in the catastrophic in 1989. You can take money out of the system, but if you want your seniors, your hospital administrators, your patients, and your physicians meeting you at the airport every Friday, very unhappy because the health care system is melting down, at that level of cut, I think that is what you are going to get.

I think, realistically and objectively, if you look at the last two big budget deals we had, the 1990 budget deal, which I was very involved in negotiating, along with Mr. Stark and others on the committee, that budget deal, the original conference report came out of the conference with $56 billion in cuts over 5 years. The major reason that failed was because now-Speaker Gingrich, along with a number of other members, thought the Medicare cuts were too big, and they were scaled back to $43 billion.

That bill very barely passed, and the single most controversial issue in that bill in the 1990 budget agreement, other than the tax increases, was Medicare cuts. So it wasn't pleasant to cut $43 billion out then.

In 1993, the level of cuts in President Clinton's budget package was $56 billion, and that was highly controversial. There wasn't a single Republican vote for that package. Those votes were largely against taxes, but I think the second most controversial issue in that package was Medicare cuts, $56 billion. They were perceived as being rather large and rather painful.

So when you look at taking much bigger numbers out this year, Medicare inflation, health care inflation is much, much lower. The baseline is lower. The pot is smaller. You are talking about taking somewhere between three and five times as much money out of the system as anyone has ever tried before, from a system that is growing more slowly, the baseline is not as fat, and the cuts are much more painful.

Obviously, if you are going to take money out of the system, can you find ways that reasonable budget targets and reasonable health care policy can meet and we can all find results that we can live with? I think there probably are. I happen to believe there are a lot of different ways to do it. I am sure we will discuss them this morning in medicheck or privatizing or voucherizing the system. I happen to believe, and our hospitals happen to believe, that privatizing the system can save a lot of money and get rid of a lot of the perverse incentives that exist in Medicare now.

General Motors, 3M, and any other large company you will find, basically goes out and buys in the private system and private plans. The Federal Employees Health Benefits Plan goes out and uses private contractors to efficiently buy health care. It works in the private sector and, I think, it can work for the public programs.

Medicare is a great program, but I think that you will find that it is a dinosaur as far as payment systems go. We have been trying to reform it for 15 years. There have been a lot of problems anytime you touch Medicare, but, if you look at the private delivery system, there are an awful lot of very rational, easy fixes you can make in Medicare that will make hospitals, physicians, and other providers perform a lot more rationally.

If you privatize, can you restrain growth? I think the answer to that is, yes. Can you get budget savings? I think the answer to that is, yes. Can you get CBO to score it, which, I assume, we will get into a little bit today? I don't think there is any question, if you do it right, CBO has no choice but to score it.

Can you get lower prices through quality and competition between private payers? I believe the answer to that is, yes, and, I think, from our hospital standpoint, we would much rather deal with the private sector and competition squeezing us, and the issue here is definitely squeezing, than having the government continue to regulate us with perverse incentives and having a squeeze that is not fair across the board.

It looks like my time is up.

Chairman THOMAS. The gentleman's time is expired.

Mr. SCULLY. The issue, I guess, for us is it is not always how you cut or how much you cut; it is how you do it. I think that, basically, we prefer to have private sector cuts.

The thing that concerns us is that if you treat Medicare as a bank for tax cuts and for deficit reduction for the next 5 years, you are going to drive terrible health care policy. If you look at Medicare as a resource to solve part of the problem, to get some of the money to solve the problems that you have, then, I think, we can work together, and we would like to work together, to get reasonable amounts of money out of a restructured system.

But if Medicare policy and health care policy is driven solely by budget policy this year, I think Congress is going to have a problem, I think you are going to have a big problem with your hospitals and your people in your home districts, and I think we could have a very ugly year with a lot of screaming and yelling.

We would like to avoid that and we would like to work with you to get reasonable budget policy, reasonable health policy, and help you meet your goals, but I personally don't think Medicare and Medicaid alone are a big enough pot or a big enough bank to pay for all the things you want to do, and I think you will find that, as well.

Thank you, Mr. Chairman.

[The prepared statement and attachments follow:]

Federation of American Health Systems

Thomas A. Scully, President and CEO
Federation of American Health Systems
Testimony on Medicare Provisions Contained in
The President's Fiscal Year 1996 Budget Proposal
Before The Subcommittee on Health
Committee on Ways and Means
February 23, 1995

Mr. Chairman and Members of the Subcommittee, thank you for inviting me to testify today. I am in an admittedly awkward -- but interesting -- position. As a former Medicare budget slasher (as Deputy Assistant to President Bush and Associate Director of OMB), some of you know me as something of an expert on proposing big Medicare cuts. But now, as President of an association of the nation's 1,700 investor-owned and managed hospitals, I'm leading the charge for the #1 "slashees" -- hospitals. Seems like something of a dilemma?

Maybe. But maybe there is a way that we can all win: Congress and the nation get needed savings; seniors get more and better choices and incentives to pick more cost effective health plans; and hospitals and other providers get a gradual transition to a more rational system that rewards them for providing quality, cost effective care.

But First, The Problem: Medicare Is Going Broke.

Even without the need to reduce the deficit, the Medicare program's growth is unsustainable. The Medicare actuaries project that, at current rates, the fund will be insolvent by the year 2001 -- maybe 2003 or 2004 with more optimistic assumptions. **Doing nothing is not a rational policy option.**

Would hospitals love it if there were no Medicare cuts this year? Absolutely! Is that likely to happen given the drive for deficit reduction, the growth of Medicare and the pending insolvency of the trust fund? No.

So what are the options? Can you control spending and help solve the Medicare trust fund problem without ruining the system? Yes-- if you're careful.

Can You Save Money In Medicare? -- Yep, But It's Not Fun

Traditional provider cuts of the past won't do it. Hospitals and facilities used to shift costs to private payers to make up for reduced Medicare payments -- but that can't happen much any more. Managed care and stronger employers have squeezed private payment rates so there is no place left to shift. The health care market is beginning to work, but Congress must recognize those implications -- cost shifting is dying.

Can you save some money without huge tremors in the provider system, and its senior patients? Yes -- but not the $100 to $150 billion over five years that some have claimed could be cut.

Can you try? Sure, but former Chairman Rostenkowski's 1989 hood ornaments could soon be yours. Seniors and health providers will rebel at cuts far beyond anything before attempted -- much less accomplished.

In the 1990 Budget deal, the Conference originally approved $56 billion in Medicare cuts over five years. That proposal went down to defeat largely because of the key defection of now Speaker Gingrich who thought the cuts were too big. The eventual cut was $43 billion over five years.

In the 1993 Budget deal, the Medicare cut was $56 billion over five years. This was enough to cause significant political pain, and was one of the most controversial parts of the package. Not a single Republican voted for the plan -- largely because of new taxes, but Medicare cuts were an oft-cited reason as well.

And these cuts were done when health inflation was higher, the baseline was much fatter, and each dollar cut had less of an impact. So how do you do it without a war with seniors and providers?

Reasonable Budget Goals Can Mesh With Good Health Policy - Restructuring Medicare

Reasonable budget savings can be had through Medicare restructuring. In fact, the budget pressures may provide an incentive to push through much-needed programmatic reforms that might otherwise never happen. Congress can gradually privatize the Medicare system, providing seniors with options/incentives to join more cost effective plans.

The federal government can pay per capita rates to private plans -- just like GM or 3M, or another large purchasing group that efficiently uses private plans, the Federal Employees Health Benefit Plan. Medicare is a wonderful system for seniors, but it is a payment dinosaur. All hospitals and other providers receive roughly the same payment -- regardless of actual price or quality. The incentives and pressures to operate efficiently are far less than they are under private payment schemes. It's no one's fault, but you get what you ask for -- good quality with a lot of wasted dollars.

By privatizing the system you can restrain the growth of payments.

> You can get significant budget savings.
>
> You can get CBO to score it.
>
> And you can create a better system without destroying the one we have.

You can get much of the savings you need, but through a private payment/voucher/certificate system, the market will adjust gradually to the payment squeeze -- with providers competing on price and quality for Medicare business. Instead of making arbitrary cuts in the physicians' Medicare Volume Performance Standard (MVPS), or the Hospital Market Basket, Medicare would slow cost growth the same way private employers have -- through competition over price and quality.

It's Not Always How Much You Cut -- It's How You Do It

If Congress tries to take $100 to $150 billion out of the system over five years, our hospitals will be leading the charge against you. That's simply too much money to take without major damage to hospitals, patients, communities and lots of would-be former employees. I'll be driving patients to the demonstrations.

But, if the cuts are in a reasonable range, we'll roll up our sleeves to work with you to find creative ways to restructure the system. We can work to change behavior -- both individual and provider behavior -- to save money.

The Options Before Policymakers And Constituents Are:

1) Punt, and scream about "protecting Medicare;"

2) Work creatively to restructure and improve Medicare, and capture the resultant cost savings; or

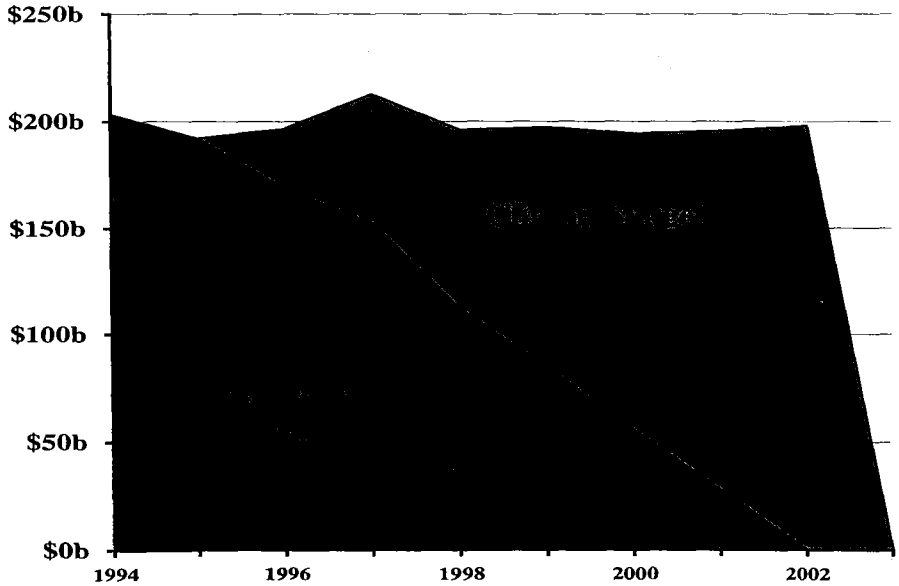
3) Treat Medicare as the "Bank" for tax cuts and deficit reduction and cut too far based on budget driven (not health care driven) policy.

Option 2 seems to be the rational course. We'd like to work with Congress to get there. If the 3rd option prevails, I'll have laryngitis -- as will lots of hospital administrators, doctors and patients -- long before September.

Attachments

The Steep Cost of Balancing the Budget

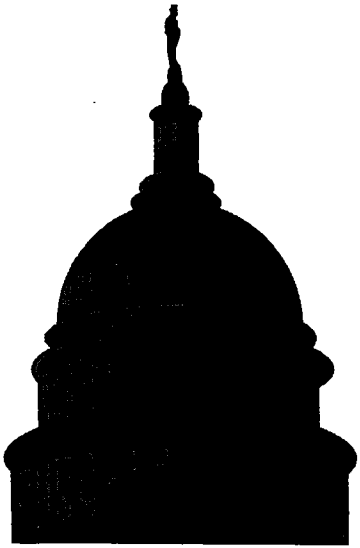
$800 Billion Must be Cut by 2002; $435 Billion in 5 Years



Federation of American Health Systems

Where's the Dough?

or How to Balance the Budget without Touching Social Security or Defense.

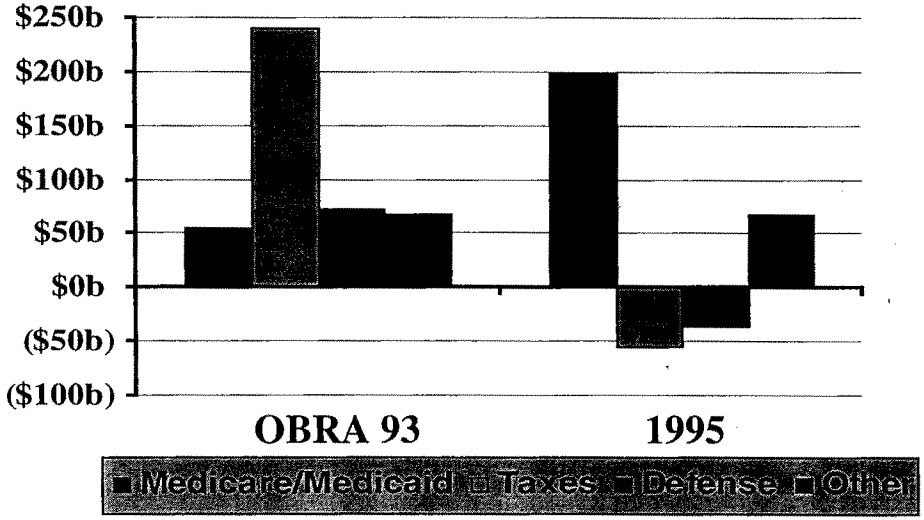


- **Cut Medicare by $100-$150 billion over 5 years.**
- **Cut Medicaid by $100 billion over 5 years.**
- **Cut Medicare again.**
- **Pray**

Federation of American Health Systems

Where Will It Come From?

Taxes Cuts and Higher Defense Spending Make Health Spending the Target*



* Even here, the numbers total only about $200 billion over 5 years— less than half the amount needed for the balanced budget glide path.

Federation of American Health Systems

Chairman THOMAS. I thank the gentleman.

Ms. Steelman.

STATEMENT OF DEBORAH STEELMAN, WASHINGTON, D.C.; FORMER ASSOCIATE DIRECTOR, HUMAN RESOURCES, VETERANS AND LABOR, OFFICE OF MANAGEMENT AND BUDGET; AND CHAIR, 1991 ADVISORY COUNCIL ON SOCIAL SECURITY

Ms. STEELMAN. Thank you, Mr. Chairman.

It is really a privilege to come here today to talk about Medicare, because Medicare reform is a thinking person's debate and has been for a long time. Presidents in both parties have previously sent up a number of proposals to try to deal with the unacceptable growth in the program. Members of Congress in both parties have long accepted the fact that this program needs to be reformed.

We have tried a number of different mechanisms over the last 10 years. I think this year is a very important year to continue what the Congress has worked on for the last decade, to try to get the program's cost down and to try to improve it for the beneficiaries and to try to stabilize its financing. This year is no different than any in the last decade, regardless of what this President's budget contains.

I think there are three reasons to talk about Medicare reform. All have budget relationships, but they are not all relationships to the Federal budget. A lot of them are relationships to beneficiaries' budgets.

For example, current beneficiaries today pay a part B premium and a part A deductible. If we don't do something to constrain the growth in the program, those costs will go up for beneficiaries, as those costs are tied to the costs of the program. In a brief 5 years the part A deductible will go from $716 to $872. In that same timeframe, the part B premium will go from $552 per year to over $700 per year.

If you take a look at just extending that out to, for example, the year 2020, the year in which I turn 65, you end up at a part B premium that is obviously beyond the means of any beneficiary. In the Advisory Council on Social Security, which I chaired a couple of years ago, we did a calculation that if the part B premium remains fixed at 25 percent of program costs, it will no longer consume about 6 percent of the beneficiary's check, which is what it consumes today. Right now, the part B premium, of course, is deducted from the Social Security check. It will consume over 13 percent, over twice as much a portion of the beneficiary's check.

The part B premium in the year 2020, unless this Congress acts, will be $310.50 a month. This isn't doable. So there are many reasons to take a look at Medicare's budget that have a lot to do with the way the program functions in people's lives, and for that reason, we owe the reform debate a serious effort this year.

Of course, there are also future beneficiaries involved. The trustees, as the chairman quoted earlier, were very clear in their instructions to the Congress last year on both part A and part B, specifically, the trustees, Secretaries Shalala, Reich, then-Secretary Bentsen, and Administrator Vladeck urged the Congress to take additional actions designed to control HI program costs through

specific program legislation. The trustees believe that prompt, effective, decisive action is necessary.

Again, I refer you to the trustees' report on SMI costs:

> Given the past and projected costs of the program, the trustees urge Congress to promptly take additional actions designed to control SMI costs through specific program legislation. The trustees believe that prompt, effective, and decisive action is necessary.

The President's current budget is the most recent policy proposal of the administration that follows this trustees' report. This trustees' report was issued in April. This budget document should have responded to the trustees' urgings. It didn't. It is, therefore, up to the Congress to do so.

Clearly, part A and part B matter to beneficiaries, not always in ways that are obvious in our inside-the-Beltway discussions. Another piece of pressure that is on the part B premium is how much of the program now goes through part B versus how much goes through part A. Part A, as you know, is paid for through a payroll tax. Part B is paid for by general revenues and by the part B premium.

When this program was enacted, part A was about 80 percent of the program. Part B only was about 20 percent of the program. Today, that ratio is more like 60:40. So when you say that you are limiting the part B premium to 25 percent of program costs, obviously, it really matters what program costs are. If part A is shifting into part B, beneficiaries' costs, general revenue costs, taxpayer costs are going up. That is why we have to have this discussion as a part of the budget.

Why is it that we keep avoiding the question of Medicare reform? Why is it? Why is it we keep going back to price slashes? Why is it we don't talk about the structural reform that is necessary to reduce the volume, that is necessary to reduce the program cost growth for current beneficiaries, for future beneficiaries, for trust fund balances, for allowing government to spend its resources more wisely and, therefore, spend within its means?

I think it is because we have been scared to face, all the unpleasant town meetings. In fact, reform can be more a matter of common sense if thinking people will engage in it.

If, for example, we were able to reduce Medicare simply to the rate of inflation in the private sector, we could save all the budget targets you need to save and we could make a part B and a part A deductible that was more in keeping with private sector levels. You can't do it by just going to old fashioned proposals. We know that after 15 years. You know how ineffective these proposals have been. They have been stop-gap, budget-driven measures.

Can we build on those to really try to stabilize the program at an inflation rate more akin to the private sector? I think, yes, if you do four things.

Number one, try to get prices to more clearly mirror private sector.

Number two, try to open up HMOs to try to give more beneficiaries the availability of purchasing managed care, if they prefer it.

Number three, open up interim steps like Medicare Select or the current risk contract law to try to create benefit packages that make more economic and rational sense to the beneficiary.

And number four, really try to restructure the program in some sort of certificate-based or voucher-based context to allow beneficiaries to use their market power to compensate for the obvious inabilities of government. Government pricing will always be countercyclical to the private sector. If we allow beneficiaries and their power in the private sector, we will be successful in getting Medicare's growth rate closer to that of the private sector. We will help beneficiaries, we will help the budget, and it won't be the kinds of screaming and pain that Tom has articulated, if we just step up to the plate now.

Thank you, Mr. Chairman.

[The prepared statement and attachments follow:]

TESTIMONY OF DEBORAH STEELMAN, ESQ.
WASHINGTON, D.C.

Thank you for the opportunity to appear before you today. Since my years in the Executive Branch, I have had the opportunity to work in the private sector as it revolutionizes beneficiary participation and health care delivery. I believe Medicare needs to be improved, and can best be improved by incorporating the type of approaches that have been innovated by the private sector.

TODAY'S MEDICARE BENEFICIARIES DESERVE A BETTER PROGRAM

Put plainly, Medicare needs to be a better program. It has failed to keep pace with the needs of beneficiaries and its financing is no longer stable. On these two issues, the President and Members of Congress in both parties agree. Yet the weaknesses persist.

Without reform, Medicare beneficiaries face a future of rising costs, and no ability to reduce their Part B premium or other costs.

- Today, the Part B premium costs $552 per year; by 2000, beneficiaries will have to pay over $700 per year for Part B coverage. Current premium costs equal a little over 6% of an average beneficiaries' Social Security check. According to technical work done by the 1991 ACSS, the Part B premium would rise to $310.50 per month, or over 13% of the average beneficiaries Social Security check. See **Chart 1**.

- The Part A deductible will rise from $716 this year to $872 by the year 2000. See **Chart 1.**

- The typical beneficiary will also incur coinsurance liabilities for physician services as well, raising the potential out-of-pocket liability to well over $2,000.

- Add these amounts to other out-of-pocket expenses typically paid by a beneficiary -- expenses for non-covered services, Medigap protection, and other routine costs -- and beneficiaries pay mightily for the crazy quilt system built on and around the inflexible and outdated Medicare program.

Without reform, Medicare beneficiaries will have only limited or no opportunity to improve their coverage.

- The ability of a beneficiary to choose a health care plan is severely limited by the rigidity of Medicare's statutory and regulatory structure and by HCFA's failure to make information about choices available. Allowing Medicare to continue as currently designed does a disservice to both current and future senior citizens.

- Some beneficiaries seek to lower their out-of-pocket burdens through managed care arrangements, but HCFA does little to provide them with a choice of health plans or information about their options.

- The only way most beneficiaries can improve their coverage is to purchase Medigap coverage that is rigid and rarely as cost-effective as a more integrated policy would be.

Unless Congress acts, beneficiaries have little ability to change this pattern of escalating expenses and inadequate coverage. The ability of beneficiaries to lower their out-of-pocket burdens through managed care -- an option afforded millions of people in the private sector -- will continue to be limited.

Absent reform, beneficiaries will have to contend with an increasingly anachronistic, fractured Medicare program falling further and further behind the private sector with each passing year. Eventually, the discrepancy between private care and Medicare will produce a two-tier system: the high-quality, cost-effective private tier, and the low-quality, high-cost Medicare tier.

It is time to provide Medicare beneficiaries with some options. At a field hearing held by the 1991 Advisory Council on Social Security, one person suggested the need for a different future: **"I think that it is time that we started looking at choices in Medicare. Medicare has gone on a single program and although there have been many reforms that have looked at reforming the payment methods to providers, there have not been reforms that have looked at making choices available and also traditional Medicare that is available today. We might well find that the business of managing the delivery of health care to the elderly is as susceptible to some cost-savings as we think the management of that care in the employment setting is. That has not been explored sufficiently in our opinion, and we believe that a choice product in the Medicare arena is something that we should look into as well."**

TOMORROW'S MEDICARE BENEFICIARIES DESERVE A MEDICARE PROGRAM THAT'S "ALWAYS THERE."

The problems experienced by current beneficiaries are not the only reason for reform. Current estimates suggest that by 2002, the Hospital Insurance Trust Fund will be broke. This year may vary by one or two, but the bottom line remains: the financing of the program is unstable, the costs are escalating too quickly, and future beneficiaries are at risk.

Absent reform of the program, Medicare's Part A Trust Fund will no longer be able to pay the bills. The time to reform the program is not when a crisis is upon us, forcing a choice between driving up already high tax rates, depriving the nation's elderly of their primary source of health care coverage, or forcing the Federal government to assume massive deficits to provide for their coverage.

The need to avoid this future has long been acknowledged by people in both parties in the Congress and the Administration. Yet the current Administration proposes no Medicare reforms in its 1996 Budget. This is especially curious given the fact that no fewer than three Cabinet Secretaries recommended prompt action in last year's Social Security Trustees Report, and the President himself has supported Medicare reforms.

Current Administration officials have said that the Medicare program is growing at an unsustainable rate, and in particular, that the Hospital Insurance program (Part A), requires decisive action in the short-term to prevent bankruptcy.

In April of 1994, less than a year ago, Secretaries Shalala and Reich, then-Secretary Bentsen, and HCFA Administrator Vladeck all signed the Social Security Trustees' Report that concluded:

> *"... the present financing (of Medicare Part A) is sufficient to ensure the payment of benefits only over the next 7 years."*
>
> *"...the HI program is severely out of financial balance and is unsustainable in its present form."*

"...the Trustees urge the Congress to take additional actions designed to control HI program costs through specific program legislation.... The Trustees believe that prompt, effective, and decisive action is necessary."

Similarly, Part B, the Supplementary Medical Insurance program, has been a constant drain on Federal revenues. As **Chart 2** shows, the burden is expected to accelerate in the years to come. I would again refer to the most recent report by Secretaries Shalala, Reich, and then-Secretary Bentsen:

"Given the past and projected cost of the program, the Trustees urge the Congress to promptly take additional actions designed to control SMI costs through specific program legislation.... The Trustees believe that prompt, effective, and decisive action is necessary."

Although few were effective, proposals to rectify the inflation problem in Medicare have been proposed by both parties throughout the last decade, in both the Congress and the Executive Branch.

In fact, in September of 1992, then-Governor Clinton noted that government health care costs were rising at nearly three times the rate of inflation, a refrain he continued to echo throughout the health care reform debate. His proposal to reduce health care inflation was to institute "fallback" price controls in the private sector, and his proposal to reduce Medicare inflation was to lower Medicare reimbursement schedules and payments to the tune of $118 billion in Medicare cuts over five years.

President Clinton's $118 billion cut focused, like many past efforts, almost exclusively on the price of Medicare services. The primary method of delivering care to Medicare enrollees has not changed substantially since 1967, the year of Medicare's implementation. Care is largely uncoordinated fee-for-service, free from appropriate utilization and quality reviews. Had the President's cuts been enacted, they probably would have suffered the fate of its predecessors: evaporation as volume increases overwhelmed any reduction in prices.

- As shown in **Chart 3,** increases in utilization and intensity accounts for most of Medicare's spending growth. Price reductions only increase the incentive for over-utilization.

- Roughly 64% of the increase in Medicare spending between 1995-1999 stems from greater and greater intensity and service utilization.

So, after over a decade of "slash prices" proposals, the lesson should be clear: such methods can achieve very short-term reductions in cost, at best, and if no reform that includes beneficiary choice and utilization is enacted, Medicare costs will return to levels much higher than those incurred by the private sector where such tools have become routine.

Mammoth price cuts to Medicare payment rates such as those President Clinton proposed last year are not "reforms." True Medicare reform addresses beneficiary choice, price, and volume.

HCFA's sole exception in the "only slash prices" method of reducing Medicare costs was a proposal in the Bush Administration to create a volume performance standard (VPS) for physicians.

- However, even the VPS, while successful in restraining the growth in physician fees, has allowed spending to rise at rates beyond inflation. **Chart 4** shows that spending on physician services is projected to rise at 10% per year between now and 2000 -- and it is the slowest growing component of Part B.

HCFA has made little real effort to incorporate modern cost-reducing technology into the Medicare program. (**Chart 5**). The agency has made no effort to adapt the success stories of the private sector. We must.

We know what works in the private sector to contain costs and ensure quality. We are not reinventing the wheel. The private sector has turned toward managed care to contain costs because managed care arrangements do a better job of giving the beneficiary something in return for organizational structure: a lower premium.

- Over 50% of private sector, insured employees were enrolled in managed care arrangements in 1993 *(see **Chart 5**)*; preliminary 1994 figures indicate that private sector managed care enrollment will exceed 60%.

- The consulting firm Foster Higgins reports that for the first time in a decade, private employers have actually lowered the costs of employee insurance. The apparent relationship between increased managed care enrollment and lower health inflation is striking *(see **Chart 6**)*.

- **Chart 7** displays per capita rates of growth in Federal health care spending; per capita Medicare spending is rising *31% faster* than private sector costs.

FOR GOVERNMENT TO SPEND WITHIN ITS MEANS, MEDICARE'S RESOURCES MUST BE SPENT MORE WISELY.

Entitlement spending consumes two-thirds of the Federal budget.

- Medicare alone takes one of every ten dollars the Federal government spends, and Medicare and Medicaid will eat up 16% of the Federal budget in 1995. See **Chart 8.**

- By 2002, the two major health programs will consume nearly one-quarter of Federal outlays, with Medicare alone costing over $325 billion. See **Chart 9.**

By 2003, Medicare will be the second largest Federal program, behind Social Security, greater than Defense and exceeding the combined total of all domestic discretionary programs (**Chart 10**).

In other words, if Medicare doesn't spend its resources more wisely, its appetite will consume more money than the combined total of every education, transportation, environmental, arts grant, occupational training, and public health program in the Federal budget.

IF MEDICARE REFORM IS SUCH COMMON SENSE, WHY DOES EVERYONE WANT TO AVOID IT?

The road to a better Medicare program is clear and there is nothing very dramatic about it except the results and satisfaction real reform will produce over time.

- Bring Medicare per capita inflation in line with that recently experienced in the private sector (**Chart 11**).

  •Reduce prices to mirror private sector prices.

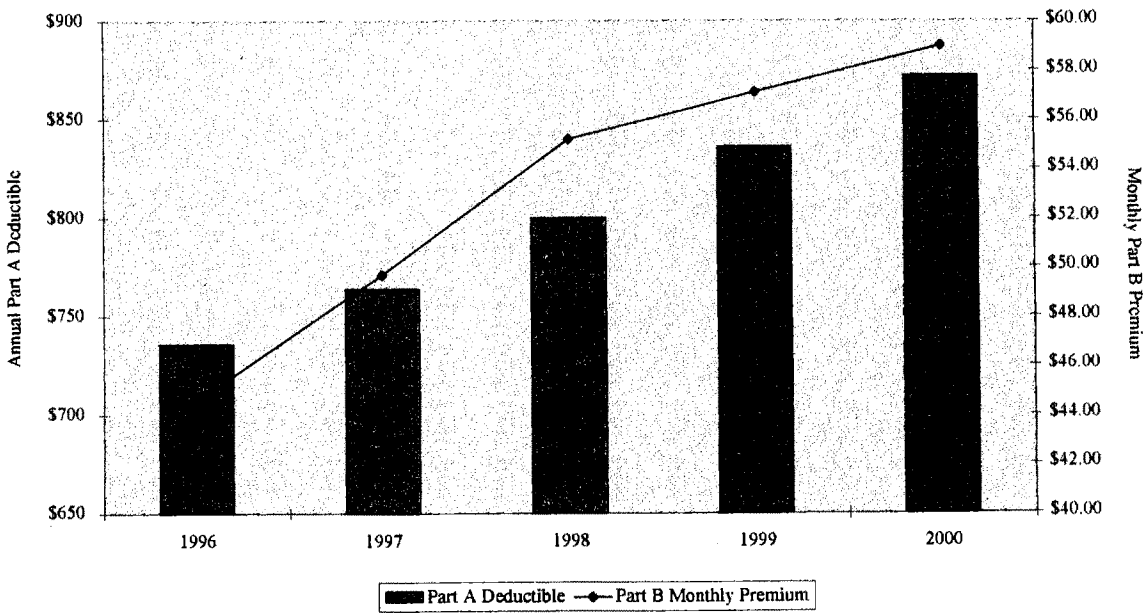
- Increase managed care enrollments by changing antiquated Medicare law and regulations to increase the availability of managed care to all beneficiaries who would prefer it.

- Increase beneficiary participation and lower utilization by opening the Medicare program to the variety of private sector innovations in health care financing and delivery, giving beneficiaries the ability to customize their benefit package and decide how best to improve their coverage.

This cannot be accomplished overnight, and will in fact will probably require the entire seven years now suggested by the Medicare Trust Fund's impending bankruptcy. Beneficiaries -- current and future -- would prefer the job finally get done right. A Congress that does not pave the way for a modern and secure Medicare program will have much to regret.

CHART 1

Rising Medicare Costs Will Require Beneficiaries to Pay More Out-of-Pocket



(Source: CBO)

CHART 2

Increasing Part B Costs Require Ever-Greater Contributions from the General Taxpayer
($ in billions)

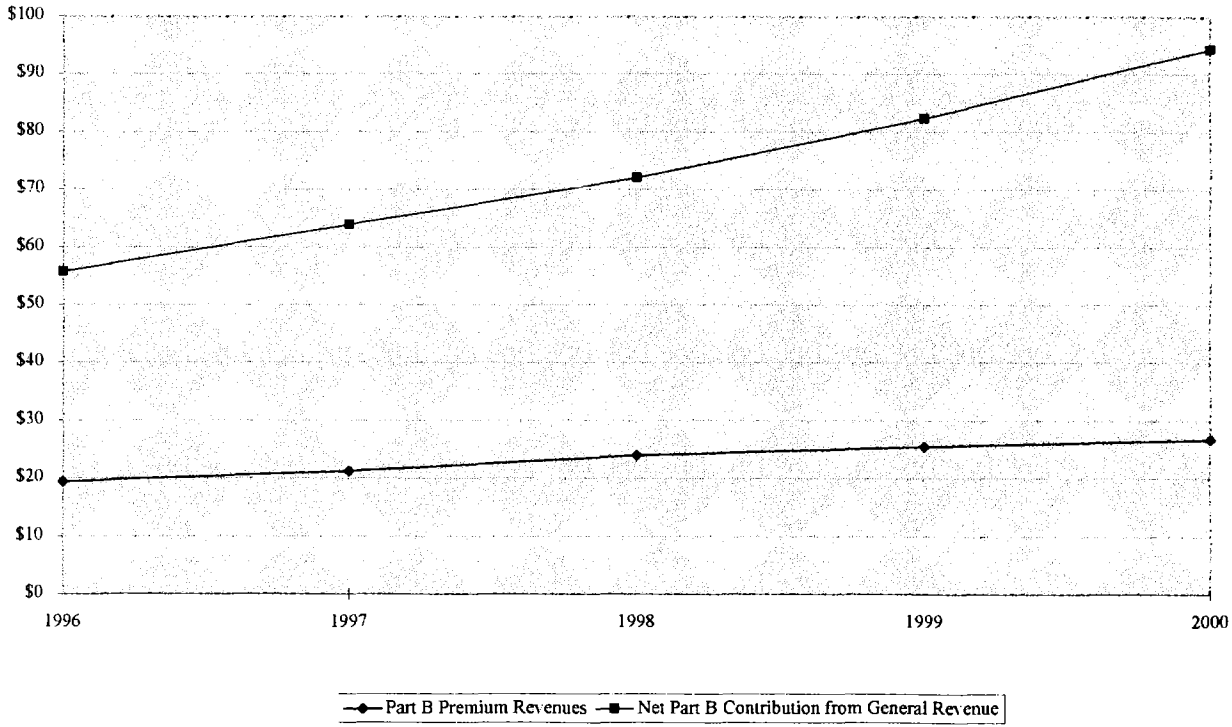
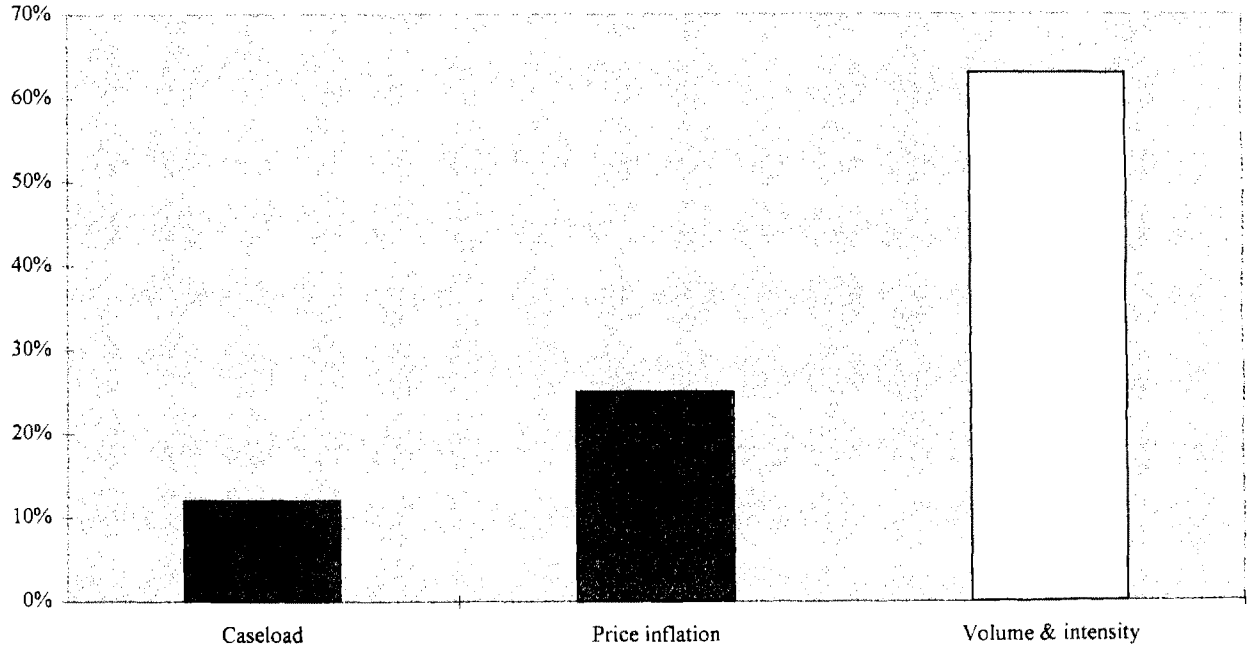


CHART 3

Baseline Projections Are Far in Excess of Current Services. Nearly 64% of Spending Growth Is Attributable to Greater Services

(Sources of growth in Medicare spending, 1995-1999)



(Source: CBO preliminary baseline estimates, January 1995.)

CHART 4

Rates of Growth for Respective Elements of Part B
(avg. annual growth rate, 1994-2000)

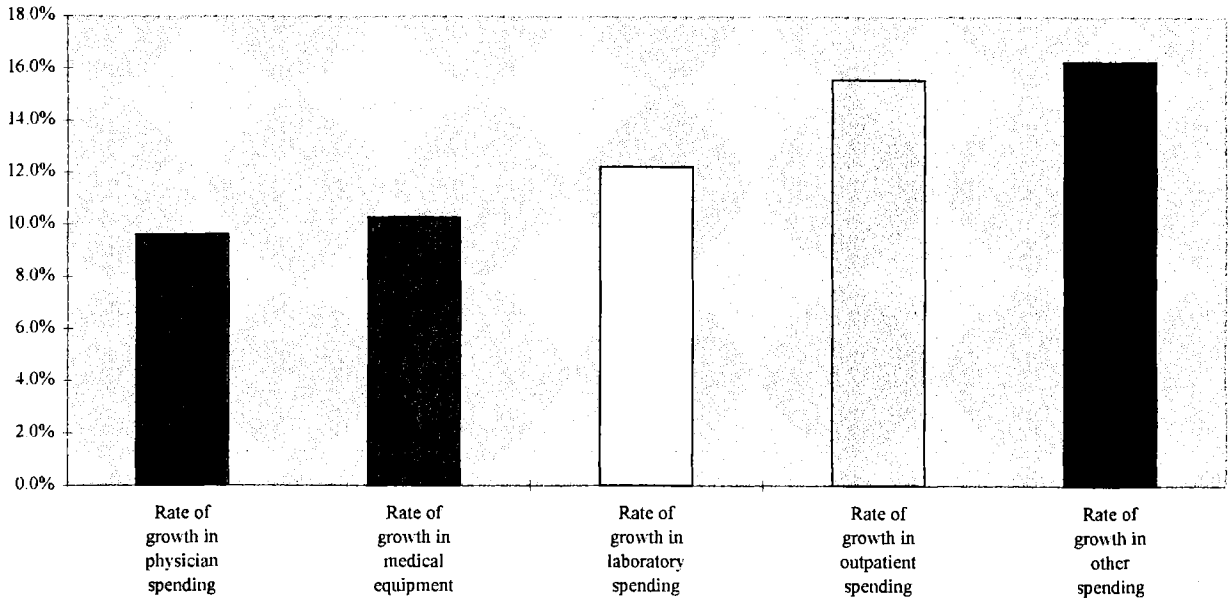
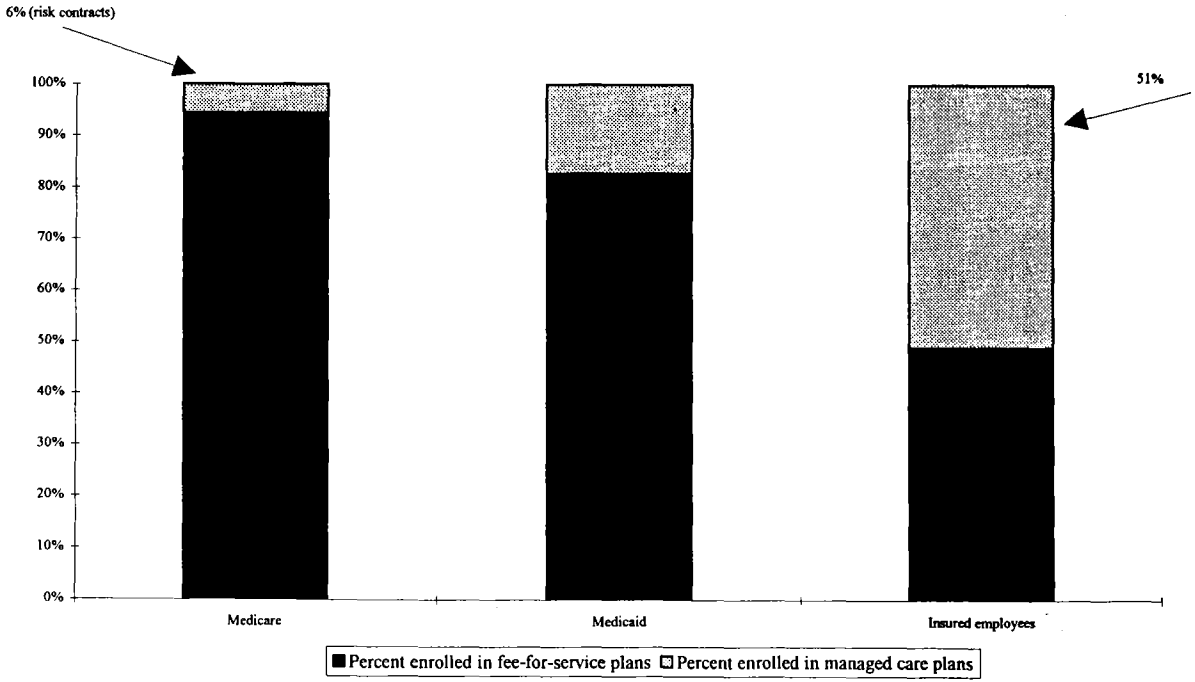


CHART 5

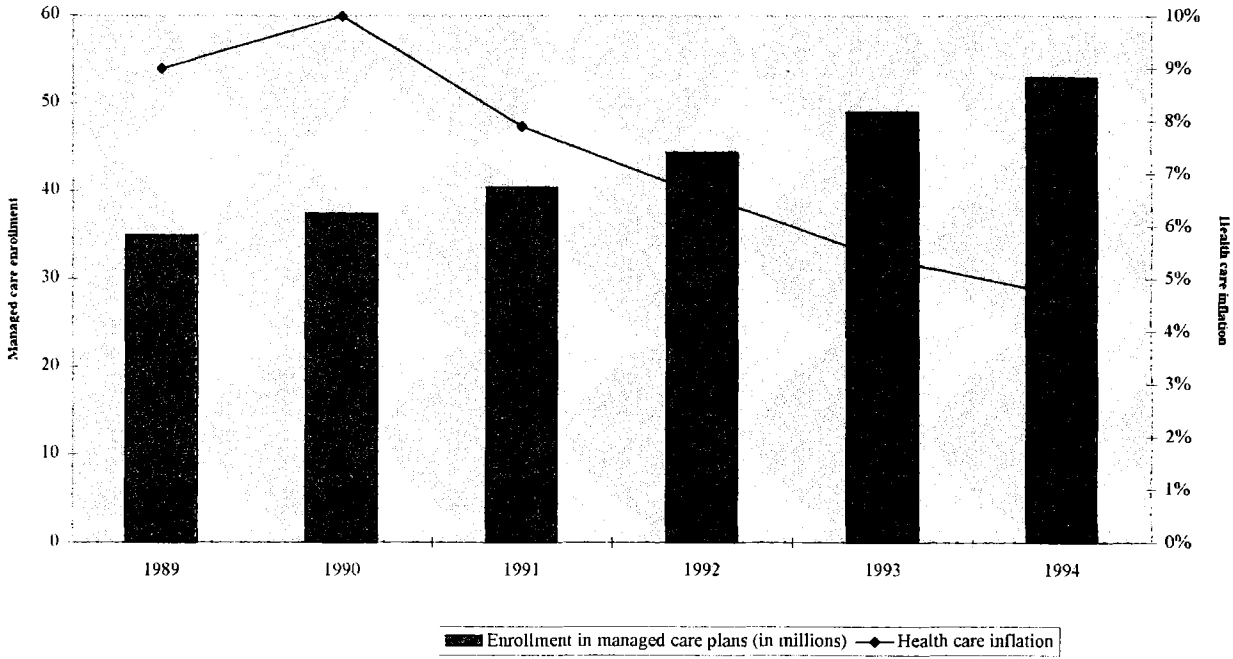
Medicare Does Not Use Modern Health Care Delivery Techniques



(Source: Aetna Health Plans, HCFA data. Managed care includes HMO, PPO, and POS plans. Data for 1993.)

CHART 6

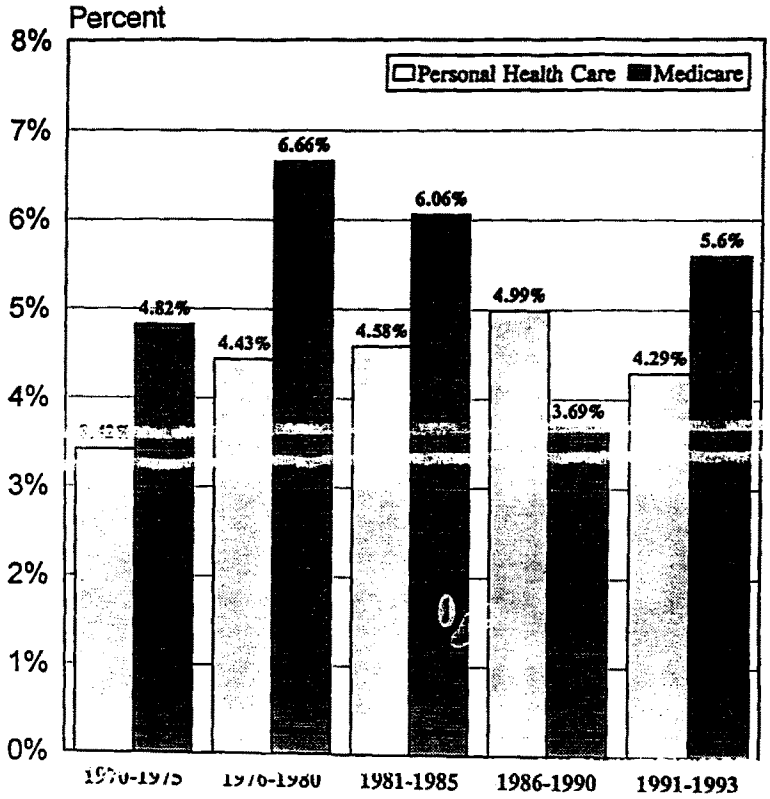
As Managed Care Enrollment Rose by 50%, Health Care Inflation Has Declined by Half



(Source: Marion Merril Dow for managed care enrollees. 1994 Economic Report of the Pres. for inflation. 1994 figures are esimates.)

CHART 7

Figure 4. Average Annual Growth Rate of Real Per Capita Medicare and Personal Health Care Spending, 1970-1993



Source: Figure prepared by CRS, based on National Health Expenditure data, Office of the Actuary, Health Care Financing Administration
NOTE: All real expenditures calculated using implicit price deflator for GDP

CHART 8

Entitlement Spending Consumes 2/3rds of the Federal Budget (Federal Spending 1995)

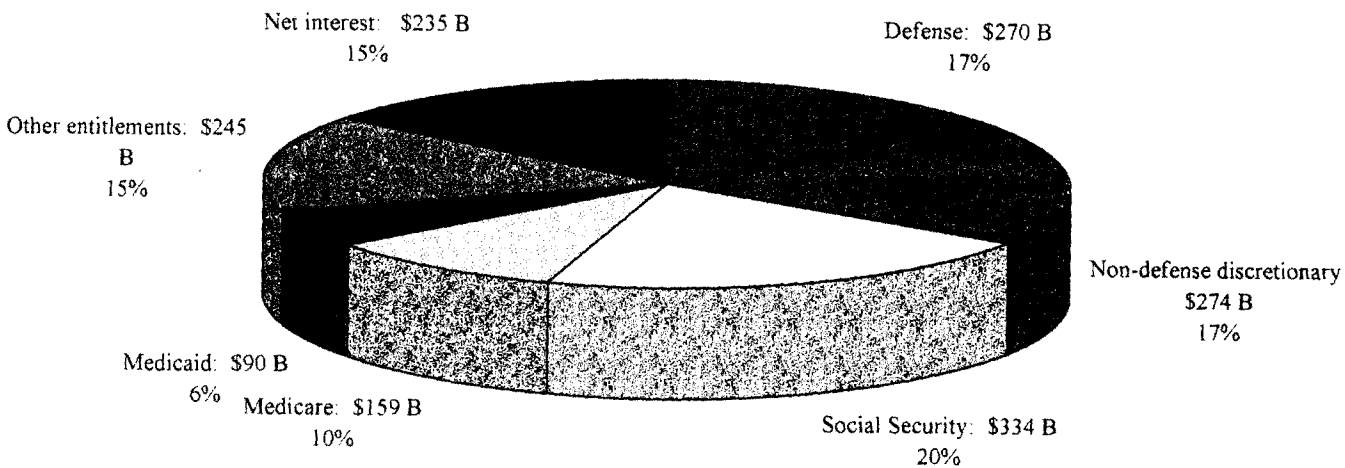
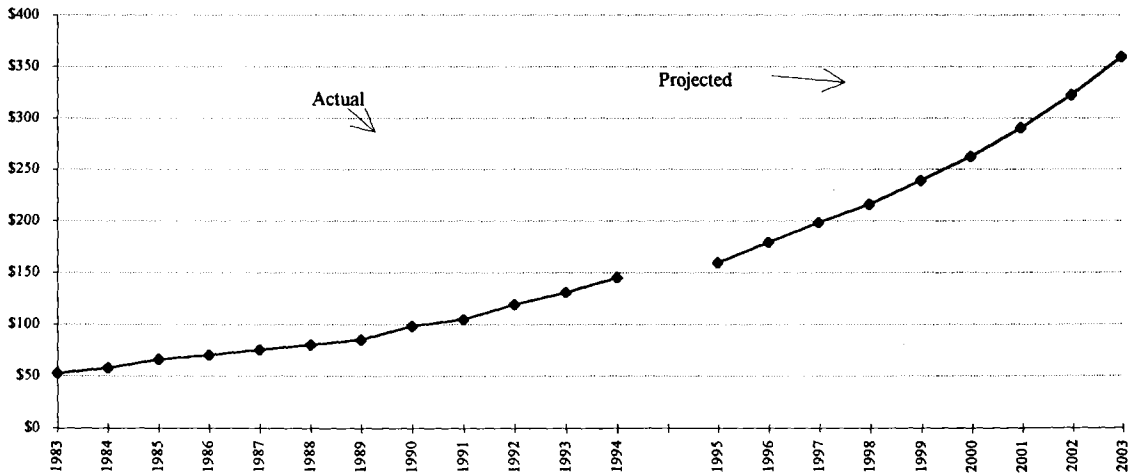


CHART 9

Medicare Will Double in Size over the Next Seven Years Unless Congress Reforms the Program

($ in billions)



(Source: Preliminary CBO baseline estimates, January 1995.)

CHART 10

Medicare is Growing Two-and-a-Half Times as Fast as Family Support or Domestic Discretionary Spending ($ in billions)

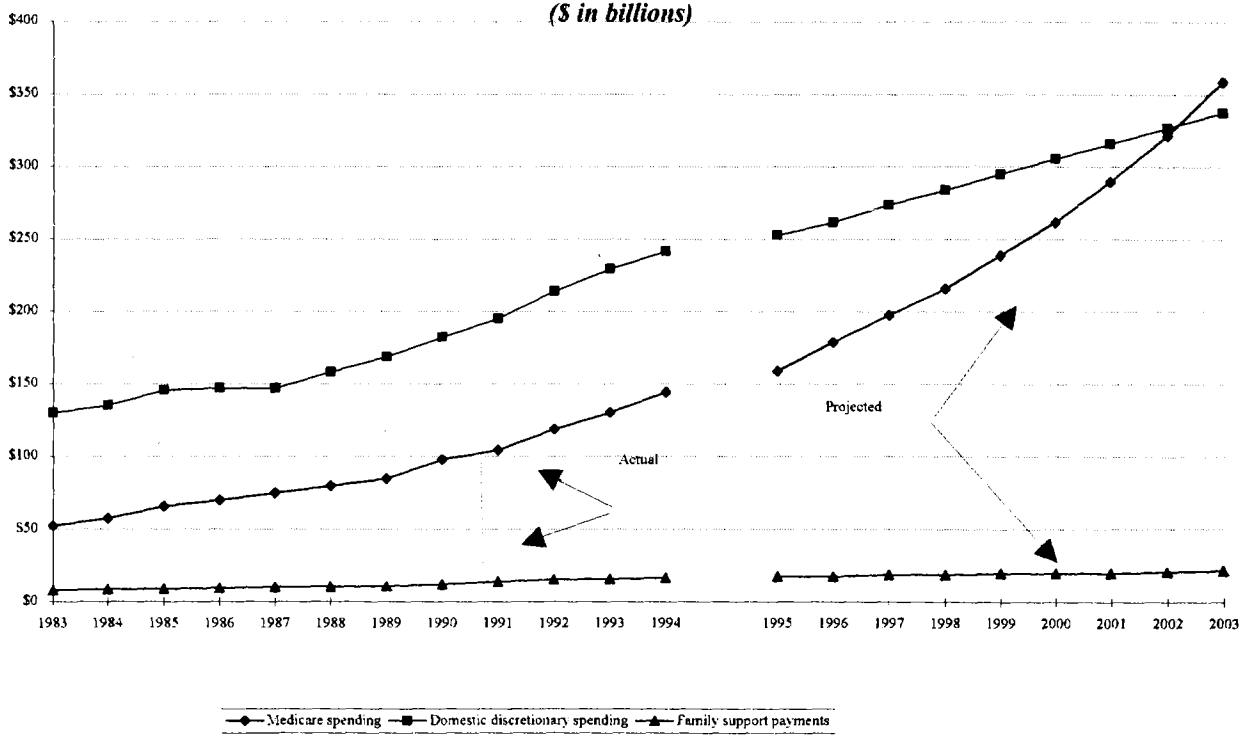
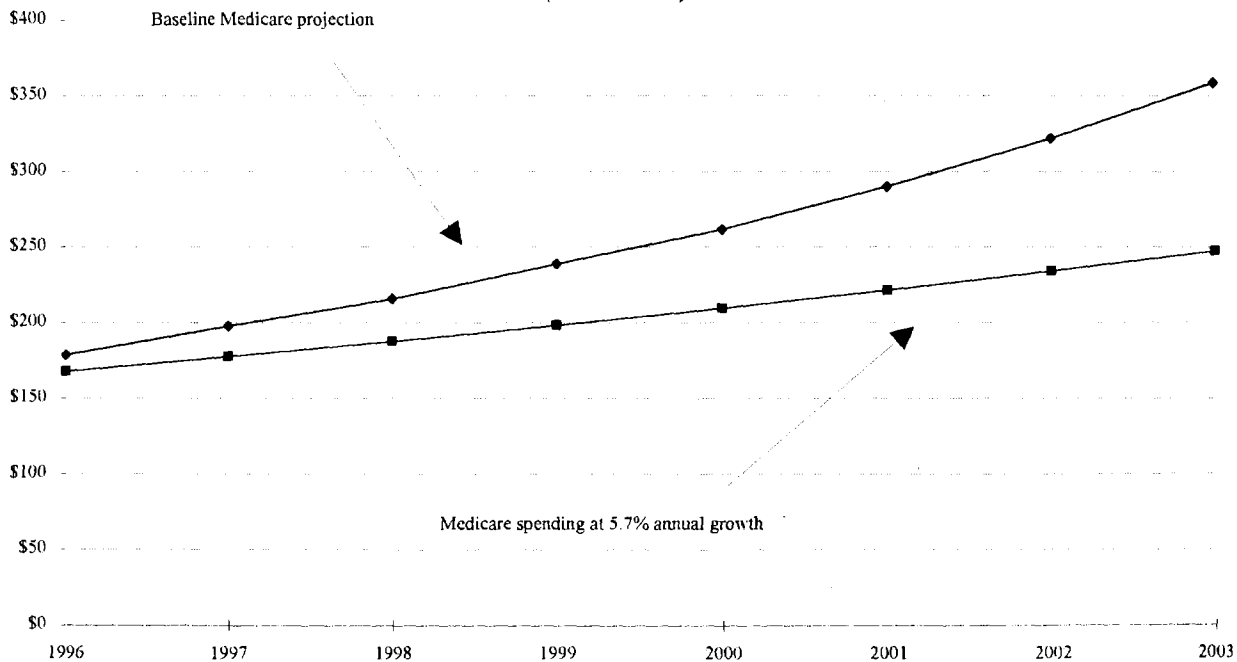


CHART 11

Holding the Rate of Increase in Medicare Spending to Private Sector Health Care Inflation Would Result in Significant Savings

($ in billions)



Preliminary 5-Year Savings from Holding Medicare to 5.7% Annual Growth: $152 BILLION

Chairman THOMAS. I thank both of you very much for a discourse in which you have obviously spent a lot of time and you have a lot of knowledge.

Mr. Ensign will inquire.

Mr. ENSIGN. Thank you, Mr. Chairman.

Ms. Steelman, people say that Medicare has worked well for the last 25 years. Why won't it work well for the next 25 years?

Ms. STEELMAN. I am not sure Medicare has worked well for the last 25 years. Obviously, the program was designed with a need in mind and on a stable financing structure. Over time, over the last 25 years, nothing in this country has stayed the same, especially not in the delivery of health care in the private sector.

The next 25 years for Medicare aren't so much a matter of making it stay the same as making it work well, and to do that, we have to get away from the kind of proposals that we have addressed here over the last 15 years, which are purely price cuts, and we have to talk about what is really going on in Medicare and how to make Medicare work better, how to make it secure for people, how to make sure it is there for all beneficiaries.

The obvious thing is, the place we are not controlling Medicare costs is in volume. The cost of Medicare goes up in three ways, the number of people in the program, the price of the services, and the utilization of the services. Utilization has gone through the roof in the last 15 years, unlike in the private sector, where tools are now routine to get that under control. Those are the kinds of things, I think, we need to do to make sure the program is there for the next 25 years and continues to work well, even though the guts of the program, obviously, have to work differently.

Mr. ENSIGN. When you are talking about the increase in volume, a lot of people say that we are talking about rationing in cutting down the amount of volume. If, in fact, we are talking about trying to decrease the volume, how do we allow the patient to make those choices instead of the government?

Ms. STEELMAN. Volume is not the same thing as rationing at all. Rationing gives the connotation that a needed service will not be provided. In health care, we have learned a lot over the last decade in the private sector on how to make sure needed services are provided and unneeded services are not provided. That is the basic lesson Medicare has not accommodated.

Mr. ENSIGN. Mr. Scully, if we move all these seniors into the private plans and managed care, how do you avoid the cherry picking or risk selection in these plans?

Mr. SCULLY. I would anticipate that Mr. Stark and others would bring that up. I think if you go to a more private sector-driven, privatized Medicare system, where people choose private plans, the single biggest problem you are going to have is risk selection.

We have been looking at that for 4 or 5 years. We did a very large study on that in the Bush administration. I know that the Ways and Means staff has looked at it. I know HCFA has looked at it. There is no perfect answer for risk selection and that is one of the problems in HMO risk contracts now.

I personally believe there are ways to get at it. If you are going to look at a structured system that is a model for it, either FEHBP or a privatized Medicare system where the Federal Government

has a relatively small group of carriers that it selects, that it basically has control over the rate payment to, is probably a good model to figure out how to avoid risk selection.

But there is no doubt that you are going to have risk selection problems in any kind of system that you move to in a privatized system and there is a danger there. My view is that HCFA has the tools to find a way to adjust the capitated payments of Medicare now to make sure that that is limited. My view is that there are a lot of ways to adjust the structure of the payments to private plans in Medicare that can improve on the current—I don't know if you are familiar with the AAPCC in Medicare now—that can improve on the current payment system to make sure that that doesn't happen.

I think the dangers of risk selection, which are clearly there, are nowhere big enough to justify not moving forward to a more efficient privatized system. Clearly, you need to experiment, and clearly, you have to be careful, but I have been looking at it for 5 years and I am convinced that there are ways around it, especially in Medicare. If you are going to experiment with these kinds of systems, Medicare is the place to do it.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman THOMAS. Mr. Stark, do you wish to inquire?

Mr. STARK. Yes. I have just a couple of questions.

One of the things, I suppose, we could do, and we are not sure yet how much it would save, but if we required hospitals to charge Medicare no higher than their lowest price in town, we would save a lot of money.

Would your group support that, Mr. Scully? There is some anecdotal evidence that some hospitals, particularly in some States, are giving discounts about 30 percent below Medicare rates to groups to get managed care plans in. It has been an old approach, to say, look, you are a hospital. You can't charge Medicare any higher than you charge your lowest rate. We would save a lot of money that way. The hospitals, of course, have fought it, but maybe that is one of the things they would accept.

Mr. SCULLY. I personally don't think that would work. In my experience, the closest thing we have to that is the Medicaid drug rebate language that I, unfortunately, helped through——

Mr. STARK. Why should I pay more than some insurance company for the same procedure? Why should the taxpayers do that?

Mr. SCULLY. I am not sure what you mean. I guess my view is the market system delivers the most efficient care, eventually. The problem you have is if you, as an individual, are out there buying——

Mr. STARK. I mean the government. I am sorry. Why should the Federal Government pay more than Prudential at the Sisters of Mercy Hospital? If they are giving a 30-percent discount—Ms. Steelman has the answer, but you may figure it out. Go ahead.

Mr. SCULLY. My suggestion is basically that——

Mr. STARK. No, why wouldn't the hospitals accept that? Why isn't that fair? That is all I want to know.

Mr. SCULLY. Because, I think, what the Federal Government should be doing, more likely, is to take 33 million beneficiaries, or,

let us say, in Baltimore, why shouldn't the Federal Government go with Prudential in Baltimore with 100,000 beneficiaries——

Mr. STARK. They can. Seventy percent of the beneficiaries have an HMO available to them. I am talking about us spending Uncle Sam's money. Why should I pay a hospital more than what they are willing to take from other payers? In Maryland, they don't do that. You get one price for everybody, and they are doing a lot better job than any other place in the country.

What is wrong, as an attempt to save the taxpayers money, to say, look, we will pay the Medicare price or the lowest price you charge for a procedure. Why is that unfair to the government? We would save some money, wouldn't we?

Mr. SCULLY. The government, for many years, was the lowest payer, and in many places, still is.

Mr. STARK. But we aren't now.

Mr. SCULLY. It depends on the area, but it is a fundamental belief in whether you prefer markets or regulation. I, as we have discussed for years, do not think fee-for-service rate regulation works.

Mr. STARK. Suppose I prefer markets. What if we go out and bid, which we are about to do, for procedures?

Mr. SCULLY. I think that is great. If the Federal Government goes out in a private payment plan and uses Prudential or uses Kaiser——

Mr. STARK. Why can't I bid directly? We do it when we build airplanes. Why can't Medicare bid in a market to set a rate?

Mr. SCULLY. If Medicare is operating as an actual market player, for instance, in centers of excellence where Medicare goes out and says, we will pay *x* number of dollars to a center of excellence for certain types of procedures, I think that is fine.

Mr. STARK. But you don't think it is fine for me just to bid in the market in a particular area and say, we will take the lowest price in town?

Mr. SCULLY. If you say, we will take the lowest price in town and providers are willing to do that with you and they can operate economically that way, then you are, in fact, operating in the market, and that is fine with me. But for the Federal Government to go out and say, as we did in Medicaid rebates, we will pay the lowest drug price or we will pay the lowest—when you look at the Medicaid rebate, it was a disaster, because——

Mr. STARK. Why should we pay a higher price than Prudential in the market?

Mr. SCULLY. You shouldn't, but just again to use Medicaid as an example——

Mr. STARK. Then what is wrong with my passing a law that says we won't? We will pay whatever a hospital is willing to charge somebody else.

Mr. SCULLY. Because what will happen is exactly what happened in the Medicaid rebate. There will be no more low price, because what will happen is you will go into the market and say, we will pay the lowest price that everybody charges. Guess what? They won't charge that low price anymore.

Mr. STARK. So you are saying you want to let your crowd shift costs onto Medicare and we should pick up the slack. That is what you are saying.

Mr. SCULLY. No, I am——

Mr. STARK. I think the honeymoon is over. You can't have it both ways. If we are expected to be cautious with the public's money, there is no reason on God's green Earth that I should pay Humana any more than they are willing to take from Prudential for the same procedure. It would be, in my mind, absolutely a dereliction of duty and there is no good reason.

Mr. SCULLY. I would agree with you, and in 1990, I helped put the Medicaid rebate law in place on the same theory, and it turned out to be a disaster because what happened was everybody dropped their best price and it hasn't worked.

Mr. STARK. Medicaid is run by a series of States. It has no relationship to Medicare. What you did in 1990 has nothing to do with what we are going to do in 1995 or 1996. I am just suggesting that where hospitals are commonly charging other people less than they are charging Medicare, we kind of look like patsies if we don't get that same low rate.

None of your clients would allow any of their purchasing agents to buy ambulances at a higher price than they could get if they walked down the street and got a bid from the other ambulance company. Why, in the best sense of private enterprise, which none of the witnesses have ever been connected with, I might add, shouldn't we get the lowest price that is being offered in the market?

Mr. SCULLY. I think you should, and I think the way to do it is through private carriers. I think the way the market has worked is for you not to go out and set rates through government regulation, but——

Mr. STARK. Why shouldn't we get it any way we can?

Mr. SCULLY [continuing]. In a market driven system, I am all for it. I think it is great.

Mr. STARK. But you are not for it under the current system? You would just as soon see Medicare waste money if we are in the current system?

Mr. SCULLY. I am very anxious to see Medicare save money, to restructure the system. I just think that going out and, essentially, having Federal Government rate regulation and price setting is very negative for the market. You have a market that is beginning to work and beginning to squeeze. We don't like the squeeze; nobody likes the squeeze. But we would rather be squeezed by the market than by an inefficient fee-for-service system that sets perverse incentives.

Chairman THOMAS. The subcommittee will recess until we get this vote and then come back.

[Recess.]

Chairman THOMAS. The subcommittee will reconvene.

Mr. Christensen may inquire.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Ms. Steelman, earlier, my colleague from California, Mr. Stark, asked a question about pricing and shouldn't the Medicare pricing be similar or the same as others in terms of the private market. He took a couple of jabs at you, and I would like to hear what your response to that question would be.

Ms. STEELMAN. Clearly, Medicare ought to try to get to a price level, inflation level, more like the private sector. That is how I concluded my opening testimony. I think there is a way you can do that, and it is called an open integrated bidding system, or a voucher-type system. That is how you get to that price.

In the private sector, one of the things that has helped the cost crash that has occurred over the last 5 years is fully integrated systems. You used to have this fee-for-service, unsupervised, things happening all over the place. Now you have an integrated system, where a hospital bid for a bed day is part of an integrated bid.

In Medicare, of course, Medicare is an extremely fractured program. What you do in part A pushes out into part B, as we talked about earlier in terms of the premium and the dollars and the flow. What you price for an inpatient bed is different than what you price for an outpatient bed is different than what you price for this or that or the other.

For Medicare to succeed in getting the same prices that the private sector gives, Medicare has to adopt the tactics and the techniques of the private sector, and that means an integrated bid. Clearly, if you gave beneficiaries a voucher or a certificate, however you want to do it, and said to the beneficiaries, here is an amount of money. Go out into the private sector and see what kind of a bid you can get, or if HCFA conducted a bid process, there is no question that prices would fall and bids would fall and that Medicare beds would cost the same as private sector beds.

But you can't simply march in and say, let us have an all-payer system for the whole United States that isn't just as countercyclical and just as regulatory and just as confusing as the current Medicare system.

To get that kind of price, you have to move away from the way Medicare prices today and go into a new structure, and I think it can be done fairly easily.

Mr. CHRISTENSEN. In subcommittee, a couple weeks ago, we heard, Mr. Vladeck never did really give us a very good reason why Medicare Select should not been extended.

It is my opinion that Medicare Select, in one of your points, talking about trying to open up HMOs, expanding it further, might be the direction to go. You have had some experience in this area. Fifteen States currently offer Medicare Select. I think only one has pulled out of that.

What is your feeling as far as extending it permanently and offering it throughout the whole country?

Ms. STEELMAN. There is no question Medicare Select is a great idea and a way for a beneficiary to rationalize their economies in their retirement years. Right now, as we have already talked about, the beneficiary has to pay about $520 on a part B premium, at least $700-plus on a part A deductible, probably $700 to $1,200 for a Medigap plan. We ought to be able to give the beneficiary a way to rationalize and reduce those expenditures.

That is what Medicare Select does. Medicare Select allows the beneficiary to buy one product, get everything covered at an integrated, discounted rate, and save some money and get some extra benefits. That is a step on the road directly to the kind of program that Medicare to has become. The HMO risk contract law is one

step. Medicare Select is another step. There are some things that we ought to do to expand Medicare Select and HMO risk contracts, but we also need to recognize that those are steps on the path.

The ultimate goal is to try to make sure Medicare can operate like the private sector in an integrated product that has all the benefits people need, including pharmaceutical and others, at an integrated price that is going to be a lot lower than buying this stuff piecemeal.

Mr. CHRISTENSEN. Mr. Scully, do you want to comment on that?

Mr. SCULLY. Yes. I spent a lot of time on Medicare. I personally think Medicare Select is great, but it is a baby step. It is a small step. Medicare Select is a very limited, very structured managed care Medigap plan, and, basically, it is a sliver of what you really could do. If you look at what people below 65 have a choice of, all kinds of hybrids, of PPOs, point-of-service contracts, managed care plans, indemnity plans. If you are under 65, you can go out and buy any kind of hybrid contract you want. If you are over 65, you either get an HMO risk contract, a very structured Medicare Select contract.

It is a step in the right direction, but you can do an awful lot more. I think that seniors have nowhere near the ability to choose between different hybrids of plans and types of plans that people under 65 do, and I think what we are talking about, really, with more of an FEHBP-like system is to give you a lot more choice than just Medicare Select.

Medicare Select is a good start, but I think it doesn't go anywhere near far enough, personally.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman THOMAS. Mrs. Johnson.

Mrs. JOHNSON. Thank you very much for your testimony this morning.

To get from where we are today to where we clearly need to go, if we are going to both control costs and expand benefits, because the current Medicare benefit package is really tragically out of touch with good medical practice, what are some of the things that we could do immediately?

This year, there are money problems, but there are also some proposals in the President's budget, the kind of things we have traditionally done that won't impose any new costs but will be scored nicely and so on and so forth, so there are some manageable aspects to this year's program. But there are a number of barriers in the law that we could eliminate.

Would either of you like to talk about a few of those barriers that we could eliminate right now to begin making change and moving in the direction we need to go, and then some of the bigger issues that we might have to face as we reform Medicare?

Ms. STEELMAN. On Medicare Select, one of the main barriers is the fact that it is not renewed for any appreciable length of time so that nobody knows whether they can count on it or not or whether the product will exist. So obviously, we need to do things that beneficiaries can plan on.

Mrs. JOHNSON. That is right.

Ms. STEELMAN. Retirement is not a short-term, 6-month type of deal for Medicare retirees. They want to plan on products that are

going to be there, so that is point on. Reauthorize some of these innovative things in a long-term format that can make a difference to people, so they know it is going to be there.

Second, obviously, one of the problems in the HMO risk contracts are the 50:50 rule and the construction of the average area per capita costs. The 50:50 rule uses a relatively arbitrary share of Medicare beneficiaries to commercial beneficiaries as some sort of a surrogate for a quality determination. I think there are a lot of quality determinations that could be made much more easily and much more productively that the private sector is actively engaged in, in terms of ranking HMOs and patient satisfaction, access to technology, and the like.

So if you open up HMOs to allow HMOs to specialize in Medicare beneficiaries and services, to bring in, perhaps, some of the social services that Medicare beneficiaries need more often, some of the sort of discharge services, after-hospitalization help with things around the house and that sort of thing, then you would have HMOs that cater much better and a much higher quality of medicine and much more likely to Medicare beneficiaries.

You also, of course, have the county-by-county problems and the rate determination. The AAPCC rate fluctuates wildly across the country because it is pegged to Medicare. It shadow-prices Medicare, so you don't really get the savings that you ought to. It overpays in some areas. It underpays in other areas. The AAPCC simply needs a fundamental reassessment to try to make it a better payment mechanism.

Of course, over time, I think any government payment mechanism is going to be countercyclical and probably off the point, so you need to get to a bid process of some kind to make sure that Medicare can match the private market.

Mrs. JOHNSON. I am not sure that trying to reform the AAPCC is worth it. It may be just flipping ourselves around it.

Ms. STEELMAN. I think there are some short-term things that could be assessed, but there is no question, your assessment of the difficulty is correct.

Mr. SCULLY. Debbie covered an awful lot. One thing I personally think would drive people much more—I think if you are going to go to more managed care, more capitation, more networks, whatever you want to call them, which, I think, is where the system is moving, you have to find incentives to do that.

The one incentive that I have always thought was missing in Medicare is the fact that most seniors, the vast bulk of them, are relatively low-income or modest-income people. If you want to give somebody a $5,000 AAPCC in Hartford, if they want to go out and limit their choice—Senator Gramm says he doesn't want anybody to limit his mama's choice. If she could get some money back for choosing to go to a more limited network, she is much more likely to go in it.

Right now, the way the Medicare risk contracts work is if you get a $5,000 capitated payment, you have to spend every dollar of it on a plan, which means more drug benefits, and more eyeglasses. Frequently, a lot of seniors would much rather say, if I saved the government $700, $800, $1,000 a year by choosing a tighter network or a more structured plan, they would just as soon get some

of the money back in savings, and I think that is the real missing ingredient that has kept seniors, in my opinion, from voluntarily choosing managed care a lot more aggressively.

Mrs. JOHNSON. Is there any problem in your mind, since we are only at the yellow light, between allowing seniors to get a discount back and still being able to have the oversight capability to assure that they do get the full bundle of Medicare benefits? Is that going to be difficult?

Mr. SCULLY. I don't think there is a problem there. I think if you went to a pure voucher system, which I, personally, do not think is a good idea, right off the bat, where you gave every senior a voucher to go out and buy whatever they want, you might have that problem. But if you have an FEHBP-like system where, say, in Hartford, you went out and had 10 or 11 or 12 HCFA-certified contractors initially going in, obviously, you would have fairly tight oversight over what they offer and an ability to make sure you have a range of products offered to seniors that gave them a choice of everything that you have as a Federal employee.

Mrs. JOHNSON. Thank you.

Ms. STEELMAN. But even today, I think it would be fairly easy to structure a rebate to a beneficiary in their Social Security check right off the HMO risk contract system. Right now, the part B premium is, of course, deducted from your Social Security check. It shows up, $46.10. Right now, the HMO only has the opportunity to build on benefits. If we structure a way that the HMO can route that money back through the government to a rebate in the Social Security check, you haven't changed anything about current law in terms of oversight or quality or anything else. You have simply given the beneficiary a tool that they can use to make sense.

Chairman THOMAS. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

I thank both of you for joining us today. I don't really have any more questions that I want to ask right now, because I am afraid of what you will say, but I do look forward to both of you contributing to our discussions. We are just starting this, as you know, and it is going to be a while before we reach any conclusions, so we will have more opportunities to get together and talk.

Again, thanks for coming today.

Chairman THOMAS. Thank you.

Let me ask you a question. In looking at Medicare as a nationwide structure and looking at the way in which managed care has caught on, that is, it tends to be coastal and in particular areas, it is clear that if we try to move Medicare into a managed care structure, in some areas, it will be a "follower." In other areas, it will be a "leader," in the Midwest, in certain areas.

Does that cause us some concern in trying to create a national program, or should we begin looking at ways in which we can regionalize it or create opportunities to let it follow more of the lead of whatever the health care direction is going in a particular area? Is it old fashioned to talk about a fundamental national program?

Mr. SCULLY. No. For instance, it will probably surprise you, most of the hospitals I work with are not wild about managed care. I don't necessarily look at this as moving to managed care. I look at it as moving to privatization. Up in Bakersfield, I am sure that

managed care is limited, but I don't see why HCFA, for instance, should be the only carrier in Bakersfield. I think you could let Aetna or CIGNA or Blue Cross of whatever offer an indemnity package.

I think what you are really talking about is how the Federal Government now runs Medicare as a cost-plus contract, where they pay the Blue Cross plans, mainly, around the country to administer a federally run insurance program. I think, aside from looking at it as managed care, it is moving toward a risk-based situation where you pay a private contractor to deliver services more efficiently, where it becomes a risk contract instead of a cost-plus contract.

Outside of areas where managed care isn't strong, that doesn't mean that you can't get better services at lower prices out of privately delivered indemnity plans. I don't think it necessarily has to be managed care.

Chairman THOMAS. Just let me respond. You quite rightly gave the answer that you were required to give, in part. The reason that I did not raise it that way is that I am just amazed at the growth in managed care. In California, every time I turn around, the statistic is another 5 percent higher than I thought it was. It literally is reaching 65, 70 percent.

So I was not correct in the way in which I phrased the question, in terms of focusing narrowly on managed care, but, frankly, in some areas of the country, the debate is already over. You were correct in terms of your response. I was simply reflecting the knowledge of the local changes that I have been familiar with.

Ms. Steelman, do you want to respond?

Ms. STEELMAN. Just to suggest that there are a number of innovative products in the health care delivery system. Very often, we end up focusing on managed care because it has made the most difference in the private sector. As managed care enrollees have gone up, health care inflation has gone down.

But, there are other innovative products, such as high-deductible plans. Clearly, medical IRAs have been an idea talked about for some time. High-deductible plans are being experimented with in a variety of Fortune 500 settings and have reached a great deal of success.

Can we use those kinds of ideas in a Medicare reform? I think it is up to us to allow the market to decide and to open the range of choices to the market and to the beneficiaries.

In an area like where I am from, Southern Missouri, where there is practically no penetration of managed care in my rural home town of 3,000 people, we need to make available the whole range of innovative products and see which one takes off and see which one the local area citizenship seems to sign on to.

Having said that, there may also be some ways to increase the tools of managed care in some of those areas. Clearly, the hospital in Springfield, which is the hospital closest to my home town, which is 2 hours away, has already made some inroads in terms of bundling tertiary care services and that sort of thing.

So I think the market is slowly but surely moving in directions that that regional area supports, and all of the movement should

be supported, whether or not it is specifically and only managed care.

Chairman THOMAS. You are correct, and my concern is that we do not lock the government into a particular profile of programs. Had we done that 25 years ago, which we did in terms of the fee-for-service, you would not have taken advantage of the innovations in the private sector. I want to make sure that that synergism is always available, that we don't make the same mistake twice in terms of locking into a time structure which, over time, will clearly change because of the dynamics of the private sector.

Mr. MCCRERY. If the gentleman will yield, since Ms. Steelman mentioned it, I will get into the concept of medical savings accounts or medical IRAs. It relates to what Mr. Scully was saying about some kind of rebate—some way to rebate savings.

In Mr. Scully's comments, though, I gather that he thought it would best work in some kind of up-front savings like in an FEHBP-style or cafeteria plan—in which you choose a lower priced plan and you get some rebate from purchasing a lower priced plan, as opposed to what Ms. Steelman brought up with the medical IRA concept—where you don't know what your rebate is going to be until the end of the year. You create your rebate by lowering your utilization.

Did I misread you, Mr. Scully? Do you think that it has to be some kind of up-front, guaranteed, agreed to savings, or can it be a more wide-open medical IRA-type setting?

Mr. SCULLY. I think you can do it both ways. I think if you went out and you give the senior, a 67-year-old, the opportunity to pick a Medisave account with a $2,000 deductible and they get to put the money in an account and save it to lower the utilization, I think you could do it that way and I think you could structure it that way, as long as there is a clear option.

I guess what I was referring to is if you wanted to go out and give somebody the choice of a tight point-of-service contract so they were going to lower the cost of the plan by 25 percent, the more effective way to draw them into that is to say, you are going to save the Federal Government $1,000 out of the trust funds but we will give you $700 of that back in a rebate. That is more likely than additional eyeglass benefits or drug benefits or something else, in many cases, to draw them into the plan.

I think you can structure it in a number of different ways, if you give people 10 or 12 choices.

My bigger concern about Medisave accounts, since you brought it up, is I think Medisave accounts are great. I also think Medisave accounts are going to bring out the purest, rawest form of risk selection there are. So if you are a fan of Medisave accounts, which I am, I think it is naive to think Medisave accounts are a good idea unless you are willing to look at and take head-on the issue of risk selection, because it is very obvious that healthier people are going to pick the lower cost plan.

Mr. MCCRERY. That is why I didn't bring it up a few minutes ago.

Mr. SCULLY. I am sorry.

Mr. MCCRERY. But I am hopeful that we can talk and maybe discover some way to harness that energy in individuals, as far as

trimming their own utilization, and yet find some mechanism to adjust so that government or insurance companies, don't get stuck with all the bad risks.

Ms. STEELMAN. I should say, I don't even think managed care has finished evolving and that managed care will find a connection with higher deductibles or Medisave-type ideas.

In managed care, one of their chief problems, obviously, with first-dollar coverage, is utilization for unnecessary cuts and bruises or things that you should have stayed home to take care of. So I think we will see a marriage over time. I don't think the market is anywhere close to being fully evolved. As the chairman indicated, we have to make sure that none of these options are prejudiced until we see how beneficiaries direct things.

Mr. MCCRERY. Thank you, Mr. Chairman.

Chairman THOMAS. To conclude the second round, the gentleman from New York, Mr. Houghton.

Mr. HOUGHTON. No questions, Mr. Chairman.

Chairman THOMAS. Mr. Stark, for a second bite of the apple?

Mr. STARK. Thank you, Mr. Chairman.

I just want to make a few attempts to straighten out the spin, at least, on the record. In the last decade——

Chairman THOMAS. The gentleman's time has expired. [Laughter.]

Mr. STARK [continuing]. From 1984 to 1993, the growth in hospital and physician expenditures per enrollee were lower for Medicare than they were with private health insurance, both for hospitals and physicians.

Second, I know that both the witnesses know this and even the Higgins analyst for the recent study that has been touted for the lower costs have warned us, don't get too optimistic, because what they basically know is that a shift to managed care or HMOs gives you a one-time savings, and that as far as we know and any evidence points out, there is no follow on and that costs after the one-time savings continue to increase as rapidly as the average.

Third, I have nothing against Medicare Select except that we have found that the growth of managed care plans in the unregulated atmosphere of Medicare have led to a lot of gouging and deaths in low-quality care.

Prudential, for example, has stolen $3 billion from its customers and has been indicted and convicted of felonies and fined over $300 million. I would say, are those the people you want to run your health care program?

Humana, in a recent HCFA study, is shown to have four or five times the number of reverse complaints, where people have asked for medical care, Humana has denied it, and it has been reversed by HCFA.

Most recently, in December 1994 in the Sun Sentinel, they have run their third exposé of the HMO systems. The national search for a workable, efficient health care system looked to Florida's HMO system as a role model, and something was wrong, terribly wrong. They have had a five-part series. They say the basic idea was sound, but the fact is that they found enrollment fraud, inadequate medical services, rampant profiteering by promoters who took advantage of the dearth of legislative regulation.

The bottom line, the HMO reform effort in Florida has evolved into a separate and dangerously unequal care system. The fraud system cost taxpayers $650 million a year. Florida's booming HMO industry is fraught with problems. Earlier projects led State and Federal officials to order corrections in HMO plans. Sadly, the latest investigation found even worse abuses, and it goes on.

The problem is that you cannot allow these people to steal, deny care, and go unregulated. I am not suggesting that the Federal Government ought to necessarily be the regulator, but what HCFA has proposed and what many of us have proposed is standards, then, if the States do not have regulations to protect patients who are not capable of making a market-based decision because they are inadequately trained and it is very confusing and the insurance salesmen are generally not very honest people.

Without adequate protection, we would be putting at risk the most fragile of our citizens, whether they are rich or poor, Republican or Democrat. You cannot do this, experience has shown us, in an unregulated manner.

So as soon as we can agree that there will be reasonable standards and regulations to protect the patients from underutilization, to protect unscrupulous operators who are rampant in the HMO industry today from stealing money and escaping to Spain or wherever they are now hiding out, until we can get some sense that there is a stewardship of the health of the seniors and the government's money, we should not trust this industry. Their record is fraught with fraud, abuse, and no one, in good conscience, can accept the responsibility for the obscene treatment in which this profit-dominated enterprise has used the sickness of elderly Americans for obscene profits.

Once we realize that we have a responsibility, not only to them to make profits but to the people who we represent, we can proceed to expand the coverage available to the seniors.

Mr. McCrery. Would the gentleman yield?

Chairman Thomas. The gentleman's time has expired. The Chair is in doubt. Is that a question?

Mr. McCrery. I was going to ask a question.

Mr. Stark. It was a major question about the efficacy of the HMO industry, as it exists today. I would be happy for them to respond.

Chairman Thomas. It is going to have to be on somebody else's time.

The gentlewoman from Connecticut.

Mrs. Johnson. I think it is very instructive that the article you are quoting, Mr. Stark, is about Medicaid HMOs and touches on some experience with Medicare HMOs. Both government-run systems, and we have no analogous degree of fraud in the privately run HMO systems. Furthermore, HCFA knew about the fraud problems in the Medicare HMO system in Florida in 1990 and did nothing. So this is hardly an advertisement for how we are going to save seniors from the dangers of the system. In fact, the big advances in quality oversight and quality monitoring have come in recent years from the private sector, not from the public sector.

But my question goes to two things and goes back to the issue of risk assessment that was raised earlier, because I think we have

to do that. If you want to get into this issue of quality and who does quality better and why the quality problems have been so big in the publicly run programs, that certainly is a good topic for us to discuss and it would be worth a whole hearing itself.

I did want to point out that these articles are all about government-run HMOs and government has known about the problems and has been completely incompetent to solve them over a number of years.

Mr. STARK. Would the gentlelady yield?

Mrs. JOHNSON. In just a moment. Let me ask my question.

My question goes to the issue of risk selection as we move Medicare into a system in which the individual has more choice. We had testimony 2 weeks ago to the effect that where 25 to 30 percent of the people in an area are in managed care, there is no problem of risk selection and companies that can medically underwrite don't, even for the senior population.

This says to me that medical savings accounts are a perfectly comfortable option for the private sector, as long as we have reached some critical mass of participation in integrated system care.

Would you agree or disagree? Are we reaching an era where medical underwriting isn't going to be a problem, anyway, and we can accelerate that through action that we might take, particularly as we look at bringing seniors into this system? We certainly can't allow seniors to be discriminated against.

Ms. STEELMAN. I agree very much with your observation, that as the market evolves, risk selection issues diminish. Much of the discussion about risk selection reminds me, unfortunately, a lot of the debate we had last year, on trying to anticipate every single problem associated with some massive restructuring, down to the 100th degree, and if we can't solve that, then we can't do anything.

I think we do need to turn this over to the market, where these problems are diminishing, and, step by step, watch it very carefully. Do we have a spiral that is out of control? We have a policy process here every year, of which this hearing is simply the beginning, in which we can go back and address those issues.

We cannot, sitting in Washington, anticipate how the market will behave or how beneficiaries will choose to use their dollars. We can only know that it cannot possibly be worse than what we have done the last 15 years, trying to run it from government.

So I think these things should not be barriers to action but should be carefully watched, try to track the private sector, try to make sure that the incentives are such that the integration of these plans does move up at some predictable simultaneous kind of level, so you don't have a massive insurgence into one kind and no availability in another area. But I think these problems are doable and we just have to do it over time.

Mr. SCULLY. If I could throw in for one brief second, I think, in a situation where we have guaranteed issue, guaranteed renewability, every plan that accepts seniors would have to take everybody, the opportunities for medical underwriting are a lot less.

Nevertheless, I think the one serious risk of going to an FEHBP-like program in Medicare, and I don't think there are any risks except this, are risk selection. I think the options for it are limited.

I think the risks are lower than most people think. I think HCFA could do a lot better job than most people think of trying to figure out a way to do a risk adjustment process, but I think you have to go in with your eyes open.

I remember in 1989 when RBRVS came up, and everybody said the same thing about the Hsiao schedule—we can't possibly figure out what we should pay at different rates. It wasn't perfect then and it is not perfect now, but they did a pretty good job of balancing off the payment scale. I think they could do a pretty good job of balancing off the payment scale as far as an amended AAPCC or some kind of a risk-adjusted payment system goes. It may not be perfect, but I think it would be a great improvement over the current system.

Mrs. JOHNSON. Thank you.

Chairman THOMAS. Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

Ms. Steelman, we have talked some in the past about the Medisave accounts, and I just wanted to get into it a little more. Some of the benefits, I think, of the Medisave accounts aren't brought up a lot of times in discussion.

As you know, with my background in veterinary medicine, one of the aspects of that is that people actually have something at stake because they are paying out of their own pocket. But also, what comes of that is that the veterinarian has to explain to the client when they come in exactly what they are paying for, why they are paying for it, why they should choose plan A or plan B, get an x ray, get a blood test, or whatever it is, and has to justify it to the client. Because of that, you have a very good doctor-client relationship there.

One of the problems we have in our health care delivery system today is the deterioration of that doctor-patient relationship. So I see one of the side benefits with the Medisave accounts is that you are getting the patient back into more of the mode where they are accountable, and also, you would put the doctor into a mode to become more of the patient advocate and say, hey, you should go over here and get an MRI for $1,800 or over here for $300 and help them justify why that person should shop in the marketplace.

I think that that is the key to the Medisave accounts, not only the benefits that it can bring to the patient by having them use less services—I don't even see that as the benefit as much as I see them actually shopping at that point, and, therefore, bringing the market forces back into the health care field.

As a veterinarian, if you look at the whole field of veterinary medicine, we have held our costs way below inflation for a long, long time, as far back as, I think, there are probably statistics held on veterinary medicine. We offer a lot more services, and yet we have the same education, we have a lot of the same drugs, the same technology and everything, we just don't have a lot of the government involvement that they have in the human health care field.

Ms. STEELMAN. In restructuring Medicare, I think we do have to take advantage of those same incentives. It is completely unclear to me how we technically incorporate a Medisave idea into a privatization and a voucher across the whole range of services. The idea

behind a voucher would be to give people the ability to make choices for themselves. Some people would rather have an HMO. Some people might want a high-deductible policy. I am not sure they would necessarily make that decision on their health status. I think there are a lot of other factors involved.

But how do we make sure that works? For example, if the Medisave or medical IRA is a tax-advantaged product, how do we make sure it works with a voucher? Do you lower the voucher level to compensate for the tax advantages this product gets? I think there is a lot of work that needs to be done to refine this idea, and I would urge you, when talking to the various proponents of medical IRAs, to try to get some of that work underway, because, to my knowledge, it isn't.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman THOMAS. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I am not sure I want my father's health care determined on the basis of what we do in veterinary medicine, but I would like to ask a question. As I know of it, there are only two studies——

Mr. ENSIGN. Would the gentleman yield for a second?

Mr. MCDERMOTT. Mathematica and GAO have done the only studies on the effectiveness of managed care in Medicare. They say when you control for risk assessment that there is no savings in managed care, both studies.

Can you give me any study, not anecdotes—I don't want to hear one case at a time, I want to hear a study, that there has been any real study of this issue?

Mr. SCULLY. I am not sure that—not to disagree with you, but you can draw the conclusions. I am familiar with the studies. I can't think of an additional one, but what those studies basically say is that 95 percent of the AAPCC, because of the fact that HMOs, given the current structure, happen to draw younger, healthier patients, for the most part, that, in fact, the government does not save money under that current structure at 95 percent of the AAPCC. I wouldn't necessarily disagree with that.

I would strongly disagree with the fact that you can't save money under a capitated network system, the changes and the incentives of the system. I just think that there is no doubt in my mind, and I used to look at it in the past, that 95 percent of the AAPCC—is the government saving money on that? Probably not. Is it costing them something? I think you can have a good debate about that.

But I think that is a fundamental flaw in the structure of the way we do Medicare risk contracts now. It doesn't mean that managed care doesn't work.

Mr. MCDERMOTT. Now that we have talked generally that there is no study that suggests there is a savings, at least, you haven't given me a name of one——

Mr. SCULLY. I am not sure there is one that suggests there aren't, either, but——

Mr. MCDERMOTT. Until you produce one, we will stipulate to the fact there isn't one. Let us go to the individual case. My father is 89 and my mother is 85. My father had an endarterectomy about 10 years ago. He had a stroke about 4 years ago. He has had chron-

ic heart disease since he was 72 years old. He has skin cancer and several other problems.

What HMO is going to want to give my father a policy and charge him the same as a 65-year-old who is playing golf everyday at some nice place and in good shape and has no problems at all?

Mr. SCULLY. First of all, under the current system, they don't have any choice. They would have to cover him.

Second, the AAPCC is geographically and age adjusted, so if he is 89, he would get a payment based on the fact that he is 89 and not 65. So it is not all that disadvantageous for them to take him, and, in fact, they do get a capitated rate based on the fact that he is 89 and where he lives.

Mr. MCDERMOTT. That is with government regulation. Remember, we are getting rid of big government. This proposal for vouchers is just to hand my father $2,000 or $3,000 and send him out into the market.

Ms. STEELMAN. No.

Mr. SCULLY. That is certainly not what I understand it to be and not what I would——

Mr. MCDERMOTT. What kind of consumer protection would you put in?

Ms. STEELMAN. There is no question that the rate and age adjustments would have to be maintained under any system that we are discussing. The voucher is not something like food stamps. The voucher is where——

Mr. MCDERMOTT. Oh. This is not community rating? You are going to allow underwriting on the basis of age even inside the——

Mr. SCULLY. No.

Ms. STEELMAN. No.

Mr. SCULLY. It is community rated on the basis of age. What you are saying is——

Ms. STEELMAN. The voucher, the value of the voucher, is linked to the individual qualities of the individual, just like in the AAPCC today. That could not change. It wouldn't work if you changed it.

Mr. MCDERMOTT. So you are saying that it won't be any problem. My father is going to get, with his voucher, enough so that he doesn't wind up coming to me and my brothers and sister for his out-of-pocket costs?

Ms. STEELMAN. I think we need to make this clear. A voucher is not a specified amount for every individual in the country. A voucher is a mechanism into a system. The individual can enroll anyplace, and the government's payment will have the same kinds of factors engaged as you do in the AAPCC.

Mr. MCDERMOTT. Can't they do that under Medicare now?

Mr. SCULLY. No.

Mr. MCDERMOTT. Why? What prevents them?

Ms. STEELMAN. How would a PPO qualify under Medicare now?

Mr. SCULLY. If the plan qualifies, in most areas of the country, there are very few and they are pure HMO risk contracts.

Mr. MCDERMOTT. If they have a qualified plan, Medicare has more choice than any plan in the country. If the plan is so bad it can't qualify, you probably don't want people in it, anyway.

Mr. SCULLY. I think it would be virtually impossible to find——

Mr. MCDERMOTT. These would just be the scumbags of the delivery system. But if they can live up to minimal Federal standards, there is absolute choice under Medicare.

Mr. SCULLY. I think it would be virtually impossible to find a city in this country where Medicare beneficiaries have the choice of as many polices as anybody in the Federal Employees Health Benefits Program.

Mr. MCDERMOTT. Seventy percent of the Medicare beneficiaries live in an area with HMO service availability. Seventy percent of the Medicare beneficiaries live in an area that has available to the Medicare beneficiary a managed care or HMO.

Mr. SCULLY. Maybe one, and it is probably a risk contract, and I will bet if you looked in those areas, the Federal Employees plan would probably have 10 or 12 choices, if not more.

Chairman THOMAS. The gentleman's time has expired.

Ms. STEELMAN. There are a number of questions that have been raised here, though, that are worth pursuing, because this is a thinking person's debate. How you structure this so that Medicare can work over the next 25 years, can be secure, is a thinking person's debate.

Chairman THOMAS. Absolutely, and I just want to ask the gentleman——

Mr. MCDERMOTT. It can't be done on a galloping horse in the next 35 days. Do you agree with that?

Ms. STEELMAN. I don't know that anyone is suggesting that.

Mr. MCDERMOTT. OK, as long as that doesn't happen.

Chairman THOMAS. The gentleman from Washington should seriously consider the idea of a sitcom based upon a psychiatrist in Seattle whose father has an interesting lifestyle that he is trying to determine what he ought to do.

Also, this afternoon, the gentleman from Washington has an opportunity, as we mark up Medicare Select, to provide us with more data as we move the Medicare Select program to a national program, so that we can better determine what is going on.

The gentlewoman from Connecticut does want just a moment.

Mrs. JOHNSON. I think it is important, because I do think that, in the end, what we are involved in here is a thinking person's debate. If we don't come out with the right answer, we are going to do great harm to our seniors.

I think it is important to clarify what choices seniors currently have. Seniors currently have primarily a fee-for-service choice. The only HMO choice they have is where an HMO has a risk contract with the government. So the fact that 70 percent of people live in an area where there is an HMO option in the market doesn't mean they have access to it, and I think that we have to be very clear about that.

Mr. STARK. Why don't they?

Mrs. JOHNSON. Because those managed care plans do not have a risk contract with the government. One of the reasons——

Mr. STARK. I said, 70 percent of them have risk contracts or other Medicare-approved contracts available to them in their area. Seventy percent of Medicare beneficiaries have it available and only less than 10 percent take it.

Chairman THOMAS. The chairman is going to exercise his prerogative and thank this panel.

Mr. SCULLY. Thank you, Mr. Chairman.

Ms. STEELMAN. Thank you.

Chairman THOMAS. One of the things that I do want to underscore is that this is a thinking person's game. We do need to look at options available to, and that only underscores, I think, the failure of the President's budget to participate in this debate at all.

I thank the panel very much.

The second panel will be Roland E. "Guy" King, who was former Chief Actuary with the Health Care Financing Administration; and Robert Myers, who was the former Chief Actuary of the Social Security Administration.

I am anxious to get these actuaries in front of us so that we can discuss trust funds, pay ins, pay outs, and that sort of thing.

Mr. Myers, why don't you begin? Without objection, all of the written statements will be made a part of the record and you may proceed as you see fit to inform us, Mr. Myers. Thank you.

STATEMENT OF ROBERT J. MYERS, SILVER SPRING, MD., FORMER CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION

Mr. MYERS. Thank you, Mr. Chairman. It is always a pleasure and a privilege to testify before the Committee on Ways and Means.

Before getting into the matter of the Medicare provisions in the President's budget, what they are and what I believe they should have been, I would like to discuss, briefly, three other matters.

First, what should be done about health care costs? We all know that, over the years, health care costs have been rising rapidly for a number of reasons—namely, the greater presence of insurance, so there was less out-of-pocket cost—although in the last few years, that, perhaps, has slackened off—the increasing utilization and the better analytical procedures and techniques that have been made available for health care generally.

There are three ways that this problem can be handled. First, costs can be contained by reducing the remuneration of providers. Second, costs can be reduced by limiting the services available, and third, the rising costs can be met by additional financing, either directly or indirectly.

In my view, although the remuneration of the providers of services can be subject to some control, this can be overdone. I think that this is well evidenced by what happened when the DRGs were instituted by the 1983 amendments. What resulted, primarily, was reduced cost for the Medicare program, but cost shifting to the private sector. Now, there appears to be some reversal going on in this area. But these procedures to me, is not the real solution.

Similarly, I do not believe that services should be limited. I believe that people should, in general, be provided good medical care and should have it readily available. Again, there are some instances where completely unnecessary services should be controlled.

Currently, there is the buzzword, "managed care." This means many different things to different people. Managed care is just fine,

in my opinion, if it is managed for the sake of the beneficiary or the patient. However, if health care is managed primarily for the sake of the insurer, so as to cut out services that really are necessary but maybe are not so clearly necessary, I think that is not a good idea. That is more like controlled care.

I come down to the fact that the real solution to the problem is to provide adequate financing. I know that it is unpopular to say that we should have higher premiums or higher taxes, but I think that people, particularly when they need medical care, do not consider the cost as the primary element.

The second thing that I want to mention is in connection with the accuracy of some past actuarial estimates for Medicare. Often, in the debate about what should be done about health care in this country, the actuarial estimates are denigrated, and the estimates are always said to be too optimistic.

This is not necessarily the case, and I refer to the original estimates for Medicare, where the comparisons that are made show that the costs were 10 times understated, that is just not correct.

I also discuss in my testimony the relationship between Medicare and Social Security programs and the general budget.

Getting now to the major subject, the future operations of the hospital insurance program, as you well know, the trust fund is going to run out of money in about 5 or 6 years. It should be noted that, when the trust fund runs out of money, the program does not come to a halt. What happens is that the payments to the providers of services are delayed more and more, and the program does not just stop.

The President's 1996 budget proposal, unfortunately, did nothing in this long-term area. It merely extended several temporary provisions, such as that the part B premium rate for the enrollees should never be more than 25 percent of the average per capita cost.

For some years, I have been saying that something ought to be done about the long-range financing problem of the hospital insurance program. If nothing else, a tax rate schedule should be put in the law, horrendous as it might seem, that will make the program self-supporting over the next 75 years and will, thus, draw real attention to the problem.

I think that something should be done about this immediately. Five years off is not far away, and it is much better to plan in advance and take action carefully than to have a last-minute crisis solution.

Any changes should be made primarily for the sake of the program, rather than for the general budget, other than as to part B, where the general budget really is paying some of the costs. As to part A, changes should be made one way or the other, and they do not affect the budget. I develop that further in my prepared testimony.

Finally, as to the recommended changes for part A, I would do it by the traditional method, a little on the financing side and a little on the benefits side. In other words, I believe that the payroll tax rate for HI could well be raised, gradually, over the years, beyond its present level of 2.9 percent for employer and employee combined. At the same time, I would put some of the pain on the

beneficiaries by introducing daily cost sharing for all days, and not wait until the 61st day.

For part B of Medicare, I believe that certain changes should be made to make the program less costly as a governmental program and shift some of the cost back to individuals. I would raise the initial deductible from $100 per year up to about $250, so as to make it comparable with what $50, the original amount, was in 1965 when the program was enacted.

Also, I think that the enrollee premium should bear somewhat more than 25 percent of the cost. It is not possible to move it back to the original 50 percent, but it certainly should be moved up that way, but, again, slowly.

I believe that these changes are feasible and affordable, especially if done gradually.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT BY ROBERT J. MYERS PRESENTED TO THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS, HOUSE OF REPRESENTATIVES, FEBRUARY 23, 1995, WITH REGARD TO THE MEDICARE PROVISIONS IN THE PRESIDENT'S BUDGET

Mr. Chairman and Members of the Subcommittee: My name is Robert J. Myers. I served in various actuarial capacities with the Social Security Administration and its predecessor agencies during 1934-70, being Chief Actuary for the last 23 of those years. In 1981-82, I was Deputy Commissioner of Social Security, and in 1982-83, I was Executive Director of the National Commission on Social Security Reform. In 1994, I was a member of the Commission on the Social Security "Notch" Issue. I am currently a member of the Prospective Payment Assessment Commission.

Before discussing the Medicare provisions in the President's 1996 budget proposal, I should like to deal with three other matters. The first one is the all-important subject of what should be done about the continually-rising health-care costs. The second relates to the accuracy of actuarial estimates for the Medicare program, particularly those made in 1965, when it was initiated. The third is the relationship between the Medicare and Social Security programs and the General Budget.

What Should Be Done About Health-Care Costs

For many years, health-care costs have been rising more rapidly than the general price level. This has been due to a number of factors, such as increasing utilization as more and more people, until recently, have had less out-of-pocket cost due to insurance (including Medicare) and such as the availability of new, although costly, techniques and medicines.

If costs are to be contained -- i.e., lowered, at least in relative terms -- this can be accomplished by either limiting the services available or reducing relatively the remuneration of the suppliers of services. Services can be limited by rationing, requiring long waits, or so-called managed care (however that may be defined and practiced). As to managed care, this may be beneficial to the individual if it is done primarily for her or his interests, but the reverse is the case if it is done primarily for the insurer's sake. Certainly, the procedure under managed care should not be that the managing physician requires the individual to use more generic drugs, have fewer lab tests, and less frequent physician and specialist visits than he or she would want for his or her own family under similar circumstances.

I believe that the problem of rising health-care costs should not be handled by reducing services, except when it is completely clear that unnecessary ones are being rendered. Nor do I believe that legislative limits should be imposed on the providers of services unless it is clear that excessive charges are being made. Certainly, as to the Medicare program, the type of cost-shifting that has occurred as a result of legislative action was most unfair and was not in accordance with the intent of the original law. No more of such cost-shifting should occur, and it would even be desirable if the present degree thereof were lessened.

Thus, I have no solution to the problem of rising health-care costs. There should be great cost-effectiveness without reducing or unduly limiting services, as well as increased cooperation among patients, insurers, and suppliers of services -- and not head-on adversarial and antagonistic relationships. So, in the end, it comes down to the matter of increased financing, rather than reduction of services.

Quite naturally, nobody likes paying more for things like health services that are not necessarily enjoyable at the moment. However, I believe that people should, and will, do this rather than spend the money on creature comforts, such as more luxurious homes, more cars, and more entertainment. And, because of the uneven incidence of health-care costs, the risk must be spread around by some insurance mechanism.

Accuracy of Actuarial Estimates for Medicare

Some critics of health care reform have cited the variation of the actual experience under the Medicare program from the estimates for it which were made in 1965 as evidence that any estimates for new proposals may be far too low. In particular, some point out that the estimate for Medicare costs in 1990 which was made in 1965 was $9 billion, whereas the actual experience was $111 billion, or over 12 times higher. Such comparisons are invalid for a number of reasons, including the changing value of the dollar and new benefit provisions being added. For details on this matter, see my article, "How bad were the original actuarial estimates for Medicare's hospital insurance program?", The Actuary (Society of Actuaries), February 1994.

Relationship Between Medicare and Social Security Programs and the General Budget

Perhaps the greatest hoax -- even fraud -- that has been imposed on the American public is the information that the federal government has given about the relationship between the General Budget and the various trust-fund programs, such as Medicare and Social Security.

Under the so-called Unified Budget procedure, the operations of these programs are included within the general operations of the federal government. Thus, any excess of income from sources outside of the federal government are shown as reducing the General Budget deficit, which does not really happen because such excesses are invested in government bonds and other obligations which are part of the National Debt. If the trust funds had not had such excesses to invest in government obligations, the general public would have had to have purchased obligations of similar amount, and the National Debt would have been exactly the same size. Thus in fiscal year 1994, the real General Budget deficit was $293 billion, or $90 billion higher than the deficit shown under the Unified Budget procedure.

Further, under the Unified Budget procedure, the interest paid to the trust funds on their investments is not counted as interest, but rather merely as an intergovernmental transaction. However, such interest is real interest and adds to the General Budget deficit and the National Debt in just the same manner as any other interest paid on obligations of the federal government. Thus, the interest on the National Debt is now running at about $300 billion per year, rather than the horrendous $200 billion quoted under the Unified Budget procedure.

The operations of the Social Security trust funds and the Hospital Insurance Trust Fund, which are with respect to self-supporting payroll-tax-financed programs, should not be considered in connection with the great deficit problems of the General Budget. The operations of the Supplementary Medical Insurance Trust Fund do, however, affect the General Budget, because about 75% of the contribution income comes from the General Fund of the Treasury and is thus a true expenditure of the federal government.

In summary then, changes in the Hospital Insurance program, as well as the Social Security program, should be made solely for the sake of such programs, and not at all for the sake of the General Budget deficit.

Estimated Future Operations of the Medicare Program

In fiscal year 1994, the Hospital Insurance Trust Fund increased by about $3.4 billion, to $129.6 billion at the end of the year. However, under the Unified Budget concept, these operations contributed about $10 billion to the budget deficit, because receipts from the general public fell short of disbursements.

In the next year or two, the balance of the Hospital Insurance Trust Fund will peak and will then decrease rapidly until becoming exhausted, likely at some time in 2001. During this period, the operations of this trust fund will result in increasing amounts being added to the budget deficit under the Unified Budget concept, but nothing at all under the real budget deficit basis, because the bonds being redeemed by the trust fund will, most likely, be purchased by the general public indirectly through new public issues.

It should be noted that, if the trust-fund balance is ever exhausted, the program does not come to a halt and go out of existence. Rather, payments to the suppliers of services are delayed, and increasingly so as time goes by.

In fiscal year 1994, the Supplementary Medical Insurance Trust Fund decreased by about $2.4 billion, to $20.9 billion at the end of the year. In subsequent years, the fund balance will fluctuate around this level (or perhaps somewhat lower), but is unlikely that it will ever be exhausted, because the premium rate is determined annually so as to maintain the solvency of the program. Both the real budget deficit and the deficit under the Unified Budget concept are significantly affected by the operations of this trust fund, because about 75% of the cost of the program is borne by the General Fund of the Treasury.

The President's Budget as a Solution to the Financing Problems of Medicare

Unfortunately, the President's 1996 budget proposal does not address the financing problems of the Medicare program -- the impending exhaustion of the Hospital Insurance Trust Fund, which will very likely occur in about 5 years, and the high, ever-rising cost of the Supplementary Medical Insurance program. Instead, the budget proposal merely extends certain financing and reimbursement provisions which were of a temporary nature.

Changes should be made in the near future to solve these problems before we get any closer to the brink of disaster. Such changes as to the Hospital Insurance program should be solely for the sake of the program's solvency, and not for the sake of the deficit under the Unified Budget concept. However, changes in the Supplementary Medical Insurance program that are made for the sake of the program will also significantly reduce the real budget deficit (and also the deficit under the Unified Budget concept).

As to the Hospital Insurance program, I believe that no changes should be made in either the reimbursement-of-suppliers provisions or in the quantity or quality of health-care services furnished to the beneficiaries, but rather additional financing should be provided. This can be done either by increasing the payroll tax rate or by payments from the beneficiaries. The latter can be done through increased cost-sharing amounts or, for middle- and high-income beneficiaries, by income taxation on the value of the benefit protection which was not "purchased" by their own after-tax payroll contributions during their working years. Also, the minimum eligibility age for non-disabled beneficiaries should be increased from age 65 when the corresponding age for unreduced Social Security benefits is so raised (i.e., beginning in 2003, on a gradual basis). Preferably, a combination of several of these alternatives should be used.

Increased payments from the beneficiaries through increased cost-sharing amounts could be accomplished by instituting relatively small daily co-payments for the first 60 days of hospitalization. Income taxation of the benefit protection could be done by the inclusion of, say, 75% of the average value of the protection for the entire covered population in taxable income; the 75% factor amply allows for the amount "purchased" by the beneficiary's own payroll taxes. Note that making the benefit protection be subject to income taxation does not mean that income tax would be payable (because low-income persons do not have any income-tax liability now, and would not have any even with the value of the protection included).

As to the Supplementary Medical Insurance program, again I believe that no changes should be make in either the reimbursement-of-suppliers provisions or in the quantity or quality of services. The overall cost of the program could properly be reduced by increasing the initial deductible from $100 to $250 per year, so as to make it be much more comparable in real terms to the $50 which it was when the program began operations in 1966. Further, this amount should be automatically changed in the future as per capita program costs rise. Also, the minimum eligibility age for non-disabled beneficiaries could be increased in the same way as was suggested for the Hospital Insurance program.

Further, the proportion of the program's cost paid by the beneficiary should be gradually increased from the present 25% to, say, 35%; this is still far below the 50% proportion which was present when the program began. Also, the Part B enrollee premiums could vary with the income of the beneficiary, so that high-income ones would pay 75% of the program's cost; however, the transition should be developed so that no sharp breaks or notches occur as the income rises. Alternatively, for each covered person, the amount contributed on her or his behalf by the General Fund of the Treasury could be made subject to income taxation.

Conclusion

The choices to be made in solving the financing problems of the Medicare program are not at all easy. However, I believe that they should be make as soon as possible, no matter how painful they may be. To postpone any longer will make matters much more difficult later. I strongly believe that no reductions in quantity or quality of health-care services should be made, either directly or indirectly, or in the reimbursement bases for providers of services. Any changes made should be in the financing area or in the benefit cost-sharing or coverage provisions.

Chairman THOMAS. Thank you, Mr. Myers.
Mr. King.

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

Mr. KING. Thank you, Mr. Chairman.

I would like to give you a little bit of perspective on my 15 years as Chief Actuary of HCFA and how the program has grown during that time. I just recently left to become a consulting actuary with the firm of Ernst & Young, so I have had an opportunity to observe the rate of growth in this program for a long time.

Back in 1978, the hospital insurance trust fund was projected to be bankrupt by the year 1990. Today, it is projected to be bankrupt by 2001, and the reason for the change, of course, is that there have been two tax rate increases, there has been additional revenue injected into the program by raising the wage base, and there have been some price cuts in part A. But with the possible exception of the DRG reform, there has really been no reforms in the hospital insurance program.

The coming bankruptcy of the program, though, is really just the tip of the iceberg. After the date when the trust fund is depleted, the hole is just going to get deeper and deeper and it is going to continue to get deeper and it is going to accelerate for many years.

I know that there are people who have said that these projections are a red herring, and they have suggested that we should just sit back and wait and see whether these dire projections really materialize before we decide to do anything.

But the financial problems that are being projected now in the hospital insurance program aren't the result of very pessimistic assumptions about the growth in health care costs. I actually consider the economic assumptions underlying the projections in the HI trustees' report to be very optimistic.

The real problem now is the coming post-World War II baby boom. When the post-World War II baby boom begins to reach age 65, the growth in the number of workers paying taxes is going to decline and, of course, the growth in the number of beneficiaries is going to accelerate. Currently, about four taxpayers support each HI beneficiary, but by the middle of the next century, only two taxpayers will support each HI beneficiary.

This problem has gotten so large that it is not going to be possible to solve it painlessly at this point. To place income and expenditures in balance, even over the next 25 years, is going to require either a 34-percent immediate reduction in benefits or an immediate 52-percent increase in the HI tax rate, or some combination of the two. Even then, that only solves the problems through the next 25 years, and the years beyond that, which are even tougher to deal with, will still remain.

Some people have suggested that the recent apparently slowdown in growth in the rate of health care costs would suggest that there is going to be favorable experience in the HI program and that we ought to wait and see if this continues. This isn't going to happen, in my opinion. My observations over the years is that

whenever the threat of government intervention in the health care delivery system was there, that health care costs behaved very well. Then, when the threat is gone, health care costs increase again.

This happened during the early 1970s with wage price controls. It happened during the late 1970s with the threatened enactment of hospital cost containment legislation. And it happened once again in 1993 and 1994 with the debate over health care reform.

The SMI program, even though it is not in financial danger, because of the way it is funded, is still growing at an unsustainable rate. The cost of the program as a percent of GDP in 1994 was 0.89 percent, and it is projected to increase to 3.27 percent of GDP by the year 2020, when the post-World War II baby boom begins to retire. It will grow further to 4.5 percent of GDP by the middle of the next century, when the baby boom is fully retired. These are in the 1994 trustees' report.

The sad thing is, if some changes, seemingly minor changes, had been made in the SMI program many years ago, this problem wouldn't be nearly as large as it is. If the deductible, for example, for the SMI program had been indexed to the per capita costs for the program, then the SMI premium—first of all, outlays of the program would be 25 percent lower than they are today. The SMI premium could have been held at $4 instead of the $42.80 that it is today, and the government contributions to the program could still be $5 billion less than they are today.

In my opinion, there are two reasons why the outlays of the Medicare program are excessive today, and these are the same two reasons why they are excessive in the private health care system. That is the combination of two factors. One is third-party payments and the other is the fee-for-service system.

Of course, third-party payments, when patients and providers are spending other people's money, they don't worry as much about either the price or the quantity of the services provided. Our research in the Office of the Actuary in HCFA showed that even the modest cost-sharing provisions which remain today in the Medicare program, when they are allowed to work, have a substantial disincentive to overutilization.

When the health expenditures of people who faced even the modest cost sharing of today's Medicare program was compared with those who had Medigap policies that filled in that cost sharing so that their services were essentially free, then the utilization was substantially lower for those people who just faced today's modest cost sharing.

More importantly, not only is the level of health expenditures related to third-party payments, but also the rate of growth in health expenditures is related to third-party payments. In a research paper which will be published in "Health Affairs" coauthored by Mark Freeland and Al Pedon, they show that not only is the health care cost higher, but the rate of increase in health care costs is higher as the Nation has shifted from out-of-pocket payments to third-party payments.

Their research shows that, roughly, as a rule of thumb, for every 10 percentage-point shift from out-of-pocket payments to third-party payments, there is an increase in the rate of increase in

health care costs of 2 percentage points. This 2-percentage-point rate of increase in health care costs persists for about 8 to 10 years.

As I mentioned, the second factor is fee-for-service medicine. It interacts with the third factor to allow unlimited increases in the volume and intensity of services. We all know that the primary driving force behind increases in Medicare expenditures are not price increases—we can control those—but it is volume and intensity.

For example, during the 10-year period ending in 1992, over three-fourths of the increases in payments to physicians rose because of increases in volume and intensity, not because of price increases.

The cost of health care can theoretically be controlled by either one of these, by eliminating either one of these. Of course, introducing cost sharing is the way to control it by affecting third-party payments, and managed care is the way to remove the factor of fee-for-service medicine.

I am not so sure—you have heard testimony earlier about the implications of the TEFRA Medicare risk sharing program, and I am not so sure that that has as great a promise as some people think it has for controlling costs, and the reason is because of the difficulty of balancing the need for allowing a higher payment level in order to get plans and beneficiaries to participate against the need for lower payments so that Medicare can save on it.

Thank you.

[The prepared statement follows:]

TESTIMONY BY
Guy King
Former Chief Actuary for HCFA
before the
Subcommittee on Health
of the
House Committee on Ways and Means

Mr. Chairman, my name is Guy King. I am a Consulting Actuary with the firm of Ernst & Young. I was the Chief Actuary for the Health Care Financing Administration from 1978 to 1994. During my time as Chief Actuary, the expenditures for both the HI and SMI programs grew at rates that are unsustainable in the long run, and they continue to grow at those unsustainable rates today and into the foreseeable future.

Hospital Insurance (HI) Trust Fund
The expenditures of the Hospital Insurance Trust Fund (Part A of Medicare) increased from $17.7 billion in 1978 to $107.2 billion in 1994. This is an average rate of increase of about 12 percent per year. In 1978, the Annual Report of the Board of Trustees projected that the HI trust fund would be bankrupt by 1990. Because of some minor price reduction changes in the program which have been legislated over the years, the date of bankruptcy has been pushed back by a few years, so that the 1994 Trustees Report projects that the HI fund will be bankrupt by 2001. Thus, during my 15 years as Chief Actuary, virtually nothing was done as the problem grew and the HI program moved closer to the bankruptcy. The impending bankruptcy of the fund is just the tip of the iceberg, though. The hole is just going to continue to continue to get deeper for many years, and the pace of decline is going to accelerate. The tax rate necessary to support the current program will have tripled by the middle of the next century. Even by the year 2020 the tax rate necessary to support the cost of the program will have more than doubled.

I know that many people view these projections as a red herring. I have often heard it suggested that we should just wait awhile to see if these problems really begin to materialize. That is apparently what lawmakers were thinking when they heard the same projections back in the mid-1970's. The financial problems of the HI program aren't just the result of some extremely pessimistic assumptions about the growth of health care costs. The assumptions regarding the rate of growth in health care costs and the growth in income to support the program are really very optimistic. These projections are being driven now by the coming demographic shift. The Baby Boomers who will retire and begin drawing benefits starting in 2010 are all alive today. As the Post World War II Baby Boom begins to reach age 65, the growth in the number of workers paying taxes is going to decline, and at the same time the growth in the number of people eligible for Medicare benefits is going to increase. Currently, about four taxpayers support each HI beneficiary. By the middle of the next century, when all of the baby boom will have retired, there will only be two covered workers supporting each HI beneficiary, so this problem is very real and very predictable.

The problem is so large that there isn't any painless way at this point to solve the problem. To place income and expenditures in balance even over the next 25 years, which is the easy part, is going to require either an immediate 34 percent reduction in expenditures or an immediate 52 percent increase in the HI tax rate, or some combination of both. And even then, the financial problems beyond 25 years would still remain unsolved.

Some have suggested that the apparent recent slowdown in the rate of growth in health care costs and the recent favorable experience in the Medicare program may be enough to save the government from having to make these decisions. That isn't going to happen. During my twenty years as a government actuary I observed that, when there was a threat of government action, health care costs

always behaved very well. This occurred with the wage-price controls of the early 1970's, the threat of hospital cost containment legislation during the late 1970's, and during the discussions of health care reform in 1993 and 1994. Once the perceived threat is past, the rate of increase in expenditures once again accelerates.

Supplementary Medical Insurance (SMI) Trust Fund

Because of the way it is financed, through a combination of premium payments by individuals and debt financing by the Federal Government, the SMI program is not in immediate danger of insolvency. However, the growth rate in the cost of the program is so rapid that it is not sustainable in the long run. During my time as Chief Actuary the outlays for the Supplementary Medical Insurance Trust Fund (Part B of Medicare) increase from $7.8 billion in 1978 to $61.8 billion in 1994. This is an average rate of increase of about 14 percent per year. During that same 16 year period, benefits paid by the SMI Trust Fund increased from .32 percent of the U.S. Gross Domestic Product (GDP) to .89 percent of GDP. This occurred despite the fact that some of the costs of the program (such as for most home health benefits) were shifted to the HI program. Even during the last five years, which have been relatively favorable, expenditures by the program have increased 59 percent in the aggregate and 45 percent per enrollee. According to the 1994 SMI Trustees report, SMI expenditures will be 3.27 percent of GDP by 2020 when the Post World War II Baby Boom has begun to reach age 65 and will be 4.05 percent of GDP by the middle of the next century when the Baby Boom will have been fully retired. As with the HI Program, these projections are being driven now by the coming demographic shift and the Baby Boom rather than pessimistic health care cost projections.

If some adjustments had been made to the SMI program years ago, this problem would never have developed to the size it is today. For example, if the SMI deductible had been indexed to increases in per capita program costs, and steps had been taken to ensure that Medicare supplemental plans did not neutralize the cost-saving features of the SMI deductible, then the outlays of the SMI program would be more than 25 percent lower than they are today. This would have allowed maintaining the SMI premium at $4.00 instead of the $42.80 it is today. At the same time, the government contribution to the program could have been nearly $5 billion less than it is today.

The outlays of the SMI program are excessive today due to two design features of the program which interact with each other to result in significant waste and abuse. These are the same two factors that are driving up health care costs for private sector health care plans.

The first factor is third party payment. When patients and providers are spending other peoples money, they don't concern themselves with either the price or the quantity of services provided. Today, even the very modest cost sharing provisions of the original SMI Program have been eroded because they were not indexed to keep up with costs and because health care is, in effect, free for the more than 80 percent of SMI enrollees who buy Medicare supplemental policies. Research conducted by HCFA's Office of the Actuary on the Medicare Current Beneficiary Survey found that, even when controlled for self-reported health status, Medicare beneficiaries who did not have Medigap plans, and who thus were subjected just to the (severely eroded) cost sharing provisions which exist in the Medicare program today, have significantly lower overall health expenditures. Moreover, an important research paper which will be published in Health Affairs, coauthored by Mark Freeland, Ph.D. and Al Pedon, Ph.D. shows that the acceleration in the rate of growth in health care expenditures in the United States has been highly correlated with the shift toward third party payments. Their research shows roughly that every ten percentage point shift from out-of-pocket payments to third party payments results in an increase in the rate

of growth of health care costs of about two percent, and this accelerated rate of growth persists for about ten years. In my opinion, this is the most important research conducted yet on health care costs because it explains the reason for the rapid growth in health care costs in the United States.

The second factor contributing to rapid growth in health care costs is fee-for-service medicine. This factor interacts with third party payments to allow for unlimited increases in the volume and intensity of services provided to patients, without regard for the efficacy or cost effectiveness of those services. During the entire history of the SMI Program, most of the increase in per-capita costs have arisen from increases in the volume and intensity of services rather than price increases. During the ten year period ending in 1992, over three fourths of the increases in payments to physicians arose from volume and intensity increases.

The cost of health care can theoretically be controlled by removing either of the two offending factors---third party payments or fee-for-service medicine. Increasing coinsurance and deductibles is an example of dealing with the third party payment factor; introducing capitated services, as in the TEFRA Medicare Risk Program, is an example of dealing with the fee-for-service factor.

The problem that I have observed with the second approach is that the TEFRA risk sharing program is structured in such a way that, even if there were no risk segmentation, and with a 10 percent capitated penetration rate the <u>most</u> that could have been saved would have been 1/2 of one percent. However, because of risk segmentation, the TEFRA risk program has increased expenditures of the Medicare Program rather than reducing them.

If the costs of the Medicare Program were going to be controlled by using managed care, then the structure of the program would have to be changed so that savings accrue to Medicare. This would have to be done in a way that didn't discourage managed care plans from participation in the program. Because of the extreme difficulty of balancing these conflicting goals, I'm not optimistic that managed care is a viable option for controlling costs in the Medicare program.

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

Chairman THOMAS. Thank you.

I mentioned earlier that the President's budget contains three provisions which are extenders in terms of a kind of cost containment, at least, a modest cost containment. In your opinion, Mr. King, does this have any impact on the budgetary concerns? Do we buy 1 year? Do we buy 2 years? Do we buy anything with the President's proposal?

Mr. KING. The proposals that are in the President's budget will, at most, increase the life of the trust fund by several months.

Chairman THOMAS. Several months?

Mr. KING. That is right.

Chairman THOMAS. Mr. Myers, you commented about the fundamental difference between part A and part B, and, of course, part B is general revenues, approximately 75 cents of every dollar. Why do we rely so heavily on the general fund of the Treasury for this particular program? Was there a historical reason?

Mr. MYERS. Yes, there was, Mr. Chairman, and it occurred in this very room. When part B, which had not been proposed by the Johnson administration, was adopted, as a result of Congressman John Byrnes pushing for something like this to the program out, it was thought that it should be on a voluntary, individual basis. The question then arose, could you charge a uniform premium rate and could it be paid all by the enrollee? The answer was, "no," because the good risks, the low-cost risks would not participate, and the high-cost ones would, so there had to be some other source of financing.

I was asked by the committee about this, and it was my opinion that roughly 50:50 cost sharing would do the job. In other words, if the general fund paid 50 percent, it would be a good buy for even the healthiest person aged 65 and over. Therefore, there would be no anti-selection against the program. Everybody would have an incentive to come in it.

That 50:50 basis worked for a while, but then the premium rates started rising faster than the cash benefits did, which only went up at the rate of the consumer price index, roughly. It was decided that the premium rate for the enrollees should not rise more rapidly than the CPI, and as a result, the share of the general fund increased steadily until it approached 75 percent.

At that point, it seeMedicare ato Congress that that level is about as far as it should go, so we have had these artificial limits—not meaning this in a bad sense of the term—that the enrollees should pay at least 25 percent of the cost. That is one of the extenders in the President's budget proposal.

So it was purely an accident of history that we went to this 25-percent figure from the original 50-percent basis.

Chairman THOMAS. So as the cost went up, instead of trying to change the program or relationships, you just began to dip into the general fund to make sure that the individual recipient didn't pay more than whatever a "fair share" amount should have been?

Mr. MYERS. Yes.

Chairman THOMAS. And when it began, it was a 50:50 fair share?

Mr. MYERS. Yes, Mr. Chairman. There was a good reason for the 50:50 basis, so that everybody at least got their money's worth.

But the deterioration to 25 percent was, unfortunately, at least in hindsight, the easy way out. That is always, I think, the difficulty with general revenue financing. People think there is an unlimited amount there, whereas we know what there really is, is mammoth deficits.

Chairman THOMAS. I appreciate the gentleman's statement because it appears that we have always taken the easy way out. In taking a look at where we need to be in 5 to 6 years, in looking at the President's budget and the responses that he has offered to where we are, at least from an actuarial point of view, 5 or 6 years out, it looks like those folks are still taking the easy way out.

Mr. Stark, do you wish to inquire?

Mr. STARK. Thank you, Mr. Chairman.

Mr. Myers, it was your testimony, or included in your testimony, that changes in the hospital insurance program as well as the Social Security program should be made solely for the sake of those programs and not at all for the sake of the general budget deficit. Is that correct?

Mr. MYERS. That is correct, Mr. Stark. I think that, these days, there is really a great hoax being perpetrated on the American public by counting excesses of income over outgo of the Social Security and hospital insurance programs as reducing the general budget deficit.

Mr. STARK. So in the sense that if the President's budget falls short of moving toward the solvency of the trust fund that should be enough, or this committee should look to keeping the Medicare trust fund solvent rather than looking to pay for Star Wars or paving roads or something like that. That would be your testimony?

Mr. MYERS. Absolutely, Mr. Stark.

Mr. STARK. Further, would it be your testimony that an individual entering the work force today and paying into the Medicare trust funds through his tax contributions, on average, will those people pay in more or less than they are anticipated to draw out in their retirement years?

Mr. MYERS. To answer your question, Mr. Stark, first of all, I think we should consider whether we are talking about the combined employer-employee tax rate or just the tax rate that the employee pays.

Mr. STARK. I have a hunch the answer is the same. I have a hunch that taxes into the trust funds for a person entering today are not enough to cover the anticipated cost of that person's medical care 45 years hence.

Mr. MYERS. It is quite likely that that is the case, although it is very difficult to predict that matter—unlike, say, the cash-benefits program of Social Security.

Mr. STARK. Given the trend lines you are talking about, if they were, it wouldn't go bankrupt, it seems to me. So if you are suggesting that, at some point beyond that.

Mr. King, I heard you say that without cost sharing, utilization goes up significantly. You get far higher utilization when you do not have cost sharing. Was that your testimony?

Mr. KING. Yes.

Mr. STARK. So, then, if I said to you, under these Medicare Select plans, which have no cost sharing, we can anticipate far higher utilization, would that not be the case?

Mr. KING. With any Medigap policy filling in the coinsurance and deductibles of the Medicare program, the utilization is going to be higher when the beneficiary doesn't face any cost sharing.

Mr. STARK. Significantly higher?

Mr. KING. Yes.

Mr. STARK. Thank you.

Chairman THOMAS. Thank you, Mr. Stark.

It is also obvious that, since Medicare Select is a Medigap program, the argument you just made applies to the entire Medigap area in terms of cost sharing.

Mr. STARK. Yes.

Chairman THOMAS. In addition to that——

Mr. STARK. Would the gentleman yield?

Chairman THOMAS. Certainly.

Mr. STARK. But Medigap is purchased by 90 percent and most of the Medicare Select either are free or at much lower, so the tend is to make the copayments less there.

Chairman THOMAS. I understand.

I would enter into the record, and we are going to need to revisit this issue time and time again, a chart which talks about the lifetime Medicare benefits, taxes, premiums, and transfers. For example, for a person turning 65 in 1995, and these are constant 1993 dollars, a single male gets benefits of about $75,000, pays taxes and premiums of about $34,700, and gets a net transfer of $40,000. When you look at a two-earner couple in terms of the benefits of about $185,000, taxes and premiums of $68,000, the net transfer is about $117,000.

[The chart follows:]

TABLE 5. LIFETIME MEDICARE BENEFITS, TAXES, PREMIUMS, AND TRANSFERS
(in thousands of constant 1993 dollars)

	PERSONS TURNING 65 IN 1995			
	Single Male	Single Female	One-earner couple	Two-earner couple
BENEFITS	75.0	110.7	185.7	185.7
TAXES & PREMIUMS	34.7	45.6	59.0	68.5
NET TRANSFER	40.3	65.1	126.7	117.2

NOTE: All amounts are discounted to present value at age 65 using a 2 % real interest rate. Adjusts for chance of death in all years after age 21. "Taxes and premiums" include the actuarial value of all employer and employee HI payroll taxes, all SMI premiums, and estimated portion of federal income tax burden devoted to financing SMI. Projections are based on HCFA 1993 intermediate assumptions, adjusted for the estimated impact of 1993 enactments. SMI premiums are assumed to remain tied to 25% of program costs after 1995. Recipients are assumed to receive Medicare insurance protection, in each year after age 65, which equals in value the average Medicare outlay per enrollee in that year. Individuals are assumed to earn average wages for their cohort.

Source: Based on Steuerle, E.C. and J.M. Bakija. *Retooling Social Security for the 21st Century: Right and Wrong Approaches to Reform.* Urban Institute Press, 1994.

Chairman THOMAS. So when you deal with what is going into the system versus, currently, what people are getting out of the system, Mr. King, as you indicate, from a 4-to-1 pay-in to a 2-to-1 pay-in, and, of course, this is not projecting the increased lifespan. I went through a fight here in 1983 in which we extended the retirement age 2 years in 2027, which was certainly shorter than it should have been, based upon the battle that was a difficult one to fight.

It is just very easy to look at the time line and get into a discussion of a couple of months or even a couple of years. That isn't the point, I think, that you folks are trying to stress. You've got to fundamentally change the system, because if you continue the way we are, regardless of the changes in the private sector, regardless of anything else that may intervene, wish, hope, or otherwise, if we don't change the system, is it inevitable? Is that what you are saying?

Mr. KING. I would say it is inevitable, Mr. Chairman, yes.

Chairman THOMAS. So we can't avoid it? We have to do something about it?

Mr. MYERS. Yes.

Mr. KING. It is a system that is so far out of balance in the long run, between the revenues and the outlays of the program, that a fundamental restructuring of the hospital insurance program is going to be necessary. You can't just cut the costs of the program by 34 percent by cutting prices. You have to make fundamental restructuring of the program in order to do that.

Mr. MYERS. Yes, Mr. Chairman, I agree that it is inevitable, but I think that the changes can be made on the financing side because I think that costs are going to be there anyhow. People are going to have the health care costs. They are going to have hospitalization costs. It is a question of how these are going to be met. Should they be met out of pocket, or through an insurance system, or how much in each way?

Chairman THOMAS. And from an actuarial point of view, since you folks have been dealing with these societal concepts, how much time is 5 or 7 years to make these kind of adjustments that we need to make? Is that a short timeframe, from your perspective? Is that a reasonable timeframe?

Mr. MYERS. I think it is barely reasonable. Changes should have been made sooner. But the sooner we get to it now, the better it is.

Chairman THOMAS. But, clearly, if we don't do anything this year or next year, we are outside of the reasonable frame for adjustment?

Mr. MYERS. I believe so.

Mr. KING. Yes. Mr. Chairman, if I could be allowed to, I am always reluctant to disagree with Mr. Myers, because we agree on so many things, but I don't believe it is feasible to make the changes on the financing side for the hospital insurance program. By the middle of the next century, the tax rate of the hospital insurance program would have to triple if we didn't make changes in the outlays. The tax rate would have to triple.

What essentially is happening with the hospital insurance program now is that we are shifting an enormous burden for the over-

payments and the overpromises that we are making now onto future generations. Unless we triple the taxes on them, those promises that we are making now are not going to be kept.

Chairman THOMAS. If there are no further questions—that was going to be a perfect segue into the next panel.

Mrs. Johnson.

Mrs. JOHNSON. Mr. King, and Mr. Myers, your testimony is simply astounding. I mean, that Medicare is in as bad shape as it is and that this Congress knew that and has received these reports every year and paid no attention is truly tragic.

I want to quote from your testimony and ask you to look back. You say, I know that many people view these projections as a red herring. Clearly, we did, because we haven't done anything. But if you look back at your projections in the past, 20 years ago, 15 years ago, have your projections on the whole materialized, or have, in the past, your projections turned out to be red herrings? In other words, by projecting problems, we addressed them and so they didn't come true.

What is the history here? How accurate have your projections been?

Mr. KING. No, the history of the projections is that they have, in fact, materialized when adjustments are made for legislation that occurred subsequent to the initial projections that either increased the revenue or decreased the outlays by making price cuts. Yes, these projections have been basically accurate.

Mrs. JOHNSON. So you feel quite confident that when you tell us Medicare is on the absolute brink of bankruptcy and that in order to provide the benefits promised by the year 2020, we will have to triple the tax rate, you believe that will absolutely happen unless we take steps to prevent it?

Mr. KING. Yes.

Mrs. JOHNSON. Thank you.

Chairman THOMAS. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Mr. King, I want to ask a question. The two factors you raise make some sense, the third-party payments and the fee-for-service system. But how do you separate the parts caused by the growth in technology and the aging of the population. You don't even mention them, and I am sure you have thought about them.

Mr. KING. Yes, I have thought about them, sir. The aging of the population on a year-to-year basis has very little effect on the growth in costs in Medicare, either in the Medicare program or in private sector programs. The aging of the population only adds a few tenths of 1 percent to the costs.

Mr. MCDERMOTT. How about technology?

Mr. KING. Technology is really a symptom of the problem rather than a cause of the problem. In other words, because of this combination of third-party payments and fee-for-service medicine, where we will pay for anything as long as it is effective—it doesn't have to be cost effective, it doesn't even have to be medically effective, really. We will pay for anything.

That has a tendency to literally suck technology into health care, because it will be paid for in health care. So technology that might be directed in other directions where it might be more productive

is actually directed into the health care delivery system because of the third-party payments and the fee-for-service medicine.

Mr. McDERMOTT. You are not suggesting that technology has not extended lifespan, or caused people to seek procedures, are you?

Mr. KING. No, I am not suggesting that at all. The technology growth——

Mr. McDERMOTT. When I look at my own professional career, I graduated from medical school about 2 years before Medicare came in. The things that they do now compared to what I was trained to do are now totally out of my realm. I feel uneasy going in to a coronary care unit. I don't know how to perform these new procedures. All of that has happened in the last 30 years, during the life of Medicare, and it is hard for me to see how you can say that it is just a factor that gets kind of sucked in. An industry was created. How can a doctor not use it?

Mr. KING. I am not suggesting that—I think you are misunderstanding me. I am not suggesting that this growth in technology is bad, nor am I suggesting that it wouldn't have occurred. It wouldn't have occurred as rapidly, and the technology wouldn't have been as expensive if it hadn't been for the fact that we had this combination of factors that would pay for virtually anything.

Mr. McDERMOTT. So basically, what you are suggesting is that we ought to set up a system where we limit access to technology only to those people who have the money to buy the high-cost health care. The rest of the people ought to be relegated, as people fear, to what the British have, where they decide when they can have a kidney transplant or whatever. Is that what you are saying, a two-tiered system?

Mr. KING. No, actually, not at all. The kind of deductibles and copayments that would act as a deterrent to excess utilization are the kind of deductibles and copayments that most people can afford to pay today. Of course, there are safety nets for poor people. The Medicaid program would still fill in the deductible and copayments for people who couldn't afford to pay those.

Mr. McDERMOTT. Let me ask one other question in the time remaining and that is, is it your understanding that the managed care plan that people are talking about would put people into a plan where they would then be under the rules of the insurance company and out from under the Federal rules? In other words, the senior citizens would go with their voucher and buy into some private HMO. They would then be under the HMO's rules, not the Federal Government's rules, right?

Mr. KING. That is basically what a managed care plan is, yes.

Mr. McDERMOTT. In your view of that, would that mean that the patients, then, would no longer have the protection from balance billing?

Mr. KING. Actually, in most managed care plans, the copayments are lower.

Mr. McDERMOTT. There are a lot of different kinds of managed care plans.

Mr. KING. They use a different mechanism in order to control utilization. In most managed care plans, the copayments are lower than they are in Medicare fee-for-service.

Mr. McDERMOTT. But balance billing, if a patient does something in a managed care plan where the physician is paid a certain amount for a procedure, then the doctor can bill the patient for the balance? There is no prohibition in the private sector on that?

Mr. KING. No, but under a managed care plan, the doctor doesn't bill the patient on a fee-for-service basis.

Mr. McDERMOTT. Yet.

Mr. KING. In the closed panel HMO, he is on a salaried basis and he doesn't charge fee-for-service.

Mr. McDERMOTT. I would suggest that that is a "yet."

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

There is just one point I want to make. The characterization of technology that was just presented is the first time I have really heard it explained that way, not as an outside driver but as partially driven by the system. The only analogy that came immediately to mind was the situation in the space race between the Soviet Union and the United States, and the fact that we did not have high-thrust rockets and the Soviets did.

The high-thrust rockets of the Soviets didn't require miniaturization. The low-thrust of the United States drove the miniaturization, the technology. That is not to say that miniaturization was bad and not to say that technology is not good. It is good, but it was driven by something else, that is, our inability to lift large objects, so it forced the miniaturization.

The ability to bill for anything is driving the technology, to a certain extent. I had not heard it put quite that way. There is clearly a two-way street there, and I have only seen it one way. I appreciate the gentleman's clarification on that point.

Mr. McDERMOTT. If the gentleman will yield, I went through this when I was in the State legislature with the University of Washington saying they wanted to have a heart transplant unit. I argued, as a State legislator, we shouldn't waste our money on that. They should send all the patients down to Stanford. The argument was, oh, no, but to be a first-class university, we must have it here at the University of Washington. Our under-used capacity then was sold to the Canadians, because we didn't have enough patients. The British Columbians bought from us the capacity to do heart transplants. That is how the system has operated.

Chairman THOMAS. I thank the gentleman.

Mr. McCrery.

Mr. McCRERY. Thank you, Mr. Chairman.

Mr. King and Mr. Myers, both, you had excellent testimony, I particularly liked Mr. King's because I think he has put his finger on the problem in our system, which started back around World War II with the growth of health insurance. This problem is government getting involved in putting wage and price controls on the private sector and allowing them to increase benefits, thereby expanding the third-party payment system in this country, until we have our system today, where almost nobody pays for their health care. Some third party pays the bill.

You are exactly right. We cannot expect people to control their consumption of anything if somebody else is paying for the items to be consumed. I don't care if it is health care or automobiles. The

fact is, we cannot afford, as a society, to provide everybody a BMW, nor can we afford, as a society, to provide everybody everything they might want or think they need in health care. Yet, that is what we are trying to do.

I really appreciate your driving this point home, Mr. King. Unfortunately, we can't get very many people to listen. So I think what is going to happen, unless we make some drastic changes in how we pay for health care in this country, is that we are going to end up with Mr. McDermott's system, which is a single-payer system. He thinks that system is going to do the same thing, provide everything to everybody, when, in fact, what we are going to end up with is a single-payer system that provides the lowest common denominator to everybody.

I hope that you will continue, Mr. King, to sing that song and to tell people the underlying, fundamental reasons why we can't control costs, either in the Medicare system or in the private health care system. Maybe, if you do, you will get enough people to listen so we can turn this boat around before it is too late, but I am not very optimistic.

Mr. McDERMOTT. Will the gentleman yield?

Mr. McCRERY. I will be glad to yield.

Mr. McDERMOTT. I would admit that Congress made one serious mistake in setting up Medicare. It was almost the last amendment they accepted, was allowing the fee-for-service system in the Medicare system at the end, to get the doctors to back off their opposition. That was a serious mistake. That gave away the store, and they have been chasing it ever since. We really have never—it didn't make any difference whether we had a Democratic President or a Republican President, nobody wanted to take on the American Medical Association. Therefore, that part has just run wild.

Mr. McCRERY. But it goes back even further than that, Mr. McDermott, to when the government got in bed with insurance companies and said, we are going to give employers a break and encourage them to provide Cadillac benefits for their employees of first-dollar-coverage insurance. That is where the fundamental problem is in our health care system. Yes, the government compounded that by creating Medicare and Medicaid and just running right along with the same kind of system.

So, Mr. King, thank you very much for your testimony. It is very enlightened, in my opinion, and I hope you will continue to tell people about it.

Chairman THOMAS. Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

I just have a quick question for Mr. Myers. I wanted to find out the underlying reason for the general fund of the Treasury. Why should the general fund of the Treasury finance such a large part of the cost of part B Medicare?

Mr. MYERS. As you know, initially, the general fund financed half of the cost of part B, so that the enrollee premium met 50 percent of the cost and the general fund met the other 50 percent. The reason for this was that it was decided that every enrollee should pay the same premium rate, in dollars. If that were done and if there were no other source of financing than the enrollee premiums and the program is on an individual, voluntary basis, the low-cost peo-

ple, those who are near 65 and are healthy, would not have joined the plan. They would have said, "We will wait until later," so there would have been antiselection, and the cost would have been much higher than if everybody were in the plan, either compulsorily or if all elected to come in.

So some proportion of the cost had to come from somewhere else if you were going to attract the vast majority of the people to participate. The only place that could come from was the general fund. Unfortunately, over the years, that 50 percent has deteriorated to the present 25 percent because of a provision that was put in the law to say that the premium rate per enrollee should not rise more than the consumer price index.

So, that was the basis for it. In other words, if you had a voluntary program, you had to make the rate attractive for everybody, including the most healthy people.

Mr. CHRISTENSEN. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Mr. Crane.

Mr. CRANE. I have no questions.

Chairman THOMAS. Mr. Houghton.

Mr. HOUGHTON. Very specifically, you have indicated that in order to keep this fund solvent, and with no dramatic differences in usage and cost, that you would have to have about a 52-percent increase as far as your rate is concerned. What would that mean? We now have a 15-percent shared rate as far as our FICA taxes. What would that do to the FICA taxes over the next 25 years?

Also, if you could take it another step beyond that, because you said there are going to be even greater problems. What are we talking about? What is the range?

Mr. KING. The FICA tax is currently 2.9 percent——

Mr. HOUGHTON. So you are increasing that by half?

Mr. KING. Yes, so that would be an additional 1.45 percent of taxable payroll.

Mr. HOUGHTON. So you are getting up to around 20 percent as far as your FICA taxes, then, is that right? Then what about beyond that?

Mr. KING. By the middle of the next century, the tax rate would have to triple, so that instead of being——

Mr. HOUGHTON. In addition to the 52 percent, you are saying——

Mr. KING. No. This is——

Mr. HOUGHTON. Including that 52 percent?

Mr. KING. Yes. So instead of being the 2.9 percent combined that it is now, it would have to be around 8.7 percent.

Mr. HOUGHTON. Thank you very much.

Thank you, Mr. Chairman.

Mr. MYERS. If I might say, just looking at it on the surface, if this were done all of a sudden, it would be unbearable. But I think that it can be done if the increases in the tax rate is graded in slowly over the decades.

I think one thing that must be kept in mind is these costs are going to be there anyhow. I think it is better to meet them through a directly visible payroll tax than to have them come out of general revenues for Medicaid.

Mr. HOUGHTON. It is too bad we can't devise a system that would threaten the Federal Government the way the private system is threatened and keep costs down that way. Maybe you can devise something like that.

Thank you.

Chairman THOMAS. Thank you, Mr. Houghton.

I would say that even if you phased it in gradually, the impact on employment in the rest of an 8.5-percent employment tax, just for a portion of the health care costs, frankly, is unacceptable to me. To say that the costs are going to be there anyway is also unacceptable to me, so I am going to try to attack it from both ends. I may not be successful, but I am sure going to try.

I thank this panel very much. Your testimony was enlightening. Actuaries are some of those folks that you don't want to sit down and talk with oftentimes because they tell you what you don't want to hear, but I believe that this particular subcommittee and this Congress needs to hear what we don't want to hear more often rather than less often.

Thank you very much.

Will the next panel come forward, please? From the Seniors Coalition, Jay Hopkins; from the Third Millennium, Heather Lamm; and from the National Taxpayers Union, Paul Hewitt.

I would say to all of you, if you have any written testimony for the record, it will be submitted, without objection. You may begin and, for 5 minutes, inform, instruct, and enlighten the subcommittee in any way you see fit.

Mr. Hopkins, we will start with you.

STATEMENT OF JAY HOPKINS, SENIOR ANALYST, SENIORS COALITION, ON BEHALF OF JAKE HANSEN, DIRECTOR OF GOVERNMENT AFFAIRS

Mr. HOPKINS. Thank you.

The Seniors Coalition is the Nation's third largest senior citizens advocacy organization, with over 1 million members across America. As a seniors organization that strongly supports the Medicare program, the Seniors Coalition must take the responsible step of recognizing that the program is broken and badly needs fixing.

Our Medicare system was designed in the 1960s, a time when America had fewer seniors, health care costs were relatively low, and many expensive medical wonders simply did not exist.

The very nature of our society has changed over the past 30 years, yet, Medicare has not changed with the times. In its current form, Medicare's costs are increasing too rapidly for the government and its citizens to bear. Medicare must be reformed now, or it will certainly perish.

The crisis cannot be exaggerated. Today, more than 32 million seniors depend on the protection provided by Medicare part A. By the turn of the century, that number will have increased dramatically. Without bold and immediate action, the health of America's seniors will be at grave risk.

Reforming Medicare will be a daunting, yet not insurmountable task. When people of good will come together, joined in a common cause, mountains can truly be moved. Such a monumental task

must be undertaken in an atmosphere of good faith and cooperation.

The Seniors Coalition was profoundly disappointed that President Clinton did not provide any measure of leadership or direction regarding the Medicare crisis in his budget for fiscal year 1996. While extending a few provisions that were scheduled to expire in 1998, the President's budget does nothing to change the Medicare system, as it stands now. In taking a dive on the issue, the President is shortchanging Medicare of the bipartisan attention it so desperately needs.

The Seniors Coalition urges President Clinton to join those who are actively looking for positive solutions to ensure Medicare's continued survival. In this time of crisis, neither party should use Medicare as a football to score political points.

The Seniors Coalition intends to take an active role in developing Medicare solutions and bringing them to the attention of America and America's seniors. Change can be an uncomfortable process, fraught with potential hazards. But in this case, change is both inevitable and necessary.

Mr. Chairman, we encourage all the other seniors organizations to roll up their sleeves and join us in the process. In tackling Medicare's problems, we must be careful to avoid the wrong solutions.

The recent national health care debate was a good example of good intentions run amuck. President Clinton was right in his attempt to focus national attention on health care reform, but his legitimate concern over serious medical problems that face the Nation did not justify his dramatic proposal for social engineering on a massive scale. Indeed, his plan would have created the sort of health care crisis, particularly for Medicare, that he said he wanted to forestall. Under any one-size-fits-all government plan, seniors would end up with less choice and poorer care.

Some policymakers favor making deep cuts in Medicare as a simple solution. The Seniors Coalition will not accept any cutbacks in Medicare without implementation of systems that would allow seniors improved access and choice in their health care.

Amidst all this peril, we find opportunities for seniors. Real Medicare reform must involve financially honest mechanisms that promote choice and market competition. Medicare reform is more than a theoretical notion. Right now, several intriguing proposals currently are in circulation and are well worth consideration.

Medicare Select right now is before Congress. We think it should be extended to all 50 States and made permanent. Medicare HMOs, given the proper funding formula, have the have the potential to shave health care costs. Voucher plans should be considered. In certain geographical areas, they can be very effective.

Without any doubt, many more alternatives will be proposed in the coming months. We can agree to disagree on what the best approaches might be, but we cannot afford to ignore this issue another day.

Mr. Chairman, thank you for bringing this matter of such importance to seniors before the American public.

[The prepared statement follows:]

The Seniors Coalition

Protecting the Future You Have Earned

TESTIMONY OF JAKE HANSEN
DIRECTOR OF GOVERNMENT AFFAIRS,
THE SENIORS COALITION

PRESENTED TO THE
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

It's time to reform Medicare

The Seniors Coalition is the nation's third largest senior citizen advocacy organization with over one million members across America. As a seniors organization that strongly supports the Medicare program, The Seniors Coalition must take the responsible step of recognizing that the program is broken and badly needs fixing.

According to last year's report by the Health Insurance Trust Fund's Board of Trustees, funding for Medicare Part A will completely dry up sometime between 2000 and 2004, depending on various sets of economic assumptions.

Right now, it takes the payroll taxes of four working Americans to support Medicare coverage for just one Medicare beneficiary. Before the end of this decade, fewer working Americans will be expected to provide Medicare coverage to even more beneficiaries. The ratio of Medicare beneficiaries to workers is expected to grow so dramatically that by the end of the century, beneficiaries will be spending between $2 to $5 for every dollar workers put into the system. By the middle of the century, only two workers will be available to support each beneficiary. But the Trustees tell us that Medicare's trust fund will be long empty before the major changes even occur.

Our Medicare system was designed in the 1960s, a time when America had fewer seniors, health care costs were relatively low and many expensive medical wonders simply did not exist. The very nature of our society has changed over the past 35 years, yet Medicare has not changed with the times. In its current form, Medicare's costs are increasing too rapidly for the government and its citizens to bear. It does not take the wisdom of Solomon to recognize that Medicare must be reformed now or it will certainly perish.

The crisis cannot be exaggerated. Today, more than 32 million seniors depend on the protection provided by Medicare Part A. By the turn of the century, that number will have increased dramatically. Without bold and immediate action, the health of America's seniors will be at grave risk.

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Reforming Medicare will be a daunting, yet not insurmountable task. When people of good will come together, joined in a common cause, mountains can truly be moved. But such a monumental task must be undertaken in an atmosphere of good faith cooperation. The Seniors Coalition was profoundly disappointed that President Clinton did not provide any measure of leadership or direction regarding the Medicare crisis in his budget for fiscal year 1996. While extending a few provisions that were scheduled to expire in 1998, the President's budget does nothing to change Medicare as it stands now. In taking a dive on the issue, the President is shortchanging Medicare of the bipartisan attention it so desperately needs. The Seniors Coalition urges President Clinton to join those who are actively looking for positive solutions to ensure Medicare's continued survival. In this time of crisis, neither party should use Medicare as a football to score political points.

The Seniors Coalition intends to take an active roll in developing Medicare solutions and bringing them to the attention of America's seniors. Change can be an uncomfortable process, fraught with potential hazards. But in this case change is both inevitable and necessary. That's why, Mr. Chairman, we encourage all the other seniors organizations to roll up their sleeves and join us in the process.

In tackling Medicare's problems, we must be careful to avoid the wrong solutions. The recent national health care debate was a good example of good intentions run amok. President Clinton was right in his attempt to focus national attention on health care reform. But his legitimate concern over the serious medical problems that face the nation did not justify his dramatic proposal for social engineering on a massive scale. Indeed, his plan would have created the sort of health care crisis, particularly for Medicare, that he said he wanted to forestall. Under any one-size-fits-all government plan, seniors would end up with less personal choice, higher bills, and poorer care.

In recent years, Medicare has turned to cost-shifting as a means of controlling the escalating cost of the program. While the results were partially successful on the surface, overall medical costs accelerated. The American public and Medicare beneficiaries suffered alike as a result.

Some policymakers may favor making deep cuts in Medicare as a simple solution. The Seniors Coalition will not accept any cutbacks in Medicare without the implementation of systems that would allow seniors improved access and choice in their health care. Others favor simply boosting the level of payroll taxes to the HI trust fund. In order to fill the gap, such an increase would need to be substantial. Such an increase, however, would harm our economy and ultimately push health care costs further out of reach for seniors.

Amidst all the peril, we find important opportunities for seniors. Real Medicare reform must include financially honest mechanisms that promote choice and market competition. A system can be designed to give seniors more choice in determining how their health care dollars are spent. As a result, seniors will receive better health care at a lower cost.

Medicare reform is more than a theoretical notion. Several intriguing proposals currently in circulation are well worth consideration:

- Medicare Select is an experimental Medicare supplement plan that has helped seniors realize considerable savings while increasing their health care choices. A bill to make Medicare Select permanent and extend it to all 50 states is now under consideration by Congress.

- Medicare HMOs, given the proper funding formula, has the potential to shave health care costs in areas with higher density populations of seniors. With only eight percent of the nation's seniors enrolled in managed health care plans, the potential for growth is considerable.

- A voucher plan would give seniors credits equivalent to the average cost of annual medical expenses in their geographical area. Seniors would be free to choose their own provider from the private sector.

Without a doubt, many more alternatives will be proposed in the coming months. We can agree to disagree on what the best approaches might be, but we cannot afford to ignore this issue another day. Mr. Chairman, thank you for bringing this matter of such importance to seniors before the American public.

Chairman THOMAS. Thank you, Mr. Hopkins.
Ms. Lamm.

STATEMENT OF HEATHER LAMM, NATIONAL POLICY COORDINATOR, THIRD MILLENNIUM

Ms. LAMM. Thank you, Mr. Chairman and members of the subcommittee for inviting Third Millennium to participate on this distinguished panel.

As we have heard already this morning, Mr. Chairman, the question before us is not whether or not the Medicare program will become insolvent. The facts speak for themselves. From Alan Greenspan to the Congressional Budget Office to the public trustees of Medicare, the experts agree that Medicare is on a 6-year collision course with bankruptcy.

By 2001, the Medicare part A trust fund is projected to simply run out of money. As one of the Nation's fastest-growing Federal programs, we are already feeling the impact of Medicare's deficits. The actual point of bankruptcy for the program may be 6 years off, but it is draining our country's resources today.

Thus, the question before us is when and how we act to change the course of Medicare. If this Congress acts soon, the changes can be relatively incremental and minor, but if the Congress waits, the solutions, out of necessity, will be draconian.

I come before you as a member of a group of people born after 1960 who are concerned about the future of America. Third Millennium's mission is to convince our Nation and its leaders to begin looking beyond the next election cycle and toward the next generational cycle.

The issue before us today is not about what size piece of the American entitlement pie one generation gets compared to the next, and it is not about generational warfare. The issue before us is about looking toward the future and realizing the severity of the problems out there. It is about dealing with those facts and those problems now before they deal with us.

Every year we wait, the problem compounds. As we have heard already this morning, unfortunately, in his 1996 budget, President Clinton and the administration punted on Medicare. It is imperative that this Congress not do the same thing. The pending insolvency of Medicare cannot be pushed off the table. The year 2001 is no longer a futuristic fantasy. To my generation, it is a reality that is literally just around the corner.

Imagine, for a moment, that we are in the year 2001. The Denver International Airport has just opened and the baseball strike has finally ended. For 6 years, Congress and the President have tossed the idea of Medicare reform back and forth. The President offered insubstantial reforms year after year, and Congress, while condemning such weak-kneed approaches, also ultimately became bogged down by special interests and partisan bickering.

Medicare is now 1 month away from running out of money. The Nation is faced with a horrendous decision. We must raise payroll taxes on young people by nearly 4.5 percent immediately to balance the program, or we must slash all benefit checks dramatically, leaving many needy seniors unprepared and without vital health care.

The Nation is, of course, outraged. Why must a country as great and wealthy as America have to choose between burdening its workers with unbearable tax rates and denying poor senior citizens health care?

Mr. Chairman, we will not have to make that drastic decision if we act soon. We can ensure that Medicare continues to provide benefits for those who need them and we can maintain reasonable tax rates if we have the courage to face the situation today rather than tomorrow.

Third Millennium's suggestions for reforming Medicare follow the approach advanced by Senator Bob Kerrey and Senator Jack Danforth of the Bipartisan Commission on Entitlement and Tax Reform. My written testimony outlines those proposals and I won't go into them further, but I will say that there are many ways to substantially reform Medicare and our solutions are just a few common sense approaches.

What is important, Mr. Chairman, is that something be done. This Congress must realize the problem and act in a bipartisan way to solve it. Congress must ensure Medicare's long-term solvency and not just slap a Band-Aid over it to get us through the next 2 years.

Congress must also begin to address the similar insolvency problems facing Social Security. Last year, Third Millennium commissioned a national survey that found that nearly twice as many young adults believe in the existence of UFOs as believe that Social Security will exist by the time they retire.

The crisis of confidence in Federal retirement programs among young people is astounding. With this in mind, we will be watching to see how the Nation's leaders confront the Medicare dilemma, with an eye to how they will confront the much larger problem of Social Security. From my generation's perspective, inaction on either of these fronts is not a justifiable alterative. Not to act now is public policy malpractice.

Young people are willing to sacrifice because we know the consequences to our generation and to future generations if we do not. In 1998, people born in the 1960s and the 1970s will represent the largest potential voting block in the country. So the good news is that doing the right thing, averting disaster in Medicare and Social Security quickly will become the politically rewarding thing to do, as well.

I believe the ultimate challenge of this Congress is one of farsightedness. Would a private business, knowing that financial disaster is pending, wait until tomorrow to deal with the situation? Would an individual family, realizing it is running into financial troubles, wait until tomorrow to change course? Why, then, should the Federal Government be held to any lower standard?

I realize I am out of time, so I will conclude simply by saying that every generation of Americans has its own assets and liabilities, and I truly don't believe that people in my generation are whining about the future we are inhering. But, we can no longer sit idly by as politicians compromise our economic future, and more importantly, the future of our children to pacify powerful special interest groups.

Mr. Chairman, no generation in American history has been left with the tail-end of so many dysfunctional systems as the generation currently graduating from college and entering the workplace. My generation and those after me will pay large amounts of our paychecks into programs that the experts tell us will be bankrupt when we retire. We are on the verge of inheriting a world of crumbling entitlement programs, a burgeoning national debt, decreased national savings, and an increasing number of retirees who expect to be generously supported.

As a generation, we cannot face this tremendous fiscal burden and still lead this Nation into greatness. Thank you.

[The prepared statement follows:]

Testimony of Heather Lamm, National Policy Coordinator for Third Millennium, before the Subcommittee on Health of the Committee on Ways and Means

Thursday, February 23, 1995
1100 Longworth House Office Building

Thank you Mr. Chairman and members of the Committee for inviting Third Millennium to participate on this distinguished panel. My name is Heather Lamm. I am the National Policy Coordinator for Third Millennium. Mr. Chairman, the question before us this morning is not whether or not the Medicare program will become insolvent. The facts speak for themselves. From Alan Greenspan to the Congressional Budget Office to the Public Trustees of Medicare -- the experts agree that Medicare is on a six year collision course with bankruptcy. By 2001, the Medicare Part A Trust Fund is projected to simply run out of money. As one of the nation's fastest growing Federal program, we are already feeling the impact of Medicare's deficits. The actual point of bankruptcy for the program may be six years off, but it is draining our country's resources today.

Thus the question before us is *when* and *how* we act to change the course of Medicare. If this Congress acts soon, the changes can be relatively incremental and minor. But if Congress waits, the solutions, out of necessity, will be Draconian.

I come before you as a member of a group of people born after 1960 who are concerned about the future of America. Third Millennium's mission is to convince our nation and its leaders to begin looking beyond the next election cycle, and toward the next generational cycle. The issue before us today is not about what size piece of the American entitlement pie one generation gets compared to the next. It is not about

generational warfare. The issue before us is about looking toward the future and realizing the severity of the problems out there. It is about dealing with those facts and those problems now, before they deal with us.

Every year we wait, the problem compounds. Unfortunately, in his 1996 budget, President Clinton and the administration punted on Medicare. It is imperative, Mr. Chairman, that this Congress not do the same thing. The pending insolvency of Medicare cannot be pushed "off the table". The year 2001 is no longer a futuristic fantasy. To my generation it is a reality that is literally just around the corner.

Imagine for a moment that we are in the year 2001. The Denver International Airport has just opened and the baseball strike has finally ended. For six years Congress and the President have tossed the idea of Medicare reform back and forth. The President offered insubstantial reforms year after year, and Congress, while condemning such weak-kneed approaches, also ultimately became bogged down by special interests and partisan bickering. Medicare is now one month away from running out of money. The nation is faced with a horrendous decision. We must raise payroll taxes on young people by nearly 4.5% immediately to balance the program, or, we must slash all benefit checks dramatically, leaving many needy seniors unprepared and without vital health care. The nation is of course outraged. Why must a country as great and wealthy as America have to choose between burdening its workers with unbearable tax rates, and denying poor senior citizens health care?

Mr. Chairman, we will not have to make that drastic decision if we act soon. We can ensure that Medicare continues to provide benefits to those who need them *and* we can maintain reasonable tax rates if we have the courage to face the situation today, rather than tomorrow.

Third Millennium's suggestions for reforming Medicare follow the approach advanced by Senator Bob Kerrey and former Senator Jack Danforth of the Bipartisan

Commission on Entitlement and Tax Reform.

When Medicare Part A was enacted, it was a self-supporting system, financed solely by payroll tax contributions. Today, the average enrollee pays only about 32% of the cost. As a result, the average enrollee collects benefits equaling approximately three times the amount contributed during his or her working life. The Medicare Part B program has undergone similar changes. When Medicare Part B began, the enrollee and the Federal government each paid 50% of costs. Today, the Federal government pays 70% of Part B costs, and that share is projected to increase to 92% by 2030. To address these inequities, Third Millennium advocates the following:

- Comprehensive means-testing of Medicare
- Adding a graduated Part A premium for beneficiaries with incomes above 150% of poverty.
- Indexing the Part B premium to program costs to maintain the 30% share of the costs currently paid by enrollees.
- Raising the Part B deductible from $100 to $300 and indexing it.
- Adding a 20% coinsurance payment for clinical lab services and home health care services costing in excess of $10.
- Reducing Medicare Provider Payments

In addition, to adapt to changing demographics caused by longer life expectancies and the aging of the Baby Boom generation we suggest raising the Medicare eligibility age to 70. Seniors would still have the option to enroll at age 62 with a charge for early retirement.

There are many ways to substantially reform Medicare. The above solutions are just a few common sense approaches. What is important, Mr. Chairman, is that *something* be done. This Congress must realize the problem and act in a bipartisan way to solve it. Congress must ensure Medicare's long term solvency, and not just slap a Band-Aid over it to get us through the next two years.

Congress must also begin to address the similar insolvency problems facing Social Security. Last year Third Millennium commissioned a national survey that found that nearly twice as many young adults believe in the existence of UFOs as believe Social Security will exist by the time they retire. The crisis of confidence in Federal retirement programs among young people is astounding. With this in mind, we will be watching to see how the nation's leaders confront the Medicare dilemma, with an eye to how they will confront the much larger problem of Social Security. From my generation's perspective, inaction on either of these fronts is not a justifiable alternative. Not to act now is public policy malpractice.

Young people are willing to sacrifice because we know the consequences to our generation and to future generations if we do not. In 1998, people born in the 1960s and 1970s will represent the largest potential voting block in the country. They will remain that way until well after the Medicare and Social Security systems are in the red. So the good news is that doing the right thing -- averting disaster in Medicare and Social Security -- quickly will become the politically rewarding thing to do as well.

I believe the ultimate challenge of this Congress is one of farsightedness. Would a private business, knowing that financial disaster is pending, wait until tomorrow to deal with the situation? Would an individual family, realizing it is running into financial troubles, wait until tomorrow to change course? Why, then, should the federal government be held to any lower standard?

Every generation of Americans has its own assets and liabilities and I truly don't

believe that most people in my generation are whining about the future we are inheriting. But we can no longer sit idly by as politicians compromise our economic future and, more importantly, the future of our children, to pacify powerful special interest groups. Young people have an obligation, both as citizens and as the parents of the next generation, to offer solutions, to have a voice, to be prepared to sacrifice, and to demand action.

Mr. Chairman, no generation in American history has been left with the tail end of so many dysfunctional systems as the generation currently graduating from college and entering the workplace. My generation and those after me will pay large amounts of our paychecks into programs that the experts tells us will be bankrupt by the time we retire. We are on the verge of inheriting a world of crumbling entitlement programs, a burgeoning national debt, decreased national savings, and an increasing number of retirees who expect to be generously supported. As a generation, we cannot face this tremendous fiscal burden and still lead this nation into greatness. Thank you.

Chairman THOMAS. Thank you very much, Ms. Lamm.
Mr. Hewitt.

STATEMENT OF PAUL S. HEWITT, EXECUTIVE DIRECTOR, NATIONAL TAXPAYERS UNION FOUNDATION

Mr. HEWITT. Thank you, Mr. Chairman.

The National Taxpayers Union Foundation and our sister organization, the National Taxpayers Union, have been trying for years to draw attention to the need to stem the runaway cost of the Medicare program. We appreciate, at long last, that some policymakers are listening, but we note that President Clinton is not among them. His budget seems to suggest that the hospital insurance program can continue running on autopilot. And that, clearly, is wrong.

The system's problems are extraordinary. Exploding costs threaten to impose unthinkable debt and tax burdens on our children. Past efforts to contain costs through capitated payment schemes are creating a two-tiered health system in which some providers no longer accept Medicare patients. These same measures are shifting enormous costs onto private payers, which, in turn, provide fuel for the administration's misguided efforts to enact national price controls, and to nationalize the health insurance system.

Mr. Chairman, we believe that Medicare's problems are solvable without higher taxes and without bigger government. But to achieve these ends, Congress will have to bite the bullet. You will have to tell today's elders that Medicare, in its current form, cannot be saved. You will have to insist that some beneficiaries, mainly the well-off, get less. And to those of us who are not yet retired, you must make it clear that, if we expect to have the very best medical care money can buy, we will have to save more toward that cost ourselves.

In their most recent actuarial report, the Hospital Insurance Trustees painted a very bleak picture. They predicted that the system's trust fund would go bankrupt at the turn of the century, provided that we can avoid a recession in the meantime. HI already costs more than its 2.9-percent payroll tax brings in, and, in this way, is adding billions to this year's budget deficit.

As a percentage of the wage base, HI surpassed 3 percent of payroll in 1992. By the year 2000, it will be close to 4 percent. By 2040, as my grandchildren enter the labor force, HI is projected to claim somewhere between 9.6 and 18.5 percent of payroll—and I would refer you to Mr. King's testimony in which, he said that 9.6 percent was very optimistic.

Together with Social Security and other health entitlements, HI will create enormous pressure for higher taxes. By 2040, the Social Security and Medicare programs alone are projected to cost between 35 and 55 percent of taxable payroll—35 percent is the optimistic number—up to four times their current combined tax burden. If it is the latter, the take-home pay of the average American worker will decline by 59 percent from today's levels. Even if economic and demographic circumstances turn out to be very favorable, the living standard for the average working family in 45 years will be no better than it is today.

I would note with dismay, Mr. Chairman, that some members of this subcommittee have argued, in light of these problems, that we dare not pass a balanced budget amendment. They say that we must keep open the option of deficit financing some or all of the spending growth.

Yet, Office of Management and Budget Director Alice Rivlin's infamous leaked budget memo from last October belies this hope. Her missive to President Clinton points out that under current taxing and spending policies, the budget deficit could soar to $4.1 trillion per year by 2030. Clearly, we cannot incur debt, or, for that matter, incur taxes on this scale. By risking such a course, we would ruin the American dream for generations to come.

If taxes and deficits are not the solution, then it follows that Congress must take decisive steps, and the sooner the better, to reign in the growth of the hospital insurance program.

The task is not as lonely as some of the interest groups who come before you would have you believe. You will have surprisingly strong support from the public.

In a September 1994 survey of working-aged Americans, we found that 94 percent agreed that the impending bankruptcy of the HI trust fund is a "serious" or "very serious" problem. There were 74 percent that said they would think more favorably of elected representatives who addressed the need for reform. Also, 69 percent favored reducing benefits to the affluent, and 88 percent favored shielding retirement savings from taxation.

We urge you to draw on this good will to fundamentally redesign the program. We recommend that you merge HI with the SMI subsidy and convert them into a single voucher that can be used to purchase private insurance. We recommend that these vouchers be means tested, based on the recipient's household wealth and income. We further recommend that you significantly expand the concept of the individual retirement account, so that working Americans who want to save and avoid dependency on the government can do so.

Let me say, in conclusion, that we at the National Taxpayers Union recognize the terrible, desperate dependency that has been created by social insurance. Many Americans have failed to prepare adequately for their old age, precisely because the government has told them: Don't save, we will fund these costs by taxing your children and grandchildren.

We must follow through on our obligations to the truly dependent. But at the same time, we must take immediate steps to improve the efficiency of our health benefit programs, and to cut their costs. And over time, we must convert these subsidies into true insurance systems that minimize dependency on government and increase national savings. Thank you.

[The prepared statement follows:]

Statement of
Paul S. Hewitt
Executive Director
National Taxpayers Union Foundation
before the
Committee on Ways and Means, Subcommittee on Health

February 22, 1995

Mr. Chairman, members of the Committee, thank you for inviting me to testify on behalf of the National Taxpayers Union Foundation concerning the Medicare provisions of the President's fiscal 1996 budget proposal.

NTUF and its 300,000 member sister organization, the National Taxpayers Union, have been trying for years to draw public attention to the need for fundamental reforms to the Medicare program. We very much appreciate that, at long last, some policy makers appear to be listening. But we are sad that the President still is not among them. From what we can see, his budget seems to suggest that the system can continue running on auto-pilot. And that clearly is wrong.

Medicare's problems are extraordinary. Exploding costs -- under both the Hospital Insurance and Supplementary Medical Insurance systems -- threaten to impose unthinkable debt and tax burdens on our children. Past efforts to contain costs through capitated payment schemes are creating a two-tier health system, in which some providers no longer accept Medicare patients. These same measures are shifting enormous costs onto private payers, which, in turn, fuels the administration's misguided initiative to institute national price controls.

Mr. Chairman, we believe that Medicare's problems are solvable without higher taxes or bigger government. But to achieve these ends, Congress will have to bite the bullet. You will have to tell today's elders that Medicare, in its current form, cannot be saved. You will have to insist that some beneficiaries, mainly the well-off, get less. And to those of us who are not yet retired, you must make it clear that, if we expect to have the best medical care money can buy, we will have to save more toward the inevitable costs of our own old age.

Hospital Insurance

In their most recent actuarial report, the HI trustees painted a bleak picture, indeed. They predicted that the system's trust fund will go bankrupt at the turn of the century -- provided, of course, that we can avoid another recession in the meantime. HI already costs more than its 2.7 percent payroll tax brings in -- and in this way it contributes to this year's unified budget deficit. As a percentage of the wage base, HI surpassed 3 percent of payroll in 1992. By the year 2000, its cost will be close to 4 percent. By 2040, as my grandchildren enter the labor force, HI is projected to claim somewhere between 9.6 percent and 18.5 percent of payroll.

Together with Social Security and Part B of Medicare, the program will create enormous pressures for higher taxes. By 2040, these three programs are projected to cost between 34.5 percent and 55.1 percent of total taxable payroll -- or between 2.3 and 3.7 times their current combined tax burden. If it is the latter, the take-home pay of the average American worker will decline by 59 percent from today's levels. Even if economic and demographic circumstances are highly favorable, the standard of living for the average working family will be no better in 45 years than it is today.

I would note, with dismay, that some members of Congress have argued that, in light of these problems, we dare not pass the balanced budget amendment. They say that we must keep open the option of deficit financing some, or all, of this spending growth. Yet, OMB Director Alice Rivlin's infamous leaked budget memo of last October belies this hope. Her missive to President Clinton points out that, under current taxing and spending policies, the budget deficit could soar to $4.1 trillion per year by 2030. Clearly, we cannot incur debt -- or, for that matter, taxes -- on this scale. By risking such a course, we would ruin the American dream for many generations to come.

Reform Recommendations

If taxes and deficits are not the solution, then it follows that Congress must take decisive steps -- and do so soon -- to rein in the future cost growth of the Hospital Insurance program. The task is not as lonely as the special interest groups who come before this Committee would have you believe.

You will have surprisingly strong support from the public. In a September 1994 survey of working aged Americans, 94 percent agreed that the impending bankruptcy of the HI trust fund is a "serious" or "very serious" problem. Seventy-four percent said they would think more favorably of elected representatives who discussed the need for reform. Sixty-nine percent favored reducing benefits to affluent households. Eighty-eight percent favored shielding retirement savings from taxation.

The National Taxpayers Union Foundation urges Congress to listen to the American people. We recommend that you merge the HI with the SMI subsidy, and convert them into a single voucher that can be used to purchase private health insurance. We recommend that these vouchers be means-tested, based on the recipient's household wealth and income. We further recommend that you significantly expand the Individual Retirement Account, so that working aged Americans who want to save, and avoid dependency on government, can do so.

This approach has important advantages. It would cut federal spending, and pressure on deficits and taxes. It would harness the market forces of consumer choice to contain costs. It would dispense with the Byzantine price controls and claims processing systems that currently plague HI. It would raise our national savings rate -- and thereby help America to retain its share of global markets in the next century. And it would remove much of Medicare's regressivity. It is beyond me, Mr. Chairman, how Congress can levy taxes on low income workers, for a program that has no future, to subsidize retired doctors and accountants.

Mr. Chairman, let me say, in conclusion, that we recognize the terrible dependency created by social insurance. Many people have failed to prepare adequately for their old age precisely because government promised to fund these costs by taxing their children and grandchildren. We must follow through on our obligations to the truly dependent. But at the same time, we must take immediate steps to improve the efficiency of our health benefit programs, and to cut their costs. Over time we must convert them into systems that minimize dependency on government.

Thank you for soliciting our views. I will be pleased to answer your questions.

Chairman THOMAS. Thank you very much, Mr. Hewitt, and I want to thank the panel.

We have a vote on now, so we are going to recess to go over and vote. If the panel will be kind enough to wait, we will come back and then we will continue our inquiry.

Thank you very much.

[Recess.]

Mrs. JOHNSON [presiding]. Mr. Thomas has asked me to resume the hearing. While I was waiting for some of my colleagues to return, I think that, given the hour and the work ahead of us, I am going to resume the hearing without them. I am sure that they will be joining me shortly.

First of all, I want to thank this panel for their input. I am very disappointed that neither AARP nor the Committee to Preserve Social Security came today. I think that is extremely unfortunate, that they chose not to come. I do not know why, but there could be no greater threat to either the seniors of America or the younger generation than the impending bankruptcy of the system on which they depend for medical care. It is not just seniors who depend on that system, it is their children and offspring, it is the larger family. I do regret their not being here.

I very much regret the administration's decision not to allow Alice Rivlin to be here, because, while, in fact, we are only a subcommittee and often the administration doesn't send people of that rank to subcommittees, and I appreciate that general policy, nonetheless, we are the only subcommittee dealing with one of the most explosive, difficult, dangerous problems that we face. If we don't fix Medicare, it could rend the very fabric of families and communities.

I just appreciate your testimony very much.

Mr. Hopkins, you recognize in your testimony the challenge of educating seniors. What plans has your group made to begin dealing with this? In my experience among members of the public, when I speak to seniors at senior centers, they are among the most rational of my constituents and also amongst the best informed. But you are right. The seniors need to understand what is at stake and how many very positive options there are.

What work has the Seniors Coalition done, or what work are you planning to do? What kind of broader coalitions can you build? Have you talked to RSVP about this? What is happening out there to help seniors understand what is at stake?

Mr. HOPKINS. Right now, we are in the process of coalition building, as you suggested, because it is going to take a lot of work from a lot of people. We don't have all the answers. We are looking at a lot of ideas out there. Your idea with expanding Medicare Select is an absolutely wonderful, necessary step, and we are supporting that actively.

But beyond that, we are exploring the idea of Medicare savings accounts. We are giving that some very serious looks. We are looking at reforming Medicare HMOs to actually make them work a little bit better and actually save some money while retaining choice and the ability to opt out. Certainly, we don't want seniors herded into one plan in which they are stuck.

We are in the building process right now. Again, we recognize that we won't have all the answers. We want to talk to as many

people as we can. The important part is recognizing that there is a problem so that everybody can work on it together.

Mrs. JOHNSON. Thank you. I appreciate that, and I appreciate your support of Medicare Select. It is a useful move. It is a very teeny, tiny action in the face of the enormity of this problem, but I do hope that we will be able to get that bill out of subcommittee and through the House in fairly rapid order, because it will, for the first time, make permanent a more flexible preferred provider option for seniors.

There is nothing mandatory about it. As you say, nobody on this side of the aisle, and, I dare say, no one on the other side of the aisle has any interest at all in forcing seniors into any plan they don't elect or in keeping them in any plan that they aren't happy in.

With that clear, I do look forward to working with you on reforms of HMO risk contracts and those kinds of vehicles to help seniors have greater choice. It is going to be their primary avenue to expanded benefits.

Ms. Lamm, I was very pleased to see in your testimony that you have picked up on some of the tougher recommendations made by some of my colleagues in the other body. The House Republicans have now, in two budgets, introduced and voted on means testing Medicare premiums. We have not gone through in the detail that you have, and I appreciate your putting on the record and talking through a little bit the specific recommendations that you are making to make Medicare more sensitive to the extraordinary variation in economic power that is typical in our seniors community.

Ms. LAMM. I will go ahead and do that, but I will start by saying, again, the recommendations that we make, and we realize, are just a few of many out there. We also realize that, after all is said and done, they might not be the best ones that could be made. Again, I say that it is most important that this body get together and act to solve the problem.

We believe, again, in the means testing of Medicare, simply because, as a group, Third Millennium believes that the elderly have gone from among the poorest in the country to the most wealthy in the country. It is important, when I say that, to begin by saying, the elderly are a very diverse group. Obviously, there are very many senior citizens who rely on Medicare and who need it, and that should not be taken away from them. But there are also very many wealthy seniors who, we believe, could pay a greater share of the Medicare costs.

That is followed by the second proposal that we had here, adding a graduated part A premium for beneficiaries with incomes above 150 percent of poverty. Again, I forward this by saying that the average enrollee only pays about 32 percent of the cost today. We feel that it would be a good move to add that premium.

The part B proposals that we recommend are, again, on similar lines, because when Medicare part B began, the share was really 50:50 and that has shifted significantly since the program began. We feel that it is only fair to make sure that we maintain the 30-percent share paid by enrollees today and that that is not decreased even further to 25 or 20 or even 15 percent.

Mrs. JOHNSON. The interesting thing about these kinds of proposals is that they could be done immediately. These are not mysterious. In my experience, actually, I have never met a senior in America who wasn't willing, in the upper-income brackets, to pay more of their Medicare premium and didn't understand how fair and reasonable it was.

I think, it is my hope, at least, that as we look at this crisis short term, we at least do some of those things that are fair and that are relatively easy to do right now. Medicare Select is among them. There are some other things that we can do, but means testing premiums is certainly one of them.

Mr. Hewitt, I thought that your laying out the costs in 2040 was very helpful, that payroll taxes could go as high as 18.5 percent, that we would be well into more than $4 trillion deficit spending per year. It is simply extraordinary.

So it is imperative that we come to grips with the significance of the problems we face in Medicare, and then, ultimately, in Social Security.

I thank you for your testimony, and I yield to my colleague, Mr. Cardin.

Mr. CARDIN. Thank you, Mrs. Johnson.

Let me apologize for not being here to listen to your testimony. I have tried to read, quickly, the summary of your statements. I was speaking downtown on health care on what is likely to be the type of health care bills to come out of this session of Congress, from the Democratic point of view. There was a Republican also there.

I know that we all share a commitment to deal with the Medicare system, to reduce the Federal cost, but, more importantly, to reduce the cost of health care growth in this country and to make it more available to all of our people.

Reading your statements, there is little to quarrel with from the point of view of trying to get a fairer financing structure for those who benefit from Medicare, and we need to take a look at that. But we also need to reduce the costs of health care and the costs of the Medicare system itself.

The problem that we confront, and I would appreciate your response to, at least, my assessment of how the problem has developed and what we can do about it, is the problem that we usually look simply to cutting provider fees. I notice in one of the statements here, from Ms. Lamm, you have reducing Medicare provider payments. When we reduced Medicare provider payments in the past, we have just seen it has been cost-shifted over to the private sector without really any reduction of the overall medical cost growth in this country.

The anomaly of it, though, is that on total, Medicare pays less than its fair share on the per-unit cost, but that if you could have a better organization for the delivery of health care, you could save money in the managing of the health care cost per beneficiary.

My State of Maryland has an all-payer rate system, where hospital rates are set for all payers to pay the same amount. So if you go to a hospital in Maryland, they really don't care whether you are a Medicare person or a Medicaid person or Blue Cross/Blue Shield or Prudential, or for that matter, a self-insured plan, be-

cause the hospital is going to get basically the same reimbursement rate. There is no difference. We have no cost shifting from one segment to the other.

When Maryland started this system in the 1970s, our costs were 25 percent above the national average on a per-admission basis. We are now about 15 percent below the national average, so we have brought our costs down considerably. We have been able to save Medicare money, save our companies money, and save costs for taxpayers generally.

I guess my point is that we are able to do that through developing a rational system for hospital reimbursement, a fair system. What concerns me in some of the testimony we have heard today is that there is at least the thought that, perhaps, Medicare could just pay less and that will mean we save money. That is not the case in my State. There is no discounting in Maryland. HMOs pay the same as a fee-for-service plan, as far as their hospital costs are concerned.

So I would hope that we would look for innovative ways to bring down Medicare costs rather than just slashing budgets and slashing provider fees. Yes, we should look at beneficiaries paying in a more rational way for what they receive, but we also should be looking at ways of delivering the product in a more cost-effective environment.

I would appreciate if anyone would like to make a comment about that in the moment or two that is left.

Ms. LAMM. I think that the concern over cost shifting is very valid, indeed. In what Third Millennium advocates, we must realize that it is part of an entire package. I would certainly not suggest that we simply reduce Medicare provider payments and that that would solve the problem. I think that, in the context of this package, it is one proposal that balances out some of the other proposals and that it must be taken as part of that package. But I certainly understand the cost shifting concern.

Mr. CARDIN. Thank you.

Thank you, Madam Chairman.

Mrs. JOHNSON. I thank the panel for your participation today and for your patience during our voting period.

Mrs. JOHNSON. I would like to call now the representative from the GAO, Sarah Jaggar, our last witness.

Welcome, Ms. Jaggar.

STATEMENT OF SARAH F. JAGGAR, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY FRANK PASQUIER, ASSISTANT DIRECTOR, AND CRAIG WINSLOW, OFFICE OF THE GENERAL COUNSEL

Ms. JAGGAR. Thank you. Madam Chairman and members of the subcommittee, we are very pleased to be here today to highlight a recent development specifically related to the Medicare secondary payer (MSP) program. This is a narrow focus compared to the broad focus that you have had this morning, but it is something that we feel needs to be brought to your attention right away.

With me today is Frank Pasquier, who has been responsible for much of our Medicare secondary payer, or MSP, work over the years. We would like to have our full statement put into the record and I would like to present a summary.

First, a bit of background on the MSP program. By law, Medicare is to be the secondary payer for certain covered beneficiaries when they have other private health insurance coverage. To be the secondary payer, Medicare must know about a beneficiary's other coverages so its claims processing systems can assure that other insurers pay claims before Medicare. This enables Medicare to avoid incurring unnecessary costs.

A second part of MSP is when Medicare retrospectively recovers mistaken payments that should have been paid by other health insurers. This is called recovery of mistaken payments. This is a difficult and costly process.

MSP is a major Medicare cost containment measure. HCFA, the Health Care Financing Administration, estimates that it saved taxpayers about $3 billion in fiscal year 1994. Today, I would like to focus on two areas that affect the ability of the MSP program to realize savings. These are the HCFA data match and the Medicare/Medicaid data bank.

First, the HCFA data match. The HCFA data match allows Medicare to match data contained in IRS and Social Security Administration files to identify beneficiaries that have health insurance coverage through their own or a spouse's employer. To date, the data match program has been cost effective. The data match for the 1987 through 1990 time period has resulted in $1.6 billion in demand notices to insurers for payment to Medicare, of which about $400 million has been collected. In seeking these recoveries, Medicare contractors have incurred about $94 million in administrative costs through fiscal year 1994.

However, a May 1994 Federal court ruling invalidated two MSP regulations that HCFA officials view as critical to continuing this program. The first deals with the timeframe for recovering MSP mistaken payments. The court ruled that Medicare must adhere to insurers' timely filing requirements in seeking recoveries from insurers, generally meaning that claims must be filed within 1 year after the date of service.

However, the data match process, because it uses IRS and SSA data, does not permit HCFA to meet these timeframes. Medicare claims are usually at least 2 years old before recovery actions can be initiated. This limitation would basically eliminate HCFA's ability to recover mistaken payments, at the loss to Medicare of hundreds of millions of dollars annually.

The second ruling invalidates a HCFA regulation that allows Medicare to make recoveries from third-party administrators, which typically adjudicate claims and write benefit checks for employers that self-insure. Because one third-party administrator may serve hundreds of employers, HCFA officials told us they will face serious administrative complications if they must pursue recovery from each employer.

This week, the Supreme Court declined to hear the Federal Government's appeal of this case, leaving the appeals court's decision intact. Without legislative intervention to reinstate these regula-

tions, HCFA will be unable to recover on previously paid Medicare claims, resulting in an estimated lost savings of at least $600 million over the next 5 years.

Further, according to HCFA officials, there is now an open question as to whether Medicare will have to refund to insurers amounts already recovered under the data match program. As you can see, this court ruling has serious implications for the cost of and funding for the Medicare program.

In conclusion, Mr. Chairman, our work suggests that several actions are needed to protect the savings available under the MSP program. First, the MSP program's recovery efforts for previously paid Medicare claims have been shown to be cost effective, resulting in $400 million in recoveries thus far. However, this effort has, in effect, been negated by the recent appeals court ruling, and as a result, at least $600 million of expected recoveries over the next 5 years will be lost. Legislation is needed to prevent this. We would be happy to work with your staff to develop suggested language to remedy this problem.

Second, we have earlier made a recommendation that funding for what is known as the Medicare and Medicaid data bank be delayed until its potential value and benefits can be demonstrated, and we continue to support that recommendation.

This concludes my statement. We will be happy to answer any questions you may have.

[The prepared statement follows:]

TESTIMONY OF SARAH F. JAGGAR, DIRECTOR
HEALTH FINANCING AND POLICY ISSUES
HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION
UNITED STATES GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to highlight recent developments related to the Medicare Secondary Payer (MSP) program that could cost the Medicare trust fund hundreds of millions of dollars. Your Subcommittee recently held several hearings on the Medicare program to identify ways to avoid excessive or unnecessary spending. As you are aware, there are a number of legislative initiatives that are intended to improve the MSP program, which is administered by the Health Care Financing Administration (HCFA), an agency within the Department of Health and Human Services (HHS).

The MSP program helps assure that other health and accident insurers pay medical costs for certain covered beneficiaries before Medicare. To do so, Medicare must obtain data on a beneficiary's private health insurance coverage so that its claims processing systems can assure that other insurers, whose coverage is primary, pay claims before Medicare. This enables Medicare to avoid incurring unnecessary costs. In addition, Medicare retrospectively recovers mistaken payments that should have been paid by other health insurers. Thus, MSP is a major Medicare cost containment measure, saving about $3 billion in fiscal year 1994.

Historically, Medicare has faced many obstacles in carrying out the MSP provisions. When Medicare pays claims that other insurers should have paid, Medicare must recover its costs from the liable insurers. This is difficult. For the past decade, our reports (see Appendix I) and those issued by HHS's Inspector General have shown problems with efforts to identify and collect from insurers that are responsible for paying ahead of Medicare.

I now would like to focus on three specific legislative initiatives intended to improve Medicare's MSP program that I will discuss are the following:

-- The HCFA data match which relies on Internal Revenue Service (IRS), Social Security Administration (SSA), and Medicare records. The anticipated recovery of hundreds of millions of dollars of mistaken payments has been negated by a recent appeals court ruling that invalidates two HCFA regulations that are critical to MSP recoveries.

-- The Medicare/Medicaid data bank. As we previously testified and reported, we believe that the data bank will be expensive and add an unnecessary administrative burden to the nation's employers while achieving little or no savings because there is no assurance that the increased record-keeping requirements would provide needed or additional information on beneficiaries' health insurance coverage.

-- A beneficiary enrollment questionnaire. While this initiative has strong potential for identifying Medicare beneficiaries with other health insurance coverage, it will be some time before HCFA can assess its overall effectiveness.

BACKGROUND

Medicare provides health insurance coverage for over 36 million elderly and disabled Americans. Its coverage is quite extensive, including physician, hospital, home health, skilled nursing home, and various other services.

In enacting the Medicare program in 1965, the Congress made Medicare the secondary payer for expenses also covered by workers' compensation programs. Concerned about escalating costs in the Medicare program, the Congress made several statutory changes during the 1980s that also made Medicare the secondary payer to certain employer-sponsored group health insurance plans and to automobile and other liability insurance plans.

The MSP provisions are intended to assure that Medicare is the secondary payer, that is, other insurers pay claims before Medicare. As a result, Medicare claims processing contractors have two interrelated responsibilities: (1) to identify beneficiaries with other insurance coverage and thus avoid paying claims that other insurers should pay and (2) to identify and recover mistaken payments that were made before it was determined that the beneficiary had other insurance coverage.

The MSP provisions apply to a relatively small portion of the total number of Medicare-eligible persons. Last year, we estimated that no more than 3 million Medicare beneficiaries have other insurance that is primary to Medicare. Nevertheless, because of the size of the Medicare program, the dollar value of Medicare claims subject to the MSP provisions is substantial.

The majority of beneficiaries who are covered by the MSP provisions are the working aged and their spouses. Contractors often must rely on health care providers to identify beneficiaries with other insurance coverage and thus may experience difficulties in screening medical claims when such information is missing. Even more arduous and costly are the contractors' attempts to recover Medicare payments after a claim has been paid. Contractors must search their records, often dating back several years, to determine whether Medicare paid claims for which another insurer was the primary payer and, if so, seek recovery.

FUTURE RECOVERIES THROUGH THE DATA MATCH PROGRAM WILL NOT BE REALIZED

To help Medicare identify and also recover costs that other insurers are responsible for paying, the Congress provided for HCFA to establish a data match process. The data match process, originally authorized under the Omnibus Budget Reconciliation Act of 1989, allows HCFA to match data contained in several federal information systems--including IRS and SSA files--to identify beneficiaries that have the potential for health insurance coverage through their own or a spouse's employer. Section 13561 of Omnibus Budget Reconciliation Act of 1993 (OBRA-93) extended HHS's authority to conduct data match activities through September 30, 1998. The President's fiscal year 1996 budget proposes legislation that would permanently extend the provision.

To date, the data match program has been cost effective. HCFA records show that an initial data match of IRS/SSA records for the 1987-90 time period has resulted in $1.6 billion in demand notices to insurers for payment to Medicare, of which about $400 million has been collected. In seeking these recoveries, Medicare contractors have incurred about $94 million in administrative costs through fiscal year 1994. However, a May 1994 a federal court ruling invalidated two MSP regulations that HCFA officials view as critical to their continued recovery of MSP mistaken payments.[1]

The first regulation deals with the time frame for recovering MSP mistaken payments. HCFA regulations (42 C.F.R. 411.24(f)) provide that Medicare contractors may recover such payments without regard to any insurer imposed requirements to file a claim within a certain time period. The court ruled that in seeking recoveries from insurers, Medicare must adhere to insurers' "timely filing" requirements that are imposed on other claimants. Generally, this means that claims for reimbursement of health care services must be filed within 1 year after the date of service. However, the data match process does not permit HCFA to meet these time filing requirements. IRS data are for prior tax years and must be matched against SSA wage information. Thus, the data by nature are over a year old before HCFA can begin processing them to identify MSP

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[1]Health Ins. Ass'n of Am. v. Shalala, 23 F.3d 412 (D.C. Cir. 1994) *cert. denied*, 63 U.S.L.W. 3439 (U.S. Feb. 21, 1995) (No. 94-919).

situations. HCFA's process involves mailing questionnaires to employers, searching Medicare paid claims data, and providing contractors with lists of mistaken payments that must be researched. As a result, Medicare claims are at least 2 years old before HCFA can initiate recovery actions. For example, HCFA has just recently initiated efforts to recover mistaken payments that were identified by the 1991-92 data match. HCFA estimates that these claims could result in additional recoveries of about $200 million.

The second regulation deals with Medicare recoveries from third party administrators (TPA). The court ruling invalidated a HCFA regulation (42 C.F.R.411.24(e)) that allows Medicare contractors to recover from TPAs. TPAs typically adjudicate claims and write benefit checks for employers that self-insure. Most self-insured health plans operated by medium and large employers use TPAs. Because one TPA may serve hundreds of employers, they often represent the most efficient entity from which to seek recoveries. Because of the ruling, HCFA will now have to identify the specific employer that provides coverage and separately pursue recovery from each employer. HCFA officials told us that they will face serious administrative complications in recovering Medicare mistaken payments if they are prohibited from recovering directly from TPAs.

The Federal government appealed the court's decision to the Supreme Court, but this week the Court declined to hear the case, leaving the appeals court decision intact. Therefore, without legislative intervention to reinstate these MSP regulations, continued and effective recovery of Medicare mistaken payments from the data match process is not possible. Not being able to effectively recover on previously paid Medicare claims will result in estimated lost savings of at least $600 million over the next five years. Specifically, in regard to the fiscal 1996 budget, HHS estimated that the matches performed in fiscal 1996 could yield $400 million in MSP savings and projected savings of $430 million if the data match is extended beyond 1998. About half of these savings represent recoveries of previously paid claims that will not be collected because of the appeals court decision. In addition, according to HCFA officials, there is now an open question as to whether Medicare will have to refund to insurers amounts already recovered under the data match program since 1993.

LEGISLATION NEEDED TO DELAY
DATA BANK IMPLEMENTATION

Another MSP initiative that could have a significant impact on HHS fiscal year 1996 administrative costs for Medicare is the Medicare/Medicaid data bank. Section 13581 of OBRA-93 directed HHS to establish a data bank, beginning in February 1995, that would contain information on about 160 million workers, spouses, and dependents covered by employer group plans. Its purpose is to save millions by (1) identifying the approximately 7 million Medicare and Medicaid beneficiaries who have other health insurance coverage that should pay medical bills ahead of the Medicare and Medicaid programs and (2) ensuring that this insurance is appropriately applied to reduce Medicare and Medicaid costs. This information would then be used to recover mistaken payments.

In May 1994 we issued a report and testified that the proposed data bank would create an avalanche of unnecessary paperwork for both HCFA and employers and will likely achieve little or no savings while costing millions. The cost to HCFA of establishing and maintaining the data bank over 5 years was estimated by the agency at over $100 million. As a result, we recommended that the data bank be delayed until its potential benefit could be clearly demonstrated.[2]

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[2] Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers (GAO/HEHS-94-147), May 6, 1994.

While the Congress did prevent HCFA from using fiscal year 1995 appropriated funds for implementing the data bank, this restriction expires at the beginning of fiscal year 1996. At that time, the OBRA-93 provision would apply, and HCFA would be required to implement the data bank with fiscal year 1996 funds. We believe our 1994 recommendation is still appropriate and that the Congress should continue to delay the implementation of the data bank until its potential value and benefit can be clearly shown.

ENROLLMENT QUESTIONNAIRE
HAS POTENTIAL TO STRENGTHEN
MSP PROCESSES

MSP works best when Medicare has accurate, up-to-date information that enables it to keep from paying claims for which other insurers are responsible for paying. To enhance this ability, section 151(a) of the Social Security Act Amendments of 1994 directed HCFA to develop and mail questionnaires to Medicare beneficiaries upon enrollment. The questionnaires are to obtain information on whether the individual is covered by a health plan that should pay claims ahead of Medicare. HCFA anticipates mailing about 200,000 questionnaires a month. As of February 2, 1995, the first mailing was in process. In fiscal year 1996, HHS has budgeted $3.6 million to continue this activity.

While the questionnaire has strong potential to strengthen the MSP process and improve savings, it also has several built-in limitations. First, consistent with the statute, completing the questionnaire is essentially voluntary, so the extent to which beneficiaries will return it is not yet known. Second, because the questionnaire is administered only once, the information is accurate only as long as there is no change in the beneficiaries' health insurance coverage.

As a result, more experience with the questionnaire will be needed before HCFA can assess whether the questionnaire's results will provide sufficient information that will result in additional MSP savings.

CONCLUSIONS

Mr. Chairman, our work suggests that several actions are needed to maximize the savings available under the MSP program. First, because MSP recovery efforts of previously paid Medicare claims have, in effect, been negated by a recent appeals court ruling, legislation is needed to assure effective recovery of MSP mistaken payments. We would be happy to work with your staff to develop suggested language to remedy this problem. Second, we continue to support our earlier recommendation that funding for the Medicare/Medicaid data bank be delayed until its potential value and benefits can be demonstrated.

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This concludes my prepared remarks. We will be happy to answer any questions you may have.

For more information on this testimony, please call Frank Pasquier, Assistant Director, at (206) 287-4861. Other major contributors included Alfred Schnupp and Craig Winslow, Office of the General Counsel.

RELATED GAO PRODUCTS

Medicare: More Hospital Costs Should Be Paid by Other Insurers (GAO/HRD-87-43, Jan. 29, 1987).

Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare (GAO/HRD-89-19, Nov. 29, 1988).

Medicare: Millions in Potential Recoveries Not Being Sought by Maryland Contractor (GAO/HRD-91-32, Jan. 25, 1991).

Medicare: Millions in Potential Recoveries Not Being Sought by Contractors (GAO/T-HRD-91-8, Feb. 26, 1991).

Medicare: Over $1 Billion Should Be Recovered From Primary Health Insurers (GAO/HRD-92-52, Feb. 21, 1992).

Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers (GAO/HEHS-94-147, May 6, 1994).

Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers (GAO/T-HEHS-94-162, May 6, 1994).

Mrs. JOHNSON. Ms. Jaggar, what was the logic of the committee's ruling in regard to Medicare's right to collect from third-party administrators?

Ms. JAGGAR. Madam Chairman, when Medicare was put in place in 1965, the early program decided that for Workers' Compensation claims, Medicare would be the secondary payer. In the early 1980s, there was an expansion of the Medicare secondary payer coverage to include other individuals who met certain selected conditions, so this has been in place for a number of years and is not a new decision.

Mrs. JOHNSON. It is not a new decision, but now it is interfering with your ability to collect?

Ms. JAGGAR. What is at question now is a court ruling which essentially says that Medicare—it doesn't say that Medicare can't make the collection for these mistaken payments. It says that Medicare must do it within a year's timeframe, or within the timeframe that the insurance companies have set. The insurance companies have wanted that timeframe—it is normally within a 6-month to 1-year timeframe that insurance companies close out——

Mrs. JOHNSON. I understand the time problem.

Ms. JAGGAR. OK.

Mrs. JOHNSON. It is the second one that you bring up, the court ruling that invalidated the HCFA regulation that allowed Medicare contractors to recover from TPAs. What was their logic in denying your right to recover in that court decision?

Ms. JAGGAR. I have with me a gentleman from our Office of the General Counsel.

Mrs. JOHNSON. We would be happy to hear from him.

Ms. JAGGAR. His name is Craig Winslow.

Mrs. JOHNSON. Mr. Winslow, welcome, and thank you.

Mr. WINSLOW. Thank you. It was based on interpretation of the statutory language. The language says, basically, they can recover from those who are required to or have a responsibility to pay. The court accepted the argument that TPAs, although they are paying claims on behalf of insurers and others, because they don't have ultimate financial responsibility, that they are not required or responsible to pay, in the context of this language.

Mrs. JOHNSON. So you believe a clarification of the law would restore your right to deal with the TPAs?

Mr. WINSLOW. Exactly, yes, ma'am.

Mrs. JOHNSON. Thank you.

Mr. Cardin.

Mr. CARDIN. Could you elaborate a little bit more specifically as to what type of legislation you would like us to consider?

Ms. JAGGAR. Mr. Cardin, the Supreme Court's decision not to hear the case occurred on Tuesday of this week. As you can imagine, the people at the Health Care Financing Administration who are responsible for conducting the MSP and have been involved in the litigation over the years are working on legislation.

Our understanding is that the changes that would be required basically go to clarifying the timeframes and the responsibility, and that what we would like to do for the subcommittee, if the subcommittee would find it helpful, is work with the lawyers at the

Health Care Financing Administration. It would be a matter of language change.

Mr. CARDIN. I would assume, on the first point, you would want to extend the period to greater than 1 year. Is that what you would be seeking, a longer time period?

Mr. WINSLOW. The court ruling didn't say 1 year. It just said that they were bound by the filing deadlines in the contract. We would want to clarify that the Federal Government shouldn't be bound by those.

Mr. CARDIN. Would not be bound at all?

Mr. WINSLOW. Would not be bound by them.

Mr. CARDIN. You don't want any of the contractual limitations to apply? You don't want to put a limit on what those contractual limitations could be?

Mr. WINSLOW. Right, because, for example, the data match takes, I think my colleagues were saying, 2 years.

Mr. CARDIN. What are your limitations now? If you don't have contractual limitations, what would the limitations be?

Mr. WINSLOW. I really can't say for sure. I am sure there is a statute of limitations, perhaps, but I don't know what it is.

Mr. CARDIN. I think it would be useful if we knew what that limitation was. If you are asking us to eliminate any contractual restrictions, we should know what the limits are.

Mr. WINSLOW. I will be glad to get back to you.

Mr. CARDIN. I can understand that this just occurred and you don't have a specific bill before us.

On the second point, you would want the ability to go against the organization rather than against each employer, is that what you are basically asking?

Ms. JAGGAR. The third party administrators pay claims for a number of individuals, for a number of employers. For HCFA to go to each individual employer to try to get those recoveries would be extremely costly and time consuming and be a big burden on it.

Mr. CARDIN. I would think that your point there is very well taken, and we would like to see the specifics there, also.

The chairperson is not only chairing today's hearing, but she also chairs our Oversight Subcommittee, and this question may be better suited for that subcommittee. I can appreciate the importance of the match program. It does bring in moneys to the Federal Treasury.

You brought in, I think, $400 million, you indicated, over a period of time, and it cost $100 million to recover. That seems like a large overhead cost, $100 million for $400 million. We don't want to lose $300 million, but it seems to me that it is an expensive collection process.

Ms. JAGGAR. Perhaps I could clarify that. In fact, $1.6 billion in repayment demands have been made and $400 million has been returned, but because of this court case or for any number of other reasons, it may well be that insurance companies were, in fact, waiting to see whether they would have to return that money.

So I don't believe that it is possible yet to say exactly what the administrative costs are. In addition, those administrative costs cover the activity that allows for cost avoidance. That is the identification of individuals who have this insurance coverage. Essen-

tially, a flag is set in the computer and then you don't have to recover because you don't make the mistaken payments from the outset. That is estimated at approximately $3 billion for 1994. So the $94 million against the $400 million is not quite the full story.

Mr. CARDIN. I appreciate that clarification. Thank you.

Mrs. JOHNSON. As you come back to us with specific recommendations, and clearly, we are all interested in that, I think open-ended legislation is really not a good idea. We have timely filing requirements for good reason. But I think we could have, in this case, the timely filing period start from the availability of the data that you need to match and that you would have 1 year from the time that the information was available, rather than an open-ended opportunity to collect.

Ms. JAGGAR. It certainly would be possible to narrow it to a reasonable timeframe. The process is an arduous one. Once the data are obtained from IRS and SSA, it is matched, and then letters are sent to the employers to find out whether it was accurate. So it takes a while, but I do agree that it wouldn't need to be open-ended indefinitely.

Mr. CARDIN. Would the gentlelady yield on that point?

Mrs. JOHNSON. Yes.

Mr. CARDIN. I think it is important that we nail down a specific time period. That is why I would like to know what the general limits would be.

It is clear that contractual time limits make very little sense for the work that you are doing. That is a contractual limit between the policyholder and the company and it relates to what the policyholder should know. You don't know that until you get the information. So, clearly, the interpretation of the court is not acceptable for purposes of what we are trying to do and collect under Medicare.

But I do think it is important to come up with a limitation that is reasonable and not to keep it open-ended, so that we are fair to the agency but also fair to the company.

Ms. JAGGAR. We thought it was important to bring to your attention because it is so much money. Of course, there is a question, ultimately, of whether past collections would have to be returned, and there is some issue associated with that. So it is a significant amount of money.

Mrs. JOHNSON. We certainly would want to clarify all those things, but recognizing the pressure which we would be under regardless who is in control, these are the kinds of things that you can do in fairness to all, the taxpayers, the beneficiaries, and the government. We do need to clean up this act, and it is a legitimate thing to try to do in the very near future. Any help you can give us and send that word back, between GAO and HCFA, we ought to be able to fix this.

Mr. CARDIN. We could have a problem on retroactivity, so you probably would want to get something to us as quickly as possible.

Ms. JAGGAR. Yes, sir.

Mrs. JOHNSON. Thank you. We look forward to working with you.

Ms. JAGGAR. Thank you.

Mrs. JOHNSON. The hearing is adjourned.

[Whereupon, at 1:07 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF
NATIONAL ASSOCIATION OF MEDICARE DEPENDENT HOSPITALS
BEFORE THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
HOUSE OF REPRESENTATIVES
FEBRUARY 23, 1995

Introduction

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE: I am John Forsman, Chief Financial Officer of the Community/Kimball Health Care System of Ocean County, New Jersey, and Chairman of the National Association of Medicare Dependent Hospitals, a national trade association representing hospitals with unusually high Medicare patient loads. I am also a past member of the Health Care Financial Management Association's National Board Matrix.

We appreciate this opportunity to submit testimony on the Medicare program. The stated purpose of this hearing is proposals for Medicare changes in the President's FY 1996 budget, and proposals for Medicare that were **not** included in that budget. Our comments address the latter area, recommendations for change **not** proposed by the Administration, but that we believe would significantly improve the performance of the Medicare program for hospitals.

Medicare Reimbursement and Medicare Dependent Hospitals

My remarks will focus on flaws in the Medicare hospital prospective payment system ("PPS"). I recognize that, eventually, Medicare may need a broad and perhaps radical transformation toward a system based on managed care rather than fee-for-service. Frankly, I will welcome the change, because, as a Medicare-dependent health system, I have already been forced to become very efficient and am well-positioned to compete in the new world. In the short term, however, Medicare's fee-for-service sector, and the hospital PPS, will continue to exist. While the new Medicare system of the future is being built, the current structure should undergo some minor, but much-needed, repairs.

Let me preface my suggestions with a bit of context concerning the PPS and its evolution. Until 1983, Medicare reimbursed hospitals on the basis of the "reasonable cost" of providing services. In 1983-1988, Congress phased in the PPS to give hospitals incentives for efficiency by establishing fair payments at predetermined levels. Under the PPS, the unit of payment is the "diagnostic related group" ("DRG"). Payment is based on each patient's diagnosis, and the amount of payment, or DRG rate, varies with the complexity of the case.

The DRG rates are national, but vary around the country according to a geographical wage index. The DRG rates are also subject to two major adjustments: medical education ("GME" and "IME") and "disproportionate share" ("DSH"). GME and IME are intended to recognize additional costs incurred by teaching hospitals in training physicians. DSH is intended to compensate for additional costs incurred by hospitals that serve an unusually high proportion of low-income patients. Together, these add-ons cost $7.5 billion ($5 billion for GME and IME, $2.5 billion for DSH) (Att. A). As the Prospective Payment Assessment Commission ("ProPAC") has reported, these adjustments have been implemented "budget neutrally" -- shifting funds **away** from basic care for the elderly toward more specialized policy goals such as training doctors and caring for the indigent. See ProPAC, March 1993 Report to Congress at 20. Over time, the combination of these adjustments and the wage index has produced some dramatic variations in PPS payments, causing the PPS to move away from its original purpose to establish fair payments with incentives for efficiency, and causing the Medicare system to move away from its original purpose to provide hospital care for the elderly.

Using the same hospital cost report database that the Health Care Financing Administration ("HCFA") uses, we have conducted an extensive analysis of profits and losses. We discovered from this analysis that, on the whole, Medicare is not as poor a payer as the annual ratcheting down of PPS payments might suggest. On average, in fact, hospitals do reasonably well under the PPS. Our analysis of the 1992 database shows that, on average, hospital Medicare margins were -3% (a 3% loss); ProPAC has recently reported that in 1993,

hospitals' Medicare margins averaged +0.3%. But there is great variation among hospitals and groups of hospitals. The 1992 cost report database shows that hospitals' profits and losses on Medicare can range from profits as great as 12% to losses as great as 17%. Medicare dependent hospitals, those with unusually large Medicare loads, incur losses well beyond the average. In effect, these hospitals pay a penalty for their service to the elderly.

Medicare Dependent Hospitals

Who are the Medicare dependent hospitals? Our group defines them as those with **Medicare patient loads of 60% or more** on a regular basis. Often, these high Medicare patient populations are a creature of demographics, as in my own area, Ocean County, New Jersey. There, a large community of senior citizens began developing about 30 years ago. Senior citizens are generally not mobile in a demographic sense; in other words, they tend to age in place. This has been true of my county and my health system's patient population, which once consisted of a large population of fairly healthy 65-year olds, and now has a very large group in their 80's -- no longer generally healthy, but plagued with the chronic problems that very old age inevitably brings.

A visit to my hospital would reveal to you what Medicare dependent hospitals know well. Very, very old people need help with many basic activities that younger ones do not, such as bathing, eating, going back and forth to the bathroom, dressing, personal grooming, taking medication, even, in some cases, simply turning in bed. They have longer hospital stays, on average, because they heal more slowly than younger people, and are more susceptible to incurring secondary conditions in the hospital, such as pressure sores, respiratory infections, and others. In other words, a very old patient needs extra help with a lot of little things, most of which are not medical in nature, and none of which results in extra reimbursement under the PPS. But this essential extra help for my very old patients requires extra labor for my staff, and thus extra costs on our expense statement. Because Medicare dependent hospitals have a greater share of Medicare patients than others, they also have a correspondingly greater share of these very old Medicare patients that are more costly to serve, but without any additional reimbursement.

There are approximately 1400 Medicare dependent hospitals nationwide. Of these 1400, more than 900, or 65%, treat a Medicare patient mix greater than 65% (Att. B), with some approaching 80% Medicare. Approximately 600 of the 1400 Medicare dependent hospitals in the nation have **never** received any adjustment for IME, DME, DSH, or anything else. The rest are small rural hospitals that previously received a small rural adjustment which expired in September 1994. Thus, today, the overwhelming majority of Medicare dependent hospitals receive **no** adjustments under the PPS.

As ProPAC has observed, PPS payments have dropped much more steeply than other payors' in the last decade, so that hospitals **on average** lost 3% from Medicare in 1992. Consequently, "hospitals that cannot generate revenue from private payors are increasingly disadvantaged." ProPAC, id. at 24-25; see also, ProPAC, March 1994 Report to Congress at 5; March 1995 Report to Congress at 5 ("Medicare's payments...continue to be below those of most private payers."). Moreover, ProPAC has noted, the medical education and DSH adjustments have "substantially affected PPS margins," so that hospitals **without** these adjustments have been "disadvantaged...relative to others." ProPAC, June 1993 Report to Congress at 55. With no Medicare adjustments, and a much smaller pool of private pay patients to rely on for cost-shifting, Medicare dependent hospitals have suffered more than others during the last decade.

The reimbursement squeeze from their major payor, Medicare, has forced Medicare dependent hospitals to become more efficient. But, notwithstanding efficiency, Medicare dependent hospitals, with much less ability to make up Medicare losses from other payors, lose much more than others on Medicare and have lower overall margins. 1992 cost report data show that on Medicare alone, Medicare-dependent hospitals **lost** about 5%, while non-Medicare-dependent hospitals that qualify for GME/IME and/or DSH had about a 4% Medicare **profit**. **Overall** margins for **non**-Medicare dependent hospitals averaged nearly 5%, but for most Medicare dependent hospitals, overall margins averaged barely more than 2%. (Atts. C and D.)

With such low margins, and payments from all payors ratcheting down, Medicare dependent hospitals face two choices now: either close or reduce service. In either case, who **really** loses? The ultimate losers will be the Medicare beneficiaries these hospitals serve. When their community hospital closes, elderly persons must find another -- one which will certainly be less familiar and will almost certainly be farther away, a serious problem for elderly persons who are not as mobile as younger people. When hospitals are forced to reduce services, the first to go will be those programs that maintain the dignity of the elderly -- but represent costs not reimbursed by Medicare: transportation and feeding assistance, community outreach centers, and social services. Next on the chopping block will be labor costs -- reducing the hospital staff on whom the elderly depend for the special care they need, such as monitoring medication, preventing falls, and help with dressing, feeding, and other basic activities. All of these service reductions cause elderly patients to suffer and require family members to step in and provide the labor-intensive service that the hospital can no longer furnish.

Such results make no sense for Medicare, a program that was designed to serve the **elderly**. Such results also make no sense at a time in the nation's history when middle-class families are already shouldering more burdens to hold down jobs, raise children, and care for elderly relatives than ever before. Both the "Contract with America" and the Clinton Administration have pledged tax relief for the middle class and senior citizens. In light of these goals, the Medicare system should **not** be distorted by reimbursement inequities that unnecessarily compromise health care for the elderly and complicate life for their families.

A Modest Solution That Meets ProPAC's Goals

We fully recognize that the projected insolvency of the Medicare hospital trust fund and the prospect of a balanced budget amendment will result in even further PPS cuts. It is **not** our objective to stem that tide. What we recommend, instead, is a small correction **within** the system. A minor, **budget-neutral** adjustment in the PPS would resolve the inequity that handicaps Medicare dependent hospitals and threatens their patients. In order to **approach** a level playing field with the rest of the hospital industry, Medicare dependent hospitals seek a modest correction in the PPS update system. This correction would recognize Medicare dependent hospitals as a class and adjust PPS updates so that the update for this class annually was sufficient to bring their average Medicare margins to the level of the average for all hospitals. We would leave it to the experts at ProPAC to recommend the specific annual updates based on their data.

This modest shift to restore Medicare equity would cost the U.S. Treasury **nothing**. It would follow the pattern of update differentials used by Medicare in the past, and currently, to equalize margins between rural hospitals and others, and to create reimbursement equity for primary care physicians. Restoring some equity for Medicare dependent hospitals is also consistent with ProPAC's recent recommendations that Congress

> continue to modify PPS payment policies to ensure the equitable distribution of payments among hospitals. Payment adjustments are necessary to recognize appropriate variations in costs across hospitals...and reflect the broader responsibilities of the Medicare program to maintain access to quality care.

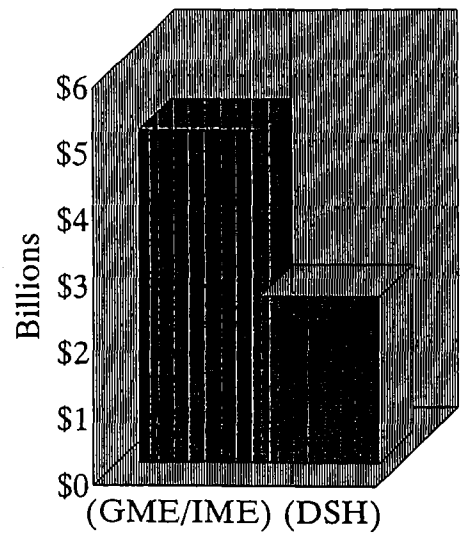
ProPAC, March 1993 Report to Congress, Recommendation #2 at 9.

We thank you for the opportunity to present our views to the Subcommittee.

3/10/95
Doc. 23818

Medicare Dependent Hospitals

Cost of Current "Special Add-Ons"



Teaching Hosp. Pymts	$5 Billion
Disprop. Share Hosp.	$2.5 Billion

Attachment A

Attachment B

MEDICARE DEPENDENT HOSPITALS
Based on 1992 Medicare Cost Reports

o Medicare Percent of Total Patients	60 - 65%	65% and over	Total
Number of Hospitals	512	918	1430
Rural Hospitals with 0-99 beds[1]	206	555	761
Urban Hospitals and Rurals with over 100 beds[2]	306	363	669

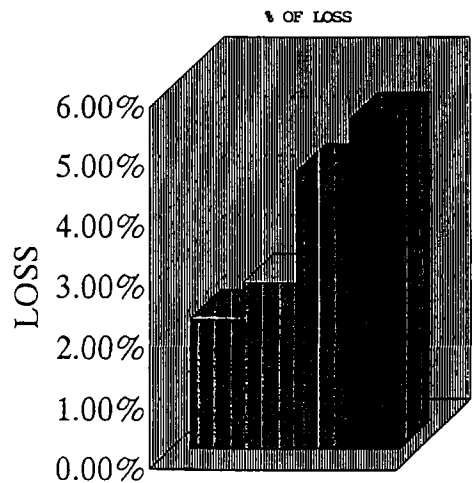
1/ The rural hospitals with 0 to 99 beds have previously qualified for a special adjustment, based on their dependence on Medicare, if they had a minimum of 60% Medicare patient days or inpatient revenues. This adjustment expired in September 1994.

2/ This group has never received any adjustment in recognition of their Medicare dependent status. The former small/rural adjustment was based on these hospitals showing lower Medicare margins. Most recent reports from HCFA and ProPAC now show performance for rural and urban hospitals to be basically equal.

2/1/95
Doc. #20866

Medicare Dependent Hospitals

Performance Under Medicare's PPS Based on 1992 Data



- < 60% Medicare Pop.
- Avg for all 5,300 Hosp
- 60%-64% Medicare Pop.
- 65% + Medicare Pop.

< 60% Medicare Pop.	2.13%
Avg for all 5,300 Hosp	2.73%
60%-64% Medicare Pop.	4.57%
65% + Medicare Pop.	5.45%

Attachment C

	TOTAL	MEDICARE % 65 % TO 100 %	MEDICARE % 60 % TO 64 %	MEDICARE % 0 % TO 59 %
TOTAL MARGINS	4.44%	2.91%	6.34%	4.41
DSH & TEACHING	3.84%	2.69%	2.34%	3.80
TEACHING	4.88%	5.20%	12.80%	3.94
DSH	3.41%	3.13%	6.52%	5.46
NON DSH & TEACHING	4.39%	2.35%	4.13%	4.99
MEDICARE MARGINS	-2.73%	-5.45%	-4.57%	-2.13
DSH & TEACHING	4.00%	-7.05%	-0.59%	4.33
TEACHING	-5.35%	-4.19%	-4.71%	-5.58
DSH	-3.02%	-6.09%	-1.73%	-2.86
NON DSH & TEACHING	-8.07%	-5.52%	-6.71%	-9.36

Attachment D

STATEMENT OF THE
NATIONAL ASSOCIATION OF PORTABLE X-RAY PROVIDERS
BEFORE THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
HOUSE OF REPRESENTATIVES
FEBRUARY 23, 1995

Introduction

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE: I am Jeffrey Burgess, President of Burgess Health Associates of Middletown, Connecticut and President of the National Association of Portable X-Ray Providers ("NAPXP"), a national trade association representing suppliers of portable x-ray and portable electrocardiogram ("EKG") services.

We appreciate this opportunity to submit testimony on the Medicare program. The stated purpose of the hearing was proposals for Medicare changes in the President's FY 1996 budget, and proposals for Medicare that were **not** included in that budget. Our comments address the latter area, recommendations for change **not** proposed by the Administration, but that we believe would significantly improve the performance of the program and especially its **cost-effectiveness**.

Portable X-Ray Suppliers: Who We Are and What We Do

I would like to preface these comments with some background about the service our members provide to elderly Americans. The portable x-ray is a relatively little-known service, although Americans should become more familiar with it in the coming years as the population continues to age and long-term care coverage expands. Portable x-ray suppliers are companies that bring x-rays and EKGs to the bedsides of elderly patients in homes or nursing homes. Historically, these suppliers have been small, local, literally "Mom-and-Pop" firms run by former x-ray technicians, but during the 1990s some consolidation has occurred, adding larger, multi-state firms that have been able to achieve economies of scale and introduce technological improvements to enhance the quality of our industry. Portable x-rays are performed entirely by x-ray technologists, with no physician involvement in the taking of the x-ray or the transportation of portable x-ray equipment to patients. Thus, portable x-rays are **not** physicians' services. (After portable x-rays are taken, the films are transported to outside, unrelated radiologists for interpretation only.)

Ninety percent or more of portable x-ray procedures are covered by Medicare. As a result, the structure of the Medicare reimbursement system has dramatic impact on the portable x-ray industry. Indeed, the way in which the incentives created by the Medicare system have affected the portable x-ray industry -- a point I will discuss later -- illustrates the enormous effect of health care reimbursement systems on market incentives.

Portable x-rays are functionally different from physicians' office x-rays and much costlier to provide. This is largely because portable x-rays entail special difficulties associated with a geriatric, infirm clientele. The technologist must position the patient in his/her bed for the x-ray and in the process, often deal with senility, orthopedic frailty, deafness, incontinence or uncooperativeness. (Sometimes these problems produce motion during the x-ray and, consequently, a flawed film. In these cases, we repeat the procedure without any additional reimbursement.) The technologist must also transport the x-ray equipment to the home or nursing home and then assemble, dismantle, and reassemble it for each patient who is x-rayed.

Taken together, these circumstances mean that, whereas a stationary x-ray technician can take about 40 x-rays per day, a competent portable x-ray technologist can take about six to seven x-rays per day. These circumstances also require special training for the technologists who perform portable x-rays and make the job relatively unattractive by comparison to x-ray technician jobs in hospitals or physicians' offices. Additionally, Medicare's Conditions for Coverage of Portable X-Ray Services require portable x-ray technologists to satisfy training and experience requirements that technicians in hospitals and doctors' offices do not have to meet. Consequently, it is NAPXP members' experience that portable x-ray suppliers must pay their

technologists higher salaries than those paid to hospital or physicians' office technicians to compensate for the higher level of training and the disadvantageous working conditions.

Portable X-Rays and Cost-Effectiveness

There are two aspects of the portable x-ray service that are critical to the principle of cost-effective health care spending. The first is that the portable x-ray service provides a highly cost-effective alternative to the other method of providing x-rays for nursing home patients: transporting the patient in an ambulance to a hospital emergency room. We estimate conservatively that the portable x-ray service generally costs Medicare one-third to one-fifth as much as this hospital/ambulance delivery method. Attachment 1 to this testimony provides a specific cost comparison for selected states.

And, in this case, what is cost-effective is also quality-effective. When very old, very frail persons are moved out of their beds and into and out of ambulances or other vehicles, they often sustain fractures. If the weather is harsh -- as it is for many months in my home state of Connecticut -- patients can get respiratory illnesses. And the many elderly patients who suffer from depression, Alzheimer's disease, or both, can become disoriented and traumatized when they are moved. Portable x-rays, by allowing patients to stay in their own beds, spare patients the physical injury and mental trauma that can occur when they are sent to the hospital. Additionally, the portable x-ray service also provides a faster turnaround of films to the attending physician than the ambulance alternative, thus speeding diagnosis and treatment of injuries. We do not believe that saving costs necessarily requires sacrificing quality, and our service illustrates that point very well.

The second aspect of the portable x-ray service that is critical to the principle of cost-effective health spending has to do with treatment settings. Many of the conditions that portable x-rays identify, such as pneumonia, chronic obstructive pulmonary disease and simple fractures, can be treated entirely in the nursing home. In contrast, when the same nursing home patient is taken to the hospital for an x-ray and the same condition appears, the patient will likely be admitted to the hospital for treatment. Generally, the hospital is the more expensive treatment setting. Thus, wherever portable x-rays identify simple conditions, patients receive treatment in the nursing home setting, the one that is least costly for the payor. That payor, in most cases, is Medicare.

Ineffective Medicare Treatment of Portable X-Rays: Fixing A System That Wasn't Broke

The legislators and regulators who shape Medicare have worked throughout the 1980s and 1990s to restrain the growth of expenditures in the Medicare system. Mr. Vladeck, in his testimony before this Subcommittee, pointed out that Medicare has pioneered the use of payment mechanisms that stress cost-effectiveness and feature incentives for efficiency, and Medicare has led other payors in establishing measures to combat the waste, fraud, and abuse that so unconscionably increase our nation's health care costs. The architects and administrators of the Medicare program are to be complimented for those successes. Other witnesses before this Subcommittee, however, have pointed out that Medicare lags behind the private-sector health care marketplace in significant respects, and that some of Medicare's payment mechanisms are ill-suited to the goals of cost-effective service and choice that the nation's leading health care insurer should achieve. The treatment of portable x-rays under the Medicare fee schedule for "physicians' services" illustrates the problem.

We do not quarrel with the concept of fee schedule payment. Indeed, portable x-rays were addressed under a portable x-ray fee schedule in 1989-1991 **before** the implementation of the physicians' fee schedule -- and neither Medicare administrators, Medicare carriers, Members of Congress, nor our industry ever found this system overgenerous, unworkable, or otherwise seriously flawed. In other words, the system wasn't broke. Nonetheless, the Health Care Financing Administration ("HCFA"), in the interest of uniformity, "fixed" it by rolling **non-physician** portable x-rays into the **physicians'** fee schedule beginning in 1992. And now the system, for portable x-ray services, does **not** work. It does not serve the goals of cost-effectiveness and appropriateness of care.

The physicians' fee schedule paints portable x-ray services with a broad governmental brush. The system includes non-physician services, such as portable x-rays, in a payment methodology designed almost solely for physicians' services and based solely on data concerning physicians' services. Currently, the system pays too little attention to the distinction between portable x-rays and physicians' services, and, most critically, the distinction between the different patient populations they serve.

As I mentioned earlier, the inherent difficulties entailed in dealing with the nation's growing population of very old, home-bound persons make it much more costly on a unit basis to provide a portable x-ray than to provide an x-ray to an ambulatory patient in a hospital or physician's office. HCFA at the urging of our industry has recognized this difference, in principle at least. Although reimbursement for the technical component of the portable x-ray service, or the taking of the x-ray itself, is exactly the same for portable x-rays as for physicians' office x-rays, HCFA has established a unique code that is billed with every portable x-ray technical component and attempts to capture the cost difference between the two types of service. However, the level of payment for this "set-up" code has not kept pace with the severe drop in technical component payment levels that portable x-ray suppliers will experience by full implementation in 1996, even with annual updates in 1992-1996.

The payment levels that portable x-ray suppliers will confront in 1996 will, very simply, be insufficient to cover the costs of providing services in many instances. In anticipation of this reality, portable x-ray suppliers are scrambling to make whatever changes they can, simply to remain in business. Many portable x-ray suppliers have already reached their limits in terms of squeezing economies out of their operations. Consequently, the choices that remain are to cut back on services so that Medicare revenues stretch the farthest. In some cases, cutting back means cutting out services on nights and weekends, when technologists must be paid overtime to work and interpreting physicians are harder to contact. Sometimes, cutting back may mean coming to nursing homes only according to a specified schedule to maximize the number of patients that can be seen at any given time. In some cases, cutting back may mean eliminating services altogether in certain localities -- such as the most rural, where driving distances and times between nursing homes are the greatest, or the most highly concentrated urban areas, where traffic waiting time is longest and the risks of vehicle damage and theft are highest. In some cases, cutting back means going out of business entirely in an area of the country where the business simply is no longer profitable -- or foregoing expansion to new geographic areas because the projected reimbursement is insufficient to justify the investment required.

At our 1994 Annual Meeting, we tried to assess the extent of these changes. A survey of just those NAPXP members present revealed the following. Companies had **eliminated** service in:

- Lompoc, CA
- Lompol, CA
- Clewiston, FL
- Maryland's Eastern Shore
- Corpus Christi, TX
- Rio Grande, TX
- Blackstone, VA and
- Irvington, VA,

affecting approximately 1700 nursing home beds. Companies had **reduced** service (e.g., from five days per week to two, or through the elimination of "after hours" work) in:

- Mt. Shasta, CA
- Red Bluff, CA

- Weed, CA
- Yreka, CA
- Hilliard, FL
- Miami, FL
- Atlanta, GA
- Atchison, KS
- Southfield, MI
- Hamilton, MO
- Maryville, MO
- Mound City, MO
- Cleveland, OH
- Columbus, OH
- Dayton, OH
- Toledo, OH and
- Houston, TX,

affecting approximately 67,000 nursing home beds. The net result of all this is a decline in the availability of portable x-ray services, even though demographics would predict exactly the opposite.

There will also be an offsetting increase in the number of hospital x-rays of nursing home and homebound patients that Medicare must pay for. The bottom line on cost will be a greater net outflow of Medicare dollars to provide necessary diagnostic radiology services to nursing home and homebound patients, plus more costly hospital admissions to treat the conditions these radiology services identify. The bottom line on quality and access will be an increase in potential injuries for patients who have to be moved to get x-rays and increased mental anguish for patients and their families when these patients have to be shifted in and out of hospitals instead of staying in the familiar environment of the home or nursing home.

Data from the Physician Payment Review Commission ("PPRC") suggests that there may be an access problem already. Data in the PPRC's 1993 report to Congress on access to care demonstrate that portable x-rays and other "routine diagnostic radiology" services are among only two categories of physicians' services that did **not** increase in volume after the imposition of the physicians' fee schedule. The average across all services for quantity of care per beneficiary increased 5.2% from 1991 to 1992. In contrast, "routine diagnostic radiology," including portable x-rays, **dropped** 6.6% in quantity of care per beneficiary during that period. PPRC, Report No. 93-2, Monitoring Access of Medicare Beneficiaries (June 4, 1993) at 15, Table 2-1. Notably, the time period addressed in this report was one when portable x-ray payments from Medicare were **higher** than they are now, since payments in most localities have fallen as the physicians' fee schedule moves toward full implementation.

Significantly, PPRC research also reveals "cause for concern" about reductions in access to care for that population group most typically served by portable x-ray providers: the "oldest old (those over 85)." Id. at 23. The PPRC's June 4, 1993 Report states:

> The Oldest Old. Patterns of service use by the oldest old (those over age 85) may also generate some cause for concern. The differentials between the oldest old and the remainder of the beneficiary population show a series of new lows for total use of

> services, primary care services, and selected other categories of services, including high-tech services, electrocardiograms (EKGs), cataract surgery, and radiology. (Emphasis added.)

Id. The "oldest old" are portable x-ray suppliers' major clients for both EKGs and radiology procedures.

Returning to the point made by other witnesses before this Subcommittee, that the Medicare program needs to be more closely aligned with the private health care marketplace, I cannot help observing that the problems of declining access to portable x-ray services and stagnation in this industry would not exist if our services were offered in an open, competitive marketplace, rather than to a single, government payor. For example, a buyer of x-ray services for nursing home and homebound patients in the private market would look at the alternatives available: purchase the services from a portable x-ray supplier, or send patients back and forth to the hospital in ambulances for their x-rays. On the issue of cost, the choice would be clear: even in those areas of the United States where reimbursement is the highest, the portable x-ray service is far cheaper. On the issue of quality, the choice is also clear: our x-rays provide physicians with the same accuracy of diagnostic information as hospital or physician's office x-rays, and give patients and their families far greater comfort and lower physical risk. Given such strong cost and quality incentives to use portable x-ray services, in a marketplace consisting of private-sector buyers, one would expect that most nursing homes would use portable x-ray services, as would most organizations supplying services to homebound patients. Purchasers would negotiate payment rates with portable x-ray suppliers that would create sufficient incentives for suppliers to provide the service, while maintaining the buyer's cost advantage of portable x-rays over the hospital/ambulance alternative.

But in the world of Medicare, as I have explained, this situation does not exist. Medicare has no policy requiring a nursing home administrator to use the cheaper portable x-ray service where it is available. And since Medicare is paying for the x-ray, it makes no difference to the physician ordering the x-ray or the nursing home administrator making arrangements for the service whether it is provided by a hospital or by a portable x-ray supplier. (And, if low reimbursement has kept a portable x-ray supplier from entering a locality or staying in it, then the alternative is simply not available at all.)

Additionally, in a private marketplace, purchasers of portable x-ray services and suppliers of those services would negotiate payment rates that fit the circumstances of the service and its cost. Our costs are significantly greater to provide service on nights, weekends and holidays, because federal wage and hour laws require us to pay technologists time and a half, or the equivalent, for service at those times. Yet Medicare payment rates make no allowance for the difference. Similarly, our costs are higher in the home care setting, where we typically have to use two technologists instead of one in the nursing home, since in the home, there are no nursing staff to assist us in dealing with frail or difficult patients, and there are often stairs (and never elevators), requiring two people to haul portable equipment. Yet again, Medicare's payment rates do not address this difference either -- whereas, in the private marketplace, the supplier and purchaser of portable x-ray service would negotiate a payment rate more sensitive to both the supplier's costs and the demands made by the buyer.

The unfortunate irony is that, if Medicare reimbursement were better attuned to the costs and circumstances of the portable x-ray service, portable x-rays would be available to more of the nursing homes and homes that need them, and Medicare would save significant sums on its costs for providing diagnostic x-rays to homebound and nursing home patients.

Small Changes for Big Benefits

In the long term, we recognize, Medicare may undergo a complete transformation. But in the short term, i.e., as long as the program maintains a fee-for-service component, there is an urgent need for some fine-tuning. Minor changes, consistent with the resource-based payment principle of the physicians' fee schedule, could solve the problems I have described and consequently allow the Medicare system to reap the full benefits in cost-effectiveness and quality care that the portable x-ray service offers.

The simplest solution would be to remove portable x-rays from the physicians' fee schedule, where they never belonged, and return them to the portable x-ray fee schedule, which, as I have said, was not "broke" and worked quite well for all concerned. That fee schedule could be simplified to make it easier and more streamlined for Medicare to administer.

Alternatively, changes could be made within the physicians' fee schedule to address portable x-rays more sensibly. When the physicians' fee schedule moves to a resource-based practice expense system in 1997, the unique practice expenses of portable x-ray suppliers **must** be taken into account. More specifically, consistent with the concept of a fully resource-based system, Medicare could establish a payment level for the portable x-ray "set-up" code that is more truly commensurate with the difference in cost involved in providing this service versus a physician's office x-ray. Similarly, the Medicare system could restore the "after-hours" code to recognize the higher costs of operating at nights and on weekends, when a substantial demand for emergency portable x-rays occurs. Medicare could also easily recognize the fact that doing a portable x-ray in a patient's home is more costly because of the nature of the treatment setting. This problem could be solved through the simple addition of a home-care code. Such changes would conform to the resource-based principle of the fee schedule and provide the same fine-tuning that is provided for physicians' services, for example, through existing codes that recognize unusual complications in surgical services and extra time required for anesthesia.

The changes I am suggesting are relatively minor. Such changes represent very small expenditures, since portable x-rays, by HCFA's estimate, are less than 2% even of Medicare **radiology** services -- a tiny, tiny fraction of Part B as a whole. Moreover, the net effect of such changes to maintain or increase the availability of portable x-rays would be **better than budget neutral**: it would produce substantial savings on ambulance and hospital services. Refining the Medicare payment system so that the distinct nature of the portable x-ray service is adequately recognized and there are adequate incentives to permit suppliers to remain in business will not alter the fact that the portable x-ray service is extremely cost-effective with respect to the alternative. Making changes along these lines would simply be an outcome-oriented way of seeing that the Medicare system gets the biggest bang for the taxpayers' buck.

We thank you for the opportunity to present our views to the Subcommittee.

3/9/95
Doc. #23775

Attachment 1

COMPARISON OF MEDICARE PORTABLE X-RAY
PAYMENTS & AMBULANCE/HOSPITAL X-RAY CHARGES
SELECTED LOCALITIES
1990

LOCALITY	ROUNDTRIP AMBULANCE[c]	EMERG. ROOM	RAD. DEPT. (X-RAY)	PHYS.FEES (RAD.AND/OR EMERG.RM.)	TOTAL HOSP.	PORTABLE X-RAY	PORT. X-RAY INTERP.	TOTAL PORT. X-RAY	AMB. PORT. X-RA
Torzana, CA	302.00	135.00	66.50[a]	150.00	673.50	104.16[a],[g]	N/A	104.16	6.47
Plantation, FL	400.00	59.00	90.00[a]	50.00	599.00	90.25[a]	13.74	103.99	5.76
Tamarac, Davie, Plantation, Coral Springs, Hollywood, Margate, Sunrise, Hallandale, Cooper City and Lauder Hill, FL (2 hospitals)	306.00	59.50	120.00[b]	65.00	550.50	90.25[b]	13.74	103.99	5.29
	306.00	102.65	115.00[b]	115.00	638.65	90.25[b]	13.74	103.99	6.14
Clearwater, FL	270.00	96.50	80.15[a]	83.15	529.80	85.99[a]	13.14	99.13	5.34
St. Petersburg/ Tampa, FL	314.40	31.07[d]	98.72[a],[d]	N/A	444.19	98.09[a]	N/A	98.09	4.53
Miami, FL	352.00	156.67[d]	99.00[a],[d]	N/A	607.67	98.09[a]	N/A	98.09	6.19
Boston, MA	299.00	100.00	127.00[a]	13.64	539.64	163.64[a]	11.18	174.82	3.09
Quincy, MA	318.12	84.00	61.75[a]	13.74	477.61	163.64[a]	11.18	174.82	2.73
Lima, OH	318.00	75.00[d]	64.85[a],[d]	N/A	457.85	97.46[a]	N/A	97.46	4.70
Cleveland, OH	268.00	93.80[d]	68.28[a],[d]	N/A	430.08	97.01[a]	N/A	97.01	4.4[illegible]
Central OH	226.00	54.95[d]	65.50[a],[d]	N/A	346.45	95.28[a]	N/A	95.28	3.64
Dayton, OH	238.00	32.18	55.63[a],[d]	N/A	325.81	98.04[a]	N/A	98.04	3.3[illegible]
Newport, RI	176.58	69.00	13.09[a]	12.44	271.11	99.44[a],[g]	N/A	99.44	2.7[illegible]

[a] Chest x-ray
[b] Hip x-ray
[c] Excludes oxygen fee; assumes 6-mi. round trip
[d] Average of area hospitals
[g] Global billing

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POLICY PAPER NO. 10 December 30, 1994

Why the Graying of the Welfare State Threatens to Flatten the American Dream -- or Worse

by Neil Howe

Despite overwhelming evidence that the cost of major senior benefit programs is due to explode over the next half-century, the notion persists that they are sustainable without major cost-cutting reform. Although tax rates may rise, this argument runs, a growing economy will still allow workers to enjoy steady gains in real after-tax earnings. However, an examination of the likely future fiscal and tax impact of three major senior programs -- Social Security, Medicare, and Medicaid for persons age 65 and over -- demonstrates that this argument is clearly wrong. Projections based on a model that incorporates all of the official (scenario II and III) assumptions used by the Social Security and Health Care Financing Administrations in calculating the growth of three programs, show that, absent major reform, *the graying of the welfare state is likely to have catastrophic consequences for the after-tax living standards of most working-age Americans.* In particular:

- **Under the official scenario II (the so-called "best-estimate" case), after-tax earnings per U.S. worker in 1993 dollars will remain unchanged over the 45 years between 1995 and 2040.** In 1995, real after-tax earnings will amount to $19,221. By 2040, they will reach $19,346 -- *less than one percent total growth over nearly half a century.* At an annual rate, this growth is negligible by any statistical standard.

- **Under the official scenario III (whose less optimistic assumptions are closer to recent experience), after-tax earnings per U.S. worker in 1993 dollars will decline steeply and steadily between 1995 and 2040.** In 1995, they will amount to $19,000. By 2040, they will fall to $7,821 -- *a devastating 59 percent fall in real terms.* Incredibly, this would be a much faster annual rate of decline than the annual rate at which after-tax earnings rose between 1951 and 1970.

- **Under both scenarios, total government spending will grow steadily as a percent of GDP.** From 34.4 percent of GDP in 1995, it will grow to 43.9 percent in 2040

under scenario II or to 54.5 percent under scenario III. **Likewise, the total tax rate on worker compensation will climb steadily.** From 41 percent in 1994, it will climb to 57 percent by 2040 under scenario II or to 69 percent under scenario III.

The practical bottom line of this analysis speaks for itself. America's political leaders cannot continue in good faith to advocate balanced budgets, tax cuts, and leaner government -- to say nothing of defending the long-term viability of the American Dream -- without also talking about major, structural reforms in "untouchable" senior entitlements. Everything must be on the table.

I. THE UNPLEASANT FACTS

In 1994, the American public was bombarded by a spate of official warnings about the crushing public cost that will accompany the rapid aging of the U.S. population early in the next century.

- In February, the Office of Management and Budget included in its FY 1995 Budget a "special analysis" suggesting that baseline budget policies will crush younger generations beneath prohibitive tax-and-transfer rates.[1]

- In April, the Social Security trustees issued an annual report announcing that their combined cash-benefit trust funds would all go belly up in 2029 -- 7 years earlier than they had reported in 1993 and 19 years earlier than they had reported in 1988.[2]

- In August, a bipartisan presidential commission agreed by a 30-to-1 vote that "the government must act now" to prevent just five benefit programs (Social Security, Medicare, Medicaid, and federal civilian and military pensions) from consuming total federal revenues by the year 2030.[3]

- In September, the Congressional Budget Office confirmed that over the next decade entitlements will grow from roughly half to two-thirds of all federal spending. "The aging of the baby-boom generation," added the CBO, "will continue to drive that share higher over succeeding decades."[4]

- And in October, Office of Management and Budget Director Alice Rivlin's leaked budget options memo illustrated how annual budget deficits would soar above $4.1 trillion by 2030 under current tax and spending policies.

By now, the public has little problem comprehending the overall arithmetic of the situation. It is widely understood that retirement, disability, and (especially) health benefits outlays are already among the fastest-growing categories of government spending.

Asked about the growing numerical imbalance of retirees to workers in the Social

Security system, 64 percent of American adults say it's a "very serious" problem; 29 percent say it's "somewhat serious." Asked the same question about the impact of runaway health costs on the survival of Medicare, 78 percent say it's "very serious"; 19 percent say it's "somewhat serious." To either question, only about 5 percent say "not too serious," "not at all a problem," or "don't know."[5] Fifty-eight percent of adults now think that "the next generation's future will be worse than life today"; only 18 percent think it will be better.[6] What's more, Boomers realize they are in line to take the hit: 85 percent of Boomers agree that "government has made financial promises to my generation that it will not be able to keep."[7]

Many say they're ready to face up. Although Americans are understandably ambivalent about cutting benefits that flow to just over half of all U.S. households, neither have they become irredeemable entitlement addicts. Asked about "the financial problems of the Social Security and Medicare systems," 78 percent of all adults (83 percent of everyone under age 50) agree that the problems are "so severe that major reforms are needed now" in both programs.[8] A large and growing majority favors imposing a strict means test on major federal entitlements programs.[9]

Why Politicians Don't Act

But if voters are rousing themselves, most of our national political leaders are still running for cover. Even in the wake of November's stunning anti-big-government message from voters, members of Congress in both parties quickly lined up to declare that the vast senior share of the federal budget remains undiscussable. Many remain convinced that the "age wave" forecasts are overblown, that the public talks bolder than it walks, and that America in the end will be able to muddle through without "tough choices" or "major reforms." Hence their claim that economizers need only cut domestic discretionary programs -- and that the political risks of attempting surgery on senior benefits far outweigh the risks of doing nothing.

To the extent there is a rational justification for this position, the logic tends to gravitate around three propositions. First, it is said that the assumptions underlying the official benefit forecasts are too pessimistic. Second, it is said that the cost explosion in health-care benefits will recede due to relatively painless "comprehensive" reforms. And third -- if one and two don't explain things away -- it is said that a tolerable tax hike can be levied on future workers to fund whatever health and cash benefit growth remains.

The first proposition, alas, is not an argument at all -- but an attitude. Many legislators chafe at the political inexpedience of rules that force them to take long-term costs into account. But no one presses a comprehensive case that the official "intermediate cost" economic and demographic scenario -- offered by the Social Security trustees as their "best estimate" -- is overly pessimistic.[10] The reason is simple: *For most of the important variables, these assumptions are decidedly more optimistic than actual U.S. experience over the past quarter century.* Yes, one does hear the occasional "eureka" remark about recent

trends in immigration or the birthrate. But all this is small potatoes at best,[11] especially since there has been no actuarially favorable change in trends in labor productivity or longevity -- the two assumptions which totally dominate the cost outcome well past the year 2040.[12] So that means the "intermediate cost" projection had better be taken seriously.

Indeed, Americans should also pay close attention to the official "high cost" scenario -- whose critical assumptions are closer to (but still more optimistic than) recent experience if for no other reason than to avoid the absurdity of regarding a continuation of current trends as unthinkably dismal. Accordingly, in this report, all findings for the "intermediate cost" scenario are followed by findings for the "high cost" scenario. While both scenarios are perfectly plausible, the former may be regarded as a best-case -- rather than most likely - outcome, the latter as a worst-case outcome. (See below, "Appendix I: Official Economic and Demographic Assumptions.")

What about health care? Everyone agrees that health-care benefits are a major part of the projection equation, constituting much of the expected growth in total benefits. Almost everyone agrees that policy changes could do something to control that growth. What's doubtful, however, is whether either political party is likely to champion any change that might make a real difference. On the left, there is much talk tough about draconian "cost containment" -- but few members have ever identified a single benefit, service, or subsidy in Medicare or Medicaid that ought to be cut. To the contrary, health reforms offered by liberals point toward *vast cost increases beyond current projections* -- including a wider safety net for low-income families and new senior citizen benefits covering prescription drugs, at-home, and long-term care. Conservatives are not as tied to benefit expansion. But neither have they shown much interest in means-testing or rationing publicly funded health services.

The outlook for health-care spending is made even bleaker by another little-known fact: The official long-term projections for Medicare and Medicaid *already assume that a vigorous program of cost control will commence early in the next century*. Specifically, they all assume that the "extraordinary" rate of real cost growth per beneficiary *will decline by three-quarters between 2000 and 2020.*[13] Partly for this reason, many experts doubt that any now-discussable reform option is likely to bring health-care benefits down much beneath their currently projected trajectory. And even if they could, the savings are likely to be offset by the extra cost of better or additional public coverage (either at the state or federal level). Bottom line: Until the political standard of "touchability" changes dramatically, Americans should consider themselves lucky if public health costs do not rise faster than currently projected. (See below, "Appendix II: Official Health Care Benefit Assumptions.")

Given the weakness of the first and second propositions, a lot rides on the third: Just raise future taxes and pray that they don't have to be raised too much. At the very least, the prevailing inertia on entitlement reform makes this possibility of serious interest to all Americans. What happens to taxes if we leave all currently-legislated benefit provisions on auto-pilot? Specifically, how high will taxes rise on future workers?

Table 1 offers a suggestive, if partial answer to this question. It shows the projected future cost of Social Security and Medicare as a percent of the FICA-taxable wages of all U.S. workers covered by the programs. Two official projections (intermediate cost and high cost) are tabulated here.[14]

Table 1:
Annual Cost of Social Security and Medicare
(Parts A and B) as a Percent of Workers' Taxable Payroll

Calendar Year	Intermediate-Cost Projection	High-Cost Projection
1993	16.5 %	16.5 %
2010	21.4 %	26.7 %
2025	30.5 %	43.0 %
2040	34.5 %	55.1 %

Strictly speaking, not *all* of the costs tabulated in Table 1 will be borne by workers. A relatively small portion will be financed by taxation of benefits and by general taxation (which is borne by capital as well as labor income). But the worker share is so dominant -- well over 90 percent of the total in 2040 under any scenario -- that this is a distinction without a difference. Moreover, this table does not include all of the public costs (e.g., long-term care covered by Medicaid) associated with the age wave. Even so, the numbers point to a breath-taking climb in the effective tax rate required to fund these two major programs over the next 30 to 45 years: a *doubling* under the intermediate-cost scenario and a *tripling* under the high-cost scenario. By 2040, the spread between these two projections implies a likely "tax load" equivalent to somewhere between one-third to one-half of the typical worker's taxable wages.

II. WHAT HAPPENS TO AFTER-TAX EARNINGS?

Few politicians actually advocate burdening future workers with costs of this magnitude. When forced to confront the issue, most voters' first inclination is to declare that such tax hikes would be unfair if not unthinkable. Defenders of the entitlement status quo, however, have long labored to change the terms of the debate and to make the unthinkable seem really pretty decent after all. Even if the tax rate on future worker earnings must ultimately climb, they argue, real pretax earnings will still grow swiftly enough to allow future workers to enjoy a steady rise in real after-tax pay. In other words, they claim,

tomorrow's workers will be so well-off that they can afford to fork over a larger share of their income to government and still be a lot better off than today's workers.

The importance of this claim to the case against cost-cutting can hardly be overemphasized. If true, it means that the current policy drift is less alarming than portrayed by the reformers. Even if the official projections are right on the mark, in the end our kids can easily afford to take up the slack. If true, it also strengthens other arguments that tend to legitimize today's institutional arrangements. For example, the often-cited "lifecycle" defense of Social Security and Medicare (which reassures the rising generation that even if they now feel fleeced by the old, they'll someday be able to fleece a new rising generation in their turn) depends critically on the programs' permanence. Most people would probably doubt this permanence if the programs did not allow workers to enjoy a significant growth rate in after-tax living standards.

Small wonder that the claim about how our kids will be better off anyway (so why worry) crops up so often.

- "Don't shed too many tears for generations who will be working and retiring in the 21st century," says Nobel-Prize winning economist James Tobin. "They will be living higher than we did and do..."[15]

- According to former Social Security Administration Commissioner Robert Ball, the extra taxes necessary to fund Social Security in the next century are "not trivial, but easily supportable" by future workers -- and "not really a big deal." He then goes on to calculate that the extra taxes needed by 2025 would only "offset about 8 percent of the growth in earnings projected between now and then."[16]

- National columnist Michael Kinsley echoes the same line in reference to Social Security: "Even if it amounts to a large transfer from today's workers to today's retirees, and an even larger transfer from future workers to future retirees, so what? ...[T]he younger generation will still be richer than the older one, even after the transfer takes place."[17]

- Brookings Economic Studies Director Henry Aaron makes the same point even more succinctly: "Even if we do nothing to change present policies, modest economic growth will produce increases in consumption that dwarf the added cost of caring for the Baby Boom Generation in retirement."[18]

- In its blanket apologia on behalf of all federal entitlements, the American Association of Retired Persons notes that Social Security, Medicare, and related senior programs "are affordable" in the year 2065 because "[f]uture growth of the aging population does not necessarily impose an unsustainable burden on future generations if the economy grows at a moderate rate."[19]

One might expect that a claim so often repeated would be carefully researched. Surprisingly, this not the case.[20] Most often, the claim comes with no supporting evidence; when it does, the calculations are out of date, look only at cash benefits, or fail to account for the total tax burden on earnings.[21]

So is the claim, in fact, true? A computerized study of the government's own long-term projections reveals that it almost certainly is not. An analysis of the official intermediate- and high-cost scenarios shows that raising taxes to cover the cost growth of three major programs -- Social Security, Medicare, and Medicaid benefits to seniors -- will have a devastating impact on future after-tax wage growth. These scenarios indicate that over the next 45 years, real after-tax earnings will stagnate at best. Quite possibly (again, assuming no major reform), they will plunge steeply.

Incomes Model

These conclusions are derived from a computer model of future after-tax earnings that are consistent with the official Social Security Administration (SSA) and Health Care Financing Administration (HCFA) scenarios II and III, as calculated for the 1994 annual reports of the Old-Age, Survivors, and Disability Insurance (OASDI) Trustees, the Hospital Insurance (HI) Trustees, and the Supplementary Medical Insurance (SMI) Trustees.[22] The model isolates the historical and projected future growth of three programs: Social Security, Medicare, and Medicaid benefits received by persons over age 65. These data, in turn, were used to generate historical values for every year from 1951 to 1993, and two sets of future values for every fifth year from 1995 to 2070[23] -- which is the scenario horizon of the 1994 annual reports.

A few definitions help explain the scope and purpose of this model.

EARNINGS refers to annual cash paid for productive labor services throughout the market economy. *AVERAGE EARNINGS* is the annual cash paid per person engaged in production. Earnings is broader than *WAGES* (or *SALARIES*), since it includes self-employed persons. It is also different from *COMPENSATION*, which includes employer-paid payroll taxes and noncash fringe benefits as well as cash wages paid to employees.

AFTER-TAX EARNINGS refers to the earnings left over after subtracting all taxes imposed on earners by all levels of government. This includes not only payroll, income, and property taxes that are directly payable by the earner, but also the fees, excise taxes, and retail taxes that are indirectly payable when something is bought or sold.

SCENARIO II refers to the official "intermediate cost" (or "best estimate") scenario. *SCENARIO III* refers to the official "high cost" scenario.

Average real after-tax earnings is intended as a measure of the average "privately consumable" purchasing power of worker earnings. It does not include everything that contributes to every worker's living standard. Some contributions -- such as dividends and interest, government benefits and services, and employer-paid fringes -- are left out.[24] It does, however, encompass all of the "earned" resources over which most Americans can exercise personal control. As such, it constitutes a time-honored political and cultural standard by which most Americans have always judged whether they are "doing better" or achieving the "American Dream."

Assumptions

Wherever possible, the model relies strictly on the SSA and HCFA scenarios for all of our quantitative assumptions.[25] These include future economic data, such as GDP, inflation, labor productivity, total compensation, and earnings. They include future demographic data, such as future employment and hours worked. And they include all future dollar outlays for the two of the three of the major programs in question: Social Security (OASDI) and Medicare (HI and SMI).

To derive after-tax earnings continuously into the future, certain assumptions were necessary in addition to those provided by SSA and HCFA. Most of them are not only plausible but even conservative:

1. **When the OASDI or HI trust fund goes bust,[26] it immediately switches over to pure "pay-as-you-go" financing.** In other words, the model assumes that Congress -- during the year in which OASDI or HI reaches its projected bankruptcy date -- will immediately raise the program's earmarked payroll tax so that total revenues equal total outlays for that program. Each year thereafter, payroll taxes will be readjusted so that program balance is exactly maintained (and the trust funds remain empty). Given the historical "self-funding" tradition of OASDI and HI -- and absent any changes in benefit policy -- this appears to be what is intended by current law.

2. **Any increase in any payroll tax rate on employers will come at the expense of worker earnings.** According to standard economic analysis, the only other place it could come from would be employer-paid benefits. But these benefits are too small to absorb more than a tiny fraction of the increase. Moreover, since they are generally tax-exempt, they will tend to grow, not shrink, in an environment of steady payroll and income tax hikes. Our modest compromise: To assume that projected employer-paid benefits remain unchanged in both scenarios -- and thus to require that the full payroll tax hike be borne by earnings.

3. **SMI will continue indefinitely to receive premium income from beneficiaries equal to 25 percent of gross SMI outlays.** OBRA 1993 specifies that SMI premiums be pegged at roughly 25 percent of gross outlays through 1998; the model assumes that ratio remains unchanged. (Note that SMI outlays refer to *net* outlays,

that is, gross outlays net of premiums.)

4. **SMI outlays, under scenario III, will exceed their scenario II path by the same multiple by which HI under III exceeds HI under II.** As it turns out, the SMI trustees do not calculate a projection III for their program. Since the influence of demographic and medical trends on SMI are essentially similar to their influence on HI, this seems like a plausible assumption.

5. **Medicaid outlays for persons age 65 and over will grow, under both scenarios, at a rate determined strictly by demographic change and the Medicare inflation rate.** That is, the age-specific utilization of Medicaid is assumed (quite optimistically) to remain constant over time. The Medicaid inflation factor is assumed to be the combined factor for both parts of Medicare.[27]

6. **All other government spending (federal, state, and local) besides Social Security, Medicare, and Medicaid for seniors will continue to rise each year at the same rate as GDP.** Since our object is to calculate total after-tax earnings, we need to make some assumption about the rest of government. GDP neutrality is a conservative hypothesis -- even if it does reflect a gradual growth in real government spending per capita. Many government services are resistant to productivity growth and thus tend to require a constant share of GDP just to maintain their current delivery ("Baumol's Law"[28]). More importantly, the same demographic forces pushing up the cost of Social Security, Medicare, and Medicaid for seniors after the year 2010 will be pushing up the cost of many other government programs.

7. **Between the years 1995 and 2010, the net consolidated public-sector budget will move to balance; every year after 2010 revenues will be adjusted so that they will continue to equal outlays; all types of general revenues (i.e., all revenues excluding payroll taxes) will be adjusted proportionally.** Any realistic projection of the tax burden has to put some limit on the public sector's ability to borrow. Either that, or it would have to reflect the negative feedbacks of rising public-sector deficits on savings, investment, productivity growth, interest rates, and budgetary debt-service charges. Our model avoids this set of issues (which clearly cannot be handled within the framework of the fixed SSA scenarios) by assuming that the public sector moves linearly to budget balance between 1995 and 2010. While this "budget-balance" assumption may seem heroic in light of recent experience, it's worth noting that the prospect of a constitutional amendment requiring a balancing of the consolidated federal budget are becoming increasingly favorable. Moreover, the future productivity growth rates projected under both SSA scenarios exceed our historical record over the last twenty years. The extra national savings generated by a balanced budget may be necessary to achieve this performance. As for timing, the 1995-2010 demographic window before the Baby Boom generations' retirement seems ideal. In any case, a more lenient assumption (e.g., keeping public indebtedness constant as a share of GDP) would not significantly change the results.[29]

8. **The incidence of taxation is distributed in a standard fashion.** Specifically, the model assumes that payroll taxes are entirely borne by workers; that corporate taxes are entirely borne by capital; and that all other direct and indirect taxation is distributed among three groups -- recipients of labor income, capital income, and benefit income -- according to each group's share of the relevant total. In deference to the prevailing consensus of economists (about the supply elasticity of capital and labor to taxation), the model then shifts three-quarters of the tax on capital to workers. To incorporate the shift, the model "grosses up" the historical and scenario values for pre-tax worker earnings and compensation. This assumption seems appropriate given the very long-term equilibrium under consideration.[30] (See below, "Appendix III: Calculating the Tax Burden.")

9. **The tax increases required to finance the growth of elderly benefits will have no adverse impacts on economic growth.** Remarkably, both scenarios envision that the rate of pre-tax income growth will actually increase relative to recent experience, despite a dramatic rise in the total tax rate on worker compensation. It is at least equally plausable that economic growth would suffer under such crushing tax burdens.

Findings

The major findings of our model are the following. All per-worker figures are translated into constant 1993 dollars.

1. **Under the "best estimate" scenario II, real after-tax earnings per U.S. worker will remain virtually unchanged over the 45 years between 1995 and 2040.** In 1995, after-tax earnings will amount to $19,221. By 2040, they will reach $19,346 -- less than one percent *total* growth over nearly half a century. At an annual rate, this growth is negligible by any statistical standard. (See Charts 1 and 2.)

2. **Under the "high cost" scenario III, real after-tax earnings per U.S. worker will decline steeply and steadily between 1995 and 2040.** In 1995, they will amount to $19,000. By 2040, they will fall to $7,821 -- a devastating 59 percent fall in real terms. Incredibly, this would be a much faster annual rate of *decline* than the annual rate at which after-tax earnings *rose* between 1951 and 1970. (See Charts 3 and 4.)

3. **Runaway health-care benefits are clearly not the only force behind the rising tax take on worker pay.** Under scenario II, fully 62 percent of the pre-tax earnings growth between 1995 and 2040 will be wiped out by general government, Social Security, and budget balance. (Medicare will take another 27 percent; and Medicaid for seniors, 10 percent.) Under scenario III, remarkably, 95 percent of pre-tax earnings growth will be wiped out by general government, Social Security, and budget balance alone. Under scenario III, in other words, after-tax earnings would stagnate *even if all levels of government could immediately and permanently restrain real health-benefit outlay growth to the growth rate of employment* (which would

require truly Draconian real cuts per beneficiary in order to compensate for the adverse demographics).

4. **The grim after-tax earnings trends are clearly not the result of pessimistic economic assumptions.** Quite the opposite: The optimism of the most important economic assumption -- pre-tax earnings -- is very visible in Charts 1 and 3. From the early 1970s to the early 1990s, pre-tax earnings hardly grew at all -- in fact, by no more than 0.2 percent annually, no matter which end year you choose. Even during the much-vaunted 1979-1989 decade, pre-tax earnings only grew by 0.4 percent annually. (See Chart 12.) *Yet from 1995 to 2040, pre-tax earnings are expected to accelerate to an average of 1.0 percent annually under scenario II or 0.5 percent annually under scenario III.* Little of this turnabout is expected to come from changes in the various linkages between real National Income per worker hour -- worker productivity -- and real earnings per worker year. (See Charts 13 through 16.) Instead, it is expected to come from an underlying improvement in worker productivity itself. Everyone agrees that such improvement is possible. The question, of course, is whether it constitutes the prudent foundation for public promises on which people base their lives.

5. **Trust-fund financing mechanisms make little difference in the magnitude or timing of the cost burden on workers.** Under scenario II, Social Security is expected to run ever-larger operating deficits from 2012 until 2029 -- at which time the trust funds go bankrupt and the program switches over to pay-as-you-go. What's the impact of this switchover on workers? As Chart 1 indicates, very little. Between 2025 and 2030, the bite from general revenues narrows and the bite from Social Security payroll taxes widens. The total bite also widens, since workers are assumed to bear the full incidence of payroll taxes, but only slightly -- since the burden of general revenues also falls mainly on workers. The same is true for the other bankruptcies scheduled in the two scenarios.

6. **Under scenario II, total government benefit spending will rise by nearly 10 percentage points of GDP by 2040.** In 1995, benefits will amount to 14.0 percent of GDP; by 2040, 23.5 percent of GDP, nearly what the entire *federal* government spends today. Meanwhile, total government spending will rise from 34.4 to 43.9 percent of GDP. In order to balance the budget, total tax revenue will rise even faster. In fact, it will rise more than *twice as much* between today and 2040 (13 percent of GDP) as it did between 1955 and today. (See Charts 5, 6, and 7.)[31]

7. **Under scenario III, total government benefit spending will rise by nearly 20 percentage points of GDP by 2040.** In 1995, benefits will amount to 14.0 percent of GDP; by 2040, 34.1 percent of GDP, roughly what *all levels of government* spend today. Meanwhile, total government spending will rise from 34.4 to 54.5 percent of GDP. Again, in order to balance the budget, total tax revenue will rise even faster. It will rise more than *four times as much* between today and 2040 (24 percent of

GDP) as it did between 1955 and today. (See Charts 5, 8, and 9.)

8. **Under both scenarios, the total tax rate on worker compensation grows steadily.** From 41 percent in 1994, it climbs to 57 percent by 2040 under scenario II and to 69 percent by 2040 under scenario III. Tax rates on return to capital and benefits also rise, but not as sharply. Under both scenarios, taxes on worker compensation comprise just under 80 percent of total tax revenue throughout the projection period. Of the remainder, the capital share gradually declines over time and the benefit share gradually rises. (See Charts 10 and 11.)

III. DISCUSSION

The foregoing analysis suggests that, absent major reform, the graying of the welfare state is likely to have catastrophic consequences for the after-tax living standards of most working-age Americans.

It has long been known that current-law spending from major entitlement programs is projected to grow considerably faster than our economy under all of the official scenarios. If budgets must be balanced at some point in the future, these scenarios imply an even steeper growth in total tax revenues as a share of GDP and in total tax rates on most definitions of income. Some observers have maintained, however, that higher cost as a share of GDP or payroll does not rule out a comfortable growth rate in real after-tax earnings. We have shown that it does. According to the official "best estimate" scenario of the Social Security and Medicare trustees, real after-tax earnings will remain entirely stagnant over the next half century. According to a more prudent scenario that better reflects recent history, after-tax earnings will decline drastically over the next half century.

Few Americans would willingly or knowingly embrace either of these visions of the future. For defenders of the entitlement status quo, then, the challenge is not so much to defend the results described here as to question the assumptions that lead to them.

But there really isn't much opening for direct rebuttal. The most critical assumptions, after all, are embodied in the official economic and demographic scenarios. And while it is easy to *imagine* a brighter future than scenarios II or III, it would be difficult to argue that we should *count on* such a brighter future on the basis of past experience. Another key set of assumptions are the official "health-care cost multipliers" -- and these too are demonstrably optimistic relative to past experience. Remember: The age wave is going to generate a huge rise in health-care benefit costs even in the absence of a significant health-care multiplier. To illustrate, let's assume (implausibly, of course) that future Medicare spending per age-adjusted beneficiary were to grow no faster than GDP per worker from now on. This is on the order of about one percent per year under scenario II. The result? Medicare spending would still *more than double* as a share of taxable payroll by the year 2040 -- as opposed to tripling under the official scenario.

As for the additional assumptions needed to complete analysis presented here, these are either uncontroversial, have limited impact on the quantitative result, or both. Yes, economists can quarrel over the "true" incidence of taxation on labor and capital. But few economists would contest the basic thrust of our approach -- that, in a long-term equilibrium framework, most taxes are borne by workers. True, the "balanced budget" proviso may seem heroic. But even if one rejects the argument that a balanced budget is necessary to achieve the projected productivity performance, the goal remains so universally popular that few political leaders would want to plan a long-term future without it.

Some conservatives may object to the assumption that discretionary spending stays constant as a share of GDP. But in the realm of what's likely, three stubborn facts remain. First, no lawmaker (Democrat or Republican) has yet devised a plan that balances the budget for even a single year through discretionary spending reductions alone.[32] Second, conservatives themselves remain profoundly conflicted about long-term spending priorities. In some well-known areas of the budget, they want to cut; but in others (from military preparedness to immigration control to crime fighting) many look forward to spending more. Third, much "rest of government" spending is going to be enlarged by the same demographic and health-care multipliers that are projected to hit the three largest senior programs. Lives are getting longer for public-sector pensioners as well as Social Security retirees. A low-income Alzheimer victim typically needs special social services as well as Medicaid. Health costs are rising at VA and military hospitals as well as among patients with Medicare cards. It is reasonable to assume that the same political consensus that sustains the major entitlement programs will also support continuance of other health and aging services.

Meanwhile, of special concern to conservatives should be the virtual certainty, in the absense of serious entitlement reform, that the total tax rate on worker compensation will have to rise sharply early in the next century. It is a basic tenet of "supply side" economics that lower tax rates boost economic growth -- and likewise, that higher tax rates suppress economic growth. It follows, therefore, that scenario II is internally inconsistent: How can our economy possibly improve its productivity growth performance (with or without a balanced budget) while raising taxes? Indeed, if the large tax increases envisioned in scenario II depress economic growth to the level envisioned in scenario III, the result will be even higher tax rates, which may make even scenario III unattainable -- and so on.

The practical bottom line of our analysis speaks for itself. America's political leaders cannot continue in good faith to advocate balanced budgets, tax cuts, and leaner government -- to say nothing of defending the long-term viability of the American Dream -- without also talking about major, structural reforms in "untouchable" senior entitlements. Everything must be on the table.

Yes, touching the untouchables is politically dangerous. Any leader who brings up the subject of Social Security or health-care for the elderly had better be ready to discuss such gut-level issues as early retirement, "spending down" for Medicaid, the function of the extended family, second liver transplants versus student loans, Lee Iacocca's Social Security check, who

should care for other people's wayward children, and how to balance the rightful claims of the young and the old on our public fisc. These are issues that force most Americans to rethink their own ideals and institutions.

On the other hand, leaving the untouchables alone is also dangerous. Much of the American electorate is convinced that government has played some enormous scam with their future that no one is willing to talk about. And if the leaders in power do not solve this problem by the time the bills come due, the electorate will surely engage in some heavy retribution -- not against who did speak up, but against who didn't. Indeed, the willingness of either party to pay attention to these issues is probably an excellent indicator of whether that party has any serious intention of governing the nation for long.

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APPENDIX I: OFFICIAL ECONOMIC AND DEMOGRAPHIC ASSUMPTIONS

Every spring, the Trustees of the OASDI (Social Security) Trust Funds publish an annual report which includes an actuarial analysis of future projected expenses and revenues. These projections are computed by SSA on the basis of long-term economic and demographic assumptions that are approved yearly by the Trustees. The same assumptions are used by the Trustees of the HI (Medicare Part A) and SMI (Medicare Part B) Trust Funds in the expense and revenue projections included in their reports. Currently, the OASDI Trustees produce three sets of assumptions, or "scenarios": low cost (I), intermediate cost (II), and high cost (III) -- of which the second is considered the Trustees' "best estimate" and is used to report the official actuarial balances to Congress as required by law.

Each scenario consists of future projections for at least two dozen separate economic and demographic variables, including inflation, unemployment, labor force participation, real earnings growth, fertility, longevity, immigration, disability rates, and so on. Just two assumptions, however, dominate the cost projections early in the next century: real earnings growth and longevity. By the year 2020, these two assumptions account for 63 percent of the cost difference between scenarios II and III. Further into the future, fertility assumptions begin to play a significant role. By 2040, when fertility alone accounts for 18 percent of the cost difference, all three assumptions together account for 72 percent of the cost difference. Any effort to assess the plausibility of the official scenarios, then, can usefully focus on the plausibility of these three assumptions. Table 2 shows their ultimate long-term values, along with a 1973-93 historical average to provide a standard of comparison. Scenario I is omitted here because its assumptions are so optimistic as to put it out of the running as a prudent forecast.

As Table 2 indicates, what is most striking about the two most dominant assumptions -- real earnings growth and longevity -- *is that recent historical experience is more "pessimistic" than even the highest-cost projection assumption.* Scenario III, for instance, posits a higher long-term growth rate of real earnings than we experienced according to any fair trend analysis of the last 10 years, 20 years, or 30 years. Likewise, both scenarios assume that gains in longevity will slow down sharply in future decades, perhaps on the supposition that there are strict natural limits on the human lifespan. Recent research is casting doubt on this assumption. In fact, the demographers on the technical panel of the current Quadrennial Commission of Social Security may suggest that the official "best estimate" for longevity at age 65 be greatly accelerated, perhaps by as much as one year by 2000 and five years by 2060. As for fertility, though the long-term trend has been downward (for over two centuries in the United States), a plausible case can be made for scenario II. Since the late 1980s, the total fertility rate has risen just above 2.0. It is likely, however, that this spurt reflects nothing more than changes in birth timing. Surveys of expected lifetime births per woman have changed very little over the past two decades and are entirely consistent with the scenario II value of 1.9.[33]

Table 2:
Official 1994 SSA Scenarios Versus Actual Historical Experience

	Assumed Long-Term Trends (After 2010) Under Scenarios II and III		Actual Historical Experience:
	Scenario II	Scenario III	1973-1993
Average Annual Rate of Real Wage Growth (in percent)	+0.98%	+0.52%	+0.11%
Average Annual Growth in Longevity at Age 65 (in years per decade)	+0.43	+0.83	+0.98
Average Total Fertility Rate (in lifetime births per female)	+1.90	+1.60	+1.87

APPENDIX II: OFFICIAL HEALTH CARE BENEFIT ASSUMPTIONS

The cost and revenue projections for Medicare depend, to a large extent, on the three economic and demographic scenarios prepared by the Social Security Trustees. These scenarios specify the real tax base from which Hospital Insurance will derive most of its revenue as well as the total number and age composition of all of the HI and SMI beneficiaries who will be receiving benefits. Yet the cost projections for Medicare clearly require something more -- some extra set of assumptions about how fast health benefit costs will rise even if general inflation, beneficiary numbers, and beneficiary age are held constant. HCFA calculates these extra assumptions according to a complex and interacting array of variables, including "labor forces," "nonlabor forces," "input intensity," and "volume of services." None of these variables are very helpful in trying to understand the plausibility of the underlying assumptions.

A conceptually simpler approach is to take the future cost projections for Medicare and to disaggregate their annual growth into four separate components: first, the cost growth due to a greater number of beneficiaries; second, the cost growth due to the higher age composition of beneficiaries; third, the cost growth due to economy-wide inflation; and fourth, the cost rate due to "extraordinary" causes. The first three of these assumptions are all determined by the Social Security scenarios. Together, they answer the question: How much must Medicare spend each year to give the same amount of inflation-adjusted care to each beneficiary at each age? What they leave unanswered is the extent to which Medicare spending may rise above and beyond any consideration of inflation, population, or age. This is the "extraordinary" cost growth. Its past history and future projected values are shown in Table 3.

Ever since Medicare got started in the mid-1960s, this extraordinary cost growth has always been a very important (and explosive) component of total cost growth. From 1970 through 1993, for instance, it has averaged over 5.0 percent annually. Yet what's especially interesting is the projected future trend in extraordinary cost growth. Until the year 2005, it stays close to its recent rate. It begins to slow down, however, over the following decade -- just when the Boomers are beginning to retire. *Past the year 2015, it recedes to roughly one-quarter of its average historical rate.* In other words, the explosive historical cost trend is supposed to cool off just when a very large generation (with a notorious habit of bidding up the prices of whatever they need throughout their collective lifecycle) begins to exert unprecedented pressure on the demand for every variety of health care. Curiously, the cost difference between the two scenarios narrows over time. Past 2030, the extraordinary growth rate under the "pessimistic" scenario III is actually less than under scenario II.

What accounts for these anomalies is, basically, an ad-hoc projection methodology that pays little attention to underlying assumptions. To generate scenario II, HCFA simply assumes that, after the year 2018 (25 years from now), extraordinary program cost growth will slow all the way down to real hourly earnings growth (for Medicare Part A) or real GDP per capita growth (for Medicare Part B). In small print, the Trustees do at one point concede the optimism of this assumption: "Given the historical experience of SMI costs per enrollee increasing faster

than GDP per capita, the assumption of the increases in costs per enrollee declining to the same rate as GDP per capita may be considered optimistic...." This sanguine methodology also explains why the extraordinary cost growth rate in scenario III ultimately falls beneath the growth rate in scenario II: the former scenario has a slower ultimate rate of real GDP growth per capita than the latter. It's as though the Trustees have already determined that if we become a less affluent country than otherwise we will be stingier in what we offer to Medicare patients than otherwise. Enormous policy choices have been built right into the "current-law" projections.

Table 3:
Official 1994 HCFA Assumptions Versus Actual Historical Experience

	Assumed Extraordinary Annual Real Growth in Medicare (Parts A and B)		Actual Historical Experience
	Scenario II	Scenario III	
1970-75			4.6 %
1975-80			5.9 %
1980-85			6.3 %
1985-90			3.0 %
1990-95			5.0 %
1995-00	5.2 %	4.9 %	
2000-05	5.0 %	5.9 %	
2005-10	4.2 %	4.9 %	
2010-15	2.9 %	3.9 %	
2015-20	1.4 %	2.5 %	
2020-25	1.0 %	1.9 %	
2025-30	1.1 %	1.5 %	
2030-35	1.2 %	0.9 %	
2035-40	1.1 %	0.4 %	

APPENDIX III: CALCULATING THE TAX BURDEN

Our model determines the distribution of taxation according to a few simple formulas. The goal is to approximate the attribution of total taxation to worker earnings and compensation -- while avoiding the complexity of simultaneous equations or inappropriate attempts at precision. Given the fixed "scenario" framework, any dynamic assumptions are of course out of the question.

Following the familiar NIPA categories, our model identifies five types of taxation for all levels of government. To each, we add here our shorthand label in parentheses: (1) personal tax and nontax receipts, exclusive of federal taxation of Social Security benefits (INCOMETAX); (2) federal taxation of Social Security (SSTAX); (3) indirect business tax and nontax accruals (SALESTAX); (4) corporate earnings taxation (BUSTAX); and (5) contributions for social insurance (PAYTAX). GENREV equals the sum of the above, minus all payroll tax revenue to the Social Security and Medicare trust funds (PAYOASDHI) and minus the employer-paid share of all remaining PAYTAX. Future values for SSTAX are determined by the scenario. Otherwise, the model assumes that GENREV (both the total and each type) remains constant as a share of 1993 GDP in all future years, except to the extent that GENREV must increase to meet the budget-balance condition (which must be met through a linear reduction of the nominal deficit between 1995 and 2010 and through a continuous balance thereafter). If GENREV increases, the model assumes that each type within GENREV increases proportionally. The model assumes that all PAYOASDHI follows the official scenarios until trust fund bankruptcy, when (for each trust fund) pay-as-you-go financing requires that PAYOASDHI be raised to cover the current trust fund deficit. The model assumes that any PAYTAX not included in GENREV or PAYOASDHI remains constant at its 1993 GDP share; in order to avoid a trivial complexity, the model assumes that increases in SSTAX above the scenario values are not credited to the Social Security trust funds.

The above account describes how the amount of each type of taxation is determined for all years. Now we move on to the incidence of taxation. To begin with, we identify four potential bearers of the tax burden. Again, we add here our shorthand label in parentheses: worker earnings (EARNINGS); employer-paid compensation minus earnings (FRINGE); return on capital (CAPITAL); and total government transfer payments (BENEFITS). the model assumes taxes on EARNINGS and FRINGE are both borne by workers, but we separate the two in order to isolate the tax reduction in earnings alone. While taxes on BENEFITS may be borne by anyone, including workers or capital owners, it makes sense to treat them as a separate category -- since they usually aren't regarded as a tax on market activity, but more as a government clawback of its own outlays. A useful subset of BENEFITS is taxable benefits (TAXBENEFITS), which consists of the major benefits other than Social Security (i.e., all local, state, and federal employee pension programs) on which many or most recipients have to pay income taxes. In all future years, BENEFITS (excluding Social Security, Medicare, and Medicaid for seniors) and TAXBENEFITS are assumed to remain constant at its 1993 GDP share.

For each type of taxation, the incidence is attributed to different bearers as follows.

- One-quarter of BUSTAX is attributed to CAPITAL; the rest is attributed to EARNINGS.
- SSTAX is attributed all to BENEFITS.
- PAYTAX is attributed to FRINGE to the extent that it lies within (a) the employer-paid OASDHI according to the scenario, plus (b) the 1993 value of PAYTAX minus OASDHI as a share of GDP. All PAYTAX in excess of this amount is attributed to EARNINGS.
- INCOMETAX is attributed to EARNINGS, CAPITAL, and TAXBENEFITS according to the proportional share of each item in the sum of all three items. Three-quarters of the CAPITAL share is then transferred to EARNINGS.
- SALESTAX is attributed to EARNINGS, CAPITAL, and BENEFITS according to the proportional share of each item in the sum of all three items. Three-quarters of the CAPITAL share is then transferred to EARNINGS.

Note that the shift of capital taxes to labor requires us to gross up the scenario definition of "earnings." Historical EARNINGS in our model equals scenario "earnings" plus the total shift of capital taxes to labor. Future EARNINGS in our model equals the historical value for 1993 EARNINGS times the scenario growth rate for "earnings" thereafter. Thus historical EARNINGS exceeds "earnings" by the historical tax shift; future EARNINGS exceed "earnings" by a fixed multiple -- reflecting the implicit SSA assumption that the relative magnitude of such a tax shift would not change in future years. For all years, our measure of "worker compensation" is grossed up by the same dollar figure.

As mentioned earlier, the share of total taxes attributed to both EARNINGS and FRINGE (i.e., to total worker compensation) by these formulas is just under 80 percent throughout the projection period; of the remainder, the BENEFITS share rises and the CAPITAL share declines over time.

The total tax rate figures displayed in Charts 10 and 11 are derived by taking the total tax attributed to each bearer and dividing it by the total "income" in question. The total tax rate on worker compensation equals the tax on EARNINGS plus the tax on FRINGE, all divided by EARNINGS plus FRINGE. The total tax rate on capital equals the tax on CAPITAL divided by CAPITAL. The total tax rate on benefits equals the tax on BENEFITS divided by BENEFITS.

ENDNOTES

1. "Generational Perspectives" in U.S. Office of Management and Budget, *Budget of the United States Government, Fiscal Year 1995: Analytical Perspectives* (1994), pp. 21-31.

2. Board of Trustees, Federal Old-Age and Survivors Insurance and Disability Trust Funds, *1994 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Trust Funds* (1994), p. 124. See also the *1988 Annual Report* (1988), p. 84.

3. Bipartisan Commission on Entitlement and Tax Reform, *Interim Report to the President* (1994), p. 6.

4. Congressional Budget Office, *Reducing Entitlement Spending* (1994), p. ix.

5. See results to survey questions 24 and 25 in Matthew Greenwald & Associates, Inc., *Entitlement Survey*, commissioned by the Congressional Institute for the Future and the National Taxpayers Union Foundation (1994).

6. Results of New York Times/CBS News Poll, as reported in *New York Times* (November 6, 1994).

7. Merrill Lynch & Co., Inc. *Saving the American Dream: An Economic and Public Opinion Study* (1994).

8. See results to survey question 26 (and unpublished cross-tabulations) in Matthew Greenwald & Associates, Inc., *op. cit.*

9. See results to survey questions 14, 15, and 27a in Matthew Greenwald & Associates, Inc., *op. cit.* See also the *Survey on Retirement Confidence*, conducted by the Employee Benefits Research Institute and Matthew Greenwald & Associates, Inc. (1994), p. 39; its summary of four years (1990-1994) of answers to this question shows growing support for benefits means-testing.

10. Interestingly, amid all the negative or hedging remarks that have been made about the "interim findings" of the Bipartisan Commission on Entitlement and Tax Reform, virtually nothing has been said to contest the official "intermediate cost" scenario upon which nearly all of the Commission's quantitative projections are based. One exception is the claim of Commission member Richard Trumka that the SSA official labor force projections are too low. Trumka prefers the more buoyant BLS projections--a dubious point for him to raise since the BLS optimism about the future labor force is more than compensated by the (possibly related) BLS pessimism about productivity growth. The future growth rates for real GDP and real covered wages are actually lower in the BLS scenario than in the intermediate-cost SSA scenario!

11. Even by the year 2030, immigration and fertility combined only explain 16 percent of the difference between scenarios II and III. That same year, real wage growth and longevity explain 59 percent of the difference.

12. See discussion in Appendix I. When applied to longevity, the phrase "actuarially favorable" means tending to lower cost--and is "unfavorable" in any broader sense. Most people consider longer lifespans to be very good news indeed. Although the "root-canal" crowd who raise the issue of long-term benefit costs are sometimes labeled "pessimists," many of the trends they point to (such as longer lifespans or earlier retirements) are unambiguously positive--so long as America can afford them.

13. See discussion in Appendix II.

14. Both parts of Medicare (HI and SMI) are included here. SMI outlays are net of premiums paid by beneficiaries. Although the payroll tax denominator for HI is slightly larger than the denominator for OASDI, the SSA actuaries have traditionally ignored this discrepancy when adding the two together. In the same spirit, this calculation for SMI uses the OASDI denominator and adds it on to the other two without adjustment. The "intermediate cost" and "high cost" projections are equivalent to the official "scenario II" and "scenario III." Since there is no official long term scenario III projection for SMI, we calculate this projection (as in the model described below) by assuming that SMI outlays will exceed their scenario II path by the same multiple by which HI under III exceeds HI under II.

15. James Tobin, in "An Exchange on Social Security," *The New Republic* (May 18, 1987), p. 22.

16. Robert Ball (with Henry Aaron), "Social Security: It Is Affordable," *Washington Post* (February 15, 1994).

17. Michael Kinsley, "Back From the Future," *The New Republic* (March 21, 1994), p. 6.

18. Henry Aaron, *Proceedings of "Children at Risk: Who Will Support Our Aging Society?"* (Conference sponsored by Americans for Generational Equity and Center for Public Policy and Contemporary Issues; Denver, Colorado; May 13, 1988.)

19. American Association of Retired Persons, *Entitlements and the Federal Budget Deficit: Setting the Record Straight* (1994), pp. 2, 15.

20. Henry J. Aaron, Barry P. Bosworth, and Gary Burtless, *Can America Afford to Grow Old?* (1989), with its long-term macro model based on SSA assumptions, promises to be an exception. Unfortunately, neither SMI nor Medicaid are modeled, and (even for just OASDHI) the authors' extensive discussion of the tax burden always skirts any direct presentation of real after-tax earnings numbers. In any event, their overall tone is far from optimistic: "These [programs'] burdens will be manageable if productivity growth recovers to the pre-1973 rate, but they will be very heavy if the improvement in general living standards continues at the recent dismal pace." (p. 97).

21. Using out-of-date trustees' reports improves the outlook because the official assumptions have changed in a pessimistic direction in recent years. Looking only at Social Security cash benefits obviously improves the outlook even though several other programs transfer resources between generally the same two populations (from working age adults to retirees), are subject to the same demographic pressures (the Boomer-led age wave), and are even more resistant to cost control. We include two of the these programs, Medicare and senior benefits under Medicaid, in our analysis. As for failing to account for the total tax burden on earnings (say, by just looking at earnings after deductions for payroll taxes), this misses the basic political issue that matters to most Americans: Where do I stand personally after all of my transactions with government are complete?

22. HI is financed mostly by an earmarked payroll tax, SMI by general federal revenues; together they are known as Parts A and B of Medicare.

23. Although we generated numbers to 2070, we limit our discussions to the pre-2040 period for the purpose of brevity and policy relevance. None of the conclusions reached here would be materially altered by including the 2040-2070 period.

24. Also left out is the historical and projected trend toward fewer average hours of work per week (see Charts 15 and 16), which may be regarded as yet another component of a higher living standard to the extent it reflects less "effort" required from each worker to obtain the same market basket of real goods and services.

25. Although the data used in our model are always consistent with the official scenarios, a few terms had to be redefined. Our treatment of capital taxation (see below), for instance, requires us to gross up the official pre-tax worker "earnings" and "compensation" measures by the amount of the tax shift. Some of the official scenario numbers are published in the OASDI, HI, and SMI annual reports. Most of the annual figures are unpublished and are available from the SSA and HCFA actuarial offices.

25. OASI and DI are separate trust funds. But to simplify the analysis (and given that the two trust funds have historically borrowed from each other), we will regard them here as one. According to scenario II in the 1994 trustees' annual reports, OASDI is expected to become insolvent in 2029; HI in 2001. According to scenario III, OASDI is expected to become insolvent in 2014; HI in 2000.

27. That is, annual Medicaid cost growth is determined as a product of: (a) the Medicaid demographic multiplier, (b) the GDP deflator, and (c) the extraordinary cost multiplier for Medicare (see Appendix II). The Medicaid demographic multiplier is calculated, each five years into the future, by multiplying the population in each age bracket (over age 65) in the future with the per-capita Medicaid cost of that age-bracket in 1992. It is optimistic to assume unchanged utilization rates because such a large share (roughly two-thirds) of Medicaid benefits to the elderly consists of long-term care. Unlike acute care, the utilization of long-term care is very sensitive to the share of eligibles living alone or without family nearby (which we know will rise among the future elderly population) and to broader definitions of disability (which are already factored into Disability Insurance cost projections).

27. "The cost disease of the personal services" is the term William J. Baumol originally used for his analysis of how many personal services resist productivity improvement. It has since become known as "Baumol's Law" and has been often been observed to work with great stubbornness in the public sector. For a provocative essay on the issue, see Daniel P. Moynihan, "Don't Blame Democracy: The Socialization of Slow-Growth Jobs," *Washington Post* (June 6, 1993).

28. It is true that a balanced budget would lead to a steady reduction of public debt-service charges as a share of GDP. But it is assumed that this reduction would be approximately compensated by per-GDP spending growth in other government functions.

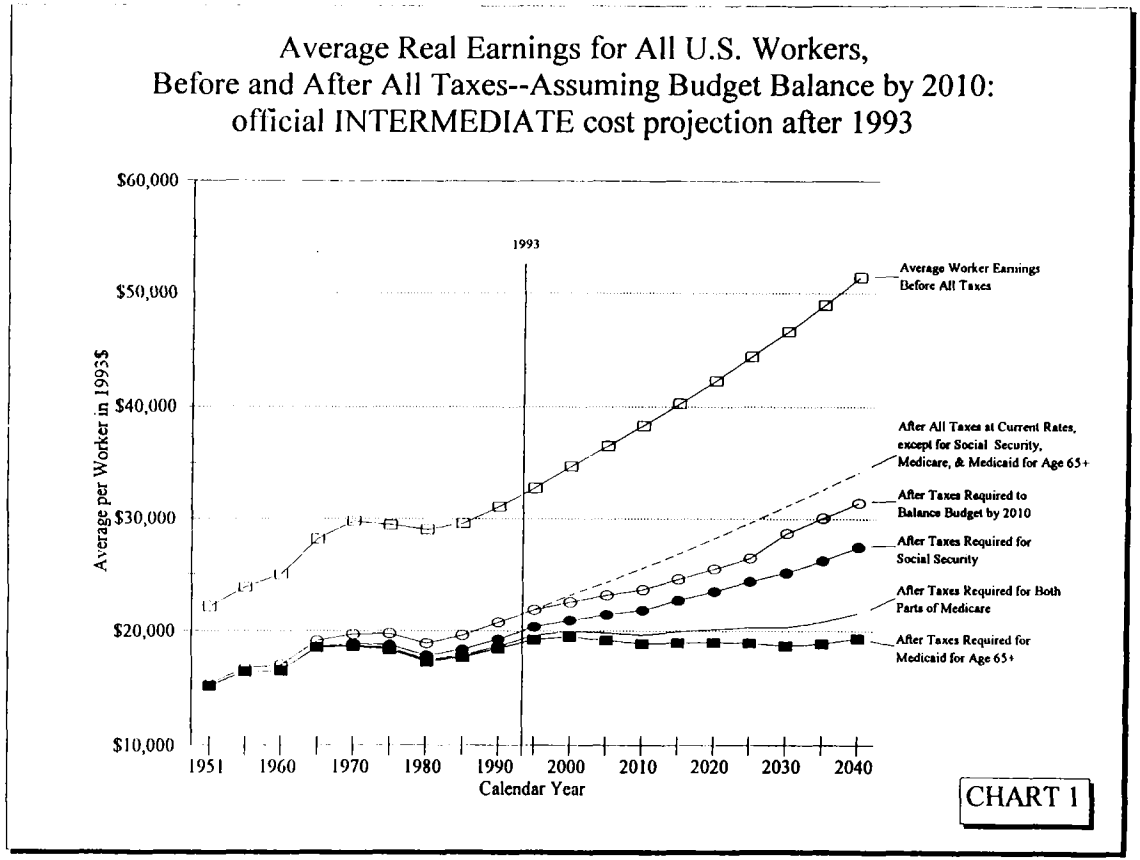
30. There is of course no consensus among economists on the incidence of taxes on the return to capital. Some analysts (e.g., the Congressional Budget Office) split the difference by presenting the results both ways--shifting the burden all to capital and then all to labor. For a long-term equilibrium framework (especially one that anticipates the expected future trend toward integrated global capital markets), we think that most economists would agree that most capital taxes are shifted to labor. Hence our choice of the three-quarters fraction. Although capital can also shed its tax burden by passing it on to consumers in the form of higher prices, it is generally believed that this shift is less important--since product markets are more competitive and integrated than labor markets. In our model, in any event, switching the assumption from shifting through wages to shifting through prices would hardly make any difference in the quantitative result for real after-tax earnings.

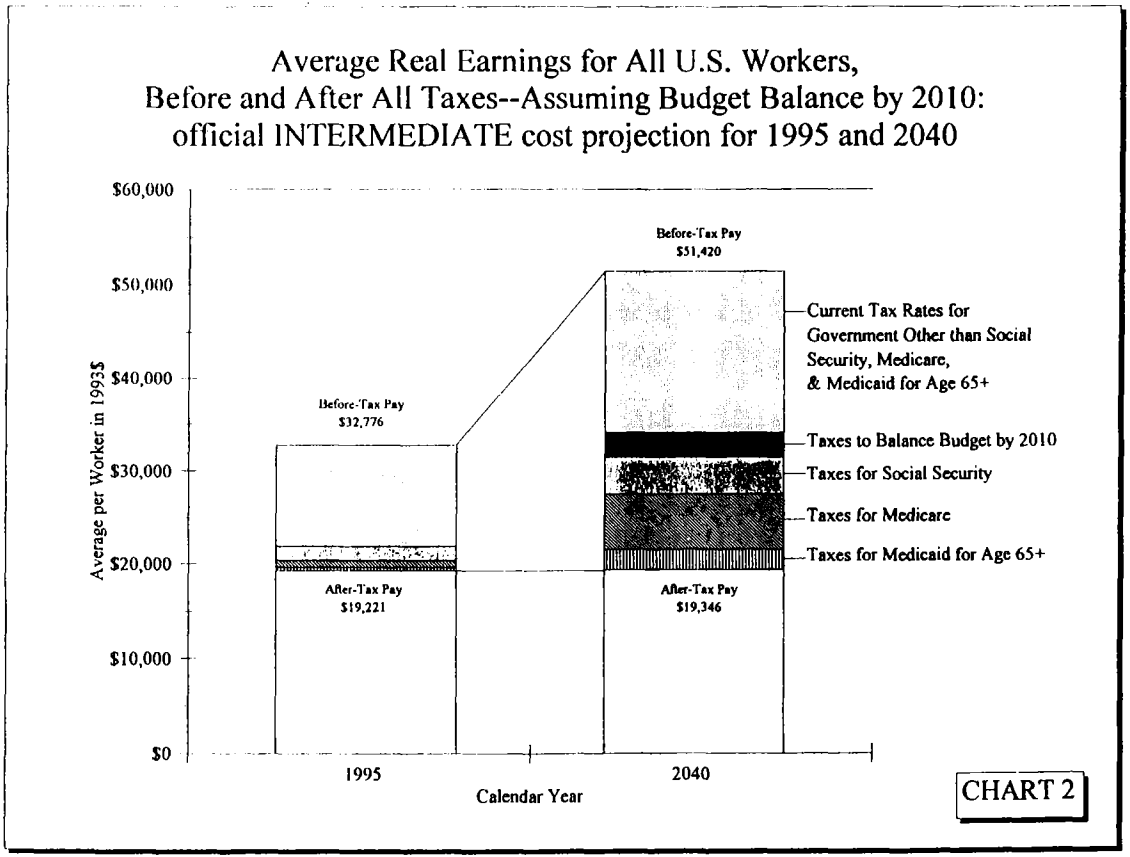
30. Here "benefit payments" refer to "transfer payments" as defined in the National Income and Product Accounts for all levels of government. At the federal level, this term is somewhat more restrictive than "federal entitlements" as defined by the Congressional Budget Office or "benefit payments for individuals" as defined by the Office of Management and Budget.

32. The plan proposed by Rep. Jerry Solomon, Chairman of the Balanced Budget Task Force, is one of the very few plans (if not the only extant plan) that meets the first two criteria--i.e., balancing the budget without raising taxes. But it does not meet the third. Even after including every line item anyone can think of, Solomon is still compelled to seek out massive reductions ($154 billion, or 22 percent of the cumulative five-year savings) in Medicare and Medicaid. If the goal is to keep the budget balanced over time, not merely to balance it once, then the need to reduce the growth in senior benefits is even more compelling; otherwise, Congress will ultimately run

out of other budget functions to cut.

33. For an up-to-date survey of these issues, see Richard Jackson, "An Analysis of Social Security and Medicare Long-Term Cost Projections," an unpublished submission to the Bipartisan Commission on Entitlement and Tax Reform at the request of Peter G. Peterson.


Average Real Earnings for All U.S. Workers,
Before and After All Taxes--Assuming Budget Balance by 2010:
official INTERMEDIATE cost projection after 1993
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
Average per Worker in 1993$
1993
1951
1960
1970
1980
1990
2000
2010
2020
2030
2040
Calendar Year
Average Worker Earnings Before All Taxes
After All Taxes at Current Rates, except for Social Security, Medicare, & Medicaid for Age 65+
After Taxes Required to Balance Budget by 2010
After Taxes Required for Social Security
After Taxes Required for Both Parts of Medicare
After Taxes Required for Medicaid for Age 65+
CHART 1


Average Real Earnings for All U.S. Workers,
Before and After All Taxes--Assuming Budget Balance by 2010:
official INTERMEDIATE cost projection for 1995 and 2040
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
$0
Average per Worker in 1993$
Before-Tax Pay
$32,776
After-Tax Pay
$19,221
Before-Tax Pay
$51,420
After-Tax Pay
$19,346
Current Tax Rates for
Government Other than Social
Security, Medicare,
& Medicaid for Age 65+
Taxes to Balance Budget by 2010
Taxes for Social Security
Taxes for Medicare
Taxes for Medicaid for Age 65+
1995
2040
Calendar Year
CHART 2

Average Real Earnings for All U.S. Workers, Before and After All Taxes--Assuming Budget Balance by 2010: official HIGH cost projection after 1993

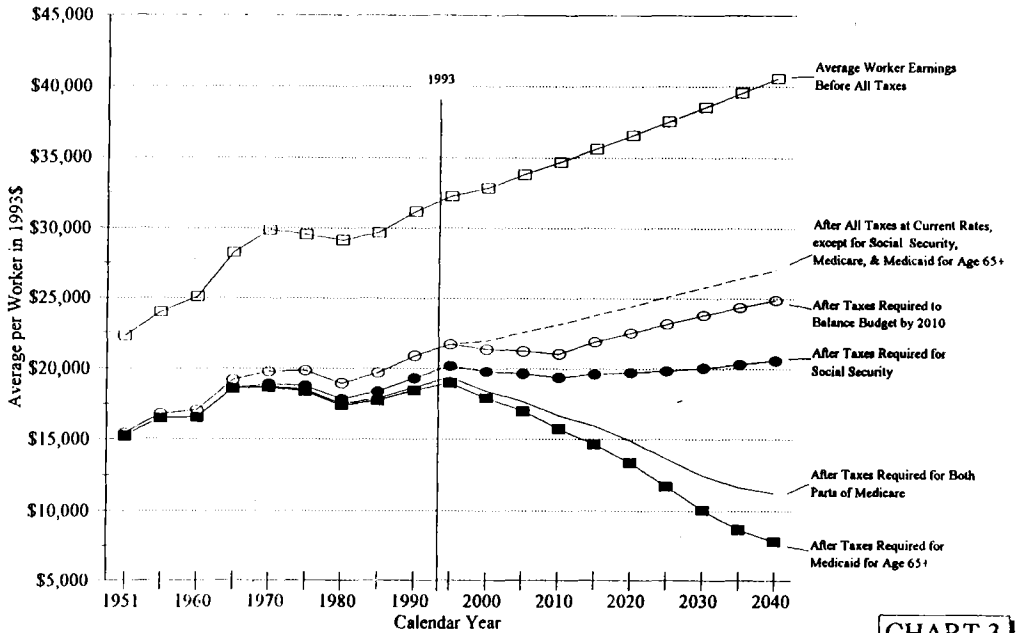


CHART 3

Average Real Earnings for All U.S. Workers, Before and After All Taxes--Assuming Budget Balance by 2010: official HIGH cost projection for 1995 and 2040

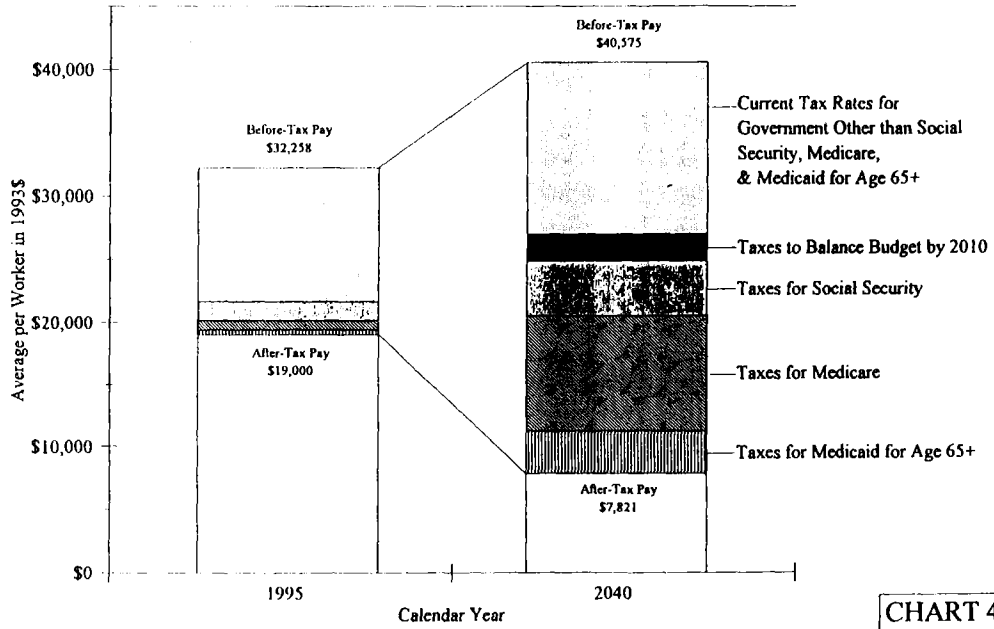


CHART 4

The Historical Record: Government Outlays as a Percent of Gross Domestic Product: Yearly, from 1951 to 1993

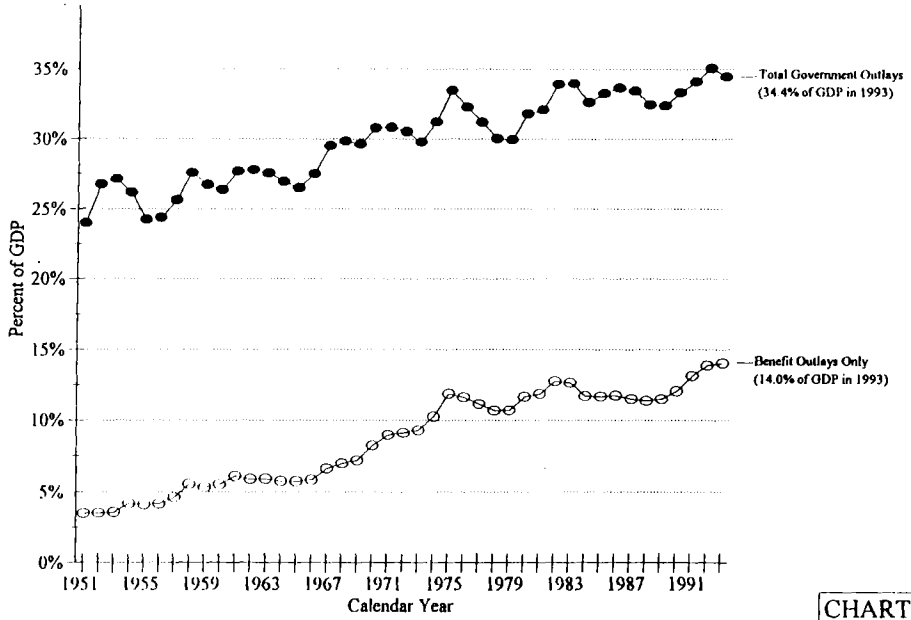


CHART 5

Total Government Benefit Outlays
as a Percent of Gross Domestic Product:
official INTERMEDIATE cost projection after 1993

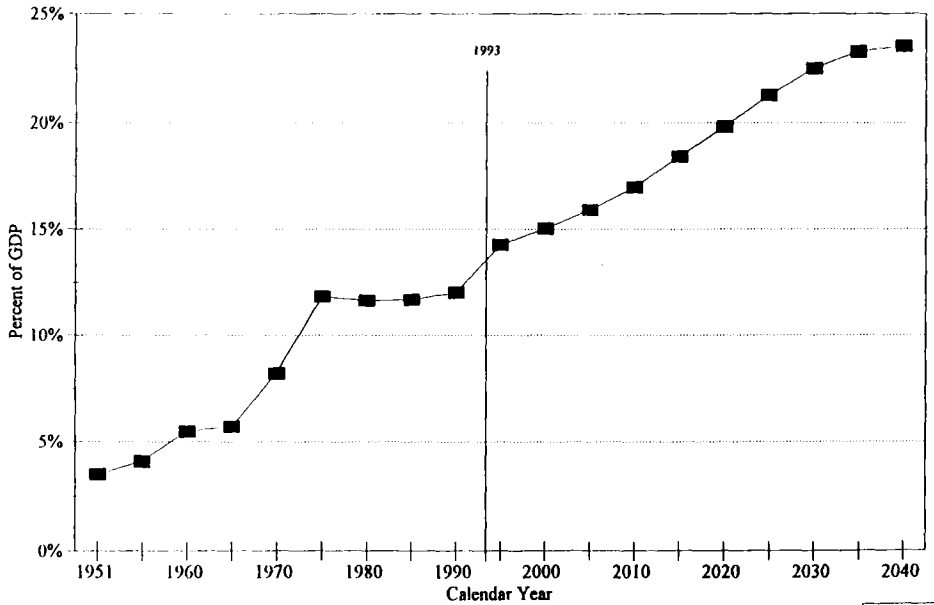


CHART 6

Total Government Outlays and Revenues as a Percent of GDP
--Assuming Budget Balance by 2010:
official INTERMEDIATE cost projection after 1993

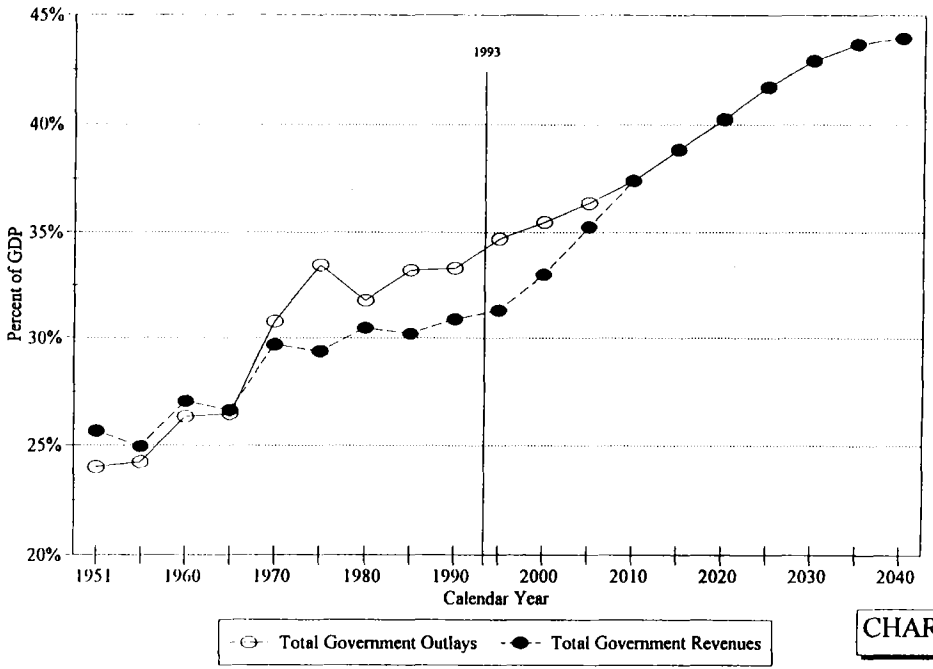


CHART 7

Total Government Benefit Outlays
as a Percent of Gross Domestic Product:
official HIGH cost projection after 1993

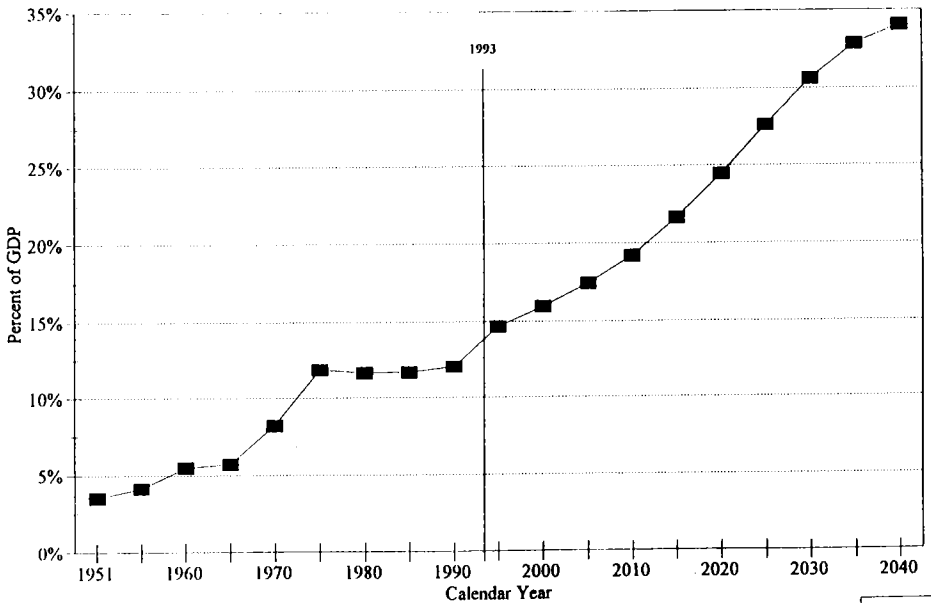
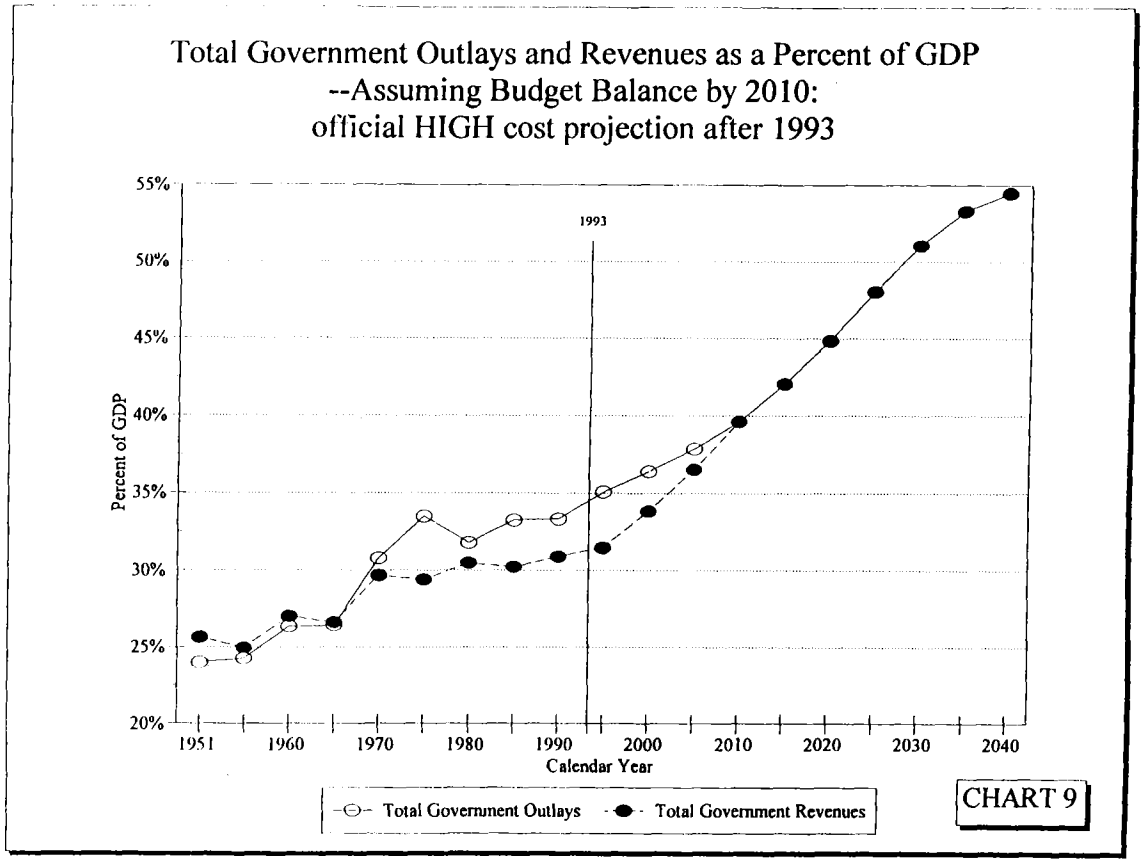


CHART 8


Total Government Outlays and Revenues as a Percent of GDP
--Assuming Budget Balance by 2010:
official HIGH cost projection after 1993
55%
50%
45%
40%
35%
30%
25%
20%
Percent of GDP
1993
1951
1960
1970
1980
1990
2000
2010
2020
2030
2040
Calendar Year
Total Government Outlays
Total Government Revenues
CHART 9

Total Tax Rate on Worker Compensation, Return to Capital, and Benefits
--Assuming Budget Balance by 2010:
official INTERMEDIATE cost projection after 1993

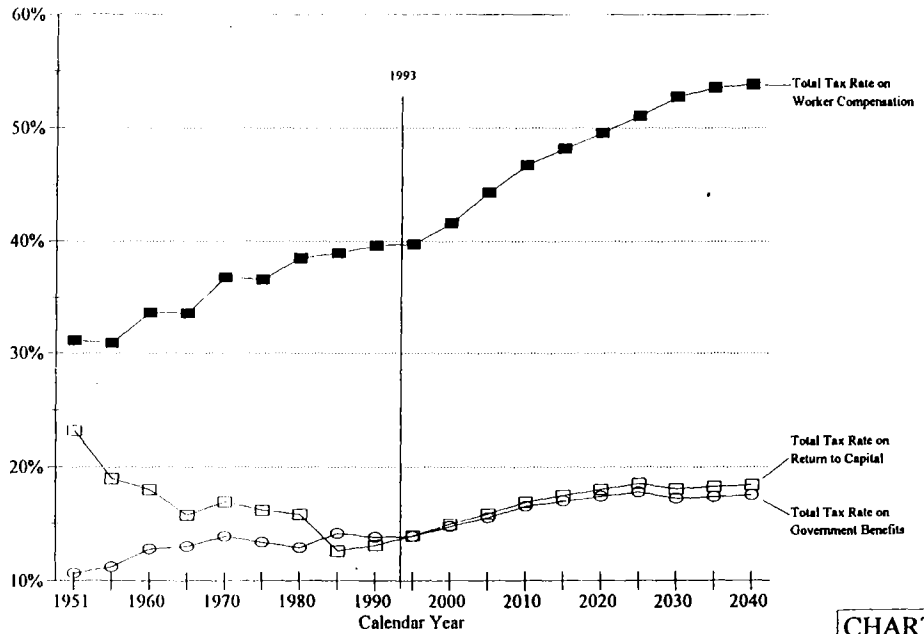


CHART 10

Total Tax Rate on Worker Compensation, Return to Capital, and Benefits
--Assuming Budget Balance by 2010:
official HIGH cost projection after 1993

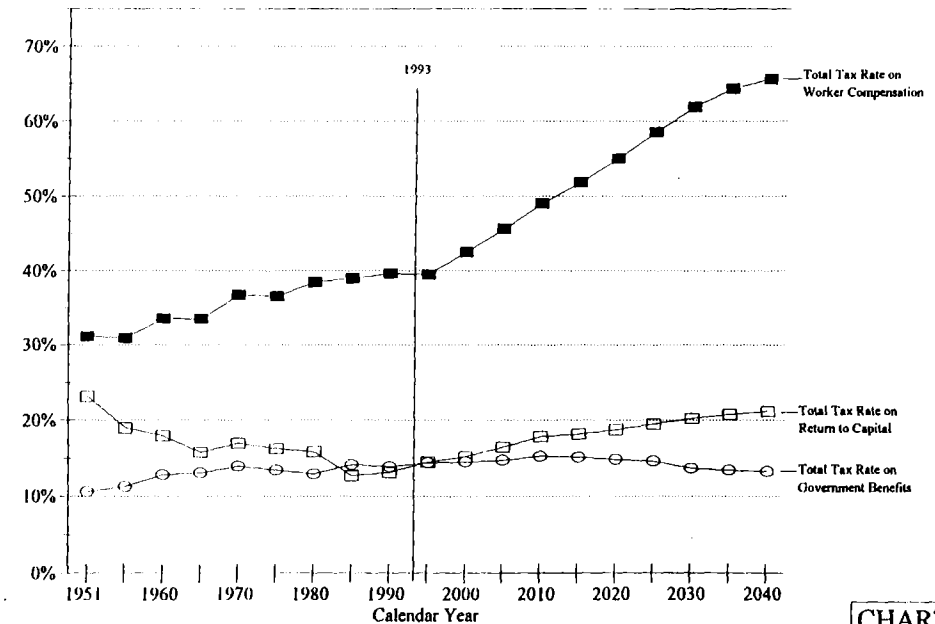


CHART 11

The Historical Record:
From National Income per Worker to After-Tax Earnings per Worker:
Yearly, from 1951 to 1993

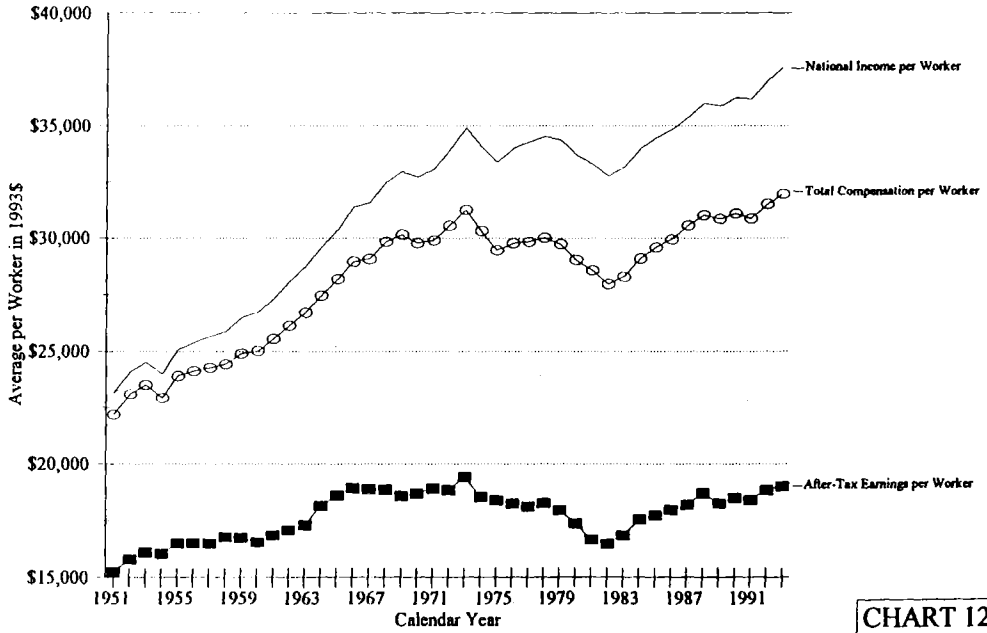
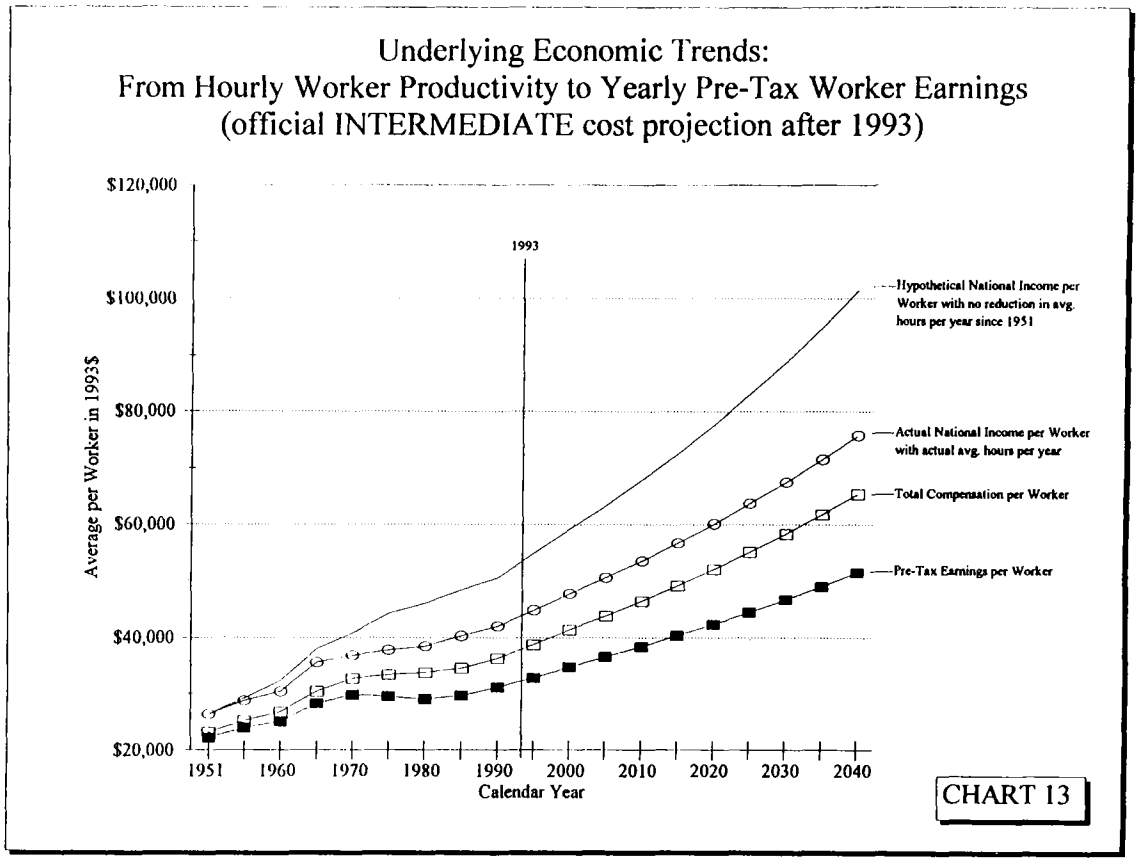


CHART 12


Underlying Economic Trends:
From Hourly Worker Productivity to Yearly Pre-Tax Worker Earnings
(official INTERMEDIATE cost projection after 1993)
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
Average per Worker in 1993$
1993
1951
1960
1970
1980
1990
2000
2010
2020
2030
2040
Calendar Year
Hypothetical National Income per Worker with no reduction in avg. hours per year since 1951
Actual National Income per Worker with actual avg. hours per year
Total Compensation per Worker
Pre-Tax Earnings per Worker
CHART 13

Underlying Economic Trends:
From Hourly Worker Productivity to Yearly Pre-Tax Worker Earnings
(official HIGH cost projection after 1993)

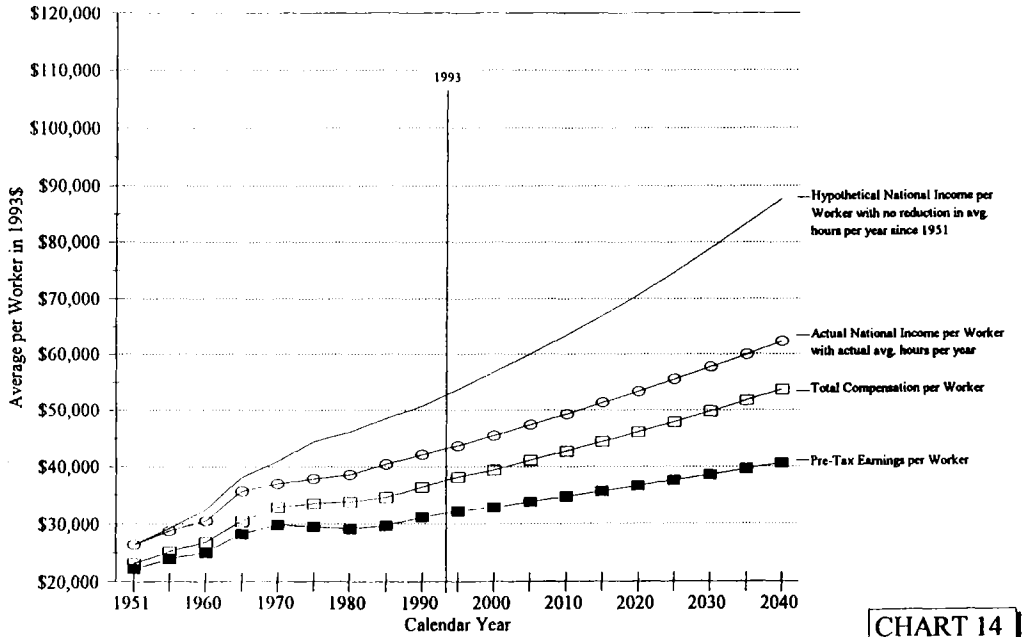
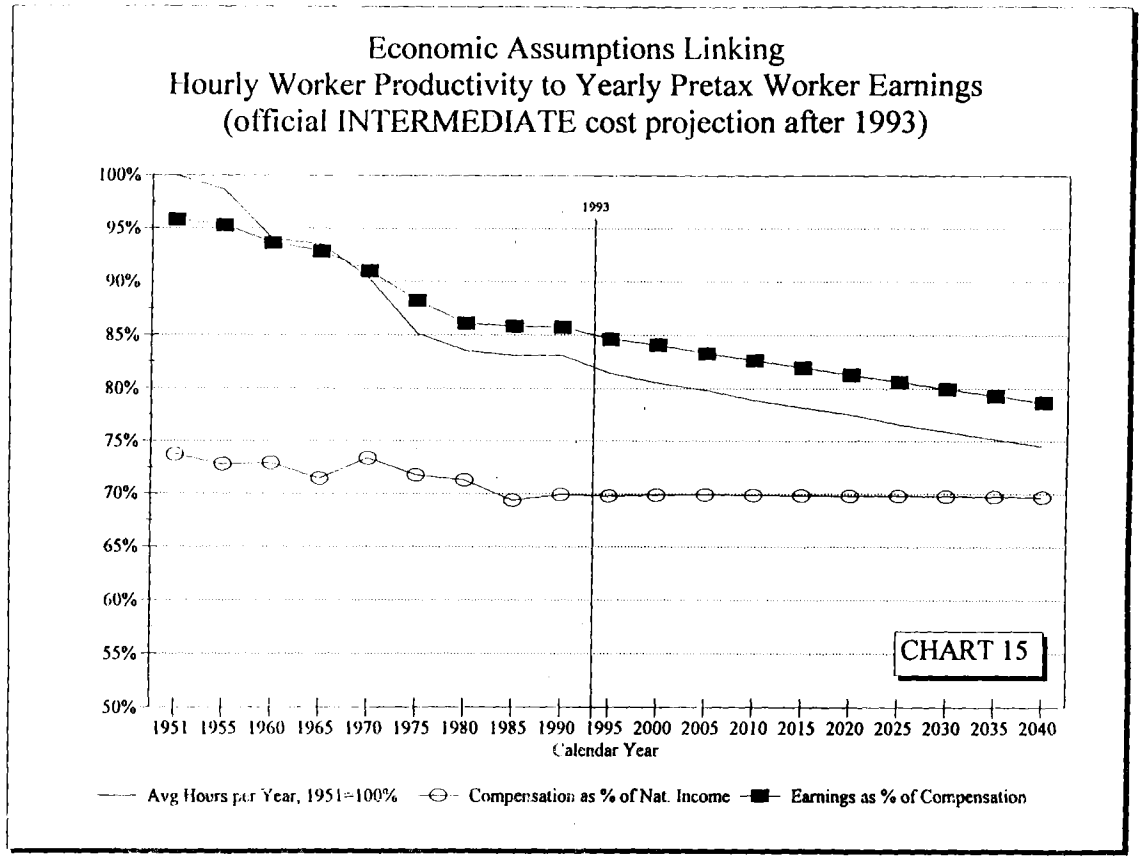
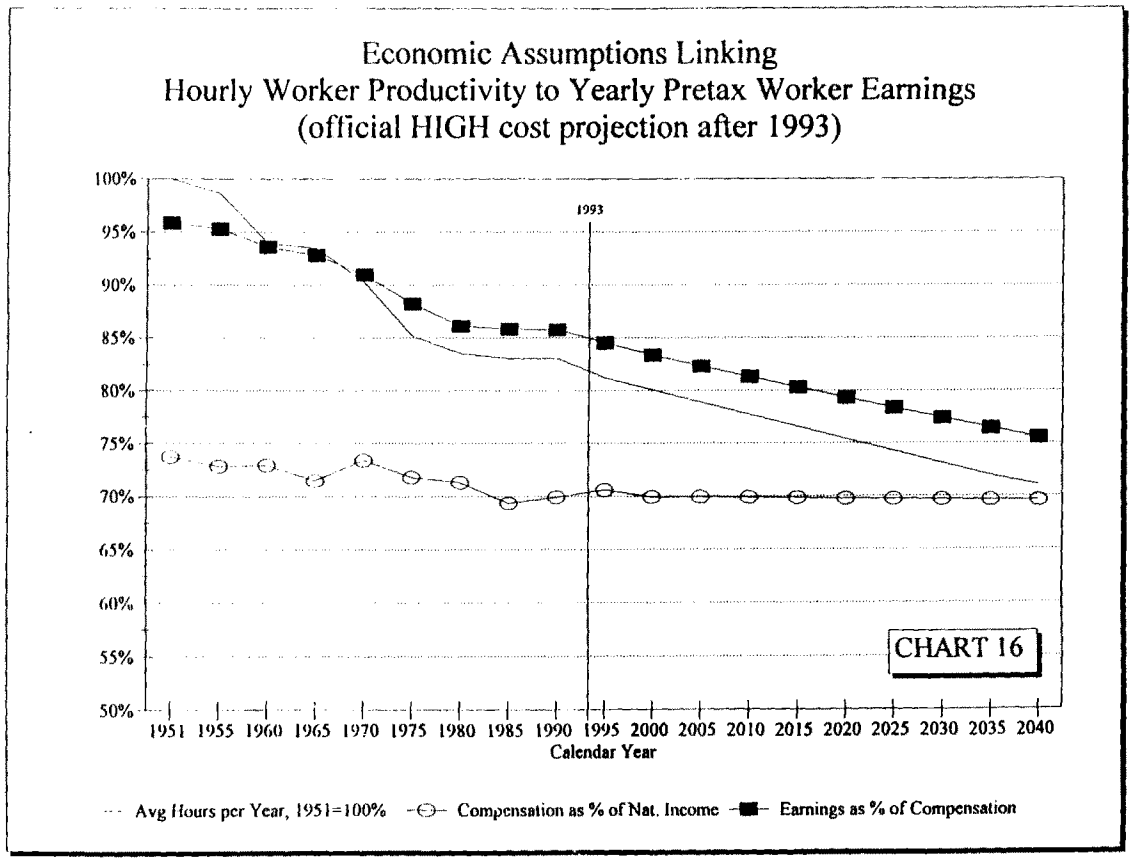


CHART 14


Economic Assumptions Linking
Hourly Worker Productivity to Yearly Pretax Worker Earnings
(official INTERMEDIATE cost projection after 1993)
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
1993
1951 1955 1960 1965 1970 1975 1980 1985 1990 1995 2000 2005 2010 2015 2020 2025 2030 2035 2040
Calendar Year
CHART 15
Avg Hours per Year, 1951=100%
Compensation as % of Nat. Income
Earnings as % of Compensation


Economic Assumptions Linking
Hourly Worker Productivity to Yearly Pretax Worker Earnings
(official HIGH cost projection after 1993)
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
1993
1951 1955 1960 1965 1970 1975 1980 1985 1990 1995 2000 2005 2010 2015 2020 2025 2030 2035 2040
Calendar Year
CHART 16
Avg Hours per Year, 1951=100%
Compensation as % of Nat. Income
Earnings as % of Compensation

STATEMENT TO THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

Subject: Hearing held on February 23, 1995 on the failure of the President's fiscal year 1996 budget proposals to address the pending insolvency of the Medicare trust fund.

Person submitting statement
Gerald S. Parker
11 Shore Acre Drive
Old Greenwich, CT 06870

Capacity
Retired citizen, age 78, with 30 years experience in health insurance management with The Guardian Life Insurance Company of America

Representing
Himself only

With respect to Part A, the hospital deductible and co-payments are already indexed annually. I see no benefit pattern modification that would be helpful in saving money and practical to administer. The hospitals have been subject for years to price controls that ensure that they will care for Medicare patients at a loss which is then shifted on to other patients and their insurers. There is no profit in further squeezing the hospitals and their patients. That leaves means testing.

The professional advocates for the elderly keep trumpeting the fallacy that " You paid for these benefits and earned them. Don't let the Congress take them away from you." To be fair, much of the blame for that misunderstanding lies at the door of Congress, which made that sort of assertion for years in its determination to capture the elderly vote. But it was never true, never intended to be true, and is now a complete falsehood of which the organized advocates should be ashamed. I am sure they know the truth!

Nevertheless, regardless of how many advocates for the elderly descend on the hearings bearing petitions and pleas to Congress to "save medicare" or "save Social Security," action must be taken soon, and the longer it is delayed, the worse will be the pain when the problem is finally faced.

The working population can no longer be expected to pay all the cost of Medicare for those of us who are beneficiaries. Those of us who can must also accept our share. And Congress should keep in mind that there are many more of them than there are of us!

It seems to me that a reasonable approach would be to make a charge, deductible from Social Security monthly pension benefits like the charge for Part B, to people who can afford it. It could be levied on taxable incomes of, for example, $40,000 or $50,000 or more and perhaps graded up somewhat for those with taxable incomes exceeding $100,000, $150,000 and $200,000.

Charges could be made for Part A, and perhaps higher charges for Part B also if they are needed. And at that level, the impoverished elderly and the lower income half of the "middle class" would escape most of it. If taxable incomes would be too difficult to keep track of, adjusted gross incomes could be used, beginning at somewhat higher levels. Consideration could be given to higher income floors for couples.

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