COMMITTEE ON WAYS AND MEANS

HEARINGS BEFORE THE

SUBCOMMITTEE ON HEALTH
(Volume 1 of 6)

104th Congress
1995-1996

	Tab No.
Long-Term Care Tax Provisions in the Contract With America	1
Health Insurance Premium Tax Deductions for the Self-Employed	2
Medicare Hearings on Controlling Costs and Improving Care	3
Medicare Provisions in the President's Budget	4

COMMITTEE ON WAYS AND MEANS

HEARINGS BEFORE THE

SUBCOMMITTEE ON HEALTH
(Volume 2 of 6)

104th Congress
1995-1996

	Tab No.
Medicare and Private Sector Health Care Quality Measurement, Assurance, and Improvement	1
Issues Regarding Graduate Medical Education	2
Physician Payment Review Commission Recommendations on Physician Payments	3
Medicare End-Stage Renal Disease (Kidney Failure) Program	4

COMMITTEE ON WAYS AND MEANS

HEARINGS BEFORE THE

SUBCOMMITTEE ON HEALTH
(Volume 3 of 6)

104th Congress
1995-1996

	Tab No.
Physician Self-Referral	1
Health Insurance Portability	2
Experience in Controlling Costs and Improving Quality in Employer-Based Plans	3
Medicare HMO Enrollment Growth and Payment Policies	4

COMMITTEE ON WAYS AND MEANS

HEARINGS BEFORE THE

SUBCOMMITTEE ON HEALTH
(Volume 4 of 6)

104th Congress
1995-1996

	Tab No.
The Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program	1
H.R. 1818, the Family Medical Savings and Investment Act	2
Saving Medicare and Budget Reconciliation Issues	3
Standards for Health Plans Providing Coverage in the Medicare Program	4

COMMITTEE ON WAYS AND MEANS

HEARINGS BEFORE THE

SUBCOMMITTEE ON HEALTH
(Volume 5 of 6)

104th Congress
1995-1996

	Tab No.
New Health Professions and Graduate Medical Education Recommendations	1
Long-Term Care Options	2
Recommendations Regarding Future Directions in the Medicare Program	3
Teaching Hospital and Other Issues Related to Graduate Medical Education	4

COMMITTEE ON WAYS AND MEANS

HEARINGS BEFORE THE

SUBCOMMITTEE ON HEALTH
(Volume 6 of 6)

104th Congress
1995-1996

	Tab No.
Administration's Medicare Choices and Competitive Pricing Demonstration Projects	1
Issues Related to Medicare Payment Policies for Home Health Agency and Skilled Nursing Facility Services	2
H.R. 2976, the "Patient Right to Know Act of 1996"	3
Rural Health Care Issues	4
Medicare Subvention	5

PHYSICIAN SELF-REFERRAL

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

May 3, 1995

Serial 104–69

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

37–488 CC WASHINGTON : 1997

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-054340-7

COMMITTEE ON WAYS AND MEANS

BILL ARCHER, Texas, *Chairman*

PHILIP M. CRANE, Illinois
BILL THOMAS, California
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
JIM BUNNING, Kentucky
AMO HOUGHTON, New York
WALLY HERGER, California
JIM McCRERY, Louisiana
MEL HANCOCK, Missouri
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
DICK ZIMMER, New Jersey
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
PHILIP S. ENGLISH, Pennsylvania
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska

SAM M. GIBBONS, Florida
CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ANDY JACOBS, JR., Indiana
HAROLD E. FORD, Tennessee
ROBERT T. MATSUI, California
BARBARA B. KENNELLY, Connecticut
WILLIAM J. COYNE, Pennsylvania
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
L.F. PAYNE, Virginia
RICHARD E. NEAL, Massachusetts

PHILLIP D. MOSELEY, *Chief of Staff*
JANICE MAYS, *Minority Chief Counsel*

SUBCOMMITTEE ON HEALTH

BILL THOMAS, California, *Chairman*

NANCY L. JOHNSON, Connecticut
JIM McCRERY, Louisiana
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska
PHILIP M. CRANE, Illinois
AMO HOUGHTON, New York
SAM JOHNSON, Texas

FORTNEY PETE STARK, California
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia

CONTENTS

	Page
Advisory of April 18, 1995, announcing the hearing	2

WITNESSES

U.S. Department of Health and Human Services, Kathleen A. Buto, Associate Administrator for Policy, Health Care Financing Administration	10
U.S. Department of Health Human Services, George F. Grob, Deputy Inspector General for Evaluation and Inspections, Office of the Inspector General	77

American Academy of Orthopaedic Surgeons, James Strickland, M.D	118
American College of Radiology, Emmett O. Templeton, M.D	128
American Group Practice Association, Alexandria, VA, Donald C. Balfour III, M.D.	49
American Hospital Association, Gail Warden, Henry Ford Health System, Detroit, MI	33
American Managed Care and Review Association, Phil Griffin	60
American Medical Association, Lonnie R. Bristow, M.D.	26
American Physical Therapy Association, Alexandira, VA:	
Connolly, Jerome B.	137
Weinper, Michael	133
American Society of Internal Medicine, Cecil Wilson, M.D.	98
Balfour, Donald C. III, M.D., American Group Practice Association, Alexandira, VA	49
Bristow, Lonnie R. M.D., American Medical Association	26
Connolly, Jerome B., American Physical Therapy Association, Alexandria, VA	137
Federated Ambulatory Surgery Association, Alexandria, VA, Bernard A. Kershner	108
Griffin, Phil, Preffered One, MN, on behalf of, American Managed Care and Review Association	60
Henry Ford Health System, Detroit, MI, Gail Warden	33
Kershner, Bernard A., Federated Ambulatory Surgery Association, Alexandria, VA	108
Medical Group Management Association, Englewood, CO, Frederick J. Wenzel,	39
Mentz, Keith, National Renal Administrators Association	113
Mitchell, Jean M.,	144
National Renal Administrators Association, Keith Mentz	113
Physicians for Quality Outpatient Infusion Therapy, Alan D. Tice, M.D.	104
Strickland, James, M.D., American Academy of Orthopaedic Surgeons	118
Templeton, Emmett O., M.D., American College of Radiology	128
Tice, Alan D., M.D., Physicians for Quality Outpatient Infusion Therapy	104
Warden, Gail, Henry Ford Health System, Detroit, MI, on behalf of American Hospital Association	33
Weinper, Michael, American Physical Therapy Association, Alexandria, VA	133
Wenzel, Frederick J., Medical Group Management Association, Englewood, CO	39
Wilson, Cecil B., M.D., American Society of Internal Medicine	98

Page

SUBMISSIONS FOR THE RECORD

American Academy of Neurology, statement 159
American Academy of Opthalmology, William Rich, M.D., statement 161
American Academy of Otolaryngology, statement 163
American Academy of Physical Medicine and Rehabilitation, statement 166
American Association for Clinical Chemistry, Inc., Peter Wilding, letter 168
American Clinical Laboratory Association, statement 169
American College of Radiation Oncology, Oak Brook, IL, statement 172
American College of Surgeons, Chicago, IL, Paul A. Ebert, M.D., letter 174
American Federation of State, County and Municipal Employees, Diane Burke; Leon Shull, Americans for Democratic Action; Jeff Jacobs, American Public Health Association; Arthur Levin, Center for Medical Consumers; Judith Stein Hull, Center for Medicare Advocacy; Cathy Hurwit, Citizen Action; Mern Horan, Consumer Federation of America; Gail Shearer, Consumers Union; Sandra Harding, National Association of Social Workers; Laura Wittkin, National Center for Patients Rights; Martha A. McSteen, National Committee to Preserve Social Security and Medicare; Linda Golodner, National Consumers League; Jon Lawniczak, National Council of Senior Citizens; Blair Horner, New York Public Interest Research Group; Charles Inlander, Peoples' Medical Society; Lauren Dame, Public Citizen's Health Research Group; Ned McCullough, Service Employees International Union; Patrick Conover, United Church of Christ, Office for Church in Society; Anne Werner, United Seniors Health Cooperative; Edmund Mierzwinski, U.S. Public Interest Research Group, joint letter 175
American Occupational Therapy Association, statement 178
American Pharmaceutical Association, statement 181
American Public Health Association, Jeff Jacobs, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
American Society of Echocardiography, Raleigh, NC, statement 183
American Urological Association, Inc., Baltimore, MD, statement 185
Americans for Democratic Action, Leon Shull, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Association of American Medical Colleges, Jordan J. Cohen, M.D., letter 186
Berger, Edward E., National Medical Care, Inc., statement 209
Burke, Diane, American Federation of State, County and Municipal Employees, joint letter 175
Caretenders Healthcorp, Louisville, KY, William B. Yarmuth, statement 188
Center for Medical Consumers, Arthur Levin, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Center for Medicare Advocacy, Judith Stein Hull, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Citizen Action, Cathy Hurwit, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Cohen, Jordan J., M.D., Association of American Medical Colleges, letter 186
Conover, Patrick, United Church of Christ, Office for Church in Society, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Consumer Federation of America, Mern Horan, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Consumers Union, Gail Shearer, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Dame, Lauren, Public Citizen's Health Research Group, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Ebert, Paul A., M.D., American College of Surgeons, Chicago, IL, letter 174
Freeman, Todd I., Larkin, Hoffman, Daly & Lindgren, Ltd., Bloomington, MN, letter 201
Golodner, Linda, National Consumers League, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Group Health Association of America, statement 192
Harding, Sandra, National Association of Social Workers, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175

Page

Horan, Mern, Consumer Federation of America, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Horner, Blair, New York Public Interest Research Group, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Hurwit, Cathy, Citizen Action, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Inlander, Charles, Peoples' Medical Society, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Jacobs, Jeff, American Public Health Association joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Joint Council of Allergy, Asthma and Immunology, statement 195
Kidney Disease and Critical Care, Minneapolis, MN, Frank J. Tycast, M.D., letter 197
Koop, C. Everett, M.D., Bethesda, MD, letter 200
Larkin, Hoffman, Daly & Lindgren, Ltd., Bloomington, MN, Todd I. Freeman, letter 201
Lawniczak, Jon, National Council of Senior Citizens, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Levin, Arthur, Center for Medical Consumers, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
McCullough, Ned, Service Employees International Union, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
McSteen, Martha A., National Committee to Preserve Social Security and Medicare, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Mierzwinski, Edmund, U.S. Public Interest Research Group, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
National Association for Medical Equipment Services, statement 204
National Association of Chain Drug Stores, statement 207
National Association of Social Workers, Sandra Harding, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
National Center for Patients Rights, Laura Wittkin, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
National Committee to Preserve Social Security and Medicare, Martha A. McSteen, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
National Consumers League, Linda Golodner, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
National Council of Senior Citizens, Jon Lawniczak, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
National Medical Care, Inc., Edward E. Berger, statement 209
Neumann, Albert C., M.D., Outpatient Opthalmic Surgery Society, statement 218
New York Public Interest Research Group, Blair Horner, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Outpatient Opthalmic Surgery Society, Albert C. Neumann, M.D., statement . 214
Peoples' Medical Society, Charles Inlander, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Public Citizen's Health Research Group, Lauren Dame, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Rich, William, M.D., American Academy of Opthalmology, statement 161
Service Employees International Union, Ned McCullough, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Shearer, Gail, Consumers Union, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Shull, Leon, Americans for Democratic Action, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Stein Hull, Judith, Center for Medicare Advocacy, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Surgical Care Affiliates, Inc., statement 217

Page

Tycast, Frank J., M.D., Kidney Disease and Critical Care, Minneapolis, MN, letter 197
U.S. Public Interest Research Group, Edmund Mierzwinski, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
United Church of Christ, Office for Church in Society, Patrick Conover, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
United Seniors Health Cooperative, Anne Werner joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Wilding, Peter, American Association for Clinical Chemistry, Inc., letter 168
Wittkin, Laura, National Center for Patients Rights, joint letter, (see listing for American Federation of State, County and Municipal Employees) 175
Yarmuth, William B., Caretenders Healthcorp, Louisville, KY, statement 188

PHYSICIAN SELF-REFERRAL

WEDNESDAY, MAY 3, 1995

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

The Subcommittee met, pursuant to call, at 9:30 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
April 18, 1995
No. HL-9

CONTACT: (202) 225-3943

THOMAS ANNOUNCES HEARING ON PHYSICIAN SELF-REFERRAL

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 Physician Self-Referral. **The hearing will take place on Wednesday, May 3, 1995, in the main committee hearing room, 1100 Longworth House Office Building, beginning at 9:30 a.m.**

Oral testimony at this hearing will be heard from invited and public witnesses. Any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) barred physicians from referring a Medicare patient for clinical laboratory services to a medical facility in which a physician has a financial interest. The law included exceptions to the ban in order to accommodate certain business arrangements. The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) expanded the restrictions to a range of additional health services and made the law applicable to Medicaid as well as Medicare.

Although the law is in effect, final regulations have yet to be issued on OBRA 1989 provisions and neither a proposed rule nor final rule has been issued on the restriction to other designated services included in OBRA 1993.

In announcing the hearing, Chairman Thomas said, "Without regulations, compliance with the self-referral laws isn't just a challenge, it's almost impossible. Furthermore, the law needs review because its prohibitions may be at odds with important efforts to encourage physicians to participate in more cost effective managed care arrangements."

FOCUS OF THE HEARING:

This hearing will examine problems associated with compliance with the self-referral provisions in the Social Security Act, the obstacles the law in its current form may present to physicians, hospitals, and health plans which are forming legitimate managed care arrangements, and will explore alternative methods of controlling the fraudulent and abusive referrals the law was intended to prevent.

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, Wednesday, May 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 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. The Subcommittee will come to order, please. Today the Health Subcommittee continues its review of Medicare policy with its hearing on physician self-referral. The original physician self-referral legislation was designed to respond to concerns over abuses, some real, some theoretical, arising from joint ventures between commercial clinical laboratories and joint venture partners, who were referring physicians. The intent of the legislation was to prohibit certain joint ventures, while attempting to allow limited exceptions for legitimate commercial arrangements.

Before the HCFA, Health Care Financing Administration, implemented this first physician self-referral limitation, the law was greatly expanded by the OBRA, Omnibus Budget Reconciliation Act of 1993. OBRA 1993 includes prohibitions on financial arrangements which encompass the majority of therapeutic and diagnostic services provided to Medicare and Medicaid patients.

The new law goes beyond the original concern with abusive joint ventures by adding detailed regulation of the internal workings of physician group practices, hospital, medical schools, and entities that employ or contract with practicing physicians. The two major changes have raised concerns that the law now may be overreaching, perhaps too complex, and too intrusive. Proof of the complexity is illustrated in HCFA's apparent difficulty to develop a final rule for the 1989 law and promulgate even proposed implementing regulations for the OBRA 1993 amendments today almost 2 years after enactment.

Further, concerns have been raised that the OBRA amendments have had a chilling effect on legitimate and worthwhile physician participation in the emerging competitive health care marketplace. In some ways the law perhaps may already be antiquated. Managed care is a reality for the private sector and is growing rapidly for public programs and simply does not have the same incentive structure which physician self-referral law was designed to limit.

Today, we will hear about the difficulties of developing the physician self-referral regulations and from witnesses who have tried to understand the law and apply it to routine physician employment and contracting situations. We should learn today whether the physician self-referral law is relevant and what should be modified, if anything, to make it more compatible with appropriate innovations in the delivery of medical care to Medicare beneficiaries and to all Americans. I would call on my colleague, the Ranking Member, Stark I and Stark II.

Mr. STARK. Thank you, Mr. Chairman. If I promise to not use hardly any time at all in inquiring during the course of the day, maybe the Chair will indulge me for a little bit longer than usual in my opening statement from which I have tried to cross all of the phlegmatic and vitriolic phrases.

Chairman THOMAS. Would the gentleman yield?

Mr. STARK. I would be glad to yield.

Chairman THOMAS. With unanimous consent, if we could shorten the questioning period to 4 minutes for each Member, the time is yours.

Mr. STARK. I am sure that we have no objection. I have a prepared statement which I would like to be made a part of the record,

and I would like to concur with the Chair, disavow what is left of my good name from the legislation and see if I can bring the present situation into perspective.

It is true that I chaired this Subcommittee when this law was written, and I suspect tradition may have accorded me the dubious distinction of having the bill named after me. The idea for the bill was brought to us by the Inspector General in a Republican administration, and the bill was agreed to originally by the then Ranking Member and the Chair, and I believe fairly unanimously in the Subcommittee because there were abuses to the billing system in Medicare. There were detailed and voluminous studies made subsequent to the legislation, and initially or prior to the legislation, which indicated something like 50 percent higher usage and higher costs for clinical labs by doctors who owned a piece of the lab. We held off covering any other procedures until we had evidence.

I have got a room full of anecdotes somewhere around here from people who sent them in, but when we had studies, we went to some length to require certain detailed financial information from physicians and so forth. The AMA will tell you later today, as their usual revision of history, that they supported the law and said this practice was unethical. They came rather late to that.

First, they said that we ought not to restrict referral. Then they voted again and decided maybe it was unethical. We were here to protect, one, the Medicare patients and, two, the system and the trust fund.

I have always taken this position. Once we set a law down to restrict referral, we created a handbook for lawyers to find a way around the law. It wasn't really the law's fault. I have always believed that if we choose not to limit investment in facilities to which a physician refers, then we ought to just open it up and have sunshine.

If my son, as has happened, fell off a horse, had a concussion, and I had to deal with radiologists and neurosurgeons through the interpretation of his pediatrician, and the pediatrician spent hours telling me, a very distraught father, what was wrong with my son. I could make the case that perhaps that pediatrician should have had a cut of the radiologists' fee. If this is the case, institutionalize it and say, OK, we will pay a collaborative fee. The problem is that when we are spending the public's money on Medicare, we have to know what we are getting for that money, and to some extent we have a responsibility to protect the patient.

This is just some of the background. We received more evidence from the studies that there were further abuses—when I say abuses, I mean that there was empirical evidence in a broad scale documenting that where there was ownership there were higher costs and higher utilization than otherwise was the norm in the country. These were not anecdotal. This evidence came from studies.

We think there were savings approaching $1.5 billion by writing this law. We do not think that we were chasing a hollow specter. We think there were instances where this was necessary. I would like to see the law simplified if that is possible. I would lay the blame for the lack of simplification on hysterical lawyers drumming up business, quite frankly.

There are more seminars around that you can go to on Stark I and Stark II and pay thousands of dollars to lawyers who can over complicate. HCFA is remiss for not getting the regulations out. I want to commend the Chair for these hearings in the nature of oversight, but I urge you to not get swayed too much by the anecdotes which you will hear on both sides. The question, as the Chair has indicated, as we move to managed care, is whether there is a tendency to want to buy doctors' practices to get at the patient lists.

Is that a referral in reverse? Do we care? Does it impact on the patients? I do not know. I think those are questions to which we may want to know the answers. I just wanted to say that I do not think there are two positions or three positions in this issue. I think there are some people who have justifiable grievances because we, the government, the administration and the Congress have not simplified, sorted through, adjusted and revised the law in a timely manner.

I think the patients are ripped off every now and again, and I think some of the specialty groups lose their ability to make money because the doctors who control—the physical therapists, for instance, generally only get to practice their profession if doctors refer—only refer to themselves. If the doctor owns the practice, the physical therapists who are independent have a legitimate gripe.

I hope you will listen to all of the testimony today and not try and classify this as government regulation against entrepreneurs. It is more complex than that, and not each group is neither a charlatan nor a knight in shining armor. It is an area that is of concern, and I hope that we can urge HCFA to complete regulations much more rapidly. We can look at the regulations and then legislate to make the changes that you all feel are necessary. Thank you, Mr. Chairman. I yield back whatever time I have abused.

[The opening Statement follows:]

OPENING STATEMENT OF CONGRESSMAN PETE STARK
PHYSICIAN SELF-REFERRAL

Mr. Chairman:

Over the past 6 years, this Committee has approved and amended this legislation because we felt strongly that a physician's ability to buy and sell patients is bad for the public and bad for the patient.

Physician self-referral is bad for the public because it inevitably encourages unnecessary duplication and overutilization of facilities and services, producing an overall significant increase in cost to the patient. In 1993, when the physician self-referral law was expanded, CBO projected that the Medicare program would save $350 million dollars over five years.

These arrangements are bad for the patient because they violate the understood principle between patient and physician -- physicians should be paid only for the services to their patients which they provide directly or which they supervise. The physician should honor the fiduciary relationship that exists between physician and patient. These unethical arrangements give doctors powerful incentives to bend their professional judgment. Without laws to prohibit abusive arrangements, doctors will continue to drift toward the opinion that medicine is just a business, and patients are theirs to be bought and sold.

The physician self-referral law is nothing but a logical extension of what has traditionally been viewed as part of the physician's professional code of ethics. The AMA's Judicial Council itself has recognized that conflicts may arise when physicians derive economic benefits from commercial ventures involving their patients. The Institute of Medicine recognized the conflict of interest in 1986 when it stated: "It should be regarded as unethical and unacceptable for physicians to have ownership interests in health care facilities to which they refer patients."

In 1989, the OIG issued a study that found that patients of referring physicians who own or invest in independent clinical labs received 45% more clinical laboratory services than all Medicare patients in general. This study was only the beginning - study after study has documented the numerous abuses in this area. Researchers in Florida found that forty to forty-six percent of physicians in Florida owned an interest in a joint venture, and that referring physicians owned, in whole or in part over ninety percent of all diagnostic imaging centers, over seventy-five percent of all ambulatory surgical facilities, and about half of the radiation therapy centers and clinical laboratories in the state. These doctor-owners consistently ordered more tests and more expensive tests than non-owners.

Researchers in California found that physician owners of physical therapy centers referred patients for physical therapy more than twice as often as other physicians. A study of radiation therapy showed that patients with similar symptoms were at least four times more likely to have diagnostic imaging performed if a physician self-referred.

The studies go on and on ...

I believe that, as with any major piece of legislation, clarifications may be required after enactment. But let me be clear -- the documented abuses in this area have convinced me that at this time, patients need protection more than doctors need the income. I hope that the revisitation of this issue is motivated solely by an interest to perfect the law and not to repeal it.

The delay in releasing the regulations has contributed to both the confusion of the doctors and to the bank accounts of the lawyers. It is unacceptable that it has taken HCFA over five years to release the regulations for the initial self-referral law. The regulations for the other designated health services must be released in a more timely manner -- this summer at the latest.

There are areas of confusion. For example, several physicians have called asking why they are prohibited from giving a patient with a broken leg a set of crutches in his office. This is an example of an unintended consequence. Let's work together to fix this problem quickly. I've also heard that the law has been interpreted to prohibit physicians from providing eyeglasses or IOLs after cataract surgery. Well, if this is what is happening, we need to clarify the law.

Some of the concerns that I hear are valid -- most of the concerns result from very imaginative lawyers. Unfortunately, the ability of lawyers to be "creative" has resulted in wide-spread hysteria about the impact of this law.

I agree that some clarifications are needed, but let me cite just an example or two of the suggested changes that have been sent to my office. One organization suggests that we repeal all reporting requirements. Well, let's imagine this scenario for just a moment. If we said to physicians, "O.K. -- We'll trust you - don't report your financial interests." I don't have much faith that doctors would comply with the law without reporting requirements. How would HCFA or OIG know if anyone was ever in violation?

Another interesting suggestion provided by an organization requests that we eliminate seven of the designated health services. Well, if we do that, most of the law has been eliminated. We might as well repeal the entire thing and return to unbridled over-utilization and over-treatment of patients.

What I suggest is that we look at the overwhelming evidence of abuse in this area. We must clarify where necessary without creating loopholes that would essentially negate the law.

Last year, we worked extensively with a number of provider groups and organizations to draft amendments during health reform that unfortunately did not pass. The American Group Practice Association was very helpful in drafting a clearer definition of "group practice" for example, and I would hope that we would consider a number of the clarifications addressed last year.

Physicians can act as stronger advocates for their patients if they do not refer patients to entities in which they have a financial interest -- it is, simply put, a conflict of interest. Independent physicians are more likely to provide neutral advice, and more apt to be sensitive to the needs of patients if they have to earn their referrals through their reputation for quality.

Physician self-referral has no inherent social value, biases the judgment of physicians, and compromises their loyalty. Physicians are only human. If a doctor has an outside financial interest, there is always the risk that his or her professional judgment will be unduly influenced. Dr. Arnold Relman said it best in 1989 – "We cannot make individual physicians more ethical by making laws or regulations, but we certainly can legislate against economic arrangements that tempt them into undesirable behavior."

Chairman THOMAS. I Thank the Ranking Member very much. I am very pleased with the tone of the opening remarks because it clearly was not our intention in moving forward in this area to create more problems. It is an attempt to understand and solve problems.

I think everyone agrees in an a priori way that where someone has an ability for self-aggrandizement simply by patronizing their own actions, their is the potential for problems. Our concern is with the manner in which it was constructed, the methodology of the materials supporting the positions that were taken, and the difficulty in getting some of the regulations formulated. The witness that will be with us shortly, I think, will commiserate with us in terms of the difficulties of putting the package together. And that the goal of this hearing is, to improve product, not to eliminate product.

And with that, I would ask our first witness, Kathy Buto, who is the highest career person in HCFA, if you have a written statement, we will place it in the record without objection, and you may proceed in any way you see fit to inform us, Ms. Buto.

STATEMENT OF KATHLEEN A. BUTO, ASSOCIATE ADMINISTRATOR FOR POLICY, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. BUTO. Thank you very much, Mr. Chairman, and Members of the Subcommittee. I am here to discuss HCFA's implementation of the physician self-referral prohibitions found in section 1877 of the Social Security Act, and I am going to keep my remarks short and ask that my written testimony be entered into the record.

The Clinton administration has been working on a number of initiatives to control fraud and abuse in the Medicare and Medicaid Programs. In fact, we will soon be announcing a comprehensive proposal for program integrity as part of our effort to reinvent government. Preventing inappropriate utilization through a prohibition on self-referrals is just one component of our campaign.

This morning, I will discuss why we believe there is a need for self-referral limitations, and review the legislative history and our regulatory activity. Self-referral is the term used to describe a patient referral made by a physician to an entity with which the physician or family member has a financial relationship.

The relationship may be an ownership or investment interest or a compensation arrangement. The American Medical Association estimates the number of physicians with financial interests in health facilities at about 7 percent. Other studies cite numbers as high as 40 percent.

A 1989 study from the Office of Inspector General of the Department of Health and Human Services found that Medicare patients of referring physicians who owned or invested in independent clinical laboratories received 45 percent more lab services than Medicare patients in general. This increased utilization cost the Medicare Program an estimated $28 million in 1987.

Aside from the cost containment issues posed by self-referral patterns, inappropriate utilization may result in health hazards. Broadly stated, beneficiaries caught in these referral patterns may

be subject to unnecessary medical procedures and/or high cost, lower quality care. Ethicists and legal scholars have argued that self-referral creates an unnecessary conflict of interest.

Physicians are members of a profession that is characterized by binding ethical obligations and a unique responsibility to care for patients who are presented to them. Indeed, the AMA has stated that physicians, "have different and higher duties than even the most ethical businessperson."

Patients depend on their physicians to guide them in making health care decisions, yet when physicians stand to benefit financially from referrals made for certain health care services, it raises questions about whether the referral is being made because of medical necessity or financial interest.

As early as 1986, the Institute of Medicine strongly condemned physician self-referral in its examination of for-profit enterprise in health care, citing among other things the unique and vulnerable position that patients are in while making health care decisions.

In December 1992, after considerable debate the AMA took a firm stand against self-referral, recommending only one limited exception for community need when alternative financing is not available. Their Council on Ethical and Judicial Affairs stated that physicians have a special fiduciary responsibility to their patients and "there is some activities involving their patients that physicians should avoid, whether or not there is evidence of abuse."

Prohibitions on self-referrals were created in the context of a traditional fee-for-service Medicare system where there are no incentives for providers to control utilization. In a managed care arrangement that uses capitated payments the implications of self-referral practices change considerably. It is highly unlikely that physicians who are receiving a capitated payment would actually refer for unnecessary services.

Accordingly, there is an exception for prepaid health plans that contract with Medicare, including risk and cost-based Medicare contractors. Therefore, we do not see these provisions as an impediment to the development of legitimate Medicare managed care arrangements.

The initial prohibition on physician self-referrals was created in the Omnibus Budget Reconciliation Act of 1989, and applied to clinical laboratories in the Medicare Program. The law has subsequently been modified in every piece of major Medicare legislation that has passed since its creation—OBRA 1990, OBRA 1993, and the Social Security Act amendments of 1994.

OBRA 1993 made the most significant changes by adding a list of 10 additional designated health services expanding and clarifying the exceptions and applying certain aspects of the law to Medicaid referrals. Because of its exceptions, the current law is complicated. However, the essence of the prohibition is clear if a physician or a family member has a financial relationship with an entity that furnishes items or services on the list, then he or she cannot refer Medicare or Medicaid patients to that entity.

Unlike the antikickback statute, the law is triggered by the mere fact that a financial relationship exists. The intention of the referring physician is not taken into consideration. The provisions state

that the relationship may be through an ownership or investment interest or a compensation arrangement.

The ownership or investment interest may be through debt, equity or other means or an interest in an entity that holds such an interest. The compensation arrangement is defined as any remuneration between the physician or immediate family member and the entity that does not fit within the specified exceptions.

OBRA 1989 provisions and many of the OBRA 1993 provisions that apply to the exceptions for clinical labs became effective for referrals occurring on or after January 1, 1992. OBRA 1993 provisions that apply to referrals for designated health services became effective January 1, 1995.

Although some inappropriate utilization may exist, Congress created a number of exceptions in recognition of existing business practices, the in-office ancillary services exception is perhaps the most important exception. It exempts physicians, both group practices and solo practitioners with ownership and/or compensation arrangements from self-referral ban from most services provided in their offices if they meet a set of requirements.

The statute also prohibits an entity from billing or influencing billings to Medicare or Medicaid, the beneficiary or anyone else for a designated health service resulting from a prohibited referral. Under the Medicaid Program the Federal Government cannot pay Federal financial participation to a State for medical assistance that is furnished as a result of a referral that would be prohibited under Medicare if Medicare covered the service in the same way as a State Medicaid Program.

If a person collects any amount for services billed in violation of the law, he or she must make a timely refund. A person can be subject to a civil money penalty or exclusion from Medicare, Medicaid or other programs violating these provisions.

Let me turn to the regulations. We are faced with twin challenges as we try to implement this law. First, while the basic concept is simple, the legislative process created complicated exceptions. Adequately defining these exceptions has proven to be a daunting task that has played an important role in the development of the accompanying regulations.

Second, the repeated modifications of the underlying legislation that I mentioned earlier have further delayed and complicated issuance of the implementing regulations. We are issuing two separate rules. The first for provisions that are related to referrals for clinical lab services, and the second for provision of the designated health services.

The proposed rule for the original legislation was published in spring 1992. We have received more than 300 comments on the proposed rule, many of which included multiple technical questions, each of which needed to be addressed in detail. These comments included detailed descriptions of practical considerations that required recognition in the rule.

Most responses to these comments needed to be recast or entirely rewritten after the OBRA 1993 changes. In addition, we have spent a significant amount of time meeting with and talking with individual practitioners, providers, their attorneys, and industry associations in an attempt to deal fairly and proactively with issues that

are raised by the law and subject to interpretation in the regulations. Many of these discussions have focused on reviewing individual situations that do not fit clearly within one of the stated exceptions, but which have the same or similar situations as those provided for in the exceptions.

Thus, the final rule for self-referral provisions for clinical lab services is under review, and we hope to publish it shortly. The rule contains many definitions and interpretations that will apply to referrals for all designated health services. As a result, we expect it to answer many questions for situations prohibited under the law as currently written.

In addition, our conversations with the provider community have also dealt with interpretation of the changes made in OBRA 1993. These outreach efforts have helped us prepare for the development of the second set of regulations. Once the final rule is published, we hope to publish a proposed rule for the remaining provisions that are related to the designated health services within a few months. At this point, we estimate we will publish the proposed rule by the end of the summer.

As I am sure you know, the provider community is concerned about enforcement. We do not have discretion to alter the effective dates, and while we recognize that the complexity of the law raises many questions about how it is to be applied, it is nonetheless in effect. We intend to implement the law using the least burdensome manner that will still allow for effective enforcement.

As we stated in a summary that we sent to provider groups, Medicare carriers, and fiscal intermediaries and other interested groups in January, we will begin compliance audits once the final rule for clinical labs is published. In addition, we will investigate reported abuses.

In summary, we feel that appropriate referral guidelines are necessary to preserve the integrity of the programs that we oversee. As I mentioned earlier, we are in the process of implementing a cost-effective effort to combat fraud and abuse in the Medicare and Medicaid Programs. Limiting abusive self-referrals is and should remain an integral part of that effort. I am happy to take questions, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF KATHLEEN A. BUTO, ASSOCIATE ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and members of this subcommittee, I am here this morning to discuss HCFA's implementation of the physician self-referral prohibitions that are found in section 1877 of the Social Security Act.

The Clinton Administration has been working on a number of initiatives to control fraud and abuse in the Medicare and Medicaid programs. In fact, we will soon be announcing our comprehensive proposal for program integrity as part of our Reinventing Government efforts.

Preventing inappropriate utilization through a prohibition on self-referrals is one part of our coordinated effort to fight fraud and abuse. Today I will be focusing on the self-referral provisions, as you requested, and not the anti-kickback provisions, which are frequently confused with self-referral.

I would like to recognize the interest and responsibility of this Subcommittee in the development and passage of these provisions. I will begin by presenting a bit of background information, discussing the research and related ethical issues which form the basis for why we believe self-referral limitations are needed; following this, I'll briefly summarize the law and our regulatory activity.

BACKGROUND AND RESEARCH

Self-referral is the term used to describe a patient referral made by a physician to an entity with which the physician or a family member has a financial relationship; the relationship may be an ownership or investment interest or a compensation arrangement.

Physicians who invest in health care entities are likely to have ownership or investment interests in magnetic resonance imaging (MRI) centers, other diagnostic imaging facilities, clinical laboratories, ambulatory surgical centers, or physical therapy facilities. Hospital-physician joint ventures are also a common form of financial relationship; the General Accounting Office (GAO) estimates that 18 percent of non-profit hospitals were participating in joint ventures with physicians in 1991.

The American Medical Association (AMA) estimates the number of physicians with financial interests in health facilities at about seven percent, although others cite higher numbers. For example, a 1991 study that examined the prevalence and scope of physician joint ventures in Florida found that at least 40 percent of Florida physicians involved in direct patient care had an investment in a health care business to which they could--in the absence of prohibiting legislation--refer patients for services.[1] However, some have suggested that increased examination of self-referral arrangements and enactment of both Federal and State laws prohibiting such arrangements has led to a decline in self-referral activity and financial relationships between physicians and entities.

In 1989, a study from the Office of Inspector General (OIG) of the Department of Health and Human Services found that Medicare patients of referring physicians

---

[1] "Joint Ventures Among Health Care Providers in Florida," State of Florida Cost Containment Board (September, 1991)

who owned or invested in independent clinical laboratories received 45 percent **more** lab services than Medicare patients in general.[2] OIG estimated that this increased utilization cost Medicare $28 million in 1987. While this report does not examine medical necessity, it clearly shows a significant deviation from general medical practice. More importantly, it illustrates the need for provisions that limit the acceptability of unnecessarily costly referral patterns.

In past hearings on this topic, this Subcommittee has heard testimony from academic researchers in Florida and from the GAO and the OIG, among others, that consistently cited problems in referral patterns for physicians who have financial relationships with the entities to which they refer patients. The problems include increased utilization, increased use of costly services, and, in some cases, higher charges per procedure, decreased access, and lower quality (e.g., less time spent with the patient or patient care is provided by health care personnel with less training). Broadly stated, beneficiaries caught in these referral patterns may be subject to unnecessary medical procedures and/or high-cost, lower quality care.

Aside from the cost-containment issues posed by self-referral patterns, inappropriate utilization may result in health hazards. Each time certain medical procedures are performed, patients could be exposed to an increased risk of injury. One study of physician ownership actually showed that the frequency and costs of radiation therapy treatments at free-standing centers were 40 to 60 percent higher in Florida than in the rest of the United States, yet Florida did not have higher cancer rates and the hospitals in the study did not have below-average use of radiation therapy to explain the higher use or higher cost.[3]

ETHICAL ISSUES

Ethicists and legal scholars have argued that self-referral creates an unnecessary conflict of interest without providing any significant benefits. Physicians are members of a profession that is characterized by binding ethical obligations and a unique responsibility to care for patients who are presented to them. Indeed, AMA has stated that physicians "have different and higher duties than even the most ethical businessperson."[4] Physicians direct the purchase of health care services. Patients depend on their providers to guide them in making health care decisions. Yet, physicians investing in health care services that they refer to, at a minimum, raise perception concerns as to whether the referral is being made because of medical necessity or financial interest.

---

[2]"Financial Arrangements Between Physicians and Health Care Businesses," Office of the Inspector General, OAI-12-88-01410 (May 1989)

[3]Mitchell JM, Sunshine JH; New England Journal of Medicine, 1992; 327:1497-1501

[4]"Conflicts of Interest: Physician Ownership of Medical Facilities," Council on Ethical and Judicial Affairs, American Medical Association, JAMA, May 6, 1992:2366-2369.

As early as 1986, the Institute of Medicine condemned physician self-referral in its examination on for-profit enterprise in health care. Describing the patients' vulnerability in health care decision making, Brock and Buchanon[5] state that patients are especially vulnerable for two reasons: first, they lack the special knowledge required to judge the necessity of the recommended or provided service; second, the presence of illness or injury may make it difficult for the patient to engage in the type of self-protective bargaining behavior typically expressed in the admonition "caveat emptor," or "let the buyer beware." The report stressed that "Only if one believes that medical training renders physicians impervious to the effects of economic incentives or that patients can adequately cope with physicians' conflicts of interest can one be indifferent to economic conflicts of interests resulting from physicians' investments."

In December 1992, after considerable debate, the AMA voted to declare self-referral unethical, with a few exceptions. One year earlier, the AMA's Council on Ethical and Judicial Affairs had concluded that physicians should not refer patients to a health care facility outside their office at which they do not directly provide services when they have an investment interest in the facility. Exceptions are allowed if there is a demonstrated need in the community and alternative financing is not available. The Council stated that physicians have a special fiduciary responsibility to their patients and that "there are some activities involving their patients that physicians should avoid whether or not there is evidence of abuse."

SELF-REFERRAL AND MANAGED CARE

Prohibitions on self-referrals were created in the context of a traditional fee-for-service system, where there are no incentives for providers to control utilization. In a managed care arrangement that uses capitated payments, the implications of self-referral practices change considerably. It is highly unlikely that physicians who are receiving a capitated payment would actually refer for unnecessary services.

Accordingly, there is an exception for prepaid health plans under Medicare, including risk- and cost-based Medicare contractors. Therefore, we do not see these provisions as an impediment to the development of legitimate Medicare managed care arrangements.

LEGISLATIVE HISTORY AND SUMMARY OF LAW

Prohibitions on physician self-referrals were first enacted in the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), when Congress amended Title XVIII of the Social Security Act to prohibit the referral of Medicare patients to clinical laboratories by physicians who have a financial relationship with those laboratories (or whose immediate family members have such a relationship), unless they qualified for one of the many exceptions.

---

[5]Brock D, Buchanon A, "Ethics of For-Profit Health Care," For-Profit Enterprise in Health Care, Gray BH, ed., National Academy Press, 1986.

The law has subsequently been modified in every piece of major Medicare legislation that has passed since its creation: OBRA 90, OBRA 93, and the Social Security Act Amendments of 1994 (SSAA 94). OBRA 90 and SSAA 94 included technical corrections and other changes, while OBRA 93 expanded the scope of the law by adding a list of ten additional designated health services, expanding and clarifying the exceptions, and applying certain aspects of the law to referrals for Medicaid services.

Health care reform deliberations during the 103rd Congress also re-evaluated the self-referral provisions. Proposals to create different exceptions, modify the list of covered services and even extend the self-referral provisions to all payers were among the changes that were considered in various bills.

Because of its exceptions, the current law **is** complicated. However, the essence of the prohibition is clear: If a physician or a family member has a financial relationship with an entity that furnishes items or services on the list, then he or she cannot refer Medicare or Medicaid patients to that entity. Unlike the anti-kickback statute, the law is triggered by the mere fact that a financial relationship exists; the intention of the referring physician is not taken into consideration.

The provisions state that the relationship may be through an ownership or *investment interest or a compensation arrangement*. The *ownership or investment* interest may be through debt, equity or other means, or an interest in an entity that holds such an interest; the compensation arrangement is defined as any remuneration that does not fit within certain narrow exceptions between the physician (or immediate family member) and the entity. OBRA 89 provisions became effective for referrals occurring on or after January 1, 1992; many of the OBRA 93 provisions that applied to the exceptions for clinical labs were retroactive to January 1, 1992. OBRA 93 provisions that apply to referrals for designated health services became effective January 1, 1995.

Following is the list of designated health services that are covered under the self-referral ban:

-clinical laboratory services;
-physical therapy services;
-occupational therapy services;
-radiology services (including MRI, CAT scans and ultrasound);
-radiation therapy services and supplies;
-durable medical equipment and supplies;
-parenteral and enteral nutrients, equipment and supplies;
-prosthetics, orthotics, and prosthetic devices and supplies;
-home health services;
-outpatient prescriptions drugs; and
-inpatient and outpatient hospital services.

Although some inappropriate utilization may exist, Congress created a number of exceptions in recognition of existing business practices. While the Secretary has authority under Section 1877 to create new exceptions, we must first determine, and

specify in regulations, that any new exception will not pose a risk of program or patient abuse.

The in-office ancillary services exception is perhaps the most important exception. It exempts physicians (both group practices and solo practitioners) with ownership and/or compensation arrangements from the self-referral ban for most services provided in their offices if they meet a set of requirements. There are 14 additional exceptions, including ones for prepaid health plans, rural providers, and isolated financial transactions.

The statute also prohibits an entity from billing Medicare, Medicaid, the beneficiary or anyone else for a designated health service resulting from a prohibited referral. Under the Medicaid program, the Federal government cannot pay Federal financial participation to a State for medical assistance that is furnished as the result of a referral that would be prohibited under Medicare, if Medicare covered the service in the same way as the State Medicaid program. If a person collects any amount for services billed in violation of the law, he or she must make a timely refund. A person can be subject to civil money penalties or exclusion from Medicare, Medicaid and other programs if that person: (1) presents or causes to be presented a claim to any payer for a service that the person knows or should know is a result of a prohibited referral, or (2) fails to make a timely refund. The maximum penalty is $15,000 for each service.

If a physician or entity enters into a circumvention scheme (such as a cross-referral arrangement), which the physician knows or should know has a principal purpose of assuring referrals to a particular entity that would be prohibited if made directly, the participating providers could be subject to civil money penalties of not more than $100,000 for each scheme and exclusion from Medicare, Medicaid and other programs.

As of October 1994, 27 states have enacted legislation that restricts or qualifies self-referral. There is great variation among the states. Some only require disclosure of the financial relationship to the patient, while others prohibit such referrals.

REGULATIONS

We are faced with twin challenges as we try to implement this law. While the basic concept is simple, the legislative process created complicated exceptions. Adequately defining these exceptions has proven to be a daunting task. The resulting issues have played an important role in the development of the accompanying regulations. In addition, the repeated modifications to the underlying legislation that I mentioned earlier have further delayed and complicated the development of the implementing regulations.

Due to the order in which they were enacted and in which work began on them, we are issuing two separate rules: one for the provisions that are related to referrals for clinical lab services and one for the provision of the designated health services.

The proposed rule for the original legislation was published in the Spring of 1992. We received more than 300 comments on the proposed rule, many of which included multiple, technical questions and each of which needed to be addressed in detail. These comments included descriptions of practical considerations that we needed to weigh in order to achieve an appropriate balance.

In addition, we have spent a significant amount of time meeting with and talking to individual providers, their attorneys and industry associations in an attempt to deal fairly and proactively with issues that are raised by the law and subject to interpretation in the regulations. Many of these discussions have focused on reviewing individual situations that do not fit clearly within one of the stated exceptions, but which have the same or similar situations as those that are provided for in the exceptions.

The final rule for the self-referral provisions for clinical lab services is under review and we hope to be able to publish it shortly.

The final rule on referrals to clinical laboratories will contain many definitions and interpretations that will also apply to referrals for all designated health services. As a result, we expect the rule to answer many questions for situations that are prohibited under the law as it is currently written. In addition, conversations with the provider community have also addressed questions relating to the interpretation of the OBRA 93 expansion; these outreach efforts have helped us prepare for the development of the second set of regulations. Once the first final rule is published, we hope to publish a proposed rule for the remaining provisions that are related to the designated health services within a few months. At this point, we estimate that we will publish the proposed rule for these provisions by the end of Summer.

ENFORCEMENT

As I am sure you know, the provider community is concerned about enforcement. We do not have discretion to alter the effective dates and, while we recognize that the complexity of the law raises many questions about how it is to be applied, it is nonetheless in effect. We feel that the spirit of the law is clear: physicians who want to continue to refer patients to entities with which they have financial relationships must fit within one of the exceptions. We intend to implement the law using the least burdensome manner that will still allow for effective enforcement. As we stated in a summary that we sent to provider groups, Medicare carriers and fiscal intermediaries, and other interested groups in January, we will begin compliance audits once the final rule for clinical laboratories is published. In addition, we will investigate reported abuses.

CONCLUSION

Appropriate referral guidelines are necessary to preserve the integrity of the programs that we oversee. While the basic concept of a self-referral prohibition is simple, the various statutory exceptions are complex, and in some cases difficult to interpret. Because the self-referral ban does not apply within the context of Medicare managed care, we do not believe that these provisions hamper the development of managed care in the Medicare program. As I mentioned earlier, we are in the process of implementing a cost-effective effort to combat fraud and abuse in the Medicare and Medicaid programs. Provisions limiting self-referral are, and should remain, an integral part of that effort.

Chairman THOMAS. Mrs. Johnson.

Mrs. JOHNSON of Connecticut. Thank you, Mr. Chairman. Thank you, Ms. Buto, for your testimony. Certainly Congress' role in the development of law in this area has not made it easy for HCFA to develop regulations, and I appreciate the time and effort that you have put in to listen to and respond to real world people out there affected by this law.

My questions are going to go to my belief that managed care is a form of delivering health care services that is in the process of evolving. I personally believe that physician-developed networks that give physicians more voice are going to be a better answer than some of the other networks developed by institutions or business organizations. But this law has slowed the evolution of physician-developed networks. That concerns me very much.

For instance, current law provides an exception for physician ownership and referral to the extent that the physician's relationship is with a federally qualified HMO. Now, of course, we have to do that.

What happens and how do your regulations address a State-qualified plan, and then how does it deal with not an HMO relationship, but a managed care relationship, and in your experience, because at this point you probably have more experience than anyone in the whole room, having talked to a lot of these people, what do you think will be the impact of your regulations on the ability of physicians to develop independent networks that then could negotiate with insurance companies or hospitals or other elements in the system to assure physician-voiced integrated care delivery systems?

Ms. BUTO. Let me start with that question and see if I can address the other questions that you have raised. We, too, as you know, are looking at trying to provide more choices for Medicare beneficiaries, more managed care opportunities along with fee for service. In looking at the rule, certainly one of our key concerns was the impact on the development of managed care entities and integrated delivery systems.

The law has a number of provisions. In past years amendments we have specifically seen changes that will allow for greater flexibility for these kinds of arrangements. Let me give you an example. The personal services provision that was added recently in OBRA 1993 recognizes many of the relationships that are evolving between group practices or other physician practices under an integrated delivery system.

Similarly recognized the recruitment provisions have the kinds of recruitment that occur in these systems. The ownership provisions in the group practice area have essentially been modified to recognize the many arrangements group practices engage in as part of these systems.

One comment about managed care in relation to these provisions—Managed care is many things, as you well know. It can range anywhere from a fee-for-service discounted managed care arrangement where under the law, the incentives are still there in some sense to fully capitated systems beyond federally qualified HMOs where there may be very little chance or no chance of abuse under this law.

The law provides for an exception that allows us to look at arrangements where there is no possibility of patient or program abuse, and we are particularly looking at these kind of bundled payment arrangements where the incentive would be entirely different.

Mrs. JOHNSON of Connecticut. Since my time has expired, could I ask you to provide me with some documentation. I do not want you to write a whole new report, but there must be memos and things you share with each other that show how changes in the current law have tried to respond to the needs of integrated delivery systems.

Ms. BUTO. We would be glad to do that.

[The following was subsequently received:]

Before OBRA 1993, it did appear that the self-referral provisions might hamper the development of integrated delivery systems (IDSs) and coordinated care arrangements. However, changes were made in OBRA 1993 to accommodate and address these concerns. Beyond the broad exception for capitated plans, following are some of the additional exceptions to the self-referral prohibition the address issues raised by the facilities and physicians involved in IDSs. Please note that each exception has specific requirements, which are set in statute, that must be met in order for the physicians and/or facilities to quality for the exception.

Exception for physician ownership interests in hospitals. This exception allows physicians to refer to hospitals in which they have an ownership interest if the investment is in the entire hospital and not a specific unit.

Exception for payments to employee. This exception allows physicians who are employed by a facility to refer to the facility.

Exception for physician recruitment. This exception allows facilities to pay physicians to relocate to a geographic area without prohibiting the physician from referring to the facility.

Exception for "isolated transactions." This exception allows an entity to purchase a physician practice (either solo practitioner or group practice) and not have the transaction count as a financial relationship that would prohibit referrals.

Exceptions for the leasing of office space and the leasing of equipment. This exception allows physicians to refer to the entity from which they lease office space or equipment, despite having a financial relationship with the entity.

Finally, it appears that IDS arrangements often include group practices that are organized by the IDS's hospital(s). To accommodate this, the definition of group practice takes into consideration the financial relationships of hospitals and group practices by not requiring that group practices be controlled or organized by physicians.

Mrs. JOHNSON of Connecticut. What other problems do you see that have not yet been addressed, and specifically I want to know what kinds of changes have to be made in the law and how you would advise making them so that we do not prejudice the physician-operated systems on the issue of capitated and noncapitated payments.

I am not sure. I think our society's experience with capitated payments is problematical. Capitated payments have resulted in underfunding in some systems and certainly have driven adverse behavior. I do not want the Federal law to take a stand on capitation versus noncapitation, bundling versus nonbundling. I think some of the managed care structures that are more flexible than that are going to prove to also provide better quality care.

If you could help me look at what are the current impediments to those more flexible care systems and what in your experience could be done to open the law to those, I would appreciate it very much. Thank you very much.

Ms. BUTO. I would be glad to do that.

[The following was subsequently received:]

As you know, there are many forms of IDSs, and the business arrangements associated with them continue to evolve and change. The law already contains broad exceptions for capitated entities under Medicare, potentially similar broad exceptions should apply under Medicaid. For entities doing business in an noncapitated environment, the exceptions already provided in the law address a wide variety of situations. given that IDSs can function in both environments, we believe that the law is neutral in regard to capitation versus fee-for-service. As a develop regulations that implement the expansion of the self-referral provisions beyond lab services, we intend to examine each service to try to prevent harm to bona fide, nonabusive arrangements operation in the both capitated and fee-for-service environments.

Chairman THOMAS. Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman. Miss Buto, you mentioned that we can expect the final regulations on the first self-referral law, which was enacted in December 1989, shortly?

Ms. BUTO. Shortly. We are sending them to——

Mr. STARK. Could you tell me in a little more detail when those——

Ms. BUTO. What shortly is?

Mr. STARK. Yes.

Ms. BUTO. They have cleared HHS. In essence, they are going over later this week to the Office of Management and Budget. I do not know if this is the right time to mention it, but I do want to add that we have been enforcing those provisions, which we do think are fairly clear in the law.

Mr. STARK. I understand that. But I am sure that there are a lot of seminars waiting to be organized around these regulations. What do you think OMB will do? Sit on them, move them quickly, what is your best guess?

Ms. BUTO. I cannot predict, but we have already been over to provide some background briefing and hope to help walk them through it as soon as they get it.

Mr. STARK. I might ask the Chair if he would consider joining with me in writing to OMB to ask them, now that HCFA has finished the regulations on the first law, to speed up their process. Then we can see what kind of problem we face, and I would ask if we might all on the Subcommittee push this along, whatever the regulations, people may not like, but the devil we know is perhaps somewhat better than the devil we do not.

Chairman THOMAS. If the Member is asking me to joust with the bureaucracy, I am more than willing to join in.

Mr. STARK. Mrs. Johnson covered another question on the issue of how as we move into managed care, we do not completely eliminate it unless basically there is capitation, one would presume there is an elimination there of incentive from between—as between procedures and referrals.

Are you now assessing or studying any of the billing procedures or payment structures in new types of managed care? I guess in Medicare, you see it in Medicaid fairly often, but in Medicare it would be only under say the Medicare Select type arrangement. Are you looking at what is happening in that area at all—is there any formal study?

Ms. BUTO. We have not done a formal study, but we have made ourselves available, to managed care organizations, hospital organizations that are interested in PHO-type arrangements, and the group practice organizations which represent a variety of different

arrangements in order to fully understand what is going on, what arrangements are under way now.

Mr. STARK. Are you prepared or do you think you will be prepared to recommend to us any changes that you feel are needed legislatively. When do you think you might do that?

Ms. BUTO. We will certainly look at it and want to work, I think, collaboratively with the Committee to look at further changes that are necessary.

Mr. STARK. You think there will be some?

Ms. BUTO. Possibly. I have to say in the regulations we have really bent over backward to try to again do what we can to accommodate evolving arrangements. We will look at them.

Mr. STARK. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Certainly. Does Mr. McCrery wish to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman. Ms. Buto, let's talk about indirect and direct relationships in the context of self-referral. As we know, some indirect relationships can be rather tenuous, and I am wondering if you can give us any idea this morning how you plan to define indirect relationships so that this law is not carried to rather absurd extremes.

Ms. BUTO. When you say indirect relationships are you talking about the family relationships or the indirect financial relationships?

Mr. MCCRERY. Indirect financial relationships.

Ms. BUTO. We have really tried to stay closely to the intent and the spirit of both just the ownership and compensation-related items along with the exceptions so that our definitions, while we try to be flexible about recognizing arrangements that fall under the exceptions, stick very closely to the exceptions laid out in the statute.

We are proposing a few additional exceptions where we think there are not any real possibilities of abuse. In terms of the indirectness or directness, I think the statute is clear on what—the tests of relationships or if fair market value is involved in an exchange, or if there is a contract, and so forth. The relationship must be constructed in such a way that it is considered to meet the requirements.

Mr. MCCRERY. So, you are sensitive to this issue of indirect relationships and you are trying to make sure that you do not apply the law in such a way that it really becomes absurd?

Ms. BUTO. One thing I think I mentioned earlier is the integrated delivery systems. They represent a much broader umbrella and we are looking at whether there are issues Which impede the development of bona fide integrated delivery systems. That must be balanced against the concern about inappropriate utilization resulting from the ownership interests. It is not an easy issue. These are complicated arrangements, as you know.

Mr. MCCRERY. Yes. I just have one more question. It is kind of a fun question. I have been told that this example is correct, but I want you to think about it and tell me if it is. I am told that an orthopedist cannot rent or sell a wheelchair or crutches to a patient that he has treated, with the effect in some cases being that the patient goes to the doctor and gets treated, and then would have

to be literally carried to a pharmacy or a medical equipment place to buy the crutches or wheelchair. Is that correct?

Ms. BUTO. That is correct. The statute providing DME by the physician's office is not permissible. I should add that one thing we have not looked at is whether that makes a difference in the amounts that are paid for DME. That would be something to look at in addition to the issue of utilization.

Mr. MCCRERY. Thank you.

Chairman THOMAS. Mr. Kleczka will inquire.

Mr. KLECZKA. Thank you, Mr. Chairman. I just have two real quick concerns. Ms. Buto, one of the criticisms of the law is the reporting requirements that physicians are going to have to go through. Could you tell the Committee in some detail what exactly will be required of physicians?

Ms. BUTO. For reporting?

Mr. KLECZKA. For reporting.

Ms. BUTO. We are concerned about that, too. There was some initial reporting not by physicians, but by the clinical labs back in 1991. We did a survey. We are looking at an unburdensome way for physicians to certify that they are in compliance with the provisions that is not burdensome does not require micromanagement of every financial arrangement.

Mr. KLECZKA. So, you are saying the actual reporting requirements have not been developed yet?

Ms. BUTO. For the new provisions, no. We have already gotten the clinical lab provisions through a survey of the labs themselves to see what physicians-owners are associated with the labs. For new provisions the question is how do you go about doing it. We would like to look at a nonburdensome way to survey physicians or certify them.

Mr. KLECZKA. One of the other criticisms I have heard, which I personally do not believe is that under this law a doctor providing a patient with sample medication free of charge would be prohibited.

Ms. BUTO. Say that again, I am sorry, sample medication?

Mr. KLECZKA. Dispensing sample medication free of charge to a patient would be prohibited.

Ms. BUTO. I do not believe so. If I am wrong, we could—as long as there is no billing involved I do not think there is an issue.

Mr. KLECZKA. That is one of the things that has also surfaced. Thank you, Mr. Chairman.

Chairman THOMAS. Mr. Christensen will inquire.

Mr. CHRISTENSEN. Ms. Buto, just for a moment here, let's have a little conversation on common sense. I know it is hard to come by at HCFA and government bureaucracies, but, following the line of questioning that Mr. McCrery had, does not it seem a little bit odd that an orthopedist could not provide crutches or a wheelchair for that patient as he was leaving the office. Would not that be a logical extension of his services to provide that patient with the needed equipment to get around?

Ms. BUTO. On the one hand it might make sense. On the other hand there are many medical equipment suppliers who deliver to the home, who have a variety of different choices of wheelchairs

and crutches. The physician may not have, even if he kept an inventory, the item that the patient needs.

We have actually many suppliers, and they operate pretty efficiently to get equipment to the patient. So, on the one hand, yes, it sounds logical. On the other hand, it may not meet the patient's need exactly.

Mr. CHRISTENSEN. Who do you think knows best? Who would know better about what is going to fit that patient's needs, the orthopedist or some medical equipment supplier?

Ms. BUTO. The orthopedist will know what fits the need, but whether the orthopedist is going to keep a huge inventory that is required to meet a variety of needs, I think, is questionable.

Mr. CHRISTENSEN. I am a whole lot more suspect of the Federal Government telling people what they need rather than an orthopedist. I would trust the orthopedist a whole lot more.

Ms. BUTO. I do not think the Federal Government wants to tell patients what kind of wheelchairs or crutches they need. The law is pretty clear on that point, but I just want to make the point that there are other ways to get the items to people.

Mr. CHRISTENSEN. In your response to Mrs. Johnson, you mentioned the exception on prepaid plans, but the exception is limited to traditional HMOs. Do you see in your discretionary authority establishing other exceptions as we begin looking at integrated delivery systems and other HMOs?

Ms. BUTO. Again, we think that integrated delivery systems can be pure fee-for-service billing, not under any sort of managed care arrangement. They can be under an overall umbrella ownership, but really be a series of fee-for-service entities billing. I do not think the incentive changes under the Stark law. If we identify situations which are not covered by exceptions where we clearly think there is no possibility of abuse, we are going to look at that and see if we can create an exception. So, yes.

Mr. CHRISTENSEN. Thank you.

Chairman THOMAS. No further questions. Ms. Buto, rather than take the time of the Subcommittee, I have just a few questions that I want to offer to you so that you can respond to them in writing for us to get a little more comfortable framework for the physician self-referral law prior to issuing the regulations.

As you might guess, these are some of the specific concerns as expressed by my colleague from Wisconsin. I would not want to try to put a timeframe on the response, simply to say as soon as practicable we would appreciate a response.

Ms. BUTO. We will try to get them back to you quickly.

Chairman THOMAS. For those that need more detail than others, if you could just give us the indication that they need more detail and that would be appreciated. Without any further questions, we want to thank you. We know you are anxious to get back to work. Thank you.

Ms. BUTO. Thank you very much. Get the regulations out.

Chairman THOMAS. I did not want to add that. If I could ask our next panel, Dr. Bristow, Gail Warden, chairman of the board of trustees of the American Hospital Association; Frederick Wenzel, Dr. Balfour, Phil Griffin.

I want to thank all of you in advance. If you have any written testimony it will be made a part of the record without objection, and you may begin to inform us in any way that you feel we need to be informed, and we will begin with Dr. Bristow, then just move across the panel, if you might.

Dr. Bristow, thank you for joining us.

STATEMENT OF LONNIE R. BRISTOW, M.D., PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION

Dr. BRISTOW. Thank you very much, Mr. Chairman and Members of the Subcommittee. My name is Lonnie R. Bristow. I am a practicing internist in San Pablo, California, and the president-elect of the American Medical Association.

Chairman THOMAS. Dr. Bristow, if I might, which will serve warning to the others, these mikes are very, very unidirectional. You have to speak directly into it and relatively up close so that everyone will be able to hear your remarks. Thank you.

Dr. BRISTOW. Thank you. My remarks today will focus on the AMA's position on physician ownership and referral issues, and our recommendations for changes in the current self-referral law.

As you know, both self-referral laws, known as Stark I and Stark II, are now in effect and are being enforced, yet the Health Care Financing Administration has not published a final rule on the implementation of the provisions of Stark I. HCFA has not yet published a notice of proposed rulemaking that sets forth the specific policies of Stark II. However, the Office of Inspector General at the Department of Health and Human Services has already published a final rule with a comment period that sets forth sanctions. Somehow it appears that the cart has gotten before the horse.

Last December the AMA, along with AHA, ASIM, and other medical specialty societies and health groups asked HHS to declare a moratorium on sanctions until final rules implementing the Stark II legislation are published.

HHS denied our request. Yet, any misunderstanding regarding when the law applies or whether an exception exists could lead to the imposition of significant penalties on physicians. Further confusion was added by the Ninth Circuit Court's recent decision in the *Hanlester* case in which the court strongly disagreed with the IG's interpretation of the self-referral law.

We urge the Subcommittee to consider a moratorium until regulatory guidance is finalized.

The AMA has been a leader in developing reasonable restrictions on the practice of physician self-referral. In 1991 the AMA's Council on Ethical and Judicial Affairs took a strong position on this issue, building on work that began in 1986 on conflict of interest.

In general, the AMA's ethical policy is that physicians should not refer patients to a health care facility at which they do not directly provide patient care or services when they have an investment interest in that facility. However, physicians may refer their patients to facilities in which they have an ownership interest if the physician directly provides care or services.

Physicians should be able to invest in and refer patients to an outside facility whether or not they provide direct care or services

at that facility if there is a demonstrated need in the community and alternative financing is not available.

Need might exist when there is no facility, when there is an inadequate number of facilities of reasonable quality in the community or when use of existing facilities is onerous for our patients. If this community need exception is met, the physician should also comply with the further ethical requirements. Investing and referring as a direct extension of a physician's commitment to serve patients' needs is ethical and also desirable. We urge inclusion of a community need exception to the law.

At this time, I would like to highlight further recommendations that the AMA considers to be important. First, we urge you to amend the law to add an exception to allow the legitimate use of shared office facilities by physicians. Without it, access to appropriate care for patients will be negatively impacted.

Physicians often share clinical labs, x-ray machines, and other in-office diagnostic equipment with physicians in their office building so that they can provide their patients with on-site health services. Without this exemption, physicians who share a common office laboratory would be forced to set up two labs in order to treat their individual patients. The alternative of closing the lab, sending possibly critically ill patients to an outside lab for lab work and forcing them to return to their physicians' offices for their treatment is simply counterproductive to effective, efficient care.

Second, we support a specific exception to the law for referrals made by nephrologists for services relating to renal dialysis.

Third, it is not clear if injectable drugs administered in a physician's office are included in the self-referral ban or if the ban is limited to oral drugs. As one example, physicians are unsure if oncologists are prohibited from administering chemotherapy in their offices. We urge that outpatient prescription drugs be deleted from the list of designated health services, or at the very least, that this provision of the law be clarified.

Fourth, we urge deletion of the site of service requirements that govern where in-office ancillary services must be furnished. The location where the services are provided has nothing to do with improper utilization.

Finally, we believe that blanket prohibitions are not appropriate nor necessary. Instead, we strongly support the use of physician profiling to first identify and then address any utilization concerns by the comparison of practice patterns. We also ask that HHS focus its efforts on those activities or entities that are thought to be troublesome.

In conclusion, Mr. Chairman, we have urged caution in drafting legislation that attempts to govern ethical issues, and we would like to underscore, however, that patient benefit and patient access to health care facilities must be the primary concern, and our goals are similar.

We are most appreciative of the efforts of Chairman Thomas and the Subcommittee to improve and clarify provisions of the self-referral statute that are unclear, unnecessary, and unduly regulatory, and we look forward to continued work with you on these important issues.

[The prepared statement follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives

RE: Physician Ownership and Referral

Presented by Lonnie R. Bristow, MD

May 3, 1995

Mr. Chairman and Members of the Subcommittee:

My name is Lonnie R. Bristow, MD. On behalf of the American Medical Association (AMA), I appreciate the opportunity to testify before you this morning. I am a practicing internist in San Pablo, California and am President-elect of the AMA. The AMA commends your examination of the important issues relating to the physician ownership of medical facilities and the referral of our patients to these facilities. My remarks today will discuss the AMA's position on physician ownership and referral issues and our recommendations for changes to the current self-referral law.

BACKGROUND

The original ban on physician self-referral, known as the Stark I law, was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989. The statute, with limited exceptions, prohibits a physician from referring Medicare patients to clinical laboratories in which the physician -- or an immediate member of the physician's family -- has a financial interest. The Stark law was enacted in response to a study conducted by the General Accounting Office (GAO) in Florida that found that physicians who had an investment or passive ownership interest in an outside laboratory ordered more tests than physicians who had no tie with the laboratory. The implication of the report was that physicians ordered unnecessary tests to assure the financial success of the venture. This theory was never proven, and the GAO report was sharply criticized for failing to examine whether or not the ordered tests were medically necessary. The Stark I law took effect on January 1, 1992.

This self-referral ban was expanded by OBRA 1993 and modified by the Social Security Act Amendments of 1994 to prohibit physicians from referring Medicare and Medicaid patients to additional entities for the furnishing of designated health services, including physical therapy services; occupational therapy services; radiology services, including magnetic resonance imaging (MRIs), computerized axial tomography (CAT) scans, and ultrasound services; radiation therapy services and supplies; durable medical equipment; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. This expansion of the law, known as Stark II, became effective on January 1, 1995.

Although both self-referral laws are now in effect and are being enforced, HCFA has not published a final rule on the implementation of the provisions of Stark I nor has HCFA published a Notice of Proposed Rulemaking that sets forth the specific policies of Stark II. It should be noted, however, that the Office of Inspector General at the Department of Health and Human Services published a final rule on March 31, 1995 with a comment period that sets forth the civil money penalty, assessment, and exclusion provisions that will be imposed for violation of Stark II.

There are a number of areas where the law is unclear and where physicians need appropriate guidance from HCFA so that they can be certain that they are in compliance with the provisions contained in Stark I and II. The AMA, along with several medical specialty societies and key health groups, asked the Department to declare a moratorium on sanctions until final rules implementing the Stark II legislation are published. The Stark II law is extremely complex, and any misunderstanding regarding when the law applies or whether an exception exists could lead to the imposition of significant penalties on physicians. Since the adoption of the OBRA 1993 self-referral provisions, physicians and their advisors have spent thousands of hours scrutinizing every word of legislative history and statutory language to determine whether the law applies to their financial relationships. Further confusion was added by the Ninth Circuit's recent decision in the Hanlester case, in which the court strongly disagreed with the Inspector General's interpretation of the self-referral law.

The Department denied our request for a moratorium on January 26, 1995, stating in written correspondence that a moratorium could not be granted because the Department lacks the legal authority to specify another date for the duties imposed and the sanctions specified in the statute. The Department also stated that self-referral practices generate significant costs to the Medicare and Medicaid programs and that any delay would have budgetary costs. Last, the Department noted in its letter that "we are sympathetic to the need for further advice and guidance on the more subtle aspects of the statute." In light of the complicated issues raised by the legislation as written, we urge this subcommittee to consider a moratorium until such time as regulatory guidance is finalized.

AMA POSITION ON PHYSICIAN OWNERSHIP AND REFERRAL

The AMA was a leader in developing reasonable restrictions on the practice of physician self-referral. In 1991, the AMA's Council on Ethical and Judicial Affairs took a strong position on this issue. While physician investment in health care facilities can provide important benefits for patient care, a potential conflict of interest exists when physicians refer patients to facilities in which they have an ownership interest. Therefore, in general, the AMA's ethical policy is that physicians should not refer patients to a health care facility outside their practices at which they do not directly provide patient care or services when they have an investment interest in the facility. **However, physicians may refer their patients to facilities in which they have an ownership interest if the physician directly provides care or services.** For example, a referral to an ambulatory surgical center by the surgeon performing the surgery should be allowed.

There are other situations where self-referral is appropriate and necessary in order to properly serve our patients' needs. Physicians should be able to invest in and refer patients to an outside facility, whether or not they provide direct care or services at the facility, if there is a demonstrated need in the community for the facility and alternative financing is not available. Need might exist when there is no facility, when there is an inadequate number of facilities of reasonable quality in the community, or when use of existing facilities is onerous for our patients. For example, the use of an existing facility could create a hardship for patients if the facility is so heavily used that patients would face undue delays in receiving health care services. There would also be a hardship if patients had long travel times that made receiving care difficult, especially if patients needed to use the facility regularly.

There may be situations in which a needed facility would not exist if referring physicians were prohibited from investing in the facility. The burden on the developer of a particular facility would be to show that adequate capital could not be raised without turning to self-referring physicians after undertaking efforts to secure alternative financing, such as acquiring funding from banks and other financial institutions. If this community need exception is met, the physician should comply with further ethical requirements relating to the marketing efforts of the facility, referral requirements, return on investment, noncompetition clauses, disclosure of investment interests to patients, and utilization review. Physicians are often exclusively motivated by the important needs of their patients in becoming involved in these arrangements. Investing and referring as a direct extension of a physician's commitment to serve patients' needs is ethical and desirable.

RECOMMENDATIONS FOR LEGISLATIVE MODIFICATIONS TO STARK I AND II

The AMA has been pleased to participate in a coalition of medical specialty societies, the Medical Group Management Association, and other health groups to develop proposed legislative changes that would improve and clarify the current law. Following are key proposals that the AMA considers to be important and which are included in the coalition's recommendations.

Shared Facilities

The current law contains a general exception to the ban on physician referrals for the provision of in-office ancillary services. However, the law does not include an exception for in-office facilities shared by physicians. We urge you to amend the law to add an exception to allow the legitimate use of shared office facilities by physicians. With the help of many Members of this Subcommittee, the Ways and Means Committee included a shared facility exception in the health system reform bill reported out of Committee in 1994. Solo practitioners and small physician groups often have sensible agreements with other physicians to share office space and equipment in order to reduce costs and to benefit their patients. For example, physicians often share clinical laboratories, x-ray machines, and other in-office diagnostic equipment with other physicians in their office building so that they can provide their patients with on-site health services, such as EKGs and ultrasounds. These practical arrangements allow physicians to save money and resources by sharing the overhead for a common clinical laboratory or x-ray machine rather than setting up duplicate facilities in the same office building.

Patient access to appropriate treatment will be impacted if an exemption for shared facilities is not implemented. For example, physicians who share a common office laboratory would be forced to set up two laboratories in order to treat their individual patients. The alternative -- closing the laboratory, sending critically ill patients to an outside lab for blood work and forcing them to return to their physicians' offices for treatment -- is counterproductive to effective care.

Community Need

As mentioned above in the discussion on the AMA's ethical policy on physician ownership and self-referral, the AMA strongly supports an exception to the self-referral prohibition if there is a demonstrated need in the community -- for example, the absence of adequate alternative facilities -- and alternative financing is not available. The AMA urges inclusion of a community need exception to the self-referral law to allow a facility owned by referring physicians to exist in an urban or rural community where there is a community need and no other financial support for the facility exists. Many areas such as inner city communities and small towns have problems similar to rural areas in attracting non-physician investors for needed health care facilities. There may be situations in which a needed facility would not be built if referring physicians were prohibited from investing in the facility. Furthermore, need might exist when there is no facility of reasonable quality in the community or when use of existing facilities is onerous for patients.

Referrals Made By Nephrologists

We support a specific exception to the law for referrals made by nephrologists for services relating to renal dialysis. Nephrologists commonly contract with hospitals to provide dialysis to hospital inpatients at facilities owned by nephrologists. Pursuant to the self-referral statute, which includes "inpatient and outpatient hospital services" on the list of designated health services, it appears that nephrologists would not be able to treat their dialysis patients at their own dialysis units. Furthermore, we have received a number of inquiries from physicians asking for clarification of the term "inpatient and outpatient hospital services." As you are well aware, the Ways and Means Committee included an exception for nephrologists in the health system reform bill reported out of Committee in 1994.

Outpatient Prescription Drugs

Outpatient prescription drugs are included on the list of designated health services contained in the self-referral statute. It is not clear if injectable drugs administered in a physician's office are included in the ban, or if the ban is limited to oral drugs. Physicians are unsure if oncologists are prohibited from administering chemotherapy in their offices and if nephrologists are forbidden from dispensing in-office prescription drugs to their renal dialysis patients. We urge that outpatient prescription drugs be deleted from the list of designated health services, or at the very least, that this provision of the law be clarified.

In-office Ancillary Services

We urge modification to the current law in-office ancillary services exception to the prohibition of certain referrals. The exception presently contains unnecessary restrictions that should be deleted on the provision of durable medical equipment and parenteral and enteral nutrition services by physicians and group practices. Such restrictions diminish the quality of care and interfere with physicians' ability to care for patients.

Furthermore, we urge deletion of the requirements that the in-office ancillary services "must be furnished in a building in which the referring physician furnishes physician services unrelated to the furnishing of designated health services, or in the case of a referring physician who is a member of a group practice, in another building which is used by the group practice for the provision of some or all of the group's clinical laboratory services, or for the centralized provision of the group's designated health services (other than clinical laboratory services), unless the Secretary determines other terms and conditions under which the provision of such services does not present a risk of program or patient abuse..." Ancillary services provided by physicians are part of a continuum of care that physicians provide for their patients whether a patient is in the physician's office, is hospitalized, or has been discharged to another facility or to his or her home.

We also ask that the supervision component of the in-office ancillary services exception be clarified. The current law exception describes designated health services that are furnished "personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are directly supervised by the physician or by another physician in the group practice..." We urge inclusion of language that changes the "direct supervision" concept to "general supervision" to clarify that nurses, technologists, technicians, and other non-physician personnel are capable of providing ancillary services to patients under the general supervision of physicians without the need for direct physician supervision in connection with each and every test or procedure.

Reporting Requirements

The self-referral statute contains a provision that requires that entities providing covered items or services for which payment is made shall provide information to the Department of Health and Human Services Secretary regarding the entity's ownership arrangements. We urge repeal of this section. Physicians are already burdened with complying with numerous regulatory requirements under CLIA, OSHA, and Medicare and should not have to spend additional time away from caring for their patients in order to provide this data. It is also not apparent how the Department of Health and Human Services intends to use this general information regarding ownership; HHS should instead focus efforts on entities thought to be problematic.

Group Practices

The current law definition of a group practice includes a physician compensation requirement that provides that no physician who is a member of a group can directly or indirectly receive compensation based on the volume or value of referrals by the physician. The law also provides that "a physician in a group practice may be paid a share of overall profits of the

group, or a productivity bonus based on services personally performed or services incident to such personally performed services, so long as the share or bonus is not determined in any manner which is directly related to the volume or value of referrals by such physician". We urge deletion of these provisions. We have received numerous questions and comments from physicians who oppose these provisions and do not understand why the law is written in such a way that the government is unnecessarily intrusive into the internal financial arrangements and operations of their private practices.

Designated Health Services

We urge deletion of the following items or services from the list of designated health services to which the self-referral prohibition applies: physical therapy services; occupational therapy services; radiation therapy services and supplies; prosthetics, orthotics, and prosthetic devices and supplies; outpatient prescription drugs; and inpatient hospital services. We would also clarify the definition of radiology or other diagnostic services, as well as outpatient services.

CONCLUSION

We have urged caution in the past in drafting legislation that attempts to govern the ethical issues related to physician ownership of health care facilities and referral of patients to these facilities. We are most appreciative of the efforts of Chairman Thomas and the Subcommittee to improve and clarify provisions of the self-referral statute that are unclear, unnecessary, and unduly regulatory. We would like to underscore that patient benefit and patient access to health care facilities must be of primary concern. We look forward to continued work with the Chairman and the Subcommittee on Health on these important issues.

Chairman THOMAS. Thank you.
Mr. Warden.

STATEMENT OF GAIL WARDEN, PRESIDENT, HENRY FORD HEALTH SYSTEM, DETROIT, MI AND; CHAIRMAN, BOARD OF TRUSTEES, AMERICAN HOSPITAL ASSOCIATION

Mr. WARDEN. Thank you, Mr. Chairman. I am Gail Warden, president of the Henry Ford Health System in Detroit and chairman of the board of trustees of the American Hospital Association. On behalf of our 4,600 institutional members who are hospitals and health systems, we are pleased to have an opportunity to talk with you today about self-referral prohibitions in section 1877 of the Social Security law.

I would like to make three points to begin with. First, the pace of change in health care makes it necessary to take another look at the self-referral law. Second, at a minimum, a moratorium for the time being should be placed on the enforcement of the law, and, third, we have some recommendations to make the law more relevant to today's health care systems.

I think you are all aware from the previous testimony and discussion that health care is undergoing a transformation like no other in history—moving away from a traditional method of paying individuals, physicians, hospitals and others for each service and treatment to one, in many cases, where the risk for utilization and cost is being borne by the hospital and the physicians instead of the insurance company.

It is moving to a more integrated approach, in which groups of providers are organized in a myriad of arrangements and paid a set fee to provide a comprehensive set of services for each enrollee. As that occurs, there is an incentive to focus on prevention and to provide appropriate services.

In all of these arrangements, of which there are many, cooperation is the key ingredient in these coordinated care systems. Ownership, employment, or exclusive contracts are not always an option, and so what is happening is that physicians and institutions try to do their best to respond to a changing marketplace, and end up with a blend of different kinds of arrangements.

In our own case we have a group practice. We also have IPA networks with community hospitals that are not part of our system. We have spot purchasing for certain tertiary care services to try to keep the cost down, and a number of other kinds of arrangements.

We believe that the guiding principles in the Stark law—which were to prevent inappropriate referrals based on the potential for financial gain—remain valid. However, at the same time, with the dramatic changes that have taken place in the delivery system, where there have been significant structural changes in the methods of payment and the business relationships between providers, we feel that the progress is being impeded by the law, and despite the encouraging comments this morning about the fact that there were ways to seek exceptions, I think we have to recognize that these changes are taking place so rapidly that once you have determined what the exception might be, a new kind of arrangement probably has been created to respond to a different thing that is happening in the competitive marketplace.

So, with that in mind, we feel that there is a need to revisit the law, particularly those elements of the law that prevent new systems from evolving. We feel there is a need to delay enforcement of the law until such time as some of these issues can be examined.

As the Chairman has said on another occasion, it is not just a challenge. It is impossible in many cases to try to stay within the law and at the same time do what you think is right. One of the considerations, I think, is that the law does provide for exceptions for what it calls pure models of managed care.

At this point, I am not sure there is a pure model. Even Kaiser, which was the original pure model, has departed from that and has a lot of different kinds of arrangements in different marketplaces. We also believe that the consideration of the changes should not occur in a vacuum and we should recognize that there are a number of other laws in place to address these issues, such as the anti-kickback law, Federal laws regulating conduct of tax exempt organizations, and so on.

Our recommendations are that we add an exception for certain risk-sharing arrangements, many of which can be enumerated if you want to talk about them; that there be an exception for ownership in integrated delivery systems, which are, in fact, structured in such a way that they are concerned both about cost and quality; and that there be an amendment to the list of designated health services, particularly as it relates to inpatient and outpatient hospital services because DRGs regulate inpatient care and in doing so control utilization. We also would suggest the establishment of an advisory opinion mechanism that includes a requirement that HHS issue advisory options under certain conditions.

In conclusion, our feeling is that we particularly think we need to look at integrated networks and the impact that this law is having upon them, and what kinds of options might be created for exceptions. We look forward to working with you to try to do that.

[The prepared statement follows:]

American Hospital Association

Liberty Place
Washington Office
325 Seventh Street, N.W.
Suite 700
Washington, DC 20004-2802
202-638-1100

Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
United States House of Representatives
on
Self-referral Provisions in the Social Security Act

May 3, 1995

Mr. Chairman, I am Gail Warden, president of the Henry Ford Health System in Detroit and chairman of the board of trustees of the American Hospital Association (AHA). On behalf of AHA's 4,600 institutional and 50,000 individual members, I am pleased to be here to discuss self-referral prohibitions in Section 1877 ("Stark I and II") of the Social Security Act.

INTRODUCTION

Health care delivery in this nation is undergoing a transformation like no other in history. We are rapidly moving away from the traditional ways of delivering care -- namely, paying individual physicians, hospitals and others for each service and treatment they provide -- in favor of a more coordinated, integrated approach. This new approach includes groups of providers paid a set fee for each person enrolled in their network, with an incentive to focus on prevention and providing appropriate services. In other words, cooperation is a vital ingredient in the coordinated care systems that are making health care delivery more efficient and cost-effective. Avoiding the delivery of unnecessary care is another. These new systems reflect AHA's vision for the future: community-based, collaborative networks of providers focused not just on treating illness and injury, but also on improving the overall health status of their communities.

RE-EXAMINING SELF-REFERRAL LAW

In light of this relatively new focus on cooperation, it has become necessary to reexamine the underlying concerns that led to the initial passage of Representative Pete Stark's (D-CA) legislation and amendments broadening the self-referral ban. And it is absolutely necessary to raise questions about the ability of providers to intelligently comply with a statute that is as broad and complicated as the self-referral law, and carries with it such significant sanctions for noncompliance.

The guiding principle for the Stark law -- to prevent physicians from inappropriately referring patients based on the potential for financial gain -- remains valid. This law, however, was drafted when the health care delivery system was dramatically different from the systems that are evolving today in communities across the nation. Since the law was enacted, significant structural changes have occurred in methods of payment and in business relationships between providers. Networks of providers are working together to respond to community health needs and payer expectations.

As hospitals, doctors and other providers develop alternatives to the fragmented fee-for-service model of health care delivery, Congress should consider that such progress could be severely impeded by a law created at a different time, for a different system, and for relationships that are becoming less prevalent.

The AHA shares the concern that only necessary care should be provided to patients. To do otherwise can create risks to people's health and drain scarce dollars from the health care

system. When the system is subjected to fraud and excessive utilization, the AHA expects and encourages rigorous enforcement to follow. We believe, however, that there are significant problems with the law as written.

REVIEW SELF-REFERRAL LAW, DELAY ENFORCEMENT

As Chairman Thomas has noted, there are two key issues to be addressed. First, there needs to be careful examination of the effects of the self-referral law on the development of new, more efficient delivery systems, and elements of the law that prevent new systems from evolving must be stricken or amended. Payment mechanisms that align incentives among providers and create disincentives to the provision of excess services are becoming commonplace. In an environment in which providers are fully or partially accepting risk for excessive utilization through capitation arrangements, withholds, incentive pools, and other methods designed to encourage appropriate and cost-effective care, the need for such sweeping legislation is questionable.

Second, a delay in enforcement of the law is needed. No final regulations have yet been issued for Stark I, a law passed in 1989 that prohibits physician referrals for only clinical laboratory services where certain financial interests exist. As for Stark II -- which in 1993 broadly expanded the list of services covered -- not even proposed regulations have been published. Yet, the Stark II provisions went into effect on January 1, 1995. There is universal agreement that the statute, as amended, is extremely difficult to interpret and apply. Without the benefit of implementing regulations, compliance with the ban, as the chairman has said, "isn't just a challenge, it's almost impossible." Considering that a violation of the law carries a potential civil penalty of up to $15,000 per claim and possible exclusion from the Medicare and Medicaid programs, a delay in enforcement is strongly urged.

In December 1994, AHA and 11 other provider organizations wrote a letter to relevant federal agencies expressing this concern and requesting a moratorium on the effective date. The response from the Department of Health and Human Services (HHS) Inspector General and the Administrator of the Health Care Financing Administration was that they lacked statutory authority. Without arguing the legal scope of their authority, there is no question that Congress does have the power to delay enforcement until regulations are drafted, subjected to public comment, and published.

We should not rush to fully implement a law that, as written, could undermine positive developments in the health care market.

REGULATION ALREADY EXISTS

Consideration of changes to Stark I and II should not occur in a vacuum. The confusion that providers face in applying the Stark law to a specific referral arrangement is exacerbated by the fact that the same arrangement is generally regulated by several other federal and state laws as well. These arrangements, which usually involve hospitals, are subject to scrutiny under the anti-kickback law, federal tax law regulating the conduct of tax-exempt organizations, state referral bans, and the corporate practice of medicine prohibition -- to name a few.

Yet another federal law that regulates fraudulent and abusive activity is the federal False Claims Act. Most recently, this act has been used to characterize billing errors as false claims subject to civil and criminal sanctions. This approach to enforcement undermines the collaborative relationship that should exist between the government and providers if we are to efficiently process the millions of transactions that occur in health care every year. The AHA supports the government's goal of preventing true fraud, but we are concerned about the consequences of painting too many billing problems with too broad an accusatory brush.

We must consider, as the chairman has noted, whether the Stark law is needed in light of the tools already available to the government to monitor and punish those who abuse or defraud the system. We suggest that the current enforcement apparatus is more than adequate to address these issues.

The proliferation of overlapping, but often inconsistent, laws is not only confusing but unfair, unwieldy, and inefficient in a time of dwindling resources. This Congress has the opportunity to simplify an unnecessarily complex federal approach to health care fraud and abuse.

AHA'S RECOMMENDATIONS

The following are recommendations for fundamental revisions to the current structure of the law, in order to make it more relevant and workable.

Add an exception for certain risk-sharing arrangements.

Currently, Stark II contains a general exception for a limited number of prepaid health plans that are federally qualified. Multi-provider networks utilize various risk-sharing arrangements to discourage excessive utilization. There is not a big difference between these emerging arrangements and federally qualified prepaid plans, in terms of creating a disincentive to provide unnecessary services. Accordingly, we recommend amending the law to include an exception for certain risk-sharing arrangements, such as those that place the provider of services at full or partial financial risk for the cost or utilization of those services through withholds, capitation, incentive pooling, per diem payment arrangements, or other methods.

Add an exception for ownership in integrated delivery systems.

While there is no single commonly accepted definition of an integrated delivery system, the health care field has evolved to a point where several types of structures are commonly adopted to help providers work together to serve patients. For example, physicians may own or invest in a management services organization (MSO), preferred provider organization (PPO), physician-hospital organization (PHO), physician-hospital arrangement (PHA), or similar organization designed to coordinate the delivery of health care services. The referring physician may be managed by, or contract with, the organization and have an ownership or investment interest in the organization itself, and not merely in a part of the organization. The Stark law should expand the current exception for physician ownership in a hospital to include ownership in integrated delivery systems. This would remove one barrier to hospitals and physicians joining together to create coordinated care systems.

Amend the list of designated health services.

Stark II contains a long list of designated health services for which referrals may be prohibited. The breadth of such a list is questionable and should be limited to services where objective studies have convincingly demonstrated overutilization by referring physicians with a financial interest in an entity.

At a minimum, the apparent catch-all designated health service called "inpatient and outpatient hospital services" should be deleted. The inclusion of this broad category of services is incomprehensible within the context of Section 1877 and adds no precision to the law's attempt to target specific health services that may be candidates for overutilization. Virtually every inpatient and outpatient service involves some form of financial relationship with physicians who may need to refer patients, making the Stark law a mechanism to restrict all health care delivery.

Establish an advisory opinion mechanism.

AHA strongly recommends amending Section 1877 to include a mandatory advisory opinion mechanism. We commend Chairman Thomas for introducing legislation (H.R. 1234) that includes provisions requiring HHS to issue advisory opinions under certain conditions. Such a mechanism is necessary given the practical problems Section 1877 presents for providers attempting to operate more efficiently, the interpretive problems that have accompanied rapid changes in health care, and the fact that a violation of Section 1877 does not require proof that a referral was made with improper intent.

Other considerations

A review of the Stark law should also consider whether a "financial relationship" should be defined to include compensation arrangements, in addition to ownership and investment interests. The law appears to apply to every legal method of exchanging consideration between physicians (and their immediate family members) and an entity, thereby requiring

exceptions for every form of appropriate financial relationship.[1] It generally prohibits a referral for services if the referring physician has any compensation arrangement with the entity to which the patient is referred.

The multi-provider networks of care that are organizing across the country rely on close coordination of a variety of health care services to yield increased efficiencies. Such close coordination makes necessary a variety of compensation arrangements between providers. With network incentives geared toward the conservation of resources, risk of overutilization is curtailed.

Congress may also wish to consider that the effect of the Stark law can be to create an uneven playing field among providers, and a disincentive for providers to work together. For example, under the current law, referring physicians may not be part of a joint venture with a hospital to develop a new hospital unit, but those referring physicians can create a loosely defined group practice to offer the same services on their own. This places one group of providers -- hospitals -- at a competitive disadvantage, and most importantly, presents a barrier to hospitals and physicians uniting to provide services.

In addition, a number of ambiguities in the statute should be clarified to conform with the rapid diminishment of fee-for-service payments and the related risk of overutilization. For example, the current exception for physician recruitment arrangements applies only to recruiting physicians to a new location, such as a new city or state, but not for recruiting physicians to a different practice in the same area or system. If providers are to serve local community needs in an efficient manner, this narrow exception should be revisited.

Other exceptions, such as the current exception for personal service agreements, should permit various incentive payments that are not dependent on the volume or value of referrals. Newer payment methodologies that require providers to accept and share risk, and do not encourage overutilization, have features that were not contemplated when Section 1877 was developed. Also, certain ambiguous definitions need to be cleared up, such as "referral" and "fair market value." In addition, we would be happy to discuss various technical changes that could improve the law.

CONCLUSION

Mr. Chairman, individual practitioners and independent hospitals cannot create coordinated delivery systems overnight. We must remain open to a variety of arrangements that involve varying degrees of ownership, control, and risk as health care delivery systems emerge that are responsible for everything from prenatal services to long-term care, providing needed services to an enrolled population within a defined amount of resources, and customer satisfaction.

While the self-referral provisions are designed to stop abuse and overutilization, they also inhibit providers' ability to respond to market demands for integration that provides higher quality, cost-effective, and readily accessible health care. Clarifying and repealing parts of the law are necessary to encourage the creation of delivery systems that can respond to these demands. We are sympathetic to the concerns that Congress has about abuses in the health care system. Indeed, we share those concerns. But the law must not be allowed to penalize providers that are trying to respond to modern demands for integrated, cost-efficient care. We look forward to working with you to keep that from happening.

---

[1] Structurally, Stark adopts a broad prohibition on certain physician referrals and permits exceptions. Under this structure, the intent of the parties is irrelevant, whereas under the anti-kickback provisions of the Fraud and Abuse Statute, the intent to induce referrals is critical. Stark is easiest to understand as an "exceptions bill" and, in that regard, is similar to section 61 (a) of the Internal Revenue Code [26 U.S.C. § 61(a) (1988 & Supp. III 1991)]. That Section defines gross income as "all income from whatever source derived" unless there is a deduction or an exclusion from gross income. Once the structure and scope of the Stark prohibition are understood, the exceptions become critical.

Chairman THOMAS. Thank you very much, Mr. Warden.
Mr. Wenzel.

STATEMENT OF FREDERICK J. WENZEL, EXECUTIVE DIRECTOR, MEDICAL GROUP MANAGEMENT ASSOCIATION, ENGLEWOOD, CO

Mr. WENZEL. Thank you, Mr. Chairman. I am Frederick Wenzel, executive director of the Medical Group Management Association in Englewood, Colorado. We appreciate the Committee's interest in exploring changes to the physician self-referral law.

While our goal is not to condemn the basic intent of the law, which was designed to curtail abusive investment and referral behavior, we have identified a number of serious problems with the statute and would like to recommend a number of changes to the Committee.

The written testimony, which was made available to the Committee, expands on my remarks. It includes conclusions from our analysis of the statute and its effects on physician practices and a discussion of specific problems with the law, and a series of recommended changes.

No single piece of recent legislation, including the Medicare fee schedule, CLIA, Clinical Lab Improvement Act and OSHA, Occupational Safety and Health Act, has as this law has complicated the lives of our physicians and our practices. While MGMA supported the original physician self-referral legislation enacted in 1989, subsequent amendments to the law in OBRA 1993 transformed it into a regulatory nightmare.

What was once a reasonable regulation of physician joint ventures has now become government micromanagement of physician practices and unnecessary intrusion into an emerging competitive market for health care services. The law is sufficiently ambiguous to defy implementation and the HCFA, as we heard earlier, has been of little help providing guidance on even simple issues.

For example, the law prohibits referral to an entity in which a physician's immediate family member has an investment. Yet, family member has not been defined.

Physician practices are prohibited from providing durable medical equipment to their patients. However, the HCFA carriers have not provided clarification on how a practice is to distinguish prosthetics, orthotics, and supplies from DME. The law ostensibly applies only to designated services and only to Medicare and Medicaid, but the key definitions of referral and group practice suggest broad applicability.

Many of the provisions are simply unnecessary. For example, what purpose is served by prohibiting a physician practice from having a practice site which provides only physical therapy services or mammography screening? In many instances practices have limited space to provide full range of service at one location.

Furthermore, satellite locations can offer a measure of patient convenience and access. Stark II restricts physician practices from opening satellite facilities unless they also provide unrelated physician services at that site, even if such services are provided better elsewhere. Many other provisions are counterproductive.

The Stark law prohibits physician ownership in certain services, such as radiation therapy, prosthetics and orthotics. These services are unlikely candidates for utilization. In fact, a case can be made that patient compliance rates for these services are the real issue and poor compliance may result in greater cost to the government programs in the long term.

The self-referral law both directly and indirectly restricts physician participation in managed care networks, and as we heard earlier, it is limited to federally qualified HMOs, and nowadays one wonders why you would want to be federally qualified anyway, and here we exclude, of course, State arrangements, IPAs and other kinds of networks.

In these arrangements, physicians are in most cases only partially at risk or capitated, may have a financial relationship with more than one network, and may even have some fee for service. Many of these arrangements could violate at least one provision of the Stark II restrictions.

The Stark law uses definitions that add additional burdensome regulatory requirements. The most glaring are physician compensation requirements included in the definition of group practice.

For example, it is impossible to apply the compensation test in Stark II fairly and uniformly across physician employees and tax exempt clinics or medical schools, physician employees of for-profit groups, physician owners who are also employees, physicians in single specialty practices, and physicians in multispecialty practices, all of whom are treated somewhat differently.

Contrary to what the defenders of the law may allege, adoption of the recommendations detailed in my written statement would hardly open the door to major opportunities for physician abuse of the Medicare and Medicare Programs. In fact, a streamlined self-referral law could actually be implemented by HCFA, and that would really make things a lot simpler for them and for us as well.

We want to thank you very much for your consideration of these issues which are very important to our group practices. We represent nearly 7,000 group practices throughout the country, and believe me, we have heard from just about every one of them on Stark I and Stark II.

Thank you, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF FREDERICK J. WENZEL, FACMPE
MEDICAL GROUP MANAGEMENT ASSOCIATION

My name is Frederick J. Wenzel, FACMPE. On behalf of the Medical Group Management Association (MGMA) and its 6,500 physician group practice members, I would like to thank you for the opportunity to appear before you this morning. I am both the Executive Director and Chief Executive Officer of MGMA, and an advisor to the President of the Marshfield Clinic in Marshfield, Wisconsin, where I served as Executive Director for almost twenty years. Marshfield is a large multi-speciality clinic which serves a largely rural population. We greatly appreciate both the Chairman's and Committee's interest in exploring changes to the so-called physician self-referral law. It is not MGMA's goal to condemn the basic intent of the law to curtail abusive investment and referral behavior, but we have identified a number of serious problems with the statute. My comments are designed to examine these problems and recommend possible solutions for them to the Committee.

No single piece of recent legislation has been as disruptive to medical group practices as has this law, including the implementation of the Medicare fee schedule, CLIA, and OSHA. While MGMA supported the original physician self-referral legislation enacted in 1989, the subsequent amendments to the law in OBRA '93 transformed it into a regulatory nightmare. What once was reasonable regulation of physician joint ventures has now become government micro-management of physician practices, and unnecessary intrusion into the emerging competitive market for health care services.

Founded in 1926, the Medical Group Management Association is the oldest and largest association representing medical group practices. Our members include over 6,500 groups of every size, description, and geographical location. They include most world renowned multispecialty clinics, all of the nation's academic practice plans, and thousands of smaller single and multi-specialty practices. Altogether MGMA member groups provide practice settings for over 130,000 physicians -- about two-thirds of all physicians in group practice in the United States. MGMA is affiliated with two other organizations: The Center for Research on Ambulatory Health Care Administration ("CRACHA"), the research arm of MGMA, and the American College of Medical Practice Executives ("ACMPE"), an organization that makes professional credentialling available to individual practice administrators.

Overview

The collapse of government-directed health care reform in the 103rd Congress sent a loud message across the country to providers, purchasers, and patients. It is now clear that the federal government is not going to assume responsibility for the management of private sector health care financing and delivery. MGMA supports this outcome, and believes that the market will sort itself out, even if it means a certain amount of pain for providers in general, and many of our members in particular. In light of the encouragement that the new 104th Congress is now giving to market competition and in particular managed care, we think that it is appropriate that the Congress explore existing laws that may impede the larger goal of this Committee's leadership to further market competition, instead of government regulation. So, we are very pleased and grateful that the Committee has decided to undertake a thorough review of the self-referral law.

For the better part of the past year MGMA has been part of a work group comprised of the American Medical Association, the American Dental Association, the American Society of Internal Medicine, the American Society of Clinical Oncology, and several representatives from managed care organizations. This group has worked tirelessly to try to make sense of the self-referral law, including work on the so-called "Stark III" amendments

debated in 1994. Together the group represents a broad cross-section of providers and payers who are engaged in the evaluation of the emerging competitive markets. In addition, we have consulted with literally hundreds of health lawyers and accountants, and thousands of medical group practices about the problems they face complying with the self referral law. Based on these experiences we have drawn several conclusions that serve as the bases for our recommended changes to the law. These are:

1. The law is sufficiently ambiguous to defy implementation, and the Health Care Financing Administration ("HCFA") has been of little or no help providing guidance on even the simplest issues, even though Stark I has been in effect since 1992 and Stark II became effective January 1, 1995. For example, the law prohibits referral to any entity in which a physician's family member has an investment -- yet family member has not been defined. Physician practices are prohibited from providing durable medical equipment to their patients -- however, HCFA carriers have provided no clarification as to how a practice is to distinguish prosthetics, orthotics, and supplies from DME. The law ostensibly applies only to designated services and only to Medicare and Medicaid -- but the key definitions of "referral" and "group practice" suggest broader applicability.

2. Many of the provisions are simply unnecessary. For example, what purpose is served by prohibiting a physician practice from having a practice site which provides only physical therapy services? In many instances, practices have limited space to provide a full range of services at one location, and furthermore, satellite locations offer a measure of patient convenience and access. Stark II restricts physician practices from opening satellite facilities unless they also provide "unrelated" physician services at the site, even if such services are better provided elsewhere.

3. Many other provisions are counter productive. The Stark law prohibits physician ownership in certain services such as radiation therapy and prosthetics and orthotics. These services are unlikely candidates for overutilization. In fact, a case can be made that patient compliance rates for these services are the real issue, and poor compliance may result in greater costs to government programs in the long term. Restricting physician ownership of these services is more likely to reflect competing financial interests, rather than concern about Medicare and Medicaid program abuse. We hope that the Committee will not permit special economic interests to dominate the market. Rather, a full range of competition should be encouraged including competition from and among physician practices. The Stark law currently favors nonphysician suppliers over physician group practices, and certain physician specialities over others.

4. Finally, the self-referral law both directly and indirectly restricts physician participation in managed care networks. The law does provide a limited exemption for federally qualified HMOs, but not state qualified ones. Furthermore, most of the emerging products are not HMOs but rather IPAs and other network arrangements. In these arrangements, physicians are in most cases only partially at risk or capitated, may have a financial relationship with more than one network, and may have some fee-for-service revenue. Many of these arrangements may violate at least one of the Stark II restrictions.

The original Stark I law was an appropriate legislative response to abuses, some real, and some potential, arising from joint ventures between commercial clinical laboratories and joint venture partners who were frequently referring physicians. In some of these arrangements, physician investors put up very little money, and provided little or no medical direction or other professional contribution to the venture, yet had significant potential for return if the investors ordered a sufficient volume of lab tests. In other words, the investment returns were thinly disguised kickbacks in return for the physician's continued or promised referral of business to the laboratory. While the worst of these schemes were already subject to prosecution under the Medicare and Medicaid anti-kickback statute found

in Section 1128B(b) of the Social Security Act, Congress perceived at the time, and with some reason, that the anti-kickback law was too difficult to invoke, and too subject to the ambiguities of individual judicial precedents, to effectively deter the behavior of concern to the Congress. Because the underlying rational for Stark I was to prevent abusive joint ventures, the law logically included a number of workable exceptions to ensure that legitimate physician office, hospital, and other laboratory services were not disrupted and patient access and cost were not compromised.

Unfortunately, before the Health Care Financing Administration could implement the Stark I law, the law was greatly expanded through amendments included in the Omnibus Budget Reconciliation Act of 1993. The law, as amended, is now commonly referred to as "Stark II." There are two major differences between the Stark I and II laws:

- Stark II expands the list of designated health care services, to which the self-referral prohibition applies, beyond clinical laboratories to encompass the majority of therapeutic and diagnostic services covered by the Medicare and Medicaid programs. These include some services for which there has been no demonstrable record of abuse related to physician ownership, and others where there is not even a significant potential problem or which may have the unattended consequence of producing the opposite effect -- the underutilization of service;

- Stark II also moved the focus away from the original concern about abusive joint ventures, by adding numerous and detailed provisions governing the internal operations of physician group practices, hospitals, medical schools, and other entities that employ or contract with practicing physicians.

The effect of these two major changes has been to convert a sound and workable law into an over-reaching, complex, and intrusive example of federal micro-management within the health delivery system. Proof of Stark II's complexity can be found in HCFA's inability to develop even proposed implementing regulations for Stark II almost two years after its enactment, and several months after it became effective and legally enforceable. Further evidence can be marshaled by talking to physicians, hospital administrators, practice administrators, and health lawyers who have tried to understand the law and apply it to even relatively routine physician employment and contracting situations within their practices and institutions. Finally, the author of the legislation has himself admitted that the legislation produced results that he had not intended.

Problem Statement

Following are some of the real world problems being encountered by those trying to understand and comply with the Stark II law. These are organized to correspond with the different types of exceptions as they appear in the statute.

1. General Exceptions to the Prohibition on Physician Ownership And/Or Compensation Relationships

   - The "in-office" ancillary exception in Stark II is overly prescriptive in terms of the site of service. There is no policy rationale for telling physician practices how many diagnostic and therapeutic service sites they should be permitted to develop for the convenience of patients, or how ancillary services and physician services should be delivered in combination. Similarly, an ownership and referral law should not dictate the degree of physician supervision necessary to maximize effective utilization of non-physician personnel, as long as physicians remain legally responsible for the ancillary services provided by non-physician personnel, and the services are billed by physicians or bona fide group practices.

- Stark II has also undercut the in-office ancillary exception by prohibiting physician practices from providing durable medical equipment ("DME") and parenteral and enteral services. Thus, an orthopod can cast a broken leg, but cannot dispense a crutch as the patient leaves the office. An oncologist can prepare a patient for a bone marrow transplant procedure, but can not give the same patient the nutritional supplements necessary to build up the patient's strength during the pre-operative phase. Certain antibiotic therapy can be delivered in connection with a physician's services, but nutritional supplements that might utilize the same pump and tubing must be provided by an outside entity. In many cases physicians are required to send injured or severely ill patients to other providers at different practice sites, significantly increasing the time, effort and cost that these patients must endure when receiving needed care.

- The general exception available for ancillary services delivered in connection with prepaid, at risk plans is too narrow to accommodate today's dynamic marketplace. Limiting the exception to federally qualified health maintenance organizations and Medicare contractors applies concepts of the 1970's and 1980's to the marketplace of the mid-90's. Groups that enroll Medicare or Medicaid patients on a pre-paid at risk basis, and are licensed or otherwise regulated under state law offer the same disincentives to overutilization as would a federal risk contractor, (and probably more than a Medicare cost contractor), but only the latter qualify for the Stark II managed care exception.

- Stark II provides an exception for physician ownership in rural areas, but not for physician compensation arrangements with entities providing care in rural areas. This seems a distinction without a difference. Similarly, just as physician investment may be necessary to bring ancillary services into under-served rural areas, so too should it be available in under-served urban areas. Also, the definition of a rural area is not in all cases workable. A county is designated as rural or urban in its entirety, without regard to its size or diversity. So a county, often in the western United States, may be designated as urban because it has one metropolitan area within its boundaries, while the remainder of the vast county, stretching, in some cases for hundreds of miles, is completely rural.

- Stark II fails to recognize the similarities between ancillary facilities shared by solo physicians operating at the same physical location, and fully integrated practices. Just as bona fide group practices are easily distinguishable from abusive joint ventures, so too are cost effective shared service arrangements developed by physicians who are on site, involved in the supervision of non-physician personnel, and utilizing the shared facility as an adjunct to their own office practices for the convenience of patients.

2. Exceptions Related only to Ownership and Investment

- Stark II permits a physician to have an ownership interest in a hospital, as long as it is in the entire hospital and not some subdivision of it, and continue to refer patients to that hospital for designated services. On the other hand, the law currently prohibits physicians from doing exactly the same thing at other facilities such as nursing homes, hospices, surgery centers, dialysis facilities, rehabilitation facilities, which may provide a designated service incidental to the facility service. For example, if physician ownership of inpatient rehabilitation hospitals is not a problem under Stark, ownership in an outpatient rehabilitation facility ("CORF") should not be either. If physician ownership in an ambulatory surgery center and referral to it for surgery is acceptable, then the fact that an incidental lab service is

also provided should not poison the well.

3. Exceptions Related Only to Compensation Arrangements

Stark II provides a number of statutory exceptions to protect routine relationships between physicians and other entities to which they may refer patients for designated services. These relationships include office and equipment leases, management and service contracts, physician recruitment situations, and others. The problems in this area of the law are more technical than conceptual, but there are many inconsistencies which need to be clarified, and arbitrary requirements which can be removed. To take one example, the contracts exception requires that a physician have only one contract with an entity to which he/she refers. This sounds reasonable in the abstract when applied to a solo practitioner providing services as a medical director of an inpatient hospital unit, but when a group practice with 150 physicians sits on the same campus with the hospital, they may have dozens of relationships, and there is no purpose to be served to force all into a single contract form for a single term.

Some compensation exceptions are available for transactions between physicians and hospitals, but not physicians and other entities that provided designated services. As with the hospital ownership exception discussed above, these distinctions have no rational basis.

4. Reporting Provisions

Stark II gives HFCA more tools than it can usefully use to gather information on physician ownership. There is no need for HFCA to engage in any "fishing expeditions" through surveys or otherwise. The fact that after several years, HFCA has not developed a reporting instrument under Stark II illustrates that point. Completion of surveys represents a cost to medical practices, and based on a review of draft survey forms prepared by HCFA, the data would be expensive to obtain and tabulate, and of questionable use to the government.

5. Definitional Problems

- The Stark law uses definitions in the law to add additional burdensome regulatory requirements. The most glaring problems are in the physician compensation requirements included in the definition of "group practice." These have proven totally unworkable, even ignoring the question of whether the federal government has an appropriate role in telling physicians who choose to practice together in clinics how they may be compensated. For example, it is impossible to apply the compensation test in Stark II fairly and uniformly across physician employees in tax-exempt clinics or medical schools, physician employees of for-profit groups, physician owners who are also employees, physicians in single specialty practices and physicians in multi-specialty practices, all of whom are treated somewhat differently under the test. Meanwhile, solo practitioners are not even subject to the test.

- Similarly, the law's definition of "referral" has added tremendous confusion and complexity to the law since it is not limited to physician referrals for those services subject to the law's prohibitions by virtue of being "designated" health services.

- Finally, the definition of "designated health services" in Stark II was the technical manner of expanding the law's reach beyond clinical laboratory services to a whole host of other diagnostic and therapeutic items. Some of these services offer little or no opportunity for excessive utilization and referral abuse. They may in fact represent just the opposite -- the potential for underutilization which then results in

greater costs to the Medicare program because the patient's condition goes untreated, resulting in more costly care down the road. Included in this category are radiation therapy, prescription drugs, physical and occupational therapy, and prosthetic and orthotic services. Permitting physician investment and referral to entities providing such therapeutic services poses no threat to the financial integrity of the Medicare and Medicaid programs. In addition, by including hospital services in the definition of designated services, Stark II has invalidated physician/hospital joint ventures designed to provide cost efficient services to hospital inpatients. For many such services economies of scale do not justify a hospital maintaining its own in-house service; instead it is more economical for hospitals and physicians to share in the cost and operation of certain services used by both inpatients and ambulatory patients. Since hospitals are paid a fix amount by Medicare for each inpatient based on his/her diagnosis, there is little incentive to overutilize ancillary services.

- In reexaming the provisions of the self referral law we believe the test should be whether or not physician ownership in services has caused or could reasonably lead to over utilization; and whether or not a restrictive provision is designed to prevent program abuse, or is just one more effort by the federal government to micro-manage an economic market that is not in need of such management. Heaping restriction upon restriction should not be raised as an excuse by regulators not to use the ample authority already provided through the fraud and abuse statutes, and the original ownership and referral law. More rules cannot substitute for the enforcement of existing laws, particularly when rules as embodied in the Stark II provisions would favor some economic entities (non-physicians) over others. We believe that the recommended changes summarized below would preserve the original intent of the Stark law, but at the same time restore market equity and patient access to services.

Section-By-Section Recommendations

1. General Exceptions Covering Both Ownership and Compensation Arrangements

   - Eliminate the prohibition against physician practices providing DME and parenteral and enteral services within their own practices
   - Eliminate the "site of service" restriction on in-office services
   - Amend the physician supervision requirement applicable to non-physician personnel to clarify that direct supervision is not required, and substitute a general supervision requirement.
   - Expand the prepaid exception to include state regulated and Medicaid plans
   - Clarify the rural exception to provide for compensation arrangements as well as ownership interests.
   - Add a community need exception
   - Add a shared services exception

2. Exceptions Related Only to Ownership

   - Expand the exception for physician ownership in hospital facilities to include ownership in other facilities including surgery centers, hospices, nursing homes, dialysis facilities, and CORFS.

3. Exceptions Covering Compensation Arrangements

   - Clarify exceptions related to space rentals, equipment leases, and personal services contracts

- Revise the compensation test in the employment exception by eliminating the reference to "direct or indirect"
- Extend the exception for compensation paid by a hospital to a physician for services "unrelated to designated health services" to include compensation from any entity - not just hospitals.
- Extend the physician recruitment exception to include all entities, not just hospitals

4. Reporting Requirements

- Repeal the section

5. Definitions

- Eliminate the physician compensation restrictions from the group practice definition
- Remove from the list of designated services those services which are not subject to abuse, whether or not they involve physician ownership, including:
  - radiology (except for CAT and MRI)
  - radiation therapy
  - prosthetics and orthotics
  - occupational and physical therapy
  - outpatient prescription drugs
  - hospital outpatient services not involving other designated services
  - hospital inpatient services

- Limit the definition of a referral to a request for a service on the designated list.

6. Preemption

- Provide for a preemption of state laws governing physician ownership and referral.

A Streamlined Self-Referral Law

The above represents a compilation of significant problems associated with the Stark self-referral law. Amending the law to correct these problems will in no way lessen protection against physician ownership in and referral to those services which have the potential for over utilization and abuse. We should note that this is not a complete compilation of the problems associated with the Stark law. There are many other minor and technical issues that should be addressed if the Congress should choose to amend the law. However, this compilation points to the need for a thorough reexamination of Stark II.

Contrary to what defenders of Stark II may allege, adoption of the recommendations detailed above would hardly open the door to major opportunities for physician abuse of the Medicare and Medicaid programs. In fact, a streamlined self-referral law, which could actually be implemented by HCFA, would enhance the government's ability to identify and prosecute those blatant joint ventures at which the law was originally directed.

An amended law, while not overreaching like Stark II, would still be far broader than Stark I, covering those ventures like major imaging centers that might provide particularly strong financial incentives to referring investors, and those lower-cost items like DME where the Inspector General suspects that unscrupulous suppliers have been taking advantage of the government payers.

The government also retains its full arsenal of other enforcement tools, including:

- Criminal sanctions under the anti-kickback law;
- Civil sanctions for medically unnecessary services and services of substandard quality; and
- Routine claims review, denial, and recoupment of overpayments for medically unnecessary services.

States also have an important role to play through facility and personnel licensure and certification to ensure that all providers of diagnostic services meet acceptable levels of quality.

Finally, the private sector payers are constraining utilization of services both through capitated payment systems, and more vigorous gatekeepers, prior approval, practice protocols, utilization review, and quality assurance mechanisms. As more Medicare and Medicaid beneficiaries are enrolled in managed care organizations, those organizations will increasingly dictate how, where, and whether ancillary services are provided. In the long run, these market pressures will better protect the federal programs than will any federal intrusion in the organizational design of physician group practices and other providers.

Chairman THOMAS. Thank you, Mr. Wenzel.
Dr. Balfour.

STATEMENT OF DONALD C. BALFOUR III, M.D., PRESIDENT, AMERICAN GROUP PRACTICE ASSOCIATION, ALEXANDRIA, VA

Dr. BALFOUR. Mr. Chairman and Members of the Subcommittee, on behalf of American Group Practice Association, I want to thank you for this opportunity to comment on problems associated with compliance with the self-referral statute.

I am Dr. Donald C. Balfour, president of American Group Practice Association, president and medical director of the Sharp Rees-Stealy Medical Group in San Diego, California. For group practices and integrated systems of care, the physician ownership and self-referral statute breaks down primarily in the area of compensation arrangements. We believe that it was Congress' intent to promote systems of care which improve access to care, continuously improve the quality of services, and reduce costs.

These simultaneous objectives are best achieved through the clinical and financial integration of services. To promote these objectives, Congress must take steps to eliminate the uncertainty regarding interpretation of the referral statute. Barriers to integration such as the compensation provisions of the statute must be removed to allow such systems to align incentives with the objective of improving the health of communities.

The Stark legislation is complicated and in some instances contradictory. Consequently, the task of interpreting conflicting provisions in the statute perplexes many group practice leaders and other providers and appears to be equally baffling to HCFA. Such confusion, when combined with the threat of enforcement and stiff statutory penalties clearly chills the interest of group practices in offering designated health services, even when doing so is beneficial to patients.

Several exceptions to the referral and billing prohibitions are set forth in the Stark law. Qualification for one of the enumerated exceptions is required if Medicare and Medicaid referrals for designated health services are to be permitted. If the standards for each exception are not met, then the referral or billing may be viewed as a prohibited activity subject to all the attendant penalties, including exclusion from Medicare.

One of the most common exceptions accessed by physicians to permit billing by group practice is the in-office ancillary services exception. Stark II allows group practices to pay productivity bonuses to physicians based upon services personally furnished by the physician or furnished incident to such physician services so long as the share of bonus is not determined in any manner which is directly related to the volume or value of referrals by the physician.

It is unclear, however, the extent to which physician members of a group can receive compensation based on a percentage of revenue generated from ancillary services. It is extremely confusing that Congress expressly permits a bonus paid upon incident to ancillary services, but also restricts the group practice from offering a bonus which varies directly based on referrals for those services.

No exception to Stark exists for integrated health care delivery systems. Referrals between and among the components of integrated systems are in the best interests of patients. The integration of common services and facilities to avoid duplication and to conserve scarce resources is the cornerstone of such systems. We believe that the current referral law which does not recognize these systems of care impedes their ability to bring even greater efficiencies to the marketplace, and working with Congress and the administration the American Group Practice Association identified many areas of ambiguity in the current physician referral law.

These are enumerated in our written testimony. The AGPA's recommendations are to promote the quality, improve the access and reduce costs. Congress must take the following steps to eliminate the ambiguity and uncertainty regarding the interpretation of the physician ownership and self-referral statute.

The first point would be without clarification HCFA faces a great deal of uncertainty about the intent of the law and the meaning of significant terms, conditions, and exceptions in the statute. Absent clarification, we believe enforcement actions are unrealistic and improper. In the absence of further guidance from Congress, we recommend the postponement of the effective date of the statute for 2 years or until final implementing regulations are published.

The second recommendation is the continued evolution of the health care options which meet the needs of patients and payers is cause to rethink the policies underlying physician self-referral restrictions. At a minimum, statutory and regulatory initiatives should preserve the intent of the in-office ancillary service exception. The ability of group practices to engage in the delivery of health care services independently or as part of an integrated system of care depends upon this exception.

The final recommendation is both the antikickback law and the compensation provisions of the self-referral law seek to prohibit payments in exchange for referrals, and the associated potential for overutilization of services. It is unclear how the compensation aspect of the self-referral law provides any real benefit over the antikickback law.

In fact, its existence is having a negative effect of impairing legitimate marketplace transactions. Deleting the compensation provision while preserving the ownership provision would maintain the law's integrity and remove its detrimental effect on the market. American Group Practice Association recommends, therefore, that the physician referral statute be clarified, eliminating the compensation arrangement provisions. Thank you for the opportunity to share these observations. I will look forward to your questions and the opportunity to work with you on these issues.

[The prepared statement follows:]

Testimony to the
Subcommittee on Health
Committee on Ways and Means

Presented By

Donald C. Balfour III, M.D.

Re: Physician Ownership and Referral
May 3, 1995

Mr. Chairman and members of the Committee, on behalf of the American Group Practice Association, I want to thank you for this opportunity to comment on problems associated with compliance with the self-referral provisions of the Social Security Act.

I am Dr. Donald C. Balfour III, President of the American Group Practice Association ("AGPA"), President and Medical Director of the Sharp Rees-Stealy Medical Group in San Diego, California, and a practicing hematologist.

The AGPA represents multispecialty group practices that provide hospital and clinical services in integrated delivery systems. Medical group practices serve as the hub of many integrated delivery systems. A substantial and evolving body of research has shown that such systems of care are the highest quality and yet most cost effective providers of health services. Frequently, these organizations are the largest employer in a community. Some of our member groups provide services through a single point of service, some have large networks in a single region, and some have multiple sites in several regions and states. We believe that group practice should be encouraged as a means of improving access to and coordination of care, reducing the administrative costs of health care delivery, and monitoring both the quality and cost of health care services.

Federal self-referral legislation is intended to eliminate opportunities for over-utilization of health care services driven by economic incentives rather than by medical necessity. We join Congress in condemning unethical practices of physicians who abuse their patients' trust for personal financial gain. I ask however that you not lose sight of the simple truth that the vast majority of physicians do not fall into that category and most physicians continue to place their fiduciary duty to their patients above any personal concern.

For group practices and integrated systems of care, the physician ownership and self-referral statute breaks down primarily in the area of compensation arrangements. We believe that it was Congress' intent to promote systems of care which improve access to care, continuously improve the quality of services, and reduce costs. These simultaneous objectives are best achieved through the clinical and financial integration of services. The marketplace is demanding consolidated and integrated delivery system approaches in the transformation from fee-for-service to capitation and managed care.

To further promote these objectives Congress must take steps to eliminate the ambiguity and uncertainty regarding interpretation of the physician ownership and self-referral statute. Barriers to integration such as the compensation provisions of the statute must be removed to allow such systems to align incentives and rewards with the objective of insuring the health of enrolled populations.

Group practices are playing an integral role in a changing and evolving health care system, but we fear that some of the innovations of group practice medicine may be stifled by rigorous application of prohibitions set forth in the self-referral statute.

The emergence of integrated multispecialty group practices is a relatively recent trend in which the elements needed to provide all aspects of health care services to a population of people are brought together in a coordinated and accountable fashion. In such a system, the traditional paradigm of medical care shifts from the treatment of acute episodes of illness in individual patients to an emphasis on the continuous maintenance of the wellness of an enrolled population, and care provided at an appropriate level.

In direct response to market forces, small groups are now unifying into larger

multispecialty groups and groups are integrating with other health care entities, such as hospitals, ambulatory care facilities, and insurers. Currently, more than 30 percent of all physicians practice in group practices. Nationwide the number of group practices has nearly doubled from about 8500 in 1975 to about 16,500 in 1991. In 1975 there were about 67,000 group practice physicians, and by 1991 that number had nearly tripled to about 180,000.

Multispecialty group practices are patient-focused systems of care, which may be geographically decentralized with multiple convenient sites. Primary and specialty care is balanced to meet the needs of large groups, communities or populations. Sophisticated information management enables complete knowledge of health care expenditures, as well as systems to monitor utilization of services, measurement of cost and quality outcomes, patient satisfaction and access.

The ability to contain costs and maintain quality of care has attracted businesses seeking to control health insurance spending. Payers, especially those businesses that self-insure as well as those that have combined to create purchasing coalitions, are increasing their demands for efficient use of health care dollars because of the harsh effect of health care costs on their competitiveness. They want cost control and they want to buy care based on documented outcomes. They want consistent quality and processes across the system, and they don't want a health plan shortcut -- they want a real partnership with their providers. In short, they want VALUE.

Payers have also recognized one way to get value is to pay one organization for the complete spectrum of care -- primary, acute, rehabilitative and nursing care -- that their employees or enrollees need. A growing trend is for employers to contract directly with multispecialty group practices for their employees' health care, working in a collaborative manner to deliver effective and high quality patient care.

Group practice success in containing cost is achieved through the proper managing of patient care. Mayo Clinic's growth in spending per capita did not exceed GDP growth from 1988-92. At Henry Ford Health System's HMO, the capitation which physicians in the Henry Ford Medical Group receive to cover all professional services, inpatient care, ambulatory care and covered ancillary services has grown at an average rate of 7.15 percent between 1985 and 1993. This compares to an 9.95 percent annual growth rate in per capita national expenditures for comparable services. Henry Ford also has evidence that once efficient practice patterns are developed, there are verifiable carry-over cost benefits to fee-for-service populations served by the same physicians. For example, for services provided to the Medicare patient population, the annual increase in the average Medicare payment to Henry Ford Medical Group averages 4.5 percent since 1988, compared to a national average of 7.9 percent annual growth in Medicare costs.

Compensation Arrangements

The self-referral provisions are complex, highly detailed and, in spite of an exemption for group practice from aspects of the law, still cause numerous difficulties. For our membership, major confounding issues are introduced by the requirements related to compensation arrangements. An important aspect of what makes group practice medicine unique is the way our physicians are compensated. There are many methodologies for determining the income of physicians in groups. Traditional fee-for-service payment methodologies are giving way to salary structures coupled with profit sharing and incentives for physician characteristics that the group values, as well as capitation payment mechanisms that fluctuate with enrollment but align individual incentives with group objectives.

Examples of indicators which an organization might use to measure member performance include:

* Patient encounters, panel and nonpanel;
* Quality of care, measured by total of charts reviewed, percentage rated satisfactory or superior, and CME credits;
* Quality of service, measured through patient satisfaction ratings, patient complaints,

liability claims, compliments, office visits, new office visits, consultations, and complete physical exams;
* Cost effectiveness, measured by primary care physician panel activity, total cost of external referrals, ancillary service usage, and length of stay in acute or SNF facilities;
*Organizational participation measured by staff, department, or committee meetings, CQI/guideline meetings, hospital and specialty society meetings;
* Contributions to medical education; and,
* Research activities.

Because of the inherent differences between fee-for-service and capitated systems, the challenge to an organization comes as it merges data from the opposing revenue sources. Patients come to group practices under a mix of payment arrangements including fee-for-service, negotiated and direct contracting, and capitation. Most physicians and caregivers in such an organization are completely ignorant of the mechanism by which any patient's care is reimbursed. Once the efficiencies of capitation are realized among clinicians in the group, the mindset which results is heavily biased towards patient and care management.

We raise these issues because: 1) we believe in a market-based health care delivery system that enhances consumer choice and access to health care services, and promotes innovation; 2) we believe that delivery systems should compete for clientele on the basis of cost and quality; and 3) the dynamics of market competition are driven by strategies which accelerate the process of clinical and financial integration within an organization.

Barriers to Compliance

AGPA has included an issue brief on the status of the self-referral statute and regulations as an attachment to this testimony. Without belaboring the details of the construction of the statute or the evolution and delay of the regulations, I would like to share our view of the difficulties and obstacles we face in attempting to comply with the prohibitions which became effective in 1992, and subsequently, for designated health services (DHS), which became effective January 1, 1995.

AGPA has actively participated in the legislative and administrative work on this statute since it was first introduced as the "Ethics in Patient Referrals Statute of 1988." We credit Representative Stark with leadership in devising legislation which has accelerated trends of integration and consolidation in the health care delivery system. Congress enacted what has come to be known as "Stark I" as part of the Omnibus Budget Reconciliation of 1989. The prohibitions of the statute were extended to a list of "designated health services" as part of the Omnibus Budget Reconciliation Act of 1993. During the initial work on the statute, we could not have anticipated the problems which we are now aware of.

We believe that changes to the statute would go far to encourage the cost-effective trends currently at work in the marketplace. Amendments are needed to repair some of the damage that has been created for a variety of transformational delivery system models by provisions in the law.

Final rules implementing the ban on referrals for clinical laboratory services are expected to be published shortly. HCFA has indicated that the final rules for Stark I will set the tone and provide guidance for implementation of Stark II. Stark II has extremely broad implications for physicians and any health care organization with which they do business.

The law prohibits a physician who has a financial relationship with an entity from referring Medicare and Medicaid patients to that entity to receive a designated health service. A financial relationship can exist as an ownership or investment interest in or a compensation arrangement with an entity. The law is triggered by the mere fact that a financial relationship exists; it does not matter what the physician intends when he or she makes a referral or whether he or she knows if a financial relationship exists.

In working with Congress and the Administration, AGPA has identified many areas of uncertainty and ambiguity in the statute since Congress passed Stark II in 1993. Without

further clarifying legislation, however, HCFA cannot resolve all of the problems apparent in Stark II. Consequently we recommend postponement of the effective date of the statute while Congress considers clarifying amendments.

Pending the publication of final regulations on DHS, which cannot reasonably be expected until 1996 or 1997, HCFA has indicated that enforcement will rely on "the language of the statute." In addition, HCFA has announced that it will begin compliance audits for these provisions once the final rule on clinical laboratory services is published.

Federal penalties which may result from a misinterpretation of the statute are potentially devastating. On March 31, 1995 the Office of the Inspector General (OIG) published final rules implementing civil money penalties, assessments, and an exclusion against any person who presents, or causes to be presented, a bill or claim the person knows or should know is for a service unlawfully referred under the self-referral statute, and has not refunded (within 60 days) amounts inappropriately collected for a prohibited referral. The OIG has announced its intentions to bring enforcement actions before HCFA has promulgated both sets of implementing regulations for Stark I and Stark II.

Absent clarification of a number of ambiguities related to the enumerated exceptions to the statute, we believe enforcement actions are unrealistic and improper.

Exceptions to Stark II

Several exceptions to the referral and billing prohibitions are set forth in the Stark law. Qualification for one of the enumerated exceptions is required if Medicare and Medicaid referrals for designated health services by a physician who has a financial relationship with an entity, including a group practice, are to be permitted. Some exceptions relate to both ownership/investment interests and compensation arrangements, and some relate to only one of these.

Specifically, the statute allows exceptions for 1) "physicians services provided personally by or under the supervision of a physician in the same group practice; 2) "in-office ancillary services;" and 3) "prepaid plans." We call your attention to the application of the exceptions because the standards for each exception must be met or the referral for a designated health service is viewed as a prohibited activity subject to all of the attendant penalties.

In the following sections we will demonstrate the breadth of unresolved issues which significantly interfere with the financial and clinical integration of a health care system. In the fullest sense of some reasonable interpretations of the statute, any organization providing designated health services in which the exception has been applied erroneously is subject to exclusion.

There are a number of exceptions related to both ownership and compensation arrangements: physicians' services when a physician refers to a member of the same group practice; certain in-office ancillary services furnished by solo practitioners and group practices; or and services furnished by certain organizations with prepaid plans (e.g., some federally qualified HMOs).

There are exceptions related only to ownership/investment interests: Ownership in certain publicly traded securities and mutual funds; DHS provided by a hospital in Puerto Rico; DHS furnished by a rural provider; or DHS provided by a hospital outside of Puerto Rico if the referring physician can perform services at the hospital and the ownership or investment interest is in the whole hospital (not in a subdivision of the hospital).

And there are exceptions related to compensation arrangements: payments made for the rental of office space or equipment; payments made to a physician (or immediate family member) who has a bona fide employment relationship with an entity; payments made to a physician or family member for personal services; payments involved in an isolated financial transaction; payments made by a hospital to a physician if the payment do not relate to DHS; payments made by a hospital to recruit a physician; certain payments resulting from a group practice's arrangements with a hospital when DHS are provided

by the group; or payments by a physician to an entity for items and services.

In-Office Ancillary Services Exception: One of the most common exceptions accessed by physicians in group practices to permit billing by the group practice entity to the Medicare program is the in-office ancillary services exception. This exception protects some (but not all) designated health services offered by group practices that meet specific standards. With the passage of Stark II, this exception is critical to enabling group practices to offer a full spectrum of coordinated medical services to their patients.

As presently constructed, the definition of the term "**group practice**" requires each member of the group to furnish substantially the full range of services the physician routinely provides within the group practice. A "group practice" is defined in the statute to be: 2 or more MDs, providing services in the name of the group, billing in the name of the group, and distributing the proceeds in a predetermined manner, and allocating overhead expenses. New provisions enacted as part of OBRA '93 require that no physician who is a member of a group may receive **directly or indirectly** compensation that is based upon the volume or value of his referrals; and, in order to qualify as a group, 75 percent of the physician-patient encounters of members of the group must be within the group practice.

Many of the definitional requirements of the Stark law are designed to limit the in-office ancillary exception to bona fide, integrated group practices. The Stark II definition of a group practice specifies that a physician in a group practice may be paid a share of overall practice revenue of the group or a productivity bonus based upon services personally furnished by the physician, or furnished "incident to" such physician's services, so long as the share or bonus is not determined in any manner which is directly related to the volume or value of referrals by the physician.

Contradictions in the Law

The OBRA '93 physician ownership and self-referral provisions have accelerated a trend in group practice financial relationships and in systems of compensation which eliminate incentives for overutilization of services. **But the Stark legislation is complicated and in some instances contradictory, consequently, the task of interpreting conflicting provisions in the statute perplexes many group practice leaders, and other providers, and appears to be equally baffling to HCFA.** Such confusion, when combined with the threat of enforcement and statutory stiff penalties, clearly chills the interest of group practices in offering DSH, even when doing so is beneficial to patients.

Several questions arise with respect to permissible compensation mechanisms. Clearly, physician members of a group can be compensated on a salaried, hourly, or fee-for-service basis for professional services personally furnished to patients or administrative services that benefit the functioning of the group, such as quality assurance or utilization review activities. It is unclear, however, the extent to which physician members of a group can receive compensation based on a percentage of revenue generated from ancillary services. It is extremely confusing that Congress expressly permits a bonus based upon "incident to" ancillary services, but also restricts the group practice from offering a bonus which varies directly based on referrals for those services.

Although distributions based on services ordered are prohibited after January 1, 1995, ancillary service revenue can be distributed to group practice members as long as the methodology for distribution does not include volume considerations. The distribution of ancillary revenue based upon ownership interests in a group practice or on an equal basis to all members of a group practice would be clearly permitted. An equal distribution of all ancillary service revenue to group members is not, however, required. To illustrate, departments within a large group practice, or individual physicians, may receive different proportions of ancillary service revenue if the distribution methodology was not volume driven. In this regard, historical data, such as patient satisfaction, outcomes, or years of service to the group practice entity could be considered. Utilization of historical data relating to personally performed services should also be permissible (e.g., the ratio of the revenue generated from the physician's personally performed services to total group practice revenue could be applied to all profit distributions, including ancillary service revenue). Utilization of historical data that is volume based (i.e., based upon past

percentages of referrals for ancillary services) would produce a compensation mechanism that would likely fail to comply with the Stark law requirements.

Integrated Delivery Systems: The physician ownership and self-referral legislation contemplates an environment in which physicians have few, if any, formal affiliations with other physicians or institutional providers. That environment is not one in which large multispecialty group practices find themselves. Rather, many group practices provide the physician component of a complex, integrated health care delivery system that has evolved over many years to serve the health care needs of large population groups. These systems have been created in response to customer-focused changes in the health care environment and specific expectations of patients. They provide the training ground for the physicians of tomorrow and the laboratory for the future's medical and scientific advances.

No exception to Stark exists for integrated health care delivery systems. Yet, referrals between and among the components of integrated systems are in the best interest of patients and intrinsic to the efficiency of such systems. The development of common services and facilities to avoid duplication and to conserve scarce resources is the cornerstone of an integrated health care delivery system, but the creation and use of these facilities might be curtailed by the Stark legislation.

Compensation Arrangements

For group practices and integrated systems of care, the physician ownership and self-referral statute breaks down primarily in the area of compensation arrangements. The following examples depict legitimate business circumstances that may be impaired by the self-referral compensation provisions. If Congress undertakes the task of clarifying the interpretation of the statute we would strongly suggest that the compensation arrangement provisions be revised. These provisions are redundant to the anti-kickback provisions which establish criminal penalties for payments to induce referrals.

Problems Arising From Self-Referral Compensation Provisions

Listed below is a sampling of the types of arrangements that may be impaired by the compensation prohibition on the self-referral law. This list is by no means comprehensive.

Shared Services

- In many instances, hospitals share services with large group practices, such as data processing, medical records, power plants, even clinical laboratories. These arrangements achieve cost efficiencies. Oftentimes one of the parties acts as the paying agent and is reimbursed by the other for its share of the expenses of the shared service based upon usage. Even where remuneration exchanged complies with the anti-kickback law, there is no apparent exception in the self-referral law that would apply to them.

Recruitment

- A hospital may recruit new physicians by paying a recruitment package for the relocation of a new physician to join a group practice that may be composed completely, or in part, of existing members of the hospital's medical staff. The payments to the group are designed as a "pass-through" directly to the recruited physician and are revenue neutral to the existing group. Assuming such payments otherwise would satisfy the self-referral recruitment exception if paid directly to a physician, technically the exception may not protect the recruitment payment to the group practice. Such arrangements are intended to increase the likelihood of the recruited physician's success in a new area, to simplify the accounting since the recruited physician generally is paid a salary as an employee of the group, and to take advantage of the ability to share overhead expenses and reduce costs.

- The self-referral recruitment exception is limited to recruitment of physicians from another geographic area. Thus, protection is not extended to recruitment of

physicians who are completing a local residency. (The proposed recruitment safe harbor under the anti-kickback law would extend such protection).

- The self-referral physician recruitment exception does not protect the recruitment of physicians who currently practice within the service area, but who will not be able to refer their existing patients to the hospital due to the nature of their previous practice (e.g., physician employees of HMOs, government clinics).

- The self-referral physician recruitment exception applies only to hospitals; group practice and other entities' recruitment efforts are not addressed by any exception and therefore are not specifically protected.

Leases

- The self-referral rental of space exception technically may not apply to the rental of non-office space, such as parking facilities, or to ground leases. Yet, group practices frequently lease such premises from hospitals and there is safe harbor protection available for such leases under the anti-kickback law. Also, it is not unusual for group practices to build their facilities on land leased from a hospital under a long-term ground lease.

- The self-referral lease exceptions may not protect commercially-reasonable short-term leases with physicians. Yet, such leases are desirable to permit physicians to assess a market before committing to a long-term lease or may be necessary in connection with a temporary relocation pending availability or completion of renovation of permanent space.

Practice Acquisition

- Hospital acquisitions of physician group practices may be stymied by the self-referral law because hospitals may not be able to pay cash for such practices and, instead, may issue notes to the physicians who remain in the practices. These notes may not be protected under the isolated transaction exception of the self-referral law, even if their terms are at fair market value.

Loans

- It is unclear whether secured or unsecured loans are considered ownership interests or compensation arrangements under the self-referral law. A loan may be desirable from a hospital to a physician group, for instance, as part of the initial capitalization of a physician/hospital organization (PHO) owned in part by physicians. If a loan is considered an ownership arrangement (because the statute defines ownership as through "equity, debt, or other means"), it is unclear whether the exception for ownership in a hospital as a whole would be available when the loan is from a hospital to a physician. Further, if a loan is considered a compensation arrangement (whether secured or unsecured) and is repaid at fair market value, the law still may not provide protection.

Management Service Organizations (MSOs)

- Group practice physicians are more frequently contracting for space, equipment, management, and other services with MSOs (that are at least partially owned by a hospital to which they make referrals and partially owned by the physicians). Existing self-referral exceptions may not permit physician ownership interests in such an MSO entity in some circumstances. Further, it is unclear whether payments from the group practice to the MSO for all the items and services provided may be based on a percentage of group practice collections.

Physician/Hospital Organizations (PHOs)

- The self-referral law may not protect the initial capitalization of a PHO (or an Independent Practitioner Association (IPA)) by a hospital. Yet, without such capitalization, the PHO (or IPA), which is a building block to managed care

arrangements, may not be established at all.

- A hospital may establish a PHO as a division of the hospital. Consequently, participating physicians' contracts with the PHO technically are contracts with the hospital itself. The contracts between the hospital and participating physicians may provide that physicians will perform services as required by the PHO's contracts with payors, at the negotiated rates under the payor agreements. The self-referral law may not protect third-party payor payments to the physicians that flow through the PHO so that the PHO can retain a portion of the payments to fund its operations and to facilitate participation in capitated arrangements.

Services Provided to Hospital Inpatients

- Physician-owned entities, other than group practices, frequently provide services under arrangements to hospital inpatients, such as dialysis. Even though dialysis is not a designated health service, it becomes one when provided to hospital inpatients. The self-referral law only protects such arrangements when provided by a group practice in accordance with an agreement in place as of December, 1989. However, such arrangements, whether established before or after 1989 and provided through physician-owned entities which are not group practices, may offer cost-efficiencies and otherwise satisfy the anti-kickback law.

Profit-Sharing with Physicians

- Hospitals may wish to pay employed physicians an annual bonus based upon the hospital's overall actual performance as compared to its budgeted performance. The self-referral law does not appear to protect this arrangement even though (i) profit-sharing is a common employee compensation mechanism; (ii) an employed physician's ability to affect overall hospital profits is insignificant; and (iii) the physician would be permitted to have an ownership interest in the hospital as a whole.

Medical Education Arrangements

- The self-referral law may not protect arrangements for medical education programs between hospitals and group practices or between a hospital and a university or its medical school. For instance, a hospital may provide new technology to a medical group as part of its teaching program for which no exception apparently exists.

Early Termination Clauses

- Many lease, employment, and personal services arrangements provide for the ability to terminate an agreement before the term expires, often after an initial year-long term has transpired. For instance, an agreement may exist between a hospital and a physician to provide services which are only required for a limited period of time, such as consultation services required in connection with the start up of a new hospital service. There would appear to be no logic to prohibiting a hospital from billing for services ordered by a physician simply because the hospital only required his or her consultation services for a period of less than one year.

AGPA Recommendations:

For group practices and integrated systems of care the physician ownership and self-referral statute breaks down primarily in the area of compensation arrangements. We believe that it was Congress' intent to promote systems of care which improve access to care, continuously improve the quality of services, and reduce costs. These simultaneous objectives are best achieved through the clinical and financial integration of services. The marketplace is demanding consolidated and integrated delivery system approaches in the transformation from fee-for-service to capitation and managed care.

To further promote these objectives, Congress must take the following steps to eliminate the ambiguity and uncertainty regarding interpretation of the physician ownership and self-referral statute. Barriers to integration, such as the compensation provisions of the statute, must be removed to allow such systems to align incentives and rewards with the objective of insuring the health of enrolled populations.

* Without clarification, HCFA faces a great deal of uncertainty about the intent of the law and the meaning of significant terms, conditions and exceptions in the statute. **In the absence of further guidance from Congress, we recommend postponement of the effective date of the statute for two years, or until final implementing regulations are published.**

* The continued evolution of health care options, which meet the needs of patients and payors, is cause to rethink the policies underlying physician self-referral restrictions. At a minimum, statutory and regulatory initiatives should preserve the intent of the in-office ancillary service exception and the ability of group practices to engage in the delivery of health care services as part of integrated systems of care, to continue innovation promoting cost efficiencies in the competitive market in which health care services are provided.

* Congress should clarify interpretations of the statute by eliminating the compensation arrangement provisions. These are redundant to the anti-kickback provisions which establish criminal penalties for payments to induce referrals.

Both the anti-kickback law and the compensation provisions of the self-referral law seek to prohibit payments in exchange for referrals and the associated potential for overutilization of services. However, while the anti-kickback law is framed in terms of the intention to seek referrals, the self-referral law sets forth a "bright line" test and prohibits certain arrangements regardless of whether any intention to seek referrals exists or any overutilization results. Moreover, due to ambiguities inherent in the compensation provisions the self-referral law has the potential to be even more overreaching. It is unclear how the compensation aspect of the self-referral law provides any real benefit over the anti-kickback law. In fact, its existence is having the negative effect of impairing legitimate marketplace transactions. Deleting the compensation provision while preserving the ownership prohibition would maintain the law's integrity and remove its detrimental effect on the market.

Thank you for this opportunity to submit written comments. We stand ready with the resources of the Association to support your efforts to improve the nation's health care system.

Chairman THOMAS. Thank you, Dr. Balfour.

Mr. Griffin.

STATEMENT OF PHIL GRIFFIN, VICE PRESIDENT, PUBLIC POLICY, PREFFERED ONE, MINNESOTA, ON BEHALF OF THE AMERICAN MANAGED CARE AND REVIEW ASSOCIATION

Mr. GRIFFIN. Thank you, Mr. Chairman. Good morning.

Chairman THOMAS. I believe your mike is not on. Down on the base there should be a switch.

Mr. GRIFFIN. Mr. Chairman, this one seems to be working. Good morning, Mr. Chairman, Members of the Subcommittee, my name is Phil Griffin. I am vice president of public policy at Preferred One, a Minnesota-based preferred provider organization, with over 450,000 enrollees.

I am testifying today on behalf of AMCRA, the American Managed Care and Review Association as chairman of their public policy committee. AMCRA is the national trade association representing the full spectrum of MCOs, managed care organizations, such as HMOs, health maintenance organizations, and PPOs, preferred provider organizations. AMCRA's 500-plus member companies provide health care services to over 85 million Americans.

In addition, AMCRA's board of directors is currently composed of 50 percent managed care physicians and 50 percent managed care chief executive officers. Thus, AMCRA can provide the Subcommittee with a unique perspective on the self-referral law.

The physician self-referral law was enacted to address overutilization in the Medicare and Medicaid fee-for-service programs. Unfortunately, the broad reach of the self-referral ban has had many unintended consequences for MCOs. Moreover, the law is affecting managed care arrangements far beyond Medicare and Medicaid. Significantly, many managed care organizations may be unaware of the legal constraints imposed by the physician self-referral law because they do not view themselves as either designated health service providers or as servicing a Medicare or Medicaid population. Yet, even MCOs with only commercial business will discover on closer examination that their employer group health plan customers include Medicare eligibles, such as working aged and retirees.

Under the self-referral ban, MCOs with any degree of physician ownership generally cannot furnish designated health services. Yet increasingly, managed care organizations are finding that it can be most effective to furnish certain designated health services and are seeking to incorporate these services directly into their business operations. For example, in my home State of Minnesota, we have seen a movement toward vertical integration in the three major health plan companies. This movement has been spurred by the employer community and its demands for cost-effective quality health care services.

At the same time, managed care organizations are seeking ways to make the provider community a partner in the delivery of cost-effective quality health care. One way of doing this is to offer physicians equity participation in the organizations. Similarly, many provider organizations are adding an insurance component in order to be in a position to accept financial risk for health care services

consistent with State insurance regulation. Overall, the line between payer and provider is becoming blurred with significant consequences under the physician self-referral law.

The self-referral ban also constrains vertical integration of MCOs when physicians have only contractual arrangements with the organizations. Any provider agreement with a managed care organization could be considered a compensation arrangement if not otherwise exempt. Once a physician has a compensation arrangement with an entity, the law precludes the physician from referring to that entity for designated health services unless the provider agreement meets certain criteria, including compliance with HCFA's forthcoming physician incentive plan rule.

This regulatory scheme mixes apples and oranges. The incentive rule is intended to address potential underutilization in Medicare and Medicaid managed care arrangements, whereas the purpose of the physician self-referral law is to prevent overutilization in the Medicare and Medicaid fee-for-service programs. In its rule, HCFA has proposed a complicated mathematical scheme for regulating the financial risk that physicians may accept from referrals. Once the rule is final, a physician only will be able to refer Medicare managed care patients to the HMO's or PPO's in-house laboratory or radiology facility if the physician's compensation arrangement with the MCO meets the guidelines of the rule. As a result, this rule, designed to regulate Medicare managed care, will now regulate all commercial managed care arrangements, which may involve Medicare eligibles only incidentally.

AMCRA does appreciate Congress' past efforts to provide exceptions for managed care activities from the broad reach of the self-referral law, but the managed care exceptions adopted thus far are not sufficient. The current prepaid exception extends only to enrollees of Medicare contracting and federally qualified health plans and to certain other statutorily recognized cubbyholes for managed care organization dealings with the Medicare Program. Medicaid managed care does not qualify for any exception, nor does the current statute protect State-licensed HMO, PPOs or even Medicare contracting or federally-qualified HMOs to the extent they also offer PPO, point-of-service or non-federally-qualified products. Yet it is the PPO and point-of-service managed care products that are especially consumer friendly, allowing patients full access to non-network providers through the payment of higher out-of-pocket costs rather than requiring patients to use plan providers.

By protecting only formal Medicare managed care and other governmental programs, the self-referral law operates to actually grant more latitude to managed care organizations with substantial Medicare operations and little latitude to MCOs with predominantly commercial business. For instance, the law would presently allow a Medicare contracting health plan to contract with a physician-owned laboratory service to service the Medicare risk or contract enrollees. However, a health plan that only incidentally serves Medicare beneficiaries would be prohibited from doing so.

It is time to adopt a reasonable managed care physician self-referral policy that acknowledges the role of the marketplace in controlling overutilization in managed care while maintaining quality of care. The success of managed care organizations depend upon

the ability to market to employers and their employees quality, affordable, and comprehensive care.

Managed care organizations control costs not only through negotiations for lower prices, but also through the adoption of utilization review policies and by placing providers at financial risk for health services they furnish and order. Each managed care organization adopts the combination of utilization review, financial risk and quality assurance measures it believes best to control utilization and provide quality.

If an MCO is unsuccessful in controlling health care costs or delivering quality health services, it will suffer from a market standpoint. The market will not tolerate managed care arrangements that lead to overutilization, lower quality health care, and increased costs for employers and consumers.

AMCRA recognizes the legitimate role of the Federal Government to regulate in order to eliminate known abuses in the Medicare and Medicaid managed care programs. Yet, we do not understand why MCOs serving largely commercial populations are subject to this complex Federal regulatory framework and to the high costs associated with regulatory compliance, when we are aware of no data demonstrating that physician investment in managed care organizations leads to the abuses typically associated with the physician self-referral law.

Managed care is part of the solution, not part of the problem. Managed care's goal of controlling overutilization is entirely consistent with the governmental objectives in limiting physician self-referral. Nevertheless, a more balanced regulatory approach toward managed care organizations with respect to physician self-referral is plainly appropriate.

Mr. Chairman, we stand ready at AMCRA to assist you and Members of the Subcommittee as you pursue this investigation. If we can provide any answers to questions or help in any way, please feel free to call on us. Thank you.

[The prepared statement follows:]

TESTIMONY OF E. PHIL GRIFFIN
AMERICAN MANAGED CARE AND REVIEW ASSOCIATION

Good morning Mr. Chairman and members of the subcommittee. My name is Phil Griffin. I am Vice President of Public Policy at Preferred One, a Minnesota-based Preferred Provider Organization with over 450,000 enrollees. I am testifying today as Chairman of the Public Policy Committee of the American Managed Care and Review Association (AMCRA). On behalf of AMCRA, thank you, Mr. Chairman, for the opportunity to provide testimony on the managed care implications of the federal "physician self-referral law"[1] before the Subcommittee on Health of the Committee on Ways and Means.

AMCRA is the national trade association representing the full spectrum of Managed Care Organizations (MCOs), including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Independent Practice/Physician Organizations (IPAs), Utilizations Review Organizations (UROs) and Physician-Hospital Organizations (PHOs). AMCRA member companies provide approximately 85 million Americans with a health care choice that emphasizes the appropriate use of health care facilities and services, resulting in high quality health care at an affordable cost. With over 500 member organizations, AMCRA also includes a broad-based membership of allied health professionals who provide services to MCOs. In addition, the Board of Directors of AMCRA is currently composed of 50% managed care physicians and 50% managed care organization CEOs. Thus, AMCRA is uniquely positioned to provide the subcommittee with a combination provider/managed care organization perspective on the physician self-referral law, as well as on other health care issues.

The federal physician self-referral law was enacted to address the abuses thought to be associated with physician self-referral in a fee-for-service health care system. In other words, the law was adopted to address the potential for overutilization in the Medicare and Medicaid fee-for-service programs when a physician has an opportunity to profit financially from his or her referrals.

---

[1] § 1877 of the Social Security Act

Specifically, the physician self-referral law prohibits a physician from making a referral to an entity for the furnishing of certain "designated health services," if the physician has a "financial relationship" with that entity, unless the financial relationship falls squarely within one of the statute's enumerated exceptions. A financial relationship includes "ownership or investment interests" as well as "compensation relationships."

Unfortunately, the broad reach of this self-referral ban language has had many unintended consequences for the health care industry generally and for MCOs in particular. Moreover, the self-referral ban is affecting managed care arrangements and transactions far beyond the Medicare and Medicaid programs. Significantly, many managed care organizations may be unaware of the legal constraints imposed by the physician self-referral law because they do not view themselves as either designated health service providers or as servicing a Medicare or Medicaid population. Yet even MCOs with only commercial business will discover, on closer examination, that their employer group health plan customers include Medicare eligibles such as working aged and retirees. The Medicare Secondary Payor law requires these Medicare eligibles to be given the same benefits as other employees.

Under the physician self-referral ban, MCOs with any degree of physician ownership generally cannot furnish designated health services directly -- in other words, own and operate, for example, a laboratory, radiology facility or hospital as a line of business or subsidiary. Yet, managed care organizations are increasingly finding that it can be more cost-effective to furnish certain designated health services directly, and are seeking to "vertically integrate" as to those services -- that is, incorporate these services directly into their business operations, much as staff model HMOs always have operated. This trend toward vertical integration can be expected to continue as the managed care marketplace becomes more competitive. For example, in my home state of Minnesota, we have seen a movement toward vertical integration in the three major health plan companies. This movement has been spurred by the employer community and its demands for cost-effective, quality health care services.

At the same time, managed care organizations are seeking ways to make the provider community a "partner" in the delivery of cost-effective, quality health care. One effective means of doing so is to offer physicians equity participation in the MCO. Similarly, many provider organizations are adding an insurance component in order to be in a position to accept financial risk for health care services consistent with state insurance regulation. Overall, the line between payor and provider is becoming blurred, with significant consequences under the physician self-referral ban.

The physician self-referral law also may be implicated if a managed care organization, which is already vertically integrated with respect to designated health services, seeks to acquire an MCO with any degree of physician ownership.

If the physician-owned organization and/or its owners take back a note from the purchaser, or accept stock in the acquiring managed care organization for all or a portion of the purchase price, the physician-owners may be deemed to have a continuing ownership interest in the acquiring managed care organization under the physician self-referral law. So long as the note is outstanding, or the physicians hold the stock, the physicians cannot send Medicare or Medicaid patients to the acquiring managed care organization for any vertically integrated designated health services.

The physician self-referral law also constrains vertical integration of MCOs when physicians have only contractual arrangements with the organizations. Any provider agreement with a managed care organization could be considered a "compensation arrangement," if it is not otherwise exempt. Once a physician has a compensation arrangement with an entity, current law precludes the physician from referring to that entity for designated health services unless the provider agreement meets certain criteria, including compliance with the Health Care Financing Administration's (HCFA's) forthcoming "physician incentive plan rule."

This regulatory scheme mixes "apples and oranges." In contrast to the self-referral ban, which is designed to prevent overutilization of health care services, the physician incentive plan rule is intended to address potential underutilization in Medicare and Medicaid managed care arrangements by regulating the amount of financial risk that physicians may accept for referrals.

In its rule, HCFA has proposed a complicated mathematical scheme for regulating financial risk for referrals.[2] Once the rule is published in final form, a physician will only be able to refer managed care organization patients to the organization's in-house laboratory or radiology facility if the physician's compensation arrangement with the MCO meets the guidelines of the rule. As a result, this rule, designed to regulate Medicare managed care, will now regulate all commercial managed care arrangements which may involve Medicare eligibles only incidentally.

AMCRA does acknowledge and appreciate Congress's past efforts to provide exceptions for some managed care activities from the broad reach of the physician self-referral ban. But the managed care exceptions adopted thus far are not sufficient to protect the broad spectrum of managed care activities. The current "pre-paid plan" exception extends only to enrollees of Medicare contracting and federally qualified health plans and certain other statutorily recognized "cubbyholes" for managed care dealings with the Medicare program.

Medicaid managed care does not qualify for any exception. Nor does the current statute protect state licensed Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs), or even Medicare contracting or federally qualified HMOs to the extent that they also offer PPO, point-of-service or non-federally qualified products. Yet it is the PPO and point-of-service managed care products that are especially consumer-friendly, allowing patients full access to non-network providers through the payment of higher out-of pocket costs, rather than requiring patients to use the plan's provider network.

---

[2] 57 Fed. Reg. 59024 (December 14, 1992) to be codified at 42 CFR pt. 1003.

Each managed care organization adopts the combination of utilization review, financial risk and quality assurance measures it believes is best to control utilization of services and to provide quality health care. If an MCO is unsuccessful in controlling health care costs or delivering quality health care services, it will suffer from a market standpoint. If it is a PPO that sells its provider network and utilization and quality control program to self-insured employers and other third party payers, it will lose contracts. If it is an HMO or insurance company, it will lose subscribers (that is, market share). The market will not tolerate managed care arrangements that lead to overutilization, lower quality health care, and increased costs for consumers and employers.

AMCRA acknowledges the legitimate role of the federal government to regulate in order to eliminate known abuses in the Medicare and Medicaid managed care programs. Yet, AMCRA is aware of no data demonstrating that physician investment in managed care organizations leads to the abuses the physician self-referral law was designed to eliminate. We do not understand why MCOs serving a largely commercial population are subject to this complex federal regulatory framework, and to the costs associated with regulatory compliance, in an area where there is no documented evidence of abuse.

Managed care is a part of the solution to the current crisis in health care, not part of the problem. Managed care's overriding goal of controlling overutilization of health care services is entirely consistent with governmental objectives in limiting physician self-referral. Indeed, the managed care community and the federal government are on the same side with respect to provider fraud generally. Many of AMCRA's members are active in the joint private/public initiatives to eliminate provider fraud in all third party payment programs. Nevertheless, a more balanced regulatory approach with respect to physician self-referral is plainly appropriate. Unnecessary regulatory constraints on managed care activities, and the costs associated with regulatory compliance, only contribute to the rising cost of health care, and impede health plans from adopting strategies that encourage the provision of cost-effective, quality health care services.

By protecting only formal Medicare managed care and other governmental programs, current law operates to actually grant more latitude in the physician self-referral area to managed care organizations with substantial Medicare operations, and little latitude to MCOs with predominantly commercial business. For instance, the physician self-referral law presently would allow a Medicare contracting health plan to contract with a physician-owned clinical laboratory to service Medicare risk or cost contract enrollees. However, a health plan that only incidentally serves Medicare beneficiaries as part of an employer group health plan, and merely coordinates benefits with the Medicare program, would be prohibited from doing so. Thus, a law intended to regulate Medicare and Medicaid physician self-referral is actually more restrictive with respect to health plans with substantially commercial business, and less restrictive as to Medicare operations.

It is time to adopt a reasonable managed care physician self-referral policy that acknowledges the role of the marketplace in controlling overutilization in managed care, while maintaining quality of care. The success of a managed care organization depends on its ability to market to employers and their employees affordable, quality health care coverage--that is, comprehensive, quality health care coverage at lower premium cost. Like the federal government, managed care organizations know that health care costs are a function of both price per service and volume. Thus, managed care organizations control costs not only through negotiations for lower prices (i.e., discounts), but also through the adoption of utilization review policies and by placing providers at financial risk for the health care services they furnish and order. Financial risk includes not only capitation--a fixed fee per enrollee irrespective of the actual volume of health care services delivered--but it also includes withholds and bonuses that reward cost-effective behavior.

Mr. Chairman, thank you once again for the opportunity to testify before this subcommittee. AMCRA stands ready and willing to assist this subcommittee as it examines changes to the physician self-referral law, as well as with any other issues related to the Medicare and Medicaid programs. I will be happy to answer any questions you, or any other members of this subcommittee, may have at this time.

Chairman THOMAS. Thank you very much, Mr. Griffin. Thank the whole panel.

Does Mr. McCrery wish to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman. Just one question to Mr. Warden.

Mr. Warden, can you give us an idea of what the reporting requirements in the law would mean to your health system?

Mr. WARDEN. The reporting requirements, what they would mean to our system? Well, I think that they would mean that we would have to document the different kinds of transactions that we have. We would have to be able to document the referral arrangements that we have within our system. We would have to document the way in which central services are provided, and what the relationship of that is to the physicians in our group.

We would also have to be able to document the organizational arrangements between fee-for-service physicians and our hospitals and the different kinds of organizations that get created as a result of the partnerships, such as PPOs and MSOs, and the many different arrangements that occur.

Mr. MCCRERY. You do not presently have such a reporting regimen in effect? In other words, are you going to have to create this reporting regimen?

Mr. WARDEN. We would not have to create a reporting regimen because I think most of us recognize that these kind of relationships have to be documented. Quite the contrary, I think the problem that occurs is that in trying to create these relationships, quite often the need for such a wide variety of arrangements become a deterrent because the attorneys representing the physicians who are going to be part of these arrangements are very leery about what the impact may be on the individual physicians who contract with us.

Mr. MCCRERY. Thank you, Mr. Chairman.

Chairman THOMAS. Does Mr. Stark wish to inquire?

Mr. STARK. Yes, just a couple of comments, Mr. Chairman. I want to welcome Dr. Bristow from California, but I am a little bit confused and maybe subsequent to the hearing the AMA could correct me, but in 1991 and 1992 the AMA policy, and I am quoting relative to self-referral, is "presumptively inconsistent with the physician's fiduciary duty to their patients," and in your testimony today you indicate investing and referring as a direct extension is ethical and desirable.

My staff finds that somewhat inconsistent. Maybe it is semantic difference, but I would be interested to know the definitive statement of the AMA. Let me suggest that the panel today may be beating a dead horse, that they may be among themselves their own problem. I do not remember who represents which groups, but for the most part group practices that charge a set fee to the patient or to the insurance company and provide generally all services are exempted. But when we exempt them, we did not exempt the hospitals, so the hospitals are losing business to the group practices, and they are saying to us, let the hospitals get that exemption too, because the group practices are now not coming to the hospitals and paying us to do x rays and tests, and there are other changes.

On the one extreme if you have just the normal fee-for-service indemnity insurance community—which I suppose people would say is disappearing, but I do not think it is really all over the country—and if a radiologist calls up a GP or an internist and says I will give you $100 cash for every patient you send me, I doubt if any of you would say that is not unethical and ought not to be tolerated.

Is that an example of where we would be on that end of the scale? Anybody think that is fair? You all agree, I assume, that it is off the table. On the other hand, I would agree, and I think you all would agree, that in a capitated system where a patient pays $1,000 or $2,000 a year and all services are provided, there is hardly any attempt, any real need for worrying about this arrangement. But there is a new phenomena arising, and that is underutilization.

What if in that capitated plan you are paying Dr. X a bonus not to refer to a psychiatrist or not to put a person in the hospital? I think you all would say that is wrong, particularly if you give the guy some kind of a commission for every case withheld—if you could figure out when they should go to the hospital and they withheld it. We are getting complaints about withholding services in managed care or denying services.

Now, so this may swing completely the other way. There isn't going to be much referring for fees anymore because everybody has got some kind of a deal to be in a group practice. It may be the other side of the coin. It may be that the problems may exist in denying services or products or referrals outside of the system. We are beginning to hear anecdotal evidence.

You all may have differences depending on how you bill for your services, receive your income, or provide the care. I am not sure that you are not a part of the problem. As soon as we set a standard for Dr. Deggy's old clinic, then it may not fit into what works for Kaiser or for one of Mr. Warden's members in the Hospital Association, and I am not sure that you want us to say there is only one standard of managed care.

Right now, there are an awful lot of definitions of managed care. We did not create those. In other words, there are probably 500 different corporate structures and partnership structures and contractual structures in managed care. I do not know how we could possibly write a law to fit all of those. What I am saying is that this is not that easy on either side of this podium to do what I think we could all agree is reasonable.

Now, the Chair has a problem, HCFA has a problem, and Members will have a problem. We won't be able to solve it if you all as a group cannot get some standards. I know that is harder to work for because that is confining your ability to be creative, but that may be the price of a more efficient medical delivery system that we cannot, each one of us, be real creative in how we bill, how we collect, how we practice. I thank the witnesses for sharing with us their problems, but I also want to come back to them and say try and work out some of these differences among yourselves, then our legislation obviously will not impact each of you differently. Thank the Chair for indulging me in those comments.

Chairman THOMAS. Mrs. Johnson.

Mrs. JOHNSON of Connecticut. Thank you, Mr. Chairman. Mr. Wenzel, your comments about a streamlined law really do interest me. We passed this law 6 years ago. We still do not have permanent, final regulations because it is terribly complex, and it is also going to be impossible, frankly, to write regulations that are going to be good for patients and good for providers.

I have been anguished to see how some of my elderly constituents have been desperately inconvenienced by this law and costs actually expanded rather than contracted by Washington trying to define what is going to be an ethical cost-effective system.

Now, I notice Mr. Stark's comment about capitated versus fee for service, and I agree with him on that. I would like to have the panel's general comment across the board on Mr. Warden's suggestion that we adopt an exception for all those situations in which there is risk sharing, not just capitation, but incentive pooling, per diem payment arrangements, withholds, could you amongst yourselves over the course of the next few days or weeks come to some clearer conclusion about what kinds of integrated systems actually manage payments in such a way that the concerns that led to the self-referral law are no longer operative? There is, it seems to me, a whole spectrum now of compensation arrangements that ought to exclude a group from the coverage of this law because the motivation and the possibility and the opportunity is simply no longer there. That kind of help would be very useful at this time.

I think we need from you clear examples of how you think a simplified or streamlined law would interact with current law, which is very tough. The current legislation that we had on the books before we passed the self-referral ban also was very tough. If you could show us which of the problems that led to the law 6 years ago would be addressed by streamlined law and which would not, that would be very helpful to us because one of the problems in this area is that we go home and we are faced with anecdotes, none of which completely addresses the problem or reveals the solution, so we really need your help in seeing how we streamline this law and what the implications of recent developments are for it.

Any comments you care to make, I would be happy to entertain, since I have the time.

Dr. Bristow.

Dr. BRISTOW. Yes, Congresswoman, I would like to respond a little bit to the comments that you made. Let me first say that you are absolutely right. The law was written based upon certain assumptions 6 years ago that increased utilization, implied misutilization. That was never proven. We would encourage that studies be done to see whether or not the care that was given was appropriate care.

I can think of several reasons that would warrant increased utilization by certain physicians. Those physicians who are treating patients who are chronically ill would very likely order more laboratory work. Those physicians who are treating patients that have more serious illness will very likely have more laboratory work. Those physicians who are better trained, more sophisticated and who are more in tune with preventive medicine approaches will very likely order more laboratory work.

The State of Florida is said to have a decidedly increased percentage of laboratory services being done. The State of Florida also has a disproportionate share of our elderly population. So, my word is that, first of all, I think we should check to find out whether or not the excessive use of services is truly inappropriate.

Second, in terms of a more streamlined approach, we in the profession are equally as concerned as the Congress to make sure that those individuals who are not using the system properly are identified and dealt with appropriately. We would suggest that you have HCFA use physician profiling to determine who are the outliers, then focus attention on those individuals to find out is it appropriate for you to be doing more, whatever it is, than other physicians in the same specialty.

There may be a rational explanation along the lines of what I just finished saying, and if that is the case, fine. If not, having identified where the problem is, take care of the problem. I would, with all due respect, suggest that in some ways this is sort of, this series of laws is sort of the Bubba Smith approach to oversight, and most of you know Bubba Smith was a very famous defensive player in professional football who was known for going into the opposing back field and gathering up all of the players and then sorting them out until he found the one who was carrying the ball.

Now, what this law tends to do is it imposes a great deal of limitations in a variety of ways, which you have heard this morning, in an attempt to find who is misutilizing the system, overutilizing and the fashion. We would suggest that there may be ways to do that which would not be quite as disruptive, and I will end my comment there.

Mrs. JOHNSON of Connecticut. Dr. Bristow, I do just want to mention, what you say is absolutely true, and if you look at the data that drove us 6 years ago, a lot of it just indicated that certain physicians referred more if they owned a facility. It did not look at whether they were in a specialty that required more tests, and maybe they had invested in the facility because there wasn't the quality of testing available otherwise, and so what you are really saying is that the old broad brush of volume no longer should play the role in our thinking because, after all, we passed it 6 years ago. Remember, we are talking about data that is now 10 years old.

When we pass legislation, it takes us 2 years to do it. It relies on data 2 years old, so the data at that time was primitive. What you are really saying is we need to look, using profiling, at whether the physician's performance is within norms or not, and then afterward look in greater depth at those areas in which they are not. That can even be done on a network-by-network basis now that we have more integrated networks, which is cheaper for the government and easier to investigate. But, developing that kind of approach for us as a group so we have a more integrated overview would be very helpful to us.

I see that my time has expired. If any of you want to communicate more about this, I think one of the most important things that we could do this session is to fix this so that we do address the underlying concerns of Mr. Stark's initial proposal of a number of years ago, and at the same time enable those concerns to not im-

pede the modernization of the health care delivery system. Thank you.

Chairman THOMAS. Doctor, was that quote attributable to Gene Big Daddy Lipscomb. The quote about gathering up the back field was Gene Big Daddy Lipscomb, wasn't it?

Dr. BRISTOW. I stand corrected.

Chairman THOMAS. I think it was. It used to be a method in the past. Apparently it is still alive.

Mr. Christensen, do you wish to inquire?

Mr. CHRISTENSEN. Mr. Warden, you have had a lot of success up at Henry Ford. Has the self-referral law been a barrier to your integration efforts or, if not, why?

Mr. WARDEN. I think the law has been a barrier to the extent that we are a group practice, but we also have 1,200 fee-for-service physicians in our system. We have hospitals that we own and hospitals that we contract with. We also own a large HMO with about 500,000 enrollees. The problems we encounter are the issues related to the need for exceptions for the different kinds of arrangements necessary to develop preferred provider organizations or physician hospital organizations.

For instance, in a lot of cases it is not clear whether you are breaking the referral law or some of the other statutes when you ask physicians to invest jointly with a hospital to create a physician-hospital organization so that they can then contract with a managed care entity. In many cases it is not just our own managed care entity, but several others on the outside, and there are issues related to that. There are issues related to the whole question of what services need to be located centrally and what can be distributed to other satellites which is something that Mr. Wenzel talked about. In many cases it is advantageous to the patient to be able to place those facilities in their community, keeping in mind that in a State like ours where we have a certificate of need law, you often do not have a proliferation of MRIs or other equipment that might cause over utilization concerns.

There also are concerns related to physicians who are paid a small fee to oversee a particular program, but who also refer their patients to that program, such as in kidney dialysis or oncology. This often occurs in community hospitals where the physicians are not part of the medical group practice arrangement. There are a lot of examples, and I think in most cases we are not sure whether we are breaking a law, but we are looking over our shoulder and trying to be very careful about how we do things.

Mr. CHRISTENSEN. Mr. Griffin, if you could just briefly give me some ideas on another issue that we are looking at and that is the Medicare situation, especially the gatekeeper situation in terms of managed care. I have talked to a lot of my friends in Omaha who are specialists that do not especially like the movement toward managed care.

How can we fix that situation? Maybe you could address that in a written answer because I know I am out of time. I do not know that managed care is the panacea in terms of the Medicare crisis.

Mr. GRIFFIN. Mr. Chairman, Congressman Christensen, just very briefly, managed care organizations do include gatekeeper organizations, but they include a variety of other types. Our PPO does

not have a gatekeeper concept so people can self-refer to specialists if they would like to.

There is a concern within managed care organizations with this issue. Some organizations are now offering a product that has been very popular, particularly in our marketplace in Minnesota, namely is a point-of-service plan which allows self-referral outside the panel. About 95 percent of the policies that are sold by the two largest HMOs now in Minnesota are point-of-service products which allow people to maintain that choice. It has become very popular in the marketplace, not because of regulation, but because of demand by employers for that service.

Mr. CHRISTENSEN. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Mr. Ensign will inquire.

Mr. ENSIGN. Thank you, Mr. Chairman. Not really directed at any one person, I would like to make a couple of comments, then have your comments on it.

As a practicing veterinarian, I experienced a lot of the self-referral because we had to do a lot of this ourselves. I mean we had a lot of this stuff in-house, and we referred it to ourselves, but the client understood that it was our equipment, and they understood we were referring to ourselves.

Occasionally, there are specialists. I mean there are subspecialists and specialists in veterinary medicine now where you are referring out, and that is obvious, but they also know when you are referring in-house. I used to do endoscopy myself. When I would refer that they knew I was doing that, they knew I owned the endoscope. It would seem to me and being through some of the group practices out there, especially one cardiology practice that I recall last year that it was incredible, that we have this self-referral law in Nevada that you cannot refer, and the burden that it puts on patients having to go across town or whatever it is, it seems to put a tremendous burden on the patient as well.

It costs more money in the long run in a lot of these cases. I will agree that there are some abuses. I see it in veterinary medicine. I see some abuses, but I think that the abuses are small percentagewise, and it would seem to me that if we just introduced, I think Mr. Stark mentioned it earlier, something about sunshine laws, where if you are referring to someplace that you own, if you are required to at least let people know, it would seem to me that that would be a better answer instead of having all this regulation. You cannot do this, you cannot do that, just inform people and then it is up to them to make that choice. Anybody's comments?

Mr. WENZEL. I would agree 100 percent on that. It takes place in both rural and urban areas. Example, in a rural area, we have a location where we have a mammography unit that moves once a year in order to get the entire population actually screen. Now, of course, under the current regulations that is not permissible because we do not have any physicians practicing on that site. The same thing is true for physical therapy. A group of orthopods with their physical therapy across town located so that it can be of great convenience, particularly to the elderly patients who we are talking about here, again is not permissible. These are the kinds of things that inconvenience a great number of patients.

I like the idea of profilings. As a matter of fact, our research institute at MGMA is currently doing a major profiling project under Robert Wood Johnson. We are studying the very issues that Congresswoman Johnson mentioned, and these are the kinds of things that I think we really need to do not only to find abusers, but also to change the behavior of physicians, which is also important.

Dr. BRISTOW. Mr. Chairman, I would love to say just a few words about that. The AMA's Council on Ethical and Judicial Affairs has taken exactly the position that was just outlined by the Congressman. We have said that it is permissible for physicians to invest in facilities to which they would like to refer patients, but they have got to satisfy certain criteria.

Among these are, there must be full disclosure to the patient. There should be no special incentive to the physician to become an investor. Others other than physicians should be able to equally invest in this venture, and there should be some internal utilization and review. I like to sum it up when I talk to doctors around the country about what it is that the council expects of doctors.

I tell them that the way to approach investments that would impact their patients is as though they were going to go to church on Sunday morning and have their mother sitting at their side and then have the minister outline their business deal from the pulpit. If they cannot do that, then it is not for them to do if it relates to their patients. That is the attitude that we are trying to promote, that it has to have full disclosure, just as you said.

Mr. ENSIGN. Very good. Thank you, Mr. Chairman.

Chairman THOMAS. I want to thank the panel. Notwithstanding, that test which is a pretty difficult one, the Chair has some concern about potential philosophical ax grinding in this area for a couple of reasons. One, in examining the methodology that was really used, at the beginning I said that it is obviously a priori that somebody who has the ability to refer to themselves to make money and who is so inclined and only has to answer to themselves probably might engage in the act.

But all of the methodology that I saw underscoring and the connection between the physician and the ownership, nowhere did I see what I would consider an adequate study approach looking at the final result; that is notwithstanding the fact that there were more referrals, not withstanding the fact that the procedure costs more money than some other procedure, in the final analysis was the diagnosis made quicker, was the cost actually less?

They never completed the analysis. They simply made the link and from that they moved forward, so from a methodology point of view, it has bothered me a lot. The fact that it makes it easier on the government if you simply show the relationship exists instead of proving intent seems to me to tip it the wrong way. If we are after crooks we ought to be comforted with the fact that where there is intent you go get them. So, you have got a chilling effect.

Then, I guess if you are in control of a body which passes laws for 40 years between the fifties and the nineties, the absolutely wrong timeframe to move a law like this is in the nineties when for the first time in a generation you are getting a lot of innovative interaction which is going to save the society money, and then last

and maybe this is where we need a comment from you, I guess I would put up with all that if I honestly believed that you could stop the unethical self-referral with this law. I guess that is my bottom line.

Yes, you deal with transactional changes and structural arrangements, but does it really ultimately stop someone who is interested in doing this in the first place, which I guess is the reason we wanted to start down the road of stopping this practice of people who intentionally were doing this. Any comments from anyone?

Dr. BRISTOW. Congressman, I believe you can have legislation that will, if not stop, certainly seriously impair those who are abusing the system.

Chairman THOMAS. Is this the legislation that does that?

Dr. BRISTOW. My concern is that it is too broad brush, as I said before, and what we need to do is focus on where the problems lie, and I think there are tools that we can use to identify where the problems lie, and then the profession certainly would join you enthusiastically in trying to get at where those problems are and treat them.

Mr. WARDEN. I think it relates, Mr. Chairman, to the way that everyone—whether in the private market or through Medicare or Medicaid purchases health care. If you are a prudent buyer and if some very clear and strict guidelines are established for these kinds of things, I think that you can expect people to comply because if they do not, they cannot be contractors.

Mr. GRIFFIN. Mr. Chairman, just briefly, I think we have dealt with the fee-for-service system in Medicare and Medicaid that you are examining here for 30 years that has collected a great deal of data. It is only within the past few years that we have really begun to gather the data on effectiveness and in trying to work with physicians to develop the best guidelines and protocols for treatment and then to measure the impact of those.

We are not there completely yet in managed care. Fee-for-service is coming with us, but we think that is the answer to determining whether or not referrals are appropriate and not rather than some broad law which just says some are inappropriate because of this reason or that.

Chairman THOMAS. More data profiling and guidelines are the answer to a lot of other problems as well, and we have been remiss in not collecting data in a way that allows us to move forward on that. I am just always concerned about a law in which before the regulations are promulgated, there are books on the bookshelves, one which is entitled, "Navigating Your Way Through The Federal Physicians Self-Referral Law,"—seven coauthors, all lawyers. It does not bode well when the books explaining the laws are on the shelves before the regulations are not even cold, but not printed. I want to thank the panel.

Dr. Balfour, did you want to say something?

Dr. BALFOUR. Thank you, Mr. Chairman. I just want to say if we eliminate the compensation arrangements, then I think the risk-sharing exceptions would not be needed. I think that is the answer.

Chairman THOMAS. I want to thank you very much. Once again, our goal here is to try to get sufficient information to perfect the process. I want to thank you for your contribution.

Dr. BRISTOW. Thank you.

Chairman THOMAS. The next panel will consist of a panel of one, George Grob, who is the Deputy Inspector General from the Department of Health and Human Services. Mr. Grob, as with the other panelists, I would indicate that if you have a written statement it will be made a part of the record without objection, and you may proceed as you see fit to inform us.

STATEMENT OF GEORGE F. GROB, DEPUTY INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH HUMAN SERVICES

Mr. GROB. Thank you, Mr. Chairman, and good morning and to the other Members of the Committee as well. My name is George Grob, and I am the Deputy Inspector General for Evaluation and Inspections in the Department of Health and Human Services. I should begin by saying that it was my office that performed the study in 1989 that is often quoted in connection with this law, and what I have come here today to discuss with you is the basis for that study as well as subsequent studies performed by others, hoping that in this presentation we can sort out some of the notions that may be attributed to scientific research as opposed to purely anecdotal kinds of evidence on the subject.

The study that we performed in 1989 was a study that was requested by the Congress. It was mandated in the Medicare Catastrophic Coverage Act of 1988, and it was completed on May 1, 1989. It was the first nationwide study of financial arrangements between physicians and various entities. It consisted of a survey of about 4,000 physicians who were randomly selected, and it focused on 3 kinds of entities—independent clinical labs, independent physiological labs, and durable medical equipment manufacturers.

The result of our studies were that 12 percent of the physicians that we surveyed were found to have an ownership interest in these entities, and 8 percent were found to have compensation arrangements. On the reverse of that, 25 percent of the clinical labs, 27 percent of the independent physiological labs, and 8 percent of the durable medical equipment companies were found to be owned in part By physicians.

As far as referral was concerned, we found that the patients of physicians who had an ownership arrangement received 45 percent more independent clinical lab services, and you can see this on the chart over here where there were on average 9.8 percent services for patients of owning physicians and only 6.7 services per individual for all patients.

The smaller bars on the right refer only to services that were performed through independent clinical labs. The one on the left is for all laboratory services, which could include outpatient departments of hospitals, for example. The difference is probably greater than that as expressed in the bars because the base includes all physicians as well as including those who have an ownership interest whereas the orange bar is just those with an ownership interest so the real difference between referrals by owners and nonowners is probably a little bit greater than you see on the chart.

We found that 13 percent more services were provided to patients by physicians who had an ownership in independent physiological labs, and we found no difference in the number of services provided by owners of durable medical equipment companies. In the case of the independent clinical labs, we also analyzed what the cost to the Medicare Program was of these different referrals. We did not perform a similar analysis for the independent physiological labs or the durable medical equipment, so in the case of durable medical equipment we do not know whether patients received more expensive equipment, for example, from physician owners than otherwise.

Regarding the cost to Medicare, at the time of our study, which was based on 1987 data, it was a cost of about $28 million, and for the purpose of this testimony we analyzed what the effect would be today just looking at the growth in Medicare labs, and for independent clinical labs alone it exceeds $100 million in today's dollars.

If you were to add on all other labs, I would have to take a guess, but I would say that it would probably put it up in the $150 million range, and in making the projection we did not take into account the fact that there has been an increasing rate of ownership as well. It assumed the rate of ownership when we did our study.

Since the time that we did this one study, nine other scientific studies have been performed using fairly large databases, some on a national basis, some in States. There have been studies done in Boston, Florida, California, and several on a national basis. These studies have been published in the New England Journal of Medicine, the Journal of Medical Associations. In general, these studies found patterns very similar to what we found, particularly for clinical labs, radiology services, especially for MRIs and CAT scans, physical therapy and rehabilitation, radiation therapy and psychiatric evaluations.

In general, the studies showed more services, higher prices, services not performed in underserved areas, and some studies showed no difference in patient characteristics, or physician specialty or in the sophistication of the test performed. In some cases, the subject showed that differences were greater for higher cost services, and in some cases the proportion of ownership was higher among physicians who were in a position to refer than otherwise.

To my testimony, I have attached a synthesis of these various studies which I hope will be helpful. Given the purpose of this hearing, we tried to find out whether any studies had been done about the effect of arrangements in managed care settings, and I can tell you that in looking at the studies, none of them addressed this particular problem as such.

One of the problems that has already been mentioned several times in this hearing is that the term, "managed care," is simply not very well-defined, and we will probably have to draw inferences ourselves of the effect of these arrangements in the various settings.

Let me just give you two really quick examples, if I may. Everyone knows and has already mentioned the case of the prepaid health care, and I think we have a pretty good agreement that this does not contain those incentives for increasing the number of serv-

ices because of referrals. Other kinds of care that are often called managed care might be preferred provider organizations, case managers, preauthorization/gatekeeper arrangements, postpayment utilization reviews with financial penalties for people who overutilize or overrefer.

Just to take one, the preferred provider organization, and to walk through it for a moment. In this case the physicians in the network might be provided a discount or accept a lower rate of pay than physicians not in the network. I think it stands to reason that the fact that a physician is receiving a lower rate of pay for his services does not mean that the incentive to refer to a self-owned facility would be any less just because the physician is in a preferred provider organization.

Similarly, if you look at the other arrangements we would have to work our way through them carefully and distinguish carefully for each of these. I think that is a fair summary, sir, of the studies that have been done. In listening to the testimonies of the people who have preceded me, I think we all recognize that there is a very complicated and delicate task before the Congress and before the members of the medical profession.

In reflecting upon the way that I could be of greater service to the Committee, I feel that it is probably in terms of answering questions regarding the study since I have heard some questions there and in terms of the various aspects of enforcing the law, although, of course, I would be happy to answer the questions on any subject that you wish.

[The prepared statement and attachment follow:]

TESTIMONY OF GEORGE F. GROB
DEPUTY INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning Mr. Chairman and members of the Subcommittee. I am George F. Grob, Deputy Inspector General for Evaluation and Inspections of the Office of Inspector General (OIG) in the Department of Health and Human Services. We appreciate the opportunity today to address the problem of self-referral in the health care industry.

Created in 1976, the OIG is statutorily charged to protect the integrity of departmental programs, as well as promote their economy, efficiency and effectiveness. We meet our challenge through a comprehensive program of audits, inspections, program evaluations and investigations. In FY 1994, we were responsible for 202 successful criminal prosecutions and 1,334 administrative sanctions imposed against individuals and entities who defrauded or abused the Medicare and Medicaid programs or their beneficiaries. In addition, we obtained $185 million in civil monetary penalties in FY 1994 and accrued more than $5 billion in program savings.

Much has been learned since 1989, when the issue of self-referral became a matter of attention by this committee and the Congress, and by our office. We believed then that physician referral of patients to health care entities like clinical laboratories with which they have a financial interest creates a situation where the profit motive can insinuate itself into patient care and possibly lead to inappropriate use of medical services. Now we are even more convinced of this. If unaddressed, this situation can result in higher costs to patients, insurers, and the Medicare and Medicaid programs, and can prevent patients from receiving the best quality of care. It can also expose patients to unnecessary medical procedures.

At the same time, we are well aware that the structure of medical practice is becoming increasingly complex, as physicians and other medical care entities try to deliver patient care through managed care and other integrated systems. We can well appreciate how complicated is the task of those physicians, medical service providers, and members of Congress who wish to reduce the potentially harmful incentives of physician ownership, while encouraging the more appropriate development of modern medical care systems. I hope that the results of our studies and those of others who have addressed these concerns will be helpful to all of you in this effort. I will summarize our work and related studies, and then discuss briefly the implications of our findings for managed care.

Concerns About Self-Referral

The overall concern about self-referral is that health care decision making should be free of the profit motive. Patients want to be assured that financial interests are not affecting physician decisions about their medical care. This concern breaks into three basic categories: over-utilization, patient choice, and competition. The over-utilization issue relates to the items and services ordered for patients which would not be ordered if the physician had no profit motive. Such over-utilization becomes a direct cost to the health care system, including Medicare and Medicaid. The patient choice issue concern relates to the steering of patients to a less convenient, lower quality, or more expensive provider, just because that provider is sharing profits with the doctor. And lastly, where referrals are controlled by those sharing profits, the medical marketplace suffers since new competitors can no longer win the business with superior quality, service or price.

Before the enactment of section 1877 of the Social Security Act, the only statute available to attack the problem was the Medicare and Medicaid anti-kickback statute (42 U.S.C. §1320a-7b(b)). This is a broadly-worded, criminal statute which requires proof of intentionally paying anything of value in exchange for the referral of Federal program business. The statute is also a basis for exclusion from Medicare and Medicaid.

As of 1989, the anti-kickback statute had never been applied to the area of physician investment in ancillary facilities where the physician was sending patients. In April 1989, we issued a Fraud Alert on Joint Venture Arrangements, which specified those types of investment interests between physicians and the providers of ancillary medical facilities which we considered to be clearly violative of the anti-kickback law. This Fraud Alert was intended as a warning to those engaging in abusive self-referral schemes, and we sent a copy to each and every provider of health care services to the Medicare program.

Inspector General's Report

In June 1988, the Congress mandated that the OIG conduct a study on physician ownership and compensation from health care entities to which they make referrals. We published the report in May 1989. (Financial Arrangements Between Physicians and Health Care Businesses, OAI-12-88-01410.)

Our methodology included surveys of health care providers and analysis of claims information. First, we conducted two surveys of health care providers to determine the prevalence of physician financial involvement with other health care entities and the nature of such arrangements. One survey was sent to physicians; the other to independent clinical laboratories, independent physiological laboratories, and durable medical equipment manufacturers. We used claims information from HCFA's Part B Medicare Annual Data files for 1987 to assess utilization patterns for patients of physician-owners identified through our survey of health care businesses. (Physicians with designated specialty codes indicating radiology or pathology were dropped from the analysis of clinical and physiological labs since these physicians are not in a position to refer patients.) Finally, we interviewed State officials, industry representatives, health care experts, and a subsample of provider respondents to our survey.

We found that 12 percent of physicians were owners of entities to which they referred patients and eight percent had compensation arrangements with such entities. Twenty-five percent of independent clinical laboratories, 27 percent of independent physiological laboratories, and eight percent of durable medical equipment companies were owned at least in part by physicians who referred services to them.

We found that patients of referring physicians who own or invest in clinical laboratories received 45 percent more such services than all Medicare patients in general, regardless of place of service. We estimated that this increased utilization of services provided by independent clinical laboratories by patients of physician-owners cost the Medicare program $28 million in 1987. The projected costs of the increased utilization of these services by patients of physician-owners would be $103 million in 1995, if there were no change in utilization patterns.

The study also demonstrated that patients of physicians known to be owners or investors of independent physiological laboratories use 13 percent more physiological testing services than all Medicare patients in general. We found no difference in number of durable medical equipment services. However, our study did not examine cost differences for either physiological tests or durable medical equipment, nor did we examine differences in the kinds of medical equipment provided to patients of physician-owners and non-owners. In other words, we did not study the question of whether owners ordered more expensive tests or equipment compared to non-owners.

Additional Studies of the Effect of Self-Referral

Since our initial study in 1989, nine more major studies have appeared in the professional literature, including the New England Journal of Medicine and the Journal of the American Medical Association. They support and expand upon our original 1989 findings. For example, a quite comprehensive study published in September 1991 by the Florida Health Care Cost Containment Board found that 93 percent of diagnostic imaging facilities in Florida are joint ventures with physicians. It also found that compared to non-doctor affiliated facilities of the same type, doctor-affiliated clinical labs, diagnostic imaging facilities, and physical therapy facilities: performed more procedures on a per-patient basis; charged higher prices; and were not located in rural or urban under served areas.

Additional studies have found increased utilization for a variety of services when the physicians have ownership interests in the entities to which they refer their patients, including clinical laboratory services, radiology services (particularly for high costs services such as MRI and CT scans), physical therapy and rehabilitation, radiation therapy and psychiatric evaluation. I have attached a synopsis of the various studies on this subject.

These studies support the proposition that some physicians respond to financial incentives. This may account for some of the growth in recent years of physician investment and ownership in medical service companies.

Federal Legislation Prohibiting Medicare Payment for Self-Referred Services

Based in part on the results of our study, in November, 1989, Congress passed Section 1877 of the Social Security Act (sometimes referred to as the "Stark Amendment", or "Stark I"). Section 1877 prohibited Medicare payment for clinical laboratory services where the physician (or immediate family member) who orders the service has a "financial relationship" with the laboratory. The statute defined the term "financial relationship" to include both ownership or investment interests in an entity (which may be through equity, debt or other means) and compensation arrangements with an entity (which are defined as arrangements involving any remuneration between a physician and an entity). The statute contained a number of detailed exceptions to the definition of financial relationship to provide for legitimate arrangements between physicians and laboratories.

In response to problems of self-referral in a broad range of services demonstrated by the additional studies cited above, in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), Congress expanded the scope of section 1877 to include 10 additional services--so-called designated health services. (These amendments are often referred to as "Stark II".) In addition to clinical laboratory services, the statute now covers:

- physical therapy services;
- occupational therapy services;
- radiology services, including MRIs, CAT scans and ultrasound services;
- radiation therapy services and supplies;
- durable medical equipment and supplies;
- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices and supplies;
- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

In addition, the statute was expanded from applying to just Medicare to apply to Medicaid as well. OBRA '93 also added new exceptions and revised the existing exceptions so that legitimate arrangements between entities and physicians can be accommodated.

Managed Care

Many of the exceptions are specifically designed to allow for the development of managed care plans, integrated delivery systems, and new health care networks which link hospitals and doctors. Because of the importance of these emerging innovations in health care delivery, some groups have argued for the creation of a new, broad exception for "managed care."

One of the problems with this idea is that the term "managed care" is not well defined. Some understand it in the narrow sense of a health maintenance organization (HMO), in which services are prepaid by the patient through a fixed monthly fee. The Stark amendment already allows an exemption for this kind of arrangement in the Medicare program, where conditions of participation and rules of financing are well defined. This exception is appropriate for at-risk HMO's, because this structure removes from the physician the financial incentive to refer patients to other service providers. Typically, the physician does not stand to gain any profit from referring the patient for a laboratory or other medical services owned by the physicians in the HMO network.

Others use the term "managed care" in a much broader sense. For example, it can be applied to a preferred provider organization (PPO), to the use of a "case manager," to pre-utilization or "gatekeeper" functions, or to a system of post-utilization review with financial punishment for those who over-prescribe ancillary services. Financial incentives in these arrangements are more complex, but in most of them the physician is not truly shielded from the influence of profit making on referral decisions.

Consider the PPO arrangement, for example. Here, the physician and ancillary service providers agree to accept a lower price for their services than those providers who are not in the network. But a physician who is an owner of a clinical laboratory which is part of the network would still gain a profit by referring patients to his or her own, rather than some other, laboratory. Hence, no exception to the self-referral ban would be appropriate. Upon close examination, it may be found that none of the arrangements called "managed care" really shield the physician from the profit influence of self-referral other than the prepaid HMO arrangement.

However, as noted earlier, many of the exceptions already allowed in the Stark amendment provide flexibility for managed care providers, even in the broader meaning of that term.

For example, there is an exception in the statute for physician ownership interests in hospitals. There is only one condition, and that is the ownership interest by the doctor must be in the whole hospital itself, not in any division or branch of the hospital, such as just the surgical wing.

Another exception allows for payments to employees, with three requirements. The payments to the employee must be for identifiable services, the amount of the payment must be consistent with fair market value and be commercially reasonable, and the amount cannot take into consideration the volume or value of referrals by the doctor to the entity. There is also a provision which allows for the payment of productivity bonuses. These are permissible if the amount of the bonus is based on services personally performed by the physician, as opposed to services that the doctor orders for someone else to perform.

There is an exception for personal service arrangements, such as consultation contracts. The agreement must be set out in writing, and must cover all services between the parties. The services cannot exceed those that are reasonable and necessary. The agreement must have a minimum one year term. The compensation under the agreement must be at fair market value for services rendered, and cannot take into account the volume or value of any referrals. The exception also allows the existence of withhold pools such as those often used in managed care arrangements.

The law allows for payments by hospitals to physicians without restriction, as long as the remuneration "does not relate" to the provision of designated health services at all. In other words, a hospital can hire a physician to operate its utilization review program with no restrictions specified in the law.

Payments for physician recruitment are permitted -- for example to get them to relocate to the geographic area of the hospital. There are only two requirements -- that there be no requirement in the contract that the physician make referrals to the hospital, and any payments not be related to the volume or value of referrals.

There is also an exception for so-called "isolated transactions," which explicitly applies to the purchase of a physician practice, either a solo practice or a group practice. The price must be for fair market value and be commercially reasonable. The price cannot be related to the volume or value of referrals.

Finally, there are other exceptions for leasing of office space, leasing of equipment, etc. All these exceptions leave room for some flexibility as they attempt to balance control of self-referral with avoidance of unnecessary controls on the industry.

Conclusion

The research on physician behavior indicates that the profit incentive does increase the rate at which physicians order services. Obviously, this conclusion does not apply to every physician. But as a general matter, section 1877 does address an issue which has a real cost to the Medicare and Medicaid programs and their beneficiaries and could adversely affect quality of care. Any revisions to the statute intended to allow the formation of health care networks should, at the same time, discourage the existence of inappropriate incentives for physicians to order ancillary services.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the General Counsel
Washington, D.C. 20201

SELF-REFERRAL STUDIES

A. Financial Arrangements Between Physicians and Health Care Businesses: Office of Inspector General - OAI-12-88-01410 (May 1989)

In 1989, the Office of Inspector General (OIG) issued a study on physician ownership and compensation from entities to which they make referrals. The study found that patients of referring physicians who own or invest in independent clinical laboratories received 45 percent more clinical laboratory services than all Medicare patients in general, regardless of place of service. OIG also concluded that patients of physicians known to be owners or investors in independent physiological laboratories use 13 percent more physiological testing services than all Medicare patients in general. Finally, while OIG found significant variation on a State by State basis, OIG concluded that patients of physicians known to be owners or investors in durable medical equipment (DME) suppliers use no more DME services than all Medicare patients in general.

B. Physicians' Responses to Financial Incentives -- Evidence from a For-Profit Ambulatory Care Center; Hemenway D, Killen A, Cashman SB, Parks CL, Bicknell WJ: New England Journal of Medicine, 1990;322;1059-1063

Health Stop, a chain of for-profit ambulatory care centers, changed its compensation system from a flat hourly wage to a system where doctors could earn bonuses that varied depending upon the gross income they generated individually. A comparison of the practice patterns of fifteen doctors before and after the change revealed that the physicians increased the number of laboratory tests performed per patient visit by 23 percent and the number of x-ray films per visit by 16 percent. The total charges per month, adjusted for inflation, grew 20 percent, largely due to an increase in the number of patient visits per month. The authors concluded that substantial monetary incentives based on individual performance may induce a group of physicians to increase the intensity of their practice, even though not all of them benefit from the incentives.

C. Frequency and Costs of Diagnostic Imaging in Office Practice -- A Comparison of Self-Referring and Radiologist-Referring Physicians; Hillman BJ, Joseph CA, Mabry MR, Sunshine JH, Kennedy SD, Noehter M: New England Journal of Medicine, 1990;322;1604-1608

This study compared the frequency and costs of the use diagnostic imaging for four clinical presentations (acute upper respiratory symptoms, pregnancy, low back pain, or (in men) difficulty in urinating) as performed by physicians who used imaging equipment in their offices (self-referring) and as ordered by physicians who always referred patients to radiologists (radiologist-referring). The authors concluded that self-referring physicians use imaging examinations at least four times more often than radiologist-referring physicians and that the charges are usually higher when the imaging is done by the self-referring physicians. These differences could not be attributed to differences in the mix of patients, the specialties of the physicians or the complexity of the complexity of the imaging examinations performed.

D. Joint Ventures Among Health Care Providers in Florida: State of Florida Cost Containment Board (September 1991)

This study analyzed the effect of joint venture arrangements (defined as any ownership, investment interest or compensation arrangement between persons providing health care) on access, costs, charges, utilization, and quality. The results indicated that problems in one or more of these areas existed in the following types of services: (1) clinical laboratory services, (2) diagnostic imaging services, and (3) physical therapy services - rehabilitation centers. The study concluded that there could be problems or that the results did not allow clear conclusions with respect to the following health care services: (1) ambulatory surgical centers; (2) durable medical equipment suppliers; (3) home health agencies; and (4) radiation therapy centers. The study revealed no effect on access, costs, charges, utilization, or quality of health care services for: (1) acute care hospitals; and (2) nursing homes.

E. New Evidence of the Prevalence and Scope of Physician Joint Ventures; Mitchell JM, Scott E: Journal of the American Medical Association, 1992;268:80-84

This report examines the prevalence and scope of physician joint ventures in Florida based on data collected under a legislative mandate. The results indicate that physician ownership of health care businesses providing diagnostic testing or other ancillary services is common in Florida. While the study is based on a survey of health care businesses in Florida, it is at least indicative that such arrangements are likely to occur elsewhere.

The study found that at least 40% of Florida physicians involved in direct patient care have an investment interest in a health care business to which they may refer their patients for services; over 91% of the physician owners are concentrated in specialties that may refer patients for services. About 40% of the physician investors have a financial interest in diagnostic imaging centers. These estimates indicate that the proportion of referring physicians involved in direct patient care who participate in joint ventures is much higher than previous estimates suggest.

F. Physicians' Utilization and Charges for Outpatient Diagnostic Imaging in a Medicare Population; Hillman BJ, Olson GT, Griffith PE, Sunshine JH, Joseph CA, Kennedy SD, Nelson WR, Bernhardt LB: Journal of the American Medical Association, 1992; 268:2050-2054

This study extends and confirms the previous research discussed in section C, above, by focusing on a broader range of clinical presentations (ten common clinical presentations were included in this study); a mostly elderly, retired population (a patient population that is of particular interest with respect to Medicare reimbursement); and the inclusion of higher-technology imaging examinations. The study concluded that physicians who own imaging technology employ diagnostic imaging in the evaluation of their patients significantly more often and as a result, generate 1.6 to 6.2 times higher average imaging charges per episode of medical care than do physicians who refer imaging examinations to radiologists.

G. Physician Ownership of Physical Therapy Services: Effects on Charges, Utilization, Profits, and Service Characteristics; Mitchell JM, Scott E: Journal of the American Medical Association, 1992; 268:2055-2059

Using information obtained under a legislative mandate in Florida, the authors evaluated the effects of physician ownership of freestanding physical therapy and rehabilitation facilities (joint venture facilities) on utilization, charges, profits, and service characteristics. The study found that visits per patient were 39% to 45% higher in facilities owned by referring physicians and that both gross and net revenue per patient were 30% to 40% higher in such facilities. Percent operating income and percent markup were significantly higher in joint venture physical therapy and rehabilitation facilities. The study concluded that licensed physical therapists and licensed therapist assistants employed in non-joint venture facilities spend about 60% more time per visit treating patients than those licensed workers in joint venture facilities. Finally, the study found that joint ventures also generate more of their revenues from patients with well-paying insurance.

H. Consequences of Physicians' Ownership of Health Care Facilities - Joint Ventures in Radiation Therapy: Mitchell JM, Sunshine JH: New England Journal of Medicine, 1992;327:1497-1501

This study examined the effects of the ownership of freestanding radiation therapy centers by referring physicians who do not directly provide services ("joint ventures") by comparing data from Florida (where 44% of such centers were joint ventures during the period of the study) to data from elsewhere (where only 7% of such centers were joint ventures). The frequency and costs of radiation therapy treatments at free-standing centers were 40% to 60% higher in Florida than in the rest of the United States; there was no below-average use of radiation therapy at hospitals or higher cancer rates to explain the higher use or higher costs. In addition, the analysis shows that the joint ventures in Florida provide less access to poorly served populations (rural counties and inner-cities) than non-joint venture facilities. Some indicators (amount of time spent by radiation physicists with patients and mortality among patients with cancer) show that joint ventures cause either no improvement in quality or a decline.

I. Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians; Swedlow A, Johnson G, Smithline N, Milstein A: New England Journal of Medicine, 1992;327;1502-1506

The authors analyzed the effects of physician self-referral on three high-cost medical services covered under California's workers' compensation: physical therapy, psychiatric evaluation and magnetic resonance imaging (MRI). They compared the patterns of physicians who referred patients to facilities of which they were owners (self-referral group) to patterns of physicians who referred patients to independent facilities (independent-referral group). The study found that physical therapy was initiated 2.3 times more often by the self-referral group than those in the independent-referral group (which more than offset the slight decrease in cost per case). The mean cost of psychiatric evaluation services was significantly higher in the self-referral group (psychometric testing, 34% higher; psychiatric evaluation reports, 22% higher) and the total cost per case of psychiatric evaluation services was 26% higher in the self-referral group than in the independent-referral group. Finally, the study concluded that of all the MRI scans requested by the self-referring physicians, 38% were found to be medically inappropriate, as compared to 28% of those requested by physicians in the independent-referral group. There were no significant difference in the cost per case between the two groups.

J. Medicare: Referrals to Physician-Owned Imaging Facilities Warrant HCFA's Scrutiny (GAO Report No. B-253835; October 1994)

The U.S. General Accounting Office (GAO) issued a report regarding: (1) referrals by physicians with a financial interest in joint-venture imaging centers; and (2) referrals for imaging provided within the referring physicians' practice settings. The analyses are based on information collected by researchers in Florida for the Florida Health Care Cost Containment Board and include information on 1990 Medicare claims for imaging services ordered by Florida physicians. GAO analyzed approximately 1.3 million imaging services performed at facilities outside the ordering physicians' practice settings and approximately 1.2 million imaging services provided within the ordering physicians' practice settings. These results are significant because they are based on a large-scale analysis of physician referral practices.

GAO found that physician owners of Florida diagnostic imaging facilities had higher referral rates than nonowners for almost all types of imaging services. The differences in referral rates were greatest for costly, high technology imaging services: physician owners ordered 54% more MRI scans, 27% more computed tomography (CT) scans, 37% more nuclear medicine scans, 27% more echocardiograms, 22% more ultrasound services, and 22% more complex X rays. Referral rates for simple X rays were comparable for owners and nonowners. In addition, while referral practices among specialties differed, physician owners in most specialties had higher referral rates than nonowners in the same specialty.

GAO also compared the imaging rates of physicians who have in-practice imaging patterns (i.e., more than 50% of the imaging services they ordered were provided within their practice affiliations) with physicians with referral imaging patterns (i.e., more than 50% of the imaging services they ordered were provided at facilities outside their practice affiliations). GAO found that physician with in-practice imaging patterns had significantly higher imaging rates than those with referral imaging patterns -- the imaging rates were about 3 times higher for MRI scans; about 2 times higher for CT scans; 4.5 to 5.1 times higher for ultrasound, echocardiography, and diagnostic nuclear medicine imaging; and about 2 times higher for complex and simple X rays.

Chairman THOMAS. Thank you Mr. Grob.

Mr. McCrery, do you wish to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman.

Mr. Grob, just a question about your figures on the Medicare cost of laboratory self-referral. In 1995 you have $103 million—explain to me again how you derived that figure.

Mr. GROB. It is a conservative estimate. What we did was we assumed the same proportion of ownership and the same proportion of self-referral as in 1987, and then we simply tracked out the growth of Medicare payments for independent clinical lab services over that period of time, performed an index, and multiplied it by the original base. The reason it is conservative is because the original proportions are probably larger now.

Mr. MCCRERY. OK. If we were to completely eliminate self-referral, let's assume that every one of those instances of self-referral were bogus, they were fraudulent, OK, and we, by this law, were able to stop every instance of that abuse, and so our total savings would be $103 million?

Mr. GROB. That would be for independent clinical labs. That corresponds to the charts on the right, which is a smaller subset. We are unable to estimate from the databases the effect of all lab services. If you want a professional guess, I would say based on the proportions in the other charts, it is probably an additional 50 percent, so we would probably be looking at $150 million.

Then if you were to work into it the rise in ownership over this period of time, it would size it up somewhat, so you might be approaching $200 million. And then, of course, this is only for the clinical labs. It does not touch the other elements in the bill.

Mr. MCCRERY. But again that is assuming in every instance the referral was fraudulent, it was not needed and it was just a physician practicing fraud.

Mr. GROB. Not to reach the intent of the individual, but your point is nevertheless well taken. These would be payments that under the Stark bill would not be made because they were referrals made by a physician who has an ownership in an entity, so laying aside the motive or the need, things of this nature, you are correct.

Mr. MCCRERY. You would also have to assume that these referrals would not be made to someone else if you are going to say we would save this amount of money.

Mr. GROB. That is correct.

Mr. MCCRERY. That the referral would not be made at all if you are going to save this.

Mr. GROB. That is correct.

Mr. MCCRERY. So, over a 5-year period, Mr. Chairman, if we make all of those outlandish assumptions, we are only looking at about $750 million in savings. While that is a lot, in the context of what we are looking at saving for Medicare over 7 years, it is not a whole lot.

Chairman THOMAS. If the gentleman would yield, if you are asking me for a response, it seems to me that the assumption that none of the tests were taken because they were needed is an enormous hurdle to overcome.

Mr. MCCRERY. Sure.

Mr. GROB. Mr. Chairman, could I address that because I have heard you asking that question to the previous panel, and you did relate it to the studies. I can speak most conclusively for the studies we did, but I did try to examine the other studies that were done, so let me try to address other studies.

I will agree in our study we certainly did not reach that question. So, I would like to give two examples from the other studies. There was one national study that did look at imaging services and showed a much higher utilization and it was nationwide, and in that case they were able to detect whether there were any differences in the characteristics of the patients or in the specialties of the physicians or in the sophistication of the tests that were given, and they were able to prove that there were no such differences.

Now, there is another study, I think, that is even more revealing, and you will have to draw your own inferences. It was a study done in Boston. It was a very small case study. It reached the question of compensation arrangements. There were walk-in ambulatory services in which physicians were paid about $24 an hour in 1985 to provide services to patients who walked in, and along that time they decided to change the compensation arrangement to allow for an alternative where the physician would receive 25 percent of the first $25,000 of payments and then 15 percent for amounts above that.

At the end of the month, one could see which method would give the greater payment. They were able to find 15 physicians who were with that organization before that change was made and were still there a year after the change was made, and they were able to collect information about the billings of those physicians during that period, and there was a very substantial increase in the billings and the services provided by those physicians simply from the 1 year to the next.

Now, during that period of time, the facilities were the same, the services were the same, the patient profiles were the same, and the physicians were the same. The only thing that was different was the compensation arrangement.

Now, again, I think everyone will have to draw their own conclusions, but here is a case where the only difference was in the compensation arrangement. I do not know that there are many other studies that are that precise in distinguishing that difference, and I will say that the study was very small, and so, again, you will have to draw your own conclusions.

Mr. MCCRERY. Thank you, Mr. Chairman.

Chairman THOMAS. Mr. Stark.

Mr. STARK. Mr. Grob, as I recall, Mr. Kusserow was the predecessor in your department when all this started—the problems that you all were having with prosecuting. In other words, what we lacked, when I think he came to us and suggested we change the law, was that you could not find intent.

We had all kinds of records of people overutilizing and getting referral fees, but they were couched in a kind of legal and joint venture type arrangement where the Inspector General could not determine intent and could not prosecute. Further, we had some problems trying to get requirements that each physician list, when

they report, when they request Medicare payment, whether there was any involvement; or whether there was any ownership. Would it be a huge difference in the way we now reimburse—I think that something like 99 or 95 percent of all Medicare reimbursement is done electronically.

Mr. GROB. I am sorry, sir, I could not hear.

Mr. STARK. Done electronically. I believe it is a pretty high percentage; is that not correct?

Mr. GROB. Yes.

Mr. STARK. If, in fact, because the entity in which a physician may have an ownership interest and from which it may receive payment, he or she may receive a referral, is also arguably getting paid by Medicare. Would it be beyond the strand so forth of our communication age to document whether the physician had an ownership interest so that you could compare the data in terms of utilization. We could probably stop making all these studies.

Now, the difficult part was if you saw an abuse, statistically, how would you prosecute them or get them to stop? Maybe just by exposing it. I guess what I am getting at is would it help for us in the future to have this data, which would be confidential to HCFA. Would that be useful?

Mr. GROB. I think there are certain categories of entities for which it would be practical to make a computer link, for example, in the case of the independent clinical labs, a straightforward matter. Other arrangements——

Mr. STARK. Where it is available.

Mr. GROB [continuing]. Would be a little bit more difficult. Perhaps this is a good opportunity to reach a question implied by the one you asked me and given to previous witnesses about the utilization review. I would have to agree that taken one at a time I do not think that any of the studies that have been done have ever demonstrated that the particular service was unnecessary or inappropriate.

It is only in the global sense and inferring from what has happened in the studies that same problem would occur as an administrative matter so that if the Health Care Financing Administration were put in a position of having to profile physicians, what you would be asking is for administrators at the Health Care Financing Administration and their carriers and contractors to look over the shoulders of physicians and second guess whether the physician had, in fact, made an appropriate——

Mr. STARK. They would not like that, would they?

Mr. GROB. Well, some of the previous witnesses said that they thought that approach might work. I simply wanted to alert the members of the danger inherent in that.

Mr. STARK. Your future request, I presume, to the Congress will be based not on whether or not you think it is ethical or better for the system to allow referral compensation or not, but whether it helps you enforce laws and end the practice or punish or get convictions if that is what you have to do.

Your interest in this legislation, I presume, is not to change doctors' practices or to change the practice of how people organize group medicine, but it is to be able to enforce the laws that we pass. Is that not true?

Mr. GROB. I do not think there has been anyone who has been in this room today that does not wish the whole thing were simpler. We certainly have a great deal of problem using our current enforcement authorities. The antikickback statute is extremely difficult to prosecute because intent needs to be shown, and——

Mr. STARK. You are talking about the 1976 law?

Mr. GROB. Yes, and physicians or others who participate in these things never do it in a straightforward matter. The schemes are always quite complicated, so it is difficult to ferret out and it is just very, very difficult for us to enforce.

Mr. STARK. Are you going to bring us suggestions? Is that part of your office duties?

Mr. GROB. We have from time to time brought suggestions on changes particularly relating to the need to prove that someone knowingly and willfully violated the law and things of this nature.

Mr. STARK. Will you bring us suggestions in the future, the immediate future? Because I think that the Subcommittee is curious to know what should be done, and it would be helpful, I think, to hear. You are the cop on the beat. If there is a law that should be enforced, you have got to do it.

Mr. GROB. I think we can bring some suggestions probably for the current enforcement authorities.

Mr. STARK. Thank you.

Chairman THOMAS. Does Mr. Ensign wish to inquire?

Mr. ENSIGN. Thank you, Mr. Chairman. On your chart when was that study done?

Mr. GROB. It was done in May 1, 1989. It was based, as you can tell, on 1987 data.

Mr. ENSIGN. OK. Have there been any studies to see whether that was accurate? Have you been enforcing the law at all?

Mr. GROB. Let me take the questions one at a time. The other nine studies that I have mentioned that were scientifically done were done after 1989, mostly during the late eighties and early nineties, so there had been studies done after this one that have had results that are very consistent with the results that we have found here, so that is the answer to your first question.

As far as enforcement is concerned, we have not enforced the ownership law because the regulations are not out. Now, we believe that the law, as it stands, could be enforced without regulations, and if a case were referred to us, we would feel obligated to investigate it.

Mr. ENSIGN. Do we have any information on whether physicians have already divested themselves so that the law has had that effect up to this point, has it?

Mr. GROB. No, sir, I do not have that information.

Mr. ENSIGN. There are States obviously with this law on, Nevada being one of them. Have there been any studies to see whether the laws in those States have been effective in eliminating fraud?

Mr. GROB. There have been reviews and the results are quite mixed. The studies are difficult to do because the State laws are quite varied in the way they are structured. Some are much stronger than others, some are weaker than others. I can simply say that the results are quite varied.

Mr. ENSIGN. In the ones that have strong laws, are they saving a statistically significant amount of money?

Mr. GROB. Could I get back to you with more precise information?

Mr. ENSIGN. If we already have States that are doing it out there it would seem to me that would be a good place. States that have a large population, so we can get some statistically significant information from a State.

Mr. GROB. We do have information about State laws. I am giving you my impression of the studies. In previous briefings, our position had always been that the results were quite varied. What I cannot do now is reach into my mind and pull out the particular instances.

Mr. ENSIGN. The other comment that I guess I would make, you mentioned that some of the studies have looked to see whether there was a difference in expertise on referrals. Just from my own personal experience when you become aware of a technology because you are investing in it, you understand it, just common sense tells you that you will understand that technology more than somebody who has not invested in it because you have something invested in that now.

I mean, just common sense tells me that a physician that has invested in a particular type of technology is going to understand the application of that technology, and that maybe a lot of the reason that these things are being referred is simply because the physician is more aware that this technology can be applied to a certain disease, a certain situation, a certain set of clinical situations, and these referrals may be because patients get better care.

Mr. GROB. Yes, sir. It is very difficult to get inside people's minds and understand it, and I think that there is room for lots of interpretations. What I was hoping to do here was, in fact, to make it possible for you to see what the data was and what the results are. I think—

Mr. ENSIGN. But when we are interpreting the data and the results, we have to look at underlying assumptions. Anytime we are looking at data, it does not mean anything unless you take all of the variables into play.

It is like when you are evaluating a study in medicine, sometimes we see the increase of a disease simply because physicians are more aware of what to look for, it does not mean the disease is increasing. I mean we have to know that as an underlying assumption. If we do not understand this as an underlying assumption, we may look at this and pass bad laws because we have a wrong underlying assumption.

Mr. GROB. I could not agree more, sir, that all these things need to be considered. I think, if I may just add to the other one, I think another assumption is that physicians are like the rest of us, human beings, and it is quite possible that the profit motive might well insinuate itself into the medical decisions, but the other reasons also need to be considered, and I think that Congress has a difficult set of decisions to make here.

Mr. ENSIGN. Are there any States that have the sunshine laws that we are talking about, the disclosure?

Mr. GROB. I believe some of them do. Now, if I could address the disclosure thing here, I think that there probably is a good point to that, but I would say, as well, that it is probably a great tribute to the American medical profession that patients have so much trust in their physician so that the disclosure to the patient of ownership may be seen by many patients as an endorsement of the service, so there is that to consider as well.

Mr. ENSIGN. OK. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you, Mr. Ensign.

Mr. Grob, attached to your testimony is the self-referral studies, A through J, I believe. You indicated one of them was a national study. The other one was the small one that you had some comfort in terms of the comparability. Which of the others, if any, out of the 10 that you have listed provide some kind of a corrected factor for the case mix or the severity of illness of the various patients?

Mr. GROB. Let's see, sir, if I can try to get some of them. The study B is the one that I mentioned was the case in Boston. That is the small one there, and because of the way that the study was structured does take that into account, the next one was study C, and that is the one that I was referring to.

Chairman THOMAS. That is the broad national one.

Mr. GROB. Yes.

Chairman THOMAS. Do any of the others, then, have a case mix or severity of illness corrective factor?

Mr. GROB. I would have to go back and examine that much more carefully. I will be happy to do that.

Chairman THOMAS. I appreciate it. I believe the answer is they do not. But I would be willing to stand corrected.

[The following was subsequently received:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY 24 1995

The Honorable William M. Thomas
Chair, Subcommittee on Health
House Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Thomas:

I am writing to follow up on two questions that were raised at the May 3, 1995, oversight hearing regarding physician self-referral held by the Subcommittee on Health, House Committee on Ways and Means. I promised to provide answers for the record.

First, Representative Ensign asked if I was aware of any studies that evaluated the effect of the various State laws on the practice of physician self-referral. We had actually conducted an analysis of State laws as part of the study which we submitted to the Congress in 1989. This was the study which I referred to in my testimony, and which I described as giving "mixed results." We found that no State had an outright ban on physicians owning a health care entity. Eleven States required a physician to disclose a financial interest to patients. Thirty six States had anti-kickback laws. Only Michigan had a law which forbade physicians from referring patients to entities in which they have financial interests.

The overwhelming majority of our State respondents said that they were unable to monitor for compliance of existing laws. This made it impossible for us to evaluate how effective these laws would be if they were enforced. Surprisingly, Michigan had the highest average of laboratory services per Medicare beneficiary, despite it having the strictest law. However, the fact that we found laboratories in which Michigan physicians had an ownership arrangement and to which they were referring Medicare patients indicates that the law was not being enforced.

I am not aware of any other studies on this subject. I have enclosed a copy of our study for your information. However, I must caution that State laws may have changed since we published this report in 1989.
Second, you asked whether any of the studies cited in my testimony took into account factors such as case mix, medical necessity, or other factors (other than ownership interests or compensation arrangements) that may explain increased utilization.
I noted at the hearing that two of the studies took such factors into account:
(1) Physicians' Responses to Financial Incentives -- Evidence from a For-Profit Ambulatory Care Center (Hemenway D, Killen A, Cashman SB, Parks CL, Bicknell WJ: New England Journal of Medicine, 1990;322;1059-1063); and (2) Frequency and Costs of Diagnostic Imaging in Office Practice -- A Comparison of Self-Referring and Radiologist-Referring Physicians (Hillman BJ, Joseph CA, Mabry MR, Sunshine JH, Kennedy SD, Noehter M: New England Journal of Medicine, 1990;322;1604-1608).

I would like to call to your attention two additional studies cited in my testimony that also take such factors into account. (Copies enclosed.) One study concluded there was no reason to attribute the differences between joint venture and non-joint venture freestanding physical therapy and rehabilitation facilities to the health status of the population. The study found that visits per patient were 39 percent to 45 percent higher in facilities owned by referring physicians and that both gross and net revenue per patient were 30 percent to 40 percent higher in such facilities. Percent operating income and percent markup were also significantly higher in joint venture facilities. "Physician Ownership of Physical Therapy Services: Effects on Charges, Utilization, Profits, and Service Characteristics" (Mitchell JM, Scott E: Journal of the American Medical Association, 1992; 268:2055-2059).

In another study, the authors compared the patterns of physicians who referred patients to facilities of which they were owners to patterns of physicians who referred patients to independent facilities. The study showed that California physician-owners of MRI facilities ordered medically inappropriate MRI scans at a rate about one-third higher than physician non-owners. A prospective precertification program was used to determine whether the referrals for MRI scans were medically appropriate. As part of this program, an independent utilization-review firm gave an opinion regarding medical appropriateness based on the medical documentation of patient's injuries, conversations with the referring physician, and criteria established by board-certified physicians. The study estimated that where referring physicians own MRI facilities, the costs to the health care system of this expensive technology goes up by 31 percent. "Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians" (Swedlow A, Johnson G, Smithline N, Milstein A: New England Journal of Medicine, 1992;327;1502-1506).

I appreciated the opportunity to testify about our 1989 report on physician self-referral as well as nine other studies that have appeared in the professional literature on this topic. I hope this additional information will be helpful to you and other members of the Subcommittee as you consider the complex issues relating to physician self-referral. I would be happy to provide you and your staff with any additional information you need and stand ready to consult with you and your staff regarding any legislative proposals to amend or revise the physician self-referral.

Sincerely yours,

George F. Grob
Deputy Inspector General for
Evaluation and Inspections

Enclosures

cc: The Honorable John Ensign

Just let me say, Mr. Grob, I have done a little bit of looking at methodology in my previous life on behavioral sciences studies. And at the end of your statement to say, "draw your own conclusion," I am not used to having a Rorschach test as the conclusion of a study.

When you say that the sum of the studies is greater than the studies themselves, that somehow you cannot find it individually, but when you look at them in total, you clearly see what is going on, I mean, to me that is a Rorschach test.

You see what you want to see, and I am telling you, I perhaps do not see what you want me to see, unless the test is structured in a way which proves relatively specific points. In your discussion with Mr. Stark, enforcement to me is a means, not an end. And when you talk about intent getting in the way of enforcement, it really does make me believe that you have already drawn the conclusions—studies do not show it, but you know it is there, and that trying to prove intent is extremely difficult. So, let's set intent aside.

We can now go out and enforce my already preconceived notion about what is going on out there, bolstered by the simple fact that here is a physician and here is involvement. Draw your own conclusions, do not encumber me with intent. But I know what is going on. That, frankly, is a relatively frightening conceptual framework, which I drew from the way you voluntarily discussed the work that you have provided and your response to Mr. Stark's questions about enforcement. And that is where we are today.

I was very upset, especially with the Florida study on the MRIs, For example, I kept asking the questions, did you do anything to examine whether or not the patient problem was solved quicker, was the diagnosis more accurate, was the total cost package cheaper? I think these questions ought to be the driving aspects here.

The answer to those questions was no, no, no. All we did was look for the relationship. And if you find a relationship in your own words, draw your own conclusions. I have a very difficult time with that kind of methodology being the basis for this kind of a law when you throw intent out the window.

Now, if that is the sole basis for our having moved this legislation not once but twice, then I think you can understand the reason for this hearing and subsequent hearings if necessary. Frankly, I just do not draw my own conclusions in the same way that apparently you do. I look at each individual study and I find each individual study almost fundamentally flawed in its methodology, and therefore in sum I find the package relatively less helpful in drawing a conclusion. So, we have some, I think, fundamental problems here in terms of laying groundwork, especially if you are going to set aside intent.

If you had brought intent into the mix, I would have a little higher comfort level. But, you have told us that in other areas of trying to move forward, intent gets in the way of enforcement. So, we do away with intent. When you talk about that, it seems to me that enforcement becomes an end, rather than a means, and I am very concerned about that kind of a draw-your-own-conclusion mentality.

You want to respond?

Mr. GROB. Yes, sir, if I may respond.

There were two areas there. One had to do with the accumulation from several studies and how it might be interpreted. The other one had to deal with intent. Let me talk about the intent first, if I may.

The intent was made in reference not to this law, but it was made to the antikickback laws. And the requirement to prove that someone intentionally violated the law is rather unusual, if you will. When a crime is committed, usually the burden of proving that the person intended and willfully intended to violate the law is a prosecutorial——

Chairman THOMAS. Excuse me. Are you equating the ownership of a piece of medical apparatus with a crime?

Mr. GROB. No, sir. The application to the antikickback law——

Chairman THOMAS. I understand that. But, transferring it to another area now, the mental set of trying to prove intent in an area of preagreed upon and prearranged criminal activity.

Mr. GROB. Yes, I wanted to be clear on that. The question I was answering there had to do with the difficulties of enforcing the antikickback law, sir, not this law. It is not related to this one. The question——

Chairman THOMAS. But this law does not have intent in it.

Mr. GROB. That is correct.

Chairman THOMAS. My understanding was one of the reasons it wasn't included was because of the difficulty to include cases in previous experience, which was the kickback law. Do you think this law would be improved if you put intent into it?

Mr. GROB. No, sir, I think it would be more difficult to use.

Chairman THOMAS. Why would not it be improved if you included intent?

Mr. GROB. It is——

Chairman THOMAS. Because it would be harder to enforce?

Mr. GROB. It would be very difficult to prove. Let me—let me—I do not mean to reverse the question, but if I could just state it hypothetically, and it goes back to the question of the utilization reviews. If you saw a pattern, as some have been indicating here where there was a much higher level of utilization among physicians, if you had a system that tried to eliminate any abuse by making it necessary for administrators to prove that the services were unnecessary one by one, or that the physician or other health care practitioner had the intention to rip off the system, it would be just a very impractical way to administer the law.

Chairman THOMAS. I understand that. But the study that you are asking me not to carefully examine the structure of, never looked at the efficacy of the decision, the comfort of the patient in terms of correct diagnosis earlier, or whether or not ultimately the whole procedure was more cost effective than was otherwise the case.

If you do not have those kinds of parameters in a study, what you have done is simply connected the dots. And then as you said, draw your own conclusion.

I will have to tell you that that is a level of proof, one, I am not familiar with; two, I am very uncomfortable with removing intent from the equation because it makes enforcement too difficult. That

is part of the reason we are examing this process. The other part, of course, is that it is occurring at a time which perhaps makes it far more difficult, creates a chilling effect on some positive arrangements that some of us think actually will wind up saving far more money than your chart indicates would be saved if every laboratory test in the United States had no rational basis for being used and that we eliminated them all. That is, obviously, overstating the parameters of that particular chart, but that is in part where we are being led.

Mr. GROB. Sir——

Chairman THOMAS. You can respond, but I will respond back. So, to save time for everybody, let's just leave it at that. I expect to be convinced by each study, and the cumulative weight of the studies never ever exceeded the sum of the studies. Because if they do, you are bringing something to those studies that is not there.

Mr. GROB. Did you wish me to respond, sir?

Chairman THOMAS. You can see it. Somebody else might see it. But, you cannot prove it to somebody else, unless they accept the same assumptions that you do in drawing your own conclusions. Unfortunately, you have not been able to convince me that the conclusions are the same, because frankly, I can come up with a number of other very viable, very rational decisions based upon the evidence. That is not enough to put a chilling effect on an area that we need a lot of positive dynamic change in. And, that is why we are looking at the law.

Thank you very much.

The gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. Thank you.

I have been very interested in the issue of the pace of change and rational law and regulation. The two studies you point to in which severity was considered, are two of the three oldest studies that you cite. They are published in 1990, which means that their data was collected in the preceding 2 to 4 years, correct?

Mr. GROB. Yes.

Mrs. JOHNSON. So, their data at this point is 6 to 10 years old?

Mr. GROB. That is correct.

Mrs. JOHNSON. Right. I think that is important to put on the record. Because it simply makes them almost irrelevant. The studies that you point to as more recent, if I understand it, did look only at volume and referral. Is that correct?

Mr. GROB. Congresswoman, I would like to examine those more carefully. In preparing for this, I tried to pick out from the nine some of the examples that would show the intent and I was very assiduous in doing that. I do not review each and every one of them for that purpose. I do not want to say that none of—not intent, excuse me, but the severity of the cases. So, I——

Mrs. JOHNSON. But your process does not consider appropriateness of care?

Mr. GROB. I am sorry, which process?

Mrs. JOHNSON. These studies do not look at appropriateness, they just look at who made the referral, to what facility?

Mr. GROB. That is correct.

Mrs. JOHNSON. Yes. I think that is just very important to put on the record. I assume your office will be eventually overseeing a provision now that HCFA is including this in its manual.

This is not a provision driven by law. It is not a new regulation, but it is going to have the force of law. And it will be in their manual and it limits the panel of tests that any physician is allowed to order to 12, and any test over that is going to have to be individually documented. This is going to increase costs not only in terms of physician time, but it is going to increase costs because fewer tests are going to be batched, and so the costs of the additional extra tests are going to be higher.

Now, when your office looks at this, as you will surely be asked to look at in a few years, you will look at appropriateness of the test, at the cost of the test, at total care to the patient, at the impact on diagnosis?

Mr. GROB. We will do our best to answer any questions that are presented to us as we always have in the past.

Mrs. JOHNSON. But traditionally, you have only looked at how many more tests were ordered from the panel.

Mr. GROB. There has not been much tradition here at all, Congresswoman. We did the one study and have examined the others.

Mrs. JOHNSON. Well, actually, the knowledge about how to look at quality and volume is fairly recent. So, that is one of the problems, your studies are not as useful to us as they might be, because they do not take advantage of more recent developments.

Mr. GROB. Could I comment briefly on the timeliness of the studies, since you never asked me, but you did raise the point about the timeliness?

Mrs. JOHNSON. OK.

Mr. GROB. In the field of conducting studies like this, it is virtually never possible to be current. The databases are almost always several years old. And a danger that we all face is sort of saying waiting until we have the absolutely definitive study before action is taken to correct a problem. Again, much judgment is needed, but I would never want to promise you more than can be delivered.

Mrs. JOHNSON. I appreciate that, but I think it is important for the record to show that it takes a couple years for you to do it, that the data takes a couple years to develop. So, almost always our data is 3 to 6 years old. And I think that is important.

In your experience from watching these things, do you think an exemption for those systems in which, by virtue of the structure of their reimbursement processes, there is no longer any likelihood of referrals being linked to profit? Do you think a blanket exception of those systems would be reasonable?

Mr. GROB. I think that is perhaps the best principle to use in considering any exemptions which are proposed. Putting that one into practice is difficult, but I think that is the key, the key matter.

Mrs. JOHNSON. Would you think it logical for this Committee to consider that proposal that was made by an earlier panel?

Mr. GROB. If there were a practical way to do it, I would think that would be a key principle to use.

Mr. JOHNSON. Thank you.

Mr. GROB. Mr. Chairman, I would like to clarify one thing I said, and it is not to engage in a back and forth with you. I hope you did not construe my remark about drawing your own conclusion to be one in which I thought that the conclusion was so obvious that it was a rhetorical question. I did not mean to put it to you in that way.

I was trying to do my best to distinguish here for you the matters on which the data did provide firm evidence from those that did not. So, I hope you would understand that that was my intention in that case.

Chairman THOMAS. No, Mr. Grob, I took it I think in the way it was intended, and that is on the merits alone, these studies do not prove the conclusion you arrived at and you have to draw your own. My conclusion is different than yours.

I would like to be convinced. Timeliness of studies and meaningfulness and usefulness of studies are two different things. You have met neither of those, in my opinion.

Thank you.

Mr. GROB. Thank you.

Chairman THOMAS. The next panel consists of Dr. Wilson, Dr. Tice, Mr. Kershner, Mr. Mentz, and Dr. Strickland.

As I have indicated to the other panels, if you have any written testimony, it will be made part of the record without objection.

If we might begin with Dr. Wilson and just move down the panel, you can inform the Subcommittee in any manner you see fit.

Dr. Wilson.

STATEMENT OF CECIL B. WILSON, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN SOCIETY OF INTERNAL MEDICINE

Dr. WILSON. Thank you, Mr. Chairman.

My name is Cecil Wilson. I am a physician in solo practice in internal medicine, Winter Park, Florida. I am also a trustee of the American Society of Internal Medicine.

In recognition of the role physician office labs play in providing high-quality, convenient, cost-effective medical care to patients, OBRA 1989 exempted physician office labs run by solo practitioners or group practices from the self-referral restrictions, allowing them to continue to operate. Shared labs, exceptionally common because they are practical and cost effective, would not explicitly provide an exemption.

For the last 21 years, I have shared an office lab and x-ray machine with an internist who is in a contiguous suite. The reason I have an office lab is to enhance my ability to provide good quality care to my patients by being able to obtain test results immediately while the patient is in the office. The reason I share a lab with another physician is that I, like most solo practitioners, cannot afford such a facility by myself.

My office lab does not differ in the way it operates from office labs run by group practices or solo practitioners on their own. My lab provides in-office testing services to my patients. I directly supervise this testing. I do not do tests on other physicians' patients. I do not derive income from any test done for my lab partner's patients and I bill only for work done for my own patients.

The law as presently written provides me and my patients with no happy choices. I can close my lab, losing that service for my practice, or the other internist, and can each have our own lab, and I would say that even if we could afford that, it makes no sense. Our office doors are 24 feet from each other, and there is just not room for two labs in that building.

The other option is for us to form a group practice in order to qualify for the group practice exemption. This would require us to completely merge our professional lives, our pension and retirement plans, our billing practices and staff, as well as assuming legal and financial responsibility for each other.

Makes no sense to us to require that we reorder our professional lives in order to continue doing what we have been doing for the past 21 years, providing lab services for our patients. We are in solo practice because we value the freedom of individual practice.

Unless Congress or HCFA on its own creates an exemption for shared facility arrangements, I and others like me across the country will be forced to close our office labs, send patients across town to other labs for a test. This change will not be beneficial for my patients.

One-third of my patients are elderly and they count for two-thirds of the patient visits to my office. Many of them rely on others to bring them for their appointments, and even for those who can drive, the trip to the doctor's office requires significant effort and planning. The additional trips to an outside lab necessitated by closure of my lab will be a hardship for them and will result in unnecessary delays and diagnosis and treatment of their medical problems.

Two patients I saw last week I think provide further emphasis of the value of the lab. The first was a 66-year-old woman with symptoms of an urinary tract infection who arrived at 3:30 in the afternoon. A urine sample was obtained. I obtained a history and examined the patient. By the time I was finished, my lab tech provided me with the results of the lab, confirming infection. The patient was able to pick up her antibiotics from her pharmacy on her way home and begin treatment immediately.

The second patient, a 73-year-old man, had diverticulitis, an infection of the colon which is similar to an abscess. A blood test performed while he waited helped me to decide that treatment at home was appropriate, saving hospitalization, a $25 test instead of a multithousand dollar hospital visit.

It is urgent, that the Committee act now to protect shared physician office arrangements. We request enactment of a shared facility exception by Congress, and if necessary, steps to ensure that the Department of Health and Human Services does not sanction shared facilities before Congress has a chance to act on such an exception.

We also urge your support of some additional recommendations for changes in the self-referral laws which are addressed in our written testimony.

Finally, I would like to express my appreciation for this opportunity, Mr. Chairman, thank the Committee for its interest in this subject, and also thank Congress for its previous support of this particular issue.

[The prepared statement follows:]

STATEMENT OF CECIL WILSON
MEMBER, BOARD OF TRUSTEES,
AMERICAN SOCIETY OF INTERNAL MEDICINE

Introduction

My name is Cecil Wilson. I am a physician and general internist in solo practice in Winter Park, Florida and a Trustee of the American Society of Internal Medicine (ASIM).

My comments today will focus on problems Internists are experiencing with the self-referral laws. We believe that there is an urgent need for a limited exception from the 1989 "Stark I" law for shared in-office ancillary service facilities and a need for a number of amendments and clarifications to the 1993 "Stark II" law that took effect on January 1, 1995.

Internal medicine is the nation's largest medical specialty. As specialists in adult medical care, internists take care of more Medicare patients than any other specialty. Our members are extremely concerned that the self-referral law will have a serious negative effect on patient access to convenient and cost-effective ancillary services. ASIM does not advocate repeal of the self-referral law. Instead, we believe amendments to the law are essential to make sure it is reasonable and workable.

Shared In-office Ancillary Services

I share an office laboratory, laboratory technician and an x-ray machine with another solo practicing internist who is in a contiguous office suite; I have done so for over 21 years. The reason I share an office laboratory and x-ray machine with another solo internist is to provide convenient and cost-effective laboratory tests and chest x-rays for my patients. The ability to get test results immediately while the patient is still in the office helps me provide good quality care to my patients. Unless Congress creates an exception for shared in-office arrangements such as my own (or the Department of Health and Human Services sees fit to grant a regulatory exception) I will be forced to close down my office laboratory and send patients across town to another laboratory for tests. This change will not be beneficial to my patients. One-third of my patients are elderly. This group accounts for two-thirds of the patient visits to my office. Many of them rely on others to take them to their appointments, and even for many of those who can drive, the trip to the doctor's office requires significant effort and planning to schedule travel during less busy periods in the day when they feel safer driving. Additional trips to an outside laboratory, which would be necessitated by the closure of my laboratory, will be an extreme hardship for them, and will result in unnecessary delays in diagnosis and treatment of their medical problems.

The current self-referral law, with its in-office ancillary services exception, protects access to ancillary services provided by group practices and solo practitioners who do not share a laboratory. The law does not specifically recognize the existence of a third common type of in-office arrangement: the in-office ancillary service facility shared by physicians in different practices who practice in the same building. This puts my office laboratory and other labs like it in immediate jeopardy of being closed.

A shared facility is an in-office diagnostic facility shared by physicians who practice in the same building but who are in different practices. The shared facility is located in the same building as the physicians who share it and provides timely and convenient ancillary services such as clinical laboratory testing and x-rays to their patients. Each physician pays part of the lab expenses and bills only for his or her own patients. Each physician supervises his or her own test results. The physician does not derive any income from the referrals of any of the other physicians in the arrangement. In these aspects, the shared arrangement is no different than in-office facilities exempt from the law, specifically those facilities operated by group practices or single solo practitioners.

Shared arrangements are common business arrangements in this country because they are practical and cost-effective. The high cost of operating a quality lab or providing x-rays within the office setting is prohibitive for most solo-practicing physicians and even some small groups. I could not afford to maintain my laboratory without sharing the cost of equipment and the salary of a technician with my laboratory partner. Our expense sharing arrangement allows me to provide testing services to my patients in the most cost-effective manner possible. The arrangement is also practical. My lab partner's office door is 24 feet from mine. It makes no sense for us to have two labs in the same office space, even if we each could afford to maintain our own labs. It also

is not a viable option for me and other physicians in shared arrangements to form group practices in order to qualify for the group practice exception. Becoming a group practice entails completely melding our professional lives, pension and retirement plans, billing practices and staffs as well as taking on legal and financial responsibility for each other. It is not reasonable to expect independently-practicing physicians to form group practices with each other just to be able to continue to provide the same services they have provided patients in the past. My laboratory partner and I are in solo practice because we want to practice individually.

There have been a number of attempts to fix the shared facility problem legislatively. Congress passed a shared facility exception as part of H.R. 11, the tax bill from 1992. H.R. 11 was vetoed by then-President Bush for unrelated reasons. Last year shared facility exceptions appeared in all the major House health system reform bills, including the bill reported out of the Ways and Means Committee. ASIM supports the specific language of the shared facility exception included in the House bipartisan health system reform bill from 1994 (H.R. 5228). This exception would exempt from the self-referral ban in-office ancillary services that are furnished:

a. personally by the referring physician who is a shared facility physician or by an individual directly employed or directly supervised by such a physician;

b. by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician unrelated to the furnishing of shared facility services;

c. to a patient of a shared facility physician; and

d. the shared facility services would be required to be billed by the referring physician.

ASIM believes these criteria will eliminate risk of program or patient abuse and will preserve this type of practical and cost-efficient delivery of patient services.

The final regulations implementing the original self-referral statute from 1989 will be published in the next couple of weeks. We have urged the Secretary to use the authority granted her under Section 1877(b)(5) of the Social Security Act to create a shared facility exception. In our view, this exception does not differ substantially from the other in-office ancillary services exceptions already provided under the law. We are concerned that the final regulation will include a shared facility exception.

It is urgent that the legislative branch take immediate action to protect shared facilities by granting an exception. At the very least, we urge Congress to take action to prevent the Department of Health and Human Services from sanctioning shared facilities until it has time to consider a shared facility exception. If the final regulations make shared arrangements illegal, I and other physicians like me will not be able to risk sanctions to keep our in-office testing facilities open even if we know Congress plans to grant a shared facility exception in the future. Access to in-office testing will be cut off for thousands of patients.

Amendments to the OBRA '93 Physician Self-referral Statute

In addition to a shared facility services exception, ASIM believes clarifications and amendments must be made to address confusing and unnecessary provisions in the OBRA 93 self-referral law.

First, the requirement that members of a group practice may not be compensated based directly or indirectly on the volume or value of referrals made by such physicians should be repealed. Not only does it interfere with the internal affairs of private businesses, but my colleagues in group practice tell me that they cannot figure out how to distribute revenue from ancillary services (if there are any after overhead expenses are paid) without indirectly taking into account the referrals made by the physician to some degree. Another problem in some cases is that ancillary services are bundled into a single payment for a particular procedure. How is the revenue for laboratory testing suppose to be separated out from other services in this case? The Department of Health and Human Services has authority under other provisions of the Medicare statute to penalize physicians who order unnecessary ancillary services without this unnecessary intrusion into the operations of private professional practices.

Second, hospital inpatient services, outpatient prescription drugs, x-rays, and parenteral and enteral nutrition and durable medical equipment (DME) provided within a physician's office should be removed from the list of designated health services covered by the self-referral ban. OBRA '93 inappropriately expanded the scope of the self-referral ban to many services integral to internal

medicine. No explanation was given to why these services were added to the prohibition. Certainly no good evidence exists to show that these services were being abused within physician practices. However, the current law makes it difficult or impossible for physicians to provide these services to their own patients. To illustrate, OBRA '93 effectively prohibits nephrologists from providing inpatient dialysis services to their own patients at a hospital where they hold a contract to provide the hospital's inpatient dialysis services. The patient is forced to have inpatient dialysis performed by someone other than his or her physician. It is wrong to prohibit physicians from providing inpatient hospital services to their own patients. Clearly over-utilization is not an issue in this case. Receiving dialysis is not an optional therapeutic procedure. Patients with irreversible kidney failure must have regular dialysis to live.

Other subspecialties of internal medicine are experiencing similar problems. For example, oncologists in group practices are effectively prohibited from providing chemotherapy drugs to their cancer patients. Endocrinologists find that they can no longer provide low cost glucose monitors to their diabetic patients. Infectious disease specialists find that they must send patients to home infusion companies for parenteral and enteral nutrition supplies because they are prohibited from providing these items within their practices.

Third, a community-need exception should be created. Many areas, such as inner-city communities and smaller towns, have problems similar to rural areas in attracting nonphysician investors for needed facilities. A discretionary community-need exception would allow physician investment in and referral to outside health care facilities in any locale where the Secretary of Health and Human Services determines that there is both the absence of adequate facilities--a plain medical need--and the absence of alternative financing if physicans are prohibited from investing. This exception is necessary to cover medically underserved areas that do not qualify for the current law rural provider exception.

Conclusion

ASIM appreciates the opportunity to present testimony to the Ways and Means Subcommittee on Health regarding these issues relating to physician self-referral. We believe that the changes we have recommended are essential to ensure that the self-referral law is reasonable, workable and does not disrupt patient access to medically necessary ancillary services.

I'd be pleased to answer any questions from the subcommittee.

Chairman THOMAS. Thank you, Dr. Wilson.
Dr. Tice.

STATEMENT OF ALAN D. TICE, M.D., PRESIDENT, PHYSICIANS FOR QUALITY OUTPATIENT INFUSION THERAPY

Dr. TICE. I am Alan Tice, I am an internist and an infectious disease specialist in Tacoma, Washington, where I have been in practice for 16 years. As part of our practice, we have developed an outpatient IV antibiotic therapy program for the last 14 years.

I am also president of the Outpatient Intravenous Infusion Therapy Association, and the Physicians for Quality Outpatient Infusion Therapy. Both of those organizations were developed and dedicated to developing an interest by physicians in outpatient therapy and to helping payors appreciate the vital role of physicians in outpatient therapy. It is important that you realize that outpatient therapies, particularly outpatient intravenous therapies, are growing rapidly, and for good reason. There are new antibiotics, there is new technology, there is new vascular access and there are new delivery devices to treat the new diseases that we must encounter. It is a rare opportunity with patient intravenous therapy to increase or improve the quality of life, the quality of care, but yet save money and reduce the costs.

At present, approximately 1 in 1,000 Americans receive outpatient intravenous antibiotic therapy each year. In my clinic, I am one of six infectious disease specialists who care for patients with AIDS, with immunosuppressive disorders and serious infections.

As our clinic experience has grown, we now treat more outpatients than inpatients, and we provide intravenous antibiotics to as many outpatients as we do inpatients. I think it is important for you to recognize that two-thirds of our patients are never even hospitalized, even though they have serious infections that warrant intravenous antibiotic therapy.

We treat only our own patients who are referred to us as part of our consultative practice. I can provide intravenous antibiotic therapy for my patients in their home, in the office, or train them in self-administration. We have any device or pump necessary to optimize and individualize therapy.

The legislation on self-referral that came from this Committee has been well-intended, but has had a negative impact on patient care and also limits the doctor's ability to provide the care that is most appropriate for patients. It is possible that the concerns behind the law are relevant to diagnostic testing, but they are not relevant when it comes to patient care.

The problem is that physicians are responsible for the care of patients and are willing to take that responsibility, but are not allowed the freedom and control necessary to provide optimal care to these patients under the self-referral law. Physicians are discouraged from outpatient care not only because of financial limitations, but also because of legal issues, especially those drafted by this Committee.

There are many physicians that I know of who have sold their programs or been reluctant to start programs through their offices because of the concerns over implementation of the self-referral law. The office-based, physician-based model is one of great oppor-

tunity. It is one that integrates and coordinates the services of the nurse, pharmacist and physician, usually under one roof. This makes it a much more efficient unit than others, which are often fragmented. It also puts the physician in control and clearly responsible for the care of people receiving outpatient therapies. It is safer, better and simpler for patients, and it can provide a variety of drugs, technology and adapt continuously to the individual patient needs. I think that this is supported by the Office of Technology Assessment report from a few years ago as well.

For my patients, I can provide virtually all appropriate methods of patient care through the office, unless they are insured by Medicare or Medicaid. Because of the limitations under Medicare and Medicaid, I have the choices only of either keeping them in the hospital, putting them in a nursing home, potentially having them come to the office once a day for therapy if drugs are appropriate in that situation, or referring them to a home care company, over which I have no control in terms of patient care.

My office, I believe, is best suited in that I have a full team of nurses, pharmacists and physicians who are centralized, coordinated. It is far simpler for the patient. We can treat virtually any type of disease, and take advantage of the new technology.

I think it is important that you realize we are treating serious diseases with toxic medications that deserve continued physician input, insight, understanding and change. Not only that, but as people are forced out of the hospital in more complex States of disease, the need for physician input will increase significantly.

An example of this occured a week ago. It involved an AIDS patient that I had who is severely immunosuppressed with multiple diseases, and who is receiving multiple medications, and who also developed a viral infection due to cytomegalovirus in his eyes. He needed intravenous ganciclovir. Because of the limitations of Medicaid, I was unable to provide it for him and he had to be cared for by an outside agency of which I did not have sufficient knowledge, and had no control. I would be in a better position to assist a patient, and a patient would receive better care through use of our own nursing services, through our IV therapy program.

It is to the point where we assign nurses to track patients referred to outside programs so that the ball will not be dropped, the tests will be done, and we can assure the quality of care that we are legally responsible for. I urge you to amend the Stark II law to protect and encourage the physician office model for outpatient infusion therapies, to foster a close doctor-patient relationship, to allow physicians to control the setting in which patients for whom they are responsible receive care, and to take advantage of all the new technologies that are coming in outpatient care.

In my role as a provider and as a representative of the PQOIT organization, we will be happy to help you develop appropriate standards and guidelines for patient care in these settings to avoid abuse. I think that we should be able to dispense drugs, pumps, enteral and parenteral products through our offices for the care of patients treated outside the hospital.

Thank you for this opportunity to come here.

[The prepared statement follows:]

TESTIMONY OF ALAN D. TICE, M.D.
PHYSICIANS FOR QUALITY OUTPATIENT INFUSION THERAPY

Thank you, Mr. Chairman and Members of the Subcommittee, for inviting me to appear before you today to discuss several problems pertaining to the delivery of quality patient care under the new physician self-referral provisions enacted in 1993. I am a physician in the private practice of internal medicine and infectious diseases; the founder and President of the Outpatient Intravenous Infusion Therapy Association (OPIVITA), an organization founded to encourage physicians to provide infusion care for patients outside the hospital and to bring recognition to their important role; and President of Physicians for Quality Outpatient Infusion Therapy (PQOIT), an organization dedicated to a better understanding of the critical role of the physician in outpatient care, and the importance of a close doctor-patient relationship. The physician members of these organizations care for cancer and AIDS patients, and patients with serious bacterial infections.

Introduction

To begin, the physicians who are members of the organizations that I represent recognize and support the need for eliminating financial incentives to overutilize services. We support high Federal standards for the provision of outpatient infusion care. We commend the work of this Subcommittee toward this end. However, we believe that the law, in its current form, has had some unintended effects and that patient care is indeed suffering as a result. The law serves to discourage physicians from becoming involved with outpatient infusion care.

We do not believe that the intention of the self-referral provisions was to prohibit a physician from managing his or her own patients' care. With sicker and sicker patients being discharged from the hospital, now more than ever a physician-based model of delivery of outpatient care should be encouraged. In sum, we believe that the law should be revised to make clear that infusion therapy can remain an integral part of a continuum of care from the physician.

Our specific recommendations include:

- Restructuring the in-office ancillary services exception to clearly allow patients to receive home infusion services from their own physicians, rather than be required to be referred to home infusion agencies.
- Restructuring the in-office ancillary services exception to allow patients to receive enteral and parenteral nutrients in the physician's office, and to allow physicians to dispense the nutrients to their own patients for home use.

Discussion

Basically, the current self-referral law applicable to Medicare and Medicaid patients requires physicians to turn over the care of their own patients to home infusion companies. We believe the current self-referral law must be clarified and amended to allow physicians to care for their own patients.

Under current law, specialists in oncology and infectious diseases are able to provide infusion therapy services to Medicare and Medicaid patients with cancer or AIDS only by requiring these patients to come to the physician's office each and every time that they need infusion therapy, or by caring for them in a hospital. Typically, these physicians already provide infusion services in their offices and have the capability to extend these services as a part of their practice into the patient's home. It is ironic that today's society mourns the passing of the era when doctors made house calls, yet the Federal government has a law that prohibits the doctor's nurse from visiting the patient in the home.

The current law arguably does not permit physicians to dispense from their offices the necessary drugs and nursing services to enable Medicare and Medicaid patients to self-administer this therapy at home. Such home care is safe, if appropriately monitored by a qualified physician. Under the current law, physicians are left with three choices for Medicare and Medicaid patients: (1) either treat the patient in the hospital or a skilled nursing facility; (2) require the patient to receive infusion services in the physician's office every time; or (3) turn the patient's care over to a home infusion agency.

We all would agree that keeping a patient in the hospital, or sending him or her to a skilled nursing home for infusion therapy, is usually not an appropriate, cost effective mechanism for treating Medicare and Medicaid patients. The cost of furnishing home infusion therapy is much less than the costs of treating these patients in hospitals and skilled nursing facilities.

However, with respect to infusion therapy provided to patients in their homes, direct physician management of the care of infusion patients is critical. These patients often are very ill and the drugs involved are toxic. Until the recent advent of advanced technology, these patients would have received this type of treatment in the hospital. Often home infusion companies are not sufficiently staffed to provide home infusion therapy to patients with AIDS, cancer and other diseases requiring complex therapy. In addition, physician management of these patients is necessary, because frequently the drug therapy must be revised. These patients cannot afford to lose contact with their physicians. For example, last year in my office practice, 14 percent of the infusion patients needed their antibiotics changed for a variety of medical reasons.

A physician office provider brings together the full team of physicians, nurses, and pharmacists who all work together for quality patient care. These health care professionals know each other well and can communicate continually in the office. The patients often see the same nurses at home that they see in the office, and appreciate the continuity of care. The physicians appreciate having care provided by nurses that they know and trust. The Office of Technology Assessment, in its 1992 report on the home infusion industry, acknowledged these advantages to a physician office-based home infusion practice.[1]

The current law clearly prohibits physicians from providing enteral and parenteral nutrients -- even in their own offices to their own patients. We believe that requiring physicians to turn their patients over to home infusion agencies for these services is not medically appropriate, in many instances.

In conclusion, I and members of the two organizations that I represent stand ready to work with the Chairman and Members of the Subcommittee to amend the current physician self-referral law so that it does not impede good patient care.

Thank you very much for the opportunity to testify on this important subject. I will be pleased to respond to any questions you may have.

---

[1] "Home Drug Infusion Therapy Under Medicare," Office of Technology Assessment (1992).

Chairman THOMAS. Thank you very much, Dr. Tice.
Mr. Kershner.

STATEMENT OF BERNARD A. KERSHNER, PAST PRESIDENT AND MEMBER, BOARD OF DIRECTORS, FEDERATED AMBULATORY SURGERY ASSOCIATION, ALEXANDRIA, VA

Mr. KERSHNER. Mr. Chairman, if I may first congratulate you on your recollection of football trivia. That was indeed Big Daddy Lipscomb that was referred to. My name is Bernard Kershner.

I am president of a company called Sun Surgery Corp., which is based in West Hartford, Connecticut. I am here in the capacity of past president and member of the board of directors of the Federated Ambulatory Surgery Association. FASA is the Nation's leading clinical trade organization of ASCs, ambulatory surgical centers, representing more than 500 member facilities, most of which provide surgical services in a variety of specialty areas and virtually all of which are Medicare certified.

There are over 1,700 Medicare certified surgical centers throughout the country. I thought it might be useful to describe what a surgical center is, and indeed it is a specifically designed health care facility. It provides a clinically appropriate setting for the performance of surgical procedures.

They are similar to hospital outpatient departments in that they provide sterile operating rooms, staff, equipment and surgical supplies and other items and services necessary for a surgeon to perform surgery on an ambulatory or outpatient basis. Virtually all the surgical procedures are performed under controlled anesthesia support, provided by an anesthesia specialist. Physicians' professional services are generally billed separately by the physicians who perform the procedures.

Surgical centers are usually organized as separate legal entities. Most States require surgical centers to meet licensure requirements, including health, safety, staffing and physical plant standards, and indeed many States also require a certificate of need for the establishment of or expansion of a surgical center. Medicare Program also does provide payment to those surgical centers that meet certification standards as set forth by Federal regulation.

I want to comment for a moment on the issue of physician ownership of surgical centers. A substantial number of these facilities throughout the country are owned in whole or in part by the physicians who perform surgical procedures in them. These facilities are used as extensions of physicians' workplaces, have often been established through the use of funds contributed by physicians, and have provided a high-quality, low-cost setting for the performance of outpatient surgical services.

There is no evidence whatsoever that physicians' ownership of ASCs has resulted in increased or unnecessary utilization of surgical services. In fact, the Office of Inspector General has indeed proposed to exclude physician ownership of these facilities from the scope of Medicare and Medicaid antikickback provisions.

During Congress' consideration of both Stark I and Stark II, Congress specifically considered provisions that would have directly or indirectly imposed the physician self-referral provisions on ASCs. After thorough consideration, Congress unequivocally and

deliberately chose to exclude surgical centers from the scope of the self-referral provisions.

Congress did so by limiting the application of those provisions to certain designated health services. That did not include ASC surgical services. Likewise, ASCs generally have not been affected by physician self-referral legislation enacted at the State level.

Unfortunately, the broad interpretation of the Federal selfreferral provisions put forward by certain officials of HCFA, inadvertently impact ASCs, despite clear congressional intent. Let me spend a moment talking about the unintended impact of Stark II, and outline a situation under which surgical centers could be adversely affected for three reasons.

The first, current legislation includes orthotics, prosthetics and prosthetic devices as designated health service. Intraocular lenses, IOLs, which are implanted in conjunction with cataract surgery, are considered a prosthetic device for certain Medicare coverage purposes. And for this reason, some HCFA officials have suggested that the implementation of an IOL in an ASC in connection with cataract surgery may trigger self-referral law.

Likewise, it has been suggested that the implantations of other prosthetic devices, such as ear tubes for patients would likewise trigger the physician self-referral proscriptions. Such a position is clearly without merit.

Let me list the second reason. The inclusion of radiology services as a designated health service may have an inadvertent impact on ASCs as well. A number of HCFA officials have suggested that the term "radiology services" is to be interpreted broadly. Specifically, those officials have suggested that any procedure involving imaging will be considered radiology for the purpose of Stark II.

If this interpretation is adopted, a number of surgical and endoscopic services performed by ASCs could be determined to fall within the scope of Stark II proscriptions.

Finally, the Stark II proscriptions include inpatient and outpatient hospital services as a designated health service. Some freestanding ASCs are located in space either leased from a hospital or might even be on a hospital campus. And freestanding surgical centers provide essentially the same services as hospital outpatient departments.

For these reasons, some attorneys have questioned whether the inclusion of hospital outpatient services as a designated health service also impact ASCs. While FASA does not believe that this position has merit, FASA members have experienced difficulty in obtaining assurances from health care attorneys on this issue.

For these reasons, FASA strongly supports a specific exemption that would make it clear that surgical services performed by Medicare certified ASCs, and designated health services integral to the performance of these surgical procedures, are excluded from the Stark II proscriptions.

We are delighted to have the opportunity to appear before you today and look forward to being able to work with you and provide additional information.

[The prepared statement follows:]

TESTIMONY OF BERNARD A. KERSHNER
FEDERATED AMBULATORY SURGERY ASSOCIATION

My name is Bernard A. Kershner, and I am Past President and a Member of the Board of Directors of the Federated Ambulatory Surgery Association ("FASA"). FASA is the nation's leading organization of ambulatory surgical centers ("ASCs"), representing more than 500 member facilities, most of which provide surgical services in a variety of specialty areas and virtually all of which are Medicare-certified.

Since their inception more than 20 years ago, ASCs have become an increasingly pivotal part of our Nation's health care system. In 1993, over 3,000,000 surgical procedures were performed in ASCs. Moreover, recent analysis suggests that approximately two-thirds of all surgical cases can be performed in this kind of outpatient basis. There are currently over 1,700 Medicare-certified ASCs located throughout the country. The use of ASCs has saved our health care system literally hundreds of millions of dollars relative to the cost of outpatient hospital care and, according to an HHS study, procedures performed in surgical centers cost the Medicare program 30-60% less than these same procedures when performed on an inpatient basis.

I. WHAT ARE ASCs?

It may be useful to describe what ASCs are -- and what ASCs are not. ASCs provide a clinically appropriate setting for the performance of surgical procedures. ASCs -- like hospital outpatient departments -- provide the sterile operating rooms, staff, equipment, and surgical supplies, and other items and services necessary for a surgeon to perform surgery on an outpatient basis. Virtually all the procedures are provided under controlled anesthesia support and are performed by an anesthesia specialist. Physicians' professional services are generally billed separately by the physicians who perform the procedures.

ASCs are usually organized as separate legal entities. Most states require ASCs to meet licensure requirements, including health and safety, staffing, and physical plant standards. And indeed many states also require a certificate of need for the establishment or expansion of an ASC.

The Medicare program does provide payment to those ASCs that meet certification standards set forth by regulation. The Medicare payment methodology used to pay ASCs for the use of the facility (the "facility costs") are based on a prospective payment system. Only procedures on Medicare's "List of Covered Surgical Procedures" are eligible for payment. These procedures are classified into several groups, and a payment rate is established for each group.

II. PHYSICIAN OWNERSHIP OF ASCs.

A substantial number of ASCs throughout the country are owned, in whole or in part, by the physicians who perform surgical procedures in them. These facilities are used as extensions of physicians' workplaces; have often been established through the use of funds contributed by physicians; and have provided a high quality, low cost setting for the performance of outpatient surgical services. There is no evidence whatsoever that physicians' ownership of ASCs has resulted in increased or unnecessary utilization of surgical services; in fact, the Office of the Inspector General has proposed to exclude physician ownership of ASCs from the scope of the Medicare and Medicaid anti-kickback provisions.

During Congress' consideration of Stark I and Stark II, Congress specifically considered provisions that would have directly or indirectly imposed the physician self-referral provisions on ASCs. After thorough consideration, Congress unequivocably and deliberately chose to exclude ASCs from the scope of the self-referral provisions. Congress did so by limiting the application of these provisions to certain "designated health services" that did not include ASC surgical services. Likewise, ASCs generally have not been affected by physician "self-referral legislation enacted at the state level.

Unfortunately, under the broad interpretation of the federal "self-referral" provisions put forward by certain officials of the Health Care Financing Administration ("HCFA"), inadvertently impact ASCs, despite clear Congressional intent.

III. THE UNINTENDED IMPACT OF STARK II.

More particularly, while ASC "facility" services are not listed as a "designated health service," ASCs could be adversely affected for three reasons.

A. The Impact of the Inclusion of "Prosthetic Devices" Under Stark II.

First, the current legislation includes "orthotics, prosthetics, and prosthetic devices" as a "designated health service." Intraocular lenses ("IOLS"), which are implanted in conjunction with cataract surgery, are considered "prosthetic devices" for certain Medicare coverage purposes and, for this reason, some HCFA officials have suggested that the implantation of an IOL in an ASC in connection with cataract surgery may trigger the "self-referral law. Likewise, it has been suggested that the implantation of other prosthetic devices -- such as ear tubes for Medicaid patients would likewise trigger the physician self-referral proscriptions.

Such a position is clearly without merit. IOLS implanted in ASCs are reimbursed at a flat rate of $150 -- a rate that was specifically and deliberately fixed by Congress. This flat payment amount is included in an ASC's "facility" payment for the cataract procedure itself; the IOL is not billed separately. Other prosthetics, orthotics, and prosthetic devices are reimbursed on the basis of a "fee schedule" which does not enable ASCs to profit from the provision of the device involved whatsoever.

Thus, the provision of such prosthetic devices in conjunction with surgical procedures does not in any manner present a potential for abuse.

In addition, an ASC serves as the "workplace" of a surgeon owner, regardless of whether or not the procedure performed by the surgeon involves the implantation of a prosthetic device. For this reason, the "workplace" rationale for the exception of ASCs from Stark II likewise applies to prosthetic devices supplied by ASCs in connection with ASC facility services.

B. The Impact of the Inclusion of "Radiology Services" Under Stark II.

Second, the inclusion of "radiology" services as a "designated health service" may have an inadvertent impact on ASCs. A number of HCFA officials have suggested that the term "radiology" services is to be interpreted broadly, for the purposes of interpreting the physician self-referral provisions. Specifically, these officials have suggested that any procedure that involves imaging will be considered "radiology" for the

purposes of Stark II. If this interpretation is adopted, a number of surgical endoscopic services performed by ASCs could be determined to fall within the scope of the Stark II proscriptions.

C. The Impact of the Inclusion of "Hospital Outpatient" Services Under Stark II.

Finally, the Stark II proscriptions include "inpatient and outpatient hospital services" as a "designated health service." Some freestanding ASCs are located in space leased from a hospital or on a hospital campus, and freestanding ASCs provide essentially the same services as hospital outpatient departments. For these reasons, some attorneys have questioned whether the inclusion of "outpatient hospital services" as a "designated health service" also impacts ASCs. While FASA does not believe that this position has merit, FASA members have experienced difficulty in obtaining assurances from health care attorneys on this issue.

IV. CONCLUSIONS AND RECOMMENDATIONS.

For these reasons, FASA strongly supports a specific exemption that would make it clear that surgical procedures performed by Medicare-certified ASCs -- and "designated health services" integral to the performance of these surgical services -- are excluded from the Stark II restrictions.

One final note is in order: Some have suggested that a specific ASC exception is not necessary if the "group practice" exception is significantly broadened. However, many ASCs -- and virtually all of FASA's members -- are not owned entirely by a single group. Rather, the physician-owners of ASCs often consist of a number of physicians in various medical specialty areas whose practices are not otherwise associated with one another. For this reason, we would respectfully submit that an expansion of the "group practice" exception would not adequately address the problems faced by ASCs with regard to the physician self-referral provisions and that a separate exception is necessary.

FASA is delighted to have the opportunity to submit this testimony and looks forward to working with the Subcommittee to draft an appropriate exception for ASCs. If the Subcommittee has any questions with respect to FASA's position on this most important issue, please do not hesitate to call Gail D. Durant, FASA's Executive Director, at (703) 836-8808.

Chairman THOMAS. Thank you very much, Mr. Kershner.
Mr. Mentz.

STATEMENT OF KEITH MENTZ, PRESIDENT-ELECT, NATIONAL RENAL ADMINISTRATORS ASSOCIATION

Mr. MENTZ. Good afternoon, Mr. Chairman, Members of the Health Subcommittee.

My name is Keith Mentz. I am an area administrator in Philadelphia for National Medical Care, but today I am here appearing on behalf of the NRAA, National Renal Administrators Association, of which I am the president-elect.

The NRAA is a voluntary organization representing professional managers of dialysis facilities and centers throughout the United States. We represent freestanding and hospital-based facilities which are for-profit and nonprofit providers, located in urban and rural areas.

A number of our members work for physician-owned dialysis units. Our members manage approximately two-thirds of the dialysis units in this country, which provide dialysis services to a majority of Medicare ESRD, end-stage renal disease patients.

We are pleased to have this opportunity to testify before the Subcommittee. My testimony will be brief and focus on the reasons we urge the Subcommittee to, one, eliminate the self-referral ban on physician-owned dialysis facilities contracting with hospitals to provide inpatient acute dialysis services. And two, clarify that the outpatient prescription drug ban does not apply to prescription drugs provided in physician-owned dialysis facilities.

As a result of the self-referral ban on inpatient hospital services included in OBRA 1993, as of January 1, 1995, physician-owned dialysis facilities, group practices and solo practitioners can no longer contract with hospitals to provide the staff and dialysis machines required to dialyze their inpatients if they refer their own patients to the hospital.

The NRAA strongly recommends that the Subcommittee explicitly exempt physicians who have ownership arrangement agreements with hospitals to provide inpatient dialysis services from the self-referral ban for the following reasons. The purpose of the exception is to assure that hospitals will be able to provide acute dialysis services to their patients. Many hospitals cannot afford to provide 24-hour a day acute inpatient dialysis services, and have therefore contracted with local dialysis facilities.

Some of these are practitioners, group practices and physician-owned, and they provide the staff and dialysis machines to dialyze patients with renal failure. Such arrangements result in continuity of care and better quality of care because the same staff is providing the patients with dialysis in both the inpatient and the outpatient setting. The patients also benefit greatly by having their treatments performed by highly qualified staff.

If these hospitals had no other option but to hire their own staff, it is likely that the staff would not be as qualified because they would provide far fewer dialysis treatments than the staff of the physician-owned facility. Smaller community hospitals and hospitals in isolated areas rely upon acute contracts with physician-

owned dialysis facilities in the community to meet patient care needs that cannot be met in any other way.

Without our proposal, some hospitals that cannot afford to staff an inpatient dialysis unit, may have to transfer their critically ill patients with renal failure to other hospitals. This could negatively impact and compromise these patients' health. It might also jeopardize the continuity of physician care, create additional hardships for the patients and their families, and increase the patient's emotional stress.

An example of this is in Clovis, New Mexico, where patients will have to travel 200 miles to another hospital if the hospital in closing is not able to replace its physician-owned acute dialysis contract. We also do not believe that these arrangements should be included simply because we believe that this is an extension of the physician's practice.

Last, because as most inpatient dialysis services are furnished to Medicare ESRD patients, the inpatient dialysis service is covered under the prospective payment system. Under this system, the hospital receives a fixed amount of reimbursement to cover all services furnished to an inpatient, and I believe that studies have shown that hospitalization rates on end-stage renal disease patients have been decreasing over the past couple years.

In summary, our proposed correction will avoid reducing access to inpatient acute dialysis care, help maintain continuity of patient care, allow hospitals to enjoy the most cost-effective means of providing inpatient dialysis services, and not increase costs to Medicare.

The NRAA would also urge you to eliminate the OBRA 1993 ban on outpatient prescription drugs being dispensed in physician-owned dialysis facilities. Nephrologist-owned dialysis facilities, like all other dialysis facilities, order a number of prescription drugs to be given to patients while on dialysis. These medications are covered under Medicare's condition of coverage and are reimbursed by Medicare.

Peritoneal dialysis, which is performed by a patient outside of the dialysis facility, is also categorized as a prescription drug for Medicare reimbursement. Prohibiting physician-owned facilities from prescribing peritoneal dialysis would mean the patients of these physician-owned facilities would be precluded from this form of dialysis.

We do not believe even the authors of the self-referral provision intended to ban the provision of prescription drugs when delivered within the physician-owned dialysis facility. Such a ban would effectively deny patients of these facilities from receiving proper care and could endanger these patients' lives.

We would like to remind you that this Committee agreed with our recommendations last year and included in the Committee's approved health care reform bill legislative language exempting nephrologist-owned dialysis facilities from the self-referral ban when they referred their patients for any dialysis-related services. In fact, this language was also included in the Gephardt bill and the bipartisan Rowland-Bilirakis bill.

We thank you for the opportunity to explain why the self-referral bans when applied to nephrologist owned dialysis facilities make

no sense. They, in fact, are counterproductive and would deny ESRD patients access to the prescription drugs available to all other dialysis patients and potentially subject hospitalized ESRD patients to less-skilled dialysis staff.

The NRAA would like to see last year's Committee language included in any bill this Subcommittee develops to address the problems created by the OBRA 1993 language.

Mr. Chairman, we stand ready to work with the Subcommittee to clarify and improve the OBRA 1993 self-referral law.

Again, thank you.

[The prepared statement follows:]

TESTIMONY OF KEITH MENTZ
NATIONAL RENAL ADMINISTRATORS ASSOCIATION

Good Morning Mr. Chairman and Members of the Health Subcommittee. My name is Keith Mentz, and I am an Area Administrator in Philadelphia for National Medical Care. I am appearing today on behalf of the National Renal Administrators Association of which I am President-Elect.

The National Renal Administrators Association (NRAA) is a voluntary organization representing professional managers of dialysis facilities and centers throughout the United States. We represent free-standing and hospital-based facilities, which are for-profit and non-profit providers located in urban and rural areas. A number of our members work for physician owned dialysis units. Our members manage approximately two-thirds of the dialysis units in this country which provide dialysis services to a majority of Medicare End-Stage Renal Disease (ESRD) patients. The association was founded to provide information and education to our members and to work with the Congress, the Administration, and other oversight organizations on the Medicare ESRD program. Our organization is dedicated to providing quality of care in the most cost effective manner.

We are pleased to have the opportunity to testify before the Subcommittee. My testimony today will focus on the reasons we urge the Subcommittee to: (1) eliminate the self referral ban on physician owned dialysis facilities contracting with hospitals to provide inpatient acute dialysis services and, (2) clarify that the outpatient prescription drug ban does not apply to prescription drugs provided in physician owned dialysis facilities.

EXEMPT PHYSICIAN OWNED DIALYSIS FACILITIES FROM THE INPATIENT HOSPITAL SERVICE BAN

As a result of the self-referral ban on "inpatient hospital services" included in OBRA 1993, as of January 1, 1995, physician owned dialysis facilities, group practices and solo practitioners can no longer contract with hospitals to provide the staff and dialysis machines required to dialyze their inpatients, if they refer their own patients to the hospitals.

The NRAA strongly recommends that the Subcommittee explicitly exempt physicians who have ownership or arrangement agreements with hospitals to provide inpatient dialysis services from the self referral ban for the following reasons.

The purpose of the exemption is to assure that hospitals will be able to provide acute dialysis services to their patients. Many hospitals cannot afford to provide 24 hour a day acute inpatient dialysis services and have therefore contracted with local dialysis facilities (solo practitioners, group practices and physician owned) to provide the staff and dialysis machines to dialyze patients with renal failure. Such arrangements result in continuity of care and better quality of care because the same staff is providing the patients with dialysis care in both the inpatient and outpatient setting. The patients also benefit greatly by having their treatments performed by highly qualified staff. If these hospitals had no other option but to hire their own staff, it is likely that the staff would not be as qualified because they would provide far fewer dialysis treatments than the staff of the physician owned facility.

Smaller community hospitals and hospitals in isolated areas rely upon acute care contracts with physician owned dialysis facilities in the community to meet patient care needs that cannot be met in any other way. Without this proposal some hospitals that cannot afford to staff an inpatient dialysis unit may have to transfer their critically ill patients with renal failure to other hospitals. This could negatively impact and compromise these patients' health. It might also jeopardize the continuity of physician care, create additional hardships for the patients and their families and increase the patients' emotional stress.

Also, we do not believe these arrangements should be included in the self-referral ban because the dialysis services are actually an extension of the physician's practice.

Further, the principal concerns underlying the self-referral prohibition, inflated charges and unnecessary utilization of services, do not apply to inpatient dialysis services. Hospitals already have oversight responsibility for utilization and admission reviews to ensure that patients are not dialyzed inappropriately. Dialysis is not an elective or diagnostic procedure, it is always performed for therapeutic purposes. Once diagnosed, most ESRD patients require dialysis three times a week, for two to four hours per session, for the remainder of their lives. As a result, little opportunity for abuse exists.

Lastly, as most inpatient dialysis services are furnished to Medicare ESRD patients, the inpatient dialysis service is covered under the Prospective Payment System (PPS). Under this system, the hospital receives a fixed amount of reimbursement to cover all services furnished to an inpatient. Therefore, opportunities for increased costs to Medicare for acute dialysis services are virtually non-existent.

In summary, our proposed correction would: (1) avoid reducing access to inpatient dialysis care; (2) help maintain continuity of patient care; (3) allow hospitals to enjoy the most cost-effective means of providing inpatient dialysis services; and (4) will not increase costs to Medicare.

EXEMPT PHYSICIAN OWNED DIALYSIS FACILITIES FROM THE OUTPATIENT PRESCRIPTION DRUG BAN

The NRAA would also urge you to eliminate the OBRA 1993 ban on outpatient prescriptions drugs being dispensed in physician owned dialysis facilities. Nephrologist owned dialysis facilities, like all other dialysis facilities, order a number of prescription drugs to be given to patients while on dialysis. These medications are covered under Medicare's Conditions of Coverage and are reimbursed by Medicare. Peritoneal dialysis, which is performed by a patient outside of the dialysis facility, is also categorized as a prescription drug for Medicare reimbursement. Prohibiting physician owned facilities from prescribing peritoneal dialysis would mean that patients of these physician owned facilities would be precluded from this form of dialysis. We do not believe even the authors of the self referral provision intended to ban the provision of prescription drugs when delivered within the physician owned dialysis facility. Such a ban would effectively deny patients of these facilities from receiving proper care and could endanger these patients' lives.

We would like to remind you that this committee agreed with our recommendations last year and included in the committee's approved health care reform bill legislative language exempting nephrologist owned dialysis facilities from the self referral bans when they referred their patients for **any** dialysis related services. In fact, this language was also included in the Gephardt bill and the Bipartisan Rowland-Bilirakis bill.

CONCLUSION

We thank you for the opportunity to explain why the self referral bans when applied to nephrologist owned dialysis facilities make no sense. They, in fact, are counter productive, and would deny ESRD patients access to the prescriptions drugs available to all other dialysis patients and potentially subject hospitalized ESRD patients to less skilled dialysis staff.

The NRAA would like to see last year's committee language included in any bill this Subcommittee develops to address the problems created by the OBRA 1993 language. Mr. Chairman, we stand ready to work with the Subcommittee to clarify and improve the OBRA 1993 self referral law. Again, thank you.

Chairman THOMAS. Thank you very much, Mr. Mentz.
Dr. Strickland.

STATEMENT OF JAMES STRICKLAND, M.D., PRESIDENT, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Dr. STRICKLAND. Mr. Chairman, and Members of the Committee, I am James Strickland, president of the American Academy of Orthopedic Surgeons, and a practicing orthopedic surgeon in Indianapolis, Indiana.

On behalf of the 16,000 board-certified fellows of the Academy and myself, I want to thank you for this opportunity to testify before this Committee on the subject of Stark II.

First, let me say that the Academy supports the overall intent of Stark II, namely, to ensure that Medicare patients are protected from fraud and abuse. However, the implementation of the program has activated the law of unintended consequences.

My testimony this morning will address three areas of Stark II that have been problematic for the orthopedic community; namely, shared facilities, issuance of equipment such as splints, canes and crutches, and periodic payments resulting from the sale of a designated health service such as physical therapy.

Mr. Chairman, for the purposes of time, my oral testimony will deal with only the first two issues. With regard to the matter of shared facilities, I am referring to a situation where orthopedic surgeons provide services within a defined and discrete facility, which may contain x ray, physical therapy, a cast application room, and all the necessary nursing and business support.

In this situation, the orthopedists are not formally established as a group practice as defined under Stark II, but rather, have retained their independence through separate billing numbers with insurance carriers. This type of practice arrangement is common.

Sharing the costs of a common facility is done in a number of ways, but the most common is the equal sharing of rent, nursing and business office costs, as well as the cost and revenue of the x ray and physical therapy on a predetermined basis.

Under Stark II, this type of practice arrangement for Medicare patients does not fall under the group practice exemption, but in actuality behaves exactly as a group practice. Consequently, these physicians sharing overhead costs are in violation of Stark II.

I am basing this statement on correspondence the Academy has had with the Health Care Financing Administration officials, and the interpretation of the law by a number of attorneys. The unintended consequence of the law, for example, is that Medicare patients, when presenting themselves for care for a condition which requires a x ray, cannot be x rayed in the discrete suite of rooms used in common by the orthopedists who have decided to share overhead in order to be cost efficient.

Rather, the patient must be sent to some other facility for the x ray and then return to the orthopedist for diagnosis and treatment. If the patient has a broken bone and the orthopedist elects to treat the fracture with closed reduction, that is to say by nonsurgical treatment, the patient must then return again to the other facility for another x ray and once again return to the orthopedist in order to determine that the reduction was indeed successful.

Obviously, this inconvenient and time-consuming shuttle between orthopedic surgeon and x-ray facility is not in the best interest of the patient, nor is it a quality, cost-effective service.

Mr. Chairman, I have made available to the Committee a copy of a letter from a patient that I believe describes the impact and the unintended consequences of this legislation better than I just did. The solution to the inefficient and inefficacious patient care which this shared facility regulation mandates, is, in our opinion, to modify the law to provide an exemption similar to that of the group practice exemption.

This would permit physicians not in a formal group to practice in situations where they work collaboratively within a discrete and definable shared facility, supervising the quality of the work of the shared staff. Moreover, it is recognized that, consistent with the group practice exemption, revenue generated from ancillary services would not be shared on a volume basis. A solution is necessary in order to provide efficient, high-quality, cost-effective and timely care, to our senior citizens.

The next area of confusion under the law seems to be the definition of durable medical equipment. A literal reading of the law has led some lawyers representing our fellows to conclude that applying a splint, putting on a cast, or prescribing and then providing a knee brace, may be considered a referral, and therefore prohibited under the law.

Mr. Chairman and Members of the Committee, these services are the essence of the orthopedic office practice, and an absolutely integral component of our nonsurgical or surgical management of musculoskeletal conditions. I am sure you can imagine the inconvenience to the patient, the potential for professional liability, and the abandonment of the quality of care if patients must be referred to another location not financially connected with the physician providing the initial treatment in order to receive a cast, a splint, a brace, a cane or crutches.

Our solution to that unintended consequence of the law is to provide an exception for the canes, braces, splints, and so forth, are an integral part of the care personally rendered by the physician or by the person under his or her supervision.

Mr. Chairman, it is important here to understand that in an effort to control costs, Medicare has consolidated the reimbursement for DME, durable medical equipment, into four regional carriers. These durable medical regional carriers, are reimbursing DME at a fixed cost. All other charges for orthotics and prosthetic devices are also fixed by Medicare. The only abuse possible on these low-cost items is to charge patients and then not provide the equipment, or to charge and provide these items to every patient.

Mr. Chairman, I can speak for the entire orthopedic community when I say that orthopedic surgeons do not supply prosthetic devices, crutches, casts, splints and canes, to patients whose medical condition does not require them. These items are part of the immediate continuum of care for orthopedic conditions and, for the most part, do not generate profit for the practitioner. Because the Medicare carriers citing the prohibitions of Stark II are in many cases refusing to reimburse for these items, our physicians in the inter-

ests of quality care are supplying items such as crutches or canes to their patients and absorbing the costs.

The decision of orthopedic surgeons to absorb the cost of providing an orthopedic or durable medical equipment is necessitated by the patient's condition. Crutches or a cane is an integral part of the patient's treatment. The decision to withhold the last step of patient care could easily result in a potential lawsuit for failure to provide crutches or a cane should the patient lose their balance and fall while leaving the office.

Mr. Chairman, we support this Committee's continued efforts to provide protections to our senior citizens for unscrupulous individuals, but not the unintended consequences of the Omnibus Budget Reconciliation Act of 1993, because they are neither protecting the patient nor are they encouraging efficient and effective health care.

This concludes my testimony, and I would be happy to answer any questions.

Thank you.

[The prepared statement and attachment follow:]

TESTIMONY OF JAMES STRICKLAND, M.D.
AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Mr. Chairman and members of the Committee, I am James Strickland, M.D., President of the American Academy of Orthopaedic Surgeons and a practicing orthopaedic surgeon in Indianapolis, Indiana.

On behalf of the 16,000 Board Certified fellows of the Academy and myself, I want to thank you for this opportunity to testify before this Committee on the subject of Stark II.

First, let me say that the Academy supports the overall intent of Stark II, namely, to insure that Medicare patients are protected from fraud and abuse. However, the implementation of the program has activated the law of unintended consequences.

My testimony this morning will address at least three areas of Stark II that have been problematic for the orthopaedic community, namely:

* shared facilities;
* issuance of equipment such as splints, canes, and crutches; and
* periodic payments resulting from the sale of a designated health service, such as physical therapy.

SHARED FACILITY

With regard to the matter of shared facilities–I am referring to a situation where orthopaedic surgeons provide services within a defined and discrete facility which may contain x-ray, physical therapy, a cast application room, and all the necessary nursing and business support. In this situation, the orthopaedists are not formally established as a group practice, as defined under Stark II, but rather have retained their independence through separate billing numbers with insurance carriers. This type of practice arrangement is rather common. Sharing of the cost of the common facility is done in a number of ways, but the most common is the equal sharing of rent, nursing and business office cost, as well as the cost and revenue of the x-ray and physical therapy on a predetermined basis.

Under Stark II, this type of practice arrangement for Medicare patients does not fall under the "group practice" exemption, but, in actuality, behaves exactly as a group practice. Consequently, these physicians sharing overhead costs are in violation of "Stark II". I am basing this statement on correspondence the Academy had with the Health Care Financing Administration and the interpretation of the law by a number of attorneys. The unintended consequences of the law, for example, is that Medicare patients, when presenting themselves for care, for a condition which requires an x-ray, cannot be x-rayed in the discrete suite of rooms used in common by the orthopaedists who have decided to share overhead in order to be cost efficient. Rather, the patient must be sent to some other facility for the x-ray and then return to the orthopaedist for diagnosis and treatment. If the patient has a broken bone and the orthopaedist elects to treat that fracture with a closed reduction–that is to say by non-surgical treatment–the patient must then return again to the other facility for another x-ray and once again return to the orthopaedist in order to determine that the reduction was successful. Obviously, this inconvenient and time consuming shuttle between orthopaedic surgeon and x-ray facility is not in the best interest of the patient nor is it a quality/cost-effective service.

Mr. Chairman, at this point I would like to make available to the Committee a copy of a letter from a patient that I believe describes the impact and the unintended consequences of this legislation better than I just did.

The solution to the inefficient and inefficacious patient care which this shared facilities regulation mandates is, in our opinion, to modify the law to provide an exemption similar to the "group practice exemption". This would permit physicians, not in a formal group, to practice in situations where they work collaboratively within a discrete and definable shared facility, supervising the quality of the work of the shared staff. Moreover, it is recognized that, consistent with the group practice exemption, revenue generated from ancillary services would not be shared on a volume basis. A solution is necessary in order to provide efficient, high-quality, cost-effective, and timely care to our senior citizens.

MEDICAL EQUIPMENT

The next area of confusion under the law seems to be the definition of durable medical equipment. A literal reading of the law has led some lawyers representing our fellows to conclude that applying a splint, putting on a cast, or prescribing and then providing a knee brace may be considered a "referral" and therefore, prohibited under the law. Mr. Chairman and members of the Committee, these services are the essence of orthopaedic office practice and an absolutely integral component of our non-surgical or surgical management of musculoskeletal disorders.

I am sure you can imagine the inconvenience to the patient, the potential for professional liability, and the abandonment of the quality of care if patients must be referred to another location not financially connected with the physician providing the initial treatment in order to receive a cast, a splint, a brace, a cane or crutches.

Our solution to this unintended consequence of the law is to provide an exception where the canes, braces, splints, etc., are an integral part of the care personally rendered by the physician or by a person under his or her supervision.

In an effort to control costs, Medicare has consolidated the reimbursement for durable medical equipment (DME) into four regional carriers. These Durable Medical Regional Carriers (DMERCs) are reimbursing DME at a fixed cost. All other charges for orthotics and prosthetic devices are also fixed by Medicare. The only abuse possible on these low cost items is to charge patients and then not provide the equipment, or to charge and provide these items to every patient.

Mr. Chairman, I can speak for the entire orthopaedic community, when I say that orthopaedic surgeons do not supply prosthetic devices, artificial limbs, crutches, casts, splints, and canes to patients whose medical condition does not require them. These items are part of the immediate continuum of care for orthopaedic conditions and, for the most part, do not generate profit for the practitioner.

Although the Medicare carriers citing the prohibitions in "Stark II" are, in many cases, refusing to reimburse for these items, our physicians, in the interest of quality care, are supplying items such as crutches or a cane to their patients and absorbing the cost. The decision of orthopaedic surgeons to absorb the cost of providing an orthotic or durable medical equipment is necessitated by the patient's condition. Crutches or a cane is an integral part of the patient's treatment. The decision to withhold the "last step" of patient care could easily result in a potential lawsuit for failure to provide crutches or a cane, should the patient lose their balance and fall while leaving the office.

PERIODIC PAYMENTS FOR SALE OF A DESIGNATED SERVICE

The final area I wish to speak to is the issue of periodic payment involving the sale of a designated health service listed in Stark II. The problem appears to be with the "isolated transaction rule" in Stark II, which according to a number of attorneys requires a "lump sum" payment for the sale of a service.

One example of the unintended consequence of the law is an orthopaedic group practice which two years ago sold its physical therapy service in anticipation of Stark II. The payments were to be made over a five year period, in equal installments, not related to the volume of patients handled by the facility. In this case the orthopaedic group, knowing the quality of the service provided, refers Medicare patients to this physical therapy service. Although title passed with the sale of the service the arrangement appears to violate the "isolated transaction rule", since the physicians appear to have a "financial interest" in this physical therapy facility until the final installment payment is made.

Our solution to this problem is to permit installment payments, not based on volume or revenues, for the sale of service such as physical therapy. Mr. Chairman, we support this Committee's efforts to provide protections to our senior citizens from unscrupulous individuals but the unintended consequences of the Omnibus Budget Reconciliation Act of 1993 are neither protecting the patient nor are they encouraging efficient and effective health care.

This concludes my testimony and I will be happy to answer any questions.

GEORGE H. MORELLO
1900 Polo Court
San Mateo, California 94402

April 10, 1995

Congressman Fortney Stark
22320 Foothill Blvd., #500
Hayward, CA 94541

RE: ORTHOPEDICS FORBIDDEN TO OFFER XRAY EXAMINATIONS

Dear Congressman:

A few days ago I visited my orthopedic doctor due to excessive pain and my inability to walk more than a few hundred feet. After a thorough examination, my doctor advised that xrays would be required and I fully expected to walk down the hall.

I was told, however, that this is no longer possible due to legislation either authorized or sponsored by you, forbidding xrays to be taken on the same premises.

I was absolutely awestruck and I write you this letter because I want you to know how much inconvenience, pain and suffering you have caused me.

On Friday, April 7, the events were as follows:

1) I arrived at my doctor's office for an 11:00 o'clock appointment and parked in the garage in the basement of his building.

2) At the conclusion of his examination, I was advised to go elsewhere for my xrays which was two blocks away and knowing full well that I wouldn't make it, I decided to drive.

3) Upon arrival at the location of the xray technician, their garage was full and no street parking was available.

4) I then returned to my original starting point, parked the car again and proceeded to walk the two blocks in the rain for my xrays.

5) I then returned to the doctor's office and walked two additional blocks in the rain to get my car and, as a result paid for parking twice.

What possible reason could you have to be motivated to create such hardships, especially for those of us who are getting older? What possesses you to enact a law which has absolutely no benefit to anyone? I have never heard of anything quite so stupid. What business is it of yours to forbid xrays to be taken in a doctor's office if they comply with regulations that ensure the patient's safety?

What's next? Are you going to enact another law to forbid dentists from taking xrays?

If your reasoning is that having xray facilities in-house and that this promotes unnecessary examinations, you, as a legislator should be more concerned about policing the unethical people who perform these acts rather than creating hardships for your constituents.

Now, instead of the doctor being able to read the xrays and make a determination within minutes,I had to go through the above scenario plus wait for the xrays, have them sent to the doctor, return to his office, then have his staff try to fit me into a packed appointment schedule and create more hardships for his staff and the other patients who are waiting.

Honestly, Congressman, don't you have anything else to do? I could name a hundred projects which need attention from influential people like you. If you can get a law passed so easily as this one was, why aren't you out there doing something constructive like ending the subsidies to the tobacco farmers or the closing of the helium plant which we haven't had use for since 1943. There are dozens of these worthwhile projects that need a champion like you. Try devoting your time to something more meaningful instead of creating headaches for us who simply don't need them.

Wake up and smell the roses. Your legislation is out of step with reality. You have not helped anyone but rather have created a nightmare.

Yours truly,

George H. Morello
GHM/ms

Chairman THOMAS. Thank you, Dr. Strickland.

No direction to my comment, but from a content analysis of statements, you used the phrase "unintended consequences" about as many times as Mr. Grob used "draw your own conclusions." And if you will allow me, I will draw my own conclusions about the unintended consequence.

Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

Just a couple of comments and reassurances.

Dr. Wilson, your comments are timely and were timely a couple of years ago. In the 1994 Health Reform Act, we got into some of the fine print, there was a paragraph or two which basically solved your problem.

I would submit, I discussed this with the Chairman. This is one of the things that should have been corrected and I wish we had done it sooner, but there are some things in that bill we could probably peel out, this section being somewhat less controversial.

I would say the same thing to Dr. Strickland. Far be it for any Member of this Subcommittee to take canes and crutches away from disabled folks. You do have a problem in your group, Doctor, with the physical therapists. Their complaint is that if you control the physical therapy center, then they as private practitioners do not have a chance to get the business.

That is a turf battle that may or may not cost more or may or may not provide better care, but it is a turf battle. You have got to understand that we represent both orthopedic surgeons and physical therapists, and if there was some way that we could find a way for you guys to make peace, I think that would help a lot.

But basically, your company operates 500 or more dialysis centers around the country. And Mr. Burger agrees that there is a real potential for abuse by nephrologists in referring to in-hospital dialysis equipment which they own. I will not bore you with all the details of your boss' letter, but there are many instances where this is just too great an opportunity.

We deal with a $16 fee for dialysis in a center, for the physician supervising it, as opposed to $180 fee for the physician supervising that dialysis in a hospital. That is not your issue, but there are some incentives for payment that are probably our fault for setting the payments. I think that this is something that I—we ought to look at in the dialysis area.

It is the one area in the country, in the world, that we pay for everything, basically, and to everybody it is, in fact, government health care. I think we have to be very careful.

I would like to enter that in the record and say that is an area which we should still view with some concern. The other issues of where the law has had unintended consequences or has created problems for you to carry on your practices efficiently, I agree should be corrected. Some we have already tried, and I appreciate your bringing others to our attention. I am sure that the Chairman will be glad to help if we can correct those inequities.

Thank you, Mr. Chairman.

Mr. MENTZ. Mr. Stark, can I clarify one thing?

I do work for National Medical Care. I have for the last 4 weeks. I was an administrator for the past 10 years of a physician-owned

dialysis facility. I cannot say that the main reason the physician sold the facility was because of the Stark legislation, but it did have an impact. So I just want to note that Dr. Burger and myself disagree.

Mr. STARK. Did he make a good profit when he sold it?

Mr. MENTZ. I cannot tell you. But nevertheless, I just—when I am here, as you are, representing your constituents, I am here representing the membership of the National Renal Administrators Association.

Thank you.

Chairman THOMAS. Dr. Tice, I am looking—go ahead, someone wants to respond.

Dr. WILSON. Mr. Chairman, I wanted to respond to Congressman Stark's remarks in regard to the shared lab, and I was aware of that previous effort for which we are very grateful. I am also very grateful for your assurances today, I appreciate it very much.

Chairman THOMAS. However, there is still no package under the tree. And, I did not hear Dr. Tice's name mentioned as being on the present list.

I can assure you that as far as I am concerned, what happened to you was an overzealous intent to create consequences on the part of the previous Majority on another Committee. And, that I am very pleased to hear my colleague and Ranking Member indicate that there is an opportunity to go in to make some specific corrections. I think he will probably fall by the wayside before I do in making changes in this area, but I would be pleased to have him with me as far as he feels comfortable in going, in correcting what I happen to think are some relatively egregious and overreaching provisions.

None of us, including those medical doctors who have taken oaths, want someone to profit unnecessarily and unfairly. I think this law can be adjusted in a number of ways without disturbing that fundamental agreed-upon goal.

I want to thank all of you.

Dr. Wilson, I am hopeful that the correction that apparently was in most of the bipartisan Republican and Democrat packages gets by the counting post soon, and it is accompanied by a number of other changes that will take care of most of the very real, very practical concerns that you have pointed out.

I very much appreciate your testimony, and your willingness to be here to help us focus on the absurdities of this law.

Thank you very much.

Chairman THOMAS. And now, we welcome the last panel, Dr. Templeton, Mr. Connolly and Dr. Mitchell.

Thank you all very much.

As I indicated to earlier panels, if you have written statements, they will be made a part of the record without objection.

Beginning with Dr. Templeton and then moving across the panel, you may proceed to inform us in any way you see fit.

Dr. Templeton.

STATEMENT OF EMMETT O. TEMPLETON, M.D., CHAIRMAN, BOARD OF CHANCELLORS, AMERICAN COLLEGE OF RADIOLOGY

Dr. TEMPLETON. Thank you very much.

Thank you, Mr. Chairman, for inviting the American College of Radiology to present the following statement from the physician self-referral prohibitions as passed in OBRA 1989 and 1993.

My name is Neal (Emmett) Templeton. I am a physician in private practice in Birmingham, Alabama.

I appear before the Committee today as chairman of the board of chancellors for the American College of Radiology.

The college represents 30,000 physicians and physicist members who provide diagnostic and therapeutic services to patients. Since 1985, the college has had official policy that physicians should not have a direct or indirect financial interest in diagnostic or radiation oncology facilities to which they refer patients. And we support the current statutes which strive to eliminate this conflict of interest by prohibiting such ownership arrangements in health care.

This position is shared by numerous physician and health care organizations. The ACR has long held that self-referral arrangements lead to inappropriate utilization of medical services, and the justification for development of these arrangements is largely contrived.

Having laid out our ethical policy, I would like to remind the Subcommittee that it was not the position we began with some decade and a half ago. Instead, we have learned through experience that joint ventures, which include referring physicians, did not proliferate because of a need to increase access to care, or to achieve economic economies of scale in providing health care services. Rather, we believe these arrangements are chiefly intended to capture the market for a given set of health care services, and that this control does not benefit patients. In radiology, a series of studies published over the last 5 years have reaffirmed the need for these prohibitions.

While we support efforts to provide high-quality patient care through more cost-effective delivery mechanisms, we must urge your caution in proposing any modification in the laws which would create loopholes for referring physicians' financial involvement in health facilities. If joint ventures are allowed to simply declare themselves shared facilities or offices without walls, then the intent of the law will be circumvented.

Fraud and abuse problems with increased utilization will be simply changed from physician-owned facilities to physicians' offices. Unfortunately, there will always be those who will want to create elaborate kickback schemes and abusive referral arrangements to augment their income, as Congress seeks to restrict the growth of the Federal health care programs and the market restricts income from private sources. But the passage of these laws has already had a substantial impact in reducing overutilization of radiologic and other designated health service, thus saving taxpayers as well as private sector dollars.

CBO scored specific budget savings for the self-referral laws of $350 million over 5 years. These savings should be carefully considered in the context of any changes proposed. The self-referral ban

in Medicare and Medicaid has also had an indirect effect of eliminating similar corresponding cost in the private sectors.

Dr. TEMPLETON. In short, we believe that alternate methods for controlling of fraudulent and abusive referrals has cost the U.S. health care system and the Federal Government more money.

Mr. Chairman, I would like to make one critical point. The claims that these laws have impeded the development of managed care are plainly unfounded. In States like California and Florida, which have self-referral bans on all payers, managed care growth has been unchanged by the self-referral prohibitions.

In conclusion, we believe that access to quality radiology services has not been restricted in any way by the self-referral laws. The American College of Radiology recognizes that many of these abusive referral practices arise from the pressures of the highly competitive health care marketplace, and we empathize with the desire to form legitimate managed care arrangements. However, we believe strongly that exploitive and unethical practices should not be condoned under the guise of competition. These arrangements ultimately hamper rather than encourage competition and should not be allowed.

Thank you.

[The prepared statement follows:]

Testimony of the American College of Radiology
to
The Subcommittee on Health
House Ways and Means Committee
by
Emmett O. Templeton, M.D.
May 3, 1995

The American College of Radiology is pleased to present the following statement on the physician self-referral prohibitions in the Social Security Act as passed under the Omnibus Budget Reconciliation Acts of 1989 and 1993 (OBRA 1989 and 1993). The ACR represents 30,000 physician and physicist members who provide diagnostic and therapeutic services to patients.

Since 1985, we have advocated the ethical principle that physicians should not have a direct or indirect financial interest in diagnostic or radiation oncology facilities to which they refer patients; and we support legislation which would eliminate this conflict of interest by prohibiting such ownership arrangements in health care. This position is shared by numerous physician and health care organizations.

The ACR has long held that these financial arrangements lead to inappropriate utilization of medical services and that the justification for development of these arrangements is largely contrived. Having stated our policy position, I would like to remind the subcommittee that it was not the position we began with some decade and a half ago. Instead, we have learned through experience that joint ventures which include referring physicians did not proliferate because of a need to increase access to care or to achieve economies of scale in providing health care services.

Rather, we believe these arrangements are chiefly intended to capture the market for a given set of health care services and that this control does not benefit patients. A series of studies – published over the last five years – have reaffirmed the need for these prohibitions. Compelling evidence of fraudulent and abusive referrals has been recognized and documented by the Inspector General and the General Accounting Offices. Moreover, studies from prestigious peer-reviewed scientific publications such as the *New England Journal of Medicine* (NEJM) and the *Journal of the American Medical Association* (JAMA) have repeatedly found that where referring physician joint ventures exist, the normal economic forces of competition do not apply. We believe these investigations clearly show that this type of market control has led to increased utilization, higher prices and lower quality which generate unmandated large profits.

We are also concerned about the resultant exploitation of referral-dependent physicians as referring physicians band together to exercise market control and by subterfuge, demand a portion of the practice income of the consulting physicians in return for referrals. The practice of physicians seeking compensation for this market control of patient referrals is pervasive and we believe any doubt as to the impropriety of these actions, ethically, legally or morally, should be eliminated.

ACR Policy

The current position of the American College of Radiology is based on our members' experience with such financial arrangements. As these joint ventures proliferated in the early 1980's, the ACR debated the merits and disadvantages of these arrangements. In 1984, our policy-making council initially adopted the position that radiologists could ethically participate in financial arrangements, such as joint ventures, in order to provide diagnostic and therapeutic care to patients. But our position also warned our members of the potential for abuse in

financial arrangements that involved referring physicians. With that caution, we believed that financial arrangements to fund imaging centers and radiation oncology centers could be structured to avoid conflict of interest, fraud, and abuse of patient confidence.

We found we were wrong. In 1988, our council recognized that it needed to reconsider this position. In the four years between 1984 and 1988, we found that the potential for, and actual abuse and exploitation of patients by unethical practices, and the flagrant disregard of physicians' ethical responsibilities to the patient to be so great and so pervasive that these arrangements could not be ignored and strengthened our policy.

Our policy adopted in 1988 and again strengthened in 1992 states:

"The practice of physicians referring patients to health care facilities in which they have a financial interest is not in the best interest of patients. This practice of self-referral may also serve as an improper economic incentive for the provision of unnecessary treatment of services. Even the appearance of such conflicts or incentives can compromise professional integrity. Disclosing referring physicians' investment interests to patients or implementing other affirmative procedures to reduce, but not completely eliminate, the potential for abuse created by self-referral is not sufficient. ...The American College of Radiology believes that radiologists and radiation oncologists should make efforts to restructure the ownership interests in existing imaging or radiation therapy facilities because self-referral may improperly influence the professional judgments of those physicians referring patients to such facilities."

AMA Ethical Policy

The scope of these problems has also been recognized in the AMA's Council on Ethical and Judicial Affairs report on physician conflicts of interest, as adopted in 1991 and reaffirmed in late 1992. The report, which remains part of the AMA's code of ethics, holds that the practice of self-referral to be "presumptively inconsistent with physicians' fiduciary duty" to their patients. These ethical guidelines state that "only when a physician can demonstrate both the absence of adequate facilities – a plain medical need – and absence of alternative financing should self-referral take place." But even when such a need may exist, the AMA also recommends that physician-owned facilities meet nine additional requirements to ensure that over utilization and patient exploitation will not occur.

Access to Care

Those who support the continuation of financial arrangements among physicians or the weakening of the physician self-referral laws have argued that these ventures are necessary to assure access to services in underserved areas. We doubt that the predominate reason for joint ventures is to provide access to services in rural or underserved areas. A major conclusion in the 1991 Florida study was that "joint ventures do not increase access to rural or underserved indigent patients." We believe that other studies underway will further support this finding.

A second point to be made in regard to access is specifically addressed to the argument that health services would be unavailable without using referring physicians as a source of capital for these facilities. We do not believe this is the case. Most often, referring physicians' participation in these joint ventures involves only signing a note for debt, not in providing capital for the facility. If in fact, an area in the country finds that lack of capital is restricting access to services, a clear exception has be made when there is concrete evidence that the referring physicians involved in a rural setting are actually providing the needed

capital for the facility. We do not believe that these joint ventures are created because "there's no money in town."

Cost Savings

While we support efforts to provide high quality patient care through the more cost-effective delivery mechanisms, we must urge your caution in proposing any modification in the laws which could create loop holes for referring physicians' financial involvement in health facilities. If facilities currently in operation are allowed to simply declare themselves as extensions of group practices or private physician offices, the intent of the legislation will have been circumvented because referring physicians will continue to self-refer. The problem with increased utilization in referring physician owned facilities will be simply changed to a problem of increased utilization of services within physicians' offices.

Unfortunately, there will always be those who will want to create new elaborate kickback schemes and abusive referral arrangements to augment their income as the Congress seeks to restrict the growth of the federal health programs and the market restricts income from private sources. But the passage of the referral prohibitions in the Social Security Act has already had a substantial impact in reducing over-utilization of radiologic and other designated health services, thus saving tax payer as well as private sector dollars.

As example, you may recall that the Congressional Budget Office (CBO) has been able to score these specific savings as a result of these laws as they affect both Medicare and Medicaid. These savings should be recognized and carefully considered in the context of any changes proposed. The self-referral ban in Medicare and Medicaid has also had an indirect affect of eliminating similar corresponding costs in the private sector. In short, we believe that alternate methods for controlling the fraudulent and abusive referrals will cost the U.S. health care system and the federal government more.

We believe that any consideration in modifying these laws should not create an incentive or circumstance where services are provided by untrained or unskilled physicians, who are either unconcerned with or unaware of proper practice standards. In the best interest of patients, we should assure access to medical care from physicians qualified to provide the service.

Conclusion

The American College of Radiology recognizes that many of these abusive referral practices arise from the pressures of the highly competitive health care marketplace and we empathize with the desire to form legitimate managed care arrangements. However, we believe strongly that exploitive and unethical practices should not be condoned under the guise of competition. These arrangements hamper rather than encourage competition and should not be allowed.

Chairman THOMAS. Thank you very much, Dr. Templeton. It is my understanding that Mr. Connolly is ill and substituting on behalf of the American Physical Therapy Association is Mr. Weinper. Is that correct?

STATEMENT OF MICHAEL WEINPER; ON BEHALF OF JEROME B. CONNOLLY, SENIOR VICE PRESIDENT FOR HEALTH POLICY AND PRACTICE, AMERICAN PHYSICAL THERAPY ASSOCIATION, ALEXANDRIA, VA

Mr. WEINPER. Yes, that is, thank you. Chairman Thomas and Members of the Subcommittee, I am Michael Weinper, and as you pointed out, I am here speaking on behalf of the American Physical Therapy Association in place of Jerry Connolly, the APTA senior vice president for health policy and practice, who is, unfortunately, ill today.

I am a physical therapist with 25 years of experience, and I practice in southern California both clinically and as the chief executive officer of a managed health care organization for a physical therapist called Physical Therapy Provider Network. The APTA is the national association representing more than 66,000 physical therapists, physical therapist assistants and students of physical therapy.

The APTA shares the desire of the American public, political leaders, and other health care providers to make quality health care services more accessible and affordable for all Americans. Two years ago APTA appeared before this Subcommittee to testify in support of expanding a ban on physician self-referral under Medicare to include physical therapy services.

Today, I appear before you to encourage this Subcommittee not to retreat from this important public policy, and ask that you would encourage its implementation and strong enforcement. At the same time, APTA is sympathetic to the concerns of the physician community given the fact that the administrator of HCFA has not yet developed any regulations to aid the physicians in their attempts to comply with the law.

The APTA recommends that this Subcommittee encourage the HCFA administrator to promulgate and implement the necessary regulations to make it easy for physicians to ensure their compliance. In 1993, Congress expanded the ban on physician self-referral to include physical therapy services. This action was based upon strong empirical data, illustrating excessive utilization associated with self-referral arrangements. Nowhere is this better documented than in the 1992 study of the California Workers Compensation Program conducted by the William Mercer Corp., an independent consulting firm.

This study found that if an injured worker received initial treatment from a physician with an ownership interest in physical therapy services, the patient received a referral to physical therapy 66 percent of the time. If, however, the injured worker received initial treatment from a physician with no ownership interest in physical therapy services, the patient was referred to physical therapy 32 percent or less than half of that of the owner frequency.

In light of such findings, patients are left with much cause for concern. Was the referral based on medical necessity or economic

motivation? The Mercer study concluded that financial incentives played a major role in these decisions. According to the study, the added incentive for investing physicians to refer to the physical therapy generated approximately $233 million per year in services delivered for economic rather than clinical reasons. These are costs neither our National health care system nor especially our Nation's elderly should ever have to bear.

With regard to consumer choice, we put into the record some examples where patients' freedom to choose their physical therapist was denied by physicians with financial interest in physical therapy and facilities. With the emerging free market in health care reform evolving more than ever, it is increasingly imperative that consumers be allowed to exercise their freedom of choice when convenience, quality, and economics hang in the balance.

Another study demonstrates that physician self-referral drives up utilization health care costs. In 1989, the Florida legislature mandated that its health care cost containment board examine the impact of joint ventures in health care on the cost, quality, and access to services in Florida. Physical therapy services were serving in two settings, freestanding physical therapy facilities and comprehensive rehabilitation centers that provide physical therapy services.

The findings were dramatic. The joint ventures that our physician-owned physical therapy facilities provided 43 percent more visits per patients than did nonjoint venture or, in other words, nonphysician-owned physical therapy facilities did. Consequently, the physician-owned joint ventures generated approximately 31 percent more revenue per patient than in a nonjoint venture facility.

At comprehensive rehabilitation facilities, 35 percent more physical therapy visits were provided per patient in joint venture facilities than in nonjoint venture facilities. More importantly, the Florida study found that the quality of care in physician-owned joint venture facilities was lower than in nonjoint venture facilities and that joint venture facilities did not increase access to services.

In fact, the nonjoint venture facilities offered increased access to a wider range of clients. An example from southern California can serve as a meaningful illustration of why particularly in the free market health care reform this current law is reasonable and necessary. A physical therapy provider network was engaged with insuring a pilot project to demonstrate the effects of self-referral on the cost of care.

A physician impacted by this study contacted his local independent physical therapist and threatened to withhold all of his referrals if the physical therapist participated in the study or remained with the managed care network. Moreover, physicians then made contact with his colleagues in an attempt to have them boycott any private practice physical therapy practice associated with the managed care network. If free market reform is going to succeed, this kind of behavior on the part of providers motivated by more economic desire than medical necessity must have some restraint resulting in the reasonable balance.

I would like to comment briefly on the proposed amendments to the current statute. First, direct physician supervision. APTA

opposes provisions that would amend the physician supervision requirement of nonphysician personnel. Current law calls for direct supervision, but recommendations have been made to replace this requirement with a general supervision requirement.

The direct supervision requirement reduces the incentive for a physician to abuse his or her referral power with respect to services provided by nonphysician practitioners under the physician's employment. Regarding the removal of physical therapy from the designated health care services list, APTA again is opposed to proposals to eliminate physical therapy from the list of designated services under the current statute.

As we have shown here today, numerous studies indicate the relationship between physicians and referrals to physical therapy services in which they have a financial interest leads to a significantly higher cost to the payer. To remove physical therapy from the list of regulated services would allow this overutilization to go unchecked, costing the American people and the Medicare Program many millions of dollars.

Next, investment in rehabilitation facilities. The APTA understands rehabilitative care is a growing segment of the health care industry and that physicians would want to invest in or possibly own a physical therapy center. The self-referral statute does not preclude such investments or ownership. However, we cannot support an expansion of the exceptions for physician ownership in hospitals to include ownership in other facilities such as surgery centers, hospices, nursing homes, dialysis facilities, and CORFs, comprehensive outpatient rehabilitation facilities.

On reporting requirements, APTA strongly opposes proposals to eliminate reporting requirements under the current State statute. These requirements provide information necessary to effectively enforce the law and must be maintained. It is vital that the Secretary of Health and Human Services have the necessary information gained from these requirements to ensure the Medicare system is used responsibly.

Regarding preemption of State laws, the APTA firmly opposes the preemption of State laws governing physician ownership and referral. The legislatures of at least 30 States have found this problem troubling enough that they have found it necessary to act. State legislatures addressed the problem in numerous and creative ways. Some States such as California, Nevada, Illinois, Maryland, and Georgia have banned referrals by various health care providers to outside entities in which the provider or sometimes a member of his immediate family has a financial interest or is an investor.

Other States such as Connecticut, Louisiana, as well as Maryland have laws requiring the provider to disclose his financial interest in the facilities where his patients are referred. Federal preemption of these State laws interferes with the State's ability to enact cost-saving legislation critical to their budget processes.

In conclusion, it is difficult to comprehend why Congress, facing a budget deficit and a Medicare solvency problem, would choose to repeal a law which alone can save the Medicare Program $350 million by the end of the decade.

In summary, APTA is supportive of the current prohibition and encourages the Subcommittee to urge the administration to actively implement and enforce the law. APTA stands ready to assist the Subcommittee in any possible way. Thank you, Mr. Chairman, for the opportunity to present these views.

[The prepared statement follows:]

Statement

of the

American Physical Therapy Association

before the

House Ways and Means Committee
Subcommittee on Health

concerning

Physician Ownership and Referral

May 3, 1995

Chairman Thomas, and members of the Subcommittee, I am Jerome Connolly, PT, Senior Vice President for Health Policy and Practice for the American Physical Therapy Association (APTA). Twenty-two years ago I graduated from the Mayo Clinic School of Physical Therapy. Before joining APTA early this year as Senior Vice President of Health Policy and Practice, I spent 19 of my 22 years as a physical therapist in private practice, many of those years serving rural areas in Montana. I am delighted to be here today, and to have an opportunity to represent APTA's views and some of my personal and professional experience with this issue of physician self-referral particularly as it affects the delivery of physical therapy to Medicare and Medicaid beneficiaries.

The APTA is the national association representing more than 66,000 physical therapists, physical therapist assistants, and students of physical therapy. The APTA shares the desire of the American public, political leaders and other health care providers to make quality health services more accessible and affordable for all Americans.

Two years ago, APTA appeared before this Subcommittee to testify in support of expanding a ban on physician self-referral under Medicare to include physical therapy services. Today, I appear before you to encourage this Subcommittee not to retreat from this important public policy,

and to ask you to encourage its implementation and strong enforcement.

At the same time, APTA is sympathetic to the concerns of the physician community given the fact that the Administrator of the Health Care Financing Administration (HCFA) has not yet developed any regulations to aid the physicians in their attempts to comply with this law. The APTA recommends that this Subcommittee encourage the HCFA Administrator to promulgate and implement the necessary regulations to make it easy for physicians to ensure their compliance.

In 1993, Congress expanded the ban on physician self-referral to include physical therapy services. This action was based upon strong empirical data illustrating excessive utilization associated with self-referral arrangements. Nowhere is this better documented than in the 1992 study of California Workers' Compensation program conducted by William M. Mercer, Inc.

This study found that, if an injured worker received initial treatment from a physician with an ownership interest in physical therapy services, that patient received a referral to physical therapy **66%** of the time. If, on the other hand, the injured worker received initial treatment from a physician with no ownership interest in physical therapy services, the patient was referred to physical therapy **32%** of the time or **less than half of that of the owner frequency**.

In the face of such findings, patients are left with much cause for concern. Was the referral based on medical necessity or economic motivation?

The Mercer study concluded that financial incentives played a major role in these decisions. According to the study, the added incentive for investing physicians to refer to physical therapy generated approximately **$233 million** per year in services delivered for economic rather than clinical reasons. These are costs neither our nation's health care system nor especially our nation's elderly should not have to bear.

Consumer Choice

Were the patients given the freedom to choose their physical therapist? Or were they simply referred to the physical therapy services in which their physician invested as in these couple of examples:

From **Indiana** where an orthopedist instructed a patient to go to his Physician-Owned Physical Therapy service rather than to a clinic which was conveniently located in the patient's own community. Even after repeated pleas the physician firmly indicated he would not continue to serve as the treating physician if the patient insisted otherwise.

From **Montana**: An elderly woman with a back condition was given a referral for physical therapy as long as she would take it to the physical therapy service in which the physician had a financial interest. In spite of the fact that her nephew had a private practice in the same town with a solid reputation in both cost and quality, the physician refused to allow Edith to choice to receive her physical therapy where she preferred.

In these two instances, now with the emerging free market health reform evolving more than ever, it is increasingly imperative that consumers be allowed to exercise their freedom of choice when convenience, quality and economics hang in the balance.

Several other studies demonstrate that physician self-referral drives up utilization and health care costs. In 1989, the Florida legislature mandated that its Health Care Cost Containment Board examine the impact of joint ventures in health care on the cost, quality, and access to services in Florida. Physical therapy services were surveyed in two settings: free-standing physical therapy facilities and comprehensive rehabilitation centers that provide physical therapy services. The findings were dramatic.

Joint-ventures that are physician-owned physical therapy facilities provided **43%** more visits per patient than did non-joint-venture (or non-physician owned) physical therapy facilities. Consequently, the physician-owned joint-ventures generated approximately **31%** more revenue per

patient than in non-joint-venture facilities. At comprehensive rehabilitation facilities, **35%** more physical therapy visits were provided per patient in joint-venture facilities than in non joint-venture facilities.

More importantly, the Florida study found that quality of care in physician owned joint-venture facilities was lower than in non-joint-venture facilities, and that joint-venture facilities did not increase access to services. In fact, the **non-joint-venture facilities offered increased access** to a wider range of clients. Higher quality of care and increased access to services are often cited as rationales to defend joint-ventures. Clearly these arguments do not hold water in the face of objective data.

Subsequent to the study conducted in the State of Florida, the Center for Health Policy Studies located in Columbia, Maryland, estimated the impact of physician joint-ventures on medical care costs in Florida. Estimates for 1991 were developed based on findings from an analysis of Medicare claims data, results from the report by the Florida Health Care Cost Containment Board, and from other sources. The estimated 1991 cost impact of joint-ventures for physical therapy services was **$10.9 million**. This figure is likely **underestimated** given that only additional costs for users of physical therapy were estimated.

An example from Southern California can serve as a meaningful illustration of why particularly in free market health reform, this current law is reasonable and necessary. A physical therapy provider network comprised of all small businesses (private practices) was engaged with an insurer in a pilot project to demonstrate the effects of self-referral of claim payment. In the very early going of the project a physician contacted not only his local independent private physical therapist and threatened to withhold all of his referrals if the PT participated in the study or remained with the managed care network. Moreover, the physician then made contact with his colleagues in an attempt to have them boycott any private physical therapy practice associated with the managed care network. If free market reform is going to succeed, this kind of behavior on the part of providers motivated more by economic desire than medical necessity must have some restraint

resulting in reasonable balance.

Even with the preponderance of empirical data pointing toward the negative effect of physician self-referral, some in the health care community would like to see this Subcommittee overturn the law even before its implementation. I would like to take this opportunity to comment briefly on proposed amendments to the current statute.

Direct Physician Supervision

APTA opposes provisions that would amend the physician supervision requirement of non-physician personnel. Current law calls for "direct supervision," but recommendations have been made to replace this requirement with a "general supervision" requirement. The direct supervision requirement reduces the incentive for a physician to abuse his or her referral power with respect to services provided by non-physician practitioners under the physician's employment.

The incentive for a physician to refer to outside facilities in which he or she might have an investment interest is not the only problem regarding self-referral. In fact, physicians stand to profit even more directly by expanding their individual or group practices to offer physical therapy or one or more or the various other health services to which they control access through their power of referral.

A study of physician self-referral was presented to Virginia's Joint Commission on Health Care in January 1993 by Virginia's Deputy Secretary of Health and Human Services. One of the findings was that Blue Cross/Blue Shield claims-paid-data indicated **60%** of physical therapy claims were paid to physician provider numbers. That amounted to **$8.3 million** out of **$14 million.**

Additionally, the Office of Inspector General found that in almost four out of five cases reimbursed as physical therapy in physician's offices do not represent true physical therapy services. The study found that **$47 million** was inappropriately paid in 1991.

Removal of Physical Therapy from the List of Designated Health Services

APTA is **opposed** to proposals to eliminate physical therapy from the list of designated health services under the current statute. As we have shown today, numerous studies indicate the relationship between physicians and referrals to physical therapy services in which they have a financial interest leads to a significantly higher cost to the payer. To remove physical therapy from the list of regulated services would allow this overutilization to go unchecked, costing the American people and the Medicare program many millions of dollars.

Investment in Rehabilitation Facilities

The APTA understands rehabilitative care is a growing segment of the health care industry, and that physicians would want to invest in or possibly own a physical therapy center. The self-referral statute does not preclude such investments or ownership. However, we cannot support an expansion of the exceptions for physician ownership in hospitals to include ownership in other facilities such as surgery centers, hospices, nursing homes, dialysis facilities, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). The law merely provides some reasonable assurances to the consumer that investment or ownership interest will not impede a health provider's judgement when referring to physical therapy and other health services. We do not wish to limit physician's investment opportunities; we only want to ensure that physicians do not misuse their referral powers to such facilities in order to turn a profit. Additionally, APTA feels exemptions provided in the law are reasonable and provide adequate flexibility for a physician to address the medical needs of his or her patients.

Reporting Requirements

APTA strongly **opposes** proposals to eliminate reporting requirements under the current statute. These requirements provide information necessary to effectively enforce the law and must be maintained. It is vital that the Secretary of Health and Human Services have the necessary information gained from these requirements to insure the Medicare system is used responsibly. These requirements are reasonable particularly in view of the objective data studies have demonstrated. To eliminate this portion of the statute is to repeal the current ban on physician self-referral.

Preemption of State Laws

APTA firmly **opposes** the preemption of state laws governing physician ownership and referral. The legislatures of at least 30 states found this problem troubling enough that they found it necessary to act. State legislatures addressed the problem in numerous and creative ways. Some states, such as California, Nevada, Illinois, Maryland, and Georgia, have banned referrals by various health care providers to outside entities in which the provider (or sometimes a member of his immediate family) has a financial interest, or is an investor. Other states, such as Connecticut, Louisiana, as well as Maryland have laws requiring the provider to disclose his financial interest in the facilities where his patients are referred. Additionally, California and Montana enacted separate bans under its Worker's Compensation Program. And, Texas and Rhode Island enacted a basic anti-kickback laws stating a person can neither pay nor accept remuneration for securing or soliciting patients. Federal preemption of these state laws interferes with the states' ability to enact cost-saving legislation critical to their budget processes.

Conclusion

It is difficult to comprehend why Congress, facing a budget deficit and a Medicare solvency problem, would choose to repeal a law which alone can save the Medicare program **$350 million** in physical therapy payments alone by the end of the decade. When imaging services, clinical laboratory tests and physical therapy are combined and the law is strengthened and expanded, the total savings is likely to reach into the billions. Real dollars, real savings and real sound decision-making. In summary, APTA is supportive of the current prohibition and encourages the Subcommittee to urge the Administration to actively implement and enforce the law. APTA stands ready to assist the Subcommittee in any way.

Thank you, Mr. Chairman for the opportunity to present these views.

Chairman THOMAS. Thank you, Mr. Weinper.
Dr. Mitchell.

STATEMENT OF JEAN M. MITCHELL, PH.D., ECONOMIST, GEORGETOWN UNIVERSITY

Ms. MITCHELL. Mr. Chairman and members of the Health Subcommittee, my name is Dr. Jean Mitchell. I am a Ph.D. economist, and I am currently an associate professor in the graduate public policy program at Georgetown University.

Prior to joining the faculty at Georgetown, I was an associate professor at the department of economics at Florida State University. While on the faculty at FSU, I was the principal investigator of the Florida study on physician joint venture arrangements, which was mandated by the Florida legislature.

I am pleased to be here today to discuss the effects of physician self-referral arrangements on the utilization and costs of health care services, and the implications of the current legislation which prohibits these abusive ownership arrangements. I think it is important to clarify that there are two types of physician self-referral arrangements.

The first is within office self-referral, which occurs when a physician orders a test or a diagnostic procedure for a patient that is performed in the physician's office. Examples include an orthopedic surgeon who orders a series of x rays for a patient which are performed using equipment situated in his or her office.

The second type of physician self-referral arrangements are known as physician joint ventures. Under these arrangements physicians have ownership interests in health care facilities and businesses to which they refer patients for services, but at which they do not practice.

The current Federal law pertains only to physician joint ventures. All within office physician self-referral arrangements are legal and thus are not subject to any prohibition on referrals. The current Federal law was enacted subsequent to the publication of several empirical studies, which documented the consequences of physician joint venture arrangements.

These studies include the following: Mitchell and Scott, which was published in JAMA July 1992, it highlights the prevalence and scope of physician joint ventures in Florida; Mitchell and Scott published in Yale Journal on Regulation, summer 1992, which highlights the complexity of these ownership arrangements and how multiple levels of incorporation or partnership can make it very difficult to identify the owners of the parent organization; Mitchell and Scott published in JAMA, October 1992, which documented the increased costs, higher utilization, limited access to poor persons, and lower quality of services that characterized physician-owned physical therapy and rehabilitation facilities in Florida.

Mitchell and Sunshine, published in New England Journal of Medicine, November 1992, which examined physician joint ventures in radiation therapy. We found that such arrangements decreased access to poor persons, had greater utilization and higher costs. Also limited indicators suggested the quality is lower in radiation therapy joint ventures. Swedlow and colleagues, published in New England Journal November 1992, examined workers' com-

pensation data from California and found physician self-referral resulted in significantly greater use of physical therapy services, higher costs for psychiatric services, and a higher percentage of MRI scans deemed to be inappropriate.

Mitchell and Scott, published in Medical Care February 1994, found that clinical labs owned by referring physicians had higher utilization and costs than those not owned by physicians; Mitchell and Sass, forthcoming in the Journal of Health Economics, examined Florida physical therapy data and found that after controlling for other confounding factors, including case mix, that patients treated at physician-owned clinics received on average 50 percent more visits than those treated at independent facilities.

Three other published studies have documented the increased utilization and higher costs that accompany within-office physician self-referral arrangements. These include Childs and Hunter, published in Medical Care, 1992; Hillman and colleagues, New England Journal of Medicine, December 1990; and Hillman and colleagues, published in JAMA October 1992.

Several other studies by the Federal Government have also documented the negative consequences of physician joint ventures. These include the 1989 OIG study, which was the basis for the initial prohibition on physician self-referral to clinical laboratories, the 1989 GAO study looking at ownership of clinical labs and imaging facilities in Pennsylvania and California, and the 1993 GAO followup analysis of the Florida joint venture study by Mitchell and Scott.

This comprehensive review of the empirical evidence on physician self-referral indicates that these ownership arrangements have a negative effect on utilization, costs, access, and quality. Specifically, the general consensus of all the available evidence is that the financial incentives that accompany physician self-referral arrangements result in increased utilization of services and higher costs to patients.

Moreover, physician joint venture facilities appeared to cream skim the patients with good insurance and thus treat relatively few indigent and underinsured patients. As regards geographic access, all physician joint ventures in Florida were located in metropolitan areas. Hence, these do not, as claimed by proponents, increase access to services, and new technology to persons residing in medically underserved or rural areas.

Finally, there is some limited evidence suggesting that joint ventures have adverse effects on quality. None of the evidence to date has been able to evaluate whether the increased utilization that accompanies the practice of physician self-referral represents inappropriate or unwarranted services.

Yet, there is no evidence to date demonstrating that physician self-referral arrangements have any benefits to consumers.

The current law is based on extensive published empirical research documenting the negative consequences of physician joint ventures. Congress should be commended for enacting comprehensive legislation on the basis of good empirical research that has been published in the leading medical journals and thus approved by the medical community.

Most researchers and policymakers recognize that the current law has a number of loopholes that limit its potential effectiveness. For example, because within office self-referral arrangements are still legal, physicians can skirt the prohibition on referrals to free-standing facilities by putting diagnostic equipment or physical therapy in their offices.

In fact, the current law has fostered the growth of clinics without walls. Also, the Federal law does not apply to privately insured patients nor does it encompass all types of medical services. The current law should be reformed to eliminate such loopholes. The reforms suggested by those opposed to the current laws will essentially make the current prohibition worthless.

The reporting requirements of the current law are critical for enforcement and monitoring these abusive ownership arrangements. The claims by opponents that the current law is burdensome to physicians is based on anecdotal evidence. I can tell you from my own experience collecting the data on all the physician owners in Florida, this was not a very difficult task. You simply give them the form, have them fill it out, and tell them there is a fine if they do not give you the information. It is a great way to collect money, especially given that Medicare is having so many problems.

Moreover, there is no empirical evidence that exists to support the contention that managed care will eliminate the increased utilization and the higher costs linked to physician self-referral. Given that less than 10 percent of Medicare patients are currently enrolled in HMOs, it is highly unlikely managed care plans will be capable of resolving this problem.

In conclusion, any reforms that weaken the current law would result in increased utilization and higher costs to consumers. Thank you for providing me with the opportunity to testify before you here today.

[The prepared statement and attachment follow:]

STATEMENT OF JEAN M. MITCHELL, PH.D.
ASSOCIATE PROFESSOR,
GRADUATE PUBLIC POLICY PROGRAM, GEORGETOWN UNIVERSITY

Mr. Chairman and Members of the Health Subcommittee, Committee on Ways and Means

My name is Dr. Jean M. Mitchell. I hold a doctorate in economics from Vanderbilt University and I am currently an associate professor in the Graduate Public Policy Program at Georgetown University. Prior to joining the faculty at Georgetown, I was an associate professor in the Department of Economics at Florida State University. While on the faculty at FSU, I was the principal investigator of the Florida study on physician joint venture arrangements, which was mandated by the Florida legislature. I am pleased to be here today to discuss the effects of physician self-referral arrangements on the utilization and costs of health care services, and the implications of the current legislation which prohibits these abusive ownership arrangements.

There are two types of physician self-referral arrangements. Within-office self-referral occurs when a physician orders a test or diagnostic procedure for a patient that is performed in the physician's office. Examples include an orthopedic surgeon who orders a series of x-rays for a patient which are performed using equipment situated in his/her office. The second type of physician self-referral arrangement are known as "physician joint ventures". Under these arrangements, physicians have ownership interests in health care facilities and businesses to which they refer patients for services but at which they do not practice. The current federal law pertains only to physician joint ventures; all within office physician self-referral arrangements are legal and thus are not subject to any prohibitions on referrals.

The current federal law was enacted subsequent to the

publication of several empirical studies which documented the consequences of physician joint venture arrangements. These studies include the following: 1) Mitchell and Scott (JAMA, July 1992) highlight the prevalence and scope of physician joint ventures. 2) Mitchell and Scott (Yale Journal on Regulation ,Summer 1992) highlight the complexity of these ownership arrangements. Multiple levels of incorporation or partnership can make it difficult to identify the owners of the parent organization.
3) Mitchell and Scott (JAMA, October 1992) documented the increased utilization, higher costs to consumers, limited access to poor persons, and lower quality of services that characterize physician-owned physical therapy and rehabilitation facilities in Florida. 4) Mitchell and Sunshine (New England Journal of Medicine, November 1992) examined physician joint ventures in radiation therapy. They found that such arrangements decreased access to poor persons, had greater utilization and higher costs. Also, limited indicators suggest that quality is lower in joint ventures. 5) Swedlow and colleagues (New England Journal, November 1992) examined workers compensation data from California and found physician self-referral resulted in significantly greater use of physical therapy services, higher costs for psychiatric services, and a higher percentage of MRI scans deemed to be medically inappropriate. 6) Mitchell and Scott (Medical Care, February 1994) found that clinical labs owned by referring physicians had higher utilization and costs than those not owned by physicians. 7) Mitchell and Sass (Journal of Health Economics, forthcoming) examined the Florida physical therapy data and found that after controlling for other confounding factors,

patients treated at physician-owned clinics received on average 50% more visits than those treated at independent facilities.

Three other published studies have documented the increased utilization and higher costs that accompany within office physician self-referral arrangements. These include Childs and Hunter (Medical Care, 1972); Hillman and colleagues (New England Journal of Medicine, December 1990) and Hillman and colleagues (JAMA, October 1992).

Several other studies by the federal government have also documented the negative consequences of physician joint ventures. These include: 1) the 1989 OIG study which was the basis for initial prohibition on physician referrals of Medicare patients to clinical labs in which the referring physician had an investment interest; 2) the 1989 GAO study which documented physician ownership of clinical labs and imaging facilities in Pennsylvania and Maryland; 3) the 1993 GAO followup analysis of the Florida joint venture study by Mitchell and Scott (1991). Their analysis of 1.3 million claims for Florida Medicare referrals for imaging services revealed that physician owners of imaging facilities had significantly higher referral rates for all types of imaging services in comparison to nonowners. The differences were greatest for costly, high technology imaging services.

This comprehensive review of the empirical evidence on physical self-referral indicates that these ownership arrangements have negative effects on utilization, costs, access, and quality. Specifically, the general consensus of all the available evidence is that the financial incentives that accompany physician self-

referral arrangements result in increased utilization of services and higher costs to patients. Moreover, physician joint venture facilities appear to cream-skim the patient with good insurance and thus treat relatively few indigent and underinsured patients. As regards geographic access, all physician joint ventures are located in metropolitan areas; hence, they do not, as claimed by proponents, increase access to services and new technologies to persons residing in medically underserved or rural areas. Finally, there is some limited evidence suggesting that joint ventures have adverse effects on quality. None of the evidence to date has been able to evaluate whether the increased utilization that accompanies the practice of physician self-referral represents inappropriate or unwarranted services. On the other hand, there is no evidence to date demonstrating that physician self-referral arrangements have any benefits to consumers.

The current law is based on extensive published empirical research documenting the negative consequences of physician joint ventures. Congress should be commended for enacting comprehensive legislation on the basis of good empirical research that has been published in the leading medical journals. Most researchers and policy makers recognize that the current law has a number of loopholes that limit its effectiveness. For example, because within office self-referral arrangements are legal, physicians can skirt the prohibition on referrals to freestanding facilities by putting diagnostic equipment or physical therapy in their offices. In fact, the current law has fostered the growth of clinics without walls. Also, the federal law does not apply to privately insured

patients, nor does it encompass all types of medical services. The current law should be reformed to eliminate such loopholes

The reforms suggested by those opposed to the current law will essentially make the current prohibition worthless. The reporting requirements of the current law are critical for enforcement and monitoring these abusive ownership arrangements. The claims by opponents that the current law is burdensome to physicians is based on anecdotal evidence. Moreover, no empirical evidence exists to support the contention that managed care will eliminate the increased utilization and higher costs linked to physician self-referral arrangements. Given that less than ten percent of Medicare patients are enrolled in HMOs, it is highly unlikely that managed care plans will be capable of resolving this problem.

In conclusion, any reforms that weaken the current law would result in increased utilization and higher costs for consumers. Thank you for providing me with the opportunity to testify here today.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the General Counsel
Washington, D.C. 20201

SELF-REFERRAL STUDIES

A. Financial Arrangements Between Physicians and Health Care Businesses: Office of Inspector General - OAI-12-88-01410 (May 1989)

In 1989, the Office of Inspector General (OIG) issued a study on physician ownership and compensation from entities to which they make referrals. The study found that patients of referring physicians who own or invest in independent clinical laboratories received 45 percent more clinical laboratory services than all Medicare patients in general, regardless of place of service. OIG also concluded that patients of physicians known to be owners or investors in independent physiological laboratories use 13 percent more physiological testing services than all Medicare patients in general. Finally, while OIG found significant variation on a State by State basis, OIG concluded that patients of physicians known to be owners or investors in durable medical equipment (DME) suppliers use no more DME services than all Medicare patients in general.

B. Physicians' Responses to Financial Incentives -- Evidence from a For-Profit Ambulatory Care Center; Hemenway D, Killen A, Cashman SB, Parks CL, Bicknell WJ: New England Journal of Medicine, 1990;322:1059-1063

Health Stop, a chain of for-profit ambulatory care centers, changed its compensation system from a flat hourly wage to a system where doctors could earn bonuses that varied depending upon the gross income they generated individually. A comparison of the practice patterns of fifteen doctors before and after the change revealed that the physicians increased the number of laboratory tests performed per patient visit by 23 percent and the number of x-ray films per visit by 16 percent. The total charges per month, adjusted for inflation, grew 20 percent, largely due to an increase in the number of patient visits per month. The authors concluded that substantial monetary incentives based on individual performance may induce a group of physicians to increase the intensity of their practice, even though not all of them benefit from the incentives.

C. Frequency and Costs of Diagnostic Imaging in Office Practice -- A Comparison of Self-Referring and Radiologist-Referring Physicians; Hillman BJ, Joseph CA, Mabry MR, Sunshine JH, Kennedy SD, Noehter M: New England Journal of Medicine, 1990;322:1604-1608

This study compared the frequency and costs of the use diagnostic imaging for four clinical presentations (acute upper respiratory symptoms, pregnancy, low back pain, or (in men) difficulty in urinating) as performed by physicians who used imaging equipment in their offices (self-referring) and as ordered by physicians who always referred patients to radiologists (radiologist-referring). The authors concluded that self-referring physicians use imaging examinations at least four times more often than radiologist-referring physicians and that the charges are usually higher when the imaging is done by the self-referring physicians. These differences could not be attributed to differences in the mix of patients, the specialties of the physicians or the complexity of the complexity of the imaging examinations performed.

D. Joint Ventures Among Health Care Providers in Florida: State of Florida Cost Containment Board (September 1991)

This study analyzed the effect of joint venture arrangements (defined as any ownership, investment interest or compensation arrangement between persons providing health care) on access, costs, charges, utilization, and quality. The results indicated that problems in one or more of these areas existed in the following types of services: (1) clinical laboratory services; (2) diagnostic imaging services, and (3) physical therapy services - rehabilitation centers. The study concluded that there could be problems or that the results did not allow clear

conclusions with respect to the following health care services: (1) ambulatory surgical centers; (2) durable medical equipment suppliers; (3) home health agencies; and (4) radiation therapy centers. The study revealed no effect on access, costs, charges, utilization, or quality of health care services for: (1) acute care hospitals; and (2) nursing homes.

E. New Evidence of the Prevalence and Scope of Physician Joint Ventures; Mitchell JM, Scott E. Journal of the American Medical Association, 1992;268:80-84

This report examines the prevalence and scope of physician joint ventures in Florida based on data collected under a legislative mandate. The results indicate that physician ownership of health care businesses providing diagnostic testing or other ancillary services is common in Florida. While the study is based on a survey of health care businesses in Florida, it is at least indicative that such arrangements are likely to occur elsewhere.

The study found that at least 40% of Florida physicians involved in direct patient care have an investment interest in a health care business to which they may refer their patients for services; over 91% of the physician owners are concentrated in specialties that may refer patients for services. About 40% of the physician investors have a financial interest in diagnostic imaging centers. These estimates indicate that the proportion of referring physicians involved in direct patient care who participate in joint ventures is much higher than previous estimates suggest.

F. Physicians' Utilization and Charges for Outpatient Diagnostic Imaging in a Medicare Population; Hillman BJ, Olson GT, Griffith PE, Sunshine JH, Joseph CA, Kennedy SD, Nelson WR, Bernhardt LB: Journal of the American Medical Association, 1992; 268:2050-2054

This study extends and confirms the previous research discussed in section C, above, by focusing on a broader range of clinical presentations (ten common clinical presentations were included in this study); a mostly elderly, retired population (a patient population that is of particular interest with respect to Medicare reimbursement); and the inclusion of higher-technology imaging examinations. The study concluded that physicians who own imaging technology employ diagnostic imaging in the evaluation of their patients significantly more often and as a result, generate 1.6 to 6.2 times higher average imaging charges per episode of medical care than do physicians who refer imaging examinations to radiologists.

G. Physician Ownership of Physical Therapy Services: Effects on Charges, Utilization, Profits, and Service Characteristics; Mitchell JM, Scott E: Journal of the American Medical Association, 1992; 268:2055-2059

Using information obtained under a legislative mandate in Florida, the authors evaluated the effects of physician ownership of freestanding physical therapy and rehabilitation facilities (joint venture facilities) on utilization, charges, profits, and service characteristics. The study found that visits per patient were 39% to 45% higher in facilities owned by referring physicians and that both gross and net revenue per patient were 30% to 40% higher in such facilities. Percent operating income and percent markup were significantly higher in joint venture physical therapy and rehabilitation facilities. The study concluded that licensed physical therapists and licensed therapist assistants employed in non-joint venture facilities spend about 60% more time per visit treating patients than those licensed workers in joint venture facilities. Finally, the study found that joint ventures also generate more of their revenues from patients with well-paying insurance.

Chairman THOMAS. Thank you very much, Dr. Mitchell. Thank the panel. Mr. Stark will inquire.

Mr. STARK. Thank you, Mr. Chairman. Dr. Mitchell, it would be self-serving to suggest that you got into this or got interested in this at any request of the Federal Government or this Committee. I believe that the State of Florida and some legislators in Florida got interested in this referral issue long before it came to the attention of this Committee; is that not correct?

Ms. MITCHELL. That is correct.

Mr. STARK. You might just, if you could in just a minute or so, summarize for the Chair and myself what was happening in general in Florida that perhaps got you going, got you started on these studies.

Ms. MITCHELL. Well, what happened was in 1989 this issue was brought to the attention of the House of Representatives in the State of Florida. In particular, in south Florida there were several joint ventures opening up and essentially cream skimming all the patients and dumping the Medicaid and the uninsured on the hospitals, and the hospitals essentially went to the Chairman of the Health Committee, Mike Abrams, and said look, this is a real problem. We need to have some legislation dealing with this. But the Florida legislature does not like to do anything unless they study the issue. So they commissioned this study, and I was contracted by the Florida Health Care Cost Containment Board to conduct the study.

Mr. STARK. Well, and I might ask you to further assuage the Chair's fears that some of these studies did not take into account the quality of treatment in the results. It is my understanding, having once attempted to write an article for JAMA, that they will not take work that is not very well researched or from someone who knows nothing about what they propose to write.

The research studies that you have provided really did attempt to see whether there was a change in practice, and whether the outcomes, to the extent that information is available, could be measured. I think this work would generally pass the highest standards of professional research.

I do not now, as you did, have any vested interest in this one way or the other, other than research that would stand the scrutiny of your peers in academia. I just wanted to qualify that most of these studies were not at the behest of the hospitals who now maybe have changed their minds because they want to get into the business or at the behest of the radiologists who are maybe losing patients or at the pharmaceutical companies or the doctors. This was a problem in general when you started doing research and not only yourself, but others studying it have not had a predetermined position. Do you want to—could you give us some further assurance that you are an honest researcher in this area?

Ms. MITCHELL. Mr. Stark, I can tell you that I worked for essentially negative wages when I was doing this study. It basically almost killed me. I have no vested interest in anything, and as an academic researcher, we are held to the highest standards. You know, the New England Journal only accepts about 3 percent of the articles that are submitted to it. The same is true of JAMA.

Mr. STARK. I am sure.

Ms. MITCHELL. You have four reviewers for each journal. It is all blind review. So, you do not know who these people are out there except that they are people who are qualified to review the material, and if your research is accepted in either of those journals, it has met the standards of the medical community that this is good research and solid empirical research. You cannot be published in any better journals than New England Journal and the Journal of the American Medical Association. It is all blind reviews, so they have no idea.

Mr. STARK. On the other hand, various groups can take your research and interpret it differently.

Ms. MITCHELL. Exactly as they want, yes.

Mr. STARK. I just wanted to reassert that this problem has a way of turning. Originally, the hospitals in Florida found they were being harmed. Now we have received testimony today that the hospitals got into the business.

I suspect that the other witnesses, the physical therapists and the radiologists would agree with the Chairman that we should define this better than we have and simplify the rules. We should chase after the administration to get the rules out more quickly, but I have never felt that physician self-referral was a problem that did not exist.

I think that the three witnesses here, Mr. Chairman, would indicate this. They are of the highest professional standing in the medical community or the medical service profession or in research they have confirmed that the Republican Inspector General originally suspected—that there is endemic in the medical care delivery a problem of unjust enrichment or overutilization; that there is an attempt to generate revenue; and that there is a new scam each year or a new innovation each year, if that is a better word to use. The laws ought to change in response. We should find a way to have a more rapid response.

I thank the Chair for bringing this excellent panel to the attention of the Subcommittee.

Chairman THOMAS. Thank you. In that regard, Dr. Mitchell, on page 6 of your testimony, the end of the first paragraph,

> None of the evidence to date has been able to evaluate whether the increased utilization that accompanies the practice of physician self-referral represents inappropriate or unwarranted services. On the other hand, there is no evidence to date demonstrating that physician self-referral arrangements have any benefits to consumers.

Ms. MITCHELL. That is correct. If you can cite me any I would be glad to know.

Chairman THOMAS. Well, no, I am saying if in fact none of the evidence to date has been able to evaluate whether the increased utilization represents inappropriate or unwarranted services——

Ms. MITCHELL. All we can say is that the utilization is much higher, significantly higher. If you were to determine whether——

Chairman THOMAS. Believe me, I understand.

Ms. MITCHELL. Actually I must qualify myself.

Chairman THOMAS. If I might, when you have those parameters for a study, any conclusions, such as, Mr. Grob's draw-your-own-conclusions, very often is not coming from the material if you cannot prove either of those basic points.

Ms. MITCHELL. Well, first of all, let me clarify this. No study has been able to determine that except for the California Workers' Compensation Study where they found that 38 percent of the MRI scans were deemed to be medically inappropriate when they were referred by self-referral physicians compared to 27 percent when they were not referred by physicians who had an investment interest. So, that is a significant difference in utilization because they were looking at specifically medical appropriateness. To have——

Chairman THOMAS. Question on that. Is it appropriate that someone who knows more about a medical technology might refer it more frequently and someone who spent so much time to learn about it that they thought it was appropriate to invest in it would probably have more knowledge and therefore refer more frequently than someone who did not?

Ms. MITCHELL. That is something you have to make a judgment on.

Chairman THOMAS. The answer on its face is, yes. But that does not necessarily prove——

Ms. MITCHELL. The financial incentive to refer is still there. I had doctors in the State of Florida who were making $400 in profit per MRI scan ordered the first year of business. I mean, that is outrageous.

Chairman THOMAS. I understand that.

Ms. MITCHELL. You tell me that physicians do not respond to financial incentive; they do.

Chairman THOMAS. As the Ranking Member said, we are interested in making sure, and I will state for the record, as I have already several times, that I have no interest in people unethically making money off of self-referrals. The question is whether or not the law as it now stands is as good as we can get it.

Ms. MITCHELL. It is not. It needs to deal with in-office, it needs to deal with private payers, it needs to have very stringent reporting requirements.

Chairman THOMAS. On page 6, in your testimony, you say all physician joint ventures are located in metropolitan areas.

Ms. MITCHELL. That was true in the State of Florida.

Chairman THOMAS. Is that a statement for all the United States?

Ms. MITCHELL. Well, let me ask you this, would you ever open a business in a rural area if no patients there? It does not make economic sense.

Chairman THOMAS. Excuse me, ma'am, you are the researcher whose credentials have been presented here as being unimpeachable in terms of your studies. I am looking at a statement in your testimony. It says all physician joint ventures are located in metropolitan areas.

Ms. MITCHELL. I should have clarified that, in Florida.

Chairman THOMAS. That is an unqualified statement of fact which I think you will find is refutable on its face, yet you make that statement.

Ms. MITCHELL. Well, that is true in Florida, I am sorry.

Chairman THOMAS. It did not say Florida in your testimony. Your unimpeachable professional credentials, which have been laid on the table, are the glasses through which I read your testimony and I did not see in Florida, I did not see in a portion of the coun-

try, I did not see in a particular region of the country, I saw a flat out factual statement which I believe to be inaccurate, and then again, draw your own conclusions and do not assume by my statement anything in motive at all. Dr. Templeton and Dr. Weinper, I invite testimony to refute the statement that with the passage of the law the universe of people who might be considered competitors has been reduced; is that correct? That prior to the law there were perhaps more people who could be in direct competition with you? After the passage of the law there are fewer.

Dr. TEMPLETON. No, sir, I do not believe that is correct in terms of this law deals with joint venture facilities. In my experience and in the experience of the American College of Radiology, by and large, those films are, in fact, read by radiologists regardless of the ownership. It does not deal with the impact.

Chairman THOMAS. Are other surgeons capable of reading the xrays?

Dr. TEMPLETON. In our opinion, they are not and in most surgeons' opinion they are not capable of reading those studies in those facilities. I think it is very unusual if not isolated instances in which the owners themselves actually participate in the interpretation of the studies, particularly MRIs.

Chairman THOMAS. But prior to the passage of the law, there was the opportunity for those individuals to exercise that if they felt so competent after passage of the law. If they do not, the universe is reduced. It is similar with the physical therapy as well, and so without indicating, as I have prefaced this whole statement in terms of motivation, there are those who could draw their own conclusion as to the rigor and the vigor with which you support the law, and I think that is a reasonable conclusion to draw from your willingness to testify in favor of retaining the law. It clearly shrinks the universe of those who would otherwise be seen as competitors, and I understand that. That is a perfectly legitimate reason.

Mr. WEINPER. In California many physicians provide physical therapy in their offices without licensed persons to do so, clearly in violation of State law, but do it nonetheless and get paid for it.

I know of no situation in California where a physician has divested himself or herself of a physical therapy operation due to Stark II. I do know of physicians who have mentioned the reforms in workers compensation which have made the national news. That makes it frankly not in their best interests to continue to do business because many times they are providing care in worker's comp environment.

Chairman THOMAS. It seems to me that that would best be treated as a malpractice issue, and there are whole areas of fraud and abuse that we can get into. I just wanted to indicate to you that someone looking at it from a slightly different perspective could draw a different conclusion.

Mr. STARK. Would the Chairman indulge me for a second?

Chairman THOMAS. Sure.

Mr. STARK. On page 6 of Dr. Mitchell's statement, you were concerned by the statement that all physician joint ventures are located in metropolitan areas. That statement refers to a specific study, Mr. Chairman, in which there were 1.3 million claims on the

previous page. There may be some syntax problems with it, but that statement of all physician joint ventures only refers to a particular study of 1.3 million claims and not the broad universe as you have suggested. If that statement is a very broad statement, I could understand the Chairman's objection, but to——

Chairman THOMAS. Well, I have to tell the gentleman, I have difficulty reading that direct transfer, when on page 5 there is a sentence that says specifically the general consensus of all the available evidence is that the financial incentives that accompany physician self-referral arrangements, is a universal statement dealing with all available evidence. Are you saying that refers specifically to the Florida study?

Mr. STARK. I am no one to analyze anybody's writing style, not the way this gentleman writes, but I have looked at it. Yes, what I am saying is that the phrase "all physician joint ventures are located in metropolitan areas" refers only to those joint ventures in that study which analyzed 1.3 million claims. Beyond that I would not——

Chairman THOMAS. On page 5 it says this comprehensive review of the empirical evidence.

Mr. STARK. And that this comprehensive review refers to the previous paragraph, the Florida joint venture study by Mitchell and Scott in 1991, their analysis of 1.3 million claims from Florida Medicare referrals, then this comprehensive review, and then it goes on. I did not mean to beg the question, Mr. Chairman, but I thought you might be more comfortable with Dr. Mitchell's credibility if I pointed that out.

Chairman THOMAS. Well, I guess in getting there I read through several other studies by the Federal Government which precedes that, and then there are references to these studies in several other paragraphs, but if we wish to break it down and grade it in terms of syntax and structure, we could take our own time to do that.

I have difficulty making the leap, but obviously you have drawn your own conclusions, and that phrase has been overused in this hearing. I want to thank the panel for their testimony. This is going to be an area which we will revisit with amendments, some of which my colleague will join in on, some I am sure he will not.

Just as we had great difficulty with the way the law was originally written, he is probably going to have some difficulty with the way in which the law is going to be changed, but I think you are going to find a kernel in there of general agreement which, hopefully, will allow us to continue to jointly make changes in this area so that no one can unethically make money off of self-referrals. I want to thank you very much for your testimony and contributions.

[Whereupon, at 1:25 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

TESTIMONY OF THE AMERICAN ACADEMY OF NEUROLOGY ON PHYSICIAN SELF-REFERRAL BEFORE THE SUBCOMMITTEE ON HEALTH OF THE HOUSE WAYS AND MEANS COMMITTEE

MAY 3, 1995

The American Academy of Neurology ("the Academy") appreciates this opportunity to present its views on issues related to physician self-referral. The Academy represents the interests of approximately 13,000 physicians Board certified in Neurology.

The Academy agrees that the problems with the current physician self-referral law identified by the Medical Group Management Association, the American Medical Association, and other organizations are ones which merit this Subcommittee's careful review. In particular, the Academy urges the Subcommittee to consider reform in the areas discussed below, which have a particularly adverse effect on the practice of neurology and appear to have little, if any, relationship to deterring abusive practices.

Site of Service Restrictions on Group Practices

The physician self-referral law restricts the ability of physicians in a group practice from providing ancillary services at more than one site. Thus, if a neurology group wishes to set up a diagnostic testing site for its patients in a rural area, it may not be able to do so. Although the law recognizes an exception for facilities in rural areas, the rural exception does not help where the main practice site is in a metropolitan area, but the group attempts to serve surrounding rural areas through satellite facilities. Thus, the law makes the development of ancillary facilities designed to bring more convenient services to patients in underserved areas extremely difficult. We do not believe there is any sound policy rationale for limiting the number of diagnostic sites physicians may develop for the convenience of their patients. We urge the Subcommittee to eliminate this arbitrary restriction on physician group practices.

No Exception for Bona Fide Shared Facilities

The law fails to recognize an exception for ancillary facilities shared between or among two or more physicians. We refer here to facilities jointly owned and run by physicians who practice in the same building, or even in the same office suite, and which are generally used exclusively for the physicians' own patients. These arrangements are cost effective ways for physicians to provide patients with needed ancillary services. In rural or underserved areas, in particular, where the hospital's resources are limited, it is often the only way to provide needed services. There is no exception for such shared arrangements under current law. As a result, patients often are required to travel to other sites for needed ancillary services, significantly increasing the cost and effort these patients must endure in obtaining needed care.

We realize that there is potential for abuse in this area but believe the law can certainly distinguish between abusive joint ventures and cost effective shared service arrangements developed by physicians who are on-site, involved in supervision of non-physician personnel, and utilizing the shared facility as an adjunct to their own office practices.

We urge that any bill modifying current law provide an exception for shared facilities.

Inpatient and Outpatient Hospital Services

The inclusion of inpatient and outpatient services in the list of designated health services has had the effect of needlessly complicating relationships between hospitals and physicians and increasing the cost of doing business with no corresponding benefit to society. As a result of the OBRA '93 amendments, everything a physician orders for a hospitalized patient becomes a potentially prohibited "referral" and must be analyzed to ensure it does not violate the law. Hospitals are already highly regulated by state and federal law. In addition, they are subject to cost control constraints from a variety of sources, including Medicare prospective payment. Hospitals have every incentive to be prudent buyers and to engage in cost-effective behavior. In addition, hospital quality assurance and utilization review provides another layer of protection against potential over-utilization associated with improper referrals. In fact, in our experience, the law often operates as an impediment to the hospital's cost-control efforts, because hospitals are unwilling or unable to contract with referring physicians, even though they may offer the best quality service for the lowest price.

Moreover, to the extent that there is likely to be collusive behavior between physicians and hospitals, the Medicare anti-kickback law, with its potential for criminal penalties, is certainly adequate legal deterrent. The restrictions in the physician self-referral law are simply not necessary. Other laws already provide adequate protection against potential abuse.

Therefore, we urge the Subcommittee to remove inpatient and outpatient hospital services from the prohibitions on physician self-referral.

Physician Compensation Formulas

The compensation test included in the definition of group practice is, in our view, a serious and unwarranted intrusion by the federal government into private business matters. Physicians practicing together as a group should be able to decide among themselves how they are to be compensated. Moreover, the law as written is so ambiguous that it is extremely difficult to determine whether or not an arrangement is legal. Therefore, we urge that the compensation test be eliminated.

Thank you for considering this statement. If you have any questions, please call our Washington counsel, Richard Verville or Rebecca Burke, at 202-466-6550.

Statement of the

American Academy of Ophthalmology

for the

U.S. House of Representatives

Committee on Ways and Means

Subcommittee on Health

hearing on

Physician Ownership and Referral

Mr. Chairman and members of the Committee:

My name is William Rich. I am an ophthalmologist in private practice in Falls Church, Virginia and the Chairman of the Federal Economic Policy Committee of the American Academy of Ophthalmology.

Ophthalmologists are physicians who provide primary and comprehensive medical and surgical eye care. The Academy is made up of nearly 20,000 ophthalmologists -- over 90-percent of the ophthalmologists in the United States.

We urge your examination of the important issues related to physician ownership of medical facilities and the referral of patients to these facilities. In particular, we urge your consideration of the impact of physician ownership and referral laws on physician's ability to adapt to the evolving health care system.

Background

The American Academy of Ophthalmology recognizes that managed care will continue to be a growing segment of our nation's health care delivery system. The Academy has been actively encouraging its members to participate in managed care arrangements and to provide primary eye care services. We believe that the key to ophthalmologists participation in such arrangements is the ability to provide comprehensive eye care. Comprehensive eye care includes the delivery of medical and surgical services, preventive services, refractions and eyeglasses and contact lenses.

Regrettably, ophthalmologists ability to provide comprehensive eye care is seriously hampered by provisions in OBRA '93 referral and ownership provisions known as Stark II.

Many managed care organizations will not contract with ophthalmologists that do not dispense eyeglasses and contact lenses. These managed care organizations seek to provide their enrollees with the convenience of "one-stop shopping" for vision care. Some ophthalmologists have been able to meet this demand by forming optical shops within their practices via the "in-office ancillary procedure exemption." In other situations, it would be more efficient for independent ophthalmologists in the same facility to open an optical shop. The Stark II provisions prohibit this second type of arrangement.

As a result of the Stark II prohibition, some of the Academy's members have not been able to compete for managed care contracts. Others have been forced to merge their practices. Some may be simply refusing to provide covered eyeglasses and contact lenses to their Medicare patients.

The Academy understands the increased emphasis on primary care including primary eye care. We believe our membership is anxious to participate. Unfortunately, efforts to provide primary eye care have been hampered by the Stark II provisions which prevent the efficient delivery of eyeglasses and contact lenses. The Academy believes it is inappropriate that, in effect, independent ophthalmologists are barred from working together to open optical shops.

It is our understanding that optical shops were mistakenly included in the Stark II provision's list of designated services. While eyeglasses and contact lenses were in an original draft of the legislation, that category was deleted later in the drafting process when the legislation was narrowed to apply to only Medicare and Medicaid covered services. We believe this category was deleted because eyeglasses and contact lenses are not normally covered by Medicare or Medicaid.

Currently, however, eyeglasses and contact lenses still appear to be covered by the Stark II provisions. That is because a provision of the Social Security Act identifies eyeglasses as prosthetic devices and the Stark language includes restrictions on such devices.

In various correspondence with HCFA, Congressman Stark has stated his legislative intent to exclude optical shops from the OBRA '93 provisions. The Academy supports this exclusion.

Recommendation

The Academy strongly recommends that optical shops be removed from the list of designated services included under the Stark II provisions. This could be accomplished by specific language excluding eyeglasses and contact lenses or by removing the prosthetic and orthotic categories.

Thank you for your consideration of this recommendation. I am pleased to have had the opportunity to present this statement to you.

Statement of the
American Academy of Otolaryngology - Head and Neck Surgery
to the
Ways and Means Subcommittee on Health
for the Record of the May 3, 1995 Hearing on
Physician Self-Referral

The American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS) welcomes this opportunity to provide a written statement for the record of the May 3, 1995 hearing on physician self-referral. The AAO-HNS is very concerned about the implications of the physician self-referral law that was mandated by OBRA '89, expanded in OBRA '93, and modified by the Medicare Technical Amendments of 1994. While the spirit of the original law is to be commended, the ambiguities in the current statutory language and the failure of the Administration to publish regulations, has rightfully caused tremendous confusion and alarm among our members. We are grateful that the Committee has decided to review this issue. A brief description of our organization and recommendations to provide legislative and regulatory relief from aspects of the law which remain problematic follow.

The American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS) is the national medical association of physician specialists dedicated to the care of patients with disorders of the ears, nose, throat, and related structures of the head and neck. We are commonly referred to as ear, nose and throat (ENT) physicians, but are formally known by our Greco-Roman name of otolaryngology or otorhinolaryngology. We have over 10,000 members worldwide, about 7,500 of whom are practicing physicians in the United States.

Otolaryngologists treat many primary care problems, including sore throats, ear aches, and allergies, in both children and adults, but we are also trained to perform the most complex of surgical procedures. Head and neck cancer, facial plastic and reconstructive surgery, and hearing and balance disorders are just a few examples of our subspecialty areas of focus.

Statement of the Problem for Otolaryngologists

1. DELAY. The Health Care Financing Administration (HCFA) has failed to publish regulations on this law even though the ban on physician self-referrals to clinical laboratories has been in effect since 1992 and the ban on the extended list of items and services subject to the law has been in effect since January 1, 1995. **The law is supposedly self-implementing, but absent federal regulations clarifying the many ambiguous sections of the statutory language, many physicians cannot be sure if they are in violation of the law even with the best of legal counsel.** We understand that HCFA is planning to issue final regulations on Stark I in the very near future, as soon as the draft clears OMB, where it is cued up, and plans to issue a proposed rule on Stark II by the end of the summer. The AAO-HNS and many members of the health provider community asked HCFA to delay enforcement of the law until final regulations were issued. HCFA declined, indicating it was not within its authority to issue a moratorium on the effective date. Clearly, it is within Congress' scope to delay the enforcement of this law until final regulations are issued. In addition to the needed amendments to the Stark physician self-referral law which are recommended below, **Congress should enact a delay in the effective date of law until at least six months after final regulations are issued. It is only fair to allow physicians and others a sufficient amount of time to ensure that they are not in violation of the law.**

2. DEFINITION OF REFERRAL. The statutory language does not sufficiently define the term "referral" and therefore at present could implicate all items and services payable under the Medicare and Medicaid programs in the ban on physician self-referrals. In fact, a recent reading of the statute by HCFA would imply this. **Congress should amend the law to make it absolutely clear that only those services noted on the Designated Health Services (DHS) list are subject to the ban.**

Audiological (Hearing) Testing: When Congress, as part of the Medicare Technical Amendments of 1994 deleted "other diagnostic services" from the section of the Designated Health Service (DHS) list in the physician self-referral statute that read "radiology and other diagnostic services," the AAO-HNS was hoping that this would put to rest any concern that audiological (hearing) tests were subject to the law. The intent of Congress was not to subject all diagnostic services to the ban on physician self-referrals, and this is reflected by the passage of the Technicals bill. Some of our members provide in-office audiological testing to their patients to detect and treat hearing and balance disorders. Physicians who provide these hearing tests in-office for diagnosis and treatment purposes should not be subject to the ban on physician self-referral as this was not the intent of the law and there is no indication that the provision of these services poses any special harm or risk of abuse to Medicare or Medicaid. **There are also other diagnostic services that otolaryngologists provide such as in-office allergy testing (not clinical laboratory) which are not on the DHS list, but which may be implicated in the law, by the lack of clarity regarding what constitutes a "referral" subject to the self-referral ban.** This remains of concern.

3. DEFINITIONAL PROBLEMS RE: PROSTHETIC DEVICES. Ambiguities in the statutory language and the absence of regulations could implicate hearing aids in the ban on physician self-referrals even though they are not specifically on the list of DHS, and Congress did not intend these items to be subject to the ban. Although hearing aids are not a Medicare covered item, they are paid for under certain circumstances by various state Medicaid programs. Current federal statute regarding optional Medicaid benefits, happens to list hearing aids under the category of prosthetic devices, along with Durable Medical Equipment (DME), for lack of its own category, even though clearly hearing aids and DME are not prosthetic devices. Does this mean that hearing aids are part of the ban on physician self-referrals because prosthetic devices are on the DHS list? Hearing aids are not a Medicare covered item, but if they were, how would they be classified? In preliminary conversations with HCFA staff, we got the impression that HCFA might classify hearing aids as a prosthetic device, even though they are not considered prosthetic devices by anyone professionally familiar with hearing aids. **An amendment to the Stark law clarifying that hearing aids are not prosthetic devices at the very least is recommended. Deleting prosthetic devices from the list of services subject to the ban entirely would be preferred as these items are not necessarily subject to abuse by virtue of physician ownership or interest.** The law as written would seem to favor non-physician suppliers over solo and group practice physicians. We would hope that Congress would not permit special economic interests to dominate the market, but would allow physicians to continue providing the highest quality care and services to their patients in the most efficient and economical manner possible.

4. GROUP PRACTICE COMPENSATION DISTRIBUTION FORMULAS. The statutory language has created a frenzy among physicians in group practices who would normally distribute compensation among partners in the group based upon the work and profits that those individual physicians generated for the group practice. It seems unrealistic for the federal government to dictate how physicians in group practice arrangements should distribute their profits. At present, physicians who are partners in a group practice could not receive individual compensation based upon their patient load. The requirements have proven to be unworkable not only for full partners but also for physician employees. It is impossible to apply the compensation test (that would provide for an exception under the law) fairly and uniformly across physician employees in tax exempt clinics, medical schools, and for profit groups. Physicians in single specialty group practices would have to be treated differently than physicians in multi-specialty groups, and physician owners who are also employees would need special treatment. All this, while physicians in solo practice are not subject to these same tests, does not make sense. **Congress should amend the law to eliminate these arbitrary requirements for group practice compensation arrangements.**

5. SHARED IN-OFFICE ANCILLARY SERVICES EXCEPTION. Many physicians share office space, equipment, employees, and general overhead, in order to promote economies of

scale, but prefer to maintain their own autonomy and billing numbers, rather than incorporating as a group practice. For all intents and purposes, they function as a group, but bill separately. The lack of an exception to the ban on physician self-referrals for shared in-office services has proven to be of serious concern to many physicians, including otolaryngologists. This Committee passed such a provision during last year's health reform debate, but it failed to pass the Congress as it was connected to the larger legislation of health reform. **We would urge that the Committee and Congress again act to provide for this exception for shared in-office service arrangements to the physician self-referral ban**. Independent physicians who may share an x-ray machine or other diagnostic testing equipment, or employees should not be subject to the ban on physician self-referrals by virtue of the existence of these types of cost-effective arrangements.

6. REPORTING REQUIREMENTS. Congress should eliminate these requirements as they are unnecessary and would prove to be unduly burdensome on the physician community and the regulatory process, financially and otherwise. HCFA has more than enough other tools to gather useful information on physician ownership and to strain out abusive arrangements.

There are several other provisions which remain of concern, but which are not discussed here, including special problems for physicians who own and treat patients at Ambulatory Surgical Centers, and for group practices who have more than one practice site. We understand that these issues will be addressed by organizations closer to these matter, and we likely will support their recommendations for legislative amendments to the law.

The American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS) is most pleased to see this Committee's scrutiny of the current physician self-referral law, and welcomes amendments to the law in 1995 as outlined above. We look forward to working with you to resolve these matters.

For additional information, please contact Beverly Nissenbaum or John Williams at the AAO-HNS at (703) 836-4444.

STATEMENT OF THE AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION ON PHYSICIAN SELF-REFERRAL BEFORE THE SUBCOMMITTEE ON HEALTH OF THE HOUSE WAYS AND MEANS COMMITTEE

MAY 11, 1995

The American Academy of Physical Medicine and Rehabilitation ("the Academy") appreciates this opportunity to present its views on issues related to physician self-referral. The Academy represents the interests of approximately 4,000 physicians Board certified in Physical Medicine and Rehabilitation.

The Academy agrees that the problems with the current physician self-referral law identified by the Medical Group Management Association, the American Medical Association, and other organizations are ones which merit this Subcommittee's careful review. In particular, the Academy would like the Subcommittee to consider reform in the following areas, which have a particularly adverse effect on the practice of physical medicine and rehabilitation and which do little, if anything, to curb abusive practices.

Prohibition on Providing DME to Patients in the Office

Physicians practicing in the specialty of physical medicine and rehabilitation (known as "physiatrists") often see a wide variety of patients with mobility impairments resulting from injury or disease. These patients often need items such as canes, walkers, splints, or braces. Before the OBRA '93 amendments to the physician self-referral law, physiatrists were able to dispense these items in the office. This allowed the physician to evaluate the fit of the item and educate the patient as to its use. Because of the changes in the law effective January 1, 1995, physiatrists are now required to send their patients to a third party supplier for these items. For patients with mobility impairments, for whom even a trip to the physician's office can be a challenge, a second trip to a pharmacy or medical equipment supplier is an extreme inconvenience. We believe it makes little sense for a physiatrist to see a patient in the office suffering from joint pain or recovering from a hip fracture and not be able to dispense a cane or a walker.

We urge that the prohibition on providing DME through the office be eliminated.

Physical and Occupational Therapy

Physical and occupational therapy are an integral part of the practice of rehabilitation medicine. As a result, many physiatrists provide these therapies in their offices or clinics by therapists they employ or with whom they contract. This allows the physiatrist to better supervise the therapy and better monitor the patient's progress. We are not aware that this has been an area of abuse in the past in our specialty. Nevertheless, the OBRA '93 amendments added physical and occupational therapy to the list of designated health services. As a result, physiatrists may no longer own therapy clinics and cannot even provide therapy in their offices unless they comply with one of the complicated exceptions to the physician self-referral law.

We urge that physical and occupational therapy be removed from the list of designated health services.

Inpatient and Outpatient Hospital Services

We also urge the Subcommittee to remove inpatient and outpatient hospital services from the list of designated health services. Many physiatrists have hospital based practices in which they provide services to hospital inpatients and outpatients. Thus, they are often in the position of ordering tests, pharmaceuticals, therapies, and other ancillary services for hospital patients. Because of the OBRA '93 amendments adding inpatient and outpatient hospital services to the list of designated health services, everything a physiatrist orders for a hospitalized patient becomes a potentially prohibited "referral" and must be scrutinized to ensure it does not violate the law.

This unnecessarily complicates relationships between hospitals and physiatrists and, in our view, is not necessary to curb abuse. Hospital quality assurance and utilization review and caps imposed by TEFRA are more than adequate to prevent over-utilization. Therefore, we believe hospital inpatient and outpatient services should be deleted from the list of designated health services.

Physician Compensation Formulas

Physiatrists in group practices who provide physical or occupational therapy must comply with the compensation test included in the definition of group practice. This test represents, in our view, a serious and unwarranted intrusion by the federal government into private matters. Physicians practicing together as a group should be able to decide among themselves how they are to be compensated. Moreover, the law as written is so ambiguous that it is extremely difficult to determine which arrangements are legal and which are not. For these reasons, we believe the compensation test should be eliminated.

Thank you for considering this statement. If you have any questions, please call our Washington counsel, Richard Verville or Rebecca Burke, at 202-466-6550.

AACC AMERICAN ASSOCIATION FOR CLINICAL CHEMISTRY, INC.

2101 L Street, N.W., Suite 202, Washington, D.C. 20037-1526 • Phone 202-857-0717 • Toll Free 1-800-892-1400 • Fax 202-887-5093

STATEMENT OF THE
AMERICAN ASSOCIATION FOR CLINICAL CHEMISTRY
SUBMITTED TO THE
SUBCOMMITTEE ON HEALTH
FOR THE HEARING OF MAY 3, 1995

The American Association for Clinical Chemistry, Inc. (AACC) supports the current prohibition against physicians referring patients to clinical laboratories in which the physician has a financial interest. We believe the intent of the original legislation, to significantly reduce the ordering of unnecessary laboratory tests, remains valid. We also believe that the data gathered over the past few years, both by the government and private sector, support the need for this legislation.

The Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) performed a study in 1989, which found that patients of referring physicians who owned or invested in independent clinical laboratories received more services than Medicare patients in general. In fact, the study reported that such physicians ordered 45 percent more services, costing the Medicare program $28 million.

A 1991 study by the Florida Health Care Cost Containment Board confirmed these findings. In addition to lab services, physician owners were overutilizing diagnostic imaging services and physical therapy services. A followup study by the General Accounting Office (GAO) for this subcommittee, reported that physician owners had a higher referral rate for all types of imaging services than nonowners. The GAO concluded their report stating "we believe this analysis of referral for imaging services, together with our earlier analysis of referral patterns for clinical laboratory services, illustrates a broad potential for higher use and higher costs through self-referral."

The American Medical Association (AMA), which is the largest physician association, has testified before this subcommittee in the past stating that "physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility." And, a similar statement is listed in the AMA's Code of Medical Ethics. AACC agrees with the AMA's statement and recommends that the subcommittee maintain the self-referral prohibition on clinical laboratory services and other areas with documented referral problems.

By way of background, AACC is the principal association of clinical chemists--professional laboratory scientists--including MDs, PhDs and medical technologists. Clinical chemists develop and use chemical concepts, procedures, techniques and instrumentation in health-related investigations. The AACC represents clinical laboratory scientists and managers working in hospitals, independent laboratories and industries nationwide. The AACC's objectives are to further the public interest and educational activities and help maintain high professional standards.

Thank you for your consideration of our views.

Sincerely,

Peter Wilding

Peter Wilding, PhD
President, AACC

The policy of the American Association for Clinical Chemistry, Inc. is that only the President, President-Elect, Past President, Secretary, Treasurer, Executive Vice President, and the Association's Legal Counsel may make official statements on behalf of the Association. This limitation does not apply to the conduct of routine business transactions.

American
Clinical Laboratory
Association

TESTIMONY OF THE
AMERICAN CLINICAL LABORATORY ASSOCIATION
BEFORE THE SUBCOMMITTEE ON HEALTH
HOUSE WAYS AND MEANS COMMITTEE
May 3, 1995

The American Clinical Laboratory Association ("ACLA") is pleased to have this opportunity to submit testimony with regard to the Subcommittee's consideration of issues related to physician self-referral. ACLA is an association of federally-regulated independent clinical laboratories located throughout the United States. All ACLA members are directly affected by the prohibition on physician self-referral contained in Section 1877 of the Social Security Act. In our testimony today, we would like to review the status of the self-referral law as it applies to laboratory services. Then, we would briefly like to review the basis for that prohibition. Finally, we would like to discuss our views on some of the modifications of the law that have been suggested.

I. Self-Referral of Clinical Laboratory Services Should Continue to be Prohibited.

Congress enacted the prohibition of self-referral for laboratory services in 1989, as part of OBRA'89. This was the first time Congress had prohibited self-referral on a large scale. While Congress did not apply the prohibition to any other services at that time, it found that the record amply demonstrated the need for a limitation on self-referral of clinical laboratory services. Under that provision, which became effective in January 1992, physicians were prohibited from referring their Medicare patients' testing to clinical laboratories with which they had an ownership or investment interest or a compensation arrangement.

The prohibition on self-referral of clinical laboratory services has been effective for over three years. While it is impossible to measure precisely the impact of the law on utilization of laboratory services, preliminary evidence is that the law has helped to reduce clinical laboratory utilization. Recent information from the HHS Office of the Actuary, on expenditures for independent clinical laboratory services, shows that expenditures for laboratory services have declined in recent years. In fact, for 1994, independent laboratory expenditures were expected to be about 2.3% below what they were in 1993. This reduction is at least partly the result of the prohibition on self-referral. Recent statements by the OIG also confirm that the reduction in laboratory expenditures is due in part to the self-referral prohibition.

ACLA continues to believe that a prohibition on self-referral for clinical laboratory services is crucial to controlling unnecessary utilization of clinical laboratory services. ACLA believes it would be inadvisable, at this time, to make significant changes in the law's prohibition on self-referral of laboratory services. Moreover, unlike other services that were added by OBRA'93, the market has now had an ample time to deal with (and respond to) the self-referral prohibition for laboratories. Indeed, the figures cited above suggest that the law has had an impact in controlling the utilization of clinical laboratory services.

Furthermore, although ACLA recognizes that some have called for removing certain services from the list of "designated health services" that were added to Section 1877 in 1993, no group that we are aware of has suggested that clinical laboratory services should be removed from the list of health services subject to the self-referral ban. In sum, given the increasing concern that is being expressed about increases in the utilization of services and the costs to Medicare, there is no reasonable justification for limiting the prohibition on self-referral as it applies to laboratory services.

II. There is Ample Support For Prohibiting Self-Referral of Laboratory Services.

When Congress passed the self-referral prohibition, it did so based on a number of significant studies. First, in 1989, the Office of Inspector General ("OIG") conducted a study entitled "Financial Arrangements Between Physicians and Health Care Businesses." That study concluded that physicians who owned or invested in independent clinical laboratories ordered 34% more clinical laboratory services than did physicians who had no ownership or investment interest in a laboratory. Moreover, in testimony before this Subcommittee, then-Inspector General Kusserow estimated that the cost of such increased testing to the Medicare program was about $28 million for 1989, a figure that he stated was conservative. The OIG concluded that these facts were "quite troubling" and a "cause for concern to the Medicare program."

The OIG also cited an earlier study in Michigan which had found the average number of services per patient furnished in physician-owned laboratories was 20% higher than the average number furnished in *all* laboratories. Moreover, physician-owned laboratories furnished 40% more services, when compared to only non-physician-owned laboratories.

These studies were basically confirmed by a study that was later performed in Florida. That study found increases in clinical laboratory utilization among physician-owned facilities. Larger laboratories that were owned by referring physicians, performed almost twice as many diagnostic tests per patient as similar non-joint venture laboratories. Not surprisingly, the study also found that the higher utilization per patient led to significantly higher gross revenues per patient. Gross revenue per patient was about $38 for laboratories with referring physician-owners compared to just under $20 for non-joint venture laboratories.

ACLA recognizes that these studies do not specifically show that the clinical laboratory services performed at joint venture laboratories were unnecessary. Still, on balance, as in 1989, when the self-referral law was passed, there appears little justification for the higher utilization of laboratory services at physician-owned laboratories. The likely, and most plausible explanation, is that physicians responded to their incentives for increased profit by ordering more services. This has been the conclusion of virtually all those who have studied the self-referral issue.

Indeed, numerous government agencies and legislators have noted the inherent conflict created by self-referral. The American Medical Association, for example, takes the position that:

> When physicians refer patients to facilities in which they have an ownership interest, a potential conflict of interest exists. In general physicians should not refer a patient to a health care facility which is outside of their office practice and at which they do not directly provide care or services when they have an interest in the facility.

The Federal Trade Commission has also acknowledged that antitrust and competitive issues can be raised by the practice of physician self-referral. The Internal Revenue Service has also expressed concern about arrangements whereby non-profit hospitals enter into certain types of joint ventures with their medical staffs.

Other lawmakers have also acknowledged the problems created by self-referral. In his Comprehensive Health Care Reform Program, then-President George Bush noted that physician self-referral should be prohibited. The report noted that "physicians and other providers increasingly refer patients for tests or to diagnostic centers at which they hold some financial stake--a clear conflict of interest." Similarly, in May 1992, Congressman Kasich and then-Congressman Santorum introduced H.R. 5142, which would have amended the Social Security Act to extend the ban on physician self-referral to all payors and to radiology and diagnostic imaging services, radiation therapy services, physical therapy services and DME. In sum, problems relating to self-referral have long been acknowledged, especially in the area of laboratory services.

III. Limited Modifications May Be Necessary.

ACLA recognizes that some modifications may be necessary to ameliorate the technical problems that have been identified. However, ACLA believes the basic framework and purpose of the law is sound; therefore, any changes should be modest and limited. We recommend the following:

First, many of the problems that currently exist in this area would be reduced had HCFA issued final regulations implementing the law, as called for in the law itself. While ACLA recognizes that the various amendments and changes to the law have complicated HCFA's task, we urge the Subcommittee to ensure that the final laboratory regulations--which were issued in proposed form over three years ago, three years after the law's enactment--are issued as soon as possible. We believe this will help clarify many issues that currently exist in this area. We especially believe that these regulations will clarify many of the questions that have arisen in the area of compensation arrangements, which we recognize have created some confusion.

Second, because ACLA believes it is necessary for the law to establish a "bright line" standard, ACLA does not believe it would be helpful to include an "intent" standard in the law. As the recent case against the *Hanlester Network* has shown, "intent" is a very difficult issue to prove in these cases. Moreover, the self-referral law is not a criminal statute, it simply limits payment for certain services. Thus, an intent-based standard is inappropriate.

Further, ACLA is also very concerned about proposals calling for the inclusion of a new exception for shared laboratory services. In the initial law, Congress drew a bright line separating permissible referrals from those that lead to increased utilization and higher health care costs. Under the law, if the physician has an ownership or investment interest in an outside entity, he or she could not refer testing or other services to that entity. However, if the testing or other services were furnished in a physician's own office or in a group practice's office, then they were permissible.

Shared laboratories blur this distinction between physician's own offices and those that are outside facilities. In the shared laboratory situation, independent physicians jointly buy laboratory or other equipment, which they put in a medical office building. Each physician sends his or her patients' testing to that laboratory. Testing is not performed by the physician referring the patient, under his or her supervision or by his or her employees. Thus, a shared laboratory is not the typical in-office ancillary service, which is exempted under Section 1877's requirements, and, accordingly, a shared laboratory should not be exempt. Moreover, the physicians who own the equipment in a shared laboratory are not a group practice because they have not taken any action to integrate their practices; therefore, they are not exempt under the group practice exemption. As a result, ACLA is very concerned that the use of a shared laboratory exception could create a new loophole that would lead to increased utilization and higher health care costs.

Finally, ACLA recognizes that there is a concern that self-referral has limited the ability of integrated health networks and other managed care entities to obtain needed services. Because the law was not designed with such arrangements in mind, ACLA recognizes that the law may present problems in this area. If an exception is added for managed care plans, we believe it should be carefully crafted to ensure that it does not protect what are basically fee-for-service arrangements with the same incentives for overutilization that currently exist. We would be happy to work with the Committee in crafting an appropriate provision.

IV. Conclusion

ACLA appreciates the opportunity to comment on these self-referral issues. We would be happy to work with the Subcommittee on resolving these issues.

Statement of the

AMERICAN COLLEGE OF RADIATION ONCOLOGY

The American College of Radiation Oncology (ACRO) is a professional association of physicians specializing in radiation oncology -- physicians who provide direct, sustained hands-on care to cancer patients. Founded in 1990, ACRO currently has more than 1,500 members. Although there are many radiology professional and scientific societies, ACRO is the only organization that specifically represents the socioeconomic interests of radiation oncologists. ACRO's membership includes physicians working in all care settings: community hospitals, freestanding centers, and academic and research institutions. It includes the directors of leading university departments, freestanding facilities, and both large and small community hospitals.

ACRO appreciates the opportunity to submit testimony for the record to the Subcommittee regarding physician ownership and referral arrangements. Before turning to our specific concerns, however, we would like to describe briefly for the Subcommittee the role of the radiation oncologist in caring for patients with cancer.

THE JOB OF THE RADIATION ONCOLOGIST

Radiation oncology is a unique, hybrid specialty that uses technology to treat patients who have or have had cancer. The radiation oncologist uses radiation as the treatment for cancer rather than surgery or chemotherapy drugs. Depending on the state the cancer is in when the patient is referred, the radiation oncologist's goal is either to cure the cancer or to relieve pain and prolong life. Approximately 60% of all cancer patients require a radiation oncologist's services at some time during the course of their disease.

There are only about 2,400 radiation oncologists in the United States. Roughly half of our members work in hospital-owned facilities, either as hospital employees or as independent practitioners. The other half work in freestanding facilities, which are typically owned by the radiation oncologists themselves.

Radiation oncologists work strictly on a referral basis. After a diagnosis of cancer is made, the patient is sent to a radiation oncologist for examination and the rendering of an opinion as to whether radiation is an appropriate treatment for the patient. If it is determined that radiation would be useful, the treatment of the patient is planned, supervised, and carried out under the immediate direction of the radiation oncologist. During the treatment period, the radiation oncologist generally assumes responsibility for the overall management of the patient's medical needs.

Because radiation oncology is entirely dependent on referrals from the diagnosing physician, radiation oncologists themselves cannot engage in self-referral. Moreover, the number of treatments that can be given to a particular area of the body is narrowly limited by effectiveness of dose on the one hand and tolerance of normal surrounding tissues on the other. Accordingly, there generally is limited risk of over-utilization of radiation oncology services.

PHYSICIAN SELF-REFERRAL IN RADIATION ONCOLOGY

Prior to the enactment of the Omnibus Budget Reconciliation Act of 1993 ("OBRA 93"), it was not uncommon for developers of radiation therapy facilities to offer ownership interests, sometimes at prices below fair market value, to internists, medical oncologists, and other referring physicians. Developers offered ownership interests so readily because they suspected that where a referring physician had a financial interest in a facility, the physician had a strong incentive to refer patients to that facility, regardless of the facility's quality, location, or charges.

In 1992 and 1993, ACRO testified before Congress about the dangers that physician self-referral posed to patient care and the growing distrust and suspicion that marred the physician-patient relationship. ACRO urged Congress to eliminate the conflicts of interest that are inherent in physician self-referral. Congress responded by enacting the physician self-referral amendments within OBRA 93, commonly known as Stark II. Most importantly, Congress included "radiation therapy services" among the list of designated health services that would be covered by the self-referral ban.

Research has concluded unequivocally that self-referral of cancer patients in radiation therapy (i.e., from diagnosing physicians to radiation oncologists) results in substantially higher costs as well as lower quality. According to a study of Florida radiation therapy facilities that was published in the November 19, 1992 issue of the *New England Journal of Medicine*, the frequency and costs of treatment at radiation therapy facilities where referring physicians had an ownership interest were 40 to 60 percent higher than at facilities without referring physician ownership. Moreover, personnel of joint-ventured radiation therapy facilities spent 18 percent less time in quality control activities than their counterparts at facilities without referring physician ownership. The study also found that no joint-ventured radiation therapy facilities were located in inner-city neighborhoods or rural areas, showing that physician self-referral does not improve access to care in otherwise underserved areas.

Existing Medicare-Medicaid anti-kickback statutes and safe harbor guidelines alone are inadequate to deter self-referral. Similarly, experience has shown that self-referral cannot be contained through voluntary ethical guidelines. Rather, federal legislation and regulations explicitly banning self-referral for radiation therapy services are needed to eliminate the threat to high-quality, cost-efficient cancer care. Thus, while some criticisms of Stark II are merited, the prohibition on self-referral for radiation therapy remains valid and important. At the same time, it is important that the Subcommittee maintain language that allows radiation oncologists to own, or have some other financial relationship with, the facilities at which they practice, because these facilities are in effect an extension of those specialists' workplace. Specifically, the Subcommittee must maintain the language included in 42 U.S.C. § 1395nn(h)(5)(C), which provides that:

> "A request by a . . . radiation oncologist for radiation therapy, if such services are furnished by (or under the supervision of) such . . . radiation oncologist pursuant to a consultation requested by another physician does not constitute a 'referral' by a 'referring physician'."

* * * * *

If the Subcommittee would like any additional information concerning this issue or if ACRO can assist the Subcommittee in any way, please contact our Washington representatives -- Guy Collier at 202/778-8016 or Eric Zimmerman at 202/778-8148 at McDermott, Will & Emery.

American College of Surgeons

FOUNDED BY SURGEONS OF THE UNITED STATES AND CANADA 1913

55 EAST ERIE STREET CHICAGO, ILLINOIS 60611 312 · 664-4050 FAX 312 · 440-7014

PAUL A. EBERT, M.D., F.A.C.S.
DIRECTOR

May 3, 1995

The Honorable Bill Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
1136 Longworth House Office Building
Washington, DC 20515

Dear Chairman Thomas:

The American College of Surgeons appreciates this opportunity to submit comments for the record of the subcommittee's May 3, 1995, hearing on physician self-referrals.

The College issued a statement in 1989 on the subject of patient referrals to ancillary services. That statement expressed the College's firm belief that professional income should be derived from the patient services that physicians personally provide or supervise, not from the goods or services they prescribe. Furthermore, the College believes that referrals made to ancillary health care facilities in which a referring physician plays no role in ensuring the quality of services, yet which result in a profit to that physician, clearly run contrary to this ethical standard. The premise for patient referrals must be quality of care, and not financial gain.

However, it is important to consider circumstances in which a physician's investment in ancillary health care services is not detrimental to patient welfare. Indeed, there may be times when such an investment addresses problems of inadequate access. In medically underserved areas physician-owned laboratories, imaging centers, ambulatory surgical centers, and other facilities may be the sole source for important health care services. In situations where some degree of patient disability is involved, a patient's comfort and convenience may be a significant concern. Also, in the case of very expensive medical equipment, it may be necessary for a group of physicians to pool their finances in order to make a valuable health care resource available to patients in the local area.

There have been studies suggesting that physician investment in ancillary facilities encourage unnecessary duplication and overutilization of services, thereby exacerbating the escalation of our nation's health care costs. Therefore, the College continues to support the principles behind restrictions on physician self-referrals, as long as they are carefully targeted to address areas of proven abuse. However, as the Health Care Financing Administration (HCFA) attempts to implement these laws, and health care professionals attempt to interpret and comply with them (in the absence of written regulations), the problems inherent in any effort to legislate ethical behavior are becoming apparent.

Indeed, using a broad, regulatory approach to eliminate certain types behavior often has the unfortunate effect of eliminating the availability of other services and conveniences that truly serve the patents' best interest. Until we actually see HCFA's Stark II regulations, it is unclear just what sorts of problems the current effort will present. However, if we are to judge from the alarming material that surgeons and hospitals are receiving from those who offer legal advice on this issue, there is a real potential that these regulations could have an impact that extends well beyond the undesirable behaviors and costly practices that Congress intended to address.

We look forward with interest to HCFA's publication of the Stark I and Stark II regulations, and will work with the agency in an effort to minimize any inappropriate applications of these laws.

Sincerely,

Paul A. Ebert

Paul A. Ebert, MD, FACS

JOINT LETTER OF:
AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, et al

May 3, 1995

Protect Consumer Health and Tax Dollars: Preserve Ban on Physician Self-Referral

Dear Member of the House Ways and Means Health Subcommittee:

The House Ways and Means Health Subcommittee meets today in order to hear testimony on physician self-referral -- doctors referring patients to laboratories and services in which they have a financial interest. We are writing as consumer, labor and patient advocacy groups to urge you to protect the current ban on physician self-referral from recent industry initiatives to weaken or repeal these laws.

The ban on physician self-referral was included in the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) and prohibited physicians from referring Medicare patients to clinical laboratories in which the physician held a financial interest. OBRA '93 extended this prohibition to apply to both the Medicare and Medicaid programs, and included certain "designated health services" in the ban.

Physician self-referral laws provide vital protection for consumers. As documented below, self-referral clearly leads to excessive utilization, which threatens the quality of health care through unnecessary medical treatment and adds unwarranted expense to our already burdened health care system. While Congress is searching for ways to reduce spending in Medicare and Medicaid programs, repeal of the physician self-referral laws would result in millions of dollars wasted on excessive testing.

A multitude of studies have documented the abuses involved in physician self-referral:

- Patients of referring physicians who owned or invested in independent clinical laboratories received 45% more clinical laboratory services than all Medicare patients in general. ("Financial Arrangements between Physicians and Health Care Businesses," U.S. Department of Health and Human Services, Office of Inspector General, OIA-12-88-01410, May 1989)

- Physicians with financial interests in laboratories ordered 34% to 96% more tests than other physicians. ("Physician Self-Dealing for Diagnostic Tests in the 1980s: Defensive Medicine vs. Offensive Profits," M. Cooper, Consumer Federation of America, October 3, 1991)

- Doctors who owned imaging devices ordered imaging tests four times more often than doctors who did not. ("Frequency and Cost of Diagnostic Imaging in Office Practice - A Comparison of Self-Referring and Radiologist-Referring Physicians," B. Hillman, C. Joseph, M. Mabry, J. Sunshine, S. Kennedy, M. Noehter, New England Journal of Medicine, 1990; vol. 322; 1604 -1608)

- Physician-owned laboratories, physical therapy centers, and diagnostic imaging centers were found to have increased utilization and higher health care costs. ("Joint Ventures Among Health Care Providers in Florida," Florida Health Care Cost Containment Board, Vol. 2, September 1991)

- The volume and total charges of non-hospital MRI tests performed in Florida facilities, which were overwhelmingly joint venture facilities, were respectively 118% and 92% greater than the national average. In addition, the impact of physician joint ventures on medical costs for imaging, clinical laboratory services and physician therapy services resulted in over $500 million in additional costs. ("Impact of Physician Joint Venture Activity on Medical Care Costs in Florida," Z. Dyckman, Ph.D., Center for Health Policy Studies, Columbia, MD, January 1992)

- Physicial therapy was initiated 2.3 times more often by physicians with investment interests than by those without investment interests. ("Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians," A. Swedlow, M.H.S.A., G. Johnson, Ph.D., N. Smithline, M.D., A. Milstein, M.D.. M.P.H., New England Journal of Medicine, 1992, vol. 327; 1502-1506)

The complexity of self-referral law and the rapid changes in the health care market may require clarification of self-referral legislation in order to assist with compliance. However, Congress must not eviscerate the intent and strength of the original legislation in the name of "clarification" or "streamlining." In particular, Congress should not eliminate vital reporting requirements or delete entire segments of the designated health services currently in the legislation.

Sincerely,

Diane Burke
American Federation of State, County and Municipal Employees

Leon Shull
Americans for Democratic Action

Jeff Jacobs
American Public Health Association

Arthur Levin
Center for Medical Consumers

Judith Stein Hull
Center for Medicare Advocacy

Cathy Hurwit
Citizen Action

Mern Horan
Consumer Federation of America

Gail Shearer
Consumers Union

Sandra Harding
National Association of Social Workers

Laura Wittkin
National Center for Patients Rights

Martha A. McSteen
National Committee to Preserve Social Security and Medicare

Linda Golodner
National Consumers League

Jon Lawniczak
National Council of Senior Citizens

Blair Horner
New York Public Interest Research Group

Charles Inlander
Peoples' Medical Society

Lauren Dame
Public Citizen's Health Research Group

Ned McCullough
Service Employees International Union

Patrick Conover
United Church of Christ, Office for Church in Society

Anne Werner
United Seniors Health Cooperative

Edmund Mierzwinski
U.S. Public Interest Research Group

STATEMENT
OF THE
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

The American Occupational Therapy Association (AOTA) appreciates the opportunity to submit testimony on the physician self-referral prohibitions of the Social Security Act as passed under the Omnibus Budget Reconciliation Act of 1989 and 1993, particularly as they affect the delivery of occupational therapy to Medicare and Medicaid recipients.

AOTA represents the interest of over 50,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. Occupational therapy practitioners provide critically important services to millions of people of all ages each year -- including Medicare and Medicaid beneficiaries -- in hospitals, nursing facilities, outpatient rehabilitation clinics, psychiatric facilities and school systems; through home health agencies and the offices of independent practitioners.

The treatment goals of an occupational therapy practitioner focus on promoting independence, preventing further disability and maintaining wellness. Individuals experience a variety of functional problems relating to aging or health problems such as heart disease, cancer, arthritis, stroke or Parkinson's disease. The therapist's interventions are designed to assist individuals in overcoming or adapting to limitations imposed by their illness or injury.

In 1993, Congress expanded the ban on physician self-referral to include occupational therapy services. Excessive utilization associated with self-referral arrangements, supported by strong empirical data, was the basis for extension of the physician self-referral ban to a range of designated health services including occupational therapy services.

AOTA strongly supports the efforts of Congress through this federal self-referral legislation to eliminate opportunities for inappropriate utilization of health care services driven by economic incentives rather than medical necessity. We commend Congress for condemning unethical practices of physicians who abuse their patients' trust for personal financial gain.
We encourage this Subcommittee not to retreat from this important public policy, but rather to work for its implementation and strong enforcement.

Frustrations expressed regarding ambiguity of the law must be dealt with swiftly. We encourage timely promulgation and implementation of the necessary regulations to assist physicians in complying with this law. Implementation of this important public policy is now more important than ever in light of increased fiscal pressures on all levels of government to cut program costs. In 1993, the Congressional Budget Office projected a cost savings of $350 million over a five-year period by enacting a prohibition on physician self-referral for designated services provided through the Medicare and Medicaid programs.

Several Studies Support Findings of Abuse

The prohibitions, enacted by Congress, were the result of several studies on physician self-referral. Since 1989, ten major studies have appeared in professional literature, including the New England Journal of Medicine and the Journal of the American Medical Association, supporting findings of excessive utilization of designated services by consumers referred by physicians who own or invest in these services.

One of the first studies on physician ownership and compensation from health care entities to which they make referrals was mandated by Congress in 1988, and conducted by the Department of Health and Human Services (DHHS) Office of the Inspector General (OIG). Findings indicated that patients of referring physicians who own or invest in clinical laboratories received 45 percent more such services than all Medicare patients in general. The OIG estimated this projected increase in utilization to cost the Medicare program $28 million in 1987 and projected costs of $103 million in 1995.

A 1992 study of California Workers' Compensation program conducted by William M. Mercer, Inc. found that if an injured worker received initial treatment from a physician with an ownership interest in rehabilitation services, that patient received a referral for therapy 66 percent of the time compared to a referral rate of 32 percent from physicians with no ownership interest in rehabilitation facilities. Findings from the study showed that the added incentive for investing physicians to refer to rehabilitation therapy generated approximately $233 million per year in services delivered for economic rather than clinical reasons.

Other studies also demonstrate abuses in the delivery of occupational therapy and other rehabilitation services. Physician referral abuses were also found in a 1989 study mandated by the Florida legislature and conducted by the Florida Health Care Cost Containment Board ("Board") to examine the impact of physician joint ventures in health care services on the cost, quality, and access to health care in Florida. Physician-owned physical therapy facilities provided 43 percent more visits per patient and generated 31 percent more revenue per patient. Thirty five percent more therapy visits were provided per patient in physician-owned rehabilitation facilities. A subsequent 1991 study by the Board found that physician self referral resulted in an additional $500 million in health care costs in just one year.

Physician Referral Laws Promote Competition and Patient Choice

The potential effects physician investment arrangements can have on quality of care, utilization of services, patient choice and competition between those who provide health care services must be scrutinized. Patients may not be referred to the facility that can provide the optimum level of services or quality of care. Rather patients may be referred for costly services that are unnecessary or excessive, and competition can be undercut when health care service providers are compelled to compete not on the basis of quality or price but on financial remuneration that flows, directly or indirectly, back to the referral source. Because these arrangements hold such significant potential for patient abuse and fraudulent billing of third party payers, it is incumbent upon ethical practitioners to avoid any arrangements or circumstances in which patient referral are contingent, directly or indirectly, upon financial remuneration to the referral source.

Where referrals are controlled by those sharing profits, the medical marketplace suffers since new competitors can no longer win the business with superior quality, service or price. Patients are vulnerable in health care decision making because they lack the special knowledge required to judge the necessity for recommended care. The presence of illness or injury may make it difficult for the patient to engage in the type of self-protective bargaining behavior necessary to insure they are receiving all the information they need to consent to services. Self-referral presents an unnecessary conflict of interest that should be avoided in the health care industry. Directing the purchase of health services is something quite different from directing the purchase of other types of services.

Several Exemptions Recognize Existing Business Practices

Even though inappropriate utilization may occur, Congress nevertheless allowed for a number of exceptions to the law in recognition of existing business practices. Additionally exceptions can be created by the Secretary as long as these exceptions do not pose a risk of program or patient abuse. Considered among the 15 exceptions are the special concerns of rural providers and prepaid health plans.

The Department of Health and Human Services reports that many of these exceptions were specifically designed to accommodate the development of managed care plans, integrated delivery systems, and new health care networks which link doctors and hospitals. The OIG has testified that creating new, broad exceptions for managed care is difficult because the term "managed care" is not well-defined. Some "managed care" situations, like health maintenance organizations (HMOs) typically operate as prepaid plan where conditions of participation and rules of financing are well defined. HMOs typically remove physicians from financial incentives to refer patients to other ancillary services. But in the case of a preferred provider organization (PPO) arrangement, physicians and ancillary service providers may agree to accept a lower price for their services than those providers who are not part of the network, but these PPO physicians may also be owners of a rehabilitation service center, which is also part of the PPO network, and gain profits from referring patients to this entity. AOTA believes it is important to be aware of an attempt to disguise inappropriate economic gain under the claim of efficient use of health care dollars in various "hybrid" approaches to managed care.

The in-office ancillary exception exempts physicians (both group and solo practitioners) with ownership and/or compensation arrangements from the self-referral ban for most services provided in their offices if they meet a set of requirements. Included among these requirements is "direct supervision" of services rendered to patients. Recommendations have been made to replace this requirement with a "general supervision" requirement. AOTA opposes amending the physician supervision requirement. A loosening of supervision requirements can only exacerbate a circumstance which currently exists that allows unqualified personnel to render substandard care. Specifically, an OIG study found that rehabilitation services conducted by employees of a physician's practice, and billed to the physician's Medicare number, did not amount to appropriate rehabilitative care by qualified individuals in four out of five cases, resulting in $47 million in inappropriate Medicare payments in 1991.

Rather, AOTA strongly recommends extending current Medicare certification requirements, which apply to independently practicing occupational therapists, to physician offices which provide occupational therapy. Currently, all Medicare-certified providers, except physician offices, must meet specific certification requirements for providing occupational and physical therapy services. The OIG study estimated a cost savings of at least $235 million over five years if the same certification guidelines are applied to physicians.

AOTA is opposed to proposals to eliminate occupational therapy from the list of designated health services under the current statute. Numerous studies have shown overutilization of rehabilitation services in which physicians have a financial interest leads to a significantly higher cost to the payer. A comprehensive list of designated services prevents physicians from substituting some services for others that would not fall under the statute. Suggestions that inclusion of a service on the list of designated services can lead to underutilization because the patient's condition goes untreated suggests that physician's simply won't refer patients for appropriate care unless they have a financial incentive to do so.

Similarly, these provisions do not prevent physicians from investing in and owning rehabilitative care services, such as occupational therapy centers, as a growing area of the health care market. But we believe it is reasonable to provide some assurances to consumers that physicians will not misuse their referral powers for profit. This law provides assurances that investment and ownership interest will not impede good medical judgment. AOTA does not support extending the exceptions to physician ownership in hospitals to include ownership in other facilities.

AOTA opposes eliminating the reporting requirements under this law. This information is pivotal to ensuring compliance with the law and these reporting requirements are reasonable and necessary as demonstrated by the findings in the self-referral studies. Eliminating reporting requirements will gut the ability to monitor and enforce the law. We also oppose exemption of state laws governing physician ownership and referral.

Conclusion

As Congress attempts to control rapid escalation in health care costs including federal Medicare and Medicaid costs, it seems counterproductive to allow self-referral practices. With Medicare insolvency imminent, it is irresponsible to repeal a law that can save the Medicare program money.

The Association and our 50,000 members are committed to providing the public with quality occupational therapy services in a cost-effective manner. We applaud efforts to ensure proper utilization of health care services and the delivery of quality care by appropriately trained health care professionals. We will support and work to secure Congressional approval of constructive proposals to achieve those ends. We believe these physician-self referral laws demonstrate a willingness on the part of policymakers to focus on these important goals of promoting competition and providing necessary, quality care while protecting taxpayers against unnecessary health care costs.

We appreciate the opportunity to submit this statement for the record, and look forward to working with the Subcommittee on the issue of physician self-referral.

STATEMENT OF THE AMERICAN PHARMACEUTICAL ASSOCIATION

The American Pharmaceutical Association (APhA), the national professional society of pharmacists, is pleased to present this statement in support of existing restrictions on the ability of physicians to refer patients to other health care providers in which they have a financial interest. The profession of pharmacy is the third largest health care profession with over 170,000 pharmacy practitioners, pharmaceutical scientists and pharmacy students. Over two billion prescription orders are written by physicians and dispensed by pharmacists each year. Our members have a direct and significant interest in the issue of physician self-referral.

APhA believes the original objective of Congress in enacting the limitations on physician self - referrals was and remains valid. There was ample evidence that the practice of self-referral presented clear financial conflicts of interest for physicians and resulted in increased utilization of a wide range of health care services and substantially increased health care costs. APhA supported the self-referral provisions applicable to Medicare beneficiaries and Medicaid recipients that were included in the Omnibus Budget Reconciliation Acts (OBRA) of 1989 and 1993. Although we realize that this area of law, especially when considered along with federal rules relating to the anti-fraud and abuse statutes, is highly complex and may require simplification, we support retaining the existing framework of the self-referral provisions. Congress must not retreat from the legitimate problems that it sought to address when it enacted OBRA '89 and '93.

We specifically ask your Committee to retain outpatient prescription drugs as a designated service to which the restrictions on physician self-referral apply. It is important to clarify that nothing in the existing law precludes physicians from dispensing prescription drugs to their patients if authorized to do so by state law.

The law does - and we believe properly - limit the ability of physicians to buy or otherwise have a financial interest in pharmacies. During the late 1980's, groups of physicians formed companies and bought pharmacies to which they referred their patients. These companies were sophisticated corporate entities that would identify one, two or perhaps three pharmacies in a community, recruit physicians in the community as investors and encourage referral to only those pharmacies which the corporation had purchased. The impact on other pharmacies in the community was both immediate and dramatic. Some pharmacies were driven out of business; others simply lost a significant number of their regular patients. A number of states enacted laws prior to 1993 prohibiting physicians from having an ownership interest in pharmacies. We do not want these kind of enterprises to resurface as they almost certainly will if pharmaceuticals are removed from the list of designated services under federal law.

The issue is not simply one of unfair economic competition. Our concern is also a matter of overutilization, increased costs to the health care system and to patients themselves and the potential threat to the best health care interests of the patient. Over three-fourths of all patient visits to physician offices result in the issuance of a prescription - a much higher proportion than any other ancillary service a physician may order. Thus, the potential abuse in terms of utilization and higher costs is greatest in the absence of restrictions of physician self-referral with respect to prescription drugs.

Where a pharmacist is employed in a pharmacy owned by physicians and where many, if not most prescriptions orders are written by the "owners", the ability of the pharmacist to make an independent assessment of the appropriateness of the prescribed medication therapy and to effectively consult with the prescriber may be compromised. In addition, our previous experience with those pharmacies that were physician-owned demonstrated that they usually stocked a less representative range of medications (typically brand name drugs rather than generic drugs) than non-physician owned pharmacies resulting in higher costs to third party payors and patients paying out-of-pocket. Our past experience also demonstrated that some physician-owned pharmacies refused to accept Medicaid and Medicare patients because of burdensome paperwork and reimbursement limitations, thus severely limiting access by patients who have the greatest need for the widest range of prescription drugs.

Pharmacists are the most knowledgeable health care professional with respect to drugs. They are also the most accessible of all health care professionals; the equivalent population of the United States goes into a pharmacy each week. Pharmacists are also selected as the most honest and trusted professionals year after year in the annual Gallup poll of twenty five professions. Pharmacists play a vital role in counseling patients and monitoring and managing their medication therapy. APhA does not want the important role that pharmacists have in the health care delivery system placed in jeopardy. We urge the Committee to retain outpatient prescription drugs as part of the list of services to which the existing self-referral limitations apply and to proceed with caution in considering revisions to the law.

APhA appreciates the opportunity to submit this statement and looks forward to working with the Committee on the issue of physician self-referral of outpatient prescription medication services.

Statement of the

AMERICAN SOCIETY OF ECHOCARDIOGRAPHY

The American Society of Echocardiography ("ASE") is a professional organization consisting of over 5,000 cardiologists, internists, pediatricians, anesthesiologists, surgeons, and cardiac sonographers dedicated to the pursuit of excellence in echocardiography. ASE membership bridges specialty and subspecialty barriers, and ASE is therefore able to provide useful input in a wide variety of situations where echocardiography and Doppler are used in the clinical decisionmaking process.

Over the past decade, ASE has been closely interactive with the Health Care Financing Administration ("HCFA") in the development and implementation of policies regarding coverage and reimbursement for echocardiographic and Doppler methods. Accordingly, ASE's membership is very interested in the physician self-referral law (commonly known as the "Stark Bill"), and in resolving the confusion that has arisen concerning whether echocardiography services may properly be considered a "designated health service." ASE requests that these comments be considered by the Committee and be made part of the record of its May 3 hearing.

Congress recently enacted a Medicare technical amendments bill (H.R. 5252), which revised several of the definitions of designated health services. As you know, Congress revised the category of designated health services relating to radiology services to clarify that the only diagnostic services covered under this category of designated health services are those that are radiology-related.

ASE understands that HCFA intends to include echocardiography as a designated health service under the category of "radiology services." ASE strongly disagrees with this position and believes that HCFA's apparent conclusion that echocardiography services are a subset of radiology services is wrong. Echocardiography services clearly and simply are not radiology services. Thus, we recommend that the Stark Bill be amended to either eliminate radiology services from the list of "designated health services" or clarify that services performed by non-radiologists (such as echocardiography services) are excluded from the Stark Bill's self-referral restrictions.

The most obvious evidence demonstrating that echocardiography services are not radiological services is the separation of the CPT codes for radiology services and echocardiography services in the American Medical Association's Manual of Current Procedural Terminology (the "Manual"). The CPT codes for radiology services (see CPT Codes 70010 - 79999) are listed in their own section of the Manual, while the CPT codes for echocardiography services (see CPT Codes 93307 - 93350) are listed in the "medicine" section of the Manual. This separation demonstrates that the medical community does not view echocardiography services to be a subset of radiology services.

Equally obvious and telling is the fact that echocardiography services are nearly always provided by cardiologists and cardiac sonographers, not by radiologists and general sonographers. In fact, in 1992, radiologists were responsible for only 2% of roughly $600 million in Medicare allowable charges for echocardiography services. Further, echocardiography is nearly always performed in cardiology departments, not in radiology departments. These distinctions are consistent with the separation of the echocardiography and radiology CPT codes in the Manual.

Of additional importance, nearly all research conducted and literature published in the specialty of echocardiography is attributable to cardiologists, not radiologists. This serves as yet further proof that echocardiography is, in fact, not viewed as a radiology-related service. Furthermore, although training in echocardiography is an American College of Cardiology-mandated component of all training programs in cardiology, this is by and large not true for radiology training programs. Consequently, echocardiography should not be viewed as a designated health service by HCFA under the category of radiology services.

Finally, ASE supported the revisions to the physician self-referral restrictions that appear in the Medicare technical amendments bill recently enacted by Congress. One of

these revisions was the elimination of the phrase "other diagnostic services" from the category of radiology-related designated health services. Thus, in enacting this amendment, Congress made it clear that the self-referral prohibition applies only to diagnostic services that are radiology-related. Historically, echocardiography has been treated by HCFA as a "diagnostic service" unrelated to radiology. In light of HCFA's historical treatment of echocardiography as a general diagnostic service and Congress' amendment to the Stark Bill to eliminate reference to "other diagnostic services," we believe that HCFA has no legal authority to treat echocardiography services as designated health services under the category of radiology services.

In sum, ASE believes that echocardiography services clearly are not radiology-related. Accordingly, ASE requests that Congress prevent HCFA from applying the Stark Bill's self-referral provisions to echocardiography services. Congress can accomplish this objective in the following ways:

- First, by amending the Stark Bill to exclude radiology services from the list of designated health services;

- Second, by explicitly excluding echocardiography from the category of radiology services in the list of designated health services; or

- Third, by clarifying that services performed by non-radiologists, such as echocardiography services, are excluded from the category of radiology services in the list of designated health services.

Thank you for your consideration of these views of ASE. If you have any questions concerning these important issues, please do not hesitate to contact ASE's legal counsel, Diane Millman, at (202) 778-8021.

American Urological Association, Inc.
1120 North Charles Street · Baltimore, Maryland 21201-5559
Fax: 410-223-4375 · Phone: 410-223-4310

Statement to the
House Ways and Means Committee
Health Subcommittee
on **Physician Self-Referral**
May, 1995

The American Urological Association represents 8,500 urologists in the U.S. We appreciate this opportunity to express our views on the current provisions regarding physician self-referral under the Medicare statute. Referral of patients to facilities for the sole financial gain of physicians is not acceptable; however, "Stark II" appears to go too far and restricts reasonable arrangements as well as fraud and abuse.

We recommend that the "Stark II" self-referral provisions be modified to allow for reasonable accommodations for cost-effective and efficient sharing of equipment, utilization of specialized equipment, and certain dispensing of durable medical equipment.

"Stark II" covers a very broad area, involving many physician modes of practice that have been in place for years, despite little if any evidence that these specific arrangements promote inappropriate behavior or result in significant additional costs to the Medicare program. The data originally cited to enact the bans in "Stark II" are several years old and of limited scope or applicability to current concerns.

Further, these provisions prevent physicians, hospitals and other health care providers from developing economical alternatives to promote cost effective care, such as integrated networks. The pressures of managed care in the private sector and the Medicare program require a greater degree of flexibility to respond to financial constraints than is permitted under "Stark II."

Urologists, like other physicians, have pooled their resources to acquire expensive equipment which they share, realizing more cost savings than if each had purchased their own.

Urologists typically provide their patients with incidental pieces of equipment that are covered by Medicare as durable medical equipment (DME) or prosthetic devices. The potential interpretation of "Stark II" restrictions on providing such equipment and devices have caused considerable confusion and led many physicians to discontinue providing these needed services to their patients. Physicians should be allowed to dispense these items for the convenience of the patients and not for profit.

Similarly, shock wave lithotripsy (SWL) is often performed by the urologist in a hospital outpatient department or in free-standing centers. "Stark II" would permit some urologists to refer their patients to SWL centers in which they have a financial interest, but is unclear on others. The American Lithotripsy Society presented additional information on the need to clarify these provisions in its testimony to the Subcommittee.

The American Medical Association and the Medical Group Management Association have also presented specific recommendations for modifying "Stark II" with which the American Urological Association agrees in principle.

In summary, the American Urological Association urges Congress to consider amending the Medicare physician self-referral provisions to clarify and allow greater flexibility in sharing equipment, utilizing specialized equipment, and in providing durable medical equipment and prosthetic devices.

Thank you.

Jordan J. Cohen, M.D.
President

AAMC

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

2450 N STREET, NW
WASHINGTON, DC 20037-1124
TELEPHONE 202-828-0460

May 17, 1995

Mr. Phillip D. Moseley
Chief of Staff
Committee on Ways and Means
United States House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Mr. Moseley:

The AAMC represents the 125 accredited United States medical schools, nearly 400 major teaching hospitals, over 90 academic and professional societies, and the nation's medical students and residents. I commend you for convening a hearing to receive testimony about the Stark self-referral laws and appreciate the opportunity to express my concerns about the current law and make suggestions for ways in which it can be improved.

The AAMC supports efforts to ensure that physicians do not refer patients to entities in which they have an ownership interest. The first Stark law was passed as a result of studies that showed that fraud and abuse is most likely to occur when there is an ownership interest. However, the present law - even for the vast majority of the medical community who agree with its intent and seek to comply - is in some cases excessively constraining and complicated. The AAMC recommends the committee consider specific changes to the law as described below.

1. Physician Recruitment
One aspect of the law has a particularly negative impact on teaching hospitals, and the AAMC urges that it be changed. An exception is currently provided in the law for physician recruitment "in the case of remuneration which is provided by a hospital to a physician **to induce the physician to relocate to the geographic areas served by the hospital** in order to be a member of the medical staff of the hospital. . .:" (emphasis added) It is a common practice for a teaching hospital to wish to recruit residents from outside its immediate geographic area. In some instances these hospitals wish to retain their individuals as members of their medical staffs upon completion of their training. Yet, because the exception applies only if a physician relocates to a new geographic area, some newly trained physicians recruited by teaching hospitals risk violation of the law if the recruitment involves even otherwise reasonable inducements. This probably is an unintended consequence of the law and should be corrected.

The additional comments that follow are of a more general nature and affect many practices of both teaching and non-teaching institutions and physicians.

2. In-Office Ancillary Exception
The exception for in-office ancillary services currently requires that services be furnished personally by the referring physician, a physician who is a member of the same group practice as the referring physician, or by individuals who are directly supervised by the physician or another physician in the group practice. The AAMC suggests that the direct supervision requirement be deleted and replaced with a requirement for general supervision. This would assure that the referring physician, or another physician in the same group, is available if necessary but does not need to provide direct supervision. Many health care professionals - including nurses, physician assistants and nurse practitioners - have the training and experience to provide ancillary services without direct physician supervision.

3. Prepaid Plans
The exception for prepaid plans should be expanded to include state-regulated plans and Medicaid plans.

4. Community Need Exception
The AAMC recommends that the law be amended to add a community-need exception for the medically-undeserved areas, whether in inner-city areas or rural locations. For instance, this type of exception might permit underserved communities to join together to purchase medical equipment that would not otherwise be available to residents in these areas.

5. Rental of Office Space; Rental of Equipment
The exceptions for rental of office space and rental of equipment provide that the leases must be for a term of at least 1 year. While we understand the possibility for abuses in the case of short term leases, the current law makes it virtually impossible for a contract to contain a clause that would allow for termination in less than one year, even for good cause. No one should be placed in the position of having to comply with the physician self-referral law by continuing an agreement which has turned out to be a bad decision for one or both parties.

6. Definition of "Designated Health Services"

The AAMC suggests that Congress consider whether the list of designated health services (DHSs) is overly inclusive and should be reduced. For instance, certain services such as radiation therapy provide little chance for abuse. To keep such services as DHSs goes far beyond the intent of the statute and may result in the elimination of many traditional, non-abusive arrangements for delivering health care.

Thank you for your consideration of the Association's views. We would be pleased to work with you to ensure that abusive referral practices are stopped, while allowing the majority of physicians to provide high quality health care without the fear that they may inadvertently be violating the law. If you have any questions, please have a member of your staff contact Jeff Sanders at 202-828-0057.

Very sincerely yours,

Jordan J. Cohen, M.D.

CARETENDERS
HEALTHCORP

William B. Yarmuth
Chairman,
President &
Chief Executive Officer

TESTIMONY ON

PHYSICIAN REFERRAL RESTRICTIONS

BEFORE THE

HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

MAY 3, 1995

Caretenders Healthcorp is a leading provider of home and community-based health care services to disabled individuals of all ages. Our company specializes in comprehensive home health care and adult day health care and serves patients in seven states. Approximately 36 percent of our current revenues is from serving Medicare beneficiaries.

Section 1877 of the Social Security Act, the so-called "Stark I and II" provisions, is intended to prohibit physicians from overutilizing designated health services in which they have a financial interest.

We are supportive of the intent and principles of the law; especially since it is now in effect and providers have made changes to be in compliance. Furthermore, we obviously want to be in compliance with the law. The strict letter of the law, however, imposes high barriers to absolute compliance and stiff penalties for a designated health service provider and physicians for inadvertent non-compliance. The basic problem is that the scope of the law goes far beyond detectable investments by referring physicians.

Our dilemma in complying with Stark II is based on our situation as a publicly-traded company which is too big to know each of our owners every day and yet too small to be have at least $75 million in shareholder equity to qualify for the general exception for our stock. Many providers are in a similarly difficult position.

Our testimony will focus on three specific interrelated problem areas for inadvertent non-compliance and recommended modifications for each. The problems are the following:

1. "Zero tolerance" of any indirect or direct investment relationship
2. Overly broad application to investments of extended family members, and
3. Impractical monitoring of prohibited investors.

Our best recommendation for each of these problems is to use a five percent ownership threshold, already established for Medicare and Medicaid purposes in section 1124.

In addition, we urge a moratorium on Stark II enforcement until final regulations are published.

1. "Zero tolerance" of any indirect or direct investment relationship

The primary problem confronting a provider our size is that the scope of Stark II prohibits even insignificant, unknown and indirect investment or compensation by a referring physician or his extended family.

It is difficult enough to monitor direct stock ownership of physicians. Subsection (c) of 1877 makes exceptions to the ban on physician referrals for investments in companies that are publicly traded and whose stockholder equity exceeds $75,000,000, or mutual funds whose assets exceed $75,000,000. This provision was intended to recognize that investments in such large companies and mutual funds are not likely to affect either the financial performance of the company or the referral decisions of the physician-investor.

The aim of this exception is appropriate. However, it creates an uneven and perverse application of the law. The unreasonableness is obvious by looking at extreme situations. There is no problem if a physician owns 100 percent of a designated health service provider with more than $75 million in equity to which he refers patients but there is a big problem if his brother-in-law owns a small mutual fund which has one share of our stock.

Caretenders, with over $16 million in stockholders' equity and over $51 million in revenues in 1994, does not meet the threshold for exemption, yet there is essentially no financial benefit to us or a referring physician from any form of a relatively small investment.

Furthermore, Stark II goes far beyond direct stock ownership of physicians to encompass broadly-defined compensation arrangements and common forms of indirect ownership, such as stock held in "street name" with a brokerage firm, small mutual funds and investment clubs. In fact, most shares of our stock are held in street name.

Even "good faith" efforts on our part to know of Stark II prohibited relationships can not assure full compliance at all times. It should be noted that there is some appearance of reasonableness in the use of a "know or should know" standard for the imposition of civil money penalties for the submission of a claim for service when there is any such relationship with the referring physician under (g)(3). However, this "know" standard is not used so that we can be reimbursed for our cost in serving the beneficiary and is undermined by the absolute requirement under (f), described more fully below, to reporting any such prohibited relationship.

Recommended Targeting Modifications

We recommend that section 1877(c) be modified to focus the law more directly on situations where a physician-investor could significantly affect his or her income and the financial performance of the provider to which referral is made.

The critical distinction is not between companies with above or below $75 million equity. The more important distinction should be between significant financial relationships and insignificant relationship.

Clearly, a physician-investor who owns one share of a company's stock will neither base decisions on that ownership, nor have an impact on the financial performance of the company. However, a 100 percent ownership relationship between a physician (or immediate family member) and provider of designated health services with a 100 percent ownership relationship is inappropriate. The question becomes: where should one draw the line?

There is precedence in Medicare and Medicaid law to support a five percent threshold. Section 1124 of the Social Security Act requires that owners of five percent or more of a Medicare or Medicaid provider disclose their ownership to HHS and state Medicaid agencies. The five percent threshold dates to the Medicare and Medicaid Anti-Fraud and Abuse Amendments of 1977. Furthermore, the SEC requires individuals and companies to report any investments and investors of five percent or greater. Thus, from the Federal Government's perspective, there is precedence for ownership of five percent or more as being "significant" and a greater motive for fraud and abuse.

We recommend usage of the five percent ownership or investment threshold and submit that it is sufficient to identify those physician-investors and providers who stand to gain from referrals.

A good, but less valid, alternative would be to ease the shareholders' equity threshold for the publicly-traded company exception. Specifically, we recommend setting the threshold no higher than $15 million. If such a threshold approach was used, consideration could also be given to allowing a revenue test as another way to qualify for the exception. An exception based on annual revenues is a simpler and more accurate assessment of a company's size and therefore, the likelihood that one physician could have a significant financial impact. A revenue amount, such no higher than $45 million (three times our recommended equity amount) would seem reasonable.

In addition, the "know" standard should be applicable for purposes of the provider being reimbursed for the cost of services rendered in "good faith."

2. Overly broad application to investments of extended family members

Few Members of Congress or potentially affected physicians and providers of designated health services realize that another way the scope of Stark II goes far beyond detectable investments by referring physicians is to stretch in financial relationships involving "immediate family." There is reason to believe that the regulatory definition of immediate family could reach to in-law and step-relationships, which sounds more like extended family.

For purposes of Stark I, the Health Care Financing Administration has proposed that immediate family means the following:

> "husband or wife; natural or adoptive parent, child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild."

Recommended Targeting Modifications

To address this problem we recommend an "either-or" modification. For purposes of a provider being reimbursed for services rendered in "good faith," either target the scope of Stark II to physician relationships or use a de minimis standard, such as our recommended five percent ownership threshold, regarding a reasonable list of family relationships.

3. Impractical monitoring of stockholders

For any provider our size, it is impossible to know the identity of every stockholder, at all times. Yet, section 1877(f)(2) imposes a "zero tolerance" requirement that we report, for every occurrence, the following:

> "the names and unique physician identification numbers of all physicians with an ownership or investment interest...or with a compensation arrangement...in the entity, or whose immediate relatives have such an ownership or investment interest or who have such a compensation relationship with the entity."

As we mentioned above, Stark II goes far beyond direct stock ownership of physicians to encompass broadly-defined compensation arrangements and common forms of indirect ownership, such as stock held in "street name" with a brokerage firm, small mutual funds and investment clubs.

Shareholder registration does not indicate the occupation and family relationships of an investor. Furthermore, Caretenders cannot know the name, occupation, and relationships of every person who invests in a small mutual fund that holds Caretenders stock. Securities law allows an individual to withhold his or her name as owner of a stock. These owners are called objecting beneficial owners.

The onus should be on a physician-investor to know and comply with the law. We submit that a written notice, at least annually, by each company to each of its referring physicians

would constitute a reasonable effort to alert physicians to the law.

Recommended Targeted Modifications

We recommend two modifications to the law that, implemented together or alone, would better target the effect of the law and reduce unreasonable and impractical requirements.

Our best recommendation for this problem is the five percent ownership threshold. Specifically, we recommend modifying 1877(f)(2) in the following manner (current language is *italicized*; added language is in **bold**; deleted language is ~~stricken~~):

> *the names and unique physician identification numbers of all physicians with* ~~an~~ **five percent** *ownership or investment interest....*

At a minimum, the "know" standard should be used to reasonably hold providers liable for reporting prohibited physician relationships under Stark II.

Moratorium needed on Stark II enforcement until final regulations are published

It has been almost two years since "Stark II" was passed. Yet, HCFA has not even proposed implementing regulations that define the specific policies associated with Stark II. However, on March 31, 1995 the Office of Inspector General at the Department of Health and Human Services published a final rule with a comment period that sets forth the civil money penalty, assessment and exclusion provisions that will be imposed for violation of Stark II.

It should be emphasized that HCFA has not even finalized regulations for Stark I, enacted in 1989!

There are a number of areas where the law is unclear; providers need guidance from HCFA to be certain they are in compliance with its provisions. We urge the Congress to legislate a moratorium on enforcement of "Stark II" until such time that a final rule is published.

STATEMENT
OF THE GROUP HEALTH ASSOCIATION OF AMERICA
ON SELF-REFERRAL
FOR THE RECORD
WAYS AND MEANS HEALTH SUBCOMMITTEE

Group Health Association of America (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 strongly supports efforts to eliminate unnecessary costs from the health care system. Through the efficient use of resources, HMOs have been leaders in making quality health care more affordable. Because fraudulent activities can undermine these achievements, our member HMOs are committed to continuing their active participation in efforts to prevent, identify, and end fraud and abuse. It is important to recognize, however, that laws designed to curb fraudulent activities in the fee-for-service sector, such as the self referral law, can unintentionally inhibit legitimate HMO activities.

The self-referral law was drafted in response to abuses in the fee-for-service system in which physicians can benefit financially from unnecessary referrals. Because HMOs combine the financing and delivery of health care services, they are in a unique position with regard to the self-referral law. Consequently, HMOs are structured in a way which mitigates against unnecessary referrals. While the health care system has evolved to include integrated delivery systems, the self-referral law does not recognize this development. As a result, the current self-referral law inhibits cost-effective forms of integration.

The challenge for lawmakers is to revise the self-referral law to prevent fraudulent activities while allowing for innovation and cost-effective integration in the health care system.

GHAA's statement includes:

- an explanation of the distinguishing characteristics of incentives inherent in HMO and fee-for-service health care delivery;
- the detrimental impact of current self-referral laws on HMOs; and
- GHAA's interest is refining the self-referral law to focus narrowly on its goal of preventing overutilization motivated by financial incentives.

Different Incentives under Fee-for-Service and HMOs

The self-referral[1] law was designed to prevent over-utilization of services under the fee-for-service Medicare and Medicaid programs. The premise of the law is that fee-for-service payment inherently creates incentives to provide services beyond those medically necessary in order to increase providers' incomes. However, by their very design, HMOs have systemwide incentives such as quality assurance programs and financial incentives that mitigate against over-utilization. Although the self-referral law was conceived as a cost-saving measure which would prevent fee-for-service practices that improperly increase program expenditures, it has unintended consequences when applied to HMOs. Because the law is broadly written, it prohibits HMO arrangements that provide incentives to provide quality, cost effective care in addition to fraudulent practices that increase costs and result in lower quality care.

---

[1] 42 USC 1395nn

HMOs commonly pay providers on an at-risk basis, under which at least a portion of the provider's payment is fixed regardless of utilization. This type of payment mechanism removes incentives for over-utilization. However, these arrangements have led to concern by some that under managed care, unscrupulous providers would be incented to under-provide care in order to profit.

Under-utilization, defined as the failure to provide medically necessary services, clearly constitutes a breach of contract between an HMO and a provider who has agreed to provide health care services in exchange for compensation. Under-utilization also may constitute malpractice when failure to provide health services results in injury.

HMOs have a vital interest in ensuring that under-utilization does not occur. Research studies consistently indicate that HMOs' cost effective care is also high quality care.[2] HMOs carefully structure financial arrangements with providers to promote high quality care and to minimize the impact of individual high-cost patients on providers' payments. To limit incentives to under-utilize, financial risk is spread over groups of providers and/or patients so that costs associated with services needed by an individual patient have little impact on an individual providers payment. In addition, high-risk conditions or high-cost patients often are carved-out of any financial risk compensation arrangement to ensure that providers receive appropriate payment for needed services. Stop-loss insurance or reinsurance also may be provided to ensure that providers' payments do not fall below the level necessary to cover the cost of providing medically necessary services. Finally, rarely is risk-based compensation to a physician based on utilization alone. Other common payment factors include patient satisfaction and quality of care.

Even when HMOs compensate providers on a fee-for-service basis, incentives within the organization mitigate against over-utilization. HMOs providing Medicare and Medicaid services are required to have quality assurance programs and undergo external quality reviews. Through these quality reviews, unusual patterns of utilization may be identified and addressed and best practices are shared and promoted.

HMOs and the Self-Referral Law

Under the physician self-referral ban, physicians are prohibited from making a referral to an entity for the furnishing of eleven designated health services if the physician, or an immediate family member of the physician, has a financial relationship with the entity.[3] A financial relationship includes ownership or investment interests, as well as compensation relationships. The list of eleven designated health services includes broad categories such as inpatient and outpatient hospital services, radiology, and clinical laboratory services.

While the self-referral law provides exceptions for HMOs with Medicare risk or cost contracts and federally qualified HMOs, these exceptions are not broad enough. Other HMOs are subject to scrutiny under the self-referral law because the laws apply to any payments made by Medicare or Medicaid. All HMOs that are not federally qualified or do not have a Medicare contract are subject to scrutiny under the self-referral law since there is no exception for Medicaid contracts and all HMOs are likely to have Medicare beneficiaries enrolled through employer group contracts (e.g. working aged and retirees). HMOs with beneficiaries enrolled

---

[2] *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).

[3] 42 USC 1395nn

under such group contracts provide services for which Medicare is a secondary payor.

As the health care system moves toward more cost-effective mechanisms for the delivery of care, the development of vertically integrated systems has increased. Vertically integrated HMOs, which own designated health service entities such as labs and radiology facilities, offer such services directly when it is more economical than contracting for the services with an outside provider. Such organizations also may offer physicians a financial stake in the cost-effective practice of medicine through an ownership interest in the HMO. As explained earlier, the structure of financial incentives in HMOs provide no motive to over-refer for profit. Nonetheless, under the self-referral law, organizations with any degree of physician ownership cannot own designated health services unless they are section 1876 cost or risk contractors or federally qualified HMOs. Only half of the currently state licensed HMOs are federally qualified, and with the sunset of the employer mandate provision[4] of the HMO Act later this year, there will be less incentive for HMOs to seek federal qualification.

The self-referral law also creates problems where physicians have only contractual arrangements with an HMO that is subject to the law. Any provider agreement could be considered a compensation arrangement and therefore subject to scrutiny under the self-referral law unless it is otherwise exempt. Once a physician has a compensation arrangement with an HMO which is subject to the law, referrals to designated health services owned by the HMO are precluded unless the compensation arrangement complies with the physician incentive requirements.[5] These requirements, intended to address *under-utilization,* have the effect of limiting the amount of risk which physicians can accept for referrals. As a result, if an HMO operates, for example, a laboratory or radiology facility as a line of business, the contracting physician cannot refer to that entity unless his or her compensation arrangement meets the guideline of the, as yet, unpublished rule.[6]

Conclusion

In order to contribute effectively to controlling health care costs, self-referral and other fraud and abuse laws must recognize the evolution in health care delivery away from fee-for-service medicine and toward HMOs and other integrated delivery systems. HMOs achieve cost savings and ensure quality by keeping referrals within the HMO system. The self-referral law should be amended to protect legitimate, cost-effective arrangements for the delivery of quality care that do not have the potential to violate the underlying purpose of the statute -- to prevent increased Medicare and Medicaid costs due to over-utilization.

---

[4] 42 USC 300e-9

[5] 42 USC 1395mm (i)(8).

[6] 57 FR 59024 (December 14, 1992).

TESTIMONY OF THE JOINT COUNCIL OF ALLERGY, ASTHMA AND IMMUNOLOGY ON PHYSICIAN SELF-REFERRAL BEFORE THE SUBCOMMITTEE ON HEALTH OF THE HOUSE WAYS AND MEANS COMMITTEE

MAY 3, 1995

The Joint Council of Allergy, Asthma and Immunology ("JCAAI") appreciates this opportunity to present its views on the prohibitions on physician self-referral. JCAAI is an organization whose sponsors are the American Academy of Allergy, Asthma and Immunology and the American College of Allergy, Asthma and Immunology. It represents the interests of over 4,000 physicians Board certified in allergy and immunology.

JCAAI agrees that the problems with the current physician self-referral law identified by the Medical Group Management Association, the American Medical Association, and other organizations merit this Committee's careful review. In particular, JCAAI urges the Committee to consider reform in the following two areas, which have a particularly adverse impact on the practice of allergy and immunology and which, in our view, have no sound policy rationale.

Restrictions on Physician Compensation Formulas

JCAAI believes that the restrictions on physician compensation arrangements included in the definition of group practice should be eliminated. This provision has a particularly adverse effect on allergists practicing in multi-specialty groups and actually discourages allergists from joining medical groups. Most multi-specialty groups provide some designated health services through the office and, as such, must meet the law's exception for in-office ancillary services, which includes the compensation restriction prohibiting physicians in the group from being compensated based on the volume or value of their referrals. "Referrals" includes not just designated health services but any service the physician orders but does not perform. Thus, even though allergy injections and allergy skin testing are not designated health services under the law, if they are performed by a nurse, as they frequently are, they are "referrals" for purposes of the compensation test. This means that if the physician is practicing in a multi-specialty group, the allergist's compensation cannot include the revenue attributable to injections and skin testing which the allergist orders and supervises. In contrast, allergists practicing alone or in a group which does not provide designated health services need not be concerned with meeting the exception for in-office ancillary services, and thus the compensation test does not apply. This creates a disincentive for allergists to join groups and participate in more cost-effective practice arrangements.

We do not believe that Congress intended such a result when it passed the OBRA '93 amendments to the physician self-referral law. We further believe that the compensation test is an unwarranted intrusion by the federal government into traditionally private matters. Physicians practicing together in a group should be permitted to decide among themselves how they should be compensated. We urge this Committee to support the elimination of the compensation test. At the very least, we believe the compensation test should only be applied with respect to designated health services and not all "referrals."

Prohibition on Providing Durable Medical Equipment

Allergists often prescribe durable medical equipment ("DME"), such as nebulizers, for their patients with asthma, particularly children, and, on occasion, as a convenience to patients, allergists would make these items available through their offices. The OBRA '93 amendments to the physician self-referral law, which went into effect January 1, 1995, now prohibit this. We urge that this prohibition be eliminated and that physicians be permitted to provide DME items to their patients if they meet the criteria for the exception for in-office ancillary services.

Thank you for considering this statement. If you have any questions, please call our Washington counsel, Richard Verville or Rebecca Burke, at 202-466-6550.

April 28, 1995

Congressman Bill Thomas
Chairman of the subcommittee on Health
Ways and Means

Dear Congressman Thomas:

I wish to submit written testimony to your committee regarding the problem we are having with the "physician self-referral to a medical facility" part of the Omnibus Budget Reconciliation Act OBRA 1989.

I believe I speak for most nephrology (kidney disease physicians) in asking you and your committee to reconsider or at least promote an exemption to the broad meaning of the self-referral Act regarding nephrologists who own and operate acute dialysis facilities in hospitals. In this situation, if we admit a patient to the hospital because they are in need of acute dialysis (urgent dialysis), we are in effect self-referring. This legislation has paralyzed our ability to participate in cost-effective managed care arrangements.

I don't believe this is the intent of the legislation as the legislation was primarily presented to prevent fraud and abuse with physicians perhaps referring to laboratories, radiology facilities, some sort of investment that's really not in the purview of their specialty.

As you can see, acute dialysis is exactly what kidney physicians do. It is almost impossible to produce a fraud and abuse situation with the present Medicare/Medicaid set up for end-stage kidney disease. Any patient that is on chronic dialysis that needs to go to the hospital acutely automatically comes out of the pool of the chronic dialysis patients. The reimbursement for that particular patient is then withheld and physician compensation is actually taken out of the picture if the patient is referred to a hospital. It's actually to the physician's benefit to keep the patient out of the hospital rather than admit. It is only in the extreme necessity of illness where a patient must go to the hospital and dialyze. Again, this is what kidney doctors do. We must have control of the quality mechanisms for dialysis, the staffing mechanisms for dialysis, the timing mechanisms for dialysis, etc.,

etc. By disallowing us to own and operate these in-hospital facilities and not allow us to refer patients to these facilities, really limits the scope of nephrology to a significant extent.

More importantly, however, and the reason for this communication is the impossibility now of collectively bargaining with the payers. We are trying to form a single capitated system for all of kidney disease. We know this can be a very effective way for kidney physicians to participate in more cost-effective managed care arrangement.

As you can see, we need to be able to offer the whole package. We cannot offer a managed care system complete kidney coverage for a specified price if we are not allowed to deliver or have any say in the cost and delivery of the acute dialysis situation in the hospitals. As it stands before the self-referral system law was passed, we were able to dramatically impact cost-savings because we were able to cross train dialysis personnel. Our nursing personnel would dialyze both in the hospital and the out-patient facility. We were able to efficiently use time and equipment so that the entire package would benefit both the payer and the payee. It was becoming a very efficient system until this self-referral ban as taken literally went into effect. This has caused us to stop our negotiations with the managed care system, it has doubled our overhead and we are trying to figure out a way to remain competitive and still offer a very quality product. It is my feeling and the feeling, I think, of most health care providers and economists that by disallowing the physician/nephrologist to own and operate the acute dialysis facilities in the hospitals, the Federal Government is actually "cutting its own throat" so-to-speak as now we will have to double the equipment, the people, the time, etc. I urge you to consider an exemption for acute dialysis in the hospital setting. Please allow nephrologists to operate these facilities and use these facilities in the hospitals as part of their entire system. We are finding it impossible to have any meaningful dialogue with managed care systems because now a large chunk of the entire kidney picture has been removed.

Lastly, as far as fraud and abuse potential for self-referral for dialysis patients is concerned, I think this is a theoretic problem only. I understand Congressman Stark has had phone calls from people indicating fraud and abuse. I don't know the motives for these calls but I frankly think it is almost impossible to create such a system. The rule is so oppressive for so little benefit that it really should be dropped in the case of acute dialysis patients. The margin of profit ranges in the several dollar amounts. It would take thousands of patients to be dialyzed for a single physician to create any significant fraud situation by referring patients to a hospital where he has facilities inappropriately. There are so many Medicare safeguards and hospital administration rules about length of stay and admission criteria, especially to dialysis units that we in Minnesota frankly find it impossible to admit patients without first satisfying very strict guidelines and dialyzing patients again without strict guidelines. As you may be aware, HCFA itself has very strong guidelines regarding who may and may not dialyze.

Therefore, Congressman Thomas, I hope you will read and disseminate this letter. I think we nephrologists very much need an exemption regarding self-referral to physician owned and operated acute dialysis facilities that are presently working very efficiently, very economically in the community hospitals. We cannot offer a competitive package to our managed care systems. It has put us in a very awkward position as far as delivering the entire package of kidney disease and the potential for fraud and abuse - I honestly believe almost non-existent.

Can you imagine a carpenter not using his own tools or a truck driver not allowed to drive his own truck, etc. This fraud and abuse problem is not the same as a physician investing in some nonrelated type investment where the physician would only refer strictly to that lab or that radiology department. This is so entirely different. I hope you can help us as the managed care systems in Minnesota are very much interested in our giving them the complete package. As it stands now, I believe this would be against the law.

Sincerely,

Frank J. Tycast, M.D.
Kidney Disease and Critical Care
9144 Springbrook Drive
Minneapolis, MN. 55433

C. EVERETT KOOP, M.D.

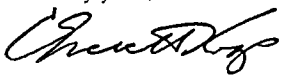
April 24, 1995

Subcommittee on Health
House Ways and Means Committee
Longworth House Office Building
Washington, DC 20515-6349

Dear Committee Members:

I have long been interested in banning physician self-referral for services provided to patients who are enrolled in the Medicare or Medicaid programs, and I would like to go on the record saying that I support the continued enforcement of the ban on physician self-referral for "designated services" provided under the Medicare and Medicaid programs, which went into effect on January 1, 1995.

Sincerely yours,



C. Everett Koop, M.D.
Surgeon General, U.S. Public Health Service (1981-89)

[illegible] 495-6003 FAX (301) 493-8160

LARKIN, HOFFMAN, DALY & LINDGREN, LTD.
ATTORNEYS AT LAW
1500 NORWEST FINANCIAL CENTER
7900 XERXES AVENUE SOUTH
BLOOMINGTON, MINNESOTA 55431-1194
TELEPHONE (612) 835-3800
FAX (612) 896-3333

JAMES P. LARKIN
ROBERT L. HOFFMAN
JACK F. DALY
D. KENNETH LINDGREN
GERALD H. FRIEDELL
ALLAN E. MULLIGAN
JAMES C. ERICKSON
EDWARD J. DRISCOLL
GENE H. FULLER
JOHN D. FULLMER
ROBERT E. BOYLE
FRANK I. HARVEY
CHARLES S. MODELL
CHRISTOPHER J. DIETZEN
JOHN R. BEATTIE
LINDA H. FISHER
THOMAS P. STOLTMAN
MICHAEL C. JACKMAN
JOHN E. GIEHL
JON S. SWIERZEWSKI
THOMAS J. FLYNN
JAMES P. QUINN
TODD I. FREEMAN
PETER R. BECK
GERALD L. BECK
JOHN B. LUNDQUIST
DAYLE NOLAN *
JOHN A. COTTER*
BEATRICE A. ROTHWELLER
PAUL B. PLUNKETT
ALAN L. WILDOW
KATHLEEN M. PICOTTE NEWMAN
MICHAEL B. LEBARON
GREGORY E. KORSTAD
GARY A. VAN CLEVE*
DANIEL L. BOWLES
TIMOTHY J. MCMANUS
TIMOTHY J. KEANE

ALAN M. ANDERSON
DONNA L. ROBACK
MICHAEL W. SCHLEY
TERRENCE E. BISHOP
LISA A. GRAY
GARY A. RENNERE
CHRISTOPHER J. HARRISTHAL
MICHAEL A. ROBERTSON
BRUCE J. DOUGLAS
WILLIAM C. GRIFFITH, JR.
JOHN J. STEFFENHAGEN
DANIEL W. VOSS
JOHN R. HILL
PETER J. COYLE
MICHAEL J. SMITH
VICKI R. INDE
DWIGHT N. HOLMES
ANDREW T. PERRIN
ANN M. MEYER
FREDERICK K. HAUSER III
LARRY D. MARTIN
JAKE E. BREMER
RENEE L. JACKSON
CHRISTOPHER K. LARUS
MARCY R. KREISMAN
MARIELLE PILLOLA
DAMON E. SCHRAMM
STEVEN J. KAMINSKI
RACHAEL A. JAROSH
AMELIA A. BUHARIN
THOMAS F. ALEXANDER
DANIEL T. KADLEC
SHARNA A. WAHLGREN

OF COUNSEL
WENDELL R. ANDERSON
JOSEPH GITIS

*ALSO ADMITTED IN WISCONSIN

May 1, 1995

Mr. 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

Re: Subcommittee on Health Hearing May 3, 1995, Concerning Self-Referral Provisions of the Social Security Act

Dear Mr. Moseley:

I am a health care attorney practicing in the Minneapolis area. I am actively involved in the American Bar Association and have appeared on several panels with representatives of governmental agencies dealing with antitrust, fraud and abuse, and the "self-referral" legislation (i.e., Stark legislation). I am writing on behalf of a radiation oncology group located in Minneapolis: Minneapolis Radiation Oncology, P.A. (MRO). I am submitting this statement for consideration by the Committee and for inclusion in the printed record of the hearing.

MRO has a staff of ten radiation oncologists and practices at seven radiation therapy facilities. Four of these facilities are owned by the physicians of MRO. The radiation therapy facilities that are owned by MRO typically have fee schedules that are substantially lower than those of radiation therapy centers owned and operated by hospitals. MRO has tremendously enhanced the quality of cancer treatment to patients in Minnesota and at the same time has made such treatment more cost effective.

ISSUE

The Stark legislation (42 U.S.C. § 1395nn) prohibits a physician or immediate family member of a physician to refer to an entity for the furnishing of radiation therapy services if such physician or family member has a financial interest in such entity. Your May 3rd hearing is intended to examine problems associated with compliance with the Stark legislation. The issue raised here is the prohibition of a medical oncologist to refer a patient for radiation therapy treatment to an entity in which such oncologist's immediate family member may have a financial interest.

CURRENT LAW

The prohibition found in 42 U.S.C. § 1395nn(a)(1) and the definition of a "financial relationship" found in 42 U.S.C. § 1395nn(a)(2) are expansive in attributing ownership of a physician to all immediate family members of such physician. The obvious rationale for having an attribution rule in this law would be to avoid physicians putting ownership in family members in order to avoid application of this law. For example, if a medical oncologist wanted to own a radiation therapy center he would simply be able to put the ownership in his wife's name (who does not work in health care) making it very easy for the oncologist to bypass the intent of the statute by conveying his ownership to her.

If, instead, the ownership of the radiation therapy facility was held in the medical oncologist's wife's name and such wife was a radiation oncologist, then the prohibition still applies. This is true even if the only practical choice is his wife for a patient needing radiation therapy and such referral is entirely within the scope of his practice.

The statute wisely contains an exception for referrals by a radiation oncologist to a facility owned by such radiation oncologist (see 42 U.S.C. 1395nn(h)(5)(C)). This exception recognized the lack of a conflict of interest that the radiation oncologist would have in such ownership. The exception, however, is not as expansive as the general rules in terms of "immediate family members."

PROBLEM

My understanding is that the Stark legislation emanated from Congressman Pete Stark's insistence that physicians were bilking the health care system. Notwithstanding that physicians are subject to "fraud alerts" and other indignities promoting to their patients their supposed lack of integrity, Congressman Stark felt the Medicare fraud and abuse rules were insufficient protections. The fraud and abuse rules make it illegal to pay or receive remuneration for referral. In discussions that my office has had with the Office of Inspector General (OIG) regarding referrals by a medical oncologist to a radiation oncologist's spouse, the OIG finds no problem with such referrals in the normal course of practice from a fraud and abuse standpoint. The Stark legislation, however, is absolute in its prohibition of such referrals. There is no requirement that a greedy or evil intent be present.

MRO had two radiation oncologists whose spouses were medical oncologists. Dr. Douglas Olson is one of the senior members of MRO and practices at a south suburban hospital. His wife is Dr. Barbara Bowers who practices medical oncology at a Minneapolis hospital. She is a dedicated practitioner in a most difficult field of medicine and several years ago was honored as one of the best physicians in the Twin Cities. This is testimony to not only the quality of her medicine, but her compassion with her patients and their families. Up until January 1, 1995 (i.e., the effective date of the Stark legislation), it had been a privilege for members of MRO to work with her in providing radiation therapy for her patients. Since that date, MRO has been required to reject all of her patients, almost all of which would be treated at facilities that Dr. Olson is not present. Dr. Olson's ownership in the practice does not allow Dr. Bowers to make referrals to any of their seven locations.

Another member of MRO was Dr. Graciela Garton. She is a talented and dedicated radiation oncologist that was recruited to provide radiation therapy services at a north suburban location. Her husband, Dr. John Garton, is a medical oncologist and was able to fill a position at the same hospital. Because of the Stark legislation, MRO was not able to accept referrals of Dr. John Garton's patients to MRO's radiation therapy facility at the hospital to which he was practicing. This resulted in an impossible situation for both them and their practices and, as a result, they left the Minneapolis area last month. The medical community at this hospital, after much searching and recruiting, lost two valuable members of its medical staff due to the arbitrary and harsh nature of this statute.

While it is not typical for married couples to both be physicians and refer to one another, it is certainly not that unusual. Many couples meet while in training and eventually get married. Because their training is in related fields and, as a married couple, they would practice in the same medical community, referrals between them would not only be typical, but almost unavoidable.

Aside from the intolerable situation it presents to practitioners in the field, the real ones hurt are their patients. A patient undergoing radiation therapy must endure daily treatments for up to five to six weeks. In addition, the patient is going through a traumatic ordeal with his or her cancer and is not feeling very well. Many are unable to drive on their own. All of these factors put a premium on convenience of geographic location of the radiation therapy facility. Dr. Barbara Bowers or Dr. John Garton would refer patients to an MRO facility if it was in the best interest of the patient. Due to the Stark legislation, MRO may no longer accept their referrals. Now their patients must literally drive past one of the MRO radiation therapy facilities every day for five to six weeks in order to travel to and from a more remote facility in order to get their treatment. This is a ridiculous result of government gone mad.

LEGISLATIVE PROPOSAL

While my first recommendation would be to repeal the Stark legislation in total, I would offer a specific change to the law as it pertains to the issues described above. The exception found in 42 U.S.C. § 1395nn(h)(5)(C) should be expanded to requests for radiation therapy services by family members of the radiation oncologist as well as the radiation oncologist him or herself. This particular provision of the law also deals with pathology and diagnostic radiology. There is no reason why a similar broadening of the exception would not apply to those areas of medicine as well. Therefore I would propose that this provision read as follows:

(C) Clarification respecting certain services integral to a consultation by certain specialists. A request by a pathologist (or an immediate family member of such pathologist) for clinical diagnostic laboratory tests and pathological examination services, a request by a radiologist (or an immediate family member of such radiologist) for diagnostic radiology services, and a request by a radiation oncologist (or an immediate family member of such radiation oncologist) for radiation therapy, if such services are furnished by (or under the supervision of) such pathologist, radiologist, or radiation oncologist pursuant to a consultation requested by another physician does not constitute a "referral" by a "referring physician."

I would like to thank you and the Subcommittee on Health for holding this hearing to address a much needed area of concern. Thank you in advance for your consideration of the issues described above, as well as the proposed solution.

Sincerely,

Todd I. Freeman, for
LARKIN, HOFFMAN, DALY & LINDGREN, Ltd.

Statement
of the
National Association for Medical Equipment Services
on
Physician Self-Referral
for
Subcommittee on Health
of the
Committee on Ways and Means
Hearing
of
Wednesday, May 3, 1995

The National Association for Medical Equipment Services (NAMES) is pleased to provide this written statement for the record on physician self-referral and unfair competitive business practices within the nation's health care system.

NAMES membership comprises over 2,00 home medical equipment (HME) companies which provide quality, cost-effective HME services and rehabilitation/assistive technology to consumers in the home. These companies take pride in providing personal, comprehensive HME services in the setting where the vast majority of individuals prefer to recuperate — the home. HME consists of basic aids for daily living and a vast array of highly specialized and advanced services, such as infusion therapy for the provision of antibiotics and chemotherapy, oxygen and ventilator systems, wound care and ostomy supplies, and advanced rehabilitation equipment and assistive technology.

SELF-REFERRAL OF MEDICARE PATIENTS

In the recent past Congress has acted to eliminate the practice of physicians referring their patients to medical entities in which they had a financial interest. The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) prohibited physicians (or their immediate family members) who have a financial relationship with clinical laboratories from referring Medicare patients to those entities, although a series of exceptions from the prohibition were provided. OBRA '90 created additional exceptions to the ban. Most recently, provisions in OBRA '93 expanded and clarified the self-referral restrictions.

In general, OBRA '93 broadened the physician self-referral statute to apply to both the Medicare and Medicaid programs. Furthermore, the ban now covers the following "designated health services" in addition to laboratory services:

- diagnostic radiology services;
- other diagnostic services (e.g., cardiology monitoring and muscle testing);
- physical and occupational therapy services;
- radiation therapy services;
- durable medical equipment;
- parenteral and enteral nutrients, equipment and supplies;
- prosthetics, orthotics and prosthetic devices;

- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

Clearly, the provisions in OBRA '93 reveal Congress understood some physicians were taking unfair advantage of their special patient-physician relationship by referring patients to their physician-owned ancillary services.

As the national association representing HME providers, NAMES supports the continued enforcement of the ban on physician self-referral for HME provided in the Medicare and Medicaid programs, which went into effect January 1, 1995.

NAMES was among the first groups to publicly endorse the physician self-referral laws. This was not an easy step for this association to take, given that our members' relationships with physicians are critical to the success of their businesses. However, the public policy reasoning and intent of physician self-referral laws are compelling and warrant the health industry's support as a step toward eliminating opportunities for abuse.

A number of studies and data support Congress' concerns in enacting a ban on physician self-referral. A 1989 General Accounting Office (GAO) study of Pennsylvania and Maryland clinical laboratory services indicated that both the utilization rate and average cost per service in physician-owned facilities was higher than that of non-physician-owned laboratories. Similarly, a 1989 HHS Office of Inspector General report concluded that patients of physicians with a financial interest in the entity to which they referred received 45% more clinical laboratory services and 14% more physiological laboratory services. The increased utilization of clinical laboratory services by patients of physician-owners cost the Medicare program an estimated $28 million nationally in 1987.

During the House Ways and Means Health Subcommittee October 1991 hearings on "Physician Ownership and Referral Arrangements", Congressman Pete Stark (D-CA) stated, "Physician ownership/referral arrangements represent an exploding virus which ultimately will erode the trust that patients have traditionally placed in their physicians. The sad thing is that we are quickly getting to the point where each of us is going to have to wonder if we are getting a service because we need it, or because it would increase our physician's dividend check." This same concern exists with regard to hospitals which have a financial interest in ancillary medical services, such as HME.

ACQUISITIONS OF HME COMPANIES BY NON-PROFIT HOSPITALS

In recent years, many non-profit hospitals have established or acquired HME companies, ostensibly to provide "one-stop shopping" for people who are being discharged from the hospital. On the surface, such a concept may sound like a simplified, cost-effective approach to administering health care. This approach, which aims to eliminate the confusing bureaucratic maze of paperwork patients face when coping with a post-acute medical episode, could appear attractive at first. Yet, it has not taken long for many health care providers to determine that such "vertical integration" is **not** as wonderful as some claim and, in fact, has led, in essence, to "self-referrals."

The following problems either exist today or could occur for consumers, government agencies, HME providers and local communities due to hospital ownership of HME businesses:

- Non-profit hospitals may refer patients to their own HME companies, wherever one exists, without the patients having knowledge of other options — in other words, patients would not be given a choice of provider;
- Hospital-owned HME companies could drive existing independent HME providers out of business, thereby creating a monopoly situation that would allow hospitals to control the home care marketplace. Eventually, patients would have no choice available to them;
- Continued "self-referral" of Medicare patients could cost the government more money in the long run;

- Private pay patients who belong to a hospital-run health plan and are referred by the hospital for HME services could receive reduced care in order to allow the hospital to lower costs and save money; and

- There would be a loss of tax revenue as well as jobs within the community if non-profit hospitals eliminate for-profit independent HME companies from the marketplace.

LIMITED CHOICE OF PROVIDER

As noted above, one of the major concerns many Americans have regarding Congressional reform of our nation's health care system is whether they still will be able to choose their own health care providers. Physicians and non-profit hospitals which own HME companies and refer patients to them do not always provide their patients with a list of other HME providers in the area from among which to choose. As a result, those patients are unable to select an HME provider based on price and quality of care.

Consumer problems associated with physician self-referrals also were discussed as early as October 1991, in testimony presented by Mark N. Cooper, Ph.D., Director of Research for the Consumer Federation of America. At a hearing on "Physician Ownership and Referral Arrangements" held by the House Ways and Means Subcommittee on Health, Dr. Cooper testified that "the American people understand this problem well.... They find it difficult to shop for ancillary medical services. The reason is clear; since physicians order them, and physicians read them, consumers cannot and do not shop.... The American people want their doctors to be doctors, not to be profit makers by selling them ancillary medical services."

RECOMMENDATION

NAMES strongly recommends that Congress not only uphold all physician self-referral laws applying to HME, but closely examine the relationship between hospital-owned and independently owned ancillary services to determine the problems associated with this type of service delivery system. The repeal of physician self-referral laws would move the home medical equipment services industry in the wrong direction.

NACDS

National Association of Chain Drug Stores

NACDS Supports the Current Ban

The National Association of Chain Drug Stores (NACDS) supports current federal laws enacted as part of the Omnibus Budget Reconciliation Acts (OBRA) of 1989 and 1993 relating to the prohibition of physician self referrals for Medicare beneficiaries and Medicaid recipients for certain medical procedures and services to entities in which the physician has an ownership interest. We support the prohibition or ban especially as it relates to outpatient prescription drugs.

NACDS includes more than 160 chain companies in an industry that operates 30,000 retail community pharmacies. Providing practice settings for over 66,000 pharmacists, chain pharmacy is the single largest component of retail pharmacy practice. With retail sales exceeding $60 billion in 1994, chain drug stores represent 72 percent of the $82 billion retail drug store market. The NACDS membership base fills over 60 percent of the more than two billion prescriptions dispensed annually in the United States.

In summary, we believe that elimination of the self-referral ban on outpatient prescription drugs would adversely impact an individual's quality of pharmacy care, and would create an inherent conflict of interest for physicians who have a direct ownership or financial interest in an outpatient pharmacy operation.

Quality of Care and Conflict of Interest Issues

The Medicare program does not have an outpatient prescription drug benefit, but the Medicaid program does. In 1994, the program reimbursed pharmacies for approximately 340 million outpatient prescriptions. We believe that removing the ban on physician self referrals to outpatient pharmacies would have a negative impact on the health and quality of care outcomes of the Medicaid population, complicating the delivery of medical care to a population which already requires more medical services and procedures than the rest of the population.

Physicians with an ownership interest in a pharmacy operation have an incentive to increase the number of prescriptions they write for Medicaid recipients, prescribe more expensive but not necessarily more effective drugs, and refer recipients to pharmacies in which they have an ownership interest, even if there are closer and more convenient pharmacies.

Medicaid recipients often do not have the ability to travel long distances to pharmacies to have prescriptions filled, and should not be required or even directed to obtain pharmacy services from a physician-owned pharmacy operation. Unsuspecting Medicaid recipients might be susceptible to misrepresentations that they are required to use a certain pharmacy, without having the knowledge of the physician's ownership interest in that particular pharmacy.

In addition, because physician-owned pharmacies often have available only a limited number of prescription drugs, the Medicaid recipient may not be prescribed the prescription drug which is best indicated for the individuals's condition. Community retail pharmacies usually have a complete selection of prescription drug products, and can help the physician select the appropriate product for individuals. For all these reasons, quality of care is maintained with the current laws relating to physician self referral.

Pharmacy Services Widely Available All Across the Nation

Some physicians may contend that they want to establish pharmacies near their office practices because pharmacy services are unavailable in the local community. However, pharmacists are among the most easily accessible and efficient health care professionals in our health care delivery system. Recent data indicate that 94 percent of the American population has a pharmacy within five miles of their homes. Many of these pharmacies have home prescription delivery services, especially in rural and other remote areas.

Medicare and Medicaid Costs are Likely to Increase

Many studies and analyses have documented the increased cost to the health care system as a result of physician self-referral practices. For example, a 1991 study by the Florida Health Care Cost Containment Board found that physician self referral resulted in an additional $500 million in health care costs in just one year. As Congress attempts to control rapid escalation in federal health care entitlement programs, it seems counterproductive to allow for this self-referral practice to be permissible again in Medicare and Medicaid programs. In addition, NACDS is concerned that an inherent conflict of interest also exists in cases where physicians have dispensing pharmacies in their offices. This should become more of a concern to Congress as an increasing number of physician group practices, which could also dispense outpatient drugs, contract with states to serve Medicaid recipients.

Managed Care Arrangements Not Discouraged Under Current Law

To our knowledge, the current physician self-referral ban has not prohibited the development and growth of managed pharmacy care programs. Because of convenience and efficiency, over 82 percent of managed care plans contract with community pharmacies to provide pharmacy services to the plans' members. Managing pharmacy care requires that the physician and pharmacist interact to determine the prescription drug best suited to the patient's medical need, which is not necessarily the drug that is the stocked by a physician-owned pharmacy operation.

Conclusion

In conclusion, Mr. Chairman, NACDS supports the current law on the ban on physician self referral under Medicare and Medicaid especially as it relates to outpatient prescription drugs, and strongly urges that it be retained. We look forward to working with you on this issue, and ask that you call on us if we can provide any additional information.

STATEMENT OF
EDWARD E. BERGER, PH.D.
NATIONAL MEDICAL CARE, INC.
to the
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
MAY 3, 1995

PHYSICIAN SELF-REFERRAL SHOULD BE PROHIBITED FOR ALL PAYERS AND ALL SERVICES

General Policy Considerations.

In recent years, public policy makers, health care provider groups and health professional associations have moved decisively to eliminate conflicts of interest - real or potential - which exist when physicians have a financial stake in services or institutions to which they refer patients. This movement is rooted in the widespread belief that the special relationship of trust which must obtain between physician and patients dictates that **personal financial considerations should never color, or in any way influence, a physician's clinical decision making on behalf of a patient.**

Because a potential conflict is always present when the physician stands to profit by making a particular referral, such referrals are increasingly proscribed by canons of professional ethics, organizational standards of conduct, and State and Federal law. *Physicians should be paid for the clinical services they provide to patients, broadly defined to allow recognition of both direct and indirect patient care and evaluation,* but **should derive no financial benefit from services provided by other individuals or by institutional entities.**

It follows that, just as the physician should not engage in fee-splitting with other professionals to whom he/she refers patients, **he/she should also not own or have an equity interest in a facility to which referrals are made.** Each of these circumstances creates a financial interest for the physician which may affect the independence and quality of clinical advice and decision making, and which can unnecessarily increase health care costs.

The Potential Pernicious Effects of Physician Self-Referral.

There are three distinct types of pernicious distortions which are introduced into the health care system when physicians are in a position to profit from referrals they make:

1. Overutilization of services. When a physician shares directly or indirectly in the income from services provided pursuant to his/her referrals, there is a clear financial incentive to increase the number of referrals made. This is obvious in the case of classic fee-splitting, but the same dynamic is at work when the physician is the owner of an entity to which the referral is made. With a capital investment or supplemental income stream at risk, the physician may in some measure be incented to make referrals to shore up a facility. Overutilization translates directly into excess costs, and indirectly into compromised quality of care.

2. Quality of care subordinated to financial self interest. If potential income corrupts the physician's judgement concerning how and where the patient can be best served, the quality of care obviously suffers. This distortion applies to quality as measured by objective parameters of clinical outcomes, and also to more subjective considerations of patient choice, convenience, comfort and satisfaction. Again, with a capital investment or secondary income stream at risk, the physician may be tempted to direct referrals to protect his/her facility rather than to optimize care.

3. Market inefficiencies and cost inflation. When the referring physician owns or has a financial interest in the entity to which the referral is made, we have a financial transaction in which the seller and the buyer are for all constructive purposes one, with the resulting price extracted from the pockets of government, private insurers, and/or the patients themselves. **The price and quality comparisons expected of buyers in an efficient marketplace are fatally compromised**; the inevitable result is higher costs and lower quality than would otherwise be the case. A special case of this distortion is seen when service providers must employ or contract with physicians who are potential referral sources in order to operate; if the physician can threaten to go into business in competition with the provider, his/her **control of referrals is a potent force in negotiating economically inefficient and excessive payment rates.**

Physicians' use of the relationship of trust between doctor and patient to negotiate with providers for favorable contractual terms or to extract economic rents through offers of referrals - either to a facility owned by the physician or to one which employs him/her - is especially troubling. This behavior turns the doctor-patient relationship, depicted as an inviolable trust when that suits the moment, into a form of practical ownership wherein the patient becomes a commodity to be bartered in the physician's self interest.

A Ban On Self Referrals Should Be Comprehensive.

Up until now, Federal legislative prohibitions against self-referral arrangements have been limited in three ways:

1. They apply to Medicare/Medicaid referrals only;

2. They apply only to designated health services; and

3. Among other exemptions, they do not apply to physician group practices.

None of these limitations is good public policy. On the contrary, the failure to implement self-referral restrictions applicable to all payers, all physicians, and all services is a significant impediment to national efforts to control health care costs and improve care quality.

The prohibition should apply to all payers.

A self-referral prohibition limited to Medicare/Medicaid leaves the great majority of patients in our health care system unprotected and subject to the distortions inherent in self-referral arrangements. It adds an additional problem by encouraging, or at least condoning, exclusion of Medicare/Medicaid patients from some (i.e. physician-owned) facilities, thereby limiting their care options. **If the self-referral prohibition is payer-specific, patients covered by that**

payer are disadvantaged in terms of access to care and their right to choose. The appropriate remedy is a blanket prohibition, which eliminates the ills associated with self-referral and promotes broad access and the maximum amount of choice for all health care consumers.

The prohibition should apply to all physicians, including group practices.

The blanket exemption for referrals within a qualifying physician group practice creates an opportunity for physicians to dodge all of the restrictions imposed by the self-referral legislation, reap all of the financial benefits of what would otherwise be seen as illegal and/or unethical cross-referral arrangements, and profit from their control over the nature and quality of diagnostic tests performed and ancillary services ordered. The problem is particularly severe for multi-disciplinary group practices, some of which comprise extraordinarily extensive closed systems of cross-referral, and is exacerbated as the group practice becomes a holding company operating ambulatory surgical centers, diagnostic testing centers, clinical laboratories, chronic dialysis facilities, and even inpatient hospitals. Operating in the context of traditional fee for service payment, such practices are powerful engines for the generation of revenue through control of referrals. They need to be controlled.

The prohibition should apply to all services.

Finally, **there should be few if any service-specific exemptions from the self-referral prohibition.** In the past, Congress has acted to extend its limited prohibition to new services as evidence of abuse through overutilization is gathered. Some medical specialties have argued that they should be permitted to make self-referrals because their services are not readily susceptible to, or have not been demonstrated to result in, overutilization. But overutilization is only one of the several distortions and inefficiencies introduced by self-referral. Quality of care, patient choice, and market distortions which drive up total costs are at least as important.

The case of acute dialysis services.

The provision of acute dialysis services to hospital inpatients provides a graphic example of this problem, and deserves extended discussion as an example of the complex incentives invoked by self-referrals. There are two distinct kinds of "acute dialysis". First, patients with no history of ESRD sometimes experience acute kidney failure secondary to other conditions or as a result of systemic shock. The kidney failure may be temporary, in which case acute dialysis in the hospital can keep the patient alive until function is restored; or it may be permanent, in which case acute dialysis may be a precursor to chronic therapy or (for the terminal cancer patient, for example) simply a postponement of the inevitable. A unifying feature of this class is that the hospitalization will have been made by a non-renal physician, and the nephrologist is in the role of consultant. No more than 5% of acute dialysis treatments fall into this group. This class of acute treatments does not seem to pose a direct risk of excessive hospital admissions. However, the consultant nephrologist may choose to dialyze a terminal patient before he or she dies, providing no real benefit to the patient or family. Similarly, the consultant may dialyze a patient who could be treated by more conservative means. If the consulting nephrologist has a financial interest in the acute dialysis program, the risk of such inappropriate treatment is increased.

The second group of "acute treatments", comprising 95% or more of all acutes, consists of those provided to chronic

dialysis patients during inpatient episodes. The nephrologist is frequently the admitting physician in these cases. Because the established dialysis regimen cannot be suspended during hospitalization, treatment is provided in the hospital by the acute program. These are the "acutes" for which the issue of nephrologists' financial incentives has been widely debated: some analysts believe that nephrologists have been gaming their payment system (capitated for routine care, per-visit or procedure for inpatient care) and thereby unnecessarily increasing admissions; if the physician can profit from the acute dialysis program, the incentive to game the system is markedly increased. For this second group of "acutes", the conflict of interest potential lies in avoidable admissions, but there is little risk of unnecessary or inappropriate dialysis.

For the second group there is also a serious concern about conflicts in the relationship between the physician who holds an acute contract and the hospital. A hospital which gives its acute dialysis contract to a nephrology group can be reasonably certain of securing the bulk of the group's inpatient referrals - whether that contingency is addressed in contractual language or not. It would of course be an explicit violation of law to write such a contract. Yet physicians hold acute dialysis contracts, and in many cases receive increased acute payment rates from hospitals without any competitive pressure, all across the country. For the hospital, changing the contractor, or holding the price line, may raise unacceptable risks on account of the nephrologists' volume of inpatient referrals.

Where the hospital has a chronic dialysis program as well, this threat is magnified: a lucrative acute contract to the physicians may be one way to prevent them from taking their patients and setting themselves up as direct competitors by starting their own facility. Of course, well-organized and managed hospitals may have some countervailing forces (such as the ability to foster cross-referrals from other specialties), but those too are ethically questionable.

The only way in which quality of care becomes relevant to this discussion is in the context of hospitals demanding and enforcing good quality as part of an open and competitive contracting process. Acute dialysis is the hospital's responsibility. The fact that a contractor is Medicare-certified to provide chronic treatment in a facility does not guarantee anything about their ability to do good acute dialysis. And even if one had reasons for restricting acute contracts to operators of certified facilities, that would not be a reason for excusing otherwise unacceptable financial conflict of interest.

There should be an exemption for acute dialysis programs in rural or isolated locations where there is a dearth of alternatives for the hospital. Otherwise, there is no good reason for supporting an acute dialysis exemption, and as discussed above a number of striking reasons to oppose one.

Conclusion.

Physician ownership of facilities to which referrals are made is structurally and fundamentally pernicious. **The exploitation of the doctor-patient relationship for financial gain, and the treatment of patients as commodities in a financial transaction, are unacceptable.** No one class of physicians or specialty, and no one group of provider entities, is inherently more or less ethical or honest than others. We should not require overwhelming demonstration of the ill effects of self-referral arrangements in each distinct area of health services before we act to eliminate the structural problem.

Financial arrangements which promote or allow physician self-referral lead to:

- overutilization of health services;
- subordination of such concerns as quality of care, patient convenience, access, and satisfaction to the financial interest of the caregiver;
- market distortions which increase the cost of discrete health care services and total health system costs; and
- corruption of the essential relationship of trust between doctor and patient.

A general prohibition against self-referrals, applicable to all payers, all physicians, and all services is an essential component of any plan to control total health costs and improve both the prevailing standard for quality of care and the responsiveness of the health care system to patient needs.

TESTIMONY OF OUTPATIENT OPHTHALMIC SURGERY SOCIETY

The Outpatient Ophthalmic Surgery Society (OOSS), an organization composed of approximately 800 ophthalmologists dedicated to providing high-quality ophthalmic surgical care in various outpatient settings, is delighted to have the opportunity to present testimony before the House Ways & Means Subcommittee on Health regarding physician ownership and referral arrangements. A substantial number of OOSS members (approximately 350) own and operate ambulatory surgery centers that serve Medicare patients undergoing cataract surgery, and are therefore both intimately familiar with, and uniquely qualified to comment on, physician self-referral restrictions.

AMBULATORY SURGERY CENTERS

Ambulatory surgery centers (ASCs) are facilities that provide high-quality, cost-effective, same-day care for a wide range of surgical procedures. In 1992, over three million surgical procedures, some 30 percent of which involved ophthalmic surgery, were performed in ASCs.

ASCs save hundreds of millions of dollars for the Medicare program each year. Medicare payments to ASCs for outpatient surgical procedures are substantially lower -- in some cases by as much as 50 percent -- than payments to hospitals (both on an inpatient and outpatient basis) for the procedures. Moreover, ASCs have brought the benefits of competition to the entire outpatient surgery market: the opening of an ASC in a particular area has frequently been followed by a significant reduction in the charges of local hospitals for outpatient surgery, as well as increased attention on the part of the hospitals to quality of care and patient satisfaction.

THE INTRAOCULAR LENS AND CATARACT SURGERY

Intraocular lenses (IOLs) replace the natural lens of the eye that is removed during cataract surgery. As cataract surgeons, OOSS members know -- perhaps better than anyone -- the extraordinary benefits that have resulted from the development and refinement of this cutting-edge technology. Instead of the thick "Coke bottle" glasses with which cataract patients once had to contend, patients who receive an IOL during cataract surgery often have vision that is better than what they had as teenagers. Moreover, IOL technology has dramatically reduced the trauma and complications associated with the cataract procedure itself; recent developments have made it possible to perform cataract surgery through an incision so small that it can be closed without even a single stitch. And research now underway will likely make it possible to implant lenses with multiple focal lengths, further reducing the need for eyeglasses in the post-cataract patient. Over one million Medicare beneficiaries receive this remarkable vision-restoring procedure each year.

PHYSICIAN SELF-REFERRAL

OOSS supports clear, unambiguous physician self-referral prohibitions that prevent unethical financial relationships and reinforce the critical element of trust in the physician-patient relationship. As discussed above, ASCs save the Medicare program hundreds of millions of dollars. A number of studies, including a noted Florida Cost Commission Review of physician self-referral, examined the issue and concluded that there was no ascertainable abuse with respect to the referral of patients by operating surgeons to ASCs in which they have an ownership interest. **Indeed, the Office of the Inspector General has issued a proposed safe harbor which explicitly protects the physician investment in the ASC.**

Why is the ASC different from other ventures with regard to which fraud and abuse is more likely to occur? There are several reasons. First, more than two-thirds of the ASCs in the country have been developed and owned by physicians to

achieve control of the surgical environment (lacking in the hospital), convenience for their patients, and reduced costs. Indeed, if physician self-referral restrictions were to prohibit doctor ownership of ASCs, **there would be virtually no ASCs left.** Second, unlike services provided by clinical laboratories and diagnostic imaging centers, **surgical services performed in an ASC are subject to a utilization review by peer review organizations**; as such, there is a check on inappropriate utilization. Finally, the physician operates in the ASC as an **extension of his or her office**, much like an internist might offer laboratory or radiology services. **The surgeon is not a passive investor; a "referral" is not really taking place.**

We are pleased that services performed in ambulatory surgical centers have not been specifically delineated as "designated health services" under the Stark II legislation. However,

- **OOSS strongly recommends that physician self-referral legislation be amended to specifically exclude services provided by ambulatory surgical centers.**

As noted above, we do not believe that Congress intended to impose physician self-referral restrictions on ASC owners. **However, regrettably, the ambiguities inherent in the Stark II legislation enacted by Congress in 1993 prevent the legislation from achieving this goal.** In fact, it is our concern that the Stark II self-referral prohibitions are already being misinterpreted by HCFA, and are destined to have a variety of unintended consequences. Specifically, a recent Health Care Financial Ventures Report regarding intraocular lenses and self-referral prohibitions suggests that HCFA considers the implantation of an IOL as within the scope of the physician self-referral ban. We strongly disagree. Accordingly, OOSS urges Congress to clarify this important measure before HCFA promulgates regulations.

The question of whether the physician "self-referral" provisions set forth at Social Security Act § 1877 are applicable to prosthetic devices and intraocular lenses implanted in conjunction with surgical procedures performed in ambulatory surgical centers for Medicare and Medicaid patients first arose because the physician "self-referral" provisions in § 1877(h)(6)(H) of the Social Security Act apply to "prosthetics, orthotics, and prosthetic devices." **This provision, however, should not be interpreted to trigger the application of the self-referral provisions to ASCs since the implantation of these devices is merely incidental to the performance of ASC facility services.**

Instead, IOLs should be considered a component of ASC facility services and not a prosthetic device, especially for physician self-referral purposes. We understand that the definition of "prosthetic devices" included in § 1861(s)(8) of the Social Security Act creates some confusion. This provision defines prosthetic devices, for coverage purposes, as follows:

> Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens; . . . (Emphasis added).

This provision, however, does not specifically define the intraocular lens itself as a "prosthetic device;" rather, this provision defines as "prosthetic devices" certain "conventional eyeglasses or contact lenses" furnished after cataract surgery.

Furthermore, ASC facility services are covered under a completely separate coverage provision than "prosthetic devices." Specifically, ASC facility services are covered under Social Security Act § 1832(a)(2)(F), while "prosthetic devices" are covered as "medical and other health services" under Social Security Act § 1861(s)(8).

Section 1833(i)(2)(A)(iii) of the Social Security Act specifically defines the ASC facility rate, or standard overhead amount, to include the IOL payment. In fact, the governing statute in § 1833(i)(6) authorizes civil monetary penalties for anyone who separately submits a claim for an IOL implanted in an ASC. Likewise, the implementing regulations (42 C.F.R. § 416.61) include IOLs in the definition of ASC facility services. Thus, IOLs implanted in ASCs are covered as a component of ASC "facility services" and are distinguishable from other "prosthetic devices," under the governing statute and implementing regulations.

We also note that Congress has established the payment rate for IOLs implanted in ASCs at $150. For this reason, ASCs' provision of IOLs does not pose any potential for abuse: ASCs' charges for IOLs are strictly limited by this Congressional mandate to 80% of $150 (or $120), with the Medicare beneficiary responsible for the remaining $30 copayment. **Under these circumstances, it is clear that applying the "self-referral" restrictions to IOLs implanted in ASCs would not serve any useful public policy objective.**

Finally, any application of the physician "self-referral" provision to IOLs implanted in ASCs could have a substantial -- and devastating -- impact on ASCs, the Medicare beneficiaries they serve, and the Medicare program. Virtually all cataract procedures are performed for Medicare patients and require the implantation of an IOL. Cataract facility services performed in ASCs are provided at substantially lower cost than in hospital outpatient departments. Therefore, applying the physician "self-referral" provisions to IOLs implanted in ASCs would likely jeopardize the financial viability of ASCs throughout the country and result in a significant increase in Medicare outlays for cataract facility services. This result is neither intended by Congress nor required by the express terms of the physician "self-referral" provisions.

- **OOSS strongly recommends that Congress clarify that the implantation of an intraocular lens during cataract surgery does not represent the provision of the designated health service ("prosthetic devices"), triggering Stark II referral restrictions.**

EYE GLASSES AND CONTACT LENSES

As noted above, the provision of prosthetic devices constitute a "designated health service" under Stark II. While the services of an optical shop maintained by a physician are not identified as designated health services (indeed, optical shops were specifically removed from the legislation by the Subcommittee prior to final passage), another section of the Medicare law, delineated above, defines prosthetic devices as including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens. **HCFA has indicated that it likely intends to interpret the phrase "prosthetic devices" to include "eye glasses or contact lenses," essentially prohibiting physician ownership of optical dispensaries.**

This is an egregious example of legislative overreach. There is no evidence of which we are aware that a physician is more likely to order eye glasses or contact lenses because he or she operates an optical shop. These optical dispensaries exist for the convenience of the patient and as a modest source of revenue to the owner-physicians. They are generally operated as an integral part of the physician's private practice. Moreover, patients are certainly aware of the myriad of alternative sources of eye glasses and contact lenses from national chains to local opticians.

- **OOSS strongly recommends that Congress clarify that the Stark II legislation was not intended to encompass the provision of eyeglasses or contact lenses dispensed by physicians who operate optical dispensaries. This can be accomplished by adding "(except that such terms do not include intraocular lenses, eyeglasses or contact lenses)" after the notation of the designated health service, "prosthetic devices and orthotics and prosthetics."**

* * * * * *

The Outpatient Ophthalmic Surgery Society appreciates the opportunity to present this testimony before this distinguished Subcommittee. Please do not hesitate to contact Washington counsel, Michael Romansky, at (202) 778-8069 if you have any questions about this matter.

TESTIMONY OF SURGICAL CARE AFFILIATES, INC.

We appreciate the opportunity to submit testimony to the House Ways and Means Subcommittee on Health, and applaud the Chairman's recognition of the various problems created by the physician self-referral law, as well as his initiative in working with the industry to implement the law in a fair and effective manner, particularly with respect to managed care arrangements.

INTRODUCTION

Surgical Care Affiliates, Inc. (SCA) is the nation's largest independent operator of ambulatory surgery centers (ASCS). It is headquartered in Nashville, Tennessee, operates 63 centers in 22 states, and has operations in 28 of the top 50 HMO markets in the United States. During 1994, the company's centers provided outpatient surgical services to over 190,000 patients.

SCA's centers historically furnished outpatient surgical services independent of their hospital outpatient surgery counterparts. Efforts within the industry to reduce costs, a growing managed care market, and the formation of integrated health care networks, however, have encouraged hospitals and other providers to integrate their services with those furnished by SCA's centers. This has resulted in maximizing efficiencies and providing quality surgical services at the lowest possible cost. Accordingly, SCA's business strategy, which primarily has involved a partnership between the company and physicians within a local community, has evolved to include other health care providers and payors, such as community hospitals and HMOs. SCA views these types of partnerships as necessary within today's managed care market, and, in addition, believes these types of arrangements are critical to achieving efficient delivery of health care services and reducing the nation's overall health care costs.

SCA recognizes the problems that the Stark II physician self-referral law seeks to address. At the same time, it recognizes that physician ownership of ASCs has been shown to be beneficial, and Congress, therefore, has determined not to ban that relationship. Expanding beyond the physician-ASC relationship in the context of integrated health care delivery networks, may, however, be problematical. Certain ambiguities in the law could permit enforcement and other regulatory officials to interpret the law effectively to prohibit ASCs (and other independent outpatient health care providers) from participating in health care networks when, in fact, services furnished by ASCs (and other similar outpatient providers) were never intended to be covered by the law. The mere uncertainty that results from these ambiguities inhibits investment in the market and discourages the development of a managed care environment.

Accordingly, we urge the Subcommittee to pass legislation that would clarify these ambiguous provisions and assist in the promotion of managed care arrangements. In particular, we urge that (1) surgeons who request surgical services for their own patients be specifically exempt from the law consistent with the existing exemption for nephrologists, radiation oncologists, radiologists and pathologists; (2) the ban on "inpatient and outpatient hospital services" be deleted or clarified to make certain that ambulatory surgical services are excluded from that ban; (3) the ban on "radiology services" be clarified to make clear that it does not apply to those ambulatory surgical services that utilize an "imaging" device, which often is merely a video camera, in performing the surgical procedure; and (4) enforcement of the law be delayed until implementing regulations are promulgated.

APPLICATION OF "STARK II" TO ASCS

The federal physician self-referral law, commonly referred to as "Stark II," applies to certain "designated health services" set forth in the law, and does not specifically apply to ASCs. The law has never been intended to cover ASCs for various reasons. ASC services are not subject to abuse, such as over-pricing, since Medicare controls these costs by reimbursing ASC services on a prospectively determined rate. Additionally, ASCs furnish therapeutic and certain diagnostic surgical procedures, which because of their invasive nature, are not reasonably subject to over-utilization or patient abuse. The physician who requests the surgical procedure personally performs the procedure, and since medical harm would ensue to the patient if the procedure were done unnecessarily, the physician has little discretion in ordering the procedure. In addition, Medicare requires pre-certification of many surgical procedures, which prevents over-utilization.

Further, surgical services are integral to a surgeon's practice, making the ASC where the surgical procedure is furnished an extension of the surgeon's office practice. It is more economically efficient for surgeons to own jointly, rather than individually, a facility where they furnish services, and that ownership better rationalizes the costs involved and provides greater access to these services. Finally, consistent with the above, various studies, including the most comprehensive study to date conducted by the Florida Health Care Cost Containment Board, have specifically analyzed physician referral and ownership of ASCs and have found that there is <u>no problem</u> of abuse or over-utilization. The Florida legislature passed legislation, based on the Board's study, that has been a model for many other states. It expressly <u>exempts</u> ambulatory surgery services from its self-referral ban, and did so on the basis that these invasive procedures are not reasonably subject to over-utilization or abuse.

AMBIGUITIES THAT COULD IMPEDE ASCS' PARTICIPATION IN MANAGED CARE NETWORKS

As we have indicated, Stark II contains certain ambiguities that cause confusion and uncertainty within the industry, and could eliminate ASCs' participation in managed care networks. If so, this would threaten these networks' ability to provide surgical services efficiently and at the lowest possible cost.

Inpatient and Outpatient Hospital Services. The list of "designated health services" covered by the Stark II ban does not specifically include ambulatory surgical services. It does, however, include "inpatient and outpatient hospital services." This term is not defined and could be interpreted to cover any services provided by a hospital. As we understand from the legislative history and prior discussions with staff involved in drafting the provision, the ban on "inpatient and outpatient hospital services" was intended to prohibit hospitals from selling a portion of the hospital to physicians in order to "lock in" those physicians' referrals and have access to the revenue stream created by these referrals. Thus, it seems clear that the ban on "outpatient hospital services" would, for example, prohibit a hospital from selling shares of its outpatient ambulatory surgery unit to physicians. Beyond this point, because of the ambiguity of the legislation it is difficult to determine with specificity the types of arrangements involving hospital participation to which this provision may apply.

On its face, the language of the "outpatient hospital services" ban could potentially be interpreted to apply to certain arrangements that were not originally intended to be covered by the law. It could prohibit hospitals from entering into any ownership arrangement with a provider of services furnished on a hospital outpatient basis if physicians with a financial interest in the provider treat patients there. For example, "outpatient hospital services" could be interpreted to cover services furnished in a freestanding ASC that is independent from and not operated as part of any hospital, but that is jointly owned by a hospital. Under this type of arrangement, the service is physically provided and billed by the freestanding ASC, not the hospital, and the physician who requests the surgical procedure performs the procedure on his or her patient at the ASC.

Alternatively, the "outpatient hospital services" provision may apply only when various factors indicate that a hospital's involvement is so significant as to conclude that the services furnished by the hospital/free-standing provider (or ASC) joint venture actually are "outpatient hospital services." Based on prior conversations with staff responsible for drafting the provision, we believe this is a more reasonable interpretation.

Either of the foregoing interpretations are troublesome, however, in today's managed care market which depends upon the integration of health care providers to provide services efficiently and at lower costs. If hospitals and ASCs are not permitted to integrate fully, this would add an additional "layer" to the health care network. For every layer added to a network, there is a concomitant increase in cost to the entire delivery system because providers are inhibited from achieving optimum efficiencies and from equally sharing the risks. Thus, it is critical for hospitals to be integrated with independent ASCs (and other independent outpatient providers) in order to bid competitively for discounted managed care contracts, which requires the ability to provide a full array of services across a broad geographic area. For instance, the hospital may more efficiently furnish surgical services to a plan's patients if it is located on one side of town and owns an equity interest in an independent ASC that is operated on the other side of town.[1] Alternatively, the hospital could construct another facility, but that would be extremely costly and duplicative. In addition, ASCs operate at a much lower cost than the hospital's outpatient surgical department. Various studies have found that list charges for outpatient surgery are 25 percent to 40 percent lower in ASCs than in comparable hospital outpatient departments. In fact, Medicare reimburses hospital outpatient departments at a significantly higher rate than ASCs. Accordingly, it is difficult to understand why Medicare would disallow any hospital from participating in a venture that bills at the lower ASC rate when the alternative is to bill at the higher hospital outpatient department rate.

Accordingly, we request that the Subcommittee amend Stark II by specifically exempting ASCs and, in addition, by deleting or clarifying the ban on "inpatient and outpatient hospital services" to make certain that it does not apply to ambulatory surgical services.

Radiology Services. Another "designated health service" covered by Stark II is "radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services." These services have been the subject of various studies, including the Florida study, that have strongly suggested that such services are over-utilized by physician owners.

In drafting Stark II implementing regulations, we understand that the Health Care Financing Administration (HCFA) will develop a list of those services that constitute "radiology services" and

---

[1] In some cases, when an ASC in which the hospital has an equity interest is on the same side of town as the hospital, ultimately the hospital closes its outpatient surgical department since the ASC provides the surgical services at a much lower cost.

thus are subject to the Stark II self-referral ban. HCFA may consider including on that list certain procedures that have as an integral part of the procedure the projection or recordation of an "image" of the body or some part thereof. We are concerned that this could thus include certain "minimally invasive" surgical services furnished by ASCs, such as laparoscopies and arthroscopies, which are surgical procedures that require the use of a video camera to visualize the relevant part of the body, i.e., the abdominal cavity and joint space, respectively.

We believe that analysis of the legislative history of Stark II and specifically, its ban on "radiology services," clearly indicates that the law is not intended to apply to these ASC services. As earlier discussed, physician ownership of ambulatory surgical services, including laparoscopies and arthroscopies, have been studied and since they have not been found to be subject to over-utilization or abuse have never been covered nor intended to be covered by Stark II. In addition, the self-referral ban on "radiology services" was recently amended by Representative Stark, the sponsor of the law, to narrow the scope of this category of services. This amendment confirms the narrow intent of the provision, and the fact that it does not thus apply to ASC procedures that use an "imaging" device, such as a video camera, as an integral part of performing the surgical procedure, particularly since these procedures are not billed as a radiology service nor are they performed by a radiologist.

Accordingly, we respectfully urge the Subcommittee to amend Stark II to clarify that the ban on "radiology services" does not apply to ambulatory surgical services.

Implementing Regulations. As you know, while Stark II has been effective since January 1, 1995, implementing regulations have not yet been drafted and likely will not be proposed or finalized for some time.[2] Even so, they may or may not provide further clarification of these foregoing matters. Accordingly, we urge the Subcommittee to delay enforcement of Stark II until final implementing regulations have been published.

---

[2] Implementing regulations for "Stark I," which is applicable to clinical laboratories and which became effective January 1, 1992, have not yet been finalized.

○

ISBN 0-16-054348-7

90000

9 780160 543487

HEALTH INSURANCE PORTABILITY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

MAY 12, 1995

Serial 104–32

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

22–355 CC WASHINGTON : 1996

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-052405-9

COMMITTEE ON WAYS AND MEANS

BILL ARCHER, Texas, *Chairman*

PHILIP M. CRANE, Illinois
BILL THOMAS, California
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
JIM BUNNING, Kentucky
AMO HOUGHTON, New York
WALLY HERGER, California
JIM McCRERY, Louisiana
MEL HANCOCK, Missouri
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
DICK ZIMMER, New Jersey
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
PHILIP S. ENGLISH, Pennsylvania
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska

SAM M. GIBBONS, Florida
CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ANDY JACOBS, JR., Indiana
HAROLD E. FORD, Tennessee
ROBERT T. MATSUI, California
BARBARA B. KENNELLY, Connecticut
WILLIAM J. COYNE, Pennsylvania
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
L.F. PAYNE, Virginia
RICHARD E. NEAL, Massachusetts

PHILLIP D. MOSELEY, *Chief of Staff*
JANICE MAYS, *Minority Chief Counsel*

SUBCOMMITTEE ON HEALTH

BILL THOMAS, California, *Chairman*

NANCY L. JOHNSON, Connecticut
JIM McCRERY, Louisiana
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska
PHILIP M. CRANE, Illinois
AMO HOUGHTON, New York
SAM JOHNSON, Texas

FORTNEY PETE STARK, California
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia

CONTENTS

	Page
Advisory of May 3, 1995, announcing the hearing	2
Blue Cross & Blue Shield Association, Mary Nell Lehnhard	49
Employee Benefit Research Institute, Paul Fronstin	9
Health Insurance Association of America, John F. Troy	39
National Restaurant Association, W.W. "Biff" Naylor	32
Physicians Health Services, Michael E. Herbert, on behalf of Group Health Association of America	44
U.S. Chamber of Commerce, E. Neil Trautwein	23
Western Growers Association, Donald G. Dressler	28

SUBMISSIONS FOR THE RECORD

Association of Private Pension and Welfare Plans, James A. Klein, letter	60
Council for Affordable Health Insurance, Greg Scandlen, statement	61
Fisher, George Ross, M.D., Philadelphia, Penn., letter	65
Healthcare Leadership Council, Pamela G. Bailey, statement	66
National Association of Pediatric Nurse Associates & Practitioners, Joan Greene, statement	68
National Federation of Independent Business, John J. Motley III, letter	70
Oncology Nursing Society, Pearl Moore, statement	71
Susan G. Komen Breast Cancer Foundation, statement	72

HEALTH INSURANCE PORTABILITY

FRIDAY, MAY 12, 1995

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

The subcommittee met, pursuant to call, at 10:07 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
May 3, 1995
HL-10

CONTACT: (202) 225-3943

THOMAS ANNOUNCES HEARINGS ON HEALTH INSURANCE PORTABILITY

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 health insurance portability. **The hearing will take place on Friday, May 12, 1995, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be heard from invited witnesses only. Witnesses will include health policy experts, insurers, and employers. 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:

Insurers and employers may choose to impose pre-existing condition exclusions on individuals when they change jobs. This has resulted in the problem for some Americans called "job lock." These Americans are reluctant to take new jobs or pursue new career opportunities because doing so would result in a loss of health insurance coverage because they or their dependents have conditions that existed prior to the change in employment.

FOCUS OF THE HEARING:

The hearing will review the impact the use of preexisting condition exclusions have had on job mobility and how a targeted approach might be designed to resolve this problem. The Subcommittee is particularly interested in technical issues involved in such a targeted approach to overcome job lock.

In announcing the hearing, Chairman Thomas stated: "A targeted portability proposal will go a long way toward eliminating the problem of job lock that has adversely affected so many Americans. Enactment of such a reform will provide peace of mind to millions of Americans."

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, May 26, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements 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. Welcome to the Health Subcommittee hearing this morning regarding health insurance portability. The hearing today will focus on the problem of "job lock" and reforms to resolve this problem for American workers. Our goal is to make sure that workers have the freedom to take their health insurance with them when they change jobs.

As the members of this subcommittee are well aware, insurers and employers may choose to impose preexisting condition exclusions on individuals when they change jobs. As a result, it has been reported that many Americans are reluctant to take new jobs or to pursue new career opportunities in part because doing so could result in a loss of health insurance coverage if they or their dependents have conditions that existed prior to the change in employment.

This subcommittee will review targeted reforms to provide individuals who play by the rules and maintain continuous coverage the peace of mind of knowing that if they decide to change jobs, they will not be penalized by the imposition of preexisting condition exclusions.

I consider the hearing today and the subject matter to be a substantial step in further reforming the health care system in this country.

No one should make the mistake about the scope of the proposal we are considering today. This legislation, H.R. 1610, and other pieces of legislation—1610, incidentally, is cosponsored by every member of this subcommittee on both sides of the aisle. This is a targeted approach. It is not intended to address every issue involved in the health care debate or in the portability debate. It focuses specifically on ensuring that individuals who participate in the group insurance system of this country are treated fairly by employers and insurers if the need to change insurance plans should arise.

It should also be pointed out that Congress this year, unlike last year, has successfully moved forward in passing health care legislation in a manner similar to the legislation we are considering today. Without the controversy that resulted from last year's effort concerning comprehensive health care reform, we have already enacted into law assistance for millions of self-employed Americans so they can obtain insurance; and the House itself has passed medical malpractice reform, tax credits for long-term care, Medicare Select; and now we are moving forward on this particular important issue of portability.

This incremental approach to health reform will give the American people what we believe to be the right dose of medicine to cure our health care problems.

Before we hear from today's witnesses, I would like to thank all of the members on the subcommittee for recognizing the importance of the problem and for cosponsoring H.R. 1610.

In addition, without objection, I would like to submit the letters of support from the National Federation of Independent Business, the Health Care Leadership Council, and the Association of Private Pension and Welfare Plans.

[The letters follow:]

May 11, 1995

Honorable Bill Thomas
Chairman
Health Subcommittee
Committee on Ways & Means
1136 Longworth House Office Building
Washington, DC 20515

Dear Mr. Chairman:

On behalf of the 600,000 small business owners of the National Federation of Independent Business (NFIB), I am writing to express our support for your bill to bring portability to the health insurance market place.

Making it easier to go from job to job without the threat of losing health coverage has long been a goal of NFIB and the small business community. The Thomas portability bill would achieve that goal without having an adverse impact on small business premiums.

NFIB hopes that the Thomas portability bill is the first step toward additional insurance reforms, like rating reforms, guaranteed renewability, and others. We very much appreciate your leadership in making health insurance more accessible to small business owners and their employees.

Sincerely,

John J. Motley III
Vice President
Federal Governmental Relations

600 Maryland Avenue S.W. Suite 700 • Washington, D.C. 20024 • 202-554-9000 • Fax 202-484-1567

The Guardian of Small Business: for Fifty Years

HEALTHCARE
LEADERSHIP
COUNCIL

FOR IMMEDIATE RELEASE
May 12, 1995

Contact: Claire del Real
(202) 347-5731

STATEMENT BY
PAMELA G. BAILEY
PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL

The Healthcare Leadership Council (HLC) is pleased to support H.R. 1610, introduced on May 11 by Representatives Thomas (R-CA) and Stark (D-CA), and commends the sponsors and cosponsors of this bipartisan effort for their leadership in finally transforming the theory of health care reform into reality.

This important market-based legislation would go a long way toward addressing the problems in the current health care delivery system by eliminating "job lock" and ensuring that American workers can change jobs without fear of losing health care coverage due to a preexisting condition or illness. The positive implications of the Thomas/Stark bill are significant and far-reaching. Their proposal would not only provide health security to America's workers, but would also extend coverage to many who are now uninsured without severely impacting health plan premium costs.

Post-election polling conducted last November by the HLC indicates that the vast majority of Americans support targeted health care reform designed to ensure portability of health care coverage between jobs. Consumers are overwhelmingly satisfied with their choice of health care coverage, and with the cost and quality of coverage. The message is clear -- keep reform simple because the market is working.

Healthcare Leadership Council
1500 K Street NW Suite 360
Washington, D.C. 20005
202 347-5731

Congress has the unique opportunity to enact targeted, consensus health care reform this year and should not get sidetracked by overly regulatory and burdensome proposals which are controversial and would threaten our market-based delivery system. The Thomas/Stark bill is a meaningful step toward enacting such common sense health reform by allowing the market to continue proving its effectiveness in health care delivery and cost containment.

The HLC is a broad coalition of 60 Chairmen and CEO's of health care companies representing all sectors of the health care industry. The HLC is firmly committed to ensuring access to quality, affordable health care through the promotion of a market-based health care delivery system. Only a system defined by market-based principles and competition can ensure health care consumers real choice in the health care marketplace while at the same time reining in costs and improving the quality of health care delivery through innovation.

Chairman THOMAS. Thank you very much, Mr. Herbert.
Ms. Lehnhard.

STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, BLUE CROSS & BLUE SHIELD ASSOCIATION

Ms. LEHNHARD. Mr. Chairman, members of the subcommittee, I am here representing the 68 independent Blue Cross & Blue Shield plans. We want to first congratulate you on identifying a strategy that can finally break this gridlock that has blocked Congress from enacting any kind of health insurance reform. This is something that is very important to prove to the American public.

You have put into practice what we all learned last year, that the only way to enact health insurance reform is to take incremental steps starting where there is widespread bipartisan agreement on what can be done.

We all found out last year that the alternative to these incremental steps, comprehensive insurance reform, is very difficult. Comprehensive reform of the insurance market involves very complex tradeoffs. It raises the whole set of issues related to subsidies between the young and the old, the healthy and the sick, those in urban areas and in rural areas, those who keep their health insurance continuously, and those who buy it only when they need it.

Your proposal breaks this gridlock by eliminating a very real concern of people who have health insurance through their jobs. That is the concern that if they change their jobs, their families will lose protection while they go through the preexisting waiting period.

There is bipartisan support in Congress to do this. There is industry-wide support to move quickly. There will be a sense of relief when families no longer have to worry about there temporary loss of coverage.

We believe that limiting insurance reforms to those in your bill are important for four reasons. No. 1, your bill, your proposal is very clear and very easily implemented. Taking one step beyond these group-to-group portability rules, for example, extending portability to the individual market, we believe, would result in a need for a major new Federal regulatory program, something this Congress may not easily accept.

No. 2, the bill applies the rules across all segments of the market. It isn't at all clear that Congress would apply rules that go beyond group-to-group portability across the market and that is very important if you want to have a stable, competitive marketplace.

No. 3, your bill is a logical division of Federal and State responsibility. It defers to the ability of States to determine what works best in their own markets. Forty-four States have already enacted various types of small group reform, and I stress various types of small group reform. However, only a Federal bill can assure portability for everyone since the States can't regulate self-funded plans with respect to waiting periods.

Finally, group-to-group portability is the only stand-alone reform. The next level of insurance reform is not a single step, it is more a complex web where one reform is meaningless without the rest of them. For example, no State has done guaranteed issue without the complex rating reforms that accompany it.

To put the benefit of your bill in human terms, if your bill is enacted, not one of the 137 million people that have health insurance through their jobs would have to turn down a job that would mean a better standard of living for their family just because changing jobs would mean a temporary loss in health insurance coverage.

Thank you.

[The prepared statement follows:]

TESTIMONY OF MARY NELL LEHNHARD
BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman, and members of the committee, I am Mary Nell Lehnhard, Senior Vice President, of the Blue Cross and Blue Shield Association, the coordinating organization for the 68 independent Blue Cross and Blue Shield Plans. Collectively, the Plans provide health benefits protection for 65 million people. I appreciate the opportunity to testify before you on the need to move forward with federal reform to achieve greater portability of coverage and address the important problem of job-lock.

For the past year or two, Congress and the American public have wrestled with the concept of comprehensive reform. We at the Blue Cross and Blue Shield Association, along with our member Plans, have been an active participant in that effort. This prolonged debate demonstrated that achieving comprehensive reform in a system as complex as ours is no easy task. The Chairman's bill draws on an important lesson from this experience, which is that to achieve real reform we must take an incremental approach, focusing on those problems that virtually all agree can be solved without doing damage to what is working in the current system.

We support the bill that has been proposed by Chairman Thomas as an important step that can be taken today to give the 137 million Americans covered by group health plans greater security because they will be able to maintain coverage when they change jobs. Chairman Thomas has proposed a common-sense approach that builds on the system of voluntary employer-sponsored health care coverage. It supports the revolution in health care that is already well underway in the private sector and the states. It is consistent with promoting market competition in health care. It addresses a significant concern of working Americans. It preserves an appropriate role for the states in the regulation of insurance. And it avoids the pitfalls inherent in attempting to enact grand, comprehensive, federal solutions — the reef on which health care reform foundered last year.

Federal health care reform should promote a competitive market and build on the foundation of employer-based coverage.

Health care reform is well underway in the private market and the states. Private sector innovation is the key to making affordable coverage more widely available by offering consumers a choice of health plans that effectively manage costs on behalf of their subscribers.

Private sector reforms are causing a virtual revolution in health care financing and delivery. This revolution was brought about by market competition. It builds on the foundation of employer-sponsored health benefits. And it responds to the public's demand for a choice of affordable, high quality health plans — a demand that we believe will best be met in a competitive market. The extent of this revolution is illustrated by our own experience. Enrollment in network-based health plans operated by Blue Cross and Blue Shield Plans has increased from 1% percent of total enrollment in 1982 to more than 42 percent of total enrollment in 1994. The success of these efforts to re-engineer health care coverage is illustrated by the 1994 Foster-Higgins survey of employer benefit plans, which reported that the average per-employee cost of health benefits actually declined between 1993 and 1994 as employees enrolled in record numbers in network-based health plans.

Government can support the revolution in the private sector, but it must be careful to build on the strengths of the current system by promoting and protecting a competitive market.

We believe that the current system of employer-sponsored coverage through which the vast majority of all Americans receive their coverage has served the nation well. More than 137 million employees and dependents obtain coverage for health care costs through employer-sponsored health benefit plans. The coverage available through employer-sponsored coverage has become broader and more comprehensive with each passing year.

In an effort to better manage costs, employer-sponsored health plans pioneered the development of health plans that rely on carefully selected networks of providers and well designed programs to ensure that the medical care provided to employees is necessary and appropriate. These efforts have allowed employers to offer their employees a choice of benefit plans that best suit their needs.

There are problems, certainly. The voluntary employer-based system of coverage cannot solve all problems. An employer-based system cannot make coverage available to those who are unemployed. Nor can it make coverage available to those who are employed by firms or in industries that cannot afford to pay for health benefits. As the past two years' debate demonstrated, however, these problems cannot be solved without funding significant new subsidies for those who cannot afford coverage because they lack the income to pay for it.

These problems notwithstanding, the employer-sponsored system of health insurance does a very good job of making coverage available to the vast majority of those who want, and are prepared to pay, for it. And it provides a foundation on which public sector programs to make coverage available to the most vulnerable members of society — the elderly, disabled, and poor — can build. One area in which improvement is both needed and possible is providing greater assurances to those who change jobs that they will be able to maintain their health benefits even if they have so-called "pre-existing" medical conditions.

The Thomas bill is a workable, well-designed, incremental step to increase portability of coverage for those who change jobs.

The Thomas bill addresses an issue that is of significant concern to working Americans who are currently covered by employer-sponsored health benefit plans. It would require all employer-sponsored group health plans to recognize prior group coverage when limiting coverage for pre-existing conditions.

This requirement would increase the ability of people who change jobs to maintain coverage — even if they or a family member has a chronic or pre-existing medical condition.

The approach taken by Chairman Thomas carefully defined an appropriate role for the federal government while recognizing the important role of states in developing viable, effective reforms. As discussed below, many of these state laws establish limits on pre-existing condition waiting periods for products sold to small employers. The Thomas bill would leave these requirements in place.

Under Chairman Thomas' proposal, the federal government does what only the federal government can do: it establishes standards to achieve greater portability of coverage that will apply to all group health plans. It would not mandate a specific pre-existing condition waiting period. Nor would it require an employer to offer coverage. It would require any employer who voluntarily offers a health benefit plan to apply waiting periods uniformly, without regard to the health status of an individual employee or an employee's family members. This requirement would apply to all employer health plans — including those that cannot be regulated by states.

In designing the portability bill, Chairman Thomas has been careful to address the potential abuse of pre-existing condition exclusions while avoiding the principal technical and policy problems often posed by limits on these exclusions. The principal value of pre-existing condition restrictions is their role in creating incentives for individuals to maintain continuous coverage. By discouraging individuals from going without coverage until they need medical care, the cost of coverage is reduced for both employers and for those covered under employer-sponsored health benefit plans. The proposed bill allows employers to establish the kind of pre-existing condition exclusions that are needed to encourage continuous coverage. At the same time, it prevents the selective use of such exclusions to deny coverage to those who have been continuously covered and who need medical care.

The Thomas bill builds on the success of states in reforming the small group market. Although the scope of the Chairman's bill is modest, it works in harmony with state efforts to reform the small group market. The successful track record of states that have enacted small group reform both demonstrates that reform is possible and suggests the futility of identifying 'the one best way' of making sure that consumers have a range of choices in a competitive market.

Since 1990, 45 states have enacted small group reforms. Of these:

- all 45 have adopted restrictions on rating that are designed to make sure that even those groups whose members are unfortunate enough to need substantial amounts of medical care continue to pay a reasonable amount for coverage.
- 42 limit the length of pre-existing condition exclusions.
- 35 require all carriers to make at least one product available to any group, regardless of the health status, age, or anticipated use of health services by members of the group.
- 13 require all carriers to make any of the products offered to small groups available to any small group regardless of health status or anticipated claims experience.

Generally, we believe that these state reforms have been successful. However, state reform efforts also teach another lesson: reforming the market for health care coverage is an ongoing process that requires a careful weighing of competing interests. The states are in the best position to design and implement solutions the complex and challenging task of regulating health insurers. For example, the maximum length of pre-existing condition exclusions has a significant impact on the expected cost of coverage. In general, the shorter the pre-existing condition period, the higher the cost of coverage. The limits that have been established by each state reflect the costs that employers in that state are able to bear.

Some may criticize the Chairman's bill for not addressing the problem facing individuals who lose coverage under group health plans.

We believe that the solution to this problem can and will be found in state efforts to reform the market for individual coverage. The issues that must be addressed in individual market reform are many and complex. There is little agreement on the best way of resolving these issues, and it is likely that different states will find different solutions that meet the needs of their citizens. We believe that the states are in the best position to find these solutions.

To date, 20 states have begun the difficult task of reforming the market for individuals who are not able to purchase group coverage. In addition, the National Association of Insurance Commissioners will be developing, this year, model legislation to provide states with guidance as they take up the difficult issues that individual market reform poses.

In summary, we believe that it is important to do what can be done to address significant concerns on which there is broad agreement on a clear set of solutions. The bill being proposed by Chairman Thomas is one such solution. We are prepared to work with you and other members of the committee to develop practical solutions to the most pressing problems in health care, to strengthen competitive markets, and to build on the solid foundation of employer-sponsored health coverage that serves so many so well today.

H:\policy\hearings\w&m\leg12may.doc

James A. Klein
Executive Director

May 11, 1995

The Honorable William Thomas
Chairman, Health Subcommittee
Committee on Ways and Means
U.S. House of Representatives
1136 Longworth House Office Building
Washington, DC 20515

Dear Chairman Thomas:

The Association of Private Pension and Welfare Plans (APPWP) commends you on the introduction of H.R. 1610, which enhances the portability of health benefits. Achieving greater portability of coverage for workers and their families while retaining appropriate incentives for individuals to purchase coverage before they become ill would be a significant accomplishment.

We are gratified that H.R. 1610 adopts a well-targeted rather than broad approach to health care legislation. The bill expands portability of coverage and reduces "job lock" while allowing employers the discretion they need to appropriately structure the health benefits that they voluntarily provide to employees. Since H.R. 1610 avoids overregulation, it will not discourage employers from voluntarily sponsoring health plans for their employees.

Again, we commend you on introducing H.R. 1610. We look forward to discussing technical issues with you in the near future and, as always, the APPWP will be pleased to work with you as H.R. 1610 moves through the legislative process.

Sincerely,

James A. Klein
Executive Director

1212 New York Avenue, N.W. • Suite 1250 • Washington, D.C. 20005 • (202) 289-6700 • FAX (202) 289-4582

Chairman THOMAS. At this point, I recognize the gentleman from Wisconsin, Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Chairman, I have before me the statement from Congressman Pete Stark, who will be here shortly. I am almost tempted to deliver the statement, Mr. Chairman, because it does border on being complimentary to you. However, for the sake of brevity and to expedite the hearing today, I ask unanimous consent that the Stark statement be put in the record.

Chairman THOMAS. I thank the gentleman, I think, and I will invoke the chewing gum rule on that. If there is any flattery in it, you are supposed to enjoy it briefly and not swallow it, and we will do that.

[Mr. Stark's statement was not available at the time of printing.]

Chairman THOMAS. Thank you all once again.

Dr. Fronstin, once again, thank you. The microphone is yours. If you have any written statement, it will be made a part of the record, without objection; and you may proceed for 5 minutes to inform us in any way you see appropriate.

STATEMENT OF PAUL FRONSTIN, PH.D., RESEARCH ASSOCIATE, EMPLOYEE BENEFIT RESEARCH INSTITUTE, WASHINGTON, D.C.

Mr. FRONSTIN. Thank you.

Mr. Chairman and members of the subcommittee, I am pleased to appear before you this morning to discuss the issue of health insurance portability. My name is Paul Fronstin. I am a research associate at the EBRI, Employee Benefit Research Institute. Dallas Salisbury, the president of EBRI, asked that I thank you for the invitation to testify and he sends his regret in not being able to appear himself.

EBRI is a nonprofit, nonpartisan public policy research organization based in Washington, D.C. 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.

I would ask that my full statement be placed in the record.

This morning, I will cover four points relating to the issue of the portability of health insurance: Continuation of coverage issues through COBRA; preexisting condition provisions, price, and job lock; public opinion results regarding job lock; and research results regarding job lock.

COBRA's original purpose was to assure workers the ability to maintain health insurance during a transition period to other coverage. Qualified employees and their dependents may continue coverage for up to 18 or 36 months if the employment is terminated. COBRA beneficiaries may be charged 102 percent of the premium or, in the case of self-insured plans, 102 percent of the cost of the plan.

Several surveys have been conducted regarding the issues surrounding the use of COBRA. Some key results of the Charles D.

Spencer & Associates survey conducted in the spring of 1994 include the following:

Of the 14.5 percent of employees and dependents eligible for COBRA coverage, about 20 percent elected the coverage.

Average COBRA costs were approximately $5,600, as compared with $3,900 for active employees. Thus, average continuation of coverage costs were 149 percent of active employee claims costs, and, assuming employees electing coverage were paying 102 percent of the premium, employers were paying for approximately one-third of the total cost of continued coverage.

Job lock may occur for several reasons. These reasons include preexisting condition clauses in a potential employer's health plan, coverage is not offered from a potential employer, the potential employer offers less coverage than the current employer, and the potential employer does not offer health insurance coverage at all.

Selected past reform proposals have assumed that disallowing or restricting preexisting condition clauses and making health insurance more portable and personal would lessen job lock.

As of January 1994, 34 States have enacted laws that prohibit employers from imposing new waiting periods before being covered for preexisting conditions. These laws primarily pertain to the small group market. No conclusive research has been done that assesses the impact of these laws on job mobility.

In the presence of COBRA, preexisting conditions are not necessarily the primary motivating reason behind individuals choosing not to change jobs. This is because individuals can continue their current coverage after moving to a new employer, but only as long as they are willing to pay 102 percent of the premium. Thus, these individuals could carry two plans until the waiting period was satisfied. In some cases, the plan may not cover a preexisting condition at all, with or without a waiting period.

Regardless of the existence of COBRA, cost, comprehensiveness of the benefit package, and the availability of coverage remain important factors affecting job lock.

The Employee Benefit Research Institute, in conjunction with the Gallup organization, has conducted several public opinion surveys regarding the perspective and prevalence of Americans on job lock.

In 1993 we found that 20 percent of surveyed Americans indicated that they or a family member passed up a job opportunity based solely on health benefits.

When asked in further detail the reason for not changing a job based on health benefits, 33 percent cited that health benefits were not offered by the prospective employers, 20 percent cited a preexisting condition, 19 percent cited that the cost of the plan was too high, and 20 percent cited a less generous benefits package.

In addition to the public opinion surveys, several studies have been conducted regarding job mobility and health insurance. The findings are mixed and do not uniformly support or refute the existence of job lock. Studies that do support the theory of job lock show wide variation in the magnitude of its effects based on demographic and employment-based characteristics.

Thank you for the opportunity to testify this morning. I will be glad to answer any questions.

[The prepared statement and attachments follow:]

TESTIMONY OF PAUL FRONSTIN
EMPLOYEE BENEFIT RESEARCH INSTITUTE

Introduction

Mr. Chairman and members of the Committee, I am pleased to appear before you this morning to discuss the issue of health insurance portability. I am Paul Fronstin, a research associate at the Employee Benefit Research Institute (EBRI). Dallas Salisbury, the president of EBRI, asked that I thank you for the invitation to testify and send his regret at not being able to appear himself. 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. I would ask that my full statement be placed in the record.

The majority (57.4 percent) of Americans in 1993 received their health insurance coverage through the employment-based system (Snider and Fronstin, 1995). This connection may affect employees' compensation and, for some, their decisions about job change. The concern about the portability of health insurance may relate to the loss of health insurance benefits when a worker is offered a new job that could alter his or her insurance status. For example, if health insurance is not offered by a prospective employer, if the worker must satisfy a waiting period before becoming eligible for coverage, if the benefits package offered through the prospective employer is less generous, or if the employee has a condition that would be considered a preexisting condition and would not be covered under the new plan, the employee may opt to remain with his or her current employer. This may result in "job lock" or in employees forgoing job opportunities that could potentially increase their productivity. For employers who want employees to leave or retire and for employees who would prefer to change jobs, this job lock can be undesirable. Congress focused on portability of health insurance in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) by providing for continuation of health insurance coverage.

This morning I will cover four points relating to the issue of health insurance portability: continuation of coverage issues through COBRA; preexisting condition provisions, price, and job lock; public opinion results regarding job lock; and research results regarding job lock.

Portability and COBRA

The original purpose of the coverage continuation provisions of COBRA was to assure workers an ability to maintain health insurance during a period of transition to other coverage. COBRA requires employers to offer continued health insurance coverage to employees and their dependents when certain qualifying events occur. Qualified employees and their dependents may continue coverage up to 18 months (29 months for disabled employees) if employment is terminated (other than for gross misconduct) or if hours of work are reduced below the level at which coverage is normally provided. Dependents may continue coverage for up to 36 months if coverage is lost as a result of the employee losing coverage, cessation of dependent status, death of the employee, divorce or legal separation, or entitlement to Medicare. The charge to COBRA beneficiaries during the coverage period is limited to 102 percent of the premium (102 percent of the cost if the plan is self-insured)[1] for similarly situated employees for whom a qualifying event has not occurred. The employer may charge disabled employees 102 percent for the first 18 months and up to 150 percent during the 19th through 29th month.

Several surveys have been conducted regarding issues surrounding the use of COBRA. Some key results of the Charles D. Spencer & Associates, Inc. survey conducted in the spring of 1994 include:[2]

- Of the 14.5 percent of employees and dependents eligible for COBRA coverage, about 1 in 5 (19.6 percent) elected the coverage in 1994, up from 19.3 percent in 1993 but down from a high of 28.5 percent in 1990 (table 1).

- Among the entire 1994 surveyed population, 2.9 percent of the active employee work force elected COBRA coverage, up from 1.7 percent in 1993 (table 1).

- Average COBRA costs were $5,584 , compared with $3,903 for active employees, according to the 1994 survey. Thus, average continuation of coverage costs were 149 percent of active employee claims costs, and, assuming employees electing coverage were paying 102 percent of the premium, employers were paying for approximately one-third (32 percent) of the total costs for continued coverage. Claims cost ratios ranged from 41 percent to 500 percent. Data also indicate that within a given plan year, COBRA costs bear little relationship to active employee costs; COBRA costs more closely resemble individual (as opposed to group) plan costs in that they are not consistent from year to year.

- Among all eligibles electing coverage, 15.9 percent were spouse/dependent elections (7.9 percent selected coverage because of termination or reduction in hours, and 8.0 percent elected coverage because of death, divorce, or plan ineligibility). Employee elections accounted for 84.1 percent of all eligibles electing coverage (table 2).

- Among all spouses and dependents eligible for coverage, 9.6 percent elected coverage, compared with 37 percent in 1993, 23.4 percent in 1992, 25 percent in 1990, and 36.6 percent in 1988. Among employees eligible for coverage, 19.8 percent elected coverage in 1994.

- For 18-month qualifying events, the average length of coverage was 10.76 months. For 36-month qualifying events, the average length of coverage was 23.1 months. Among individuals electing coverage, less than 1 percent converted to an individual policy.

- Difficulties surrounding COBRA coverage according to survey respondents included adverse selection/claims cost (36 percent); difficulties in collecting premiums (36 percent); administrative difficulty such as paperwork, record keeping, etc. (30 percent); excessive time for beneficiary response, tracking eligibility (24 percent); notification from continuee of election or change in status (19 percent); and lack of final rules, complexity of law (15 percent).

Why people do not elect to take COBRA coverage has not been well documented.

Preexisting Conditions, Pricing, and Job Lock

Part of the issue of portability is the issue of job lock. Job lock may occur either because a worker cannot get health insurance coverage through a prospective position, or because while the worker can obtain coverage, the premium is higher at the prospective job than at the initial job, the benefits package is less generous, or selected conditions are not covered (i.e., a preexisting condition clause may discourage a worker from leaving the current job and health insurance plan to move to a new plan that does not cover a given health condition). Selected past health care reform proposals have assumed that disallowing or restricting preexisting condition clauses and making health insurance more portable and personal would lessen job lock.

As of January 1994, 34 states have enacted laws that prohibit employers from imposing new waiting periods on employees before they are covered for preexisting conditions. These laws primarily

pertain to the small group market (Atchison, 1994). No conclusive research has been done that assesses the impact of these laws on job mobility.[3] However, in the presence of COBRA, among plans that will cover a preexisting condition following a waiting period, preexisting conditions are not necessarily the primary motivating reason behind individuals choosing not to change jobs. This is because individuals can continue their current coverage for a maximum of 18–36 months even once moving into the new position if they are willing to pay 102 percent of the premium. Thus, these individuals could carry two plans until the waiting period was satisfied. In some cases, though, the plan may not cover a preexisting condition at all—with or without a waiting period. Regardless of the existence of COBRA, cost, comprehensiveness of the benefit package, and availability of coverage remain of importance.

Public Opinion Results on Job Lock

EBRI, in conjunction with The Gallup Organization, Inc., conducted several public opinion surveys regarding Americans' perspective on job lock. Some key findings include:[4]

- In 1993, 20 percent of surveyed Americans indicated they or a family member passed up a job opportunity based solely on health benefits, up from 11 percent in 1992 and 13 percent in 1991 (chart 1).

- In 1993, among respondents who stated they or a family member passed up a job opportunity based solely on health benefits, age, annual income, and education showed the greatest variation (chart 2), while other variables, such as occupation, sex, race, region, and marital status, showed little variation.

- Among age groups, 18–34 year olds were most likely to have passed up a job opportunity based solely on health benefits (28 percent). This compares with 21 percent among individuals aged 35–54 and 7 percent among individuals aged 55 and over (chart 2).

- Individuals with an annual income of $20,000–$75,000 were most likely to have passed up a job opportunity based solely on health insurance (23 percent) (chart 2).

- In looking at education level, individuals with some college experience were most likely to pass up a job opportunity based solely on health benefits (26 percent), compared with individuals with a high school diploma or less (16 percent) and individuals with a college or post graduate education (19 percent) (chart 2).

- When asked in further detail the reason for not changing jobs based on health benefits, the reason most often cited was that health benefits were not offered by the prospective employer (58 percent in 1991). The likelihood of this reason declined to 33 percent in 1993 yet remained the most commonly cited reason. Among other reasons cited, having a preexisting condition showed the largest increase, moving from 10 percent in 1991 to 20 percent in 1993 (chart 3).

- Individuals in 1993 most likely to respond that the reason they did not change jobs was that "the prospective employer did not offer health benefits" were individuals with less than a high school education (48 percent), individuals with a high school diploma (38 percent), and individuals with an annual income of $20,000–$75,000 (35 percent). Individuals least likely to give this reason were individuals with an annual income of $75,000 or more (16 percent).

- In 1993, individuals most likely to respond that they did not change jobs because "the prospective employer's health benefits provided less coverage than you or a family member had previously" were unmarried individuals (30 percent), college graduates (26 percent), and individuals with an annual income of less than $20,000 (26 percent). Individuals least likely to give this reason were secretarial and clerical workers (6 percent) and individuals with an annual income of $75,000 and more (7 percent).

- In 1993, individuals most likely to respond that they did not change jobs because "you or someone in your family had a medical condition the prospective employer's health plan did not cover" were individuals with an annual income of $75,000 and over (30 percent), women (27 percent), and individuals with a postgraduate degree (27 percent). Individuals least likely to give this reason were individuals aged 55 and over (8 percent), men (12 percent), and individuals with an annual income of less than $20,000 (12 percent).

- In 1993, individuals most likely to respond that they did not change jobs because "the prospective employer's health plan cost too much" were secretarial and clerical workers (41 percent) and individuals who did not graduate from high school (36 percent). Individuals least likely to give this reason were individuals with an annual income of $75,000 or more (6 percent) and individuals with a postgraduate degree (10 percent).

Research Results on Job Lock

In addition to public opinion surveys, several studies have been conducted regarding job mobility and health insurance. The findings are mixed and do not uniformly support or refute the existence of job lock. Studies that do support the theory of job lock show wide variation in the magnitude of its effects based on demographic and employment-based characteristics. Findings from these studies are summarized below and in an accompanying table I will submit for the record (table 3).

- Mitchell (1982 and 1983) conducted one of the first studies regarding the magnitude of job lock. Mitchell found evidence that the loss of a pension promise was a particularly strong deterrent to quitting. While Mitchell also found evidence that medical coverage deterred employees from quitting, it was at a fairly low level of reliability.

- Madrian (1993) and Cooper and Monheit (1993) provided the strongest evidence of job lock. Madrian estimates that job lock reduces the voluntary turnover rate of those with employer-provided health insurance by 25 percent, from 16 percent to 12 percent per year. Cooper and Monheit found that policyholders of employment-based coverage were three and one-half times less likely to change jobs than uninsured workers. However, they did not find worker or dependent health conditions associated with job mobility.

- Cooper and Monheit (1993) also indicate that mobility rates vary based on worker characteristics. Most likely to change jobs were younger workers with little job experience, part-time workers, workers with low levels of education, and workers with low hourly wages. Least likely to change jobs were full-time workers, workers with high levels of education, and workers with high hourly wages. The authors also indicate that married men who expected to lose coverage were 23 percent less likely to change jobs. Workers who were likely to gain coverage through a change in employment were 52 percent more likely to change jobs as compared with those whose insurance prospects were not expected to change.

- Madrian (1993) cites three factors to consider in evaluating the implications of job lock for economic efficiency: Does job turnover result in a better match between workers and firms and thereby increase productivity? To the extent that job lock does lower productivity, are losses temporary or permanent? and Is job lock a benefit or a cost for firms?

- Gruber and Madrian (1994) found that continuation of coverage mandates were successful in reducing job lock. They found that one year of continuation benefits was associated with a 10 percent increase in mobility among those with health insurance.

- In a later publication, Monheit and Cooper (1994) found that job lock was present in the labor market but that the proportion of workers affected and the magnitude of the welfare loss was less than generally supposed.

- Holtz-Eakin (1993) indicated that there was little evidence that health insurance provision interferes with job mobility. In his study of individuals who changed jobs as compared with those who did not he found that, in analyzing health insurance alone, there was a correlation between job mobility and health insurance. However, when looked at as part of a total compensation package, the importance of health insurance with regard to incentive to change jobs disappeared.

Conclusion

Several questions must be addressed when assessing the impact of preexisting conditions and health insurance portability on job lock. Does the issue of the portability of health insurance affect job mobility? And, if so, to what extent? Only a few studies have been done in this arena to date and results of these studies are mixed. In addition, studies that find that having employment-based health insurance impacts on job mobility indicate that there is wide variation in the magnitude of that impact. COBRA may act to reduce whatever job lock does exist. However, based on public opinion surveys, some Americans still indicate having passed up a job opportunity because health insurance was not offered in the new position (33 percent in 1993), because the new job offered less coverage (20 percent), because of a preexisting condition (20 percent) or because the new health insurance cost too much (19 percent). While preexisting conditions are indicated as a reason for not changing jobs, the existence of COBRA should mitigate this as an issue for those whose prospective employer's plan covers the preexisting condition following a waiting period.

Thank you for the opportunity to testify this morning. I'll be glad to answer any questions you may have.

References

Atchison, Lisa, et al. *Major Health Legislation in the State: '93.* Washington DC: The George Washington University, 1994.

Cooper, Philip F., and Alan C. Monheit. "Does Employment-Related Health Insurance Inhibit Job Mobility?" *Inquiry* (Winter 1993): 400-16.

Employee Benefit Research Institute/The Gallup Organization, Inc. "*Public Attitudes on Benefit Trade Offs, 1991.*" Report no. G-28 (Washington, DC: Employee Benefit Research Institute, December 1991).

Employee Benefit Research Institute/The Gallup Organization, Inc. *"Public Attitudes on Health Benefits, 1993.* Report no. G-50 (Washington, DC: Employee Benefit Research Institute, November 1993).

Employee Benefit Research Institute/The Gallup Organization, Inc. *"Public Attitudes on Health Benefits, Part 1."* Report no. G-30 (Washington, DC: Employee Benefit Research Institute, February 1992).

Gruber, Jonathan and Brigitte C. Madrian."Health Insurance and Job Mobility: The Effects of Public Policy on Job-Lock." *Industrial and Labor Relations Review* (October 1994): 86-102.

Holtz-Eakin, Douglas."Health Insurance Provision and Labor Market Efficiency in the United States and Germany." Working Paper Series, no. 4388. Cambridge, MA: National Bureau of Economic Research, 1993.

Madrian, Brigitte, C. "Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job-Lock?" Working Paper Series, no. 4476. Cambridge, MA: National Bureau of Economic Research, 1993.

Millholland, Paul. "Employers COBRA Costs," *EBRI Notes* (November 1992): 1–4.

Mitchell, Olivia S. "Fringe Benefits and Labor Mobility" *The Journal of Human Resources* (Spring 1982): 286–298.

Mitchell, Olivia S. "Fringe Benefits and the Cost of Changing Jobs" *Industrial and Labor Relations Review* (October 1983): 70–78.

Monheit, Alan C. and Philip F. Cooper." Health Insurance and Job Mobility: Theory and Evidence." *Industrial and Labor Relations Review* (October 1994): 68–85.

Snider, Sarah C. "Public Opinion on Health, Retirement, and Other Employee Benefits." *EBRI Issue Brief* no. 132 (Employee Benefit Research Institute, December 1992).

Snider, Sarah C. and Paul Fronstin."Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1994 Current Population Survey." *EBRI Issue Brief* no. 158 (Employee Benefit Research Institute, February 1995).

Spencer's Research Reports. "1994 COBRA Survey: One in Five Eligible Employees Takes COBRA; Employers Pay One-Third." Chicago, IL: Charles D. Spencer & Associates, Inc., August 19, 1994.

---

[1]The Internal Revenue Service has issued guidance for determining the premium for self-funded plans. Premiums may be based on an actuarial determination for providing benefits for active employees during the same period, or may be based on past cost. The latter is the cost equal to the plan's cost for similarly situated beneficiaries for the same period during the previous determination period adjusted by increases or decreases in the cost-of-living as measured by the gross national product. See Terry Humo and Keith C. Kakacek, "Employers Guide to Self-insuring Health Benefits" (Washington, DC: Thompson Publishing Group, 1993).

[2]A total of 270 companies responded to Spencer's 1994 survey, representing 1,527,648 employees. Data are for the 1993 plan year. Surveys have also been conducted by the International Society of Certified Employee Benefit Specialists and Towers Perrin and the National Association of Manufacturers. For a synopsis of findings from these surveys, see Paul Millholland, "Employers' COBRA Costs," *EBRI Notes* (November 1992): 1–4.

[3]In looking at the issue of limited insurance portability as a whole, Gruber and Madrian (1994) found that continuation of coverage mandates were successful in reducing job lock. They found that one year of continuation benefits was associated with a 10 percent increase in mobility among those with health insurance.

[4]EBRI/Gallup public opinion surveys are stratified random sample telephone surveys of 1,000 individuals. These surveys have a maximum expected error range at the 95 percent confidence level of ±3.1 percent.

Table 1
Entitlement and Elections for Consolidated Omnibus Budget Reconciliation Act (COBRA), Plan Years 1988–1993

Survey Year	Employees Elected as a percentage of active employees	Employees Entitled as a percentage of active employees	Employees Elected as a percentage of those entitled
1989	1.70%	16.00%	11.20%
1990	2.60	9.20	28.50
1991	2.20	10.60	20.50
1992	1.60	12.06	13.23
1993	1.68	8.71	19.30
1994	2.86	14.54	19.64

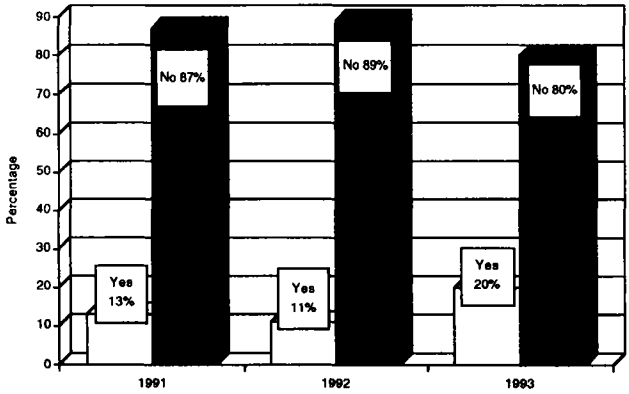
Source: Charles D. Spencer and Associates, Inc., "1994 COBRA Survey: One in Five Eligible Employees Takes COBRA; Employers Pay One-Third," *Spencer's Research Reports* (August 19, 1994).

Table 2
Reasons for Consolidated Omnibus Budget Reconciliation Act (COBRA) Elections, Plan Years 1990–1993

Survey Year	Total Electing Coverage	Spouse/Dependent Election		Employee Election
		Termination or reduction in hours	Death, divorce, plan ineligibility	Termination or reduction in hours
		(percentage)		
1991	100%	16.00%	7.60%	76.40%
1992	100	10.15	8.29	81.56
1993	100	15.00	13.50	71.50
1994	100	7.90	8.00	84.10

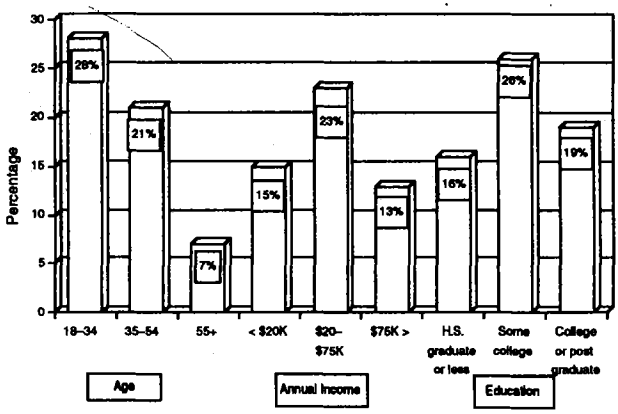
Source: Charles D. Spencer and Associates, Inc., "1994 COBRA Survey: One in Five Eligible Employees Takes COBRA; Employers Pay One-Third," *Spencer's Research Reports* (August 19, 1994).

Chart 1
Question 9: "Have you or a family member ever passed up a job opportunity or stayed in a job you would have preferred to leave solely because of health benefits?," 1991–1993



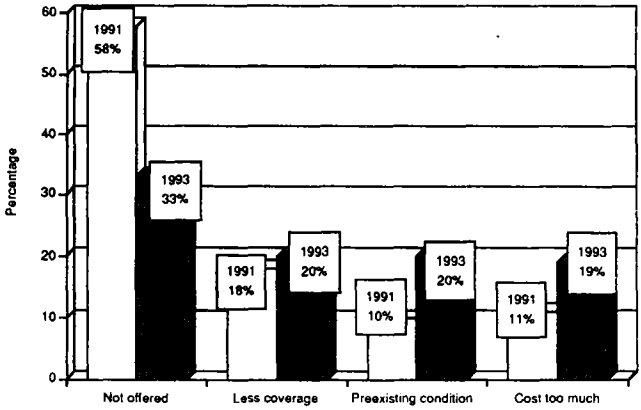
Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Benefit Trade Offs, 1991* (Washington, DC: Employee Benefit Research Institute, December 1991); and *Public Attitudes on Health Benefits, Part 1* (Washington, DC: Employee Benefit Research Institute, February 1992); and *Public Attitudes on Health Benefits, 1993* (Washington, DC: Employee Benefit Research Institute, November 1993).
Note: Asked of 1,000 individuals age 18 or older from randomly generated telephone lists.

Chart 2
Question 9: Percentage of individuals who responded yes to, "Have you or a family member ever passed up a job opportunity or stayed in a job you would have preferred to leave solely because of health benefits?," by age, annual income, and education level, 1993



Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Health Benefits, 1993* (Washington, DC; Employee Benefit Research Institute, November 1993).

Chart 3
Question 10: "Which of the following best describes the reason you or your family member chose not to change jobs?," 1991 and 1993



Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Benefit Trade Offs, 1991* (Washington, DC: Employee Benefit Research Institute, December 1991; and *Public Attitudes on Health Benefits, 1993* (Washington, DC: Employee Benefit Research Institute, November 1993).
Note: The balance of reasons are the following: in 1991, other (3 percent); in 1993, other (4 percent); secure at present job (3 percent); and none of these reasons (1 percent).
Refer to charts 1 and 2 for the number of individuals who responded yes to the question, "Have you or a family member ever passed up a job opportunity or stayed in a job you would have preferred to leave solely because of health benefits?"

Table 3
Employment-Related Health Insurance and Job Mobility: Alternative Estimates of Job Lock in the United States

Study	Sample/Method	Magnitude of Job Lock
Mitchell (1982)	Wage earners 18–65 years of age from the Quality of Employment Survey in 1973 and 1977. Estimated a reduced form probit equation of likelihood of job change using baseline insurance status.	Probability of job change for men reduced by 4.24 percentage points.[a] Not statistically significant.
Madrian (1994)	1987 National Medical Expenditure Survey. Sample of married men 20–55 years of age. Used a probit estimate of the likelihood of job change to derive a "difference in the difference" estimator; examined three empirical tests for job lock.	Mobility rates reduced by 30%–31% for those with employment-related coverage compared to those without such coverage; mobility rates reduced by 33%–37% for those married men with employment-related coverage and large families (proxy for medical care costs); mobility rates reduced by 67% for those with employment-related coverage and a pregnant wife (proxy for medical care costs). All statistically significant.
Holtz-Eakin (1994)	1984 wave of the Panel Study of Income Dynamics. Sample of full-time workers 25–55 years of age. Derived a "difference in the difference" estimator for job changes over one- and three-year intervals.	For job changes during 1984–1985: mobility rates for married men reduced by 1.59 percentage points (result insignificant); rates for single women reduced by 1.06 percentage points (insignificant); job lock effects for other groups not found (wrong sign and insignificant). Results for three-year intervals insignificant.
Cooper and Monheit (1993)	1987 National Medical Expenditure Survey. Sample of wage earners 25–54 years of age. Predicted whether workers would gain or lose coverage on a new job, and used the results in a structural probit model of job change. Compared their mobility rates to the mobility rates of workers whose insurance status was expected to remain the same.	Among workers likely to lose coverage: mobility for married men reduced by 24.8%; single men by 23%; married women by 34.7%; single women by 38.8%. Results significant for one- or two-tail tests.

Source: Monheit, Alan C. and Philip F. Cooper, "Health Insurance and Job Mobility: Theory and Evidence" *Industrial and Labor Relations Review* (October 1994): 68–85.

[a]This figure is based on Monheit and Coopers computation based on coefficient and mean values reported by Mitchell (1982). Mitchell (1983) did not provide an explicit estimate of job-lock.

Mr. ENSIGN [presiding]. Thank you, Doctor.

Mr. Christensen.

Mr. Crane, questions?

Mr. CRANE. No.

Mr. ENSIGN. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Fronstin, since we are only dealing with the COBRA section of the Internal Revenue Code, and that is the jurisdiction of the subcommittee, as we all know, how many employees would we be covering with this legislation and how many would still not get the benefits of this bill?

Mr. FRONSTIN. Offhand, I do not know the total number of employees covered by COBRA, but I would be glad to get that information for you.

Mr. KLECZKA. OK. Thank you very much.

[The following was subsequently received:]

In response to your question on the number of Americans covered by COBRA, I have estimated that between 110 and 120 million Americans would be eligible for continuation of coverage under COBRA. These individuals include all workers and their dependents with health insurance coverage working for public and private estabishments with 20 or more employees. Health plans located within the District of Columbia are exempt from COBRA. Our estimate reflects this exemption. However, health plans that are sponsored by churches (as defined in section 414(e) of the Internal Revenue Code) are exempt from COBRA coverage. Unfortunately, we do not have data on the number of individuals in this category.

Mr. ENSIGN. Mr. Johnson.

Mr. JOHNSON of Texas. No.

Mr. ENSIGN. OK. In your testimony, you conclude that the fact that COBRA allows individuals with preexisting conditions to carry two policies until they are eligible for full coverage suggests preexisting conditions are not necessarily the primary motivating reason behind individuals choosing not to change jobs. It is hard to imagine an individual paying 102 percent of premium for a COBRA policy plus their contribution to a second policy isn't a factor. Wouldn't you agree?

Mr. FRONSTIN. I would agree that the cost is definitely a factor contributing to job lock, especially when expecting workers to pay 102 percent of one premium and possibly pay a portion of the other.

Mr. ENSIGN. Ideally, if you had to set up a program to prevent job lock, what are some of the ideas that you would come in with?

Mr. FRONSTIN. I haven't really thought about it in that much detail. If we were to just reduce the preexisting condition clauses, we are possibly going to affect the cost of the premium, and that is going to—what may happen is we found that about 20 percent were affected by preexisting conditions and about 20 percent were affected by the cost of the new plan. If we reduce preexisting condition clauses, we may increase the price of the plans and we may just be redistributing people among reasons. We just don't know. There is not enough evidence.

Mr. ENSIGN. OK. No other?

Well, thank you very much. I guess you did such a great job that nobody else has any questions. I appreciate your testimony this morning.

I would like to call the next panel forward: Neil Trautwein, manager, Health Care Policy, U.S. Chamber of Commerce; Donald Dressler, president for Insurance Services, Western Growers Association, Newport Beach, Calif.; and W.W. "Biff" Naylor, vice president-elect, National Restaurant Association.

Mr. ENSIGN. Mr. Trautwein, why don't you proceed, the yellow light will go off when you have 1 minute left. Thank you.

STATEMENT OF E. NEIL TRAUTWEIN, MANAGER, HEALTH CARE POLICY, U.S. CHAMBER OF COMMERCE

Mr. TRAUTWEIN. Thank you.

Mr. Chairman and members of the subcommittee, my name is Neil Trautwein and I am manager of Health Care Policy for the U.S. Chamber of Commerce. The chamber is the world's largest business association representing——

Mr. CHRISTENSEN. Mr. Trautwein, would you move closer to the microphone, please?

Mr. TRAUTWEIN. Yes, sir. The chamber represents 215,000 businesses, 96 percent of which have fewer than 100 employees and 71 percent of which have fewer than 10. We also represent 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 you this morning to comment on the chairman's proposed legislation on health insurance portability.

We commend the chairman and the members of this subcommittee for supporting H.R. 1610, bipartisan legislation to address health insurance portability. Targeted reforms such as those proposed by the chairman are important and valuable steps in reforming our health care system.

Our members remain committed to this effort. In fact, health care reform was a topic of a membership survey conducted in 1994, the largest survey ever conducted by the Chamber of Commerce. Results of that survey indicated that the chamber membership overwhelmingly endorses a free market approach to health care reform.

In conjunction with that trend, 84 percent of the members who responded sought to enhance the current health care system rather than impose burdensome regulations. That survey clearly illustrated opposition to any effort to enact hasty, all-encompassing reform legislation.

The chamber advocates the following steps as being integral and achievable steps toward positive health care reform. These are:

No. 1, insurance market reform designed to address the issues of availability and portability of health insurance coverage. The chairman's proposal on portability is certainly in line with these principles.

No. 2, price and quality report cards would allow consumers to compare the performance of the health plan they select with others in the market. Such information could be used to see which plan's record had the best balance between outcomes and cost.

No. 3, consumer choice among a variety of health plan structures should be facilitated, but incentives for consumer price sensitivity should be built into the system as well.

No. 4, voluntary purchasing pools would provide small employers and individuals with the same economies of scale and market leverage enjoyed by larger companies.

No. 5, administrative simplification measures would include standardized claim forms, greater emphasis on electronic processing, and computerized patient records.

No. 6, malpractice reform should include a cap on noneconomic damages and contingency fee percentages, provision for periodic payments, and a mandatory offset of payments from collateral sources.

No. 7, for the purpose of comparison shopping only, a benchmark package that all insurers would offer. This package could be modified by agreement between the insurer and purchaser, whether individual or employer.

Finally, 100 percent deductibility for the self-employed.

The targeted legislation before the subcommittee today seeks to address the problem known as job lock. For some, a new job or change of career is out of the question because of health conditions that existed prior to the desired change of employment. These preexisting conditions might limit or bar coverage under the prospective new employer.

We support the chairman's effort to address this problem by limiting the use of preexisting exclusions where continuous coverage was maintained. This approach would seem to be an important and effective step toward unlocking the job lock barrier.

Again, Mr. Chairman, we support this subcommittee's efforts. The chamber will continue to work in support of this and other market-based reforms based on the principles I discussed earlier.

We appreciate the opportunity to work with this subcommittee, and I would be happy to answer your questions.

[The prepared statement follows:]

STATEMENT
on
HEALTH INSURANCE PORTABILITY
before the
SUBCOMMITTEE ON HEALTH
of the
HOUSE COMMITTEE ON WAYS AND MEANS
for the
U.S. CHAMBER OF COMMERCE
by
E. Neil Trautwein
May 12, 1995

Mr. Chairman and members of the Subcommittee, my name is Neil Trautwein and I am Manager of Health Care Policy for the U.S. Chamber of Commerce. The Chamber federation represents 215,000 businesses (96 percent of which have fewer than 100 employees and 71 percent of which have 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 Chairman's proposed legislation on health insurance portability.

The Chamber commends Chairman Thomas for introducing bipartisan legislation to address health insurance portability.

The need to reform our health care system clearly is a challenge we face today. Targeted reforms such as that proposed by the Chairman are important and valuable steps in addressing this need.

Our members remain committed to improving our market-based health care system. In fact, health care reform was the topic of a membership survey conducted in April of 1994, the largest membership survey ever conducted in Chamber history.

Results of that survey indicated that Chamber membership overwhelmingly endorse the free market approach to health care reform. In conjunction with that trend, 84% of the members who responded sought to enhance the current health care system rather than sap its strengths by imposing burdensome regulations. The survey

clearly illustrated opposition to any effort to enact hasty, all-encompassing reform legislation.

The Chamber advocates the following elements as critical steps toward positive health care reform which is free of mandates, new taxes and expanded bureaucracy:

- Insurance market reform designed to address the issues of availability and portability of health insurance coverage. Insurers would be required, for example, to offer insurance to anyone who wanted it and would not be able to cancel coverage based on a person's or group's claims experience. There would also be a limit on the ability to deny coverage for pre-existing conditions. The Chairman's proposal to address portability is in line with the Chamber's views.

- Price and quality report cards would allow consumers to compare the performance of the health plan they select with others in the market. Such information could be used to see which plan's record had the best balance of successful outcomes and reasonable prices.

- Consumer choice among a variety of health plan structures (HMO, PPO, point-of-service, indemnity, etc.) should be facilitated, but incentives for consumer price sensitivity should be built into the process. That is, consumers should be able to save money for themselves by selecting a lower-cost plan, and should participate via deductibles and copayments in the cost of medical services.

- Voluntary purchasing pools would provide small employers and individuals with the same economies of scale and market leverage enjoyed by large employers.

- Administrative simplification measures would included standardized claim forms, greater emphasis on electronic processing, and computerized patient records.

- Malpractice reforms should include a cap on non-economic damages and contingency-fee percentages, provision for periodic payments, and a mandatory offset of payments received from collateral sources (e.g. health insurance and disability benefits or auto insurance).

- For the purposes of comparison-shopping only, a benchmark package that all insurers would offer. The package could be modified by agreement between the insurer and the purchaser (whether individual or employer) to suit different

needs and preferences.

- 100% deductibility of health insurance expenses by the self-employed would end an indefensible discrepancy in how different business structures are treated for tax purposes.

The targeted legislation before the subcommittee today seeks to address the problem known as "job lock." For some today, a new job or change of career is out of the question because they or their dependents have health conditions that existed prior to the change of employment. These "pre-existing" conditions might limit or bar coverage under the prospective new employer.

The Chairman's proposal will address this problem by limiting use of pre-existing condition exclusion where continuous coverage was maintained under a prior employer without a substantial break in coverage. This approach would seem an important and effective step to "unlocking" the job lock barrier. We support your efforts.

The Chamber will continue to work in support of this and other market-based reforms based on the principles discussed above. We appreciate the opportunity to work with this Subcommittee and I would be pleased to answer any of your questions.

Mr. ENSIGN. Thank you, Mr. Trautwein.
Mr. Dressler.

STATEMENT OF DONALD G. DRESSLER, PRESIDENT OF INSURANCE SERVICES, WESTERN GROWERS ASSOCIATION, IRVINE, CALIF.

Mr. DRESSLER. Mr. Chairman, members of the subcommittee, thank you for the chance to be here.

Western Growers Association is a trade association of fruit and vegetable growers in California and Arizona, and we have a seasonal work force. We supply collectively about one-half of all the fruits and vegetables grown in the United States. This legislation is particularly critical for us.

I have compiled some statistics in our own group health plan, which we administer for our members. In 1994 we had 14,915 employees who we began coverage for who were subject to preexisting conditions, and they had approximately 25,000 dependents. So we had, basically, 40,000 people who we began coverage for last year who had preexisting condition exclusions apply to them.

We think that this is an issue which will help encourage workers to seek employment, which will help in making the transition from job to job, and we support the idea as a particular benefit to those employees.

We have had small group underwriting reform in California since 1993, and we have had a form of restrictions on preexisting conditions as well as a bridging between health care plans.

When we began this, we were concerned there would be some slight increase in health care costs resulting from the portability issue because, clearly, some people will have health care coverage paid for that they hadn't had before. It has been a surprise and a pleasant one to us that there hasn't been any noticeable increase in health care costs because of bridging and/or preexisting, and I would predict that would be the result of this legislation as well. So it is definitely a win for employees, and it doesn't seem to have a significant cost, as long as it is shared universally, as long as everybody plays by the same rules.

I think the portability issue is very important to small employers. Large employers have a lot of choices in their health care plans and what they do, but small employers often find themselves subject to the equivalent of job lock. If either they or someone in their family or one of their small group of employees have a severe medical problem, they are concerned about switching group health coverage because of the starting again of a preexisting condition exclusion.

So I believe this legislation will help increase competitiveness in the small group health insurance market as well as make it easier for employers to seek coverage and competitive pricing. So I think this legislation definitely provides an advantage for small employees over the status quo.

In terms of the practicality of applying this legislation, the issue which always arises for a new health care plan or an employer who is picking up a worker: How do you determine whether the preexisting conditions are going to apply or not? Since we have a num-

ber of people who join our plan every year, we have a lot of experience with this.

There are really two ways to do it. One is at the time someone is enrolled in the plan. This is the most efficient, economical way to do it, because then the patient's records are set up and there is clear processing for handling of any claims that come in later.

The situation becomes more complicated if we don't get this preexisting condition issue resolved at the beginning of enrollment and we then have to resolve it later, when a person actually requires medical care. At that point, you are trying to look at a medical condition that looks like it had care that has been continuing for some time. You have the problem of holding up claims processing while you go back to the doctor or hospital and ask, "What is your pattern of care with this patient?" Or going back to the employee or his dependents and asking, "What is your proof of prior coverage?" So handling the determination of preexisting conditions at the time of claim, which is possible, is a complicated and expensive process.

Frankly, I would hope that when employers give their notice of COBRA rights, which they do when someone leaves health care coverage, that we could include in that COBRA notification information that could then be used to qualify the employee for the next health care plan. In that case, an employee would only have to submit, for example, a copy of his COBRA notice to his new employer or new carrier so that they could determine at the time he is enrolled his status and make it a much smoother operation.

But, in any event, we think this legislation is a wonderful step forward. We support the bill. We think it is going to be helpful to both employers and employees, and it is particularly important to agriculture.

[The prepared statement follows:]

Western Growers Association

Serving the California and Arizona Fresh Produce Industry

Statement of Donald G. Dressler

Western Growers Association

before the

Health Subcommittee

House Committee on Ways and Means

May 12, 1995

Mr. Chairman and members of the Committee, thank you for the opportunity to testify on the issue of portability of health insurance, which is very important to agricultural employers.

I am Don Dressler, President of Insurance Services for Western Growers Association, of Irvine, California. Western Growers is a non-profit trade association representing growers and shippers of fresh fruits and vegetables throughout Arizona and California. We have 2,600 members who collectively produce approximately one half of our nation's supply of fresh fruit and vegetable supply. The vast majority of our members run small businesses of less than 10 employees.

For over thirty eight years, Western Growers Association has sponsored health benefit plans for our members and their employees. We operate as an ERISA health benefit trust, and are self-funded. We began our group health benefit plan because conventional insurance companies would not cover seasonal and often migrant agricultural workers, many of whom were not fluent in English and lived in rural, hard-to-reach areas.

Today, we provide benefits for 19,000 farm employees, and the total number of beneficiaries covered by our plan, including dependents, is now over 50,000.

I want to commend Chairman Thomas and the other members of the Subcommittee who have co-sponsored the portability legislation for moving ahead with this initiative on a bi-partisan basis. I believe that the passage of this legislation would be real progress in this nation's efforts to provide health insurance that is more affordable and secure for the vast majority of Americans.

The portability legislation that the Subcommittee is considering today is of vital concern to Western Growers Association due to the seasonal employment nature of many of our agricultural workers. There is a significant transition period between employers and between health benefit plans for our workers. Our coverage is on a monthly basis, and each month we average 2,000 newly covered employees. The ability to have benefits apply without beginning the period of qualification again to satisfy pre-existing qualifications is vitally important to these workers and their families.

A large number of our beneficiaries may not be working for periods ranging from several weeks to several months during the year. With varying crop seasons, harvest peak employment needs, and changes in weather, intermittent work schedules are quite common in our industry. Currently, we reinstate employees and their beneficiaries when they return to work and regain eligibility.

Mailing Address: P.O. Box 2130, Newport Beach, CA 92658 • Street Address: 17620 Fitch St., Irvine, CA 92714
(714) 863-1000 • FAX: (714) 863-9028

Within our plan, if someone does not have an absence of more than 90 days, we "bridge" their satisfaction of the pre-existing period, and they do not have to start the waiting period over again. This encourages workers to seek new jobs during periods of seasonable layoff, and helps our members in recruiting new employees.

When our group program competes with other plans which do not offer similar portability of coverage, costs are shifted to our members and our plan. The proposed legislation will even the playing field for us in this regard. Moreover, it will eliminate the incentive for some group plans to avoid appropriate and reasonable risk, thus expanding the availability of coverage for workers.

The limitation on how long portability is assured contained in the proposed legislation encourages workers to seek and to maintain health insurance coverage. Furthermore, the bill would deter them from waiting until they have pending medical problems.

To conclude, Western Growers Association strongly supports Chairman Thomas's legislation to provide portability of health insurance. This is a very important step along the road to providing greater access to health benefits among our nation's work force.

In your future legislative deliberations, WGA hopes that you will also address the role of association sponsored multiple employer health plans and the benefits of self-funding. These issues are also important to the goal of reducing the costs of health insurance and encouraging small employers to provide health benefits to their employees. Chairman Thomas's H.R. 1234 contains important consumer and employer projections in this regard.

Mr. ENSIGN. Thank you, Mr. Dressler.
Mr. Naylor.

STATEMENT OF W.W. "BIFF" NAYLOR, VICE PRESIDENT, NATIONAL RESTAURANT ASSOCIATION

Mr. NAYLOR. Mr. Chairman, members of the subcommittee, thank you for inviting me here today.

My name is Biff Naylor. I own the Naylor Establishment in Los Angeles. We operate Beverly Hills Cafe in California and Cindy's Coffee Shop in Idaho. I am vice president of the National Restaurant Association, the leading trade group for the U.S. food service industry. Our industry, with its over 9 million workers and its nearly 740,000 units in every town and city in the United States, is the Nation's No. 1 retail employer.

I am also a cofounder of the American Restaurant Employers Trust. Twenty years ago, a group of restaurant owners in southern California got together with the goal of making it easier to provide health benefits for both their employees and their employers.

I endorse the approach Congressman Thomas is taking in the bill he has introduced today. Reducing the waiting period for covering preexisting conditions by allowing credit for coverage under a previous employer's plan is a good deal all around for employees who won't be locked into jobs out of fear that they will lose coverage if they move on and for employers who will be part of a seamless system that results in broader health insurance coverage.

Not everybody is touched with some kind of medical condition—nearly everybody is. Employers might realize this better than most because they deal so closely with employees. If it is not the restaurateur himself, it is the chef with the heart problem or the server whose child has a chronic illness.

Employers who provide insurance to employees do all they can to keep insurance premiums reasonable. But when you ask for a policy that covers preexisting conditions from the start, you are asking for higher prices. No matter how good your intentions, it is hard to be the only employer to foot the bill.

In the American Restaurant Employers Trust, we have a little more bargaining power—which is why this year we were able to do exactly what Congress and Mr. Thomas would like us to do.

No. 1, we are providing 24-hour insurance coverage that combines Workman's Comp. with health insurance.

No. 2, each employee that enrolls in our plan gets a card that entitles him to continuous coverage with no limits on preexisting conditions if they move from one restaurant in the Trust to another. Especially in an industry that can be as transient as ours, we realize employees often have to move on, and we think they ought to be able to take their health care with them. We hope the biggest fans of our job-to-job coverage will be the employees themselves. In industries like ours, it is a big selling point.

In some cases, perhaps reducing waiting periods for coverage may increase premium costs slightly, but there is a tradeoff. Often these insurance clauses have less to do with cost and more to do with wanting some guarantee that the employee will stick around and become a valued part of our work force. Allowing seamless cov-

erage for an individual who has already qualified for coverage in one job recognizes that person has staying power.

In the case of our restaurant Trust, there is an added benefit: The new restaurant gets an employee who is already part of our system, somebody who has already been trained in workplace safety and healthy lifestyles, as our plan requires.

As Congress debates the all-important question of how to make today's health insurance system work better, I encourage Congress to pass H.R. 1610. The employees would be better off, insurance rates would be more standardized, and people would be out of the business of worrying about preexisting conditions.

As the National Restaurant Association has said for years, this is one important way to chip away at the problem of how to make health insurance more accessible. Thank you.

[The prepared statement follows:]

TESTIMONY OF W.W. BIFF NAYLOR
NATIONAL RESTAURANT ASSOCIATION

Mr. Chairman, members of the subcommittee, thank you for inviting me here today.

My name is Biff Naylor. I own The Naylor Establishment, in Los Angeles. We operate Beverly Hills Cafe in California, and Cindy's Coffee Shop in Idaho. I am Vice President of the National Restaurant Association, the leading trade group for the U.S. foodservice industry. Our industry, with its over nine million workers and its nearly 740,000 units in every town and city in the U.S., is the nation's number-one retail employer.

I am also a co-founder of the American Restaurant Employers Trust. Twenty years ago, a group of restaurant owners in southern California got together with the goal of making it easier to provide health benefits for their employees. As you know, restaurants tend to be smaller businesses and often have a hard time getting affordable coverage. We wanted to come up with a high-quality insurance plan for restaurants—something *specifically* designed with restaurant companies and their employees in mind.

Today, several hundred restaurants in four states buy their health insurance plans through the Trust. This means coverage for about 10,000 employees and their dependents.

So I'm doing double duty here today, talking both from my experience as a restaurant owner and from my experience in insurance. From both perspectives, I endorse the approach Congressman Thomas is taking in the bill he has introduced today. Reducing the waiting period for covering pre-existing conditions by allowing credit for coverage under a previous employer's plan is a good deal all around—for employees who won't be locked into jobs out of fear that they'll lose coverage if they move on, and for employers who will be part of a seamless system that results in broader health insurance coverage.

Nearly everybody is touched by some kind of medical condition. Employers may realize this better than most because they deal so closely with employees. If it's not the restaurateur himself, it's the chef with a heart problem, or the server whose child has a chronic illness. Employers who provide insurance to their employees do all they can to keep insurance premiums reasonable, but if you ask for a policy that covers pre-existing conditions from the start, you're asking for higher prices. No matter how good your intentions, it's hard to be the only employer to foot the bill.

In the American Restaurant Employers Trust, though, we have a little more bargaining power—which is why this year we were able to begin doing exactly what Congressman Thomas would like to do. First, we are providing 24-hour insurance coverage that combines workers' comp insurance with health insurance. Second, each employee who enrolls in our plan gets a card that entitles them to continuous coverage — with no limits on pre-existing conditions — if they move from one restaurant in the Trust to another. Especially in an industry that can be as transient as ours, we realize employees often have to move on — and we think they ought to be able to take their health care with them. We hope the biggest fans of our job-to-job coverage will be the employees themselves. In an industry like ours, it's a big selling point.

In some cases, perhaps reducing waiting periods for coverage may increase premiums costs slightly. But there's a tradeoff. Often these insurance clauses have less to do with costs and more to do with wanting some guarantee that the employee will stick around and become a valued part of our workforce. Allowing seamless coverage for an individual who has already qualified for coverage at one job recognizes that person's staying power. In the case of our restaurant Trust, there's an added benefit: The new restaurant gets an employee who is already a part of our system, someone who has already been trained in workplace safety and in healthy lifestyles, as our plan requires.

As Congress debates the all-important question of how to make today's health insurance system work better, I encourage Congress to pass H.R. 1610. Employees would be better off, insurance rates would be more standardized, and people would be out of the business of worrying about pre-existing conditions.

As the National Restaurant Association has said for years, this is one important way to chip away at the problem of how to make health insurance more accessible.

Mr. ENSIGN. Thank you, Mr. Naylor.

Mr. Christensen, would you care to inquire?

Mr. CHRISTENSEN. Not at this time.

Mr. ENSIGN. Mr. Kleczka.

Mr. KLECZKA. Thank you.

Mr. Trautwein, the bill is narrowly drafted because of a jurisdictional concern, and so it only covers group plans. Does the chamber support providing this type of portability legislation for all policies and all people insured with health insurance?

Mr. TRAUTWEIN. The same basic principle applies to that, and the chamber would generally support that as enhancing mobility in the marketplace. There are some technical issues that come into play, and perhaps the next panel would be better suited to discuss what that might do to prices at the one life group and individual level.

Mr. KLECZKA. I say that because our colleague on the Ways and Means Committee, Nancy Johnson, will be introducing legislation which is more comprehensive than the Thomas bill before us.

Mr. Naylor, you indicate in your testimony that there are 9 million workers in restaurants around the country working for some 740,000 restaurateurs. Do you have any idea how many of the 9 million workers are covered with some type of health insurance?

Mr. NAYLOR. Well, I would guess that virtually—I am going to say maybe 80 percent of them in some manner or fashion are covered, maybe 90 percent, somewhere in that range.

I will have to describe that a little bit to you because there are a lot of young people working in our industry that are going to college, and they are covered at their universities or with their families. There are a lot of senior people working in our industry that are covered under Medicare, Medi-Cal, and so forth. Roughly 50 percent of all the restaurant employers in California offer health care to all of their full-time employees.

Mr. KLECZKA. Do you have a figure for nationwide?

Mr. NAYLOR. I would guess it would be similar to that, but I do not. Our studies were done—Fresno is our test market, and we did our studies based on that. So the employer-based, about 50 percent. Throughout the total work force, I would guess closer to 80 or 90 percent have some coverage or other.

Mr. KLECZKA. So 50 percent for full-time employees?

Mr. NAYLOR. Right.

Mr. KLECZKA. For part-time employees, do you have any idea?

Mr. NAYLOR. The part-time employees would fall in the category of the young folks working 3 months in the summertime and be covered at home, in their colleges, or so forth.

Mr. KLECZKA. If I were working for a restaurant in Wisconsin, could I apply as an individual for coverage in your Trust?

Mr. NAYLOR. Not at this time. We are only in four States so far. But we will, hopefully, get to Wisconsin in the near future. Right now——

Mr. KLECZKA. But as an individual—it would be the individual applicant versus the establishment?

Mr. NAYLOR. I will tell you the one problem we have and haven't addressed yet but will be during the course of the year.

Because of the laws in all the different States, the company that is the sponsor of this plan—it is a large company; it is a $4 billion company—has to be established differently in each one of the States that they operate in. So while they can move from job to job in California within this Trust and within our industry quite easily, moving from California to Colorado, where we are also offering this plan, is a little more difficult.

Mr. KLECZKA. Is this a fee-for-service type of policy?

Mr. NAYLOR. It is, basically, HMO based. About 95 percent of the employees are in the HMO, a health maintenance organization, that work—out of this Trust that work in our industry. There is some indemnity. There are some PPO, preferred provider organization, aspects of it for the other 5 percent or so.

Mr. KLECZKA. Well, I hope you expand it to Wisconsin and other States, too.

Mr. Trautwein, a little off the subject of portability, one of the problems we are experiencing in Wisconsin—and I am assuming in other States—is that prior to retirement the employer has offered the employee health benefits in the retirement years. We are seeing now that employers are canceling that type of coverage, be it primary health coverage or a supplemental policy to Medicare.

What advice would you have for us as to how to curtail this practice or to ensure that companies that promise benefits to people who are working there and then retire do not stop the coverage, leaving these people out there to hang and dry?

Mr. TRAUTWEIN. Congressman, that is a very compelling problem. I would ask leave to respond to you in writing on that. I have not received instructions from our Health and Employee Benefits Committee, which formulates our policy on that, and I know of no chamber policy on that position. So if I may respond in writing to your question.

Mr. KLECZKA. But you are aware that it is happening out there in the various States?

Mr. TRAUTWEIN. I have seen reports of that, yes.

Mr. KLECZKA. OK. I think that is something that we have to look at. Some of these policies were bargains, some were not. However, after the employee leaves employment and is retired, one day they wake up to the bad news that the company, for whatever reason, has just suspended their health care coverage; and you can see the real trauma that that inflicts on a lot of our constituents. So I look forward to your written response.

Thank you, Mr. Chairman.

[The following was subsequently received:]

CHAMBER OF COMMERCE
OF THE
UNITED STATES OF AMERICA

R. BRUCE JOSTEN
SENIOR VICE PRESIDENT,
MEMBERSHIP POLICY GROUP

1615 H STREET, N.W.
WASHINGTON, D.C. 20062-2000
202/463-5310

May 24, 1995

The Honorable Gerald D. Kleczka
U.S. House of Representatives
2301 Rayburn House Office Building
Washington, D.C. 20515

Dear Representative Kleczka:

The U.S. Chamber of Commerce appreciated the opportunity to testify at the May 12 hearing before the Health Subcommittee of the House Committee on Ways and Means on H.R. 1610, Chairman Thomas's health insurance portability legislation.

During the course of the hearing, you asked for the Chamber's views regarding reductions or cessation of employer-sponsored retiree health benefits. We understand and appreciate your concerns.

The provision of retiree health benefits is an issue of great concern for many employers. While companies may desire to provide health benefits to both active employees as well as retirees, unexpected financial constraints preclude many from doing so. Rather than completely foregoing retiree health benefits, many employers strive to provide scaled-back benefits to their retirees. However, others faced with mounting financial pressures and increased health care costs may have no alternative but to cease coverage for retirees.

As you know, the Employee Retirement Income Security Act of 1974 (ERISA) does not set forth the legal standards that govern modifications in retiree health benefits. However, employers faced with the difficult choice of reducing or eliminating health coverage for retirees are guided by a developing body of federal common law that outlines various rights and obligations under ERISA-regulated plans. This evolving area of federal common law provides an appropriate and adequate means for addressing the questions that arise when retiree health benefits are adversely affected by employer actions.

I hope this answers your question. Should you have any additional questions, please do not hesitate to have your office contact Neil Trautwein or David Kemps of the Chamber's Domestic Policy staff at (202) 463-5500.

Sincerely,

R. Bruce Josten

R. Bruce Josten

Mr. ENSIGN. I would just like to toss something out to the panel. The intent of this legislation is for simplification, especially for the employers.

Basically, what employers have to do is they must provide verification on length of coverage on the date the employee leaves the plan. Do you see that this is a simple enough thing for employers to go through?

Mr. DRESSLER. As far as Western Growers is concerned, we handle COBRA administration now for all of our members because of the nature of agriculture and the seasonal nature of harvesting and so on. So it would be very easy for us to do.

For those who are eligible for COBRA, as I said earlier, my preference would be that we include notification in the COBRA notice which the employee gets at the time his coverage ends, which also informs him of his rights to alternative coverage. But I think that it is a very practical thing to do, and I would hope that a new worker would go to his new job with this evidence at the time he starts coverage.

Mr. ENSIGN. Mr. Naylor, maybe you can address that. We are trying to accommodate employees and do the right thing; and, obviously, I think that it shows, by your being here today, that there are people out there that care about your employees. You are not just evil businesspeople and that type of thing. But is this something that is going to be burdensome on business or is this something that should be fairly easy to administer?

Mr. NAYLOR. I don't think so. The Trust has its own administration. We model up very much like Western Growers in the fact that we provide the COBRA, and it could be included as a part of that as well.

For the independent operators, I think that the insurance companies themselves would aid in—when they design plans and so forth, so that notification has to be given by the employer, would be a part of the package. So I don't think it would be too difficult to do. I don't see an administrative burden to this at this point.

Mr. KLECZKA. If the chairman would yield, I think Mr. Dressler makes an excellent recommendation. I don't know if it is necessary to have it part of the bill. It could be part of the regulations, although we all get nervous when we say the word regulation. But if this information on the employee's past medical history could be put on the COBRA notice, it would be very easy for the next employer.

My problem is, if we mandate that by regulation, the COBRA notice will be 10 pages long. Your suggestion is an excellent one.

Mr. ENSIGN. Thank you. Thank you for your comments.

I would like to thank the panel for your testimony this morning. I appreciate the concern you are showing, and thank you very much.

I would like to call the next panel to the table: John Troy, the executive vice president, Health Insurance Association of America; Michael Herbert, president and chief executive officer for Physicians Health Services, Inc., Trumbull, Conn., on behalf of Group Health Insurance Association of America; and Mary Nell Lehnhard, senior vice president, Blue Cross & Blue Shield Association.

Mr. Troy, why don't you go ahead and proceed.

STATEMENT OF JOHN F. TROY, EXECUTIVE VICE PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. TROY. Mr. Chairman, Bill Gradison, the president of HIAA, the Health Insurance Association of America, is sorry he is unable to be here today. Bill would have liked to have the opportunity to comment on such a positive piece of legislation.

Mr. Chairman and members of the subcommittee, I am John Troy, executive vice president of the Health Insurance Association of America. I am very pleased to be here today to discuss the critical issue of health insurance portability as it affects job mobility.

HIAA has long supported reforms to make our health insurance system more secure for Americans. We think Congress should act this year to move the Nation toward the health security goals we share. Solving the problem of job lock would be an important step, and I commend the subcommittee for addressing this early in the 104th Congress.

It is particularly appropriate that we focus our attention on employment-based coverage, for it is the backbone of America's privately financed health system.

The problem of job lock is a major concern for Americans. People are afraid to leave their jobs for fear their new employer would not provide coverage for existing health conditions.

In a survey conducted earlier this year for HIAA, 78 percent of the respondents supported the concept that once an employee has satisfied an employer's preexisting condition clause, coverage under a new plan should not be denied based on health conditions. It is clear that dealing with the job lock issue would address a major concern with the health care system.

The issue of job lock can only be addressed comprehensively through Federal legislation. States can and do regulate insurance carriers and HMOs, and HIAA has played a leading role in developing and advocating reforms for the small employer market at the State level. But only Federal action can assure consistent nationwide application of basic continuity of coverage protection for all workers.

Mr. Chairman, HIAA strongly supports H.R. 1610 as a very important first step in health care reform. H.R. 1610 would require every employer providing a group health plan to credit newly eligible employees or dependents coverage under prior group health plans toward any preexisting condition limitation the plan imposes if certain conditions are met. It would also prohibit group health plans from denying coverage to employees or dependents with qualifying prior coverage based on health condition.

The genius of H.R. 1610 is that it gets to the heart of the job lock problem and remedies it in the least intrusive way possible. It sets up the right incentives by rewarding people who maintain continuous health insurance coverage. H.R. 1610 also avoids the temptation to enact measures which appear on the surface to be reforms but which could actually increase costs and reduce access.

Recent evidence suggests that employer-sponsored health plans have made great strides in controlling costs. In 1994 total per employee costs actually fell a bit more than 1 percent. Employer sponsors deserve great credit for aggressively moving to contain health care costs. HIAA believes the private sector is better equipped than

government to control costs while maintaining quality. We are pleased that H.R. 1610 allows the private sector the flexibility it needs to continue to do so.

HIAA does believe that broader Federal action in some areas of health care reform would be beneficial. For employers with 2 to 50 employees, we endorse requirements for insurers to guarantee to issue and renew coverage, together with reasonable limitations on rating.

We also endorse a range of cost containment proposals, including simplifying the administration of claims, enacting legislation to aid in detecting and prosecuting health care fraud, and reforming medical liability rules.

In the long run, the most effective cost containment technique available to us is the continued development and evolution of managed care. For over 20 years, managed care has demonstrated its ability to restrain the growth of health care costs while maintaining or improving quality of care. HIAA believes public policy should seek to promote the refinement and effective operation of managed care plans.

That said, Mr. Chairman, we do not believe that it would be wise to delay enactment of H.R. 1610 in an attempt to achieve consensus on a broader agenda. Your bill is an important first step. It should move forward quickly. Our written testimony discusses a number of technical concerns that we believe the subcommittee should consider.

Mr. Chairman, I thank you for the opportunity to appear here today, and we stand ready to help you in any way that we can.

[The prepared statement follows:]

TESTIMONY OF JOHN F. TROY
HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. Chairman and Members of the Subcommittee, I am John Troy, Executive Vice President for the Health Insurance Association of America (HIAA), a trade association which represents approximately 225 of the nation's health insurers, including managed care plans and HMOs, which in turn provide health coverage for tens of millions of Americans.

I am very pleased to be here with you today to discuss the critical issue of health insurance portability as it affects job mobility. HIAA has long sought to make our health insurance system more stable and secure for all Americans by advocating sensible reforms based on what we believe consumers want. We think the Congress should act this year to move the nation toward the health security goals we share. Solving the problem of "job lock" would be an important first step in this direction, and I commend the Subcommittee for moving to address this issue early in the 104th Congress.

It is particularly appropriate that we focus our attention on employment-based coverage; it is the backbone of America's privately financed health insurance system. About 70% of Americans under age 65 currently have private health insurance and, of these, fully 87% obtain that coverage through an employer, either directly from their own employer or indirectly through a spouse's or parent's employer.

The problem of "job lock" is a major concern that Americans have about our current health insurance system. People who have jobs that provide health coverage are afraid to leave their current jobs, for fear that their new employer would not provide coverage for medical problems they or their dependents already have.

It is difficult to estimate how large the "job lock" problem is. We do know [from analysis of the Census Bureau's Survey of Income and Program Participation] that the turnover rate for workers in jobs that provide health insurance is about 14 percent per year. That is, each year roughly 10 million U.S. workers (not counting covered spouses and children) leave jobs that provide health insurance. We do not know how many more would like to change jobs but hesitate because of concerns about losing coverage for existing medical conditions.

Even without precise estimates of the magnitude of this problem, it is clear that dealing with the "job lock" issue would go a long way toward addressing one of Americans' major concerns about their health care system. In a survey conducted earlier this year, for the HIAA by Public Opinion Strategies and Hamilton & Staff, 78 percent of respondents supported the concept that, once an employee has satisfied his employer's pre-existing condition clause, he should not be denied coverage when he changes jobs in the future, even if he is sick.

I want to emphasize that "job lock" can only be addressed comprehensively through Federal legislation. States can – and do – regulate insurance carriers and HMOs, and HIAA has proudly played a leading role over the last 5 to 7 years in developing and advocating sensible reforms for the small employer insurance market at the state level. Since 1990, 42 states have enacted laws intended to reform how medical insurance for small employers is rated and sold.

But states cannot – and should not – regulate self-insured employers, who today provide coverage to at least half of all workers with employment-based health coverage. Therefore, only Federal action can assure consistent, nationwide application of basic continuity-of-coverage protection for all U.S. workers.

For these reasons, Mr. Chairman, HIAA strongly supports your recently introduced bill as a very important first step in health care reform. It would require every employer-provided group health plan to credit a newly eligible employee's or dependent's coverage under prior group health plan(s) toward any pre-existing condition limitation the plan imposes, if certain conditions are met. It would also prohibit employer-provided group health plans from denying coverage to otherwise-eligible employees or dependents with qualifying prior coverage based on factors related to the person's medical condition or use of health care.

The technical language can get quite arcane, but it's really a very simple concept: Whenever you change from one insured job to another, you get credit for your prior coverage, as long as you haven't let your coverage lapse for more than 60 days.

The genius of this bill is that it gets to the heart of the "job lock" problem and remedies it in the least intrusive way possible. It sets up all the right incentives for the maintenance and effective operation of a voluntary, private health insurance system by rewarding people who do the right thing and maintain continuous health insurance coverage.

Another virtue of the bill is that it avoids the temptation to enact measures which appear on the surface to be "reforms" but which would, in fact, increase health insurance costs and reduce access. For example, the bill properly leaves to group health plans and insurers the flexibility to determine such matters as:

- what benefits to provide, with what cost-sharing requirements;
- how to contain costs and assure quality, including provider reimbursement, provider qualifications and network design, utilization review requirements, and other managed care features; and
- what provisions are necessary to discourage healthy workers from delaying enrollment in their employer's plan until they know they will use it, or from allowing their coverage to lapse when they are between jobs. (Simply allowing such behavior, as some earlier reform proposals have suggested, would raise premiums for all insureds, penalizing those who conscientiously maintain their coverage.)

Mr. Chairman, recent evidence suggests that employer-sponsored health plans have made great strides in controlling health care inflation. In 1994, total per-employee costs for all such plans actually fell a bit more than one percent, the first time such a year-to-year decline has been recorded. While the pressure of the health care reform debate may have had some influence on this result, I believe that employer-sponsored health plans deserve most of the credit for aggressively moving to contain their own health care costs. HIAA believes that the private sector is much better equipped than the government to determine how best to rein in costs, and I commend you, Mr. Chairman, for crafting a bill that allows the private sector the flexibility it needs to continue to do so.

Also, and again very properly in our view, the bill does not attempt to deal with the very difficult problem of how to improve availability and affordability of individually purchased medical insurance. Due to the nature of this market, regulatory approaches to improving access need to be considered very carefully. We would be happy to meet with you, Mr. Chairman, or any member of the Subcommittee or your staff, to discuss our ideas and concerns regarding the individual insurance market. But we do feel quite strongly that the bill we are discussing today is not the appropriate vehicle for addressing individual insurance.

HIAA does believe that broader Federal action in some areas of health care reform, specifically with respect to national standards for all insurers and health plans serving small employers, would be beneficial for the nation. For example, for employers with 2 to 50 employees, we endorse requirements for insurers to guarantee issue and renew medical coverage, together with reasonable limitations on rating variability across employers. We also endorse a range of cost containment proposals, including simplifying the administration of health insurance claims, enacting legislation to aid in detecting and prosecuting health care fraud, and reforming medical liability rules.

In the long run, the most effective cost containment technique available to us is the continued development and evolution of managed care. Over the past 20 years, managed care has demonstrated its ability to restrain the growth of health care costs while maintaining or improving quality of care. Even better results can be expected in the future, as managed care continues to evolve and improve. Therefore, HIAA believes public policy should seek to promote the ongoing refinement and effective operation of managed care programs. We support the repeal or pre-emption of a range of existing laws, rules and regulations that restrict the effective operation of managed care programs, at whatever level of government they may currently be imposed; and we oppose efforts to enact additional legislation that would interfere with managed care plans' ability to contract with providers or otherwise organize themselves to deliver high-quality, cost-effective medical care, such as "any-willing-provider" laws and the so-called "Patient Protection Act."

That said, Mr. Chairman, we do not believe that it would be wise to delay enactment of the bill you have proposed in an attempt to achieve consensus on a broader reform agenda.

Your bill is a very, very important and significant first step. It should move forward quickly, and should not be delayed by attempts to broaden it at this time.

Mr. Chairman, we do have three concerns about the bill that we ask you to bear in mind as Subcommittee consideration of the bill proceeds; two of them are inter-related. First, there is no requirement in the bill that, in order to be considered "qualified," a newly eligible worker's prior coverage must be substantially similar to the coverage offered by his or her new employer. In the absence of such a requirement, "gaming" of the system is possible. For example, a small employer might initially buy coverage with a very high deductible to minimize his premiums, then switch to more comprehensive coverage when the owner, the owner's child, or a particularly valued employee becomes ill. (The guarantee-issue requirements for small employer coverage in more than 30 states make this possible.) A similar dynamic could arise when workers change employers. The problem here is that it permits people to minimize their contributions to the insurance system while they are well, yet benefit from more comprehensive coverage when they become ill without having paid their fair share of the cost of the more comprehensive coverage. That will raise premiums for everyone.

The omission of a "substantially similar coverage" requirement is most likely to create problems when individuals arrange health plans for themselves (and their families) only, as self-employed people do who work alone without employees. (I'll refer to this group as the "solo self-employed"). This brings me to our second issue. Addressing concerns about the individual insurance market is much more difficult than dealing with problems in true employment-based insurance. With respect to deciding whether, when and how much medical insurance to buy, solo self-employed people behave more like individuals than like groups, so we strongly recommend that the provisions of this bill should apply only to group health plans that serve either 2 or more employees or an owner with at least one covered employee.

If this definitional problem is dealt with, the need for a "substantially similar coverage" requirement is also reduced. So long as the crediting-of-prior-coverage requirement applies only between plans in which a true employer-employee relationship exists, we feel the proposal will not result in excessive adverse selection even in the absence of a "substantially similar coverage" requirement.

Finally, we note that the bill as introduced would prohibit denial of coverage on the basis of factors related to health status <u>only</u> when the individual in question has qualifying previous coverage. While we recognize the Subcommittee's desire to focus on "job lock" and portability concerns, we see no reason to restrict this "non-discrimination" requirement. HIAA has long supported the following concept, which we call "whole group coverage": Employers should have full flexibility to determine which categories of workers they wish to cover in their group health plans (full-time v. part-time, etc.), but having once made that decision, neither employers nor their insurers should be permitted to exclude an otherwise-eligible employee or dependent based on factors related to health status, medical condition, claims experience or similar factors. This is a very popular concept with the American people -- 85 percent supported it in the recent survey I referred to earlier -- and I urge the Subcommittee to adopt such a provision.

In conclusion, Mr. Chairman, I thank you and the Subcommittee for the opportunity to testify today, I applaud you for addressing the "job lock" issue head on, and I urge the Subcommittee and the Congress to move quickly to enact the bill you have proposed.

Chairman THOMAS [presiding]. Thank you very much, Mr. Troy, I appreciate your testimony.

Mr. Herbert.

STATEMENT OF MICHAEL E. HERBERT, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PHYSICIANS HEALTH SERVICES, TRUMBULL, CONN., ON BEHALF OF GROUP HEALTH ASSOCIATION OF AMERICA

Mr. HERBERT. Mr. Chairman and members of the subcommittee, my name is Michael E. Herbert. I am president and chief executive officer of PHS, Physicians Health Services, a 19-year-old HMO serving 200,000 members in Connecticut and New York. PHS is Connecticut's largest HMO, and I have served as its chief executive officer since its inception in the seventies.

I am testifying today on behalf of the GHAA, Group Health Association of America, the leading national association for health maintenance organizations. Actually, I am pinch-hitting for Karen Ignagni, GHAA's president who, ironically, is in Middletown, Conn., today meeting with Connecticut's HMO industry.

GHAA's 380-member HMOs serve 80 percent of the 50 million Americans who receive health care from HMOs. Our member plans started, and continue to lead, the Nation's move to high-quality, organized health care.

GHAA has long supported insurance market reforms, including State-level small group insurance market reforms and appropriate Federal-level insurance market reforms. We are pleased that the subcommittee is beginning its deliberations on insurance reform issues this year by starting with Chairman Thomas' bill to assure group-to-group portability, and we are pleased to see that every member of the subcommittee shares our support for making health care coverage portable for working Americans.

Chairman Thomas should be commended, as should the whole subcommittee, for their leadership in undertaking a small but important step toward improving the health care delivery system. In general, this bill amends COBRA to provide that individuals moving from one employer's group health plan to another would have any preexisting condition limitations in their new plan reduced by the length of their prior group health plan coverage, so long as there is no more than a 60-day break in coverage.

The bill also adds a nondiscrimination provision to the statute prohibiting discrimination against covered employees—on the basis of health status, medical condition, claims experience, medical history, disability, or evidence of uninsurability by a group health plan for purposes of determining eligibility, continuation, enrollment, or contribution requirements. Based on COBRA, the proposal applies to all individuals who are covered by an employer-sponsored insured or self-insured group health plan, down to group size of one, especially self-employed individuals and certain independent contractors.

This bill addresses a substantial part of the "job lock" problem where individuals—or their dependents—who have preexisting health conditions find it difficult to change jobs because a new employer-sponsored group health plan could require them and/or their family members to go without coverage for the treatment of their

condition for a set time period, even if they have met their former health plan's requirements for preexisting condition waiting periods.

By "crediting" the period of prior coverage in a qualified group health plan, Chairman Thomas' bill would allow individuals who have previously been covered by a group health plan to change jobs without being subject to new preexisting condition waiting periods.

The majority of HMO enrollees, roughly 80 percent, already benefit from the provisions outlined in the bill. These individuals are enrolled in federally qualified HMOs which, by law, do not apply preexisting condition waiting periods.

GHAA believes that H.R. 1610 fulfills most of the key criteria that any such portability provision must meet. The proposal applies to all employer-sponsored coverage, self-insured and fully insured; and it applies only to employment-based coverage.

Our one area of concern is that group-to-group coverage should be clearly defined to include all groups down to groups of two employees. As drafted, the bill includes groups down to group size one. While experience in the group market above group size one is extensive and supports portability among such groups, there is insufficient experience to foresee the impact of including groups of one in the bill's portability requirements. Research should be undertaken to ensure that the inclusion of groups of one will not have a detrimental impact on the group market as a whole.

Although the potential problems are less serious than those raised in providing the same portability provisions for individual-to-group coverage, they remain significant.

As you proceed with this measure, and other insurance market reforms, I would like to flag for the subcommittee some issues of particular importance to HMOs.

No. 1, in any reform related to preexisting condition waiting periods, it is important to recognize that most HMOs are not designed to administer such waiting periods. The Federal HMO Act precludes such provisions, and, for the most part, HMO systems are not structured to track or pay claims in a manner that differentiates among types of conditions for each enrollee.

No. 2, we would caution that substantial complications could arise if portability rules are extended beyond "group-to-group" coverage to include individuals moving to or from individual products, Medicaid, and high-risk pool coverage.

As I have stated before, GHAA believes that group-to-group coverage provisions are a good starting point for insurance reform. However, based on our experience in States that have adopted similar portability provisions, we believe that the market is not yet ready to extend such provisions to people moving between individual coverages or from individual-to-group—or group-to-individual—coverage.

For plans that offer comprehensive coverage, such as HMOs, serious adverse selection problems can arise if individuals can convert from high-deductible or "bare bones" coverage to comprehensive HMO plans. This issue is likely to arise in the context of any MSA, medical savings account legislation, if such proposals require MSA participants to purchase high-deductible catastrophic cov-

erage, and then allow conversion at any time to a more comprehensive policy.

If comprehensive coverage, such as that provided by HMOs, must bear the risk that individuals can select such coverage whenever a health care need is anticipated and drop the coverage as soon as the need goes away, its affordability for the vast majority of employees who maintain continuous coverage in a comprehensive plan will be diminished.

Finally, we are very concerned that any insurance reform measure such as this portability bill not become a "vehicle" for "antimanaged care" provisions, such as mandatory contracting, mandatory point-of-service, and so-called "Patient Protection Act" provisions. Such provisions will inhibit the ability of HMOs to provide high-quality, cost-effective health care. Consequently, they will also undermine the progress that is being made in holding down premium increases; a trend due in large part to the growing number of employees who are selecting HMOs and other managed care options. We would strongly oppose any bills that include such measures.

We encourage you to continue with your strategy of taking carefully studied legislative steps that promote a market-based health care delivery system and help to solve the specific problems in the current marketplace. For this approach to remain successful, the bill should remain clean of such controversial provisions.

In essence, we are saying that the market is working in health care delivery in America today, and this bill provides a small but important step forward in allowing the market to work better. GHAA would be pleased to work with you and the staff as you proceed with this bill and other insurance reforms, and I would be pleased to answer any questions.

[The prepared statement follows:]

TESTIMONY OF MICHAEL E. HERBERT
GROUP HEALTH ASSOCIATION OF AMERICA

Mr. Chairman and members of the Subcommittee, my name is Michael E. Herbert. I am President and CEO of Physicians Health Services (PHS), a 19-year old health maintenance organization (HMO) serving 200,000 members in Connecticut and New York. PHS is Connecticut's largest HMO, and I have served as its CEO since its inception in the 1970s.

I am testifying today on behalf of the Group Health Association of America (GHAA), the leading national association for health maintenance organizations (HMOs). GHAA's 380 member HMOs serve 80 percent of the 50 million Americans who receive health care from HMOs. Our member plans started -- and continue to lead -- the nation's move to high quality, organized health care.

GHAA has long supported insurance market reforms, including state-level small group insurance market reforms, and appropriate federal-level insurance market reforms in the context of last year's comprehensive health care reform debate. We are pleased that the Subcommittee is beginning its deliberations on insurance reform issues this year by starting with Chairman Thomas' bill to assure "group-to-group" portability. In general, this bill amends COBRA to provide that individuals moving from one employer's group health plan to another would have any pre-existing condition limitations in their new plan reduced by the length of their prior group health plan coverage, so long as there is no more than a 60 day break in coverage.

The bill also adds a nondiscrimination provision to the statute, prohibiting discrimination against covered employees -- on the basis of health status, medical condition, claims experience, medical history, disability, or evidence of uninsurability -- by a group health plan for purposes of determining eligibility, continuation, enrollment or contribution requirements. Based on COBRA, the proposal applies to all individuals who are covered by an employer-sponsored insured or self-insured group health plan, down to group size of one (e.g., self-employed individuals and certain independent contractors).

This bill addresses a substantial part of the "job-lock" problem, where individuals (or their dependents) who have preexisting health conditions find it difficult to change jobs because a new employer-sponsored group health plan could require them and/or their family members to go without coverage for the treatment of their condition for a set time period -- even if they have met their former health plan's requirements for preexisting condition waiting periods. By "crediting" the period of prior coverage in a qualified group health plan, Chairman Thomas' bill would allow individuals who have previously been covered by a group health plan to change jobs without being subject to new pre-existing condition waiting periods.

The majority of HMO enrollees (roughly 80 percent) already benefit from the provisions outlined in the bill. These individuals are enrolled in federally-qualified HMOs, which by law, do not apply preexisting condition waiting periods.

GHAA believes that this bill fulfills most of the key criteria that any such portability provision must meet:

- the proposal applies to all employer-sponsored coverage, self-insured and fully-insured; and
- it applies only to employment-based coverage.

Our one area of concern is that group-to-group coverage should be clearly defined to include all groups down to groups of two employees. As drafted, the bill includes groups down to group size one. While experience in the group market above group size one is extensive and supports portability among such groups; there is insufficient experience to foresee the impact of including groups of one in the bill's portability requirements. Research should be undertaken to ensure that inclusion of groups of one will not have a detrimental impact on the group market as a whole. Although the potential problems are less serious than those raised in providing the same portability provisions for individual to group coverage -- as I will describe later -- they remain significant.

Additional issues

As you proceed with this measure, and other insurance market reforms, I would like to flag for the committee some issues of particular importance to HMOs. First, in any reform related to pre-existing condition waiting periods, it is important to recognize that most HMOs are not designed to administer such waiting periods. As I mentioned before, the Federal HMO Act precludes such provisions and, for the most part, HMO systems are not structured to track or pay claims in a manner that differentiates among type of conditions for each enrollee.

Second, we would caution that substantial complications could arise if portability rules are extended beyond "group-to-group" coverage to include individuals moving to or from individual products, Medicaid, and high-risk pool coverage. As I've stated before, GHAA believes that group-to-group coverage provisions are a good starting point for insurance reform. However, based on our experience in states that have adopted similar portability provisions, we believe that the market is not yet ready to extend such provisions to people moving between individual coverages or from individual to group (or group to individual) coverage.

For plans that offer comprehensive coverage, such as HMOs, serious adverse selection problems can arise if individuals can convert from high-deductible or bare bones coverage to comprehensive HMO plans. This issue is likely to arise in the context of any Medical Savings Account (MSA) legislation if such proposals require MSA participants to purchase high-deductible, catastrophic coverage, and then allow conversion at any time to a more comprehensive policy. If comprehensive coverage, such as that provided by HMOs, must bear the risk that individuals can select such coverage whenever a health care need is anticipated and drop the coverage as soon as the need goes away, its affordability for the vast majority of employees who maintain continuous coverage in a comprehensive plan will be diminished.

Finally, we are very concerned that any insurance reform measure, such as this portability bill, not become a "vehicle" for "anti-managed care" provisions -- such as mandatory contracting, mandatory point-of-service, and so-called "Patient Protection Act" provisions. Such provisions will inhibit the ability of HMOs to provide high quality, cost effective health care. Consequently, they will also undermine the progress that is being made in holding down premium increases; a trend due in large part to the growing number of employees who are selecting HMOs and other managed care options. We would strongly oppose any bills that include such measures. We encourage you to continue with your strategy of taking carefully studied legislative steps that promote a market-based health care delivery system and help to solve the specific problems in the current marketplace. For this approach to remain successful, the bill should remain clean of such controversial provisions.

Mr. Chairman, thank-you for this opportunity to testify. GHAA would be pleased to work with you and the staff as you proceed with this bill and other insurance reforms, and I would be pleased to answer any questions that you have.

Chairman THOMAS. I want to thank all of you very much. No one thinks that this bill solves all of the problems as has been accurately and quite well stated. This is a group-to-group solution. When you get into that seamless transition for employees or the self-employed, you do run into problems.

Mr. Herbert, you outlined several gaming-the-system potentials especially between radically different insurance proposals like MSAs to a more comprehensive plan, the possibility of incompatibility between the kind of health delivery system models that start with some different basic assumptions and would be difficult to move between those.

Nevertheless, no one on this panel who cosponsored H.R. 1610 believes that that is the end of the process. Our job is to move forward and my colleague to my right, Nancy Johnson, is to be commended for introducing H.R. 1604, which goes where no one has gone before, and willingly, into answering a number of those questions.

So we are viewing this as the quite painfully obvious first step. Why it wasn't painfully obvious previously just continues to perplex me, but clearly my colleagues in supporting this step indicate why not do what we can do in a timeframe that we can do it.

But we are going to be looking forward to probing with you all of those concerns that you rightfully share with us in terms of the difficulty of moving on to the next step, because solving the group-to-group problem is not solving the job lock problem. It does help.

I want to thank you for your willingness to begin this process. This is not the end, this is the beginning.

The gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. All right.

Chairman THOMAS. If the gentlewoman would withhold for a moment, the question was obviously we have a vote on and there are a series of votes following. My intention is to try to get some testimony on a question-and-answer basis, but it may well be one-half hour or longer before we come back, with these multiple votes, and so my assumption is that when we do have to recess for the vote, the subcommittee hearing will be over.

Mrs. JOHNSON of Connecticut. I just want to take this opportunity to thank you for your testimony and I appreciate your commitment to portability. I do think that one of the reasons the American public hates the government is because it overpromises. Much as I support the Thomas bill and cosponsored it, I have put out a bill that puts forward a broader challenge and I think it is one that we must meet.

So I invite your input and normally in this process I would put it out and we would have a lot more discussion before it actually took a legislative form. There will be another evolution of this bill. Because of the nature of the first 100 days and, frankly, the project before us in the budget, we don't have the luxury of the old process, but I think guaranteed issue, for instance, without rating reform has some merit.

It is true that then a company could up the premiums and have the effect of knocking you out, but they may not up them as high as the risk pool which is the only other option for that person. I think we ought to look at what guaranteed issue offers us and

what does doing it through the Tax Code offer us, which is far easier than doing it through a mechanism that sets up a Federal level of regulation and how can we make that work. But far more important is we have to deal with this issue of portability of the individual plan and individual-to-group plan.

I simply have a hard time from the point of view of equity of dealing with somebody who paid their own insurance premiums for years and years, they have maintained their coverage, then they go to work for an employer who has his own plan and have to endure a preexisting condition exclusion. They have taken the heavy burden. They have paid the higher rates of the individual. Then they come in to a plan and that employer is covering a number of people.

At least that ought to be portable for groups larger than 25 or whatever. But we now know that when a group hits a critical mass, underwriting isn't an issue. So there is someplace that we can begin talking about individual-to-group portability.

You will notice in my bill that individual-to-individual portability is very constrained. You can only exercise that portability if your company goes out of the business or you move. In other words, you have no choice. But again, you, having taken your responsibility, ought to carry some weight in the system. I think the exposure to the adverse selection problem for those people is really minimal. But I think even my bill doesn't go far enough. We have to figure out how to do individual-to-individual portability because that is fairness.

So in the end, we really have a bigger challenge and the industry has got to help us with this because America desperately needs it and anyone who works hard and pays his way ought to have the right to make change. We now know when managed care plans get big enough, it doesn't matter to them. My people tell me, we get a certain size we don't medically underwrite. So let's figure out what is the size, how do we do it, how do we make it happen, and let's pass the Thomas bill tomorrow and the Johnson bill 1 week later.

Chairman THOMAS. Thank you. Although the gentlewoman from Connecticut did not mention, she is a cosponsor of my bill. I am a cosponsor of her bill. To underscore the fact that H.R. 1610 does not end the quest, I am looking for answers to the larger questions as well.

Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. Just one question, Mr. Herbert brought up the issue of medical savings accounts and high deductible policies. If we were to allow medical savings accounts as a tax-favored insurance vehicle, would it not pose the potential problem of a group plan offering that vehicle to its group and then having a problem transferring from that group to another group that had low deductibles?

Mr. HERBERT. Mr. Troy, would you like to address that?

Mr. TROY. Well, the HIAA has developed criteria to measure legislation in terms of the MSA issue overall and there are a number of what we would call adverse selection issues related to the medical savings account issue. But we would hope that as the public policy debate continues on MSAs, that there would be ways to ac-

commodate the proponents, but also maintain the integrity of the insurance system.

Mr. McCrery. So you think it is possible to do that within the context of tax-favored MSAs?

Mr. Troy. I think when we flesh out the criteria, perhaps the proponents would have to measure it against their goals because there is significant adverse selection concerns. It is a matter of whether they can be circumscribed by provisions.

Mr. Herbert. Just to further comment, I think the greatest concern is you would have someone belonging to an MSA for perhaps several years while they are healthy and then when they have a significant medical experience coming up, they would then move into a more comprehensive plan like an HMO, and some way or another we need to learn how to deal with that.

Mr. McCrery. Thank you, Mr. Chairman.

Chairman Thomas. I want to thank the witnesses very much and the subcommittee is adjourned.

[Whereupon, at 11:07 a.m., the hearing was adjourned.]

[Submissions for the record follow:]

James A. Klein
Executive Director

May 11, 1995

The Honorable William Thomas
Chairman, Health Subcommittee
Committee on Ways and Means
U.S. House of Representatives
1136 Longworth House Office Building
Washington, DC 20515

Dear Chairman Thomas:

The Association of Private Pension and Welfare Plans (APPWP) commends you on the introduction of H.R. 1610, which enhances the portability of health benefits. Achieving greater portability of coverage for workers and their families while retaining appropriate incentives for individuals to purchase coverage before they become ill would be a significant accomplishment.

We are gratified that H.R. 1610 adopts a well-targeted rather than broad approach to health care legislation. The bill expands portability of coverage and reduces "job lock" while allowing employers the discretion they need to appropriately structure the health benefits that they voluntarily provide to employees. Since H.R. 1610 avoids overregulation, it will not discourage employers from voluntarily sponsoring health plans for their employees.

Again, we commend you on introducing H.R. 1610. We look forward to discussing technical issues with you in the near future and, as always, the APPWP will be pleased to work with you as H.R. 1610 moves through the legislative process.

Sincerely,

James A. Klein
Executive Director

1212 New York Avenue, N.W. • Suite 1250 • Washington, D.C. 20005 • (202) 289-6700 • FAX (202) 289-4582

TESTIMONY OF A. GREG SCANDLEN
COUNCIL FOR AFFORDABLE HEALTH INSURANCE

Full portability of health insurance coverage for American workers has always been a goal of the Council for Affordable Health Insurance's free market approach to federal health care reform. As Executive Director of the Council for Affordable Health Insurance, I am therefore pleased to provide the Ways & Means Health Subcommittee with this testimony supporting the goals and concepts of HR 1610. This legislation would require employer-provided group health plans to credit coverage under a prior group health plan against any preexisting condition limitation.

The Council for Affordable Health Insurance and the health insurance companies and several hundred individual members we represent, firmly believe that anyone who has maintained health insurance coverage without interruption in premiums should not be canceled or denied health insurance for any reason other than failure to pay premiums, or are guilty of insurance fraud and abuse.

Further, the Council maintains that if a preexisting condition limitation has been previously satisfied, there is no need actuarially to satisfy a second waiting period. By giving a credit to individuals changing jobs for their periods of continuous coverage, as HR1610 provides, there will never be a sense of fear that another period of eligibility must be met, thus successfully eliminating "job lock."

Job lock is a very real phenomenon that keeps American workers from changing jobs because of their fears of either losing coverage for themselves and members of their families, or to be forced to go without full coverage until a waiting period is satisfied.

However, the Council for Affordable Health Insurance believes that federal portability legislation cannot possibly address the "job lock" dilemma entirely. For example, a worker moving from one job to another may not have the disposable income to afford health insurance premiums under COBRA. Under the tenets of HR1610, that worker would need to maintain health insurance coverage between jobs if the hiatus in employment lasts longer than 60 days. Otherwise, the worker may be exposed to a waiting period to satisfy a preexisting condition.

Out-of-work Americans have always had difficulty making COBRA premium payments, but the Council for Affordable Health Insurance has a solution to that problem.

Medical Savings Accounts (MSAs) are tax-deferred accounts set up to pay for routine medical care and to allow for the build-up of savings to pay for future medical expenses. MSAs would allow employers, to purchase a high-deductible policy and put the premium savings into a Medical Savings Account to pay for routine medical care, until the deductible is satisfied. The funds in the MSA belong to the insured, and if not spent, accumulate over time as savings, pre-funding future health care expenses such as insurance premiums under COBRA.

If Medical Savings Accounts were enacted on the federal level, workers would have the funds available to pay their own insurance premiums under COBRA. In fact, the Council for Affordable Health Insurance believes that portability legislation such as HR 1610 would be greatly enhanced by passage of Medical Savings Account legislation.

The Council for Affordable Health Insurance also believes that premiums paid directly out of pocket should enjoy the same favorable tax treatment that employer-paid premiums enjoy. This "tax equity" is another measure that would address the "job lock" problem. Many employers do not provide health coverage at all, and tax equity would enable those workers to purchase their own insurance policy, thus keeping coverage continuous and avoiding additional underwriting.

Medical Savings Accounts and tax equity will not solve all the nation's health care woes. But coupled with legislation such as HR 1610, the U.S. Congress can begin a plan a rebuild, strengthen, and extend health insurance access to all Americans, regardless of their employment, health or economic status.

The Council for Affordable Health Insurance has developed an 8-point plan for free market reform of the American health care system. Listed here are the elements of the CAHI plan:

Tax Policy Current tax policy should be modified to equalize the tax treatment for individuals with that available to employers for health care costs.

Medical Savings Accounts CAHI supports legislation that would permit medical care savings accounts to be established by employers for their employees, and for self-employed individuals.

Universally Available Coverage CAHI supports guaranteed access for all citizens through the establishment of a national high risk pool, or a system of state-based high risk pools.

Small Group Reform CAHI endorses many features of small group reform proposals, including limited rating bands, limits on annual rate increases, full portability for those with continuous coverage, and renewability of coverage.

Tort Reform Limits on malpractice awards need to be developed, while the system of peer review and professional discipline of negligent physicians should be improved.

Price Disclosure Patients should know the cost of their treatment in advance and have a stake in paying for it, then they will act in the same manner as they would for purchasing any good or service - they will shop for the best service at the lowest price.

Patient Education Patients should be made aware of alternatives for treatment, differences in quality of services, and the importance of personal behavior on health.

Abolition of State Mandated Benefits Buyers should be able to purchase insurance policies that cover benefits they wish to have and can afford, rather than having the political system dictate a benefit structure.

By incorporating Medical Savings Accounts and full portability with other concepts that 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 limiting government's involvement to

protecting those who are incapable of caring for their own needs; we can fix the current health care delivery system instead of destroying it.

On behalf of the members of the Council for Affordable Health Insurance, I would like to take this opportunity to thank the chairman of the House Ways & Means Subcommittee on Health, the Honorable Bill Thomas, for introducing HR 1610 and for conducting these important hearings. The Council stands ready to assist this committee in the passage of HR 1610, and other elements of free market health care reform. Thank you, Mr. Chairman.

WALNUT 2-5252

GEORGE ROSS FISHER, M.D.
829 SPRUCE STREET
PHILADELPHIA, PA. 19107

Honorable Bill Thomas, Chairman
Subcommittee on Health,
Ways and Means Committee,
United States House of Representatives

Re: Hearing on Health Insurance Portability, May 12, 1995

The oral testimony before your committee was uniformly favorable to proposed legislation creating portability of health insurance for members of an employer group moving to another employer group. I join the employers and insurers who testified, in endorsing such legislation. However, I greatly regret the suggestions which were offered to exclude groups of one, or other definitional ways of extending the same portability to those who move from employed to self-employed status. Or from self-employed to employed status, as though an episode of self-employment were some sort of unforgivable sin.

To restrict portability to large employer groups has the effect of encouraging job leavers to enlist in post-employment COBRA plans within a brief 60-day grace period. It is easy to see why such incentive is appealing to employers who wish to augment the number of well persons in their insured pool. It is also easy to see the appeal to insurers who would envision a greater retention of their business among job-leavers. No one, however, troubled to mention the financial hardships often suffered by those who have just lost a job and may be uncertain when they will get another. Or the fact, quite apparent in the data offered in testimony, that job-leavers are typically in worse health than those whose employment is retained. In all this talk about adverse risk selection, it is well to remember who is doing the selecting.

In other words, large employer groups are a privileged class, seeking to become even more privileged. It is unbecoming for them to invoke vague unspoken dangers of extending similar privileges to self-employed persons. Employer groups enjoy total tax exemption for their health insurance, while self-employed persons have only recently been extended a 30% exclusion. For self-employed persons to come away from this legislation with an additional discrimination relating to pre-existing conditions would heighten their sense of injustice.

What might be more satisfactory would be for the legislation to focus on whether or not the individual is coming from a period of continuing coverage of comparable degree. If the individual was covered for a particular condition under the previous policy, and if a standard period of contestability had previously been satisfied, a new carrier should be precluded from imposing a pre-existing illness clause. That should be true, regardless of the number of persons in the group, including a group of only one as much as a group of a thousand.

I also urge you to consider some form of mandatory waiver of premium, or alternatively reduction to minimum coverage, for job-leavers. While this might slightly increase the costs for those who remain behind in the lifeboat, it would recognize that those who are dumped out of the lifeboat are selectively impoverished, and have selectively worse health.

Mr. Chairman, I approached these hearings with the expectation that after the group-to-group transfer issue had been addressed, the subcommittee would turn to the self-employed issue, probably through some form of Medical Savings Account. I certainly hope that is the case, and representatives of group insurance will then reflect further on the equities involved.

George Ross Fisher, MD
Trustee (for Philadelphia), Pennsylvania Medical Society

HEALTHCARE
LEADERSHIP
COUNCIL

FOR IMMEDIATE RELEASE
May 12, 1995

Contact: Claire del Real
(202) 347-5731

STATEMENT BY
PAMELA G. BAILEY
PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL

The Healthcare Leadership Council (HLC) is pleased to support H R. 1610, introduced on May 11 by Representatives Thomas (R-CA) and Stark (D-CA), and commends the sponsors and cosponsors of this bipartisan effort for their leadership in finally transforming the theory of health care reform into reality.

This important market-based legislation would go a long way toward addressing the problems in the current health care delivery system by eliminating "job lock" and ensuring that American workers can change jobs without fear of losing health care coverage due to a preexisting condition or illness. The positive implications of the Thomas/Stark bill are significant and far-reaching. Their proposal would not only provide health security to America's workers, but would also extend coverage to many who are now uninsured without severely impacting health plan premium costs.

Post-election polling conducted last November by the HLC indicates that the vast majority of Americans support targeted health care reform designed to ensure portability of health care coverage between jobs. Consumers are overwhelmingly satisfied with their choice of health care coverage, and with the cost and quality of coverage. The message is clear -- keep reform simple because the market is working.

Healthcare Leadership Council
1500 K Street NW Suite 360
Washington, D C. 20005
202/347-5731

Congress has the unique opportunity to enact targeted, consensus health care reform this year and should not get sidetracked by overly regulatory and burdensome proposals which are controversial and would threaten our market-based delivery system. The Thomas/Stark bill is a meaningful step toward enacting such common sense health reform by allowing the market to continue proving its effectiveness in health care delivery and cost containment.

The HLC is a broad coalition of 60 Chairmen and CEO's of health care companies representing all sectors of the health care industry. The HLC is firmly committed to ensuring access to quality, affordable health care through the promotion of a market-based health care delivery system. Only a system defined by market-based principles and competition can ensure health care consumers real choice in the health care marketplace while at the same time reining in costs and improving the quality of health care delivery through innovation.

TESTIMONY OF JOAN GREENE, RN, MSN, CPNP
NATIONAL ASSOCIATION OF PEDIATRIC NURSE ASSOCIATES & PRACTITIONERS

The National Association of Pediatric Nurse Associates and Practitioners (NAPNAP) is grateful for the opportunity to submit testimony on the issue of health insurance portability. NAPNAP represents over 4,400 nurse practitioners dedicated to pediatric care. We strive to enhance the quality of health care for infants, children and adolescents. Children are the nation's most valuable resource, and we believe that they need access to health care regardless of race, economic status or religious beliefs.

We find that health insurance is a critical link to health care, for children as well as the population as a whole. Uninsured children use fewer health care services than do insured children. Uninsured children are also significantly less likely than publicly insured poor children to identify a usual source of routine care.

At the same time, recent trends show a decline in health coverage for children from private insurers and an increase in coverage from publicly funded insurance, Medicaid. However, growing budget constraints point toward a decrease in Medicaid spending. This is of great concern to pediatric health care providers like us, because it is the children of low-wage working families who will lose out under this scenario. More incentives for private health insurance coverage for working families, such as improved health insurance portability, would certainly help to prevent or alleviate the lack of access to health insurance that would result from these trends.

We commend Chairman Thomas and the members of this subcommittee for taking the lead on the issue of health insurance portability. It is clear to those of us who work with children that access to primary and preventive health care is the first step toward a rewarding and valuable life. Improving the health insurance portability of families increases access to health care for children. It is good for families, good for children and good for society.

We strongly support the premise of removing pre-existing conditions barriers for workers who need or desire to move from one job to another. In fact, we believe that Congress should do everything within its power to guarantee health insurance coverage for all children. Ensuring access to primary and preventive care for children would provide all children with a healthy start in life and would reduce the costs of treatment for the uninsured. Removing pre-existing conditions barriers for working families with employer-based insurance is the first step toward ensuring care for all children.

The Thomas legislation, H.R. 1610, would reduce the waiting period for covering pre-existing conditions by allowing credit for

coverage under a previous employer's plan, so long as there is no more than a 60 day stop in coverage. It would apply to transfers from one group health plan to another group health plan. We see this is a great step forward. We would support going even further toward guaranteeing health insurance coverage protections for all children.

The subcommittee is also considering bi-partisan legislation which goes further than H.R. 1610. The Johnson plan, H.R. 1604, would apply portability protections to all group and individual plans, including self-insured plans. It would also make extension of health insurance coverage through COBRA more affordable for those who leave or lose their jobs. Simply put, the Johnson plan would apply to more workers. More families with children would be protected from loss of insurance due to job loss, pre-existing conditions barriers, or the "job lock" that often results from these harsh realities. We support this legislation because we believe it will help ensure access to health care for more children.

As health care providers for children, we continue to advocate for legislation which will increase their access to care. We believe that the health system should encourage the promotion of health and the prevention of disease. Of primary importance to us is the renewability of coverage and the continuous coverage for individuals and families when the wage earner changes jobs. Health care plans which utilize pre-existing clauses for designated diseases must be eliminated.

We strongly support the continuing bi-partisan efforts of this subcommittee to improve health insurance portability and to eliminate pre-existing conditions barriers for working families. We encourage the subcommittee to enact coverage protections for as broad a group as possible, because behind many of those wage earners are children who need primary care. Ensuring the portability of health insurance for workers who change jobs and eliminating pre-existing limitations are important steps toward removing all the barriers that stand between working families and health care coverage.

NFIB
National Federation of Independent Business

May 11, 1995

Honorable Bill Thomas
Chairman
Health Subcommittee
Committee on Ways & Means
1136 Longworth House Office Building
Washington, DC 20515

Dear Mr. Chairman:

On behalf of the 600,000 small business owners of the National Federation of Independent Business (NFIB), I am writing to express our support for your bill to bring portability to the health insurance market place.

Making it easier to go from job to job without the threat of losing health coverage has long been a goal of NFIB and the small business community. The Thomas portability bill would achieve that goal without having an adverse impact on small business premiums.

NFIB hopes that the Thomas portability bill is the first step toward additional insurance reforms, like rating reforms, guaranteed renewability, and others. We very much appreciate your leadership in making health insurance more accessible to small business owners and their employees.

Sincerely,

John J. Motley III
Vice President
Federal Governmental Relations

600 Maryland Avenue S.W., Suite 700 • Washington, D.C. 20024 • 202-554-9000 • Fax 202-484-1567
The Guardian of Small Business for Fifty Years

Statement of
Pearl Moore, RN MN FAAN
Executive Director, Oncology Nursing Society

The Oncology Nursing Society is pleased to have this opportunity to submit testimony for the written record to the House Ways and Means Committee, Subcommittee on Health.

The Oncology Nursing Society is a national specialty organization of more than 25,000 registered nurses dedicated to excellence in patient care, teaching, research and education in the field of oncology.

The American health care system is the most expensive in the industrialized world; yet, it is a system that delivers inconsistent quality of care and distributes benefits unequally. As nurses, we provide a unique perspective on the health care system. Working in a variety of settings provides us with the opportunity to interact with patients who benefit from the health care system's most sophisticated services as well as those individuals seriously compromised by the system's inefficiencies.

Millions of Americans have medical histories that include cancer and they face problems in obtaining adequate health insurance due to ineligibility, unaffordable premiums, and/or pre-existing conditions exclusion clauses.

The Oncology Nursing Society strongly supports health insurance reform legislation that eliminates pre-existing condition restrictions, addresses out-of-pocket deductible and co-payment expenses and restricts risk rating.

We applaud Chairman Thomas for holding hearings as they relate to the issue of health insurance portability and encourage the introduction of legislation which would eliminate the use of pre-existing condition exclusions.

On behalf of our members and the patient population we serve, we thank you for this opportunity to address this committee. We would welcome the opportunity to appear before you and provide more extensive testimony as the health care debate continues.

STATEMENT OF THE
SUSAN G. KOMEN BREAST CANCER FOUNDATION
ON
PORTABILITY AND PRE-EXISTING CONDITION PROVISION
HOUSE WAYS & MEANS SUBCOMMITTEE ON HEALTH

The Susan G. Komen Breast Cancer Foundation of Dallas, Texas, is an organization dedicated to the eradication of breast cancer and carries out this mission by raising private funds for research, education, screening and treatment of breast cancer. Started in 1982 in Texas, the Foundation now has a network of volunteer affiliates in 32 states and 57 cities in which it sponsors the RACE FOR THE CURE®, a 5k and 1k running/walking race to raise awareness of breast cancer. In 1995, 235,000 people are expected to participate in the RACE events. The Foundation uses 75% of the funds raised in each city to fund breast cancer programs in the specific cities. These programs include providing education programs, free or underwritten mammograms, and attendant services for patients undergoing treatment. The remaining race funds are used for the Foundation's National Grants Program to fund important and cutting-edge research on breast cancer. Currently, the Foundation is the largest private sector funder of research solely dedicated to breast cancer.

The Foundation wishes to comment on the policies and insurance requirements that affect approximately 2 million survivors of breast cancer, and the 46,000 women per year who will be diagnosed with breast cancer. The insurance policies of many major health insurers exclude coverage for "pre-existing conditions". Women who have been diagnosed with breast cancer are, in many instances, denied coverage for treatment because they are deemed to have a "pre-existing condition". This exclusion varies from one insurance company to another, but can apply to any number of treatments, including the potentially life-saving and costly bone marrow transplant. In the 1990s alone, close to 1.8 million women will be afflicted with breast cancer and many will be denied coverage for treatment if the current insurance policies are continued. The financial impact on these women and their families is substantial, and in some instances, so costly that some families resort to near bankruptcy to pay bills.

In addition, breast cancer survivors and/or their spouses may be precluded from making job changes because new employers carry insurance that exclude "pre-existing conditions". Often women with breast cancer or survivors change jobs in response to the disease. These women may be unable to do so, or risk losing insurance coverage if they do. A spouse may be precluded from changing jobs because his wife has breast cancer and the new employer's insurance has a "pre-existing condition" provision. In many instances, a spouse may lose a job due to corporate down-sizing or reorganization and will find that a new job has insurance with "pre-existing condition" exclusions.

A change in insurance policies that would eliminate abuses of "pre-existing condition" provisions and would allow for "portability" of insurance policies would assist the millions of women in getting coverage for needed treatments, or in changing jobs, and would save many families from job or financial problems caused by lack of coverage.

ISBN 0-16-052405-9

90000

9 780160 524059

EXPERIENCE IN CONTROLLING COSTS AND IMPROVING QUALITY IN EMPLOYER-BASED PLANS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

MAY 16, 1995

Serial 104–18

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

92–605 WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-052023-1

COMMITTEE ON WAYS AND MEANS

BILL ARCHER, Texas, *Chairman*

PHILIP M. CRANE, Illinois
BILL THOMAS, California
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
JIM BUNNING, Kentucky
AMO HOUGHTON, New York
WALLY HERGER, California
JIM McCRERY, Louisiana
MEL HANCOCK, Missouri
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
DICK ZIMMER, New Jersey
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
PHILIP S. ENGLISH, Pennsylvania
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska

SAM M. GIBBONS, Florida
CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ANDY JACOBS, JR., Indiana
HAROLD E. FORD, Tennessee
ROBERT T. MATSUI, California
BARBARA B. KENNELLY, Connecticut
WILLIAM J. COYNE, Pennsylvania
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
L.F. PAYNE, Virginia
RICHARD E. NEAL, Massachusetts

PHILLIP D. MOSELEY, *Chief of Staff*
JANICE MAYS, *Minority Chief Counsel*

SUBCOMMITTEE ON HEALTH

BILL THOMAS, California, *Chairman*

NANCY L. JOHNSON, Connecticut
JIM McCRERY, Louisiana
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska
PHILIP M. CRANE, Illinois
AMO HOUGHTON, New York
SAM JOHNSON, Texas

FORTNEY PETE STARK, California
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia

CONTENTS

	Page
Press releases announcing the hearing	2

WITNESSES

Employee Benefit Research Institute, Paul Fronstin	23
Foster Higgins & Co., Inc., Dennis J. Treat	13
General Mills Restaurants, Jon R. Reiker	78
Hay/Huggins Co., Inc., Edwin C. Hustead	8
Health Care Network of Wisconsin, Jim R. Wrocklage	56
Pacific Business Group on Health Negotiating Alliance, Paul Fearer	40
Storage Technology Corp., James P. Spence	85
University of California, Michele E. French	52

SUBMISSIONS FOR THE RECORD

Coalition of Mental Health Professionals and Consumers, Inc., Karen Shore, statement and attachments	97
Consortium for Psychotherapy, Judith Storms Kraft, statement and attachments	107

EXPERIENCE IN CONTROLLING COSTS AND IMPROVING QUALITY IN EMPLOYER-BASED PLANS

TUESDAY, MAY 16, 1995

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

The subcommittee met, pursuant to call, at 10:09 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
May 9, 1995
No. HL-11

CONTACT: (202) 225-3943

Thomas Announces Hearings on Increasing and Improving Options for Medicare Beneficiaries

– Private-Sector Lessons to be Sought –

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a series of hearings to explore increasing and improving options for Medicare beneficiaries, with a focus on private-sector successes.

The hearing dates and subjects are as follows:

Tuesday, May 16, 1995:	**Experience in Controlling Costs and Improving Quality in Employer-Based Plans**
Wednesday, May 24, 1995:	**Medicare HMO Enrollment Growth and Payment Policies**
Thursday, May 25, 1995:	**The Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program**

The hearings on May 16 and May 24, will be held in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. The hearing on May 25 will be held in room B-318 of the Rayburn House Office Building, beginning at 10:00 a.m.

Oral testimony at these hearings will be heard from invited witnesses only. Witnesses will include health policy experts, representatives from the health care industry, and employer groups. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee or for inclusion in the printed record of the hearing.

BACKGROUND:

According to the 1995 report of the Board of Trustees, the outlays of the Medicare Hospital Insurance (HI) trust fund will exceed income beginning in 1996 and the HI trust fund is projected to run out of reserves in 2002, using the intermediate set of assumptions.

To keep the HI trust fund in actuarial balance for 25 years would require, in the absence of spending restraints, an immediate 44 percent increase in the payroll tax rate. As a result, taxes on a person earning $20,000 would be increased by $260 annually and a person earning $30,000 per year would see their taxes hiked by $390 a year. Those who make $75,000 a year would pay an additional $975 in taxes every year.

In the report, the Board of Trustees called for "prompt, effective, and decisive action" to put the HI trust fund into balance.

The Board of Trustees also expressed "great concern" about spending growth from the Supplementary Medical Insurance trust fund. As noted by the Board of Trustees in the 1995 report:

> "In spite of evidence of somewhat slower growth rates in the recent past, overall, the past growth rates have been rapid, and the future growth rates are projected to increase above those of the recent past. Growth rates have been so rapid that outlays of the program have increased 53 percent in the aggregate and 40 percent per enrollee in the last 5 years."

Medicare insurance coverage remains largely as it was originally enacted in 1965: traditional fee-for-service indemnity insurance with beneficiary cost-sharing requirements to control utilization.

However, private health insurance has evolved substantially since that time. More and more privately insured Americans are enrolled in managed-care plans, such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations. According to the Group Health Association of America (GHAA), some 56 million Americans were enrolled in HMOs in 1994, up from 36 million in 1990, and 65 percent of people with employer-based health insurance plans were enrolled in some form of managed-care arrangement, according to the KPMG Peat Marwick Health Benefits in 1994 (October 1994).

Moreover, managed-care organizations have recently been successful in slowing the rate of growth of premiums. In 1995, on average, HMOs are expected to reduce their per person premiums by 1.2 percent, according to GHAA.

Some private employers have also begun to offer their employees Medical Savings Accounts. Such accounts allow employees and their dependents to control their health care dollars, providing strong incentives for cost conscious spending.

Medicare beneficiaries can enroll in HMOs under the risk contracting program and other managed-care arrangements, but, due to certain features of the program, managed-care remains a relatively small part of Medicare, with only 8 percent of the beneficiaries enrolled in managed-care plans as of December 1994. Medicare beneficiaries are also not currently able to enroll in any kind of Medical Savings Account.

FOCUS OF THE HEARINGS:

The hearings will focus on successful private-sector approaches at controlling costs and improving quality and an exploration of how such approaches can be made more available to increase choices for Medicare beneficiaries.

The hearing on Tuesday, May 16, 1995, on "Experience in Controlling Costs and Improving Quality in Employer-Based Plans" will review the approaches employers have taken to improve the cost-effectiveness and quality of their coverage for their employees, the issues and problems encountered as these approaches were implemented, the effectiveness of these approaches, and lessons the Federal Government can learn from these private-sector experiences.

The hearing on Wednesday, May 24, 1995, on "Medicare HMO Enrollment Growth and Payment Policies" will investigate the reasons for increasing beneficiary enrollment in Medicare risk contracting HMOs, and current and alternative HMO payment methods.

The hearing on Thursday, May 25, 1995, on "The Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program" will explore issues involved in enabling employers and associations to offer Medicare coverage to former employees and members, respectively, and the potential role Medical Savings Accounts could play in the Medicare program.

(MORE)

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, Thursday, June 8, 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'.

*****

** *NOTICE -- CHANGE IN LOCATION* **

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 17, 1995
No. HL-11-Revised

CONTACT: (202) 225-3943

Thomas Announces Change in Location for Health Subcommittee Hearing on the Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on the potential role for employers, associations, and medical savings accounts in the Medicare program, which was originally scheduled for Thursday, May 25, 1995, at 10:00 a.m., in Room B-318 of the Rayburn House Office Building, **will be held instead in the main Committee hearing room, 1100 Longworth House Office Building.**

All other details for the hearing remain the same. (See Health Subcommittee Advisory No. HL-11, dated May 9, 1995.)

*****

Chairman THOMAS. The subcommittee will come to order, and I want to welcome you to our continuing series of hearings on Medicare and health reform in general. This is the 13th hearing the subcommittee has conducted this year, and this committee and this Congress have already moved aggressively to enact real health care reform for the American people.

As you know, the Congress has passed and the President has signed a law permanently increasing the health insurance tax deduction for the self-employed prospectively at 30 percent. And this House has passed long-term care insurance improvements and extension of the Medicare Select program, reforms in the malpractice area to prevent lawsuit abuse in the medical field. They are all over on the Senate side, and we were anxiously awaiting some action from the Senate.

Today's hearing will focus on experience in controlling costs and improving the quality of employer-provided health coverage as we begin to consider options for preserving Medicare. In the 21st century, it is to the private sector we should look for lessons that have been learned and changes that we might be able to make in our delivery system. Although Medicare remains predominantly a 1960s-style fee-for-service health insurance plan, private health coverage has evolved substantially since that same time period.

Employers, especially in the past 5 years, have moved more rapidly from traditional insurance into sponsoring more options for their employees, such as health maintenance organizations, preferred provider organizations [PPO's] and other coordinated care arrangements. Some 56 million Americans were enrolled in health maintenance organizations [HMO's] last year—that is up from 36 million in 1990—and 65 percent of people with employer-based coverage were enrolled in 1994 in some form of a coordinated care program.

Employers are also joining forces with each other in many market areas, using their buyer power and new-found knowledge to force dramatic changes in the health care delivery system to lower costs and improve quality. We will hear from witnesses today about these arrangements.

I believe employers in private health plans have turned a corner in terms of cost control in recent years. In the last Congress, Stuart Albert and I carried on a conversation about the fact that both of us believed that these changes are relatively fundamental and permanent, notwithstanding the relatively few years that these changes have been in effect.

In 1995, on average, HMO's are expected to reduce their per-person premiums by 1.2 percent. In 1994, private health spending grew at about 4.4 percent, compared to Medicare spending growth of over 11 percent.

As we consider solutions for Medicare, I believe we should take the time to focus on successful private-sector efforts so that we might learn from their experience as we seek changes in the Medicare program. I look forward to hearing from our witnesses.

I recognize the gentleman from California, Ranking Member Mr. Stark.

Mr. STARK. Mr. Chairman, thank you. I am pleased you have scheduled today's hearings to see what experiences with employer-

based health plans are relevant and possibly applicable to the Medicare program.

The hearings wouldn't be complete unless we heard from the prosecutors who are now trying to put the rest of the Prudential Life Insurance executives in jail for shoddy sales practices, and unless we examined all of the malpractice suits filed for denial of benefits to people which caused death or serious illness when zealous bean counters for insurance companies deny benefits in their interpretation of managed care.

I feel it is necessary to raise these words of caution before we hear from our witnesses today, particularly in light of the tone of the announcement for the hearing.

Your announcement described Medicare in the following manner:

> Medicare insurance coverage remains largely as it was originally enacted in 1965: traditional fee-for-service indemnity insurance with beneficiary cost-sharing requirements to control utilization. However, private health insurance has evolved substantially since that time.

There is some confusion, I think, over Medicare's commitment to health security for America's seniors, which does remain largely as it was originally in 1965, versus Medicare's means of paying for that security. Today over 99 percent of seniors have health insurance coverage. That is a commitment we made in 1965. And it is as necessary and valued a commitment today, as it was when we enacted it in 1965.

As to the operations of the Medicare Program over the past 20 years, Medicare has actually led the way in innovations in administration, cost containment, quality of care, and beneficiary choice. The fact is that no employer in the country, no witness today, provides the range of health insurance options to the range of Americans in the variety of locations as does the Medicare Program.

The diagnosis related group [DRG]-based hospital prospective payment system led the way in reforming the way hospitals get paid. Similarly, Medicare's resource-based relative value scale payment system has changed forever the way in which doctors are compensated. Both payment mechanisms are in widespread use across the country and across systems, both public and private. In our own State of California, Blue Cross and Blue Shield both use these methods of reimbursing hospitals and physicians.

Medicare has not only been concerned with costs but with the quality of patient care received. 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, as I know the Chairman is aware, the Federal Government's involvement in outcomes research and the development of practice guidelines is serving to improve quality of care for Medicare and non-Medicare patients alike. As reported in lost month's issue of the Journal of Transplantation.

> Heart transplant patients at Medicare-approved hospitals have a 20 percent lower risk of death within 30 days of the procedure. Better outcomes persist for 5 years.

While I disagree with your characterization of Medicare today, I do agree that if the proposals put forth in the recent Republican budget are enacted, like abolishing the Agency for Health Care Policy and Research and slashing Medicare funding, the clock on Medicare could be turned right back to 1965.

The last issue I would like to touch on is the growth in Medicare and private-sector expenditures. There are available to us all charts and graphs prepared by a host of private consulting firms. Some show private health expenditure increasing at a slower rate than Medicare; others show private-sector spending above Medicare. None of the numbers are the same. Perhaps the most accurate numbers I have seen are from the Health Care Financing Administration's [HCFA] 1995 analysis of the National Health Expenditures Account. While total Medicare spending is projected to increase faster than private-sector expenditures, when they are adjusted for enrollment growth in Medicare, Medicare and private health insurance expenditures are anticipated to grow at almost exactly the same rate, 7.9 percent for Medicare and 7.6 for private health insurance.

I offer these thoughts to emphasize that there are lessons to be shared both ways between the private sector and Medicare. This hearing I think will be more fruitful if we keep that in mind.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman from California for his usual really constructive comments; and he is absolutely correct, no other program—certainly not those in the private sector—are going broke like Medicare, according to the trustees report.

I ask for the first panel, please—Mr. Hustead, Mr. Treat, and Mr. Fronstin.

Chairman THOMAS. I thank the panel. I would tell any of the panel that if they have a written statement, it will be made a part of the record, without objection, and you may proceed for 5 minutes to inform the subcommittee in any way you see fit.

We will start with Mr. Hustead and move across the panel.

STATEMENT OF EDWIN C. HUSTEAD, SENIOR VICE PRESIDENT, HAY/HUGGINS CO., INC.

Mr. HUSTEAD. Thank you, Mr. Chairman. My name is Edwin C. Hustead, senior vice president with the Hay/Huggins Co., Inc., former chief actuary of the Office of Personnel Management, currently chair of the American Academy of Actuaries Work Group on medical savings accounts [MSAs].

I would caution, as many of us will and as we have heard already, that solutions that work in the private sector may not necessarily be transferable both to Medicare and vice-versa. However, they all deal with the same basic problem and that is, when the patient, the buyer, is facing the physician, the seller, there is no economic buyer involved in that transaction. And each system in its own way is dealing with this basic problem which, in effect, creates a monopoly.

Since 1990, as you have noted, employers have moved rapidly to adopt a series of steps to involve a third party at the point of transaction. Our charts show that both the classic health maintenance organization and the more recent additions of preferred provider organizations and point-of-service plans have grown very rapidly until, together, they now all outweigh the number of traditional fee-for-service plans.

The result is hard to measure. There is much background noise in what is happening in the health sector, particularly in pre-

miums. As you have noted already, there are charts that show the private sector is worse than Medicare, and others show better trends.

One of the reasons for that is the underwriting cycle which I show in my written testimony and would be glad to discuss. When you cut through all of that, it does look, certainly in 1994, that health care cost increases in the private sector were around 4 to 5 percent. This year, however, as the HCFA study shows we think the increases are going to be around 8 to 10 percent.

We think that what happened last year, the 4-percent private sector versus the 11-percent Medicare, was an anomaly; just as many times in the past the private-sector growth has apparently been greater than Medicare, when in fact it has not.

When these provisions are adopted, when HMOs are put in place and PPOs and point-of-service plans, the immediate question is, what happens to the quality of care? The employers we work with, the employers that are thinking of their employees—and most of them do—look very carefully at this question and they look at a lot of ways to get feedback from their employees as to what is happening, and to get feedback from the health plans themselves.

One way that they can easily see what is happening is the way the employees vote with their feet. During the open seasons, if employees continue to stay in the HMO's and the PPO's and the point-of-service plans, then it is clear that quality is being provided; and when the individuals do choose a preferred provider organization or point-of-service plan, we look for 70 percent of the employees to use the networks that are set up by the employers. If they don't use those networks, we begin to question whether those networks are effective and advise employers to look at the quality of care that has been delivered.

In closing, let me mention that while it does look hopeful that cost increases are as low as 8 percent when they have been 15 percent, keep in mind that 8 percent is twice the rate of inflation and that 8 percent, even though it is below double digits, will cause us to continue to have health care that consumes a greater part of our economy.

Thank you very much.

Chairman THOMAS. Thank you.

[The prepared statement and attachment follows:]

TESTIMONY OF EDWIN C. HUSTEAD
HAY/HUGGINS CO., INC.

Thank you for the opportunity to address the Subcommittee on Health of the Committee on Ways and Means on the issues of controlling cost while preserving quality in employer-based plans. I am a Senior Vice President with the Hay/Huggins division of the Hay Group. We are an international benefits and compensation consulting firm. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

The central problem in the rising cost of health care has been the absence of an economic buyer. When confronted with a need for health care, a patient is usually not in a position to bargain for the best rates or search for the most efficient provider. This problem is exacerbated, in the United States, by the fact that a large share of most health care bills is paid for by a third party. The result is predictable - patients will "buy" much more health care than they need and at higher rates than could be negotiated. In effect, the health care system simulates a monopoly that sets the price and use of its product.

Cost Controls

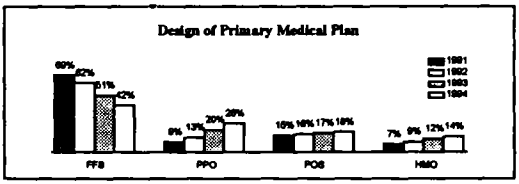
Insurers and employers have used two strategies to attack this problem. The first is to lessen unnecessary **utilization** of care through the management of the treatment. The second is to negotiate price **discounts** with the providers of care.

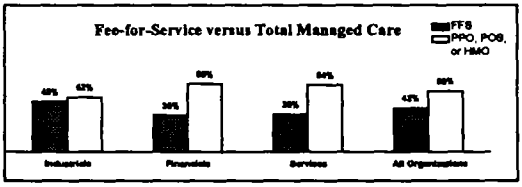
Health Maintenance Organizations (HMOs) apply both utilization and discounts. Other arrangements that deal with one or both of these aspects of health care have grown rapidly in recent years. These include Preferred Provider Organizations (PPOs) and Point of Service Plans (POS).

The PPOs deals only with the discount aspect of cost control. Patients are encouraged to select a physician or hospital from a network of providers who have agreed to provide services at a discount. The incentive to the patient is that the plan will pay a larger share of the bill for these providers.

The POS plan also asks the employee to select a provider at the time that services are needed. Unlike the PPO, however, if the employee selects the in-network POS plan then that plan manages the provision of care, as in an HMO, and provides discounts.

The following chart shows the percentage of employer health insurance plans by the type primary plan. The chart, and other data in my testimony, is from the Hay/Huggins Benefits Report (HHBR). This is a comprehensive report on the benefits practices of over 1,000 medium to large employers in the United States. Fee-for-service (FFS) plans are the traditional method of providing care. In the last four years, FFS plans have dropped from a majority of primary plans (69 percent) to a minority (42 percent). The fastest growing primary plan is the PPO but the POS and the traditional HMO plans have also increased substantially. We expect these trends to continue until very few primary plans are traditional FFS plans.

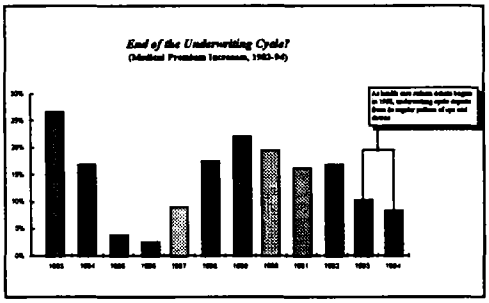




A recent innovation has been the application of **capitation** and **carve-out** arrangements by groups of health care providers. Capitation is the basis for HMO pricing but the new use is to capitate groups within the plan. Under these arrangements, a group of providers agrees to offer all of their services for a pre-determined fixed rate (the capitation). The insurer can then pass on the risk for that part of the care. Many plans carve out all of their psychiatric claims to a separate organization. And, capitation is now being applied to other parts of the delivery system such as nursing and drugs. Through sharing of risks, these arrangements should result in additional control of cost.

Results

An encouraging, but puzzling, trend in 1994 was the very low increase in health insurance rates. Some credit must go to the accumulative impact of the cost control measures. However, the true impact of these measures is masked by a phenomenon known as the **underwriting cycle.** The following chart of rate increases in the private sector since 1983 clearly shows that cycle in operation.



The underwriting cycle begins when actuaries set rates that are higher than needed to cover current costs. Rates must be set two to three years in the future and, given the volatility and growth in health care costs, actuaries tend to be very conservative about these trends. They may also need to cover past losses.

When experience shows that the rates are too high rate increases can be reduced to below the actual cost trend. Further, the excessive rates build large reserves that can be drawn on to keep rates at an artificially low level. These factors lead to unusually low trends for several years. The rates are kept down by market forces.

The cycle begins again when the excess reserves are expended and costs appear to be increasing again. Actuaries again set trends higher than needed and the reserves that might have been available to offset these increases have been spent.

Prior patterns suggest that 1994 should have begun the movement upward and that we should be faced with unusually large increases in 1995 and 1996. In fact, preliminary indications are that rate increases in 1995, while higher than in 1994, may not reach the double digit level that occurred in most years from 1980 through 1994.

There has been speculation that one of the reasons for the low rate of increase in 1994 was a restraint on cost increases by insurers and providers to show that health care reform was not needed. However, in the cases that we have examined, we find that the low cost increases resulted from a build-up in reserves because of overstated premiums before 1994.

Our hypothesis is that the extensive cost control measures introduced by most large plans in the last few years have resulted in a slowing down of the underlying trend of health care cost increases. The result is that insurers still hold much of the large reserves that they built in the early 1990s and increases continue to be moderate.

If the hypothesis is correct then we may finally have broken the back of the underwriting cycle. One very troublesome feature of that cycle is that it has resulted in artificial effects on the national health care debate. The alarming peak of the cycle leads to widespread calls for health care reform. The reform proposals take several years to develop and, by the time they are ready for consideration, the low part of the cycle causes us to relax and wait for the next cycle to consider large-scale reform.

Quality

Most of the employers we work with are very sensitive to the quality of health care provided to their employees. They work with the HMOs, PPOs and other organizations to assure themselves that the controls being used do not result in a deterioration in the quality of health care provided to their employees. This assessment is done through a number of feed back mechanisms such as employee surveys.

Outcomes measurement, a relatively new tool, shows promise of quantifying the quality of health care. These systems measure the quality of treatment from a number of perspectives including the most critical one of the success in curing the patient. Employers and insurers are working with providers to develop effective outcomes measures.

A critical part of many employer packages is the choice offered to the employee. We find that, when offered as a choice, well managed HMOs and similar organizations, will attract a significant and growing portion of the employee group. By maintaining a traditional FFS choice, or an out-of-network benefit, employees can always use unmanaged care if they become unsatisfied with managed care.

As risk is shared to smaller units through carve-outs there is a danger that quality will be lost. For example, if a separate organization is in charge of all mental care then there is a danger that the critical co-ordination of mental and physical treatment will not be effective. This could easily result in a deterioration of care.

Future

Health care cost increases have been very difficult to predict. Even when the underwriting cycle was predictable, it was difficult to be optimistic when rate increases were very high. Conversely, it is difficult to be pessimistic when, as is the case today, rate increases are low.

Our best guess at this point is that rates for 1995 will average about 5 to 10 percent higher than in 1994. This is lower than during the underwriting peaks but is still significantly higher than general inflation. Even at these relatively low trends, health care will continue to grow as a percent of our economy.

The trend toward tightly controlled health care plans, that is now becoming the norm in the market, appears to have significantly lowered health care costs. The critical question now is whether the cost controls put into place will reduce future health care cost increases to near the rate of general inflation. If so, then major health care reform may not be needed. If not, then health care will continue to consume a greater share of the economy and major reform will be needed.

Again, thank you for the opportunity to address the Subcommittee on Health. I will be happy to address any questions on these important topics.

Chairman THOMAS. Mr. Treat.

STATEMENT OF DENNIS J. TREAT, MANAGING CONSULTANT, FOSTER HIGGINS & CO., INC.

Mr. TREAT. Good morning, Mr. Chairman, members of the subcommittee, I am honored to be part of the proceedings this morning. Thank you for inviting me.

I am Dennis Treat with Foster Higgins, a benefits consulting firm that has been doing a survey on employer-sponsored health care for 9 years. I would like to give you an overview of the 1994 results.

In concert with an unprecedented increase in managed care enrollment, U.S. employers successfully drove down overall health benefits costs last year. This marks the end of two decades of health benefit cost increases that have consistently outpaced inflation.

Total health benefit costs in 1994 averaged $3,741 per employee, down 1.1 percent from 1993's average of $3,781. While aided by relatively low medical cost inflation, the reduction in benefit costs was a direct result of employer cost management activity, namely: First, shifting employees from traditional indemnity plans to managed care plans; second, carving out medical plan benefits with more volatile costs such as prescription drug and mental health/substance abuse care and offering them through freestanding managed plans; and third, enrolling a growing number of retirees in managed care plans, particularly HMOs.

Large employers were the most active in 1994; 29 percent of employers with 500 or more employees reported making significant changes to their health benefits program in 1993, compared to only 20 percent of smaller employers, and large employers had the most success in holding down costs. While the average total health care cost dropped 1.9 percent among large employers, among small employers it rose 6.5 percent.

The slowdown in costs was driven by the biggest increase in employee enrollment in managed care plans in the nine-year history of our survey. In 1994, 63 percent of all covered employees were in a PPO, point-of-service, or HMO plan, up from 52 percent in 1993. This represents a 21 percent increase in managed care enrollment nationwide.

The fastest growth by far was in point-of-service plans, which include open-ended HMOs as well as insurance carrier plans. As the number of employers offering point-of-service plans more than tripled, enrollment jumped from 7 to 15 percent of all covered employees. Enrollment in traditional closed-panel HMO's grew moderately in 1994 from 19 to 23 percent. Among the managed care alternatives, only PPO's failed to capitalize on declining indemnity plan enrollment. In fact, nationwide PPO enrollment fell from 27 to 25 percent in 1994 despite a slight increase in the number of employers offering a PPO.

If more evidence was needed to prove that health care markets around the country vary widely, the survey supplied it. In the Northeast, where the biggest shift in enrollment into managed care occurred, rising from 34 percent of covered employees in 1993 to 63

percent in 1994, employers experienced a dramatic 9.7 percent decline in total health care benefit costs from $4,267 to $3,851.

In the Midwest, managed care enrollment grew from 51 to 60 percent in 1994 with costs essentially flat, rising from $4,020 to $4,048. In the West, where managed care enrollment was already high, the growth in 1994 was more moderate, from 72 to 80 percent, and costs rose 2 percent to $3,693. In the South, there was little growth in managed care enrollment, from 57 percent to 58 percent, and total costs rose 3.9 percent to $3,389.

Because cost is measured per active employee, the employers who provide retiree coverage have significantly higher average costs than those who don't. Among employers of all sizes who provide retiree coverage, average total cost is $4,221; among those who don't, average cost is $3,238.

In 1994, for the first time, employers induced a significant number of retirees to join HMO's, particularly in the West. Among large employers, defined as 500 or more employees, 17 percent offer an HMO under a Medicare risk contract, up from 7 percent in 1993. In the West, 36 percent of large employers offer a Medicare risk contract HMO to their employees. Retirees traditionally have been very reluctant to leave their own doctors and join HMO's. Employers who move this high-cost population into low-cost plans will improve their health care liability over the long term.

While total health benefit plan costs per employee decreased, the average cost of the four types of medical plans rose at various rates. With significant shifts in enrollment from indemnity plans into managed care plans—and even among the three types of managed care plans—and growing use of prescription drug and mental health carve-outs, the relationship between the medical plan costs and the all-inclusive total health costs has become more complex. In addition, changing plan selection by retirees also affects medical plan costs. Significant retiree enrollment in HMO's will raise HMO costs but may lower the actual cost of providing retiree medical benefits.

For instance, in HMO's, costs rose 6.4 percent from $3,276 per employee in 1993 to $3,485 in 1994. Some of this cost increase is the result of growing retiree enrollment in HMO plans which raises the per-employee HMO cost but lowers the total cost of providing health benefits to retirees.

The survey results also show that many employers are beginning the process of measuring the performance of their health care vendors: cost-effectiveness and quality of care, including medical outcomes, access to providers, and patient satisfaction. With this information, employers can determine which plans offer the best value, and make their buying decisions accordingly. Fifty percent of large employers offering HMO's tried to evaluate the quality of their plans in 1994, up sharply from 38 percent in 1993. In the West, where managed care first took hold, 68 percent of large employers measured HMO quality last year.

While employee satisfaction surveys are the most common type of quality evaluation, employers are also seeking data on provider outcomes. Thirty-seven percent of large employers sought outcomes data from their point-of-service plans, 29 percent from their PPO's, and one-fourth from their HMO's.

Despite these encouraging results, the health care cost crisis is by no means over. A large part of employers' favorable experience in 1994 is a one-time savings due to moving employees from a higher-cost plan to a lower-cost plan. The underlying factors driving health care costs—the aging population, expensive new technology, and cost-shifting from government programs and the working uninsured—have not gone away.

At the same time, managed care has the potential to deliver long-term savings by emphasizing prevention, more efficient care and better outcomes. To help achieve that potential, employers will have to face new challenges with new measures of success. Quality, access and effectiveness of care—issues employers haven't had to deal with in the past—will now be of greater concern.

Thank you.

[The prepared statement and attachment follow:]

TESTIMONY OF DENNIS J. TREAT
FOSTER HIGGINS & CO.

In concert with an unprecedented increase in managed care enrollment, U.S. employers successfully drove down their overall health benefit cost last year. This marks the end of two decades of health benefit cost increases that have consistently outpaced inflation. Total health benefit cost in 1994 averaged $3,741 per employee, down 1.1% from 1993's average of $3,781.

While aided by relatively low medical cost inflation, the reduction in benefit cost was a direct result of employer cost management activity:

- Shifting employees from traditional indemnity plans to managed care plans
- Carving out medical plan benefits with more volatile cost, such as prescription drug and mental health/substance abuse care, and offering them through freestanding "managed" plans
- Enrolling a growing number of retirees in managed care plans, particularly HMOs

Large employers were the most active in 1994 — 29% of employers with 500 or more employees reported making "significant" changes to their health benefit program in 1993, compared to only 20% of smaller employers. And large employers had the most success in holding down cost. While the average total health care cost dropped 1.9% among large employers, among small employers it rose 6.5%.

The slowdown in cost was driven by the biggest increase in employee enrollment in managed care plans in the nine-year history of the survey. In 1994, 63% of all covered employees were in a PPO, point-of-service plan, or HMO, up from 52% in 1993. This represents a 21% increase in managed care enrollment nationwide.

The fastest growth by far was in point-of-service plans (which include "open-ended" HMOs as well as insurance carrier plans). As the number of employers offering POS plans more than tripled, enrollment jumped from 7% to 15% of all covered employees. Enrollment in "traditional" closed-panel HMOs grew moderately in 1994, from 19% to 23%. Among the managed care alternatives, only PPOs failed to capitalize on declining indemnity plan enrollment. In fact, nationwide PPO enrollment fell from 27% to 25% in 1994, despite a slight increase in the number of employers offering a PPO.

If more evidence was needed to prove that health care markets around the country vary widely, the survey supplied it. In the Northeast, where the biggest shift in enrollment in managed care occurred — rising from 34% of covered employees in 1993 to 63% in 1994 — employers experienced a dramatic 9.7% decline in total health care benefit cost, from $4,267 to $3,851.

In the Midwest, managed care enrollment grew from 51% to 60% in 1994, with costs essentially flat, rising from $4,020 to $4,048. In the West, where managed care enrollment was already high, the growth in 1994 was more moderate (from 72% to 80%), and cost rose 2.0% to $3,693. In the South, there was little growth in managed care enrollment (from 57% to 58%), and total costs rose 3.9% to $3,389.

Because cost is measured per active employee, employers who provide retiree coverage have significantly higher average cost than those who don't. Among employers of all sizes who provide retiree coverage, average total cost is $4,221.

Among those who don't average cost is $3,238.

In 1994, for the first time, employers induced a significant number of retirees to joint HMOs, particularly in the West. Among large employers (500 or more employees), 17% offer an HMO under a Medicare risk contract, up from 7% in 1993. In the West, 36% of large employers offer a Medicare risk contract HMO to their employees. Retirees traditionally have been very reluctant to leave their own doctors and join HMOs. Employers who move this high-cost population into low-cost plans will improve their health care liability over the long term.

While total health benefit plan cost per employee decreased, the average cost of the four types of medical plans rose at various rates. With significant shifts in enrollment from indemnity plans into managed care plans (and even among the three types of managed care plans), and growing use of prescription drug and mental health carve-outs, the relationship between the medical plan costs and the all-inclusive total health cost has become more complex. In addition, changing plan selection by retirees also affects medical plan cost. Significant retiree enrollment in HMOs will raise HMO cost but may lower the actual cost of providing retiree medical benefits.

HMO costs rose 6.4%, from $3,276 per employee in 1993 to $3,485 in 1994. Some of this cost increase is the result of growing retiree enrollment in HMO plans, which raises the per employee HMO cost but lowers the total cost of providing health benefits to retirees.

Survey results also show that many employers are beginning the process of measuring the performance of their health care vendors: cost-effectiveness and quality of care, including medical outcomes, access to providers, and patient satisfaction. With this information, employers can determine which plans offer the best value and make their buying decisions accordingly. Fifty percent of large employers offering HMOs tried to evaluate the quality of their plans in 1994, up sharply from 38 percent in 1993. In the West, where managed care first took hold, 68 percent of large employers measured HMO quality last year.

While employee satisfaction surveys are the most common type of quality evaluation, employers are also seeking data on provider outcomes. Thirty-seven percent of large employers sought outcomes data from their point-of-service (POS) plans, 29 percent from their PPOs, and one-fourth from their HMOs.

Despite these encouraging results, the health care cost crisis is by no means over. A large part of employers' favorable experience in 1994 is a one-time savings due to moving employees from a higher cost plan to a lower cost plan. The underlying factors driving health care cost — the aging population, expensive new technology, and cost-shifting from government programs and the working uninsured — have not gone away.

At the same time, managed care has the potential to deliver long-term savings by emphasizing prevention, more efficient care, and better outcomes. To help achieve that potential, employers will have to face new challenges, with new measures of success. Quality, access, and effectiveness of care — issues employers haven't had to deal with in the past — will now be of greater concern.

KEY DATA FROM THE 1994 SURVEY RESULTS

	ALL* EMPLOYERS	LARGE** EMPLOYERS	SMALL*** EMPLOYERS
AVERAGE PER EMPLOYEE COST			
Total Health Benefit Costs	$3,741	$4,040	$3,452
MEDICAL PLAN COST			
Traditional Indemnity Plans	$3,850	$4,229	$3,528
Preferred Provider Organizations	3,386	3,529	3,140
Point-of-Service Plans	3,609	3,975	2,884
Health Maintenance Organizations	3,485	3,663	3,230
PERCENT OF EMPLOYERS OFFERING			
Traditional Indemnity Plans	46%	60%	46%
Preferred Provider Organizations	30	40	30
Point-of-Service Plans	15	25	15
Health Maintenance Organizations	22	53	22
PERCENT OF EMPLOYEES ENROLLED			
Traditional Indemnity Plans	37%	34%	42%
Preferred Provider Organizations	25	23	27
Point-of-Service Plans	15	17	13
Health Maintenance Organizations	23	27	17

* All employers in the US with 10 or more employees
** Large employers: 500 or more employees
*** Small employers: 10–499 employees

A copy of the complete survey report costs $500. Order now by calling Lisa Gilleeny at 212-574-9025, or use the order form inside.

Foster Higgins

National Survey of Employer-sponsored Health Plans 1994

EXECUTIVE SUMMARY

With 2,097 respondents in 1994, the *Foster Higgins National Survey of Employer-sponsored Health Plans* is the largest, most comprehensive annual survey on the topic. This summary, released in advance of the full report, focuses on the movement of employees into managed care plans and on health benefit costs. In addition to a more detailed discussion of cost and enrollment trends, the full report provides a wealth of plan design information for each of the four major medical plan types (traditional indemnity plans, preferred provider plans, point-of-service plans, and health maintenance organizations). It also reports on:

- Dental benefits
- Prescription drug benefits
- Mental health and substance abuse benefits
- Retiree health benefits
- Flexible benefit programs
- Wellness programs

The report will be available in April 1995.

Overview

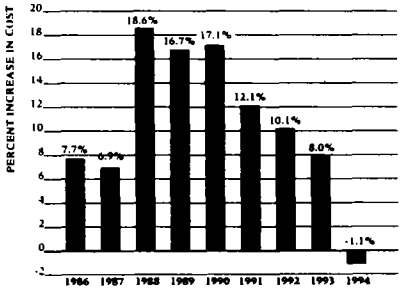
In concert with an unprecedented increase in managed care enrollment, U.S. employers successfully drove down their overall health benefit cost last year. This marks the end of two decades of health benefit cost increases that have consistently outpaced inflation. Total health benefit cost in 1994 averaged $3,741 per employee, down 1.1% from 1993's average of $3,781.

While aided by relatively low medical cost inflation, the reduction in benefit cost was a direct result of employer cost management activity:

- Shifting employees from traditional indemnity plans to managed care plans
- Carving out medical plan benefits with more volatile cost, such as prescription drug and mental health/substance abuse care, and offering them through freestanding "managed" plans
- Enrolling a growing number of retirees in managed care plans, particularly HMOs

Large employers were the most active in 1994—29% of employers with 500 or more employees reported making "significant" changes to their health benefit program in 1993, compared to only 20% of smaller employers. And large employers had the most success in holding down cost. While the average total health care cost dropped 1.9% among large employers, among small employers it rose 6.5%.

Increase in total health benefit cost per employee, 1986–1994



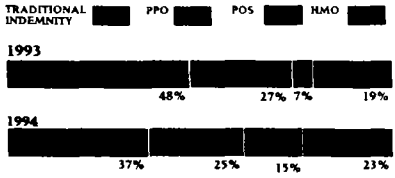
Enrollment in managed care surges

The slowdown in cost was driven by the biggest increase in employee enrollment in managed care plans in the nine-year history of the survey. In 1994, 63% of all covered employees were in a PPO, point-of-service plan, or HMO, up from 52% in 1993. This represents a 21% increase in managed care enrollment nationwide.

The fastest growth by far was in point-of-service plans (which include "open-ended" HMOs as well as insurance carrier plans). As the number of employers offering POS plans more than tripled, enrollment jumped from 7% to 15% of all covered employees. Enrollment in "traditional" closed-panel HMOs grew moderately in 1994, from 19% to 23%. Among the managed care alternatives, only PPOs failed to capitalize on declining indemnity plan enrollment. In fact, nationwide PPO enrollment fell from 27% to 25% in 1994, despite a slight increase in the number of employers offering a PPO.

National employee enrollment in plan type

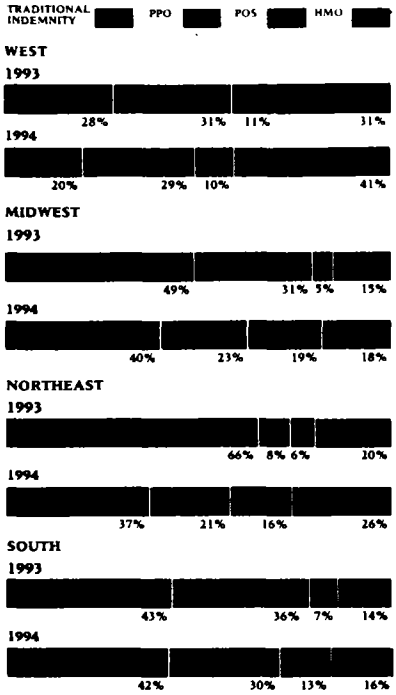
PERCENTAGE OF ACTIVE COVERED FULL-TIME AND PART-TIME EMPLOYEES IN EACH TYPE OF PLAN



Regional differences in cost

If more evidence was needed to prove that health care markets around the country vary widely, the survey supplied it. In the Northeast, where the biggest shift in enrollment into managed care occurred—rising from 34% of covered employees in 1993 to 63% in 1994—employers experienced a dramatic 9.7% decline in total health care benefit cost, from $4,267 to $3,851.

Regional employee enrollment in plan type

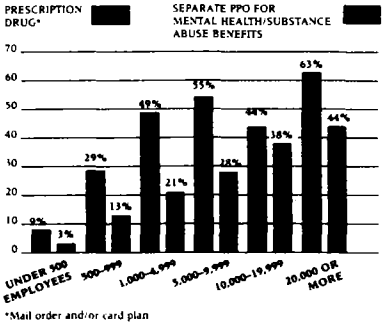


In the Midwest, managed care enrollment grew from 51% to 60% in 1994, with costs essentially flat, rising from $4,020 to $4,048. In the West, where managed care enrollment was already high, the growth in 1994 was more moderate (from 72% to 80%), and cost rose 2.0% to $3,693. In the South, there was little growth in managed care enrollment (from 57% to 58%), and total costs rose 3.9% to $3,389.

Use of medical plan carve-outs

Many employers—particularly among the trend-setting Fortune 500 companies—"carved out" their high-cost prescription drug and mental health care benefits from their medical plans and provided them through special managed care programs. More than a third of large employers (500 or more employees) offer a freestanding prescription drug plan (mail order and/or card plan). Among very large employers (20,000 or more employees), the percentage offering prescription drug card plans leapt from 36% to 66% in 1994. The proportion of these large employers offering a separate PPO for mental health care rose from 23% to 44%.

Use of medical plan carve-outs, by employer size



*Mail order and/or card plan

Effect of retiree coverage on total health benefit cost

Because cost is measured per active employee, employers who provide retiree coverage have significantly higher average cost than those who don't. Among employers of all sizes who provide retiree coverage, average total cost is $4,221. Among those who don't, average cost is $3,238.

In 1994, for the first time, employers induced a significant number of retirees to join HMOs, particularly in the West. Among large employers (500 or more

employees), 17% offer an HMO under a Medicare risk contract, up from 7% in 1993. In the West, 36% of large employers offer a Medicare risk contract HMO to their employees. Retirees traditionally have been very reluctant to leave their own doctors and join HMOs. Employers who move this high-cost population into low-cost plans will improve their health care liability over the long term.

Medical plan cost increases

While total health benefit plan cost per employee decreased, the average cost of the four types of medical plans rose at various rates. With significant shifts in enrollment from indemnity plans into managed care plans (and even among the three types of managed care plans), and growing use of prescription drug and mental health carve-outs, the relationship between the medical plan costs and the all-inclusive total health cost has become more complex. In addition, changing plan selection by retirees also affects medical plan cost. Significant retiree enrollment in HMOs will raise HMO cost but may lower the actual cost of providing retiree medical benefits.

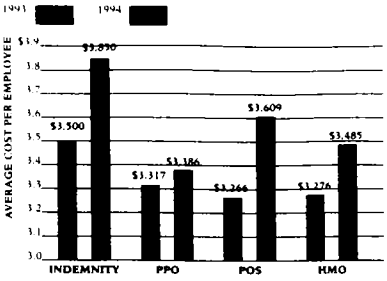
Indemnity plan cost averaged $3,850 per employee in 1994, up 10 percent from 1993's average of $3,500. This was a higher increase than was experienced in 1993. Enrollment in indemnity plans dropped from 48% to 37% in 1994. Lower enrollment raises the potential for adverse risk selection in indemnity plans, which likely contributed to higher cost.

Point-of-service plans, which saw a surge in enrollment in 1994, cost on average $3,609 per employee in 1994. While this is a 10.5% increase over the average cost reported in 1993, the increase largely reflects a change in the regional distribution of POS enrollment. In 1993, 46% of the employers offering POS plans were in the West region, where the average POS cost was low. Because of the rapid growth of POS plans in the higher-cost Northeast and Midwest regions, in 1994 employers in the West represented only 17% of those offering POS plans.

PPO plan cost rose 2.1% in 1994, from $3,317 to $3,386. PPO sponsors benefited not only from a lower rate of growth in medical care costs, but also from a significant increase in the use of financial rate guarantees from PPO administrators.

Medical plan cost, 1993–1994

IN THOUSANDS OF DOLLARS



HMO costs rose 6.4%, from $3,276 per employee in 1993 to $3,485 in 1994. Some of this cost increase is the result of growing retiree enrollment in HMO plans, which raises the per employee HMO cost but lowers the total cost of providing health benefits to retirees.

Implications for employers

Despite these encouraging results, the health care cost crisis is by no means over. A large part of employers' favorable experience in 1994 is a one-time savings due to moving employees from a higher cost plan to a lower cost plan. The underlying factors driving health care cost—the aging population, expensive new technology, and cost-shifting from government programs and the working uninsured—have not gone away.

At the same time, managed care has the potential to deliver long-term savings by emphasizing prevention, more efficient care, and better outcomes. To help achieve that potential, employers will have to face new challenges, with new measures of success. Quality, access, and effectiveness of care—issues employers haven't had to deal with in the past—will now be of greater concern.

About the survey

The Foster Higgins National Survey of Employer-sponsored Health Plans had 2,097 respondents in 1994. Both printed questionnaires and telephone interviews were used to collect data.

The survey was conducted using a national probability sample of public and private employers. Results are weighted to reflect the demographics of all employers in the U.S. with 10 or more employees who offer health insurance. Therefore, the survey results are valid for more than 550,000 employers and 68 million full-time and part-time employees.

ORDER FORM

If you would like to order a survey report, please provide the information requested below. The report will be available in April 1995.

REPORT

Comprehensive analysis of data by Foster Higgins consultants, covering traditional indemnity plans, managed care plans, flexible benefit plans and retiree benefits.

number of copies _____ @ $500 = _____

REPORT AND TABLES

Report described above and separate appendix of data tables showing results of most questions. Breakouts for employer size categories, geographical regions, and industry groups are given along with the total response.

number of copies _____ @ $1,000 = _____

Prepayment is required. You may order reports with an American Express charge card by calling 212-574-9025. Or mail this form with a check for the appropriate amount (payable to Foster Higgins) to:

Lisa Gilleeny
Foster Higgins
125 Broad Street
New York, NY 10004

Send report to:

NAME _____

ORGANIZATION _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE _____

Chairman THOMAS. Dr. Fronstin.

STATEMENT OF PAUL FRONSTIN, Ph.D., RESEARCH ASSOCIATE, EMPLOYEE BENEFIT RESEARCH INSTITUTE

Mr. FRONSTIN. Mr. Chairman and members of the committee, I am pleased to appear before you this morning to discuss employer responses to rising health care costs. My name is Paul Fronstin. I am a research associate at the Employee Benefit Research Institute [EBRI], a nonprofit, nonpartisan, public policy research organization based in Washington, DC. EBRI has committed, since its founding in 1968, 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.

Employers' use of cost management strategies in health care has become more prevalent as a result of the growth in employment-based health insurance, third-party reimbursement, and technological advances. Firms have been increasingly requiring workers to contribute to health insurance premiums and subjecting them to direct out-of-pocket provisions.

There has also been a simultaneous increase in the cost-sharing provisions of traditional fee-for-service health insurance. There have been increases in the use of deductibles, coinsurance and out-of-pocket maximums. In 1992, 83 percent of employers required coinsurance of 20 percent for physician visits, up from 77 percent in 1989.

Evidence from the RAND health insurance experiment suggests that increased cost-sharing does reduce health care costs and utilization. Employers have increased their use of utilization review programs [UR]. These programs are designed to monitor the progress and appropriateness of health care services on a case-by-case basis.

For example, in 1992, 83 percent of surveyed employers required prior authorization for certain procedures nonemergency hospital admissions and elective surgery, up from 73 percent in 1989.

Studies have found that UR is an effective mechanism for controlling health care costs and utilization. One study found that UR lowered hospital expenditures by 11.9 percent, total medical expenditures from 8.3 percent, hospital admissions by 12.3 percent, and inpatient stays by 8.3 percent.

The use of HMO's has been one of the most prevalent methods utilized by employers to control rising health care costs. In 1980, there were 236 HMO's with 9.1 million enrollees. By 1994, there were 547 HMO's with 43.4 million enrollees. These plans range from staff models where the HMO owns its health care facilities and employs health care providers on a salaried basis, to independent practice arrangements where groups of physicians practicing independently contract with an HMO to provide health care services to the HMO enrollees. The recent movement of individuals into HMO's has not been into the more controlled staff or group model HMO's but into the Independent Practice Association [IPA's], where patients have a greater choice of physician. New evidence suggests that HMO's reduce use of health care services by an aver-

age of 8 percent, compared with services that similar patients would be expected do use in a traditional fee-for-service indemnity plan. However, staff and group model HMO's were shown to reduce services by nearly 20 percent, and IPA's reduce use by an average of 0.8 percent.

Preferred provider organizations and point-of-service plans have also emerged as strong alternatives to fee-for-service plans and HMO's. The number of individuals enrolled in these arrangements increased significantly between the mid-1980's and today. Evidence on the savings from these plans is largely lacking, but does suggest there is a potential for savings. For example, AT&T was able to reduce its annual growth rates for medical expenses from 12.9 percent in 1991 to under 5-percent in 1992, partly because they moved their workers into a point-of-service plan. Other factors contributing to reduction include managed care, hospital discounts, and an increase in employee coinsurance when out-of-pocket network providers are utilized.

In 1991, Cincinnati Bell, General Electric Aircraft Engines, Proctor & Gamble, and the Kroger Co. formed a health care coalition to increase bargaining power for discounts with area hospitals, monitor quality improvements, and search for other ways to control costs. Annual savings in the Cincinnati area have been estimated at $75 million for all private and public payers of health care because of a 5-percent decrease in the average charge per patient and a 10-percent decrease in the average hospital length of stay.

Coalitions have also been formed in many other cities. These coalitions are successful in reducing expenditures on health care because they create a competitive market with sound economic principles such as volume purchasing and competitive bidding.

Thank you for the opportunity to testify this morning.

[The prepared statement and attachment follow:]

TESTIMONY OF PAUL FRONSTIN
EMPLOYEE BENEFIT RESEARCH INSTITUTE

Introduction

Mr. Chairman and members of the committee, I am pleased to appear before you this morning to discuss employer responses to rising health care costs. My name is Paul Fronstin. I am a research associate at the Employee Benefit Research Institute (EBRI), 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. I would ask that my full statement be placed in the record.

Currently a majority of workers receive health insurance through their employers.[1] In addition, over 60 percent of nonelderly Americans participate in an employment-based health plan. The employment-based health system has been evolving since World War II, with employers being very active in the development and implementation of cost management strategies.

Cost Management Strategies

Employers' use of cost management strategies in health care has become more prevalent as a result of the growth in employment-based health insurance, third party reimbursement, and technological advances. Responding to rising health care costs, employers have moved to managed care, which can be defined as any type of intervention in the provision of health care services or reimbursement of health care providers that is intended to provide health care services in the most efficient settings. These interventions not only include the movement of individuals into health maintenance organizations (HMOs) but also include increased employee contributions for health insurance premiums and increased cost sharing in traditional fee-for-service health insurance.

Premium and Cost Sharing

Firms have been increasingly requiring workers to contribute to health insurance premiums and subjecting them to direct out-of-pocket provisions. In 1979, employers fully paid for single coverage health insurance for 73 percent of full-time workers employed in medium and large private establishments. By 1993, only 37 percent of workers had their individual coverage fully paid for. In 1979, employers fully paid for family coverage health insurance for 54 percent of full-time workers employed in medium and large private establishments. By 1993, only 21 percent of workers had their family coverage fully paid for.[2]

There has also been a simultaneous increase in the cost-sharing provisions of traditional fee-for-service health insurance (table 1). In 1992, 26 percent of surveyed employers required a deductible of over $200, up from 11 percent in 1989. In 1992, 65 percent of employers required coinsurance of 20 percent for inpatient care, up from 62 percent in 1989. In 1992, 83 percent of employers required coinsurance of 20 percent for physician visits, up from 77 percent in 1989. In 1992, 26 percent of employers limited out-of-pocket expenses to between $1,500 and $2,499, an increase from 21 percent in 1989.

Evidence suggests that increased cost sharing does reduce health care costs and utilization. The RAND Health Insurance Experiment found that individuals enrolled in health plans with a 25 percent coinsurance rate had 15 percent lower per capita costs than individuals in plans with no coinsurance. The RAND study also found that low-income individuals with lower coinsurance rates experienced health specific gains for high blood pressure, myopia, and dental problems—three prevalent chronic conditions that are relatively inexpensive to diagnose and treat. If individuals choose to forego preventive care and intervention services because of high cost sharing, they run the risk of necessitating more costly services in the future. This may have the effect of increasing total health care expenditures and utilization because individuals may be sicker once they seek treatment for a health problem.

Utilization Review

Employers have increased their use of utilization review (UR) programs (table 2). These programs are designed to monitor the progress and appropriateness of health care services on a case-by-case basis. In 1992, 83 percent of surveyed employers required prior authorization for certain procedures, nonemergency hospital admissions, and elective surgery, up from 73 percent in 1989. In 1992, 66

percent of employers required health care to be monitored as it was provided and/or determined the length of a hospital stay and the scope of the treatment prior to treatment, up from 52 percent in 1989. Second surgical opinions were the only type of UR whose use decreased between 1989 and 1992. Studies have found that UR is an effective mechanism for controlling health care costs and utilization. One study found that UR lowered hospital expenditures by 11.9 percent, total medical expenditures by 8.3 percent, hospital admissions by 12.3 percent, and inpatient days by 8 percent.[3]

HMOs

The use of HMOs has been one of the most prevalent methods utilized by employers to control rising health care costs. In 1980, there were 236 HMOs, with 9.1 million enrollees.[4] By 1994, there were 547 HMOs, with 43.4 million enrollees.[5] These plans range from staff models where the HMO owns its health care facility and employs health care providers on a salaried basis, to independent practice arrangements (IPAs), where groups of physicians practicing independently contract with an HMO to provide health care services to the HMO enrollees. The recent movement of individuals into HMOs has not been into the more controlled staff or group model HMOs but into the IPAs, where patients have a greater choice of physician. Between 1993 and 1994 there was a 42.6 percent increase in enrollment in mixed models, followed by a 7.6 percent increase in enrollment in IPAs. Group-based plans, i.e., staff, group, and network models, experienced a decline in enrollment between 1993 and 1994. New evidence suggests that HMOs reduce use of health care services by an average of 8 percent, compared with services that similar patients would be expected to use in a traditional fee-for-service indemnity plan.[6] However, staff and group model HMOs were shown to reduce services by nearly 20 percent, and IPAs reduced use by an average of 0.8 percent.

Preferred Provider Organizations and Point-of-Service Plans

Preferred provider organizations (PPOs) and point-of-service (POS) plans have also emerged as strong alternatives to fee-for-service plans and HMOs. The number of individuals enrolled in these arrangements increased significantly between the mid-1980s and today. Recently, the growth rate of enrollees in these plans has exceeded the growth rate of enrollees in HMOs because they allow greater choice of physician. Evidence on the savings from these plans is largely lacking but does suggest there is a potential for savings. For example, AT&T was able to reduce

its annual growth rates for medical expenses from 12.9 percent in 1991 to under 5 percent in 1992 because they moved their workers into POS plan. In 1991, the Pacific Telesis Group moved their fee-for-service enrollees in POS plans and reduced its annual growth rate from 12 percent to 5 percent. Surveys of their employees found that they were generally satisfied with the system once they understood it.

Coalitions and Cooperatives

In 1991, Cincinnati Bell, General Electric Aircraft Engines, Proctor and Gamble, and the Kroger Company formed a health care coalition to increase bargaining power for discounts with area hospitals, monitor quality improvements, and search for other ways to control costs. Annual savings in the Cincinnati area have been estimated at $75 million for all private and public payers of health care because of a 5 percent decrease in the average charge per patient and a 10 percent decrease in the average hospital length of stay.[7]

Coalitions have also been formed in Denver, CO; Memphis, TN; Cedar Rapids, IA; Houston, TX; Minneapolis, MN; Kingsport, TN; and many other cities. The activities of these coalitions have varied greatly, including the selection of preferred providers on the basis of efficiency, assistance in the purchase of cardiovascular care, the provision of mental health and substance abuse programs at reduced rates, the enactment of healthy lifestyle programs for adults and children, and the provision of small business insurance options. These coalitions are successful in reducing expenditures on health care because they create a competitive market with sound economic principles such as volume purchasing and competitive bidding.

States have responded to growing health care costs not only as government entities but also as employers. The California Public Employees' Retirement System (CalPERS) has had success with its own purchasing cooperative for health care services. CalPERS experienced premium decreases in both 1994 and 1995 by negotiating more aggressively with health care providers, asking HMOs to forego rate increases, and the state introduced a standard benefits package in 1993, requiring copayments of its employees.

Conclusion

The health care delivery and financing system is evolving rapidly. There have been changes in the way health care is financed, the types of treatments available, the sites of care, and the physician-patient relationship. These changes have resulted primarily from reactions to health care cost inflation, and employers' experiences in managing health care costs have varied with the methods chosen. We can expect to observe a continued increase in cost-sharing responsibilities of workers, the monitoring of care, the movement of workers and their dependents into managed care arrangements, especially those that offer greater choice of physician, such as IPAs, PPOs, and POS plans, and the formation of employer coalitions to negotiate for volume discounts for health care services.

Thank you for the opportunity to testify this morning. I'll be glad to answer any questions you may have.

---

[1] In 1993, 54.2 percent of workers aged 18-64 received health insurance coverage from their employer. See Sarah Snider and Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1994 Current Population Survey," *EBRI Special Report* SR-28/*Issue Brief* no. 158 (Employee Benefit Research Institute, February 1995).

[2] U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms*, 1979–1989 (Washington, DC: U.S. Government Printing Office, selected years); *Employee Benefits in Medium and Large Private Establishments*, 1991 and 1993 (Washington, DC: U.S. Government Printing Office, 1993 and 1995).

[3] Paul J. Feldstein, Thomas M. Wickizer, and John R.C. Wheeler, "Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures," *New England Journal of Medicine* (May 1988): 1310-1314.

[4] Nancy Kraus, Michelle Porter, and Patricia Ball, *Managed Care: A Decade in Review 1980-1990*, (Excelsior, MN: The InterStudy Edge, 1991).

[5] The InterStudy *Competitive Edge*, 5.1 (Minneapolis, MN: Interstudy, 1995).

[6] U.S. Congressional Budget Office, "The Effects of Managed Care and Managed Competition," CBO Memorandum, February 1995.

[7] Danae A. Manus, Robert J. Strub, and Thomas R. Werner, "The Cincinnati Initiative," *Managed Care Quarterly* (Winter 1994): 20-26.

Related EBRI Publications

"The Future of Employment-Based Health Benefits." *EBRI Issue Brief* no. 161 (Employee Benefit Research Institute, May 1995).

Sarah Snider, and Paul Fronstin. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the 1994 Current Population Survey," *EBRI Special Report* SR-28/*Issue Brief* no.158 (Employee Benefit Research Institute, February 1995).

Paul Fronstin. "The Effectiveness of Health Care Cost Management Strategies: A Review of the Evidence." *EBRI Issue Brief* no. 154 (Employee Benefit Research Institute, October 1994).

Paul Yakoboski, et al. "Employment-Based Health Benefits: Analysis of the April 1993 Current Population Survey." *EBRI Issue Brief* no. 152 (Employee Benefit Research Institute, August 1994).

"The Changing Health Care Delivery System: An EBRI/ERF Policy Forum." *EBRI Issue Brief* no. 148 (Employee Benefit Research Institute, April 1994).

William Custer. "Health Care Reform: Examining the Alternatives." *EBRI Issue Brief* no. 147 (Employee Benefit Research Institute, March 1994).

Table 1

Percentage of Employers With Cost-Sharing Provisions, by Level of Cost Sharing and Year for Traditional Indemnity Plans, 1989–1992

Individual Deductible Amount	1989	1990	1991	1992
$100 or less	40%	38%	34%	29%
$150	15	15	15	13
$200	29	27	28	28
Over $200	11	18	23	26
Coinsurance Rate for Inpatient Care	**1989**	**1990**	**1991**	**1992**
0%	23%	25%	27%	25%
10	7	5	4	4
15	2	2	2	2
20	62	65	63	65
25	a	2	1	1
Coinsurance Rate for Physician Visits	**1989**	**1990**	**1991**	**1992**
0%	8%	6%	6%	5%
10	6	5	4	4
15	2	2	2	2
20	77	84	82	83
25	a	2	1	1
Employee Out-of-Pocket Maximums	**1989**	**1990**	**1991**	**1992**
<$1,000	35%	37%	30%	28%
$1,000-$1,499	38	37	39	38
$1,500-$2,499	21	20	24	26
$2,500-$4,999	4	5	6	6
$5,000+	2	2	2	2

Source: A. Foster Higgins & Co., Inc., *Health Care Benefits Survey, Report 1: Indemnity Plans: Cost, Design and Funding* (Princeton, NJ: A. Foster Higgins & Co., Inc., 1990-1993).

[a]Data not available.

Table 2

Percentage of Surveyed Employers with Utilization Review Programs for Traditional Indemnity Plans, 1989–1992

Type of Program	1989	1990	1991	1992
Precertification of Elective Admissions	73%	81%	81%	83%
Concurrent Review	52	65	65	66
Catastrophic Case Management	55	65	67	69
Outpatient Utilization Review	19	20	19	22
Second Surgical Opinion	89	88	82	71
Mandatory[a]	59	55	49	45
Voluntary[b]	30	33	33	26
None of These	9	7	8	7

Source: A. Foster Higgins & Co., Inc., *Health Care Benefits Survey* (Princeton, NJ: A. Foster Higgins & Co., Inc., 1990–1993).

[a]For specific procedures.

[b]For all procedures.

Mr. ENSIGN [presiding]. I want to thank the panel.

Mrs. Johnson.

Mrs. JOHNSON of Connecticut. Thank you.

I won't ask the panel what their opinion is of the claim that has been made that managed care reduces costs primarily and simply by negotiating hospital discounts.

What is your opinion of that analysis?

Mr. HUSTEAD. I think HMO's, in particular, use discounts as well as the management of the care through the primary care provider.

Mrs. JOHNSON of Connecticut. Is there any difference in the mix now and 5 years ago? In other words, what proportion of the cost savings was the result of negotiated agreements with hospitals, 5 years ago versus now?

Mr. HUSTEAD. I am not sure. I do know that hospitals are a much lower percentage of the total cost now, through all the control measures, but the hospital discounts you mentioned actually now go throughout the economy. It is no longer just HMO's; it is all insurance plans, all employers are negotiating hospital discounts.

Mr. TREAT. If I might add, discounts are just one factor in reducing costs. The philosophy of managed care is providing the right care, and as I mentioned earlier, there is a push to measure the quality being provided by vendors in terms of patient satisfaction surveys, outcomes measurements and so forth; and that knowledge and experience will just increase over time. But, again, discounts are just a small part of the overall.

Mrs. JOHNSON of Connecticut. Would you enlarge on how those other things actually affect the cost structure?

Mr. TREAT. If we can determine through outcomes measurement processes that care is better provided a certain way, the logical outcome of that is that you will not be providing unnecessary care and, that way, costs are reduced.

Mr. FRONSTIN. I would have to agree, it is a combination of discounts and decreased utilization. Not only have HMO's been negotiating for discounts, but other types of health plans have also been negotiating for discounts as well as just employers provide their own care to their own population of workers.

Mrs. JOHNSON of Connecticut. I am interested in your comments because it appears to me, from having watched the system evolve at fairly close range, that hospital discounts were more important to soft savings initially and now it is more the system's ability to determine what is appropriate care, get prevention in there early, and things like that that have to do with quality and appropriateness and elimination of excess care.

Mr. TREAT. You are absolutely correct.

Mrs. JOHNSON of Connecticut. The more information you can give us about that in the future, the better off.

I did want to ask you, Mr. Treat, about this chart that you gave us. I don't understand why point-of-service plans are doing as poorly as you report they are doing, when for small employers they clearly are dramatically lower cost.

Mr. TREAT. One of the things I didn't mention earlier is that in 1993, 46 percent of the employers offering point-of-service plans were in the West region where costs were actually already very low

and kept under control. Because of the increase in point-of-service plans' in 1994, particularly in the Northeast and the Midwest, where costs are naturally higher, you see a dramatic rise in point-of-service plans, but it is due to the mix or the shift from the West Coast to the East and the greater popularity of point-of-service plans.

Mrs. JOHNSON of Connecticut. Thank you.

Thank you, Mr. Chairman. I thank the panel.

Mr. ENSIGN. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

Let me first comment about the discounting as a way of saving costs. I find that somewhat suspect. I appreciate managing the utilization of services as being a real way of bringing down health care costs.

I am concerned that by discounting, in many cases, what we are doing is shifting costs, rather than bringing down health care costs generally; and that because of the large presence of certain health care providers in our community, they can negotiate lower costs when, in reality, it is not lower health care costs for our community because the cost is just picked up by another segment.

Just to underscore that, in Maryland where we have an all-payer rate system for hospital care, where we have no discounting, you still have a very high penetration of HMO, the third highest in the country on a per capita basis, which indicates that managed care can work very efficiently by managing utilization and not relying upon the deep discounts, which is happening in many other parts of the country.

But my question I would ask any of the panelists, if they would like to respond, is why have we not seen much improvement in HMO's or managed care as it relates to special needs categories? Is there a way in which a capitated plan can deal with people who have special needs? Has the private sector come up with any way of dealing with targeted groups?

I know that the private insurance market has found it hard to come up with ways of doing risk adjustments. Is there some way that we can utilize a capitated system for dealing with target groups, whose health care needs may be more expensive than others? I find in most cases HMO's try to steer away from these groups of people. Any suggestions?

Mr. HUSTEAD. Well, actually, quite a bit is going on in that area. The sellers and buyers of health care at all levels are working with innovations like disease management approaches where, say, the drug companies will work with the HMO's to try to take charge and control of all asthma cases and make sure that the most effective delivery is made of treatment to these asthma cases.

It may not necessarily involve the drugs of that particular company. We are trying to take an overview of all care.

Another thing that happens with psychiatric care is that a good deal of carving-out is going on. One problem with all of that is that if these are segmented, there is a danger of loss of total treatment of the individual. If one group is dealing with the psychiatric care for this individual and another person with their nonpsychiatric, there may be a loss of quality and control on them.

Mr. CARDIN. But my concern is that—within a capitated plan is that managing the risks within that plan, or is that identifying prior to entering into an agreement, that there are certain risks that we need to handle? You understand my point? Is it just trying to manage the risk within a plan, or is there identification prior to the selection of the person or the entering into the contract on a capitated rate?

Mr. HUSTEAD. I think it is largely cost driven, and I think it probably doesn't address what you are searching for as helping the individual by saying "let's identify people with these particular conditions and let's deal most cost effectively with them."

Mr. CARDIN. What I am raising is that with asthma treatment the plans, or that an HMO has less asthma cases than the typical population that is out there. Fine. They are managing their asthma cases in the most cost-efficient way. We appreciate that.

But is there an effort made to have a representative group within an HMO? Or do we find that they are taking more of the easier cases and not handling the more difficult cases because there—as a capitated system, you make money by taking in easier patients.

Mr. TREAT. I think that is an argument of probably 10 years ago, and I think it is less of an argument today.

Another way that managed care vendors will manage risks within the confines of capitation is through centers of excellence programs where they perhaps could develop global case rates for certain types of problems and carve out niches that way, have all of their cardiac problems done at a particular facility or by a particular organization.

Mr. CARDIN. Could I just proceed—just for one more moment, if I might?

I appreciate that and that, in fact, is occurring, but we also have difficulty in financing the academic health centers, and I haven't seen many suggestions coming forward with the HMO's willing to help pay the extra costs associated with hospital care on training costs. It is something that we may want to take a look at.

I appreciate the fact that you use centers of excellence for particular needs, but we don't find any real initiatives coming forward from the managed care community to deal with whether we are going to have people trained in order to provide the services in these centers of excellence.

Thank you, Mr. Chairman.

Mr. ENSIGN. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Mr. Treat, we have talked a lot about costs being controlled by various changes in employer actions and going more to managed care. Is it your opinion that it is really not the underwriting cycle, so-called underwriting cycle, but changes in management by employers that are responsible for controlling these costs?

Mr. TREAT. Yes, sir. If you look at the underlying factors, they are still there—less so than in prior years, but they are still there. If you look at the costs for each plan type—indemnity, point-of-service, et cetera—you will see that there were increases between 1993 and 1994, but the shift in enrollment patterns from the high-cost indemnity plans to the lower-cost point-of-service and HMO plans has caused the overall cost of health care, per employee, to

drop by 1.1 percent. And it is the management of the employers in shifting employees into lower-cost plans that has resulted in the drop in costs.

Mr. HUSTEAD. I think there is a mix of things going on with health care. It is always difficult to tell. Clearly, the insurance companies and the HMO's are all pretty fat and happy these days. Blue Cross, I think, for instance, increased their reserve position by 75 percent last year. The HMO's have built to the point where they have rates that are more than adequate for their coverage; that is the way they are able to hold costs down.

At the same time, there is a shifting going on. The key question for the future is, having shifted into a PPO or an HMO or a point-of-service plan, will those operations then be able to have trends that are below average, or will they all just go back up to the same average trend?

We all hope that they will be able to not only control costs when they go to that new organization, but keep costs down, but we really don't know yet.

Mr. MCCRERY. It appears to me, looking at your charts—some of your charts, Mr. Treat, that a significant number of large employers, particularly, have carved out their drug programs. Is it possible that much of the savings that we are seeing comes from shifting, so to speak, their prescription drug benefits to a mail order program?

Mr. TREAT. In the total cost that we are measuring, that includes carved-out programs so that even though they are supplied by another vendor in a different approach, the cost is included.

Mr. MCCRERY. Yes. My question is getting back somewhat to Mrs. Johnson's question about deep discounts.

Mr. TREAT. Typically, the plans in a noncarved-out approach—prescription drugs, et cetera—would be included as subject to a deductible and subject to a coinsurance whereas in a carved-out approach, typically retail, which is a low copay, $5, $6, $10, $12, if there is a mail order program in place, typically you are getting 90-day supplies with a single copay, so in fact the benefits under a carved-out approach typically are better benefits than they were under the copay—I mean, under the deductible/coinsurance arrangement.

Mr. MCCRERY. Isn't it true that the reason there are better benefits for the employee is because of deep discounts the employer gets through a mail order or similar arrangement——

Mr. TREAT. But the deep discount is supported by efficiencies in providing the services.

Mr. MCCRERY. While that may be true, let me get back to my original question.

You said that there has been a per employee decrease in cost and that is due to better management. My question originally was, how much of that decrease might be due to shifting to a mail order drug program? How big a factor is that in the overall cost for employers?

Mr. TREAT. That is a question I don't know, and perhaps when the full survey data is available, we could see. I don't know at this point.

Mr. HUSTEAD. We find that there is not a lot to be saved in mail order; it is an efficient way of providing the service, but it is not

a major impact in the total cost. I think the management and the carving-out is what does the step.

Again, as with the other changes, the big question will be having moved to that and having achieved as much as you can through management and discounts, will you be able to keep the trend down or not.

Mr. McCrery. OK. Thank you.

Mr. Ensign. Mr. Treat, I think it was you who mentioned the POS plan, the point-of-service plans growing in cost more percentage-wise, compared to the other plans. Is that because more people in the East are now going to that?

Mr. Treat. That is correct.

Mr. Ensign. Are there any studies just in the West? Are the plans not growing as fast, percentage-wise, where they already have the plans?

Mr. Treat. There is not as significant a growth pattern in the West because that was all—it was already saturated to a greater extent with point-of-service plans. In the East there were relatively few point-of-service programs in 1993 and prior to that, and the growth has been substantial in 1994. So you are starting from a much lower base in the Northeast. Obviously, you have had a significant increase and that has diluted the effect of the lower cost on the West Coast. What you look at, it looks like an increase in point-of-service costs. In fact, it is a geographical shift.

Mr. Ensign. You also indicate in your testimony that health costs per employee actually fell about 9.7 percent in the Northeast from 1993 to 1994. Is that part of what is going on, the Northeast is going to point-of-service as some of these other plans were?

Mr. Treat. Absolutely. There has been a significant shift from indemnity plans to managed care plans in the Northeast. Unions have accepted or embraced managed care plans more readily.

Mr. Ensign. OK. When we are talking about HMO's and we are talking about some of the cost savings attributed, you hear some physicians say that this is because they are denying services because they are gatekeepers.

HMO's—in their defense, say that they are not denying, they are encouraging people to go for appropriate services, not inappropriate services, and their studies show that their quality of results—in the long run, they actually end up with better quality of results.

What is your opinion on whether HMO's are actually denying valuable services to patients or whether they are, through better management techniques and practice guidelines, actually directing patients to more appropriate treatments?

Mr. Hustead. I think I would come down on the latter, that clearly where there is no management involved, there is a lot of overuse of health care. Not only in HMO's, but other organizations have shown how much can be saved by taking a quality approach to what happens, looking to the gatekeeper. I think the evidence is that there is very little movement out of HMO's by those that join HMO's, plus the fact in the point-of-service plans that three-fourths of the care is selected in the networks suggests that the patients certainly are satisfied with the quality of care.

Mr. TREAT. You could also point to the fact that HMO's are the ones that initiated the NCQA process to measure quality. They are interested in making sure they are providing proper care.

Mr. ENSIGN. I would just like to address the IPA's versus the HMO's. And, Dr. Fronstin, I think it was you in your paper that talked about those, and the difference between saving costs, the IPA's obviously don't save the costs as some of the other plans. What is the benefit and why do you see more people choosing that?

Mr. FRONSTIN. More people tend to choose the IPA now. They provide a greater choice of physician, so when people have a better chance of sticking with their physician, once they join this type of plan, as opposed to a group or staff model HMO, that is the main difference.

Mr. ENSIGN. Do you see more companies going to that, offering that as an option to their employees, or do you see that because it is not saving or decreasing the costs?

Mr. FRONSTIN. That is the recent trend. Studies have shown that as IPA physicians treat more and more of the—IPA is just a form of an HMO—as they treat more and more HMO patients, the cost savings actually increase, there are some economies of scale. That seems to be the place where people are going, so I could see that—employers offering that on a wider basis.

Mr. ENSIGN. OK. Mr. Houghton, you had a question.

Mr. HOUGHTON. Yes. Thank you, Mr. Chairman. I am sorry I wasn't here earlier, and I may be a little redundant; and if I am, you have just got to bear with me.

I have a chart here by the CBO which shows the trends in private health care insurance, out-of-pocket Medicare costs; and as I read the chart, with the exception of a couple of blips—one was in 1973 and the other is in 1980—the Medicare costs, Medicare expenditures and the private health insurance were about on a parallel until about 1991, then something happened in 1991. So that is point number one.

Point number two is that I understand that the thrust of this hearing is to review the approaches that people like yourselves have taken, and also the lessons which can be garnered from these approaches in the Federal Government. So without trying to belabor something which you have already possibly expressed, for each of you gentlemen, would you share with me the single most important lesson that we can learn from what you have done and apply it to our thinking.

Mr. TREAT. Our survey over the last several years has shown that a shift from nonmanaged programs to managed programs has produced a significant decrease in the cost of employer-sponsored health care. The lesson learned, I guess, is to continue to push and to make sure that the care provided under a managed environment is, in fact, quality care. And that push is going along in a parallel fashion with an emphasis on quality measurement processes being implemented.

Mr. HOUGHTON. I don't know what the percentages are in the country, but if I remember the percentages in California, about 20 percent of the people are under managed care programs. That is pretty high, isn't it?

Mr. TREAT. It is significantly higher than that. Depending on how you define "managed care," if you include——

Mr. HOUGHTON. But you would say the major driving force has been the managed care programs?

Mr. TREAT. Yes, sir.

Mr. HOUGHTON. Could the rest of you gentlemen just share with me your thoughts.

Mr. HUSTEAD. I think the differences between the trends in the two, the Medicare and the private sector, can be overemphasized. Taken over any long period, they are about the same. Each one has its different ways of responding. A large single Medicare Program cannot respond as effectively or quickly as managed care in situations like an employer can do.

I think, in general, the idea of moving to managed care will be of help; but keep in mind that Medicare has already taken many of the steps that would be involved in management such as the DRGs and relative value schedule. So I cautioned at the beginning that solutions that work in the private sector may not work in Medicare, and vice-versa.

Mr. HOUGHTON. What would be the primary issue you think that we ought to latch on to when we are rethinking this whole Medicare cost deal here?

Mr. HUSTEAD. I think to continue to try to get somebody involved in the decision between the patient and the doctor, other than those two people. And if that can be done through more managed care, that could achieve savings, but they will be fairly slow savings. Medicare is a glacial program.

Mr. FRONSTIN. I think the single most important lesson is that people are generally satisfied with their managed care plan, with their HMO, their POS plan, and the ones that tend to be unsatisfied with it generally don't understand the system. That is what one employer has shared with us, that there is a learning process involved with moving individuals into the managed care arrangements and there is a time commitment involved.

I think one of the reasons why the point-of-service plan premium increased data from A. Foster Higgins was higher in the Northeast than in the West was because of this learning process, the time it takes to implement the system to people opposed.

Mr. HOUGHTON. I can't hear you.

Mr. FRONSTIN. Part of the reason why the data on our point-of-service premiums were higher in the Northeast than in the West was because of this time adjustment people need, the time that people need to make the adjustment to managed care arrangements. There is a learning process people need to go through, and I think people on Medicare will have to go through that same learning process.

Mr. HOUGHTON. OK. Can you say that in one sentence?

Mr. FRONSTIN. If we move individuals in Medicare into managed care, there is going to be—you are going to need some time for people to make the adjustment to the different system.

Mr. HOUGHTON. So the direction is, right, time; we have got to be patient on that, and we have got to have proper understanding and education in the process.

Mr. FRONSTIN. It may be more effective to—the nonelderly are moving into managed care, and they are used to the system; and as they move into Medicare, they are more likely to accept the managed care than the current Medicare population.

Mr. HOUGHTON. Thank you.

Mr. ENSIGN. Mr. McCrery has another question.

Mr. MCCRERY. Thank you, Mr. Chairman.

There is nobody on any of the panels today from companies that have gone to a MSA-type structure or plan, but there are a lot of people who contend that we are never going to get the growth rate in health care costs down unless we get the individual more involved in the costs, the true costs of providing health care, and managing his own costs, managing his own health care. They see MSA's as a way to do that though I am not talking about the Medicare population right now; I am talking the non-Medicare population.

In your studies, have you looked at any of the companies that have gone to these type plans? Some of them have gone to them—even though they are not tax favored, they have gone to them anyway, and the experience—as we have been told, has been significant savings.

Have you looked at any of those and could you comment on those, and if you agree with those experts who say we have got to get the individual involved in the cost, whether it is enough just to have a managed care plan where you have got a gatekeeper and that kind of system.

Mr. HUSTEAD. I have chaired the American Academy of Actuaries work group on MSA's. We recently completed our work, and involved actuaries from all aspects of—those who work with MSA's and those who don't.

We see that they are cautiously optimistic on what MSA's might do. Where an individual is in a typical fee-for-service plan and there are no controls in place, there can be savings achieved. However, we have to question if you take an employee from an HMO or a managed program and put them on their own in a high-deductible plan we are not sure they can each achieve the savings that are there now.

In our study we asked these companies that have reported significant savings to open their books to us and tell us how they have done. We have heard a lot of headlines and a lot of numbers being thrown around, but the ones that did respond to us had very little and very inconclusive data; and the larger ones that have talked a lot about it just have refused to respond. We tried to get their data, so we could really study it, and it was not forthcoming.

So we are cautiously optimistic. If it does happen, if MSA's are enabled and they are successful, they will achieve that success very slowly. I would guess if you enacted MSA's this year, maybe by the year 2000, 5 percent of the people in the country would have MSA's and high-deductible plans.

Mr. MCCRERY. Does either of the other two gentlemen want to comment?

Mr. TREAT. I agree with those comments. I am concerned that—where the threshold might be, where you create a perverse incentive for someone looking at cash and a buildup of an MSA versus

receiving proper care and problems developing later on for care not received. So your premise that the individual needs to be involved in his or her own care is absolutely correct, but should not be the only individual involved in his or her own care; and I think at some point you reach a point where you create some danger.

Mr. FRONSTIN. I think it really depends on how individuals view the MSA, if they view it as an extension of their insurance plan, or if they view it as just savings that they could roll over from year to year or cash out at the end of the year.

If they choose to view it as saving and forgo interventive services, it may create additional problems down the line where, by the time they seek care, they are sicker than they would have been otherwise.

Mr. MCCRERY. Do you have any evidence that people will forgo health care for savings?

Mr. FRONSTIN. I couldn't understand you.

Mr. MCCRERY. Do you have any evidence or do you think people might forgo health care?

Mr. FRONSTIN. People might. It depends on how they view their MSA. If they view it as insurance, they would just——

Mr. MCCRERY. You are not aware of any data that supports that?

Mr. FRONSTIN. No. No.

Mr. MCCRERY. Thank you.

Mr. ENSIGN. I would like to thank the panel for your excellent testimony.

We call the next panel up. We have Paul Fearer, senior vice president of human resources at Union Bank, on behalf of the Pacific Business Group on Health Negotiating Alliance, San Francisco; Michele French, director of health and welfare benefits, Office of the President, University of California, Oakland; and James R. Wrocklage, chief executive officer, Health Care Network of Wisconsin, Brookfield, WI.

Each one of you will have 5 minutes. Proceed as you see fit. The amber light will go on when there is 1 minute left.

Mr. ENSIGN. Mr. Fearer.

STATEMENT OF PAUL FEARER, SENIOR VICE PRESIDENT OF HUMAN RESOURCES, UNION BANK, ON BEHALF OF PACIFIC BUSINESS GROUP ON HEALTH NEGOTIATING ALLIANCE, SAN FRANCISCO, CA

Mr. FEARER. I am here today representing the Pacific Business Group on Health Negotiating Alliance [PBGH], which is a coalition of 30 employers that are headquartered in California and represents nearly 3 million employees, dependents and retirees. PBGH has as its reason for being, improvement in the quality and efficiency of health care delivery.

I also personally serve in a human resources management capacity at Union Bank and, among other things, oversee the bank's benefits programs for its 8,000 employees and 1,500 retirees.

By way of background, my own employer, Union Bank and other members of the Pacific Business Group on Health experienced explosive growth in health care costs in the mid- and late-1980s; at that time, most of us used a variety of techniques to manage these costs.

We implemented managed care programs for our employees, and we created incentives to encourage employees to enter such plans.

We also, later in the 1980's and into the early 1990's, consolidated our health plan offerings. Many of us had been offering more and more choices to our employees, but we found that we needed to increase our leverage, that is, our purchasing power in terms of price and quality.

We also increased the employee share of cost through higher premiums, copays and deductibles.

Finally—and you have heard much about this already—we implemented new forms of managed care, such as point-of-service plans, which are basically a hybrid design combining aspects of an HMO and the traditional fee-for-service plan. For most of us, these initiatives helped to at least moderate the rate of growth in health care costs. But we began to run out of techniques that were effective and we needed more information and we needed more expertise to manage these costs. To that end, a number of employers formed PBGH, the Pacific Business Group on Health. Its initial activities were focused on information-sharing and research in the areas of cost control, benefit plan design, and employee satisfaction, that is, employee satisfaction with their plans. We developed, initiated and implemented a series of annual surveys of employees' satisfaction.

Our early experiences were favorable. We found there was enormous value in pooling our expertise, and it became immediately clear that there were numerous opportunities for win-win situations, that is, ways in which we could both improve quality and reduce long-term costs.

A few examples of our early activities: We spent a lot of time in the area of wellness and preventive care in researching plan design and also initiating some activities—data collection, research, et cetera—in the area of best practices.

In 1992, we saw an opportunity to manage costs and improve quality through more aggressive techniques, to engage in collective negotiation with the health plans that we offer to our employees. We realized that, given our bargaining power, we could readily identify win-win situations for both our employees and ourselves as employers.

With 2 years of preparation, we successfully completed our first round of negotiations with 17 HMO's last year. The result was a 10-percent price rollback with multiyear caps on future premium increases and performance guarantees, with a percentage of premium at risk in order to meet those guarantees.

There was enormous effort behind this result. We had to design a common benefit plan. We had to develop quality and performance standards that were common to all of us. We needed to develop contractual relationships between employers. We needed to seek the concurrence of the Department of Justice in terms of this purchasing approach, and we also needed to develop a negotiating strategy.

We are pleased with the outcome, and we are now expanding into other areas, into Medicare plans for retirees and into other types of health plans other than HMO's. Workers compensation is

another area of activity; we are also considering initiatives in the small employer market.

In conclusion, the challenge ahead for us is to improve the quality of care while pressuring plans and providers to reduce inefficiency, to wring out excess capacity, to quickly disseminate and adopt best practices, and to reduce the prevalence of inappropriate and/or unnecessary care, which is both expensive and harmful to the health of our employees. We firmly believe it is possible both to reduce costs and to improve quality, and that improved quality of care is the primary avenue to effective cost control.

Thank you.

[The prepared statement and attachment follow:]

TESTIMONY OF PAUL FEARER
PACIFIC BUSINESS GROUP ON HEALTH NEGOTIATING ALLIANCE

Mr. Chairman and members of the Subcommittee, I commend you for conducting this hearing on employer health care initiatives. I am delighted to have the opportunity to speak with you today.

My name is Paul Fearer and I am the Senior Vice President of Human Resources at Union Bank. My responsibilities include oversight of the benefit plans offered to the Bank's 8,000 employees and 1,500 retirees. Prior to joining Union Bank in 1990, I worked at Stanford University in human resources for fourteen years.

I am here today representing the Pacific Business Group on Health (PBGH) and its subsidiary, the PBGH Negotiating Alliance, of which I serve as Chairman. I joined the coalition shortly after its inception, and participated in its growth from a loose organization of like-minded businesses to a major force shaping California's health care market.

WHY A LARGE EMPLOYER COALITION?

As the Subcommittee is well aware, over the past two decades rising health care costs have made this benefit one of the most important cost centers of any business. As an example, Union Bank's total health care costs are approximately $30 million. From the mid-1980s through the early 1990s our medical inflation was sometimes in excess of 20 percent. Although the Bank derived some short term benefit reductions from the pace of annual health care inflation -- primarily through redesigning benefits and increasing employees' share of the costs -- we ultimately recognized that more fundamental reform was needed. Such reforms could only be accomplished through the combined efforts of a number of employers. The Pacific Business Group on Health is the preeminent large business coalition in California, and one of the country's most active employer coalitions. The nonprofit coalition was founded in late 1989 by two executives from Wells Fargo and Bank of America to improve the quality of health care and moderate rising costs.

PBGH (formerly the Bay Area Business Group on Health) expanded its membership from ten to nearly thirty member companies -- and continues to grow rapidly. Today, the coalition represents 2.5 million employees, dependents, and retirees, and *$3 billion* in annual health care expenditures. Membership in the group is open to both private and public sector purchasers if they have at least 2,000 California benefits-eligible employees and are not in the health care business (see Attachment A). Public sector members include the California Public Employees' Retirement System (CalPERS), the University of California, and the Federal Reserve. Most member companies have a workforce dispersed throughout California; many employ workers in multiple states, and some are international. On average, *two-thirds* of PBGH's California employees and dependents are enrolled in health maintenance organizations (HMO). Our annual employee surveys reveal that HMOs rank highest in terms of overall satisfaction.

The remaining one-third of California employees is enrolled in a point-of-service (POS) health plan, or in some cases such as Union Bank, a preferred provider organization (PPO). Very few employees are enrolled in traditional indemnity insurance health plans.

THE NEGOTIATING ALLIANCE; MOVING TOWARDS VALUE-BASED PURCHASING

Initially, PBGH primarily concentrated on standardizing health data collection and benefits across member companies. Recently, however, the organization has taken a significantly more active role by negotiating with health plans on behalf of interested members. In 1994 eleven of (at that time) nineteen members participated in an Alliance to negotiate premiums, benefits, and performance measures with managed care plans through a process of competitive bidding. The members of the Negotiating Alliance represented 300,000 actives and early retirees and $400 million in premium with HMOs. Participants in the Negotiating Alliance are bound to an agreed upon model plan design and the negotiated rates and performance measures. However, plan contracts are held by the individual employers. In this sense, each employer decides independently whether to renew, add, terminate, or freeze enrollment in a given health plan.

The Negotiating Alliance proved to be a great success for its members. In 1995--the first year in which bargained premiums took effect-- PBGH negotiations achieved actual *reductions* from 1994 HMO premiums approaching 10 percent, or *savings of $37 million*. In addition, caps on rates were established for 1996 and 1997. From a Congressional budgetary point of view, savings were even higher -- expected increases in premium were eliminated and actual decreases in real costs were obtained. Under the Alliance, Union Bank saved more than $1.5 million off of our roughly $15 million in 1994 HMO expenditures. Several companies experienced double digit decreases.

In addition to negotiating on price, an equally important component of the Alliance process focused on establishing measures and targets for evaluating health care quality. Each HMO agreed to place a portion of their premium "at risk" for performance across two dozen uniformly defined measures for customer service, quality, and the provision of data (see Attachment B). Targets demonstrating improvement for each measure and the amount of money at risk across the standards were negotiated with each plan.

Success in 1995 brought six additional large companies into the Negotiating Alliance for the plan year starting January 1996 - a total of seventeen large employers. Last year's efforts have expanded to add POS performance measures (e.g., timeliness of out-of-area claims payments) to the negotiated package. More important, PBGH is negotiating HMO rates and benefits for 40,000 Medicare-eligible retirees. (Early retirees are included with actives.) PBGH companies are eager to offer their retirees continuity of care with HMO plans through Medicare risk arrangements. Many of these plans provide more generous benefits than fee-for-service plans at no cost to the retiree.

CREATING A CLEAR BENEFIT AND RISK PACKAGE

PBGH is interested in creating competition on a level playing field. Many health plans historically competed on the basis of their ability to attract healthier enrollees through subtle differences in benefit design. For example, we discovered one health plan that did not cover insulin - an obvious disadvantage for diabetics. Similarly, if each plan was able to define customer service and quality in a slightly different fashion, purchasers could neither (a) fairly compare them nor (b) know whether such differences biased performance results. PBGH addressed these important issues by standardizing the content of our benefits and creating consistent definitions to evaluate plan performance. Most important, consumer confusion related to the overwhelming array of benefit design differences and incomprehensible performance data was eliminated. Further administrative efficiencies were created through a single RFP on behalf of all Alliance participants.

Under the managed competition model, another critical component is to appropriately adjust health plan payments to reflect differences in risk. In other words, a health plan with a relatively high risk population should receive more monies to deliver services than a health plan that has a relatively low risk population that requires fewer services. PBGH employers have expended considerable effort studying these differences. We have a three-year grant from the Robert Wood Johnson Foundation to advance and test tools for risk adjustment purposes.

In 1993, when employer health premiums were examined in an uncompetitive marketplace, we saw large differences in prices for the same health plan across employers. These price differences were evident after we adjusted for any employer risk and benefit design differences. Surprisingly, the biggest companies did not have the best prices and the "low risk" companies with young single populations did not have the best prices. Differences in benefit design and or risk accounted for only twenty-five percent of the significant price differentials! Seventy-five percent was unexplained. These findings encouraged the large employers to join forces and request one price for all on a standard benefit plan. Although for now we have postponed implementation of any risk adjustment mechanism, we will continue to evaluate the need for one as pricing becomes less arbitrary. We would never want health plans to compete on the basis of selecting healthier people than their competitors.

The last feature to creating competition in the health care market involves explicitly linking the amount of employer contribution to the least cost -- eventually the "best value" -- health plan.

Fifteen of the seventeen companies participating in this year's negotiations provide a financial incentive for employees to select the least cost plan offered to them. This approach encourages employees to act as partners in selecting health plans which offer the best value for the money.

NO COST SHIFTING: WHERE DO PRICE REDUCTIONS COME FROM?

A key part of the negotiations was an agreement by all HMOs that any cost reductions given to PBGH companies would not result in increases to other employers or populations. While it is difficult to monitor whether or not this in fact occurs, we do know anecdotally that other companies in California last year experienced a downward trend.

In this year's negotiations we are asking each managed care plan to describe how they are supporting cost reductions through efficiencies in medical management and administration. California has more than five hundred hospitals which are only half full, and more than 80,000 physicians, one per approximately 400 people (the average primary care doctor has roughly 2,000 patients). Seventy percent of the physicians are specialists. More than 30 HMOs are licensed by the California Department of Corporations, and there is tremendous overlap in managed care provider networks. As purchasers, we do not want to sustain the cost of this unnecessary capacity. We will continue to put pressure on health plans and providers to restructure, to eliminate excess capacity, to adjust physician mix to better meet the needs of enrollees, and to reengineer processes of delivering care. Not only will significant cost savings be achieved through these efforts, quality of care will be improved and consumers will be better off.

EMPLOYER COMMITMENT TO QUALITY

PBGH employers are very concerned that health care payments are not reduced to the point that quality of care is compromised. For the past several years, PBGH members have worked collaboratively with health plan medical directors and representatives of hospitals and medical groups to gauge the quality of health care. Key accomplishments include two published consumer report cards (see Attachment C) on: (a) employee survey results measuring satisfaction with health plan coverage, service quality, and costs, and satisfaction with physician and hospital care, and whether or not prevention/health promotion services were received; (2) chart review data to determine the delivery of population-based preventive services, such as prenatal care, cholesterol tests, and pap smears. Where available, national measures, such as those published by the National Committee on Quality Assurance (NCQA) are followed.

PBGH works with researchers at the University of California at Berkeley, San Francisco, and Santa Barbara, as well as RAND, the New England Medical Center, and the Health Outcomes Institute, and the Federal and state governments, to assure that all studies are of the highest research caliber.

As a strong demonstration of their commitment to advance health plan and provider performance measures and data collection, PBGH employers established a Quality Improvement Fund totaling over $1 million. Monies are also being used to research consumer perspectives on report cards and disseminate decision support tools for them. A key criterion for Fund projects is that they benefit all Californians, not only the employed insured population.

STRATEGIC ALLIANCES/FUTURE GOALS

St. Louis and Denver business coalitions are replicating the PBGH model in 1995. Strategic alliances are also being formed with regional employers in Seattle and Portland. The successes of PBGH can be transferred readily to other communities, especially those where purchasers, in both the public and private sectors, are eager to increase enrollment in managed health care plans.

In addition to expanding its large employer membership, future plans for PBGH in California include transferring the successes in group health to workers' compensation and disability, integrating data across all benefits, and exploring the inclusion of medium/small businesses in the Alliance.

CONCLUSION

Chairman Thomas, I am honored to be here today. Thank you for the opportunity to present the unique market driven approach to health care reform that we have undertaken in California. PBGH's track record of success demonstrates that private and public sector purchasers can leverage their dollars and volume to bring more rationality to our health care system. This approach is certainly not the entire solution for our problems; however, it can make a significant contribution toward a better health care system.

- ATTACHMENT A -
Member Companies

MEMBER COMPANIES

Atlantic Richfield Company

Automobile Company of Southern California

Bank of America

Bank of the West

Bechtel

California Public Employees' Retirement System

Charles Schwab

Chevron Corporation

Federal Reserve Bank of SF

Fireman's Fund Insurance

First Interstate Bank

GTE

Lockheed

Longs Drug Stores

LSI Logic

McKesson

Mervyn's

Pacific Telesis

PG&E

Ross Stores

Safeway, Inc.

Southern California Edison

Stanford University

Transamerica

Union Bank

University of California

Varian Associates, Inc.

Wells Fargo Bank

- ATTACHMENT B -
1996 Performance Standards

NEGOTIATING ALLIANCE

90 New Montgomery Street, Suite 818, San Francisco, CA 94105
Tel 415-281-8660 Fax 415-281-0960

PBGH 1996 Performance Standards

Customer Service

Measures which have penalties attached

Claim turnaround time -15 days & 30 days
ID card turnaround
EOC and member material distribution
Average speed to answer by live voice
Telephone abandonment rate
Time to respond to written correspondence
Member notification of PCP disenrollment & group notification of medical group change

Measures which are reported only (no penalties are attached)

Claim financial accuracy
Claim transaction accuracy
Claim pending
Initial call resolution rate
Identification of member services calls
New member contact
Identification of written correspondence

Quality

Measures which have penalties attached

Plan satisfaction
Plan dissatisfaction
Satisfaction with physician
C-section rate
Mammography rate
Pap smear rate
Childhood immunization rate
Prenatal care rate
Diabetic retinal exam rate
Cholesterol screening rate
Wellness program communications

Measures which are reported only (no penalties are attached)

PCP turnover rate
Open PCP/member ratio
PCP / specialist ratio
Formulary compliance rate
Generic substitution rate

Provision of Data

Additional HEDIS measures
Encounter data capture
Third party management
Smoking cessation

- ATTACHMENT C -
PBGH Report Cards

Bay Area Business Group on Health: 1994 HMO Consumer Satisfaction Report Card

CALIFORNIA HEALTH PLAN	Satisfaction with Aspects of the Health Plan		Satisfaction with Physician Services			The Health Plan's Preventive Care Performance		
	Coverage	Service Quality	Convenience	Medical Treatment	Personal Treatment	Screening	Health Promotion	Counseling
Health Maintenance Organization (HMO)								
Aetna HMO	C	B	B	B	B	B	B	B
Blue Shield	B	B	B	B	B	A	A	B
CIGNA	C	C	B	B	C	B	B	C
California Care	A	B	B	B	B	A	C	C
FHP	B	B	B	B	B	A	A	B
Foundation	B	B	A	B	A	B	C	B
HP of Redwoods	A+	A+	A	A	A+	B	B	A+
Health Net	B	B	B	B	C	A	B	B
Kaiser North	B	C	C	C	B	C	A+	A
Kaiser South	B	B	C	C	B	B	A+	B
Lifeguard	B	A	A	A	A	B	C	B
Maxicare	C-	C	C	C	C	B	B	C
Omni	A+	A	B	A	A	B	C	A
PacifiCare	B	C	C	C	C	C	B	C
QualMed	C	B	B	B	B	C	B	B
TakeCare	B	B	B	B	B	B	B	B
ValueCare	A+	A	A	A	B	C	B	A
Point-of-Service (POS) Avg.	C-	C-	C	C	C	B	C	C
Preferred Provider Organization (PPO) Avg.	C-	C	A	A	A	B	B	B

Satisfaction with Aspects of the Health Plan	**Coverage**: Coverage for doctors' office visits, hospitalizations and mental health **Service Quality**: Paperwork as well as with the plan's process for paying claims and approving care.
Satisfaction with Physician Services	**Convenience:** The location of the doctors' office, the hours when appointments are available and the length of time spent waiting. **Medical Treatment:** The length of time the doctor spends with an individual, the doctor's skills and the quality of specialists. **Personal Treatment**: The doctors' explanations, the courtesy of the office staff and the care provided by nurse practitioners.
The Health Plan's Preventive Care Performance	**Preventive Screening**: The plan's provision of blood pressure screenings, cholesterol screenings, mammograms and pap smears. **Health Promotion**: Consumer participation in health promotion programs and whether they helped the individual make lasting changes. **Counseling**: Counseling in such topics as nutrition, exercise, smoking cessation and sexually transmitted diseases.

©Bay Area Business Group on Health (BBGH)

Bay Area Business Group on Health: 1994 HMO Consumer Satisfaction Report Card

The Bay Area Business Group on Health 1994 Consumer Satisfaction Report Card is based on the results of the 1994 Employee Medical Plan Satisfaction Survey. This survey was mailed to nearly 60,000 employees and early retirees of ten large organizations. Approximately 27,000 individuals, or 46%, responded to the survey. **Grading:** HMO scores were ranked together from high to low. HMOs scoring above the top 25th percentile were given an A. HMOs scoring below the lowest 25th percentile were given a C. Unusually high HMO scores were given an A+ and unusually low HMO scores were given a C- based on statistical criteria. All other HMOs were given a B (no B+ or B- scores were given). POS and PPO plan average grades were assigned in the same way.

CALIFORNIA HEALTH PLAN	Overall Consumer Satisfaction With...			
	The Health Plan	Doctor Seen Most Frequently	Care Received at Hospital	Plan's Health Improvement Programs
Health Maintenance Organization (HMO)				
Aetna HMO	C	B	A	B
Blue Shield	B	B	C	B
CIGNA	B	B	B	B
California Care	B	B	C-	C
FHP	C	B	B	B
Foundation	B	A	B	B
HP of Redwoods	A+	A	A	A
Health Net	B	B	B	B
Kaiser North	B	C	C	A
Kaiser South	B	C	B	A
Lifeguard	A	A	A	C
Maxicare	C	C	C	B
Omni	A	B	B	C
PacifiCare	C	C	B	B
QualMed	B	B	A	C
TakeCare	B	B	B	B
ValueCare	A	A	B	A
Point-of-Service (POS) Average	C-	C	C	C-
Preferred Provider Organization (PPO) Average	B	A	B	C

©Bay Area Business Group on Health (BBGH)

California Cooperative HEDIS Reporting Initiative

A Collaboration Among Purchasers, Health Plans and Providers in California

Overview of 1993 Health Plan Performance

Health Plan	Preventive Services: Childhood Immunization	Cholesterol Screening Age 40-64	Breast Cancer Screening	Cervical Cancer Screening	Prenatal Care	Diabetic Retinal Exam
Aetna North	*	○	◒	◒	◒	○
Aetna South	◒	◒	◒	◒	◒	◒
Aetna San Diego	○	◒	◒	◒	◒	◒
Blue Shield HMO	◒	N/A	◒	◒	◒	*
CaliforniaCare	◒	◒	◒	○	◒	◒
CareAmerica	◒	◒	●	◒	◒	◒
CIGNA North	○	●	●	◒	○	◒
CIGNA LA IPA	◒	◒	◒	◒	◒	◒
CIGNA LA Staff	◒	◒	◒	○	◒	○
FHP, Inc.	◒	◒	◒	○	◒	●
Foundation Health Plan	◒	◒	◒	◒	◒	◒
Health Net	◒	◒	◒	○	◒	○
Health Plan of the Redwoods	●	◒	◒	○	◒	●
Kaiser Permanente Northern California	○	◒	◒	◒	◒	○
Kaiser Permanente Southern California	○	◒	●	◒	◒	○
Lifeguard	◒	◒	●	●	◒	◒
Maxicare	◒	◒	○	◒	◒	○
MetLife	●	◒	●	◒	●	*
OMNI Health Plan	●	○	◒	◒	◒	◒
PacifiCare	*	◒	●	◒	◒	*
PruCare	●	N/A	◒	◒	●	◒
TakeCare	○	○	◒	○	◒	○
ValueCare	●	◒	○	◒	*	●

○ Above Average
◒ Average
● Below Average
* Insufficient data submitted by the plan
N/A Not Applicable[1]

[1]Health plan was not operational for length of time required for the study.

©Copyright 1995, California Cooperative HEDIS Reporting Initiative

Mr. ENSIGN. Ms. French.

STATEMENT OF MICHELE E. FRENCH, DIRECTOR, HEALTH AND WELFARE BENEFITS, OFFICE OF THE PRESIDENT, UNIVERSITY OF CALIFORNIA, OAKLAND, CA

Ms. FRENCH. Thank you, Mr. Chairman, members of the committee. I appreciate the opportunity to talk to you today.

I am going to tell you a little bit about the University of California, give a snapshot of where we were in 1993 and then tell you what we have done to reduce costs since then.

The University of California is the second largest employer in California. We have nine campuses, five teaching hospitals, and three research laboratories, and in addition, we have widespread agricultural and remote research locations.

We have about 96,000 employees who work 20 or more hours per week and are eligible for career benefits; 99 percent of that group is enrolled in some kind of a medical plan.

We have another 4,900 that are part-time employees, that we cover for catastrophic medical care. We automatically enroll them unless they decline coverage, and we have about 70 percent of them in our health plan.

We have another 33,000 retirees who receive career medical benefits. That is a growing group, both in terms of size and cost, over time. There are also 40,000 to 45,000 student employees who have access to coverage through student services programs at each campus.

I am going to talk about the employee population. We provide medical coverage to nearly all of our employees through a choice of various plans. We have six HMO's, a point-of-service plan, and a preferred provider indemnity plan in addition to the catastrophic coverage. We contribute to those plans for the employees plus their family members. And retirees have access to the same coverages with the same contribution available to them.

We require Medicare enrollment as retirees and spouses age into the program, and we contribute to the cost of their part B premium.

Historically, the university's contribution was based on the average of the four largest health plans. Those were not necessarily the most cost-effective plans; they were the most popular plans, so we had had a couple of very special expensive programs in that mix. This meant that our—that several of our plans really did not have to compete on the basis of price. They only had to stay slightly below the maximum available university contribution.

Since we have about 75 percent of our population in HMO's, that became a fairly costly strategy. Since they weren't competing on the basis of price, HMO's, in particular, competed on the basis of slight variations in coverage, things like zero copays for office visits or low prescription drug costs. They also used subtle variations in coverages to direct more expensive-type patients to other plans—things like higher copays on infertility services.

In 1993, we were looking at the third year of budget cuts, so we needed to develop some more economies in the area of benefits. While we wanted to offset our cost trend and, hopefully, reverse it, we also wanted to maintain a range of choices for our members and

we wanted to keep the quality of the program, so we adopted a managed competition strategy.

We set the maximum contribution at the level of the most cost-efficient plan. We standardized the HMO copayments. We added a point-of-service program. We set caps on the increases for 1995 and 1996.

We have also put the carriers at risk for a percentage of their premium for performance guarantees; and we have implemented Medicare risk plans for our retirees who are enrolled in HMO's.

In that 2-year period, our costs have declined by $63.5 million, or about $624 per employee or retiree. Most of that reduction is from the cost competition among the HMO's. Rather than passing those costs on to their members, they chose to reduce their premiums; some of them dropped premiums as much as 10 percent in a single year.

In a 2-year period, our total decrease in medical plan costs is about 17 percent. The second largest savings is in implementation of Medicare risk plans. We dropped our retiree cost about 5 percent by implementing that for the two largest plans.

In 1995, our average cost per employee is $2,847. That compares to the 1993 national average of $3,358. We have done this without any major reductions in coverage, and the premiums paid by the employees are modest. An HMO member will pay anywhere from zero to $45 a month for family coverage, and our point-of-service family plan is $11 a month charge. So we think we have achieved some sustainable cost efficiencies without compromising either the benefits or the quality of care that we provide to our members.

Thank you.

Mr. ENSIGN. Thank you.

[The prepared statement follows:]

TESTIMONY BY MICHELE E. FRENCH, FOR THE UNIVERSITY OF CALIFORNIA
MAY 16, 1995 MEETING OF THE SUBCOMMITTEE ON HEALTH OF THE
HOUSE WAYS AND MEANS COMMITTEE

Mr. Chairman, members of the Subcommittee on Health of the Committee on Ways and Means, I would like to thank you for the opportunity to testify before you on cost-control and quality improvement in employer medical plans.

My name is Michele French and I am the Director of Health and Welfare Benefits for employees of the University of California system.

The University of California is the second largest employer in California, with nine campuses, five teaching hospitals and three research laboratories plus various agricultural and remote research locations.

> Of the 96,200 working 20 hours or more and eligible for "career" benefits; almost 99% are enrolled in a medical plan.
>
> 4,900 part-time employees are eligible for "catastrophic" medical coverage and almost 70% are enrolled. The remainder have declined University coverage because they have coverage elsewhere. (The University automatically enrolls these employees in the catastrophic plan unless they sign a form waiving coverage.)
>
> 33,000 retirees receive the "career" medical benefits.
>
> 40-45,000 student employees have access to medical coverage via student services programs at each campus.

Medical coverage is provided to nearly all employees through a choice among 6 HMOs, a point-of-service plan, a preferred-provider indemnity-style plan or a catastrophic plan. The University contributes towards these plans for employees, their spouses and their dependent children. Retirees have access to the same medical plans and are eligible for the same maximum contribution amount as is available to employees. We require Medicare enrollment for retirees and their spouses when they become eligible and pay the "Part B" as part of the maximum University contribution.

Historically, this contribution was based on the weighted average cost of the four largest plans. These were the most popular, not the most cost-effective plans so the averaging method included some of the most expensive programs. Given this contribution strategy, many of the medical plan carriers did not need to compete on the basis of price, they only needed to keep their cost below the maximum available University contribution.

Since they were not competing on price, HMOs, in particular, competed on the basis of slight variations in benefits - such as zero copayments for office visits or low prescription drug costs. There also were subtle variations in coverage that might encourage those with more expensive conditions to select other plans; for example, higher copayments for infertility services.

In 1993, the University was faced with the third year of budget cuts and the necessity to develop more economies in the area of benefits. While we wanted to reverse or, at least, slow the cost trend of our medical plans, we also wanted to maintain quality, a full menu of choices and stability in the programs. To this end, we adopted a "managed competition" strategy by:

- setting the maximum contribution at the level of the most cost-efficient plan;
- standardizing the HMO plan copayments;
- adding a "point-of-service" plan to our options;
- requiring second and third year caps on premium increases;
- putting the carriers at risk for meeting agreed-upon performance standards, implementing Medicare "risk" plans for retirees enrolled in HMOs.

The University's medical plan costs have declined by $63.5 million, or $624 per employee/retiree since 1993, despite the increase of almost 4,600 primary lives in the same period. Most of the reduction comes from the effects of setting the contribution at the lowest cost plan, thereby forcing "market competition" among HMOs. Rather than passing the costs to members, these plans reduced their gross premiums, some by as much as 10% in a single year. The total decrease in the medical plan premiums since 1993 was almost 17%. The second largest single source of savings was implementation of the Medicare risk plans in 1995 for two of our largest HMOs, in addition to the two plans already converted to risk-style benefits. This saved $4 million dollars, reducing the 1995 retiree cost by approximately 5%.

The University's 1995 average cost per employee is $2,847, compared to the 1993 national average of $3,358. This has been achieved without any major reduction in coverage. And the premiums paid by employees are generally modest. For HMO coverage, the employee cost ranges from $0 to $45 per month for a family plan. The cost for a family enrolled in the point-of-service program is not quite $11 per month.

We believe we have achieved sustainable cost-efficiencies without compromising the quality of benefits or care for our plan members.

ATTACHMENT TO TESTIMONY BY MICHELE E. FRENCH - UNIVERSITY OF CALIFORNIA
MAY 16, 1995 MEETING OF THE SUBCOMMITTEE ON HEALTH OF THE
HOUSE WAYS AND MEANS COMMITTEE

The following summarizes the medical plans available to employees and retirees of the University of California:

PLAN	DESCRIPTION
FEE FOR SERVICE	
CORE	Catastrophic coverage, primarily for part-time employees $2,000 deductible 20% coinsurance $1 million maximum lifetime benefit
High Option	Major Medical coverage with a preferred provider network (PPO) $200 deductible 20% coinsurance (10% with PPO) $2 million maximum lifetime benefit
POINT-OF-SERVICE PLAN	Triple option with 3 benefit tiers - choice of tier each time care is received HMO tier - $5 copays for office visits $0 copays for prenatal/pediatric visits $0 copays for inpatient care PPO tier - $250 deductible/20% coinsurance Non-network - $500 deductible/40% coinsurance $2 million maximum lifetime benefit for PPO plus Non-network services; no limit on HMO services Drug card program - $12 copay, mail order service Mental Health/chemical dependency from exclusive, specialty network
HEALTH MAINTENANCE ORGANIZATIONS (HMOS)	
	Benefits standardized across 6 plans $5 copay - office visits $5 copay - drugs $0 copay - hospital inpatient care $0 copay - prenatal, well-baby care; pediatric office visits

Mr. ENSIGN. And Mr. Wrocklage, please.

STATEMENT OF JIM WROCKLAGE, CHIEF EXECUTIVE OFFICER, HEALTH CARE NETWORK OF WISCONSIN, BROOKFIELD, WI

Mr. WROCKLAGE. Thank you, Mr. Chairman, members of the subcommittee. My name is Jim Wrocklage, and I am chief executive officer of the Greater Milwaukee Health Care Purchasing Plan, which does business in Milwaukee and southeastern Wisconsin as the Health Care Network [HCN] of Wisconsin.

I hope that my testimony today will convey to you our message that the value of health care, which is a function of both cost and quality, can best be enhanced through employer-led, community-based reform which is market driven.

Our organization was created in the fall of 1986 by 10 major employers, and the mission was to arrange for, promote, and otherwise encourage programs and activities which are designed to promote the general health of the community, promote access to quality care in the most appropriate setting, and contain the increase in costs of health care.

We originally started on July 1, 1987, serving 10,000 employees of eight private employers and two public employers. All 10 of these were self-funded. We represented 10,000 employees. Today we represent 51,900 employees through 250 self-funded employers and another 47,100 through another 2,900 employers who buy insurance contracts through 10 insurance carriers. In total, we represent 247,000 covered lives in the greater Milwaukee metropolitan area.

Through 1989, HCN only served the self-funded employers, but in the interest of wanting to serve as many employers as possible in our community, HCN sought out insurers who were interested in offering the network to their insured clients generally, small to medium in size. Today, whether insured or self-funded, employers ranging in size from 2 to 200 employers represent 50 percent of our business clients.

As a demonstration of controlling costs, for the 7½-year period ending December 31, 1994, HCN had processed $596 million of hospital charges. However, its negotiated contracts permitted reimbursement of $438.4 million, so that a difference of $157.6 is the economic savings derived on behalf of all of our participating purchasers. This equates to a 26.5 per year weighted average savings for all hospital costs.

As implied by the title of this hearing, quality is as essential to HCN as cost, and as such, we have undertaken several quality initiatives of varying scope with providers in our community. These have varied from doing simply pure data analysis, identifying complication rates which are unexplainable, to serving on joint work committees of employers and providers in order to reduce administrative costs and complexity within the health care system.

Within the last few months, it has become clear to us that the following principles must guide the extent and type of our involvement in future community-based quality initiatives. Those who deliver care are the only ones who can truly manage it. Therefore the

purchaser involvement should be focused at the highest level feasible, given the scope of the project.

Patient outcomes are improved by managing the delivery processes that drive the outcomes, and before an endeavor is undertaken, thought must be given to the impact it will have on the entire community and the industry of health care. Valid data is a prerequisite to improvement. In order to promote the use of valid data, HCN encourages the use of strong operational definitions that are consistently applied and exercise due diligence in the manner with which it accepts data from providers and other community sources.

It is our concern for the consistent application of operational definitions that forces it to approach comparative data for the selection of providers with great caution. HCN is aware of interpretive differences that occur during the coding of medical records. In order to mitigate the effect of these differences, we prefer to stimulate quality improvement in our community by studying the data from each institution over time, rather than to make selection decisions based on interinstitutional comparisons.

And we have also acknowledged that the gain through these quality initiatives should be shared in the community, not hoarded.

Although we recognize that our operational structure and degree of success are not necessarily replicable throughout the United States, we do view HCN as a prime example that community-based, employer-driven market reform works. And having established a community presence, which we think is the most important thing, by consolidating a fragmented purchasers' set into a critical mass which negotiates lower prices and encourages quality improvement initiatives, we will continue to take catalytic-type action which impacts the underlying structure of the local delivery and financing of health care. When doing so, we recognize that reactions by providers, insurers, and managed care organizations in response to our actions or as part of our activities has a positive effect on our community.

Given the changes currently occurring in our community, it is highly likely that our activities will continue to create other structures which enhance the working of an organized market, create competition between clinical caregiver systems organized around efficient and effective delivery, not consolidated provider cartels. We would also empower employees as consumers and purchasers of health care, promote personal responsibility, and promote user-friendly information regarding health care value.

Given the limited time available to prepare for this hearing, I offer the attached letters as documentation of the value attributed by our board of director, employers, and participating insurers who were able to respond within the given time frame. I thank you for the opportunity to testify and I would be glad to answer any questions you may have.

[The prepared statement and attachments follow:]

TESTIMONY OF JAMES R. WROCKLAGE
HEALTH CARE NETWORK OF WISCONSIN

Mr. Chairman, and members of the Sub-Committee, my name is Jim Wrocklage and I am chief executive officer of the Greater Milwaukee Health Care Purchasing Plan, Inc. which does business in Milwaukee and southeastern Wisconsin as Health Care Network of Wisconsin (HCN). I want to begin by thanking you, Mr. Chairman, for calling this hearing today and for inviting me to testify.

I hope that my testimony today will demonstrate our organization's experience in controlling costs and improving quality on behalf of our employer clients in Southeastern Wisconsin. Most importantly, I wish to convey the message that the Value of health care (cost/quality) can best be enhanced through local community based reform which is market driven.

MISSION

After almost one year of planning, the Greater Milwaukee Health Care Purchasing Plan, Inc. was founded in the fall of 1986 by 10 major Milwaukee employers, almost all of whom continue to serve on its voluntary Board of Directors. The organization's mission is "to arrange for, promote, and otherwise encourage programs and activities which are designed to promote the general health of the community, promote access to quality care in the most appropriate setting, and contain the increase in costs of health care." To date, the mission of this Wisconsin non-stock corporation has been accomplished under the name of Health Care Network of Wisconsin (HCN), a broad network of hospitals, physician, and ancillary providers offered to self-funded and insured employers as a preferred provider overlay to their indemnity health plan.

EVOLUTION OF CLIENT MIX

On July 1, 1987, HCN began serving 10,000 employees of eight private employers and two public employers. HCN now serves 51,900 employees of 250 self-funded employers and another 47,100 employees of 2,900 insured employers who obtain insurance coverage through 10 carriers. These two groups of employees and their dependents represent approximately 247,000 covered lives in the greater Milwaukee metropolitan area and southeastern Wisconsin. HCN participating employers continue to include public employers such as municipalities and school districts.

Through 1989, HCN served only self-funded employers. However, in the interest of wanting to serve as many employers as possible in our community, HCN sought out insurers who were interested in offering the HCN provider network to their insured clients, generally, small to medium in size. Whether insured or self-funded, employers ranging in size from 2 to 200 employees currently represent 50% of our business.

COST CONTROL

As a demonstration of controlling costs, I can report that during the time period of July 1, 1987 through December 31, 1994, HCN on behalf of all of its clients has processed 55,700 inpatient hospital claims totalling billed charges of $397,000,000 and 534,900 outpatient claims totalling billed charges of $199,000,000. Through its negotiated contracts, HCN's allowable reimbursement for this $596,000,000 of hospital charges was $438,400,000. The difference of $157,600,000 is the economic savings derived on behalf of all our participating purchasers. The HCN Board of Directors believes that this weighted average savings of 26.5% per year for all hospital costs over seven and a half years is an example of superb performance.

QUALITY

As implied by the title of this hearing, quality is as essential to HCN as cost. As such, HCN has undertaken several quality activities of varying scope with providers in our community. These have varied from pure data analysis identifying unexplained complication rates to full participation on joint employer/provider work teams oriented towards reducing administrative cost and complexity.

Within the last few months, it has become clear to us that the following principles must guide the extent and type of our involvement in future community based quality initiatives:

1. Those who deliver care are the only ones who can truly manage care. Therefore, purchaser involvement should be focused at the highest level feasible given the scope of the project.

2. Patient outcomes are improved by managing the delivery processes that drive the outcomes.

3. Before an endeavor is undertaken, thought must be given to the impact it will have on the entire industry.

4. Valid data is a prerequisite to improvement.

   In order to promote the use of valid data, HCN encourages the use of strong operational definitions that are consistently applied and exercises due diligence in the manner with which it accepts data from provider and other community sources.

   It is HCN's concern for the consistent application of operational definitions that forces it to approach comparative data for the selection of providers with caution. HCN is aware of the interpretative differences that occur during the coding of medical records. In order to mitigate the effect of these differences, HCN prefers to stimulate quality improvement by studying the data from each institution over time, rather than to make selection decisions based on interinstitutional comparisons.

5. Knowledge is meant to be shared.

CONCLUSION

Although we recognize our operational structure and degree of success are not necessarily replicable throughout the United States, we do view HCN as a prime example that community based, employer driven market reform works.

Having already established a community presence by consolidating a fragmented purchaser's set into a critical mass which negotiates lower prices and encourages quality improvement initiatives, HCN will continue to take catalytic type action which impacts the underlying structure of the local delivery and financing of health care. When doing so we recognize that reactions by providers, insurers, and managed care organizations in response to or as part of our activities has a positive effect in our community.

Given the changes currently occurring in Southeastern Wisconsin, it is highly likely that HCN's future activities will:

- Create other structures which continue to enhance the working of an organized market.

- Create competition between clinical care giver systems organized around efficient and effective delivery -- not consolidated provider cartels.
- Empower employees as consumers/purchasers of health care.
- Promote personal responsibility.
- Promote user friendly information regarding health care value (cost/quality).

Attachments

Given the limited time available to prepare for this hearing, I offer the attached letters as documentation of the Value attributed to our community activities by those HCN Board of Director employers and participating insurers who were able to respond within the given time frame.

Vice President

May 5, 1995

Mr. James Wrocklage
Chief Executive Officer
Health Care Network
250 Bishops Way
Suite 300
Brookfield, WI 53005-6222

Dear Jim:

You asked for a statement regarding Firstar's participation in the Health Care Network for testimony to the House Ways and Means Subcommittee on Health. As a charter member and continuing with representation on the board of directors, Firstar Corporation remains committed to the philosophy and objectives of HCN. Participation in HCN has enabled us to better control and manage our self-insured health care expense in the greater Milwaukee area. You should know that Firstar's self-insured cost for 1995 is 5% below 1994 cost levels. In addition, participation has given us the opportunity to communicate to providers about the concerns that all employers face with respect to cost and quality of care.

I hope this information is of value to you as you prepare for your appearance before the Subcommittee.

Sincerely,

Jack R. Chmiel

Badger Meter, Inc.

4545 W. Brown Deer Road, P.O. Box 23089
Milwaukee, WI 53223-0089 (414) 355-0400

May 12, 1995

James Wrocklage
Health Care Network of Greater Milwaukee
Suite 300
250 Bishops Way
Brookfield, WI 53005-6222

Dear Jim:

As a member and participant of Health Care Network (HCN) since its inception, Badger Meter, Inc. cannot over emphasize the positive impact HCN has had in helping control our employee health care costs in Milwaukee.

The average cost per employee in the Milwaukee HCN plan has increased less than twenty five percent (25%) since 1988 through 1994. Few companies can make this claim in an environment which saw double digit inflation for each or most years in that seven year period. The value of those health care dollars spent during this period has also been enhanced.

Educating employees and making them more conscious purchasers of quality health care through the HCN provider network has contributed greatly in controlling our costs. With 475 employees based in Milwaukee, these cost controls have, in part, contributed to Badger Meter's continued financial strength and maintained its market position as a leading manufacturer of flow measurement products worldwide.

As the health care delivery system has and continues to change, HCN has been able, through its flexibility and foresight, to change and help provide for cost effective quality care for our employees. HCN has added value to health care in Milwaukee.

Sincerely,

Ronald H. Dix
V.P. - Adm./Human Resources

Allen Bradley Company, Inc.
Headquarters
1201 South Second Street
Milwaukee, WI 53204 USA
414.382.2000
Fax 414.382.4444
Telex 4311018

Rockwell Automation
Allen-Bradley

May 12, 1995

Mr. James Wrocklage
Executive Director
Health Care Network
250 Bishops Way Suite 300
Brookfield, WI 53005-6222

Dear Jim:

We feel that, as a major self funded employer with a large number of active and retired employees in the greater Milwaukee area, our participation in the Health Care Network has had a meaningful impact in controlling our health care cost increases. We have participated in HCN since its inception and have found that health care costs at locations where employees have an indemnity plan available have generally increased at a faster rate than we've experienced in the Milwaukee area.

We feel it is important however, that all employers, both large and small, have the opportunity to participate in purchasing initiatives of this nature. The cooperative environment in which HCN developed has proven beneficial for our community as a whole and not necessarily a select few.

Very truly yours,

Roger J. Freitag

Roger J. Freitag
Manager-Employee Benefit Programs

DEPARTMENT OF HUMAN RESOURCES

Milwaukee County

GARY J. DOBBERT • DIRECTOR
JOHN H. GIVENS, III • DEPUTY DIRECTOR

JAC R. AMERELL
Retirement
CYNTHIA A. BARNES
Policy Procedures
JAMES M. EGGERS
Compensation
ROBERT A. KIEFERT
Information Systems
JERTHA RAMOS
Employment & Staffing
RONALD A. STANNY
Recruitment
PATRICIA A. VILLARREAL
Employment Relations
JOHN S. WOJTECKI
Budget

VIA FACSIMILE - 784-2976

May 12, 1995

Mr. Jim Wrocklage
Executive Director
HCN Health Care Network of Wisconsin
250 Bishops Way, Suite 300
Brookfield, WI 53005-6222

Dear Jim:

Milwaukee County government, as a board member of Health Care Network of Wisconsin and a large employer with a self-insured indemnity medical plan, is happy to provide confirmation of the benefits realized through the "Network's" successes in controlling health care costs.

Through direct provider discounts (hospitals, physicians and other ancillary medical care providers), "Centers of Excellence" services, guaranteed "package" rates, etc., Milwaukee County has achieved substantial medical cost savings. There have been favorable responses from our employees who now just pay their co-insurance without fear of being billed for amounts above, "usual, customary and reasonable" fee schedules. Also, with the growth of the Network, providers have been more willing to cooperate with payers in quality of care and cost containment efforts.

Such successes by the Network in acting as a catalyst in eliminating unnecessary cost and in suppressing the amount of medical cost increases ultimately benefit the taxpayers of Milwaukee County who pay for the salaries and benefits of our public employees.

We support your efforts on our behalf through your testimony to the House Ways and Means Subcommittee on Health.

Sincerely,

Gary J. Dobbert
Director of Human Resources

GJD:vo

BRIGGS & STRATTON CORPORATION

May 12, 1995

Mr. James Wrocklage
Health Care Network of Wisconsin
250 N. Bishops Way
Brookfield, WI 53005-6222

Dear Jim:

"For the largest group of Milwaukee active employees under its self-insured plan, Briggs & Stratton's current cost per employee per month is virtually the same* as it was 3 years ago, when the plan was changed to incentivize use of the HCN network. As there have been no other significant plan changes during that period, Briggs & Stratton attributes its participation in HCN, and the collective purchasing power of its employer base, as being the principal reason for the leveling of that cost."

*less than a 1% increase

Sincerely,

BRIGGS & STRATTON CORPORATION

R. C. Reynolds
Manager, Group Insurance & Employee Benefits

RCR:bkd
cc: file

JERRY BURG
Director - Human Resources
(414) 299-3430

Northwestern Mutual Life

May 12, 1995

Mr. James Wrocklage
HCN
250 Bishops Way, Suite 300
Brookfield, WI 53005-6222

RE: HCN PPO Savings

Dear Jim,

Northwestern Mutual Life Insurance Company has participated in HCN's network since its inception in 1989 and participated as a founding employer organization. We firmly believe in the savings potential available to us and to our employees as a participating member of HCN.

The benefit of participating in HCN is twofold. First, as an employer, our total claims cost is less as a result of being able to take advantage of discounted negotiated fees with providers. Second, our employees share in the savings by receiving a higher benefit and having a lower out-of-pocket cost on services received from HCN participating providers.

As you can see on the enclosed exhibits:

- Over the 5-year period of time from 1990 to 1994, we recognized an average savings of 8% for hospital expenses.
- This translates to an average savings of $330.82 per employee per year or $132.33 per covered member per year.
- As employees have become more aware of the benefits of the HCN PPO and as HCN has expanded its network, our savings have continued to grow and remain strong.

I would like to add two last important points:

1. The savings shown on the exhibits are "NET" savings after subtracting out our cost to participate in HCN.
2. The exhibits only reflect savings realized on hospital expenses. They do NOT include savings as a result of fees that have been negotiated for office visits, lab and x-ray work, medical supplies, etc. Therefore, our true savings are even greater than shown on the exhibits.

If you have any questions on the information enclosed, please call me.

Sincerely,

Jerry Burg

GE Medical Systems

General Electric Company
P.O. Box 414, Milwaukee, WI 53201

May 15, 1995

Jim Wrocklage
Health Care Network Of Wisconsin
250 Bishops Way, Suite 300
Brookfield WI 53005-6222

Dear Jim:

As you are aware, General Electric has been a participating employer in HCN since its inception. It is clear to us that our participation in HCN over the past seven and a half years has had a meaningful impact on controlling our health care costs in Milwaukee while providing access to quality providers desirable to our employees.

Sincerely,

Thomas C. Larche
Manager, Employee Health and Benefits

/rk

MILLER BREWING COMPANY

May 12, 1995

Mr. James Wrocklage
Executive Director
Health Care Network
250 Bishops Way Suite 300
Brookfield, WI 53005-6222

Dear Jim:

We feel that, as a major self funded employer with a large number of active and retired employees in the greater Milwaukee area, our participation in the Health Care Network (HCN) has had a meaningful impact in controlling our health care cost increases. We have participated in HCN since its inception. We have found that health care costs at locations where employees have an indemnity plan available have generally increased at a faster rate than we've experienced in the Milwaukee area.

We feel it is important however, that all employers, both large and small, have the opportunity to participate in purchasing initiatives of this nature. The cooperative environment in which HCN developed has proven beneficial for our community as a whole.

Very truly yours,

John R. Van Vliet
Corporate Benefits Manager

JRV/tm

13M.doc

May 12, 1995

Mr. James Wrocklage
Health Care Network of Wisconsin (HCN)
250 Bishops Way, Suite 300
Brookfield, WI 53005-6222

Dear Jim:

I welcome the opportunity to summarize the very tangible benefits of the partnership that WPS and HCN have had over the past three years. This partnership, using the HCN provider network, has provided our customers with a successful private sector, market driven, approach to controlling medical costs, utilization, and outcomes.

The availability of Health Care Network of Wisconsin (HCN) provides our small employer clients (2-100 employees) access to a broad network of providers that offers quality health care services on a cost effective basis The availability of this network to the small business insured market has allowed our small employers to share in the purchasing power generated by this larger employer coalition and creates opportunity for the small employers to benefit directly from controlled costs. The savings are reflected in the premium and medical trend differential as shown in the following paragraph. As can be seen, using the HCN network has provided substantial savings to our insured small business clients over the years, and has done so much sooner than otherwise would have been possible.

Compared to our standard, non-managed indemnity product, the HCN PPO and Point of Service (POS) provides a legitimate 12% savings on the physician component, 36% savings for in-network hospital stays, and 20% savings for in-network outpatient. Over the three year period these discounts translate into a medical trend differential of 6% for the HCN network products compared to our indemnity product. We expect this differential to widen in the future. Taking the arithmetic to the final level, i.e., what does this mean to the customer paying the premium bill, the HCN managed care products provide a 8-14% lower premium compared to our indemnity products for similar or better benefits.

The final proof of the HCN offering is the sales and retention levels for the WPS/HCN products in the three county metro-Milwaukee marketplace. Currently, WPS insures

roughly 35,000 people in this market, which makes the WPS/HCN product a primary insurance product in this three county area.

WPS and our customers are very satisfied with the price, product, and medical quality of the HCN managed care operation. The numbers, whether they be sales, loss ratio, or premium charged, certainly speak highly of the HCN approach to delivering quality, affordable health care.

Sincerely,

Lon Sprecher
Corporate Senior Vice President
Market Services

LS:jy

Midwest Security
INSURANCE COMPANIES

Health Care Network of Wisconsin Product

The availability of Health Care Network of Wisconsin (HCN) provides our Midwest Security small employer clients (2–100 employees in size) access to a broad network of providers that offers quality health care services on a cost effective basis. The availability of this network to the small business insured market has allowed our small employers to share in the purchasing power generated by this larger employer coalition and creates the opportunity for the small employers to benefit directly from controlled costs. The savings are reflected in the premium differential as shown in the following history. As can be seen, this has provided substantial savings to our insured small business clients over the years, and has done so much sooner than would otherwise have been available.

	HCN Premium Rates				Traditional Indemnity Premium Rates				
Date	Single	Limited Family	Full Family	Average Increase	Single	Limited Family	Full Family	Average Increase	Premium Differential
1/1/90	74.09	173.50	239.24		76.34	177.86	249.48		-4%
1/1/91	81.00	187.00	261.00	9%	84.30	196.00	276.00	11%	-5%
1/1/92	89.00	203.00	288.00	10%	99.30	228.00	331.00	19%	-12%
1/1/93	109.00	222.00	318.00	10%	119.30	257.00	377.00	14%	-15%
1/1/94	106.00	226.00	324.00	2%	130.30	281.00	417.00	11%	-21%
1/1/95	113.00	242.00	350.00	8%	138.30	297.00	442.00	6%	-20%

	HCN Medical Inforce Data		
Date	Number of Employers	Number of Employees	Avg. Size of Group
1/1/89	0	0	
1/1/90	62	577	9.3
1/1/91	129	1212	9.4
1/1/92	247	2322	9.4
1/1/93	366	3404	9.3
1/1/94	426	3943	9.3
1/1/95	491	4631	9.4

David J. Jacobs, FSA, MAAA
Vice President and Chief Actuary
05/12/95

BENEFIT DIFFERENCES IN THE HCN AND TRADITIONAL INDEMNITY PRODUCTS

A comparison of current HCN and Traditional Indemnity benefits is given below; $250 Deductible is assumed for each.

BENEFIT	HCN		Traditional Indemnity
	In Network	Out of Network	
Coinsurance	90%/10% next $2500 after deductible	80%/20% next $2,500 after deductible	80%/20% next $2,500 after deductible
Physician/Clinic Office Call	$10 Copayment 100% thereafter includes x-ray and lab	$20 Copayment 100% thereafter x-ray and lab are subject to deductible and coins.	Subject to deductible and coinsurance including x-ray and lab
Emergency Room	$25 Copayment Then subject to deductible and coins.	$25 Copayment Then subject to deductible and coins.	Subject to deductible and coinsurance

NOTES:
HCN copayments do not help to satisfy the deductible and coinsurance.
Emergency room copayments are waived if the patient is hospitalized.

The Mutual Group (U.S.)
Employee Benefits
Mutual Life
401 North Executive Drive
Brookfield, Wisconsin 53008-0980
tel: 414 797-3000
fax: 414 797-5035

HCN HISTORY

The availability of Health Care Network of Wisconsin (HCN) provides our small employer clients (1-100 employees) access to a broad network of providers that offers quality health care services on a cost effective basis. The availability of this network to the small business insured market has allowed our small employers to share in the purchasing power generated by this larger employer coalition and creates opportunity for the small employers to benefit directly from controlled costs. The savings are reflected in the premium differential as shown in the following history. As can be seen, this has provided substantial savings to our insured small business clients over the years, and has done so much sooner than otherwise would have been available.

HCN Employer Premium
(PPO Plan)

	Premium**			
Date	Single	Limited Family	Full Family	Ave. % Change
Jan 92	$63	$138	$297	
Jan-93	$75	$163	$316	16.1%
Jan-94	$74	$161	$312	-1.3%
Jan-95	$81	$176	$342	9.8%

WI Traditional Indemnity Premium
(CMO Plan*)

	Premium**				
Date	Single	Limited Family	Full Family	Ave. % Change	Differential
Jan-92	$71	$158	$301		-11.3%
Jan-93	$84	$183	$356	18.1%	-11.3%
Jan-94	$88	$181	$352	-1.0%	-11.5%
Jan-95	$91	$199	$387	9.8%	-11.5%

HCN Medical Inforce Data

Date	Number of Employers	Number of Employees	Ave. Size of Group
Jan-92	236	1,558	6.55
Jan 93	246	1,626	6.61
Jan-94	227	1,251	5.52
Jan-95	233	1,805	8.89

*In addition to the premium savings, the PPO Plan has a better benefit, due to a lower coinsurance cost to the insured if network providers are used.

**Premiums shown are for a Single Male Employee, age 36, a Single Male Employee with one child, and a Male Employee, Age 30 with a spouse and two children, as of the date shown. The rates shown are for Milwaukee, Zip 532. The plans shown have a deductible of $500 and a Stop Loss level of $5,000. The PPO plan has a coinsurance of 90% in-network and 80% out-of-network. The CMO plan has a coinsurance of 80%. Maternity coverage is included.

Name: James B. Meyers
Title: Executive Director, Managed Care Development

Mr. ENSIGN. I would like to thank the panel.

Before I turn it over to Mr. McCrery, Ms. French, you mentioned some savings at the University of California by implementing some of the ideas that you have outlined. You mentioned $65 million, $624 per year per enrollee. Would you consider that those savings—if somebody was asking you, would you consider that a cut in your employee services?

Ms. FRENCH. No, as a matter of fact, I wouldn't. The bulk of that savings really came from the price of the gross premium, not from shifting that cost to employees.

Mr. ENSIGN. The reason I mention that is because you hear a lot up here on Capitol Hill about our attempt to save Medicare by implementing some of the ideas that you have outlined in your testimony that we will be cutting Medicare, we will be slashing Medicare's budget.

If we are able to save $300 billion over the next 7 years because we are able to implement some of the changes that you have implemented, would you consider those a cut or a slash in the Medicare budget?

Ms. FRENCH. I think you have to look at the costs to the member versus the cost of the program as a whole; and when you compare those two things in our environment, the cost to the member has not increased very much at all, only about 2 percent in that period of time. So the cost savings that we are talking about, the 17 percent off the gross premium, has really come out of the plans.

So in answer to your question, no. If your relationship works like that, I would not consider that a cut in the program.

Mr. ENSIGN. In your opinion, do you think that what you have implemented at the University of California would be applicable to the Medicare population?

Ms. FRENCH. I think the Medicare population is a little more difficult to deal with. It is largely still in a fee-for-service environment. It is moving slowly into an HMO or managed care environment. One of the earlier panelists remarked that there is an educational or a learning curve involved there. I think it can be done. I have seen it happen in our population, but it takes time.

Mr. ENSIGN. Thank you.

Mr. McCrery.

Mr. MCCRERY. Ms. French, let me just follow up on that. I thought I heard you say that you have experienced significant savings among your Medicare population; is that correct?

Ms. FRENCH. That is correct.

Mr. MCCRERY. How have you done that?

Ms. FRENCH. We are moving in through Medicare risk programs.

Mr. MCCRERY. What do you mean by that?

Ms. FRENCH. By that, I mean, if they are in an HMO, that they will receive all of their care from the HMO. They will no longer be available to opt out and use Medicare on a fee-for-service basis outside the HMO.

Mr. MCCRERY. Anything else?

Ms. FRENCH. That plus the gradual shift of that entire population into HMO's per se.

Mr. MCCRERY. How are you shifting that population to the HMO's?

Ms. FRENCH. That has been driven primarily by the price. The traditional indemnity program has become extremely expensive as it compresses into higher utilizers and a smaller population, so gradually people are moving out of that program into the managed care programs.

Mr. MCCRERY. Explain to me how if your retiree population is eligible for Medicare, how have their prices increased?

Ms. FRENCH. Excuse me?

Mr. MCCRERY. How have their prices increased if they are in Medicare?

Ms. FRENCH. The population that is in Medicare can be priced one of two ways. It can remain in a fee-for-service environment, which is more expensive even though they are less expensive as a group than the employees—if you compare the retirees who are in the fee-for-service programs to retirees in the HMO's, straight line, the ones in the HMO's or the managed care products are running at a lesser cost.

Mr. MCCRERY. Yes, but when your folks retire, you say that you help pay their part B premiums?

Ms. FRENCH. Yes, we do.

Mr. MCCRERY. Is that all you do? Are they in the Medicare system?

Ms. FRENCH. They are in the Medicare system.

Mr. MCCRERY. And the only assistance you provide them is helping with their part B premium?

Ms. FRENCH. No, that is not the case. They still maintain the opportunity to stay in a university-sponsored health plan in addition to Medicare.

Mr. MCCRERY. OK. And you control the prices on the university plan?

Ms. FRENCH. That is right. I don't control Medicare.

Mr. MCCRERY. Correct. So for those employees who choose to stay in the university plan, it is their choice to go into an HMO?

Ms. FRENCH. Yes. They have the full range of choices that we offer to employees. In that sense, they are treated no differently.

Mr. MCCRERY. To your employees you only offer them, fully paid, the low-cost plan?

Ms. FRENCH. That is correct.

Mr. MCCRERY. Which is an HMO, I presume.

Ms. FRENCH. It is an HMO. However, the level of cost of that HMO for an employee is still above what it costs to provide a Medicare risk program; let's give you an example.

We pay about $140 a month for a single party plan. That is available to a retiree as well. If that retiree is in a Medicare risk plan, the cost for the risk plan is probably around $40 a month, so we can also pick up the cost of their Medicare B and still be within that budget allowance.

Mr. MCCRERY. So can you translate that or can you think about it for a second and give us some guidance as to how to change the Medicare Program at the Federal level to exact some of the same type of efficiencies?

Ms. FRENCH. I think the difficulty is in the approach to the delivery of service. The Medicare Program has been traditionally embedded in fee-for-service with self-referral and very little manage-

ment of access to care. I am not sure that always gets you the best quality of care, but I think you are talking about an educational issue as much as a money issue when you are dealing with Medicare members.

It is certainly a lot easier for us to work with the Medicare members of our population who have already been in an HMO setting. They understand the delivery. They understand how the system will work for them, and they are not frightened, if you will, by the thought of some utilization management.

Mr. MCCRERY. Thank you.

Mr. ENSIGN. The last panel—and I appreciate the question. Maybe we will open it to the rest of the panel on Mr. McCrery's question; and that is, some of the ideas that have worked in the private sector, the basis for this panel discussion today is how do we incorporate some of those ideas into the Medicare Program.

You mentioned education. How do we convince seniors that this can work because especially as you age, change becomes less attractive. I think when you are in your teenage years, change is inevitable, it is just part of life, and you accept it. But as you age, you like things the way they are, you don't like to change, so education is certainly more important.

How do we educate, but also which of these programs do you think that we should bring into Medicare? Should we have a list of choices similar to what Federal employees have, similar to what the University of California has, whether that is fee-for-service or whether that is HMO's and point-of-service plans and on down the line?

Does anybody else care to comment?

Mr. FEARER. I agree with Michele French that the primary issue is the health care delivery system itself, and that we need to find ways to eliminate excess capacity. Hospitals, for example in California, are 50 percent full and we are paying for that overhead; Medicare is paying for that overhead. There is still a significant problem of inappropriate and unnecessary care and solving this problem is important to controlling cost.

Preventative care is vital, particularly for the elderly, and early intervention in disease management is also critical. The best managed care programs are effective at that, but managed care programs are not all created equal. Some are more effective than others.

I also agree that consumer education is important. In fact, I believe that Medicare has begun a program with contracts in each State and is now beginning to roll out a pilot program of consumer education for Medicare eligibles. I don't know how well that will work, but I think it has the potential to be helpful.

There also needs to be, in general, a cost-benefit approach to treatment. It may be that the most expensive treatment has a 99-percent success rate and another treatment has a 98-percent success rate, but only costs half as much. We need to think whether we can always afford the most expensive method.

I think the real issue is health care delivery, not design of the plans themselves.

Mr. WROCKLAGE. I was going to comment that I think if you could create a system where there is a defined contribution for each

Medicare recipient, and then in a given community they saw the multiple options of the delivery systems, the widest to the most narrow, and there were quality service and satisfaction measurements, then that individual retiree could make a decision as to which health plan they want to choose, knowing that if they chose the more expensive health plan, the difference would become a cost to them.

I did not talk about a program that we have—that we are creating where we are trying to create an employer alliance, a purchasing alliance for health insurance where the employer would define their contributions and the individual employee would make a health plan choice much like they are doing in California for the small employer programs. And again, I think this incorporates the idea that an employer is paying the cost or a significant portion for a good plan, but then the employee is actually making the decision on the health care delivery system they want on their own. And if they want the more expensive option, I think they must realize that that is a cost that they have to bear. And if we could give them good quality and satisfaction and service information, I don't think this would be such a difficult decision for people to make.

Mr. ENSIGN. Mr. Wrocklage, you mentioned that half of your coalition covered lives or employees of small businesses, under 200 employees. How are you able to include these small businesses into your organization? Has this helped stabilize insurance coverage for small businesses in your region and has including small businesses in your coalition improved your purchasing power?

Mr. WROCKLAGE. We have done it because Wisconsin has a very high penetration of self-funded employers, even down to employers as small as 50, so a large number of our self-funded employers are premium from 50 to 200 lives, so they came into the program under the initial phase which was to serve self-funded employers.

Many small employers don't want to take that self-funding risk and so they look to insurance carriers, and what we did was find a contractual way to provide our network of hospital doctors and physicians to insurance carriers who wanted to offer it to small employers. And what we have done is taken almost two different segments, employers who are self-funded ranging from 50 to 6,000 and then also another group of employers who are looking for an insured product—and I gave you the numbers in my testimony—and we almost had—50 percent of our business is for people who need insurance and are less than 200 in size and work through insurance carriers.

But we are the negotiators for all of those people. We are their community representative when it comes to sitting at the table to bargain on quality and cost.

So, in effect, my large employers do believe that their buying power have been enhanced by the lives that are represented by the small employer, and the small employers see their buying power enhanced. And the interesting thing, they get access to the same doctor-hospital network and the same price per unit, and so there is not this cost-shifting from one segment of the population to the other.

Mr. ENSIGN. I would like to thank the panel.

We do have a vote. We will reconvene after the vote. Thank you.

[Recess.]

Mr. ENSIGN. I would like to call the panel forward: Jon R. Reiker, vice president for benefits, General Mills Restaurants, Inc., Orlando, FL; James P. Spence, senior manager, Corporate Insurance Benefits and Medical/Wellness Services, Storage Technology Corp., from Louisville, CO.

Mr. Reiker.

STATEMENT OF JON R. REIKER, VICE PRESIDENT FOR BENEFITS, GENERAL MILLS RESTAURANTS, INC., ORLANDO, FL

Mr. REIKER. Thank you. My name is Jon Reiker. I am vice president of benefits for General Mills Restaurants. I appreciate the opportunity to testify today regarding our company's demonstrated successes in using managed care programs, and principles to control health care costs and quality in our company and the communities in which we operate.

With more than 126,000 employees, General Mills is one of the 25 largest private-sector employers in the United States. Our restaurant operations—Red Lobster, the Olive Garden, and China Coast—employ over 115,000 workers in 49 States and in Canada.

Unlike many U.S. corporations, our employment has grown sharply. We have added 20,000 new jobs in the past 2 years and more than 60,000 new jobs since 1988. It has been critical to our continued growth that we find a way to offer high-quality, competitive benefit programs which are affordable to both the company and to our employees. The collective changes which I will cover in this testimony have resulted in a reduction in cost per participant of over 50 percent since the introduction of managed care in 1992.

These savings have been accomplished without any increase in employees' premiums or any cutback in benefits, and with a significant reduction in employees' out-of-pocket costs.

I think to fully understand the programs and the process of installing those, I need to give a little background. I can tell you, that our decision to venture into managed care was not an easy one. We felt strongly that health care should be bought on the basis of quality and not discounts and that long-term solutions would have to be based on outcomes.

We initially had concerns about the impact that managed care would have on our employees, the quality of their health care, and the logistics of a plan that could reach the majority of our 200-plus markets in which we operate. But like most companies in 1991, the promise of significant cost savings was a driving consideration.

Since 1986, we have been actively involved in an extensive and relatively successful war on the cost of health care benefits for both the employee and the company. Under the banner of "Teaming Up to Tackle Health Care Costs," General Mills Restaurants initiated steps based on a theme of shared responsibility and shared savings. The group health plan was simplified so participants could better understand how to use it. We introduced MediCALL, a program of company-employed registered nurses who serve as patient advocates, assisting employees through their health care encounters by providing health care education, arranging second opinions, and counseling on how to maximize the use of the benefit plans.

Surveys consistently indicated high satisfaction with MediCALL. It was seen as a nurse in the family. We benefited by having hands-on awareness of employee health care issues. We made some minor plan changes to improve and address problems and opportunities as they appeared. We put in automated health care data systems for patient tracking and reporting and, rewarded employees for discovering and correcting billing errors. We became fully self-insured and self-administered, got very involved in community and government reform efforts, but still all of that was not enough.

In 1991, we faced again double-digit health care inflation, and cost-shifting in the health care community caused further premium and expense increases. Holding the line had become almost impossible. It seemed that our employees and the plan were the last ones in America paying retail for health care services. So, in 1991, we joined the move to managed care.

The selection of our managed care partner was critical. We conducted a nationwide search of HMO and PPO programs along five criteria.

First was network coverage. With our broad expansion, we needed a program that could cover, we felt, at least 75 percent of our employees.

We wanted an emphasis on quality that was demonstrated by a strong commitment to measuring and ensuring the highest quality of care.

Projected cost savings: We had repriced the plans to make sure that savings would be there.

Utilization control, a strong retrospective review of network providers for utilization and billing patterns.

And a program that would be customer driven.

After careful review, we chose CAPP CARE Preferred Network as our managed care partner. To introduce the plan—and this is, I think, something that was significant—we employed what we would liken in the restaurant industry to a soft opening. Essentially, minimum changes were made to the benefit plan in the first year except to forgive a hospital admission deductible when an employee chose a CAPP CARE hospital. The emphasis was placed upon discussing the advantages for employees. This included referrals to providers that had been prescreened for quality, lower out-of-pocket expenses, and providers who would accept assignment of benefits with no upfront payment.

Initially, only about 15 percent of our employees chose the network providers. However, that demonstrated a higher satisfaction and lower costs than other employees.

Specific employee testimonials were shared with the message "think what would happen if everybody used CAPP CARE providers." Today our network coverage has grown to 90 percent through aggressive expansion.

Through the end of the first year of the partnership, over $3 million had been saved in reductions from billed charges, not to mention savings from improved utilization patterns. For the first time, there would be no increase in employee premiums. Basically, 4 years later, we are still in a position with no increase in employee premiums and reduced out-of-pocket expenses, as I mentioned; phy-

sicians are paid at the CAPP CARE rate, allowing full choice to employees, with them just paying the difference.

I have in the written testimony several other examples of ways that we have worked into the MediCALL program, but in summary, just let me say that we are convinced by actively managing an employee health care plan, you can accomplish the seemingly contrary goals of lower costs, improved quality, and increased satisfaction.

For General Mills Restaurants, managed care is more than selecting a network of providers, it is the blending of the highly personal touch of our MediCALL program and CAPP CARE's leading-edge practice guidelines and health information systems. It is incorporating eligibility and improved data reporting and coordinating the broad spectrum of care to address managed care opportunities presented by workers' compensation and disability. Perhaps most importantly, it is about giving employees the information and support they need to make good health care decisions within a managed framework of quality providers.

Thank you.

Mr. ENSIGN. Thank you, Mr. Reiker.

[The prepared statement follows:]

Testimony Of Jon R. Reiker

Vice-President, Benefits, General Mills Restaurants, Inc.

Committee on Ways And Means

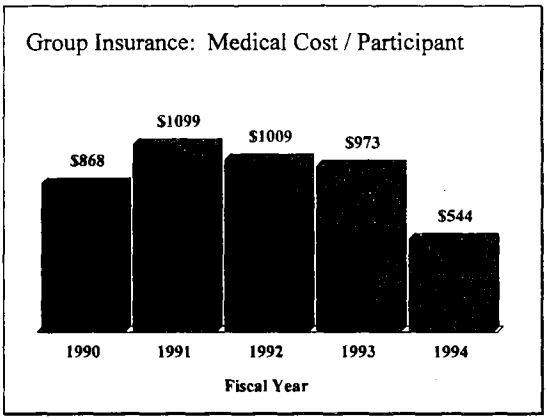
Subcommittee on Health

May 16, 1995

Introduction

Good Morning, Mr. Chairman; members of the subcommittee– my name is Jon Reiker. I am Vice President of Benefits for General Mills Restaurants. I appreciate the opportunity to testify regarding our company's demonstrated successes in using managed care programs and principles to control health care costs and quality in our company and in the communities in which we operate.

General Mills' Experience



General Mills Restaurants- Annual Medical Plan Expense / Participant

With more than 126,000 employees, General Mills is one of the 25 largest private-sector employers in the United States. Our restaurant operations (Red Lobster, The Olive Garden, and China Coast) employ over 115,000 workers in 49 states and Canada. Unlike many major U.S. corporations, our employment has grown sharply. We have added over 20,000 new jobs in the past two years and more than 60,000 new jobs since 1988. It has been critical to our continued growth that we find a way to offer high-quality, competitive benefit programs which are affordable both to the company and to our employees. The collective changes which I will cover in this testimony have resulted in a reduction in cost/per participant of over 50% since the introduction of managed care in 1992. These savings have been accomplished without any increase in employees' premiums or any cutbacks in benefits, and with a significant reduction in employees' out-of pocket costs.

Background

From 1986 to 1991, GMRI had waged an extensive, and relatively successful, war on the cost of health care benefits for both the employee and the company. Under the banner of "*Teaming Up to Tackle Health Care Costs*," GMRI initiated steps based on a theme of shared responsibility and shared savings. The group health plan was simplified so that participants could better understand how to use it. We introduced MediCALL - a program of company employed registered nurses to serve as patient advocates for our employees and their families. These nurses assisted employees through their health care encounters (hospitalizations, surgeries, births, etc.) by providing health care education, arranging second opinions, and counseling on how to maximize the use of the benefit plan. MediCALL has been very favorably perceived – like "having a nurse in the family." Surveys consistently indicated high satisfaction. The company benefitted by having a hands-on awareness of employee health

care issues. Plan design changes were made to address problems and opportunities as they appeared. Automated systems were created for patient tracking and reporting. Employees were rewarded for discovering and correcting billing errors. GMRI built heroes of those employees who by example conveyed the image of smart health care consumers. Eligibility and enrollment procedures were tightened. GMRI became fully self-insured and self-administered. Community and government reform efforts took on increased priority.

But it still wasn't enough! The cost shifting in the health care community caused further premium and expense increases, our previously stable insurance costs returned to double-digit inflation. Holding the line had become almost impossible. It seemed that our employees, and the plan, were the last ones in America paying "retail" for health care services. So, in 1991, GMRI joined the rush to managed care.

Our Move to Managed Care

I will tell you that our decision to venture into managed care was not an easy one. We initially had concerns about the impact it would have on our employees, the quality of their health care, and the logistics of a plan which could reach the majority of our 200 or more market areas. Philosophically, we favored outcomes management and quality improvement initiatives over discounted fees as long-term solutions. But like most companies in 1991, the promise of significant cost savings was a driving consideration.

The selection of our managed care partner was critical. We conducted a nationwide search of HMO and PPO programs along 5 criteria:

- Network Coverage -- Our target was to cover at least 75% of our covered employees with a commitment to meet expansion needs
- Emphasis on Quality -- Strong commitment to measuring and ensuring the highest quality of care through provider selection and contracting
- Projected cost savings -- A large sample of historic claims were "repriced" to estimate our potential savings under discount contracts
- Utilization control -- Strong retrospective review of network providers for utilization and billing patterns
- Customer Driven -- Open and enthusiastic response to the development of new programs and features.

After careful review, GMRI chose the CAPP CARE Preferred Network as our managed care partner. To introduce the plan, GMRI employed a soft-opening approach. Essentially, minimal changes were made to the benefit plan except to forgive a hospital admission deductible when an employee chose a CAPP CARE hospital. The emphasis was placed upon discussing the advantages for employees. These included:

- Referral to Providers screened for quality,
- Lower out-of-pocket expenses, and
- Providers who accept assignment of benefits with no up-front payment.

Initially, only 15% of the employees chose network providers. However, those that did enjoyed far higher satisfaction and lower costs than other employees. Specific employee testimonials were shared with the message "think what would happen if everyone used CAPP CARE providers!" After six months, an employee satisfaction survey found that those employees who used the network were over 90% satisfied- higher than those in non-network areas. CAPP CARE pursued an aggressive network development campaign to bring network providers to those areas where it didn't exist. GMRI prioritized the expansion plan.

As a result, more and more employees began benefiting from the availability of preferred providers. By the end of the first year of the partnership, over $3,000,000 had been saved from reductions from billed charges, with additional savings from improved utilization patterns. For the first time in many years, there would be no increase in employee premiums. Encouraged by these positive results, GMRI made plan changes to place stronger incentives for employees to choose CAPP CARE providers. Penalties were raised for out-of-network hospitals. Physicians were paid at the CAPP CARE preferred rate thereby allowing the employee to retain their choice of physician with the requirement that, if they charged more than the PPO rate, the employee would pay the difference. Videos featured employee testimonials on how easy it was to use CAPP CARE providers and how much employees and the company could save by doing so. Employees were counseled in how to recruit their physician into the network, assuming successful completion of the stringent credentialing requirements imposed by CAPP CARE.

Impact to Costs and Quality

As seen in the earlier chart, General Mills Restaurants, Inc. has reduced its employee medical insurance costs by over 50% through managed care initiatives. Improved data meant information was more readily available to take action correcting problem areas, and led us to additional opportunities to coordinate and improve each employee's continuum of care. Preferred provider networks, outsourced utilization review, automated practice guidelines, and the integration of workers' compensation and group health insurance have all been implemented since the partnership began in late 1991.

Perhaps most importantly, we are convinced that we are seeing better quality of care provided to our employees at a more affordable price. MediCALL provided an important cornerstone on which to build. CAPP CARE's full provider referral capability was outsourced to MediCALL. When an employee contacted MediCALL, they were counseled on the best way to maximize their benefit plan by using CAPP CARE providers. They were also informed of the financial impact of going to non-network providers. Employee satisfaction with the benefit plan has never been higher. Problem calls related to group insurance issues are on the decline. Claims administration has improved -- fewer pended claims, shorter turnaround times. MediCALL is better able to focus its major case management efforts on more patients than before.

CAPP CARE is well known as a leader in the development and use of practice guidelines. In keeping with a vision of electronic coordinated care, CAPP CARE and GMRI embarked on a project to blend their full practice guidelines and utilization review program with MediCALL's patient education, counseling and case management program. Nurses now interact with the physicians prior to services being provided. This proactive approach allows patients to receive the best quality care as defined by the highest medical standards. Procedures or services suspected of being unnecessary or questionable would be reviewed with the GMRI and CAPP CARE medical directors prior to being performed. All records were fully automated and individualized letters were distributed to the patient, physician and facility provider.

Finally, CAPP CARE provided a proprietary program called VIM (Volume and Intensity Management). Practice and billing patterns were analyzed for the purpose of ensuring consistently high-quality, cost-effective care. Savings were realized from reducing the number of unnecessary C-sections, increasing the number of patients diverted to outpatient services, and reducing the length of stay for several mental health diagnoses. Equally important was the identification of problem areas. Anything showing a loss or poorer performance than prior years became the focus for corrective action. Benefit plan enhancements or improved procedures were implemented to address these issues. Innovation requires continuous evaluation and improvement.

Recent Developments

Another opportunity existed to expand the impact of managed care. Our Workers' Compensation expenses were as large as those for health care. GMRI saw a clear opportunity to better integrate the functions of group health, workers' compensation and disability insurance. Liberty Mutual has joined with GMRI and CAPP CARE in a unique pilot project to extend the value of the managed care to workers' compensation. Liberty Mutual, our workers' compensation carrier, will provide a registered nurse in the MediCALL program to assist restaurant managers in referring injured workers to CAPP CARE preferred providers. The nurse will work closely with store management to ensure the injured employee receives the most appropriate high quality treatment. The goal is to manage the medical treatment of the diagnosed condition until the employee can return to full productivity

CAPP CARE has proven the transportability of these new products - Outsourced UR and Workers Comp Provider Network - by providing them to other high profile customers such as Adolph Coors, Inc., Flagstar Restaurants and Accordia National.

The Future

Looking to the future, CAPP CARE is in the forefront of the practice guideline initiative. This year, physicians in the Orlando, Florida (home of GMRI) and Orange County California markets will serve as beta sites to begin using highly sophisticated, hand-held data managers in the day-to-day operation of their offices. These devices contain the practice guidelines and allow the physician to assure total quality of care without the level of outside intervention currently required. The Physician will be able to diagnose, prescribe treatment, make a referral, write a

prescription (if necessary), file notes to the medical record and even bill the payer -- all electronically. We view such initiatives as the inevitable future of managed care.

In Summary

We are now convinced that by actively and continuously managing an employee health care plan, you can accomplish the seemingly contrary goals of lower costs, improved quality, and increased satisfaction. For General Mills Restaurants, managed care is more than selecting a network of providers. It's the blending the highly personal touch of our own MediCALL program with CAPP CARE's leading edge practice guidelines and health information systems. It means coordinating the broad spectrum of health care from initial eligibility through claims administration and large case management to workers' compensation and COBRA. Perhaps ultimately, it is about giving employees the information and support they need, at precisely the moment they need it, to make good health care choices -- within a managed framework of quality plans and providers.

Mr. ENSIGN. Mr. Spence.

STATEMENT OF JAMES P. SPENCE, SENIOR MANAGER, CORPORATE INSURANCE BENEFITS AND MEDICAL/WELLNESS SERVICES, STORAGE TECHNOLOGY CORP., LOUISVILLE, CO

Mr. SPENCE. My name is Jim Spence. I am senior manager for corporate insurance benefits and medical/wellness services for Storage Technology Corp. I also want to mention I am a graduate of Johns Hopkins Medical School, as a physician's assistant, so I have 15 years of medical experience as well as seeing both sides of the coin from the benefits perspective.

Storage Technology is a high-tech firm that manufactures computer data storage. We employ 11,000 worldwide, 9,000 domestically, and 6,500 at corporate headquarters in Louisville, CO.

We are self-insured and introduced our managed care program in 1990, primarily to attempt to curb the rapid rise in our medical costs. Since 1990, we have offered two managed care programs to employees. We have also offered a traditional indemnity plan only where managed care networks do not exist.

The first program is a preferred provider organization, or PPO. This program offers a network of providers that have agreed to negotiated rates for services. Employees have the option of going in network or out of network, but with higher deductibles, higher out-of-pocket maximums, and a significantly reduced reimbursement level.

The second program is an exclusive provider program [EPO's]. This is similar in structure to an HMO with funding slightly different. EPO utilizes primary care providers as gatekeepers. Employees must first see their gatekeeper and receive a referral prior to seeing a specialist. Employees' expenses are covered 100 percent in this plan with no deductible. There is no coverage for care provided outside of the EPO network. And our indemnity plan is a traditional plan with 80/20 coverage.

Employee premiums are the same for the EPO product as they are for the premier PPO product. Premiums have only increased 5-percent since 1990.

Prior to introduction of our managed care plans, our total medical costs rose 11 percent in 1988 and 46 percent in 1989. With implementation of our managed care program, 1990 saw a 5-percent decrease in total medical costs. Between 1990 and 1994, our total medical costs have averaged a decrease of 2 percent per year. During this time, our population has remained relatively constant.

On the other hand, our indemnity plan has increased 11 percent a year since 1991.

As we continue to manage our costs, we are convinced that managed care is a long-term solution for the present as well as the future. We also believe that managed care is effective in controlling our medical costs without sacrificing quality of care.

Why have we been successful in controlling the meteoric rise in medical costs? I believe the reasons are threefold.

One, managed care: Managed care has clearly been the most important factor in bringing our costs under control. We have offered the PPO plan, as well as the EPO plan, and 65 percent of our employees have enrolled in the PPO plan, which is less restrictive but

at a higher cost both to the company as well as the employee; 35 percent in an EPO; and less than 1 percent in the indemnity plan. The EPO, which has tighter management controls, has kept the annual benefits paid per employee at an average of $2,600, while the PPO benefits paid per employee is averaging $2,900.

Although less expensive, we have not made great efforts to drive employees into the EPO plan. This is due to employee surveys showing that employees like some flexibility and have made efforts to receive their care in network and have been excellent consumers in controlling their health care costs.

STK, Storage Technology, views managed care as a four-legged platform. The legs are comprised of the employer, employees, providers, and a third-party administrator. And the platform itself is quality medical care. We feel that each leg must communicate with the other legs in order to be successful.

For this reason, the benefits department meets regularly with the employees through focus groups to understand their needs and satisfactions with the program. We meet frequently with Aetna, our third-party administrator, as well as with our highly utilized hospitals and provider groups. In these meetings, we discuss concerns, exchange data on utilization and costs, and develop strategies to address issues. By doing this, we feel that each party understands clearly where the other legs of the platform are focused.

As an example of this, we noted in 1991 that our largest medical expense was in pregnancy and childbirth. We met with two of the local hospitals to ask how they would help us control costs and assure us a high quality of care for our members in this area. Their response was to enhance their facilities in birthing centers, provide an educational program for pre- and postnatal care, and they participated in successful negotiations with us to provide package rates for their services. We believe this occurred because we developed an open dialog and were able to create a partnership with them in responding to our needs.

Another advantage of managed care is the ability to provide cost control measures while assuring that quality care is being delivered. As an example, the chronic passive motion machine is somewhat new technology that orthopedists use frequently on their patients after knee and hip surgery. Studies have shown that there is no advantage to using this machine over standard physical therapy and has no effect on improving outcomes. For this reason, we provide only very limited coverage.

Another example is autologous bone marrow transplant for end-stage metastatic breast cancer. We have an employee who requested this therapy, which was controversial at the time. Aetna worked with us in evaluating this last-effort treatment for efficacy. Though very experimental and risky, in an attempt to save this woman's life, treatment was approved. She underwent the treatment 4 years ago and is currently still employed as an engineer at Storage Technology.

Other advantages to network care are the ability to perform case management on high-cost, complicated claims and utilizing centers of excellence that can control costs while delivering the highest quality of care.

Employees are another key to controlling our costs. We have done extensive communication and education programs to develop our employees into wise medical care consumers. After having delivered these programs to employees, we are focusing on incentives that motivate them to be good consumers. We do this through paying them one-half the savings they find in hospital billing errors and by reporting fraud. We are currently looking at paying the employees a retrospective dividend of $100 as a way of saying thanks for actively working to control medical expenses.

Evidence that our employees are wise consumers is shown by the average number of outpatient visits but significantly lower inpatient admissions and lengths of stay than expected. This is what we call the worried well syndrome. Our plan members go to the doctor often but generally for mild problems or early-stage symptoms. We have encouraged employee usage of outpatient care because it reduces our costs through early treatment intervention and greater protection against the higher cost claims of hospitalization. This appears to be effective, shown by the low hospital usage.

In 1990, our inpatient psychiatric admissions were twice the expected rate as was the length of stay. Mental health was our second most expensive category of care. The benefits department met with our employee assistance program to provide us with a plan that would bring these costs under control. We communicated these changes to employees. The plan changes increased accessibility of outpatient mental health, increased the number of covered visits by placing a liberal cap on charges per member per year, and negotiated rates with providers and encouraged members to seek help whenever needed. We also put very restrictive coverage for inpatient care and limited it to 14 days in most cases. This change fell in line with our philosophy and that of the AMA that 75 percent of all diseases are stress related and that if focus is placed on dealing with this stress at an early stage, morbidity would be significantly reduced, thus reducing the higher cost claims.

Employees have viewed this as a positive step and have taken advantage of this coverage. Since making this change, the plan has saved over $250,000 per year.

In 1994, an employee survey showed a 94 percent satisfaction rating on their health and welfare benefits. This satisfaction rating has remained consistent since 1992. This level of satisfaction has not always been the case. Implementing managed care in 1990 was not without its travails and anguish. Employees were upset with the loss of total freedom of choice they had with indemnity, were confused about the regulations of managed care and wanted grandfather clauses for their care. In some cases, we did grandfather mental health and maternity indemnity coverage for one year. Our communication program continued through these trying times, and by 1992, most of the angst had passed and employee satisfaction quickly soared.

Is it okay to continue or do you want me to stop?

Mr. ENSIGN. That is fine. The rest of your written statement will be included in the record.

[The prepared statement and attachments follow:]

TESTIMONY OF JAMES P. SPENCE
STORAGE TECHNOLOGY CORPORATION

Storage Technology Corporation (STK) is a high tech firm that manufactures computer data storage. STK employs 11,000 worldwide, 9,000 domestically and 6,500 at corporate headquarters in Louisville, Colorado.

We are self-insured and introduced our managed care program in 1990, primarily to attempt to curb the rapid rise in our medical costs. Since 1990 we have offered two managed care programs to employees. We also offer a traditional indemnity plan only where managed care networks do not exist . The first program is a preferred provider organization (PPO). This program offers a network of providers that have agreed to negotiated rates for services. Employees have the option of going in network or out of the network but with higher deductibles, higher out of pocket maximums and a significantly reduced reimbursement level. The second program is an exclusive provider program (EPO), this is similar in structure to an HMO. The EPO utilizes primary care providers as "gatekeepers". Employees must first see their gatekeeper and receive a referral prior to seeing a specialist. Employees expenses are covered at 100% with no deductible. There is no coverage for care provided outside of the EPO network. The indemnity plan is a traditional plan with 80/20 coverage. Employee premiums are the same for the EPO product and the premier PPO plan. Premiums have only increased 5% since 1990. Prior to introduction of our managed care plans our total medical costs rose 11% in 1988, and 46% in 1989. With implementation of our managed care program, 1990 saw a 5% decrease in total medical costs. Between 1990 and 1994 our total medical costs have averaged a decrease of 2% per year. During this time our population has remained relatively constant (see chart #1). On the other hand, our indemnity plan has increased 11% a year since 1991. As we continue to manage our costs, we are convinced that managed care is a long term solution for the present as well as the future. We also believe that managed care is effective in controlling our medical costs without sacrificing quality of care.

Why have we been successful in controlling the meteoric rise in medical costs? I believe the reasons are three-fold:

1. Managed Care- Managed care has clearly been the most important factor in bringing our costs under control. We offer a preferred provider organization (PPO) and an exclusive provider organization (EPO) which is similar in coverage to an HMO. We have 65% of our employees enrolled in the PPO which is less restrictive but at a higher cost, 35% in the EPO and less than 1% in the indemnity plan. The EPO, which has tighter managed controls, has kept the annual benefits paid per employee at an average of $2,600 while the PPO benefits paid per employee is averaging $2,900 (see chart #2 and #4). Although less expensive, we have not made great efforts to drive employees into the EPO plan. This is due to employee surveys showing us that employees like some flexibility in choosing providers, have made efforts to receive their care in network, and have been excellent consumers in controlling their health care costs.

In the EPO network- 98.4% of members utilized network providers for office visits
99.1% of members utilized network hospitals for inpatient care

In the PPO network- 75% of members utilized network providers for office visits
87% of members utilized network hospitals for inpatient care

STK views managed care as a four-legged platform. The legs are comprised of the employer, employees, providers and a third party administrator and the platform itself is quality medical care. We feel that each leg must communicate with the other legs in order to be successful. For this reason, the benefits department meets regularly with the employees through focus groups to understand their needs and satisfaction with the programs. We meet frequently with Aetna, our third party administrator, as well as with our highly utilized hospitals and provider groups. In these meetings we discuss concerns, exchange data on utilization and costs and develop strategies to address issues. By doing this we feel that each party understands clearly where the other "legs of the platform" are focused. As an example of this, we noted in 1991-92 that our largest medical expense was in pregnancy and childbirth. We met with two of the local hospitals to ask how they could help us control expenses and assure us a high quality of care for our members in this area. Their response was to enhance their facilities into birthing centers, provide an educational program for pre- and post-natal care and they participated in successful negotiations with us to provide package rates for their services. We believe this occurred because we developed an open dialogue and were able to create a partnership with them in responding to our needs.

Another advantage of managed care is the ability to provide cost control measures while assuring that quality of care is being delivered. As an example, the chronic passive motion machine is somewhat new technology that orthopedists use frequently on their patients after knee and hip surgery. Studies have shown that there is no advantage to using this machine over standard physical therapy and has no effect on improving outcomes; for this reason we provide only very limited coverage. Another example is autologous bone marrow transplant for end stage metastatic breast cancer. We have an employee who requested this therapy, which was controversial at the time. Aetna worked with us in evaluating this last effort treatment for efficacy. Though very expensive ($250,000) and risky, it appeared to be a plausible treatment and, in an attempt to save this woman's life, treatment was approved. She underwent the treatment four years ago and is currently still employed as an engineer at STK. Other advantages to network care are the ability to perform case management on high cost, complicated claims and utilizing centers of excellence that can control costs while delivering the highest quality of care for specific cases.

2. Employees control our costs and are our customers.

Employees are another key to controlling our costs. We have done extensive communication and education programs to develop our employees into wise medical care consumers. After having delivered these programs to employees we are now focusing on incentives that motivate them to be good consumers. We do this through paying them one-half the savings they find in hospital billing errors and by reporting fraud. We are currently looking at paying the employees a "retrospective dividend" of $100, as a way of saying thanks for actively working to control medical expenses.

As evidence that our employees are wise consumers is shown by the average number of outpatient visits but significantly lower inpatient admissions and lengths of stay than expected(see chart #3). This is what we call the "worried well" syndrome. Our plan members go to the doctor often but generally for mild problems or early stage symptoms. We have encouraged employee usage of outpatient care because it reduces our costs through early treatment intervention and greater protection against the higher cost claims of hospitalization. This appears to be an effective strategy as shown by the low hospital usage.

In 1990 our inpatient psychiatric admissions were twice the expected rate as was the length of stay. Mental health was our second most expensive category of care. The benefits department met with our Employee Assistance Program providers to develop a plan that would bring these costs back under control. We then communicated these plan changes to employees. The plan changes increased accessibility of outpatient mental health, increased the number of covered visits by placing a liberal cap on charges per member per year and negotiated rates with providers and encouraged members to seek help whenever needed. We also put very restrictive coverage for inpatient care and limited it to 14 days for most cases. This change fell in line with our philosophy (and that of the AMA) that 75% of all diseases are stress related and that if focus is placed on dealing with this stress at an early stage, morbidity would be significantly reduced thus reducing the higher cost claims. Employees viewed this as a positive step and have taken advantage of this coverage. Since making this change the plan has saved over $250,000 per year.

A 1994 employee survey showed a 94% satisfaction rating of their health and welfare benefits. This satisfaction rating has remained consistent since 1992. This level of satisfaction has not always been the case. Implementing managed care in 1990 was not without its travails and anguish. Employees were upset with the loss of total freedom of choice they had with indemnity, were confused about the regulations of managed care and wanted grandfather clauses for their care. In some cases, we did grandfather mental health and maternity indemnity coverage for one year. Our communication program continued through these trying times and by 1992 most of the angst had passed and employee satisfaction quickly soared.

3. In-house services are another facet that have helped to keep our costs under control. Headquarters has an on-site wellness facility that contains a 50,000 sq. ft. fitness facility, a fully staffed medical clinic and a day-care center for 80 children. The fitness facility has a utilization of over 7,500 participants a month. We track these utilizers and in the future plan to correlate medical costs of utilizers versus non-users. The medical clinic offers acute care, treatment of workers compensation injuries, emergency care, physical therapy, EAP, dental hygiene, lab and xray, as well as preventive services. The clinic provides substantial savings to the medical plan of over $1,000,000 per year. There is no charge to employees who use the clinic.

STK firmly believes that prevention and early intervention have played a significant role in controlling our medical expenses. The wellness, benefits and medical staff have developed incentives for employees to follow preventive health guidelines. As an example, our WellFlex program consists of a health risk assessment, a medical screening, a medical exam that is age appropriate, and wellness counseling. Employees can sign up for this program during the yearly benefit plan enrollment. If they agree to participate in this program, not smoke and wear their seat belts, STK will pay them $152/year. We have a 93% participation rate in this program. Through the health screen we have detected numerous silent disease processes in participants and referred them for further care. From this program we have also determined that 30% of our population have elevated lipid levels that put them at risk for cardiovascular disease. We have developed wellness programs to help employees address concerns such as this in hopes of preventing future problems that are preventable now. Again, we believe that patient education, early intervention and prevention are some of the keys to controlling patient morbidity and controlling costs.

Another wellness success story is our stop smoking program. In 1989 approximately 35% of our employees smoked. The present and future costs to the plan by increased utilization from this population were substantial, though not measured. The wellness and medical departments implemented free stop smoking programs to employees and spouses. This included distributing stop smoking patches through the medical clinic, three different types of stop smoking classes through the wellness department and ongoing group support of ex-smokers. Today only 11% of our population are smokers.

What can Medicare learn from this?

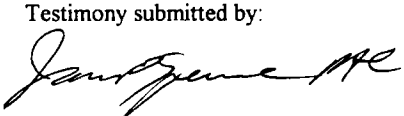
We feel we have been successful because we have empowered, motivated and provided incentives for our employees to be smart consumers of medical care in controlling costs. Given that the Medicare program has been projected to become insolvent by 2002, an important factor is to recognize the significance plan participants play in controlling costs. Any plan redesign needs to include incentives and consumer education to effectively motivate participants to manage costs.

Preventive services, early detection programs and utilization of these services should help control costs, particularly in the Medicare age population which has a significant screening yield rate.

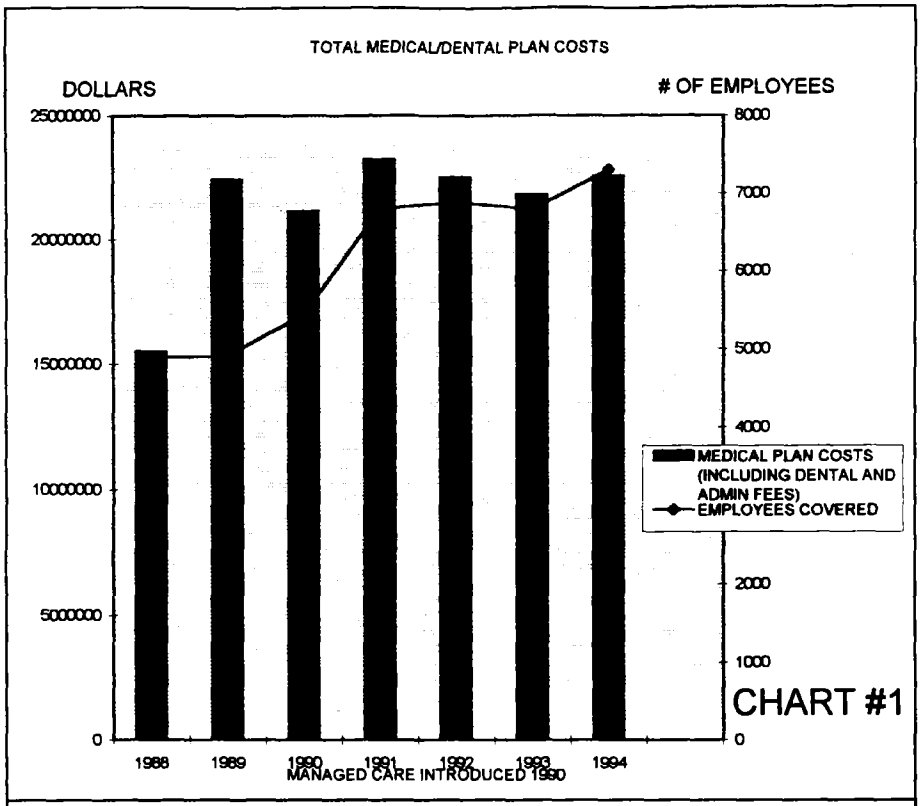
Our experience has been that the marketplace will quickly adapt to changes in enrollees' coverage while continuing to meet the needs of plan participants within the greater accountability of managed care. Enrollees may feel a loss of freedom as the program is implemented but will reasonably adjust in short order.

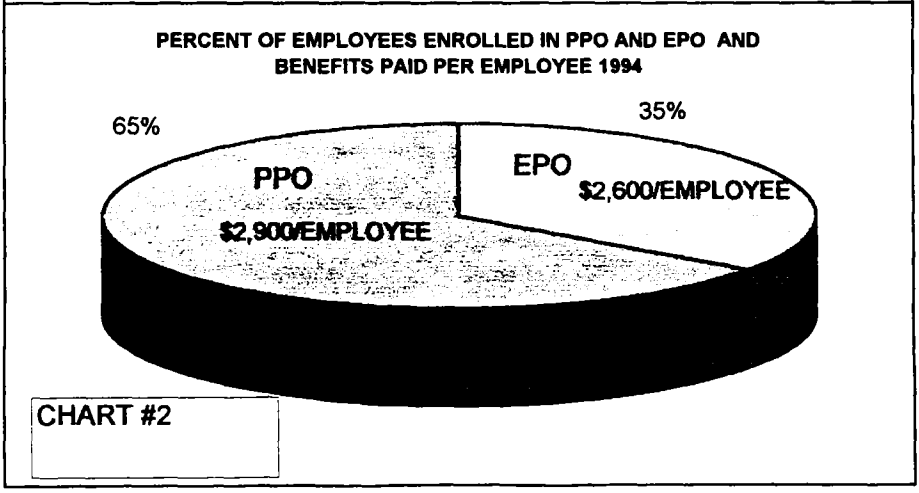
We have experienced little evidence that quality of care is hampered by managed care. In fact, most studies have shown that quality of care is improved with managed care. There is some evidence that unnecessary care is limited and controlled while preventive and early intervention care is greatly enhanced. You will hear the argument that quality of care is sacrificed due to cost controls. In reality, managed care has had to show accountability and proof of the effectiveness in delivery of medical care and treatment regimen efficacy. The outcome of this has been an impressive improvement in assessing and measuring clinic outcomes. This clearly benefits all "legs" of the "quality medical care platform". STK firmly believes managed care will provide us the means to keep our employees and their families at the top of the platform.

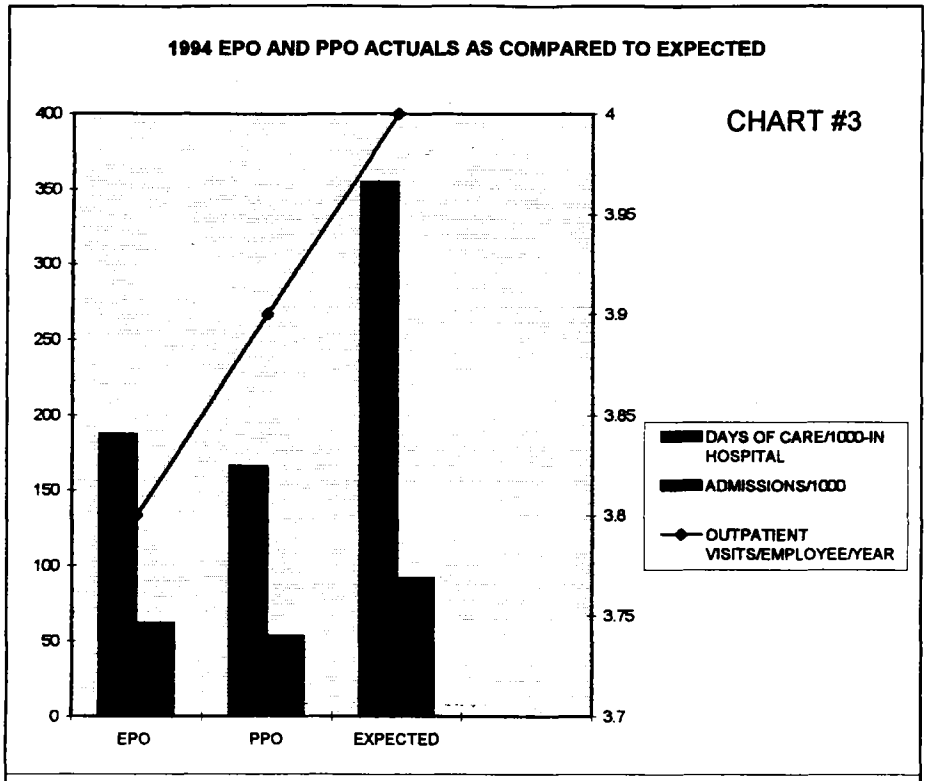
Testimony submitted by:

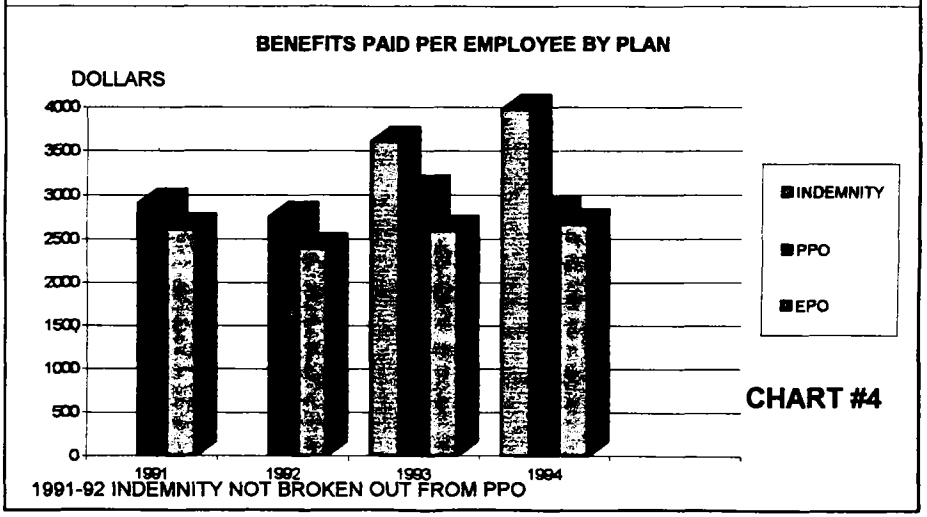


James P. Spence P.A.-C.
Senior Manager
Corporate Insurance Benefits &
Medical/Wellness Services
Storage Technology Corporation
2270 S. 88th St.
Louisville, Colorado 80028-0030
(303) 673-5314
Fax- (303) 673-4049


TOTAL MEDICAL/DENTAL PLAN COSTS
DOLLARS
OF EMPLOYEES
25000000
20000000
15000000
10000000
5000000
0
8000
7000
6000
5000
4000
2000
1000
0
MEDICAL PLAN COSTS (INCLUDING DENTAL AND ADMIN FEES)
EMPLOYEES COVERED
1988
1989
1990
1991
1992
1993
1994
MANAGED CARE INTRODUCED 1990
CHART #1


PERCENT OF EMPLOYEES ENROLLED IN PPO AND EPO AND BENEFITS PAID PER EMPLOYEE 1994
65%
35%
PPO
$2,900/EMPLOYEE
EPO
$2,600/EMPLOYEE
CHART #2


1994 EPO AND PPO ACTUALS AS COMPARED TO EXPECTED
CHART #3
400
350
300
250
200
150
100
50
0
4
3.95
3.9
3.85
3.8
3.75
3.7
EPO
PPO
EXPECTED
DAYS OF CARE/1000-IN HOSPITAL
ADMISSIONS/1000
OUTPATIENT VISITS/EMPLOYEE/YEAR


BENEFITS PAID PER EMPLOYEE BY PLAN
DOLLARS
4000
3500
3000
2500
2000
1500
1000
500
0
1991
1992
1993
1994
INDEMNITY
PPO
EPO
CHART #4
1991-92 INDEMNITY NOT BROKEN OUT FROM PPO

Mr. ENSIGN. Just a couple of quick questions. We do have another vote, and so we will wrap this hearing up.

But being from the private sector myself, I have gone through these same changes. What was your experience and did you survey your employees as far as satisfaction with their health care coverage before these changes and after these changes, especially the managed care changes?

Mr. REIKER. We have been continuously surveying our employees for the past 5 years. And probably we had a little blip of negative response when we went to the harder approach—with the disincentives. But since we have used the soft opening approach the first year without disincentives, it wasn't very great and that went away, I would say, within the first 2 months.

We encouraged employees to have their physicians petition for membership within the network. We provided them the forms to do that. We would facilitate that where possible, made it as easy as possible. We gave them the choice to stay with their physician and just pay the difference. So it really quickly rebounded to the prechange levels, and in fact it is higher now than it ever was before.

Mr. ENSIGN. To follow that up to apply to Medicare, you know, the testimony, and you hear this all the time, is educating seniors; and both companies sound like they went through extensive communications efforts and education efforts of your employees——

Mr. SPENCE. Absolutely.

Mr. ENSIGN [continued]. To try to educate seniors on some of the benefits, some of the ways that this is actually going to be better for them than worse for them. Do you see that as the soft approach maybe the first year and the disincentives the second, third, or fourth year, whatever it is?

Mr. SPENCE. I think so, and I think the option, or one the things that you can do, that didn't make sense because of how we work, was to offer a choice of plans. We needed to put our eggs all in one basket, if you will, and so we chose only one plan. But I think to provide the seniors with a choice of plans and the ability to get their doctors to enroll in those plans; if they wanted them, let them continue to choose providers, but if they go outside, they pay the difference.

That took away all the opposition that we had; it seemed eminently fair. So I would say that to offer the choice, to educate them about the differences, I think is very valuable.

Mr. ENSIGN. One last quick question—maybe both of you could comment on it, because you both mentioned something that the Speaker has mentioned about giving seniors incentives for errors in billing or fraud as far as financial rewards. Do you have any statistics on how successful that was?

Obviously, it is well received by the employees, I am sure, but do you have any dollar amounts or anything?

Mr. SPENCE. It is not very significant from a dollar standpoint. I would say we have rewarded less than $150,000 in savings since the beginning of the plan and that is based on $50 million a year in claims. But if you used those stories in your communication, you build heroes out of those people, you get far more in terms of active consumers and people really watching the bills. And I have talked

to a lot of employers, and that has been their experience; you get few significant savings, but it really does heighten awareness.

Mr. REIKER. In terms of fraud and hospital billing errors, it has been very insignificant. I think we provide the incentives for employees to actively participate as health care consumers, and I think that has been much more successful and has greater cost savings.

Mr. SPENCE. We have put in some very sophisticated billing errors or billing problem checks, clinical logic in our claims system volume, and intensity management in our PPO system, so we pick up a lot there and refuse them, which are much more sophisticated than employees; and employees are more of a public relations thing.

Mr. ENSIGN. The reason I brought that up is because you hear that there is so much fraud in Medicare, that there are gross abuses. That is controversial. Some people think it is a very small percentage and the amount of saving that we could get with these incentives to seniors; I think I would tend to agree more with you that it will be more of a show that they actually have something to save the government and themselves money as far as the buy-in to some of these new techniques that will save us a lot more money.

I thank you both for your testimony. It was excellent.

[Whereupon, at 12:15 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Coalition of Mental Health Professionals and Consumers, Inc.
P. O. Box 438, Commack, NY 11725 Phone/Fax: 516-424-5232

Testimony

Karen Shore, Ph.D., Executive Director
1966 Ashley Place, Westbury, NY 11590
516-997-3390

A) Introduction:

I am submitting testimony on behalf of the Coalition's approximately 1250 members. The Coalition is a national, grass-roots organization, made up of clinicians from all mental health disciplines and consumers of mental health care, their family members, and their advocates. The Coalition is working with approximately 24 regional "affiliated groups" that have no legal tie to the Coalition, though some have taken out memberships. Thus, I am not officially testifying for these groups, but do want the Subcommittee to know that several of these groups are state or regional Coalitions (MA, NY, NJ, PA, DE, MD, NC, GA, TN, IL, OH, CO, CA, WA, MO) that have been inspired by our Coalition or that formed prior to our forming (November, 1992), have similar goals, and are attempting to work together. Each of these groups may have dozens, hundreds, or thousands of members.

I am testifying because of plans to increase the number of Medicare beneficiaries to be enrolled in HMO's and other forms of managed care. The Coalition formed specifically because of the decline in quality of mental health treatment brought by managed care organizations (MCO's). MCO's also have a strong impact on the ability of professionals to deliver proper care. The problems of managed care have the most impact on beneficiaries who need treatment, as opposed to those who are generally healthy. Thus, a larger percentage of the Medicare population covered by MCO's than of the general MCO population will experience these problems, as our elderly generally require more treatment than does the general population.

In this testimony, I will outline the problems we have seen in delivery of services under MCO's in the private sector and will offer recommendations. We cannot assume that Medicare beneficiaries will receive better care under MCO's than those in the private sector.

B) Problems with Managed Mental Health Care for Consumers and Providers:

1. Citizens lose the right to freely choose clinicians and treatment facilities.

a) MCO's increasingly limit their provider list to providers who demonstrate a willingness to perform short-term treatment, whether or not it is truly appropriate, and on their willingness to do so without complaint. Thus, the pool of providers available to the consumer may exclude those who would perform or advocate for quality care.

b) Primary care providers often must act as gatekeepers and may limit access to psychiatrists and to psychotherapists. Often, there are financial penalties if primary care providers make "too many" referrals. Corporate profits are often more important than the consumer and treatment. Primary care physicians are asked to do "counseling," but do not have the training to do real psychotherapy.

c) MCO panel limitations often cause the consumer to travel a great distance for their care, which could be especially burdensome for the elderly, and may prevent needed care.

d) Consumers may have to change clinicians often as plans drop providers and merge with other MCO's, or as the consumer changes health plan. Continuity of care and the building of trust in the clinician are impeded. Continuity of care and trust may be particularly important for the elderly, who often are more in need of ongoing treatment than the general population.

e) Clinicians are impeded in their ability to make the best referral possible due to panel restrictions preventing them from referring "out-of-network."

f) Generally, psychiatrists and other doctoral-level clinicians, and even master's level clinicians, may be prevented from performing psychotherapy by MCO's, as MCO's often search for the "cheapest" clinicians. One MCO reportedly has begun using bachelor's level counselors rather than professionally trained master's and doctoral level professionals. When beneficiaries cannot receive reimbursement for treatment by clinicians with advanced training, quality of care is compromised.

g) Patients hospitalized in a non-network hospital in an emergency may be forcibly transferred to a network hospital before they are well, impeding recovery and possibly increasing symptoms.

h) Even if the MCO offers out-of-network benefits (Point-of-Service Option), consumers with limited incomes may be unable to access out-of-network providers, as they are financially penalized for doing so. This may affect the elderly in large proportions due to the large percentage on limited incomes.

2. Patients lose the right to make their own treatment decisions.

a) The MCO may pre-determine that all or most patients are to receive brief hospitalizations and brief, crisis-focused psychotherapy, regardless of patients need. This is based on decisions about money, not treatment and consumer need.

b) The MCO often requires reports from the treating clinician and then takes over treatment decisions. The patient and his/her clinician may be powerless to decide the course of treatment. The sense of powerlessness and the prevention of access to proper treatment may increase a patient's symptoms, especially depression and anxiety. Hospitalization or intensive psychotherapy for a particular patient may be declared "not medically necessary," even though the standards of practice in the professions would clearly show the need for treatment.

c) What is "medically necessary" varies from one MCO to another, as it generally has more to do with costs than with care.

d) Many MCO's will only authorize three or four psychotherapy sessions at a time, leaving the beneficiary and provider unable to know how long their work will be able to continue. Anxiety often rises before each "approval" and session time is often spent on discussing the MCO, rather than on the problem for which the patient sought treatment.

e) Some MCO's deny funds for psychotherapy if the patient refuses medication. This is because medication may produce a fast relief of symptoms, even though it may actually fail to correct the actual problem. This then allows the MCO to discharge the patient without investing much money. In general, there is concern that too many of our elderly are already over-medicated. Often, they are considered too old to make changes and not good candidates for psychotherapy, which is not necessarily true. This puts the elderly at increased risk of over-medication. Further, there is a bias among some physicians and scientists toward medication and away from "talk therapies," but this may reflect little more than an honest bias and the difficulty of forcing "talk therapy" into the molds of empirical science. Patients may have a strong need to talk out their problems, yet their voices do not count under managed care.

3. Consumers lose the right to privacy under managed care.

Because reports must be submitted to the MCO by the provider in order for the MCO to determine whether or not continuing care is "necessary," information that should not leave the treatment room must be given to the MCO, which may store it in their data banks. Psychotherapy patients often require privacy over information involving personal problems. Many consumers are not at all comfortable allowing such information to be divulged, but may have to sacrifice reimbursement if they withhold this information. Under Medicare, psychotherapy providers are not permitted to treat beneficiaries outside the plan. Thus, those requiring privacy or those with paranoid conditions may be forced to forego needed treatment due to inappropriate cost-containment techniques that may be suited to "industry," but not to human services.

4. MCO's may be grossly under-treating consumers of mental health care due to cost-containment. Because it is illegal for psychotherapists to provide treatment for Medicare beneficiaries outside of Medicare, those consumers who need treatment beyond what the MCO dictates may be prevented from legally obtaining needed services.

a) Many MCO's provide a grossly inadequate model of "short-term therapy," "solution-oriented therapy," "crisis intervention," or "stabilization," or they may state that they only treat the "acute phase" of a problem, refusing to pay for proper treatment for "chronic" or "ongoing" problems. This is a standard that would never be tolerated in medical care, and should not be tolerated in mental health care. Examples of MCO literature stating these limits can be provided to the reader.

b) Many patients need time to build trust in the clinician and to tell their story. Patience and understanding from the clinician are as necessary as advice. The clinician needs to spend enough time with the patient in order to know if the problem goes deeper than the surface "presenting problem." These things are too often impossible under managed care.

c) MCO's are misusing research data by not speaking to the limits of the research in order to support their bias toward short-term treatment.

d) Even though the literature in many MCO plans may state that beneficiaries may have "up to 20 sessions" in a year, often times the companies' reviewers are told never to allow more than a few sessions (see vignettes), or providers are warned that if they average more than a few sessions per patient, they will be ejected from the panel or refused further referrals. Thus, the provider may be too afraid to give the consumer the treatment that is needed.

e) A recent Harvard study (James Hegarty, MD, at McLean Hospital, Boston, as reported in *Newsday*, "Study: Managed-Care Squeezes Hospital Stay," 5/24/95) showed that there has been a dramatic increase in re-hospitalizations of psychiatric patients under managed care due to premature discharges. The average length of stay (LOS) at McLean in 1989 was 45 days. By 1994, due to managed care, the average LOS was 15 days. There was a concomitant increase in the number of people readmitted within a month, from 0% in 1989 to 21% in 1994, and an increase in patients who were minimally improved or worse at discharge than at admission, from 4% to 18%.

f) The industry is ignoring 100 years of development in the field of psychotherapy and is creating standards for treatment that are *substandard*.

5. Many managed care provider contracts contain "non-disparagement clauses," prohibiting the provider from saying anything negative about the managed care company to the patient or anyone else, often preventing providers from making the consumer aware that he/she is not receiving proper care.

Consumers are prevented from accessing professionals who follow their ethics and refuse to sign such agreements, as these providers will not be included on the MCO's panel. Also, this can mean that if a panel provider believes that the MCO's recommendations would be harmful to the patient, the provider may not tell this to the beneficiary. The consumer should have the right to know his/her provider's opinions of treatment decisions made by the MCO, especially if the provider believes that the MCO's decision is not in the patient's best interests. Also, these clauses prevent managed care abuses from reaching the press and legislators.

6. Patients may find that they must fight for benefits when they are ill, when their energy should be spent on getting well.

Patients never know whether or not their treatment will be covered until they become ill. Since providers may be at risk if they advocate for the consumer, this leaves consumers often having to spend their energy on advocating for themselves when needed treatment is being denied. Patients who do not have the ability, self-confidence, or energy to advocate for themselves may be seriously under-treated. Often, mental health patients are too derpressed, anxious, or too humiliated by their problems to advocate for themselves. With providers being at risk for unemployment if they advocate for their patients, there may be no one left to advocate for the elderly patient, especially if family is uninvolved or lives far away.

7. Under managed care, many providers fear doing what is right for the patient, putting the consumer at risk.

Since the MCO's now decide which providers will be able to continue working, many have been frightened into silence. Many feel too powerless to protest poor treatment of consumers to the MCO, the press, or to their legislators. When New York State's Assembly held hearings on managed care in January, 1994, several providers told me they were too afraid of being identified by the MCO's to testify. Their fear was that they would be ejected from the networks, refused referrals, or that their patients would be refused future sessions. These very real threats put the consumer at risk, especially in mental health, where patients usually do not advocate for themselves, and especially with the elderly patient, who may not be able to advocate for him/herself.

8. Quality and quantity of care will always be a problem under managed care and any form of capitation, as *there is an inherent conflict of interest when an entity that is supposed to offer care, be it an MCO or an individual provider, keeps whatever money is not spent on treatment.* This is especially destructive when mental health is under-capitalized.

a) MCO's keep money that is not spent on treatment. Corporate profits are soaring while beneficiaries are prohibited from receiving care for chronic and ongoing problems and are being discharged from hospitals prematurely.

b) Even capitated contracts that are made between employers and providers directly, bypassing MCO's, are problematic. One California therapist told me that she was called by a capitated plan and told that she would receive approximately $235 for each patient they send her. Obviously, if she performs one session only, she does very well. She still does well if she performs only two. Obviously, if the patient requires 10 sessions, she is receiving poor wages (with no benefits) for someone with a doctorate or even a master's degree. If the patient requires 40, 50, or more sessions, it becomes ludicrous. Thus, there is a strong incentive to under-treat, and clinicians may simply not be able to afford to

treat patients properly due to under-capitation. It is the bias of the corporations that people should only require 1-3 sessions. This is not reality.

c) It is true that under the fee-for-service system, there was some incentive to over-treat the patient. However, not all providers over-treated, as wise clinicians knew that they would receive future referrals from patients whom they treated appropriately. Also, under a fee-for-service system, if a consumer feels that he/she is not being treated properly, he/she can easily leave that clinician and find another. Further, a system of appropriate co-payments, when used by the insurers, encouraged consumers to be cost- and utilization-conscious.

9. Despite claims that managed care and managed competition comprise a "free market solution," there is no free market for the patient, the actual consumer of health care.

a) Managed competition is really about the elimination of competition. As consolidation continues, only a few large insurers will remain.

b) In several areas, the industry already controls 90% of the market. Where managed care squeezes out fee-for-service plans, *there is no competition for managed care itself.* A lack of competition always bodes poorly for quality.

c) A free market for the patient would mean that the patient is the one who would determine what care is needed, determine the value of that care, and choose freely from all who are qualified to provide that care. Managed care does not allow the patient these liberties. As managed care becomes an arrangement between employers or governments and the insurer, and the "consumer" becomes the employer or government, for they pay the premiums, the "free market" exists between the MCO and the payor. Under managed care, the MCO determines who will receive what kind of treatment, for how long, and who can deliver it. The true consumers of care, the patients, as well as the body of professionals who could administer care, are kept out of the "marketplace."

d) The managed care industry controls both supply and demand in regard to health care services. MCO's have declared that there is an over-supply of mental health professionals. This is predicated, however, on the industry's assumption that only brief forms of crisis-oriented therapy are needed, and that few people need treatment. This is not based upon true demand, which would be based upon the citizens' requests for care. Although fee-for-service is a "subsidized" market, it is still based on a more true supply and demand than under managed care. Under a fee-for-service system which had, in recent years, seen extremely high co-payments for psychotherapy, the demand for services was far greater than what is allowed under managed care. There will soon be a drastic shortage of mental health professionals and other providers, for the number will be based on what the managed care industry "needs," not upon what our citizens need. This will affect our entire society.

C) **Recommendations:**

1. Allow Medicare beneficiaries to choose among a variety of health plans, including fee-for-service plans, Medical Savings Accounts, MCO's, and any other type of health plan that currently exists or is yet to be devised.

a) Medical Savings Accounts (MSA) are attempts to return the rights of the "free market" to the actual consumers of health care. Incentives are provided that make the consumer cost- and utilization-conscious. Up to the catastrophic limit of the MSA, the consumer retains the right to choice of provider, the right to privacy, and the right to make his/her own treatment decisions.

b) There are some problems with MSA's, however:

i) Beyond the catastrophic limit, the consumer retains freedom of choice, but loses privacy and the right to make his/her own treatment decisions, as treatment may be subject to utilization review. However, because there are no panels, and MCO's can't threaten the providers with unemployment, providers are free to advocate for patients.

ii) The standard MSA contract written by the Golden Rule Insurance Company, has a limit on mental health services of $10,000 per year per individual. This is generally adequate for a patient requiring only psychotherapy, but not for one requiring a day treatment program or hospitalization.

iii) There is some concern that MSA's will not be appropriate for those who are unable to be responsible for their funds. This may affect some of the elderly. It may be necessary to arrange for a relative to make MSA decisions or, when there is no such relative close by, for a consumer case manager (not a case manager contracted by the insurer) to do so.

c) Some MSA plans are combined with MCO's. Again, this penalizes consumers for using out-of-network clinicians, which limits their choice of providers, especially for those with a limited income.

2. Return control over health care to the citizen:

a) Phase out employer involvement in health care. It no longer works. For employees, premium money actually belongs to the employee, for it is taken from his/her wages. Return this money to the employee so that employed citizens can purchase, own, and control their own health care plans. Under Medicare, and for citizens with limited incomes, beneficiaries should be expected to pay a portion of their premiums, based on their incomes, with government paying the balance.

b) Return the three basic rights consumers have lost under managed care (choice, privacy, and decision-making). Employees lost these rights because we now expect employers to pay for insurance, and because employers needed to cut costs once the patient became separated from the consequences of their decisions under the fee-for-service system. Citizens have been separated from the fact that it is their money to begin with, and the greater the separation, the less care they take with that money.

c) In order to protect their freedom, citizens must be financially responsible for their care to whatever extent they can afford to be so.

i) Medicare beneficiaries with adequate incomes would buy their own plans, or at least pay for a portion of their premiums. Government would pay that portion of the premium which is unaffordable for the Medicare beneficiary or other citizens.

ii) Benefit design must create incentives for patients to be cost- and utilization-conscious, without restricting access to care and other freedoms.

d) Individual mandates might be considered. Car insurance is required of all who drive, not just of all who have accidents. Why can't health insurance be required of all who live, not just those who get sick? While we might wish to protect the freedom of the citizen NOT to be insured, all citizens must then pay for emergency care and follow-up treatment when an uninsured individual requires treatment he/she cannot afford out-of-pocket.

3. Protect quality care and consumer freedoms by encouraging citizens to buy and own their own insurance plans. Allow a 100% tax deduction for all citizens buying their own health care plans.

All citizens deserve the tax break now given to employers, especially those who are self-employed or unemployed, which may include a large number of Medicare beneficiaries. Also, it is important for a government to encourage people to take care of themselves, so they will be less dependent upon the government for services. The more health insurance coverage one owns, the less dependent one will be on the government for care.

4. Guarantee portability of health care plans.

5. Prohibit "pre-existing condition" barriers to treatment.

6. Guarantee all citizens in MCO's access to "Point-of-Service" options:

Unfettered access to specialists is crucial for those who are ill.

7. Guarantee the right of all citizens, including Medicare beneficiaries, to "contract privately" with providers of their choice.

In the case that a health plan denies reimbursement for a particular service, the citizen must still be allowed to purchase health care he/she believes is necessary. The MCO might be making incorrect decisions. Medicare beneficiaries cannot currently purchase psychotherapy except from Medicare providers. If Medicare comes under managed care, beneficiaries will also frequently be denied more than a handful of psychotherapy sessions, as is already happening to the general population. Most MCO's are only allowing "crisis" care, and are prohibiting true forms of psychotherapy. We cannot make it *illegal* for Medicare beneficiaries, or anyone else, to obtain genuine psychotherapy.

8. Allow the States to regulate the managed care industry.

a) With a true "free market" system, in which the citizen has the ability to make his/her own health care decisions while being given incentives to be cost-conscious, there will be less need for regulation than there is under managed care.

b) Managed care plans frequently short-change the patient, and often prevent providers from advocating for patients and from delivering the best care they know how to

provide. It is imperative that the federal government allow the States to regulate this industry. ERISA laws were not intended for health care. They were intended for pension plans. If employer involvement were phased out, employers would not object to state regulation of health insurance plans.

9. Allow states the flexibility to experiment with a variety of health care plans.

a) Encourage the States and regions to develop insurance plans that involve "freedom with responsibility." MSA's attempt to do this.

b) There are many ideas yet to be devised and written down (e.g., see "Managed Cooperation," item F, below). Please do not lock Americans into any particular form of system, as this will prevent better ideas from being formulated and implemented.

D) Summary:

There are many problems that have already occurred in the private sector under managed care. These problems generally involve the loss of consumer freedoms to make their own treatment decisions, in private, with their chosen clinician. In mental health, the industry has changed the "standards of care" to substandard care.

In general, we urge Congress to institute some insurance reform and to allow the States to regulate the managed care industry. We urge Congress to increase choice of plan for Medicare beneficiaries and others, and to pass legislation that enables the development and implementation of programs that offer alternatives to managed care and managed competition, especially those that re-institute a true free market for the actual consumers of care. We support plans which retain consumer freedom while containing costs by providing incentives for consumers to be cost- and utilization-conscious, thus expecting some financial responsibility from the consumer, according to the financial means of the consumer.

E) Vignettes from Managed Mental Health Care - see pages 7 & 8.

F) "Managed Cooperation:" A Medical/Mental Health Care Plan - see pages 9 & 10.

These pages contain ideas ("Managed Cooperation") designed by the Coalition. Many of these ideas could be helpful in designing systems of cost-containment that put the consumer of care back in charge of his/her own treatment.

Original Vignettes (#1)
Managed Mental Health Care
(Revised 12/18/93)

The following vignettes are summaries of managed care (MC) cases. Decisions about who can be in treatment, how long treatment can continue, what type of treatment patients can have, and who can provide it, are being made by the MC companies. While they state they are basing decisions on "medical necessity," the companies cannot be free of a need to themselves be profitable. Unfortunately, the cases below are not atypical.

1. Ten year-old "Susie" was involved in a tragic and frightening accident. She and one parent escaped, but the other parent and her sibling died. "Susie" became mute, and began drawing pictures of a little girl with a noose around her neck. The surviving parent brought "Susie" to their HMO. "Susie" began therapy, but her pictures became increasingly darker (a symbolic indication of deepening depression and increasing suicidal risk). After the ninth session, the parent found "Susie" about to make a suicide attempt. This was reported to the therapist (who had not yet earned a master's degree) at the 10th session. This HMO therapist concluded treatment with the 10th session, stating that "Susie" "should be" finished. "Susie" was still mute and suicidal. Fortunately, the parent had some money available to pay for therapy without insurance coverage. The parent asked a friend for a referral outside the HMO and found a psychiatrist who offered a reduced fee. "Susie" was seen three times/week for 18 months. It took 12 months before "Susie" began to speak again.

2. "Mary," a depressed woman with several physical problems related to her emotional disorder, was denied therapy after 8 visits, even though her policy allowed up to 20 visits. The therapist (licensed) strongly recommended further treatment, but the reviewer (not licensed) refused authorization, saying that he had been instructed not to approve any outpatient treatment beyond 8 sessions regardless of the diagnosis or provider recommendation. "Mary" was too depressed to appeal. Within a month, she was hospitalized for severe gastric distress and required surgery. The therapist believes this was caused by inadequately treated depression.

3. "Jane," a depressed and suicidal woman, had finally left her physically abusive husband. She called her MC company for permission to begin therapy and for a referral. The request was refused. The reason given was that "domestic violence is a social problem, not a psychological problem."

4. "Sean," an adolescent boy, asked to be in therapy. His mother called the MC company for permission for him to begin therapy and for a referral. "Sean" stated he would not be comfortable seeing a male therapist. No list of network therapists is published, so the mother could not find an appropriate referral herself. The company agent refused to offer the name of a female therapist, though there were many in the network in that area. Despite many protests by the mother, the agent gave only names of male therapists, stating: "Listen, if you're sick, it doesn't matter who you see. And if you don't take the names I gave you, I can't help you anymore."

5. "Rosa," a young mother with 3 young children, cuts her wrists. Her HMO approved only 8 sessions. The therapist believes her symptom is due to feelings of anger at the responsibilities of motherhood. As the oldest of 9 children herself, "Rosa" had been over-burdened with responsibility as a child, for her own mother was unable to care for the children. Without appropriate treatment, "Rosa" will not likely understand the reasons for her distress. She will likely continue to cut her wrists, possibly escalating to serious cuts. The potential for child abuse is also present should "Rosa" begin directing her anger outward instead of toward herself.

6. "Henry," a middle-aged man with a childhood history of being severely humiliated, requested treatment due to interpersonal problems, including difficulty trusting others. "Henry" refused to return to treatment when the therapist was required to submit a detailed report about him and his therapy. The therapist finally convinced him to return and they spent much time discussing what the therapist should write. The report was written and more sessions were authorized, but "Henry" never returned for treatment. When the therapist called him, "Henry" said that the experience of having to divulge information to the company was too humiliating for him.

(over)

7. "Steven" experienced increasing depression, panic attacks, and phobic anxiety that prevented him from working. His psychiatrist provided psychotherapy and medication. There was a brief admission to a local hospital for a suicide attempt. After a year of treatment, "Steven's" insurance was changed to a MC company. The psychiatrist joined the network to be able to continue the treatment. The treatment resistant depression and severe anxiety showed some improvement, but the MC company said "Steven" was a "chronic" patient who wasn't showing enough improvement. The psychiatrist had to plead for more sessions. "Steven" did show more improvement. Later, a new anti-depressant helped lift "Steven's" mood and eliminated almost all panic attacks. However, "Steven" then began manifesting increasing manic symptomatology, including spending sprees. Restarting Lithium, which had been helpful in the past, now led to an organic brain syndrome. To be hospitalized under his MC plan, "Steven" would have had to enter the MC company's "anchor" hospital, which was not in his community, and would have been required to change psychiatrists. "Steven" refused to change psychiatrists and thus refused the hospitalization, though he would have agreed to a local hospitalization with his own psychiatrist. The organic symptoms decreased, but the manic symptoms remained. However, the psychiatrist did not feel "Steven" qualified for an involuntary hospitalization. "Steven" endured a full month of manic symptoms, infuding spending sprees. The cost to "Steven" was great in terms of financial, interpersonal and emotional effects before the manic symptoms remitted with outpatient treatment.

8. "Barbara" was in individual and group therapy before a MC company took over her insurance. She had been sexually abused by her grandfather in many horrifying ways between the ages of 5 and 12. She was also abused by a neighbor at age 12. Marital sex was accompanied by terrifying flashbacks of the abuse. The therapist was told by a reviewer to "hurry it along." Unfortunately, the symptoms had worsened because "Barbara" was given a new assignment at work which required her to work with men about the same age as her grandfather. Also, she had recently undergone her first gynecological exam, which left her psychologically disorganized for several weeks. The reviewer, a psychiatrist, asked if "Barbara" was suicidal. When the therapist said she was not, the reviewer disallowed further group treatment, stating she was just "following company policy." Group treatment, in addition to individual treatment, is often extremely important for sexual abuse survivors.

9. "Linda" was in treatment for about 1 1/2 years before a MC company took over. "Linda" was unable to tolerate anti-anxiety medication, but did respond to psychotherapy. Toward the end of the second year, "Linda" witnessed her 22 year-old daughter being hit by a car, leaving her a quadriplegic. "Linda's" symptoms increased dramatically. She was likely manifesting signs of Post Traumatic Stress Disorder. The therapist called the reviewer for permission to continue treatment. The therapist was told: "Well, doctor, let me tell you something. We are going to cut you off - be prepared - its coming down the pike soon!"

10. "Allison" had been sexually abused by two of her brothers for several years during childhood. She was raped as an adolescent, and battered throughout her first marriage. She was in group and individual therapy. Group therapy was later denied by the MC company. When the therapist, a recognized expert in treatment of sexual abuse, told the reviewer that the literature speaks to the importance of individual and group therapy for optimal treatment, the reviewer said: "Listen, we are not interested in providing optimal treatment. We are interested only in providing that which is absolutely medically necessary."

11. "Bill" is usually in control of his anger, but when he loses his temper, he threatens his pregnant wife with a loaded gun. His therapist was encouraged to complete the work in 8-12 sessions. Although the reviewer agreed this was a "long-term" case, he stated that it is not the company's policy to provide long-term treatment.

12. "Jennifer," in her late 30's, noticed pain in one breast, though she found no lump on self-examination. Her HMO doctor also found no lump. "Jennifer," suspecting a problem, asked for mammography. The doctor, who also acted as "gatekeeper," stated that the HMO does not pay for mammography for women under 50 unless there is a physical finding upon examination. With this refusal, "Jennifer" had a mammogram outside her HMO at her own expense. The test showed breast cancer. She decided to sue the HMO. Distressed by the cancer and the refusal of the HMO to provide the services she deemed necessary, "Jennifer" requested psychotherapy to deal with the stress. The HMO refused to authorize psychotherapy for her.

MANAGED COOPERATION

A Medical/Mental Health Care Plan

An idea for the future

(revised 2/14/95)

---

1. The success of a health care plan will depend on the value system upon which it is based. Cooperation seeks solutions that enhance and are fair to all parties involved.

2. Managed Cooperation optimally balances patient choice and freedom with responsiblility, instills provider responsibility to the patient, and engenders cost- and utilization-consciousness in patients and providers.

3. Managed Cooperation can be written in both single and multiple payer versions.

4. Benefit design would encourage patients and providers to be conscious of costs. When little or no co-payment is expected at the time of service, patients may not be motivated to question a provider's fees or suggested procedures. External controls (gatekeepers, case managers, and utilization reviewers) may then be called upon to do this, reducing patient control over their care. It is important, therefore, for patients to be financially responsible for their care at the time of service to the extent that out-of-pocket expenses are significant enough to the patient that the patient questions providers about fees and recommendations, but not to the point where out-of-pocket costs are burdensome and present a barrier to treatment for those with limited incomes. Sliding scales for premiums, fees and co-payments, deductibles, and catastrophic limits are all possibilities under Managed Cooperation.

5. We suggest a gradual phase-out of employer involvement in health care. When employers buy coverage, they may, understandably, seek to control the care given, limiting the freedom of citizens to make their own treatment decisions, in privacy, with their chosen clinicians. Since the money used by employers to buy insurance really comes out of the employees' income, we encourage a return of this money to employees in the form of income so that they may buy and own their own policies. This returns control over health care choices and decisions to the individual citizen. The possibility of an individual mandate might be considered.

6. Managed Cooperation relies upon regional cooperation. Cost-containment procedures as described below would be carried out by Regional Boards made up of consumer advocates, professionals, government representatives, and insurers (if a multiple payer plan is used).

7. Annually or every other year, Regional Boards would recommend fee ranges and insurance reimbursement levels for each procedure and send this information to consumers, clinicians, and insurers (the government if single payer systems are used or to insurance companies if a multiple payer system is used). Insurers would set dollar amounts for each procedure's reimbursement. Providers would set fees, preferably on a sliding scale, starting with a fee minimally above the reimbursement, up to a reasonable "full fee." The co-payment would be the difference between the reimbursement and the fee for the patient's income level, and could be legally waived if necessary. Clinicians would provide current and prospective patients with their fee schedule

upon request. The intention is to provide true discounts for those with limited incomes. The Board's recommended fee ranges would protect wealthier patients from being over-charged. High-priced clinicians would have to be able to justify their fees to patients. Caps on fees and the mandatory use of sliding scale fees could be instituted if a voluntary sliding scale did not adequately control fees. Sliding scales might be able to be used for hospital expenses if the percentage share for costs was graduated according to income (e.g., citizens earning $30,000 might only pay 5% of hospital bills up to a catastrophic limit appropriate for their income, while those earning $300,000 might pay 50% of all bills up to an affordable catastrophic limit.

Under this system: a) the insurer's liability is limited by the fixed reimbursement, b) patients and providers, due to a co-payment scaled to the patient's income, become cost- and utilization-conscious, c) patients could "comparison shop" and have freedom of choice, and d) practitioners would be guaranteed at least a minimum payment for each procedure (the fixed reimbursement), yet would retain some independence to compete in a truly free market based upon training, talent, reputation in the community, and fees.

8. Regional Boards could regulate purchases of expensive machinery; perform outcome studies; focus on fraud and incompetence, rather than micromanagement; and settle disputes between patients, providers, and insurers.

9. Government support for building hospital-based and free-standing primary care centers would reduce emergency room visits and encourage primary care use.

10. Outpatient psychotherapy would cover individual, group, and marital/couple/family treatment, as allowing children, adults, or families to remain in distress is harmful and costly to our country. Coverage for 40-50 sessions/year is recommended, as: a) 85% of patients use less than 26 sessions, even with liberal benefits and no UR (utilization review), b) liberal outpatient benefits reduce inpatient costs and, thus, overall mental health costs, and c) preventing the 15% of patients who need long-term psychotherapy from receiving it may increase society's costs and harm patients and their families. UR can be used to provide additional sessions beyond the annual limit for those who demonstrate strong psychological and/or medical need AND financial need. UR would not intrude on session content or personal information. Inpatient treatment would require UR, but at reasonable intervals. Medication management would be given the same status as any medical visit. Partial hospitalization, half-way houses, and group homes would be supported to reduce inpatient costs and the costs to society of inadequately treated mental health needs. There would be no limit to inpatient care for the seriously mentally ill (schizophrenia, bipolar disorder, major depression, severe borderline personality disorder, etc.), but appropriate UR would be utilized. Patient education would be developed to explain mental health problems, different forms of treatment and psychotherapy, and the educational requirements of different types of clinicians.

11. UR, or at least denials of benefits, would be done by licensed, practicing professionals who are independent of the insurer, and who have training comparable to that of the treating clinician. UR would focus only on those procedures known to be over-utilized.

12. Incentives in the form of partial premium rebates could be used to encourage patients to refrain from submitting smaller claims.

13. Claims procedures would be simplified and standardized, and claims could be submitted either by patients or providers.

TESTIMONY OF JUDITH STORMS KRAFT, LICSW
CONSORTIUM FOR PSYCHOTHERAPY

The industrialization of Mental Health is a revolution like the one in the 19th century when capitalism exploited the masses to increase the gross national product and achieve world power. Driven by a need to cut spending on health care, our system has institutionalized violence against humane social/psychiatry services, agencies, professionals (who are guardians and providers of services), and, ultimately patients/clients/consumers.

Managed Care companies, competing for control by reducing utilization of health insurance benefits (so that insurers will be able to offer lower premiums for mutual profit,) have forced a shift in the therapeutic, confidential contract between a patient and the therapist of his choice. Therapy has changed from a fiduciary relationship of healing to factory-like piecework on an assembly line, with interchangeable therapists performing efficient, cost-effective, programmed functions to produce widgets of minimum, measureable, changed behavior, and positive outcome statistics. Confidentiality is compromised because Managed Care authorizes payment for sessions based on detailed information about the problem, symptoms, psychiatric diagnoses, strengths, weaknesses, and behavioral goals--which they enter into their computer files. The State mandated $500 Mental Health benefit is virtually eliminated by making it subject to Managed Care's determination whether therapy is medically necessary and follows their guidelines of being short-term. Some capitated contracts pay for only $400, so anything beyond that is dependent upon the therapist or agency absorbing the loss. Client self-determination is non-existant because Managed Care's policies override it, stating that long term treatment for changing personality disorders, ingrained behavior patterns, or non-medical situational problems like abuse will not be authorized. Restoration to prior level of functioning, not cure, is the recommended approach.

Professions and agencies, competing for survival, have been bullied into resigned accomodation. Initial protests were extinguished by threats of annihilation. Managed Care has monopolized 3rd party payers. If therapists don't agree, they are not empanelled as providers. If they argue, they are dropped. If they are dropped, they generate no income, and go out of business.

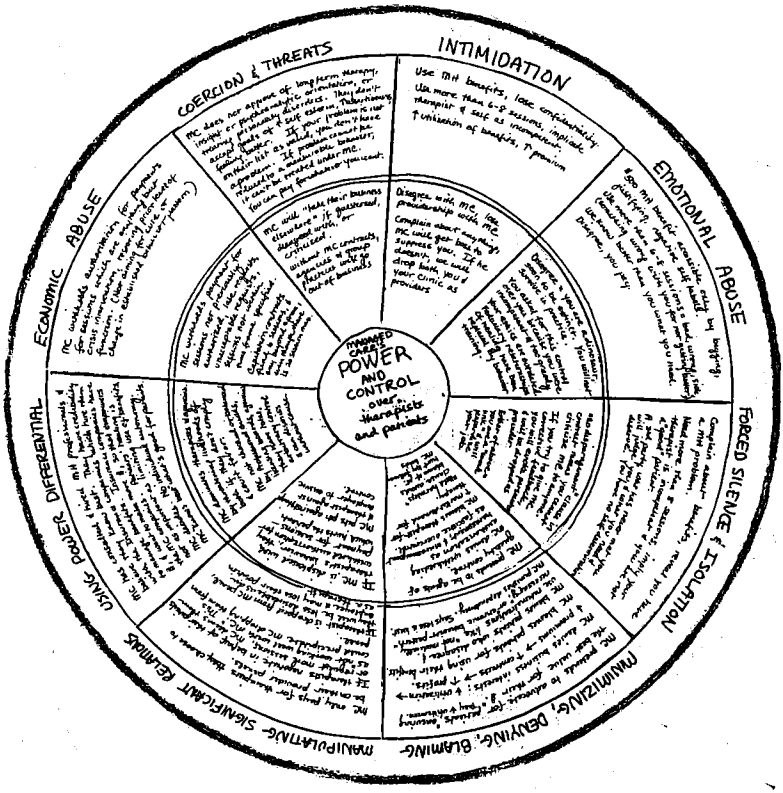
Contracts prohibit criticism of Managed Care. Contracts excuse Managed Care from liability if a bad outcome results from the treatment they authorize or fail to authorize; they are "held harmless." Therapists have to sign and uphold the contracts or they lose providership.

There are no checks and balances, since Managed Care answers only to insurance companies and business profits, not professional guilds, licensing boards, or agencies and codes of ethics. Managed Care has total, arbitrary control and can dismiss without cause. No laws govern their operations.

Professions and agencies, competing for survival, are victims of their own powerlessness under the abuse and fascistic rule of managed care. Powerlessness corrupts values and ethics. Therapists and administrators mindlessly identify with the aggressor and comply with demands. All Mental Health professionals are confounded in their thinking under this oppression. Managed Care is incompatible with Mental Health. Mental Health professionals are afraid of losing their livlihoods if they don't "ride the wave." Victims are treating victims, unwittingly participating in a pernicious mutation of Mental Health practice.

VIOLENCE AGAINST MENTAL HEALTH

Managed Care's mission is to decrease utilization of Mental Health Insurance benefits. They succeed by micromanaging therapists & double-talking patients. Any attempt to use benefits at any point automatically sets abuse in motion to curtail treatment. The forms of abuse are the same as those batterers use to gain power & control over their victims. *



* Adapted from POWER AND CONTROL WHEEL developed by Domestic Abuse Intervention Project, Duluth, MN. (See example following)

POWER AND CONTROL WHEEL

This diagram, developed by the Domestic Abuse Intervention Project in Duluth, Minnesota, indicates the different forms of abuse that batterers use to gain power and control their victims.

MANAGED CARE DOES NEITHER

by Judith Storms Kraft, LICSW
11/94

As an LICSW (M.S.W liscensed to practice independantly) with a quarter of a century of experience as a psychotherapist, I will remember the '90s as the most difficult. It isn't that the clients are harder to treat, or that the society is more violent, or that the resources are more scarce. It is because Managed Care reigns over professionalism and mental health.

Managed Care emerged as a panacea to beleagured medical insurance companies struggling to compete with Health Maintenance Organizations by offering more care options for lower rates. It was an umbrella superimposed on existing professional organizations with ethics and standards, and liscensing boards governing practice. It presented as a kind of consumer advocate, assuming that upwardly spiraling medical costs were from self serving professionals who were not accountable to their monitoring agencies, and were ripping people off. Managed Care companies hired professionals to oversee, control, and evaluate the professionals providing the care. The insurance companies, politicians, and the public put their faith in them.

In describing mental health benefits, they did not limit services to a $500/year maximum out-patient cost, but said "as much as needed", "each episode," "up to 20 visits/year." It sounded good to providers recruited to cooperate in this venture, and it sounded good to the subscribers. No one clearly established who would determine what ""needed" meant.

I have been a Managed Care provider for about 5 years. Their mode of operation is much less benign than their words convey. I have interpreted the "messages" communicated by their behavior, which contradicts what they say. Their "double messages" to clinicians, and my response to them follows below:

DOUBLE MESSAGES FROM MANAGED CARE TO CLINICIANS

1. Cover up and don't question our duplicity: We have to offer up to 20 sessions of therapy in order to compete with other HMO's. We really only want to pay for 4-6.

2. We will pretend to defer to your clinical judgement about what the problem is and how many sessions over what period of time it will take to treat it for a solution or favorable outcome. We will give you 4-6 sessions in a shorter time frame than you reguested, and ask you to repeat yourself each time you ask for more time. We hope you'll get tired of the time it takes to call

us, call us back, leave messages, fill out forms to extend authorizations for treatment. If that doesn't work, maybe the client will get tired of your cancelling appointments because you haven't received the authorization number yet, and you won"t be reimbursed for the service without it.

3. We will only accept words we want to hear in minimizing, reductionist, dehumanized terms. We won't consider anything abstract or having to do with feelings. We have to be able to quantify and measure so we can feed numbers into our computers and manipulate them for our statistics so we look like we are reducing costs for the insurance companies.

4. If you ask for more sessions, we will punish you by questioning your competence, not referring any more cases, and banning you from our panel of providers. We only want providers who "work well with managed care" (who will cover up for us, lie, not complain, who are willing to abandon themselves and their integrity in order to help us reduce usage of mental health services so we can look effective in reducing costs for insurance companies and still make a profit.

5. If you dare tell clients what is going on and are up front about how many sessions they can have without you going out on a limb for them (which will destroy you), you will be punished because we will withdraw our business from your organization.

6. If you express anger about the position you are in: double binded, powerless, oppressed, unable to advocate for clients, we will attack you by calling your boss to suppress any further outbursts. We will warn him that if he doesn"t comply by scaring you into submission that we will assume all his employees are like you--wimps, upstarts, incompetents who can't play hardball. We do not want feedback and we will interpret appropriate assertiveness as mutinous. You should be ashamed for being angry, and you seem to have a problem with authority.

7. We are so powerful that we don't have to obey the laws about paying you for services within 90 days. You just have to wait for us to get through our red tape. Too bad if that means you have to borrow money to survive. If you put your interests ahead of our interests, you don"t look like a loyal team player. (The important thing is that we cut costs for insurance companies and make money--not you.) We haven't been obeying the law, and we are getting away with it. Therefore we are right. We can do anything we want.

8. If you make any mistakes and don't meet our time schedules, you are punished by not getting paid for the service. We have the power. You don't. Therefore, we are right and you are wrong.

9. We have a cooperative relationship with our providers,not an adversarial one, so that, together we can provide better mental health care for less money.

A CLINICIANS RESPONSE TO MANAGED CARE

A. I experience Managed Care as fascistic, abusive and damaging to clinicians, and incompatible with mental health and Mental Health practice. It has the seeds of catastrophic portent. Hitler's ideas were originally appealing to the German people who wanted to preserve their culture and cut costs. He meant well.

B. I feel that I have been overpowered, intimidated and bullied by some of my professional collegues working for Managed Care who have identified with the aggressor and abandoned their humanity, compassion, and their profession.

C. If I accept this without confronting the double messages, without rejecting the role of sacrificial foil, without refusal to embody the conflicts as a scapegoat, I will abandon myself and will dis-integrate. Then I will be impaired and will not be able to function as an authentic person or a therapist.

D. I have survived by compartmentalizing the therapy, keeping it separate from seeking authorization for payment of it. The anxiety comes up in the latter, when all hangs on my ability to be clear, succinct, and compelling. My energy is being dissipated in defense mechanisms in order to do that--repression, suppression, denial, dissociation, depersonalization, identification with the aggressor, reaction formation, rationalization. This is what traumatized victims do in order to survive. I have to do this to help people?

E. Working with Managed Care, therefore, compromises the mental health, performance, and job satisfaction of the clinician providing the therapy. If I admit that I am stressed, I expose myself as weak, unfit, and will be blacklisted. Practice groups don't want to be associated with losers, so this condemns clinician-victims to silence and isolation--which is the problem we treat in our clients.

F. Staff training in brief treatment to better meet the demands of Managed Care so we will be winners (and be chosen to remain on provider panels) perpetuates the myth that the problem is in the clinicians rather than in the system, and that it can be solved by controlling the clinicians and forcing compliance with the rules made by profiteers serving

the insurance companies.

G. Mental Health professionals need a safe forum to address the process of becoming casualties in this frenzy of Managed Care and Managed Competition which has penitrated the central Massachusetts area more than anywhere else in the country. All eyes are upon us. We need to support each other and have the courage to tell it like it is, and work to find better alternatives.

○

MEDICARE HMO ENROLLMENT GROWTH AND PAYMENT POLICIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

MAY 24, 1995

Serial 104–58

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

26–329 CC WASHINGTON : 1996

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-053954-4

COMMITTEE ON WAYS AND MEANS

BILL ARCHER, Texas, *Chairman*

PHILIP M. CRANE, Illinois
BILL THOMAS, California
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
JIM BUNNING, Kentucky
AMO HOUGHTON, New York
WALLY HERGER, California
JIM McCRERY, Louisiana
MEL HANCOCK, Missouri
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
DICK ZIMMER, New Jersey
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
PHILIP S. ENGLISH, Pennsylvania
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska

SAM M. GIBBONS, Florida
CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ANDY JACOBS, JR., Indiana
HAROLD E. FORD, Tennessee
ROBERT T. MATSUI, California
BARBARA B. KENNELLY, Connecticut
WILLIAM J. COYNE, Pennsylvania
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
L.F. PAYNE, Virginia
RICHARD E. NEAL, Massachusetts

PHILLIP D. MOSELEY, *Chief of Staff*
JANICE MAYS, *Minority Chief Counsel*

SUBCOMMITTEE ON HEALTH

BILL THOMAS, California, *Chairman*

NANCY L. JOHNSON, Connecticut
JIM McCRERY, Louisiana
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska
PHILIP M. CRANE, Illinois
AMO HOUGHTON, New York
SAM JOHNSON, Texas

FORTNEY PETE STARK, California
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia

CONTENTS

	Page
Advisory of May 9, 1995, announcing the hearing	2

WITNESSES

Physician Payment Review Commission, Gail R. Wilensky, Ph.D., Chair	7
Prospective Payment Assessment Commission, Stuart H. Altman, Ph.D., Chairman	17
U.S. General Accounting Office, Health, Education, and Human Services Division, Jonathan Ratner, Associate Director, Health Financing and Policy Issues	43

Butler, Stuart M., Heritage Foundation	76
CIGNA HealthCare of Arizona, Inc., Martin Block, M.D	98
FHP Health Care, Richard Jacobs, M.D	108
HealthPartners of Southern Arizona, Paul A. Zucarelli	116
Kendall, David B., Progressive Policy Institute	88
PARTNERS Health Plan of Arizona, Paul A. Zucarelli	116

SUBMISSIONS FOR THE RECORD

Air Force Sergeants Association, James D. Staton, statement	132
American Academy of Actuaries' Medicare Work Group, statement	134
American Rehabilitation Association, statement	144
American Society of Plastic and Reconstructive Surgeons, statement	149
Coalition of Mental Health Professionals and Consumers, Inc., Karen Shore, statement and attachments	153
Consortium for Citizens with Disabilities, statement	163
Luther, Hon. Bill, a Representative in Congress from the State of Minnesota, statement	167
Patient Access to Specialty Care Coalition, statement and attachment	168

MEDICARE HMO ENROLLMENT GROWTH AND PAYMENT POLICIES

WEDNESDAY, MAY 24, 1995

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

The Subcommittee met, pursuant to call, at 10:08 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 9, 1995
No. HL-11

CONTACT: (202) 225-3943

Thomas Announces Hearings on Increasing and Improving Options for Medicare Beneficiaries

– Private-Sector Lessons to be Sought –

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a series of hearings to explore increasing and improving options for Medicare beneficiaries, with a focus on private-sector successes.

The hearing dates and subjects are as follows:

Tuesday, May 16, 1995:	**Experience in Controlling Costs and Improving Quality in Employer-Based Plans**
Wednesday, May 24, 1995:	**Medicare HMO Enrollment Growth and Payment Policies**
Thursday, May 25, 1995:	**The Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program**

The hearings on May 16 and May 24, will be held in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. The hearing on May 25 will be held in room B-318 of the Rayburn House Office Building, beginning at 10:00 a.m.

Oral testimony at these hearings will be heard from invited witnesses only. Witnesses will include health policy experts, representatives from the health care industry, and employer groups. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee or for inclusion in the printed record of the hearing.

BACKGROUND:

According to the 1995 report of the Board of Trustees, the outlays of the Medicare Hospital Insurance (HI) trust fund will exceed income beginning in 1996 and the HI trust fund is projected to run out of reserves in 2002, using the intermediate set of assumptions.

To keep the HI trust fund in actuarial balance for 25 years would require, in the absence of spending restraints, an immediate 44 percent increase in the payroll tax rate. As a result, taxes on a person earning $20,000 would be increased by $260 annually and a person earning $30,000 per year would see their taxes hiked by $390 a year. Those who make $75,000 a year would pay an additional $975 in taxes every year.

In the report, the Board of Trustees called for "prompt, effective, and decisive action" to put the HI trust fund into balance.

(MORE)

The Board of Trustees also expressed "great concern" about spending growth from the Supplementary Medical Insurance trust fund. As noted by the Board of Trustees in the 1995 report:

> "In spite of evidence of somewhat slower growth rates in the recent past, overall, the past growth rates have been rapid, and the future growth rates are projected to increase above those of the recent past. Growth rates have been so rapid that outlays of the program have increased 53 percent in the aggregate and 40 percent per enrollee in the last 5 years."

Medicare insurance coverage remains largely as it was originally enacted in 1965: traditional fee-for-service indemnity insurance with beneficiary cost-sharing requirements to control utilization.

However, private health insurance has evolved substantially since that time. More and more privately insured Americans are enrolled in managed-care plans, such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations. According to the Group Health Association of America (GHAA), some 56 million Americans were enrolled in HMOs in 1994, up from 36 million in 1990, and 65 percent of people with employer-based health insurance plans were enrolled in some form of managed-care arrangement, according to the KPMG Peat Marwick Health Benefits in 1994 (October 1994).

Moreover, managed-care organizations have recently been successful in slowing the rate of growth of premiums. In 1995, on average, HMOs are expected to reduce their per person premiums by 1.2 percent, according to GHAA.

Some private employers have also begun to offer their employees Medical Savings Accounts. Such accounts allow employees and their dependents to control their health care dollars, providing strong incentives for cost conscious spending.

Medicare beneficiaries can enroll in HMOs under the risk contracting program and other managed-care arrangements, but, due to certain features of the program, managed-care remains a relatively small part of Medicare, with only 8 percent of the beneficiaries enrolled in managed-care plans as of December 1994. Medicare beneficiaries are also not currently able to enroll in any kind of Medical Savings Account.

FOCUS OF THE HEARINGS:

The hearings will focus on successful private-sector approaches at controlling costs and improving quality and an exploration of how such approaches can be made more available to increase choices for Medicare beneficiaries.

The hearing on Tuesday, May 16, 1995, on "Experience in Controlling Costs and Improving Quality in Employer-Based Plans" will review the approaches employers have taken to improve the cost-effectiveness and quality of their coverage for their employees, the issues and problems encountered as these approaches were implemented, the effectiveness of these approaches, and lessons the Federal Government can learn from these private-sector experiences.

The hearing on Wednesday, May 24, 1995, on "Medicare HMO Enrollment Growth and Payment Policies" will investigate the reasons for increasing beneficiary enrollment in Medicare risk contracting HMOs, and current and alternative HMO payment methods.

The hearing on Thursday, May 25, 1995, on "The Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program" will explore issues involved in enabling employers and associations to offer Medicare coverage to former employees and members, respectively, and the potential role Medical Savings Accounts could play in the Medicare program.

(MORE)

WAYS AND MEANS SUBCOMMITTEE ON HEALTH
PAGE THREE

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, Thursday, June 8, 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. The Subcommittee will come to order.

I want to welcome you to our hearing on Medicare's HMO Program. This morning, we are going to hear from a number of panels to allow us to begin to focus on an effort to make Medicare better by improving the solvency of the trust funds and by examining ways to provide more options to the beneficiaries for their health care coverage outside of the traditional program.

Clearly, one of the options among many beneficiaries will be the enrollment in cost effective HMOs. Today we will examine the current Medicare HMO Program, the recent enrollment growth, current policies for paying HMOs under risk contracts and, obviously, options for modifying the payment system.

In April, 1993, 1.6 million Medicare beneficiaries were enrolled in HMOs with risk contracts. In April of this year, there were 2.5 million beneficiaries in such plans, a 56-percent increase in just 2 years. All signs indicate that enrollment will increase another 20 to 25 percent this year.

Clearly, coordinated care is making some inroads into the Medicare Program. Beneficiaries are finding that in many parts of the country, well-run private health plans can provide more coverage at less cost than the traditional Medicare Program. By enrolling in risk-contracting HMOs, they can reduce their Medigap premiums and, to a certain extent, their paperwork hassles.

Nonetheless, managed care remains a relatively small part of Medicare, with only 9 percent of beneficiaries enrolled in coordinated care plans; and the payment methodology for risk contracts, which is essentially a fee-for-service shadow price, has been criticized by many as arbitrary and really ineffective in reducing costs for the program.

I am anxious to hear from the list of experts we have testifying today about how we might move away from the current payment methodology, the so-called AAPCC, or the average area per capita cost payment structure, to a payment system that promotes cost effectiveness, is more stable geographically, and encourages more plans to offer coverage to more Medicare beneficiaries.

I am also pleased that we have a sufficient number of witnesses from Arizona to take more of an indepth look at that particular HMO market. Arizona is a highly competitive market. Well-coordinated care organizations have been very successful in enrolling large numbers of Medicare beneficiaries, even though the payment rates are not as high as other areas with managed care enrollment rates that are high as well. I am grateful that the three HMO representatives from Arizona are here today and are going to share their insights with us.

These HMOs differ in terms of their evolution, size, and approaches to managed care. So their particular perspective is something that we want to get on the record in the hopes of finding some common patterns that will assist us in this evolutionary process.

I look forward to hearing from all our witnesses, but prior to that, I would recognize the Ranking Minority Member, Mr. Stark, for his opening statement.

Mr. STARK. Thank you, Mr. Chairman.

We are going to talk about managed care today and how to improve managed care for Medicare's beneficiaries. I think we have got to deal with three things. Does managed care actually save us any money? If one assumes that managed care restricts the use of health care services, does that serve the patients well? And, in general, how have managed care plans been working for the Medicare population?

CBO has consistently reported that the savings from managed care are pretty elusive. It only works generally with staff model and group model HMOs. You only get savings from those. There is little evidence that managed care reduces any growth in health spending over a period of time, and virtually all of the recent growth and enrollment in managed care plans has been in looser arrangements, such as preferred provider, point-of-service plans, those which have no evidence of saving any money.

The issue of consumer satisfaction, I find that studies which tend to show people who like fee-for-service don't really reflect whether or not we save money or not, and I tend to dismiss those; but my own district experience is that half of my constituents belong to the Kaiser Permanente Health Plan and they seem to be satisfied. A large number of them choose to stay in Kaiser when they mature into Medicare. And yet, I receive a lot of mail from people who are unhappy. The stories are anecdotal, but they largely have to do with restricted or withheld care.

Managed care options have worked reasonably well, but we know that the AAPCC payment system needs fixing. This Subcommittee made that clear in legislation we approved in 1989. Wide variations in payments to HMOs make little or no sense, and they leave the impression that access to low-premium, high-benefit HMOs may be an act of where the beneficiary lives, rather than a function of the particular health plan.

To devise a fair payment system is going to be a real problem. The potential for risk selection within the Medicare population is high. The citizens are uniquely vulnerable in that population, and it provides an opportunity for health plans, usually through unscrupulous insurance salesmen, to skim off the low-risk beneficiaries; and proposals to increase managed care enrollment of that nature could cost Medicare more, not less.

So last, I think that we have to preserve managed care's voluntary nature. My feeling is that efforts to coerce beneficiaries to enroll in HMOs or other managed care organizations will cause problems and eventually end in failure.

Taking away the freedom of choice of doctors and hospitals from the Nation's seniors, to me, is a sure way to start a revolution. No amount of planning can take away the fact that the choice of a plan is not the same thing as the choice of a doctor, and I think if we keep that in mind, we may avoid a lot of problems that we have had in the past when we have legislated too quickly for seniors.

We could provide new profit centers for insurance companies, but that is not what this Committee ought to be doing. We can find ways to cut Medicare benefits, but I am sure that the public will call that to our attention, and I think we have to continue to protect the benefits that seniors receive and do that incrementally.

I don't think there is a quick fix out there. We looked for it on a bipartisan basis for 10 years and didn't find one. I am sure we will have some suggestions. I don't know if we have got anybody from Jackson Hole, but I am sure that oxygen starvation still prevails in that group, and they will have some kind of a quick fix, but we will see. I think we could just keep doing what the Chairman has done so well and move slowly and cautiously.

I look forward to the witnesses that you have assembled today. Thank you.

Chairman THOMAS. I thank the gentleman for his opening statement, notwithstanding all of those cautionary and sometimes wise observations. We have got the Medicare Hospital Insurance Trust Fund going bankrupt, and I am looking for any and all options.

Our first panel is Gail Wilensky, who is the new Chairperson of the Physician Payment Review Commission. I believe this is the first time she will be appearing before us in that particular capacity. We also have Stuart Altman, Chairman of the Prospective Payment Assessment Commission; and Jonathan Ratner, who is Associate Director in the U.S. General Accounting Office in the area of Health Financing Issues.

I would tell each of the panel members that any written testimony that they may have will be made a part of the record, without objection, and that you may proceed to inform us in any way you believe will be useful in educating us.

And we will start with Dr. Wilensky and then move to Dr. Altman and Mr. Ratner. Dr. Wilensky, again, congratulations, and welcome to the Subcommittee.

STATEMENT OF GAIL R. WILENSKY, PH.D., CHAIR, PHYSICIAN PAYMENT REVIEW COMMISSION

Ms. WILENSKY. Thank you, Mr. Chairman. I appreciate this opportunity to be here to present the Physician Payment Review Commission's views concerning Medicare managed care.

The Commission, as you know, has devoted considerable thought to this important issue in its 1995 annual report, and it has made recommendations on some needed improvements in the payment policies. We are also beginning to work on several projects that will provide the Congress with information we hope will be helpful in extending the role of Medicare managed care.

As we speak, U.S. health care is undergoing major changes. Employers are fundamentally changing the way that they purchase health care services, and managed care plans are growing rapidly and evolving toward integrated systems of care. Hospitals and physicians are joining together in new types of organizations, which are transforming the way that care is being delivered.

These developments, along with the financial pressures that face the Medicare Program, as you know only too well, are bringing Medicare to an important juncture. Dynamic change in the marketplace is creating both opportunities and challenges to the Congress to improve the performance of the Medicare Program and to further such policy goals as containing costs, expanding access, and ensuring quality of care. While the innovations in the private sector suggest new solutions to longstanding policy problems, the pace of change varies widely around the country. Multiple approaches

and policy responses will be needed to reinforce the positive effects of these market changes.

Although managed care remains a small part of Medicare, its rapid growth does suggest that the time may be ripe for policy changes that will help guide this program into the next century. Much can be done to make changes in Medicare that are consistent with the innovations that are going on in the private sector and to ensure that the program acts as a prudent purchaser in responding to the changing health care environment. The challenge that lies ahead will be to expand the number of choices available to beneficiaries and encourage the use of cost effective providers, and to do so in ways that protect the fiscal integrity of the program and also, of course, preserve the beneficiary's access to high-quality care.

I would like to provide some background information on what has been going on, but more importantly, to talk about some of the changes that are needed in payment policy. And I will also outline very briefly some of the work that is going on now to try to help this Committee as it develops a Medicare reform package.

As you well know, beneficiaries can choose HMO enrollment when they become Medicare eligible or at other times when HMOs offer open enrollment. As the health care system has moved toward managed care and integrated delivery systems, the willingness of HMOs to participate in Medicare and the beneficiary enrollment has grown rapidly, although it still remains a very small part of the program. We should note, however, that about three-quarters of the elderly live in an area where there is a Medicare managed care plan available to them.

Enrollment rates vary considerably across the country as you have mentioned, but there are high rates that tend to occur in some areas where there is very high commercial HMO penetration. We may be able to learn something about the growth in those areas.

Further expansion will depend on a number of factors: The capacity of HMOs to accommodate elderly and disabled patients, the willingness of the plans to do business with the program, and of course, the willingness of the elderly to receive care under these arrangements.

The ability of a plan to attract and retain the elderly will grow over time as people who are now in managed care plans age into the Medicare Program. At the same time, Medicare can encourage greater plan participation and also ensure that cost savings achieved occur as a result of efficiencies rather than by risk selection.

Changes in the payment methodology are urgently needed and these need to be considered as a first step in encouraging a more substantial role for managed care. The Commission, in its 1995 report, has made a number of recommendations which we believe would enhance the program performance. There are a number of problems now about the way that Medicare payment occurs to HMOs, and it has contributed to the limited participation.

These problems include linking the managed care payment to the Medicare fee-for-service expenditures in the area and the very wide geographic variation in terms of the amount that is paid. They in-

clude the highly volatile county-level payment rates, particularly those with small Medicare populations. They include an inadequate risk adjustment mechanism, and also the unrestricted movement between risk and cost contracts which results in HMOs with risk contracts attracting patients with less expensive patterns of care.

In the Commission's view, the first step toward expanding managed care should be improving the payment policy for risk contracts by correcting the flaws in the current program, and that means correcting the flaws in the AAPCC. There are at least two approaches to improving the capitation payments: A competitive bidding mechanism and, also, refining the current AAPCC, because we won't be able to have competitive bidding early on in all areas. That is, because there are just not enough HMOs in some areas, both approaches will be needed.

We also need to make payment adjustments that mitigate the financial impact of adverse risk selection. Because my written testimony provides some information about how we see competitive bidding occur, I would just like to indicate that we believe that it will have to generally occur by having the plan submit offers of minimum payment rates that they would be willing to take and give HCFA the ability to establish a payment rate that is based on the bids submitted and to make sure that there are some penalties for those plans that try to have high bids in there to protect themselves.

HCFA needs to be given sufficient authority and flexibility to introduce a competitive bidding process in those markets where they have the best chances for success and then to expand the competitive bid process as they learn from those activities. But as I have indicated, we have to recognize that the AAPCC will continue to be used in some areas because there won't, at least early on, be enough HMOs to permit competitive bidding; and that means we need to make some adjustments to some of the flaws that are there.

Right now what happens is that the ratio of the county-level per capita costs are taken relative to the national average. It is flawed because it provides very unstable rates over time that are susceptible to extreme geographic variations and service use patterns. It also encourages HMOs to go into the areas that have very high expenditure per capita.

We need to recognize that input prices can vary and those are factors HMOs can't control, but we need to protect ourselves from incorporating the effects of the very high service rates which now occur.

All of these changes are currently affecting the AAPCC. A blended AAPCC, one which uses a weighted average of the AAPCC and the national average per capita, the so-called USPCC, adjusted for local differences in prices, would be a way to make that kind of adjustment, still taking account of some local variations, but not automatically incorporating all the high use that may occur.

To reduce payment volatility, there are at least two approaches that could be used. One is to define a larger geographic area and the other is to use a statistical technique that establishes county-level payment rates that are based partly on the county's average payment and partly on the payment rate for a larger area. There

are also such things as partial capitation that would use a blended rate of the average of the capitation payment and fee-for-service payments; and also we could consider having something like a risk corridor that would adjust capitation to an HMO's net financial gains or losses exceeding some established threshold.

Because these are new ideas, we would suggest you think about some demonstrations for using these partial capitation rates before extending them to the whole Medicare Program.

There is also an issue with regard to the enrollment policy. Now, as you know, people can opt in and opt out on a 30-day basis and that may contribute to risk selection. The Commission suggests that a more structured enrollment process be considered that provides for a more coordinated open enrollment period and also, importantly, furnishes the elderly with information so that they can make comparisons about the choices that they would have available. Choices are good, but information to make wise choices are crucial.

I think you should also reconsider the use of the cost contract, particularly in areas where you consider using competitive bidding. That invites increased spending in Medicare and also risk selection.

There are a number of areas where the Commission is now working to try to provide information that we hope will be helpful to you. Let me just summarize those quickly.

One is further work to set the capitation payment rates for the risk contracting programs, to identify potential markets where competitive bidding would be feasible, to design a bidding process, to structure the premiums for high bidders, and to consider how to establish payment rates in areas where we know competitive bidding just won't be able to work.

The Commission is also updating its assessment of current risk adjustment methods. We all know that this has been one of the major problems confronting the increased use of managed care in Medicare, and of course, in the private sector it is also a problem.

We would like to explore more structured choices for Medicare beneficiaries. The questions of interest here include whether or not financial incentives for the elderly to choose more cost effective plans could be made available and how exactly you would structure these incentives. Options and information are important, but without the use of incentives, we shouldn't fool ourselves that there will be enormous amounts of change in the Medicare Program.

We need to look at statutory barriers that also may be inhibiting managed care growth and figure out how to manage better the fee-for-service sector of Medicare, which we understand will always exist in the future.

Access to care for the elderly will be a continuing issue of interest. We need to be sure that we are monitoring access, for both those that are enrolled in managed care programs and those that are enrolled in fee-for-service. And also, finally, with respect to graduate medical education, we need to consider whether or not the payments that are now going to HMOs for expenses related to graduate medical education make sense and if there needs to be a modification, what that should be.

The Commission is focused on improving the methods of paying HMOs, and changing these methods is long overdue. We just have to remember, it is only one element in making reforms to the Medicare Program. Medicare can remain the last open-ended program dominated by fee-for-service medicine and unrestricted choice of providers; or it can follow the kinds of changes that are going on in the market in terms of the choices that it offers the seniors. We need to remember that when Medicare was first set up in 1965, it was modeled after the program primarily in existence in 1965, Blue Cross-Blue Shield. I think it is appropriate to now look at the changes that are going on in the medical marketplace and make changes in Medicare that reflect this continuing evolution.

I would be glad to answer any questions that you may have. Thank you.

[The prepared statement follows:]

TESTIMONY OF GAIL R. WILENSKY, PH.D., CHAIR PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman, I appreciate the opportunity to be here this morning to present the Physician Payment Review Commission's views concerning Medicare managed care. The Commission has devoted considerable thought to this important issue in its 1995 Annual Report, making recommendations on needed improvements in Medicare's payment policies for managed-care plans. In addition, we are now beginning work on several projects that will provide the Congress with information it can use to extend the role of managed care within the Medicare program.

As we speak, the U.S. health care system is undergoing a major change. Employers are fundamentally altering the way they purchase health services. Managed-care plans are growing rapidly and evolving toward more integrated systems of care. Physicians and hospitals are joining together in new types of organizations, transforming the way care is delivered.

These developments, along with the financial pressures facing the Medicare program, are bringing Medicare to a turning point. Dynamic change in the marketplace is creating both opportunities and challenges for the Congress to improve performance of the Medicare program and to further such policy goals as containing costs, expanding access, and ensuring quality of care. While the innovations in the private sector suggest new solutions to longstanding policy problems, the pace of change varies widely around the country. Multiple approaches and policy responses will be needed to reinforce the positive effects of market evolution and to mitigate any adverse consequences.

Although managed care is now only a small part of Medicare, its recent rapid growth suggests that the time may be ripe for policy changes that will guide the program into the next century. Much can be done to make changes in Medicare consistent with innovations in the private sector, and to ensure that the program acts as a prudent purchaser in responding to the changing health care marketplace. The challenge that lies ahead will be to expand the number of choices available to beneficiaries and encourage the use of cost-effective providers, and to do so in ways that protect the fiscal integrity of the program and preserve beneficiaries' access to high-quality care.

In my testimony this morning, I will provide some background information on the current role of managed care within the Medicare program and then present the Commission's recent recommendations on changes needed in Medicare payment policies. I will also outline the work that is getting underway which we hope will be of assistance to you as you develop a Medicare reform package.

The Context for Change

Under the provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Medicare beneficiaries have the option to enroll in health maintenance organizations (HMOs), all of which offer Medicare-covered benefits and most of which also offer coverage of cost sharing and supplemental services that replaces Medigap policies. Beneficiaries may choose HMO enrollment when they become Medicare eligible or at other times when Medicare HMOs offer open enrollment.

As the health system has moved toward managed care and integrated delivery systems, both the willingness of HMOs to participate in the Medicare program and beneficiary enrollment in these plans have grown rapidly. The number of managed-care plans with Medicare risk contracts increased by over 80 percent from the end of calendar year 1990 to the end of calendar year 1994, and enrollment increased by about 85 percent during the past 5 years. Currently about 9 percent of Medicare beneficiaries are enrolled in HMOs. 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."

Fully three quarters (74 percent) of Medicare beneficiaries now live in an area with a Medicare managed care plan available to them. But enrollment rates vary considerably across the country, with higher rates tending to occur in areas where commercial HMO penetration is high. Almost one-third (28 percent) of those Medicare beneficiaries living in California and Arizona are enrolled in risk contract HMOs. By comparison, 15 percent of those in Florida receive care

from HMOs and just 5 percent of those in Massachusetts and Texas. There are virtually no Medicare HMO enrollees in 28 states.

Policy Responses

Further expansion of managed care within the Medicare program will depend upon several factors: 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. Plans' ability to attract and retain Medicare beneficiaries and beneficiaries' comfort level with managed care will likely grow over time. At the same time, Medicare could encourage greater plan participation and ensure that the cost savings achieved as a result of managed care efficiencies accrue to the Medicare program by reforming its methods for paying HMOs.

Changes in this methodology are urgently needed and should be considered a first step in encouraging a more substantial role for managed care within Medicare. The Commission has made a number of recommendations in this area which would enhance program performance and help Medicare capitalize on innovative changes in the health care market.

The Problem. Current Medicare payment policies for HMOs are fundamentally flawed, and have contributed to problems of limited HMO participation (and thus low beneficiary enrollment rates), and higher costs per enrollee than their fee-for-service costs would have been. These problems include:

- the linking of managed care payment rates to Medicare fee-for-service expenditures, so that the cost efficiencies achieved by HMOs do not result in savings for Medicare;
- wide geographic variation in payment rates due to local variations in fee-for-service patterns of use;
- highly volatile county-level payment rates, particularly for those with small Medicare populations;
- inadequate risk adjustment methods; and
- unrestricted movement between risk and cost contracts, resulting in HMOs with risk contracts attracting patients with less expensive patterns of use.

The Solutions. 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 adjusted average per capita costs or AAPCCs). If Congress fails to address these problems, a greater role for managed care will not necessarily lead to cost savings. Building upon this foundation, additional managed care choices (such as Medicare SELECT and other preferred provider or point-of-service options) also can be expanded. In addition, other approaches that would create competition among fee-for-service and managed care options within Medicare should 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 more 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 needed are 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. Since current risk adjustment methods are inadequate, partial

capitation methods that base HMO payment partly on a capitation rate and partly on actual experience could also be tested. Reconsideration of the 30-day enrollment policy should also occur. These are discussed below.

Competitive Pricing. Competitive pricing would uncouple HMO payment rates from expenditures in the fee-for-service sector, 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 (HCFA) 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 how the final payment rates established from the bidding process compare with the level of the AAPCCs in those markets. Because it is not clear how competitive bidding might affect Medicare costs, some have proposed using payment limits -- for example, using the national average per capita cost, adjusted for local input prices, as an upper limit. This approach is not ideal, 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 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 markets where multiple plans can compete for Medicare business, AAPCCs or some other form of administered payment rates will be needed for the foreseeable 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, geographic variation could be addressed by making payment adjustments that recognize input price factors that HMOs cannot control, such as local wage rates, and the portion of service use variation that is attributable to differences in health status. The current AAPCC reflects all service use variation, a portion of which reflects service underuse or overuse, and we are not able to measure the individual components accurately. Until more direct measures are developed, the Commission has recommended that a blended AAPCC be used, which is a weighted average of the AAPCC and the national average per capita cost (USPCC) adjusted for local differences in input prices.

To reduce payment volatility, two possible approaches are suggested. The first is to define geographic areas with larger Medicare populations, to obtain a more stable base of health care expenditures for calculating AAPCCs. The second is to use a statistical technique (called a shrinkage estimator) to establish county-level payment rates that are based partly on the county's AAPCC and partly on the payment rate for a larger area that contains the county.

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 an HMO's net financial gains or losses exceeding established thresholds.

Although this is a promising solution, partial capitation could be difficult to administer. Before this method is widely used, 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.

Enrollment Policy. In addition to the changes in payment policy described above, the current enrollment policy with its lack of coordination in enrollment periods may have contributed to low enrollment and risk selection. The Commission is recommending that a more structured enrollment process be established that provides for coordinated open enrollment periods and furnishes beneficiaries with objective, comparative information to allow them to make informed choices for HMO enrollment. Permitting beneficiaries to disenroll at the end of any month allows them to leave managed care plans more freely than is common in the private sector and may result in disenrollment when they require more services. This policy should be reevaluated, weighing benefits of reducing opportunities for risk selection by locking beneficiaries in over a longer period against the risk of beneficiaries being unable to "vote with their feet" in response to poor service and quality.

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 is implemented, cost contracts should not be available. If a choice of contracts is offered in other markets, HMOs should be required to commit to the contract form they choose for more than one year.

Future Work

In addition to these recommendations, the Commission will be in a position to offer this Committee and others in the Congress additional policy advice concerning Medicare managed care options over the next few months. Among the many projects on our work plan are:

- Setting capitation payments for the risk contracting program. These analyses will extend the Commission's previous work by identifying potential markets where competitive bidding would be feasible, designing a bidding process and the structure of premiums for high bidders, and considering how to establish payment rates in areas where competitive bidding is not applicable. The Commission will also update its assessment of risk adjustment methods. In addition, it will analyze regional variation in benefits offered to Medicare HMO enrollees resulting from the current structure of payment policy.

- Structuring choices for Medicare beneficiaries. Questions of interest include the range of arrangements that might be made available; whether there should be financial incentives for beneficiaries to choose more cost-effective options and how those incentives would be structured; identification of statutory barriers to managed care growth; and how to better manage the fee-for-service sector of Medicare including case management, bundled payments, and risk-based carveouts.

- Access to care for Medicare beneficiaries. Building on the Commission's previous work on access, a strategy will be developed for monitoring access for those enrolled in managed care plans. In addition, a survey will be fielded to explore beneficiaries' willingness to enroll in managed care and to learn what policy changes might facilitate enrollment.

- Graduate medical education. Medicare's current payment methodology for risk-contracting HMOs has a flaw that results in overpaying many HMOs for expenses related to graduate medical education. The Commission will assess the impact of this policy and the implications of moving towards alternative financing approaches.

Conclusions

This past year, the Commission focused on improving the methods of paying HMOs. Changing the payment method is long overdue, but is also only one element in a strategy to improve the performance of the Medicare program. Medicare is at a crossroads. It can remain the last open-ended program dominated by fee-for-service payment and unrestricted choice of providers or it can follow the rapid evolution of the market in the choices it offers and the incentives it creates for beneficiaries to choose more cost-effective options. In addition to the policy changes the Commission has recommended, the Medicare program needs to continue monitoring the development of the market over time. Markets will continue to change and Medicare needs to be able to adapt to both current and future trends.

Chairman THOMAS. Thank you very much, Dr. Wilensky.
Dr. Altman.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Mr. ALTMAN. Thank you, Mr. Chairman. To keep things on a level playingfield and minimize time, I won't go through the recommendations that Gail Wilensky indicated, but I do want to make it clear that ProPAC shares the general thrust of those as well.

Another thing I want to make known to you is that the two Commissions are working together on managed care. We have had several meetings together. We are working collectively on our staffs to minimize duplication of effort, and in the future, we may be presenting you with joint recommendations and reports so as to be a more efficient help to you.

It is clear to us that Medicare needs to change. Managed care is growing quite rapidly in the Medicare Program, but it will never be able to get close to what is occurring in the private sector, and more importantly, you will never see the kinds of savings that you need in order to bring some balance in the trust fund and other areas unless and until substantial changes are made in Medicare, and particularly the way the current managed care system works. Gail has articulated well the problems with the AAPCC and some possible solutions which we mostly agree with.

What I would like to do this morning, though, is to give you the benefit of some recent research that ProPAC's staff have been engaged in to further your thinking about the issues; and quite frankly, Mr. Chairman, this information came as quite a shock to me, and I think I have a pretty good sense most the time of what is going on, and I suspect very few people realize what is going on.

One, we have been looking at total expenditures by the aged, not only the amount of money that is spent by Medicare and Medicaid, but also what is spent by the VA, the Defense Department, and other agencies of the government on behalf of the aged. And we have found that while, on average, it adds about 3.1 percent in total expenditures to the aged; in some areas of the country it exceeds 7 percent.

So to be fair in terms of an appropriate payment, it is appropriate to include these payments when one is calculating what the average aged person in an area receives, or you will discriminate against certain areas that currently use a lot of VA and DOD.

On the other side, the current AAPCC system was set up for the government to save a little, for the beneficiaries to get the benefit of joining these plans by getting extra benefits. What came as a rude shock to me is how large the difference is. Medicare has always prided itself on being the same program in all parts of the country and to all beneficiaries; that was its stock in trade. It turns out today that if you are a Medicare beneficiary in a high AAPCC area, a high-cost area, you can receive from the Medicare Program over $110 a month in extra benefits.

On the other hand, if you happen to be in a low AAPCC area, for a variety of reasons, you could receive zero extra benefits, even if you join a managed care plan. That is $110 versus zero per month. The average difference is $50.

Medicare is very quickly turning into a geographically experience-rated program, and it is being driven by what seemed like a fair way of paying, which is, you pay at the fee-for-service level, but it doesn't work like that.

The other thing we found is that the current way that Medicare pays the managed care plan for profits and administrative costs deals directly with the percent that they get for such services from the private sector. Then Medicare takes that rate and multiplies it times a much higher payment and gives the same percent, but a much higher amount to a plan.

Take two plans. One plan, say, provides most of its benefits to large beneficiary groups and therefore has low administrative cost; and let's say there is a fair amount of competition in that area, so their profit rates are down to a reasonable level.

Another area sells primarily in the fee-for-service market with a lot of extra advertising. So it has high administrative costs, plus maybe it doesn't have as much competition and so it has high profits. Medicare comes in and pays those rates. So you could have wide differences in the Medicare profits and administrative costs that are going to plans, when in fact the cost of providing those services to Medicare is exactly the same for both groups. So we are very concerned about restructuring the system to deal with that in a fair and equitable way.

Gail has indicated a number of changes that could be made in the way Medicare sets the rates, and they seem reasonable and consistent with the way we are thinking, as well; and the idea of phasing in and recognizing that you can't go to competitive bidding or some other form overnight also makes a lot of sense, but one needs to move.

We also recognize, when managed care started, the Medicare Program was very fearful of it, and there have been some abuses. We must recognize them, but also we recognize that most—the overwhelming proportion of Medicare beneficiaries in managed care plans enjoy it. They find the services more than adequate. They find the benefits fine. And this idea of counting on the 50–50 rule as the sole way to protect quality, that you have to have 50 percent of your population from the private sector, seems to be outdated. There are new and better methods of ensuring quality.

We need to guard the Medicare beneficiary against poor quality and bogus access, but the 50–50 rule is an arbitrary system that probably should go, if not immediately, over time, as we begin to develop better mechanisms for dealing with the system.

Now, one or two other points which we have talked about in context. The AAPCC includes a portion of the $10 billion of extra payments that Medicare makes to teaching hospitals, disproportionate-share hospitals and rural hospitals. We at ProPAC believe that the Congress was correct in trying to recognize certain special problems of the hospitals. We don't see the justification for continuing to include those payments in the AAPCC unless and until those moneys get redirected back to those institutions.

We don't want to force the managed care plans to use teaching hospitals if they don't want to. We want to encourage efficiencies. We believe other mechanisms should be set up to recognize the legitimate needs of this country for teaching hospitals, the special

problems of disproportionate-share hospitals and special problems of rural hospitals. So some mechanism needs to be developed to take that money out and then reallocate it in a different way.

Now, much has been made about the lack of adjustment for health status. There are 35 different adjusters and rate bases that Medicare now uses, but every study that has been done says, no matter how many different categories you come up with, we still do a poor job in adjusting for health status. And it is not because Medicare doesn't try; it turns out the methodology is just not there. And so the system gives many encouragements for plans, either directly or indirectly, to adjust who they select.

Now, to be fair to the managed care plans, most of them don't need to do anything. It is just how they market, who comes to them. My sense is that while there are a few bad apples out there that really do figure out ways, most of them don't have to do it. The problem you run into from the Medicare Program, though, is you are paying an average, and even if they didn't do anything, if they wind up with a less sick population, the Medicare Program loses substantial amounts of money.

So in total, Medicare should be moving much more to managed care. It is becoming the basic way health care is delivered in this country. Yes, senior citizens do need safeguards. One needs to be very concerned about the frail elderly, about people who have been in the fee-for-service for a long time. This should not be a shotgun, but we do need to move and move fairly aggressively to change the structure of the payment method and restructure the managed care program so that Medicare, as Gail has pointed out, moves into what is now becoming the dominant form of health care delivery in this country.

Thank you, Mr. Chairman.

[The prepared statement and attachments follow:]

TESTIMONY OF STUART H. ALTMAN, PH.D., CHAIRMAN PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Good Morning, Mr. Chairman. I am Stuart Altman, the Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied by Donald Young, M.D., Executive Director of ProPAC. I am pleased to be here today to discuss Medicare's managed care options and the improvements that are needed to improve their effectiveness. During my testimony, I will refer to several charts. These charts are appended to the end of my testimony.

You have recently held a series of hearings at which we and others have described the rapid rise in Medicare spending and the factors accounting for this growth. You also have examined the contributions of the Medicare program to the rising Federal deficit and the impending insolvency of the Medicare Part A Trust Fund. These are not new problems. In the early 1980s, Congress addressed these problems by enacting the Medicare prospective payment system for inpatient hospital services, physician payment reform, and other initiatives that collectively slowed the rise in Medicare spending and delayed the insolvency of the Trust Funds. As a result of these initiatives, the growth in Medicare expenditures per enrollee slowed considerably, falling substantially below the rise in private health insurance spending per member. These initiatives effectively controlled the increase in payment per unit of service, such as a hospital admission or visit to a doctor. They were less effective, however, in controlling the total number of services provided to each Medicare enrollee. More recently, Medicare spending has again accelerated, while the rise in private health insurance expenditures has moderated.

THE CONSEQUENCES OF FEE-FOR-SERVICE PAYMENT

Without additional reforms, Medicare spending is projected to continue growing about 10 percent a year. About half of this rise, or 5 percentage points, is due to increases in the number of Medicare enrollees and their average age and to inflation in the general economy. The remaining 5 percentage points is due to increases in the price of medical goods and services above general inflation and especially increases in the number and intensity of services furnished to Medicare enrollees. This rise in service volume and intensity is a result of several factors, including the aging of the

population and continuing medical advances. These factors are exacerbated, however, by Medicare's reliance on fee-for-service payment methods. These methods provide strong incentives for physicians and other providers to furnish more and more services and for beneficiaries to request more care, including the newest technologies. Frequently, however, the added services are of limited medical value.

THE TURN TO MANAGED CARE

The private insurance market has responded to rising health care costs by developing alternative payment systems based on capitation and managed care. These methods contain strong financial incentives for providers to control the number of services furnished, as well as the cost of each unit of service. There also are incentives for purchasers and their enrollees to choose the most efficient plans and to seek out plans that can demonstrate that they provide high quality care.

In 1993, 24 percent of insured individuals in the private sector were enrolled in health maintenance organizations (HMOs) (Chart 1). An additional 40 percent of individuals were enrolled in preferred provider organizations (PPOs), which use fee-for-service payment methods but limit enrollees choice of providers and frequently manage some of the care they receive. In contrast, in 1994 only 5.1 percent of Medicare beneficiaries were enrolled in the risk contracting program, which most closely resembles private sector options. This figure recently has increased to 6.6 percent. There are also substantial differences in Medicare risk plan enrollment across the states, ranging from more than 20 percent to none. While the number of Medicare beneficiaries choosing managed care plans is continuing to grow, we do not believe these rates will equal those for the privately insured under age 65 population until substantial changes are made in the Medicare program.

IMPROVING MEDICARE'S MANAGED CARE PROGRAMS

I would like to turn now, Mr. Chairman, to what we at ProPAC have learned about the operation of the current Medicare managed care options, their policies, and the problems with how they work.

Medicare offers several different types of managed care programs (Chart 2). In 1990, 1.9 million individuals were enrolled in one of these programs. By 1994, enrollment had increased to almost 3 million individuals (Chart 3), and by early 1995 more than 3.2 million beneficiaries were in Medicare managed care programs. More than 400,000 additional individuals were in the SELECT program. The most popular option is the fully capitated risk contracting program, which now enrolls over 76 percent of all Medicare managed care beneficiaries. Under a risk contract, Medicare pays a health plan a capitated rate per enrollee, and the plan is responsible for providing all necessary Part A and Part B covered services. Beneficiaries may be charged a copayment and, under certain circumstances, receive additional benefits. The plan can also offer Medicare enrollees additional benefits for which it can charge a premium, like other supplemental coverage policies. Plans must have annual enrollment periods and meet other requirements. Each month, however, beneficiaries may elect to disenroll from the plan.

In addition to the risk contracting program, Medicare also contracts with managed care plans to provide benefits on a cost-reimbursement basis. These contracts allow managed care plans to participate in Medicare without assuming financial risk for treating these patients. There are two types of cost contracts. The first, referred to as Section 1876 reasonable cost plans, provide all Part A and Part B Medicare benefits and must meet requirements that are similar to those for risk plans. In 1994, about 5 percent of Medicare's managed care beneficiaries were enrolled in one of the 27 cost plans (Chart 2). The second type of contract, known as health care

prepayment plans (HCCP), provides only Part B services. There were 62 of these plans in 1994, accounting for about 20 percent of Medicare's managed care enrollees.

Medicare also has several managed care demonstrations. These include the Medicare Select program, which uses a preferred provider network to furnish Medigap supplemental coverage. The Medicare program is also sponsoring the Social Health Maintenance Organization (SHMO) demonstration, which uses HMOs to link nursing home and community-based services with acute care. The PACE program provides managed care for the frail, generally poor, elderly population.

THE RISK CONTRACTING PROGRAM

The Medicare risk program has the potential to slow the rise in Medicare spending. The evidence to date, however, indicates that it has not achieved this goal. There are a number of reasons for this. They include the methodology used to calculate the payment for each plan, requirements regarding differences between each plan's payments and expected costs, and Medicare's policies regarding enrollment and disenrollment, including the lack of an adequate adjustor for health status. In addition, each year plans are allowed to convert from a risk contract to a cost contract or vice versa. There also are problems regarding Medicare's extra payments to teaching, disproportionate share, and rural hospitals that I will describe.

The development of Medicare's payment rate is based on a simple idea that has not worked as intended. The notion was to calculate a capitated amount that gives HMOs incentives to provide care at less cost than fee-for-service providers. In concept, Medicare was to generate savings because its payment to risk plans is set at a level less than the average spending that would otherwise be expected to occur in an area. Medicare pays a risk plan a capitated rate equal to 95 percent of the average Medicare fee-for-service program spending in the county in which the enrollee lives. This amount is adjusted to reflect age, sex, Medicaid status, institutional status,

and employer-based coverage. This average county-level spending is called the adjusted average per capita cost or AAPCC. In practice, this payment approach has numerous flaws that discourage many plans from participating and limit savings to the Medicare program.

CALCULATING THE AMOUNT OF THE AAPCC

A major problem with the AAPCC is the geographic area used to calculate the capitated payment rate. This area currently is the county. Many counties, however, may not have a sufficiently large population to adequately average fluctuations in fee-for-service payments. This may result in wide variations in the AAPCC from one year to another. Between 1994 and 1995, the increase in the AAPCC ranged from 2.1 percent to 9.5 percent for the 50 counties with the largest risk enrollment (Chart 4).

There also are large variations in payment rates among areas. In the top 50 counties, the monthly payment rates in 1995 varied from $292 in Marion County Oregon to $647 in Kings County New York. These regional variations are significantly larger than the variations in payment by the Federal Employees Health Benefit program for HMO coverage for federal workers. In addition, a plan offering services across several neighboring counties may receive very different capitated amounts even though their costs per beneficiary may be similar. For example, in 1995 in the Washington D.C. area the monthly capitated rate varied from $361 in Fairfax County to $543 in Prince Georges County. In the Minnesota Twin Cities Metro Area, the rate varied from $277 to $380 (Chart 5).

Part of the variation may be due to flaws in the calculation of the AAPCC, which excludes average expenditures for VA, military, or other programs used by Medicare enrollees. A recent ProPAC analysis found that the value of the services provided by these non-Medicare programs averaged about 3.1 percent of total Medicare per enrollee costs across all states. The variation across individual states ranged from 1.2

percent to 7.4 percent. The failure to recognize the value of the services furnished by VA and DOD facilities results in a capitated amount in some counties that is too low, possibly discouraging plan participation.

The variability and uncertainty regarding the level of the AAPCC may discourage some plans from participating in the program. Currently, about 25 percent of plans operating in the private sector participate in Medicare's risk contracting program. The wide variation in payment rates at the county-level also provides incentives and opportunities for plans to attract beneficiaries who live in counties with higher payment rates and to avoid those in counties with low rates.

While fee-for-service spending may provide a useful benchmark to gauge the level of the capitated payment, setting the rate at this level may not result in Medicare achieving the savings, especially in high cost areas, that HMOs should be able to achieve. In addition, this approach does not provide incentives for plans to compete with each other to enroll beneficiaries at the lowest price. It also encourages plans to participate in high cost areas, while discouraging participation in low cost areas.

COMPARING EXPECTED COSTS AND PAYMENTS

Medicare allows plans to choose to either return any difference between expected cost and Medicare payments to the program or to provide additional benefits, that otherwise would not be covered by Medicare, to the beneficiary. Not surprisingly, plans opt to provide the benefits rather than returning the savings.

These policies limit Medicare savings and result in beneficiaries' benefit packages varying by plan and where they reside. ProPAC has recently completed a preliminary analysis of the effects of these policies. Plans that wish to enter into or continue risk contracts are required to submit an adjusted community rate proposal (ACR) that calculates their expected cost (which include overhead and profits) to

provide Medicare covered services to Medicare enrollees. If these costs are less than the expected payment, plans are required to provide additional benefits to the enrollee or to return the difference to the Medicare program. Of course they all elect to provide the benefits, and the Medicare program fails to gain from their efficiencies. Plans argue that if they do not offer these extra benefits, given the structure of the Medicare program, few beneficiaries will join a managed care plan. While there may be truth in such contentions, it is hard to understand why all of the higher payments should go to these extra benefits.

Our analysis of the ACR data indicate that managed care plans in areas with high fee-for-service (FFS) costs have higher costs than plans in areas with lower costs. However, the costs incurred by managed care plans rise more slowly than FFS costs and Medicare payments. In fact, our analysis showed that in 1994 a $100 increase in Medicare's payment to the plan was associated with only a $72 increase in its cost of providing Medicare covered services. Consequently, in high cost areas plans returned $28 in additional services or reduced liability to the beneficiary for every $100 increase in the AAPCC, and Medicare did not share in the savings.

There is substantial variation in the monthly value of the added benefits that are provided at no cost to Medicare risk plan enrollees (Chart 6). Ten percent of enrollees received additional monthly benefits worth between $111 and $139. At the other end of the spectrum, 10 percent of enrollees received additional benefits of less than $10 with some receiving no extra benefits.

There is one other aspect of Medicare's treatment of expected plan cost and payments that I would like to mention, Mr. Chairman. As part of their calculations, plans include the combined percentage of their costs due to administrative overhead and profits in their private business. Medicare allows them to keep this same percentage of their expected costs for overhead and profit. Since Medicare's capitated payment is much higher than the capitated rate in their private business, the

actual payment per enrollee for administrative costs and profit is also much higher. This policy encourages plans with high administrative costs and profits to participate in the Medicare program, and it discourages plans that have kept these costs low.

TEACHING, DISPROPORTIONATE SHARE, AND RURAL HOSPITALS

There also are substantial problems with the way the Medicare risk contracting program deals with payments to teaching, disproportionate share, and vulnerable rural hospitals. Capitation and managed care in the public and private sectors is designed to increase the pressure on all providers to contain costs in order to compete. Certain providers, such as those located in remote rural areas or urban underserved areas may be disadvantaged in responding to such pressure. Other providers that furnish services such as training of the future health care work force and research and those that serve a disproportionate share of low income patients are also at risk. During 1994, 41 million people had no health insurance at some time during the year. Hospitals, physicians, and other providers traditionally have furnished needed services to many of the uninsured, by subsidizing these costs.

In 1994, the Medicare program provided about $10 billion in extra payments to certain rural, teaching, and disproportionate share hospitals to recognize the costs they incur that other hospitals do not bear. The extra costs to produce socially valuable services, however, may not be recognized in a price competitive health care financing and delivery system. The Medicare risk contracting program, in fact, does not appropriately account for these payments or costs. Because the AAPCC is based on Medicare's total fee-for-service payments in a particular geographic area, it includes the special payments to these facilities. The plan, however, is not obliged to use these providers or pass along the extra payments to them.

The Medicare program provides these extra payments in recognition of the unique contributions of these facilities by assisting them financially and, therefore,

maintaining access to care for Medicare beneficiaries. Removing these extra payments from the calculation of the AAPCC and distributing them to the appropriate providers, based on the care they furnish to Medicare risk enrollees, would allow these facilities to compete for patients on a more equal footing with other providers in their area.

LACK OF ADJUSTMENT FOR HEALTH STATUS

Another concern with Medicare's capitation rate is the lack of an effective means to adjust payments to reflect differences in beneficiary health status. Medicare uses five factors to adjust the capitated rate--age, sex, institutional status, Medicaid status, and employer-based coverage. However, these measures do not adequately account for variations in potential costliness, and plans have strong incentives to avoid sicker enrollees. The recent evaluation of the risk contracting program found that this lack of adequate risk adjustment was responsible for the failure of the risk contracting program to achieve the Medicare program savings that were expected. Program costs were almost 6 percent higher than they would have been under the fee-for-service option. A recent national household survey, however, did not find substantial differences in self-reported health status between those elderly enrolled in HMOs and those in the fee-for-service program.

Adjusting capitated payment rates to reflect health status will be much more difficult for the Medicare program than for the private sector because Medicare enrollees generally are sicker than the general population. It is even more important to do so, however, since it may be easier for plans to identify and avoid more costly Medicare beneficiaries.

ENROLLMENT AND DISENROLLMENT POLICIES

Medicare's enrollment and disenrollment policies differ substantially from those in the private sector. In the private sector, employees may not have the choice of a fee-

for-service indemnity plan. They also may be required to select from among a small number of the HMOs participating in their geographic area (Chart 7). Some employees pay higher premiums or face greater cost sharing requirements if they choose a more costly plan. Further, once they enroll in a plan, they must wait up to one year for the next open enrollment period before they can disenroll or change plans.

Unlike private sector enrollees, Medicare beneficiaries can choose any fee-for-service provider or participating managed care plan operating in their area. They may not bear the added costs related to choosing the most costly providers or plans. In fact, as I described, beneficiaries living in areas with the highest capitated payments receive substantial additional services at little or no added cost while beneficiaries living in lower cost areas must pay for their additional services. Further, Medicare beneficiaries enrolled in a capitated health plan may disenroll from that plan on a monthly basis and automatically be covered under Medicare's fee-for-service policies.

While Medicare's enrollment policies are more favorable to beneficiaries than private sector policies, it is important to note that the benefits they receive may not be as extensive as those provided to private sector HMO members. The lack of a prescription drug benefit is especially noteworthy.

There is much more movement of Medicare beneficiaries in and out of plans than there is in the private sector. Medicare enrollees in many areas seem to be confused about how the plans operate and, therefore, drop out. In other situations, Medicare beneficiaries seem to find it advantageous to disenroll from one HMO and enroll in another. In 1993, risk plan enrollment increased 37 percent; disenrollment during that year was 18 percent of enrolled beneficiaries (Chart 8).

The relationship between the rates of enrollment and disenrollment varied across geographic areas (Chart 9). The Dallas, San Francisco, and Philadelphia regions

were characterized by higher than average enrollment rates during 1993 and average or slightly higher disenrollment rates. Enrollment rates in the Seattle and Kansas City regions were notably low. The Boston and Denver regions experienced lower than average enrollment and disenrollment rates in 1993. Anecdotal information suggests that Boston enrollment has accelerated in the last year. No clear patterns emerge to explain the variations in these findings. The Seattle region had high private sector HMO penetration and exhibited little Medicare risk beneficiary turnover--either enrolling or disenrolling. In contrast, however, the San Francisco area, again with high private sector managed care enrollment, had higher than average enrollment rates, possibly due to the large number of plans, particularly new plans, in the area.

CHARACTERISTICS OF PLANS

Plan-specific data for those with the highest and lowest disenrollment rates highlights some characteristics that may be important in determining a plan's ability to satisfy Medicare beneficiaries (Chart 10). The five plans with the highest disenrollment rates in 1993 were for profit, independent practice association model HMOs. In contrast, the five plans with the lowest disenrollment rates were all nonprofit and group or staff model HMOs. Group and staff model HMO plans have more controls over enrollee service use and tend to have stronger relationships with their providers than IPAs. Further, they are the older HMO models, so they likely have a longer history in the private sector market. Plans with the lowest disenrollment rates also had participated in the Medicare risk program longer and, although they had about the same number of enrollees as plans with higher disenrollment rates, they had fewer new enrollees.

Analysis of data from the Group Health Association of America highlight some of these characteristics as important in distinguishing plans that participate under Medicare at all. IPA model HMOs and for-profit plans are the predominant types of HMOs, yet have lower than expected Medicare participation. Younger plans and

those with smaller total enrollments are also less likely to participate. These factors may reflect the added risk of the Medicare population, the administrative costs of enrolling Medicare beneficiaries, or the geographic distribution of plans.

In a survey conducted by the Office of the Inspector General, most Medicare risk plan enrollees indicated that they were satisfied with their care. In fact, most who disenrolled from a plan, enrolled in another risk plan. About one-third of those who left a plan did so for administrative reasons--they moved or their supplemental insurance changed. The rest disenrolled for reasons that may relate to the quality of the health plan or beneficiary preferences in health care delivery. These reasons for disenrollment included believing that premiums or copayments were too high, wanting to use providers not participating in the plan, or having to wait too long for appointments. It should be recognized, however, that most Medicare enrollees remain in the capitated plan they selected initially.

IMPROVING MEDICARE'S MANAGED CARE PROGRAMS

Major changes in Medicare's policies are necessary to achieve the savings that are possible through managed care. Information presented to the Commission suggests that managed care is capable of generating significant reductions in beneficiary utilization without impairing access to quality care. In addition, ProPAC analyses have shown that those states with the lowest hospital per capita cost increases between 1980 and 1993 generally had the highest percentage of private sector HMO enrollment in 1993. In contrast, all the states with the highest per capita cost growth had lower than average HMO enrollment (Chart 11).

Medicare, however, is not taking advantage of the potential for savings. To do so requires altering the method for determining the monthly capitated rate and the services included within this rate, changing the incentives for beneficiaries to choose this option, and encouraging HMO growth and participation in the program.

The first step is to change the way Medicare determines its capitated payment mount, especially breaking the link to fee-for-service spending at the county level. ledicare could avail itself of the competition that is occurring in the private market nd require plans to compete for enrollees based on a premium bid from each plan for ıe standard set of Medicare benefits. Medicare could then set its capitated payment ased on the average price submitted or some percentage of it. Medicare also should xplore approaches that use a process of negotiation. Such an approach may be specially valuable in areas with a limited number of plans. Under any approach, owever, Medicare can use its payments for comparable patients receiving care in the e-for-service sector as a benchmark or ceiling in determining the capitated rate. his benchmark, however, should be adjusted to reflect the services Medicare eneficiaries receive from the Departments of Veterans Affairs and Defense that are ot now included in the AAPCC.

The benchmark and the capitated rate also should not include Medicare's aduate medical education, indirect medical education, disproportionate share, or dditional sole community hospital payments. Other mechanisms can be used to stribute these payment to the appropriate facilities when they provide services to edicare beneficiaries enrolled in the managed care program.

To assist plans that wish to participate in the program and to reduce the cost of rolling Medicare beneficiaries, Medicare should establish mechanisms to help duce the cost of advertising. It may also need to require beneficiaries to pay more if ey wish to stay in the fee-for service program. Such a requirement could be phased over time.

In addition, the county should be eliminated as the geographic area used to etermine the capitated amount. There are a number of alternatives that can be onsidered, including Medicare's current geographic groupings (metropolitan statistical eas) used for hospital payment. The feasibility of combining counties to achieve a

minimum population level or to reflect reasonable managed care market areas also should be explored.

The capitated rate that is set should cover Medicare's standard benefit package, although plans should be allowed to offer supplemental benefits to their enrollees for an additional premium. The current practice of comparing a plan's expected costs with its expected payments and allowing it to use the difference to provide additional benefits severely limits the opportunity for the Medicare program to share in the savings from more efficient service delivery. It also alters the uniform benefit structure of the Medicare program and raises questions of fairness for those beneficiaries who reside in relatively low cost areas.

Medicare's beneficiaries also should share in the savings when they choose a cost efficient plan. This can be done by linking their cost sharing requirements to the plans' premiums. Beneficiaries that wish to choose a more costly plan should share in the additional cost of their choice. Such an approach maintains Medicare's tradition of freedom of choice but provides financial incentives for beneficiaries to evaluate the value of a higher cost plan in terms of their added payment responsibilities. Plans, however, must make appropriate information concerning price, access, and quality of care available to Medicare enrollees during a coordinated annual open enrollment period.

Newly enrolled beneficiaries also should be given a limited period of time following each enrollment period during which they can switch plans or return to the fee-for-service sector. Thereafter, however, they should be required to wait for an annual enrollment season.

PROTECTING BENEFICIARY ACCESS TO QUALITY CARE

While expansion of Medicare's risk contracting program has the potential to slow the rise in Medicare spending, it also could have negative effects on beneficiary access to services and the quality of care they receive. Because plans use network providers, beneficiaries may be limited in their choice of physicians and hospitals. If their current provider is not in the plan's network, they will have to change practitioners, thereby disrupting their relationship with their physician and their continuity of care. In addition, managed care plans rely on utilization management practices that may limit the services they receive. Although there is no consensus about whether these restrictions impede or improve quality, they are sometimes perceived as limiting the beneficiary's access to services.

Collecting and making data available on plan and provider outcomes can help enrollees measure the strengths and weaknesses of different plans, and help them choose the plan that best meets their needs. The availability of such data in the Medicare managed care program varies widely. In California, Arizona, and Nevada, HCFA's regional office is disseminating information. In other areas, elderly advocacy and insurance advisory groups are compiling it. However, in most of the nation no such information exists.

Current program rules require participating HMOs to enroll at least 50 percent of their membership from sources other than Medicare or Medicaid. When this requirement was established, it was intended to be a quality assurance measure. The rule was predicated on the assumption that quality care for Medicare beneficiaries could be enhanced since plans would have to provide an appropriate level of care to attract private sector enrollees. Since then, quality measures have been developed in the private sector that allow enrollees to compare plan prices, outcomes, beneficiary satisfaction ratings, and other related information. These measures are now being refined to reflect the elderly population. Medicare should make these alternatives for

assuring quality of care widely available to its beneficiaries, rather than relying on arbitrary enrollment percentages.

Finally, Mr. Chairman, the Medicare program needs to move quickly to improve its ability to adjust payment rates to reflect differences in the health status of Medicare beneficiaries. Although coordinated annual enrollment and other plan requirements can help to reduce the ability of plans to favorably select the healthiest enrollees, this will continue to be a problem that will reduce the amount of Medicare savings from its managed care program.

CONCLUSION

Medicare's current managed care policies have several serious problems that have limited plan participation and beneficiary enrollment and kept the program from achieving the savings that are possible. These policies allow risk plans the opportunity to select healthier enrollees as well as individuals who reside in areas where Medicare's capitated payments are higher. They also allow beneficiaries the opportunity to return to the fee-for-service sector when they believe that is to their advantage. Further, beneficiaries who live in relatively high cost areas are rewarded for joining such plans with additional services that are not otherwise covered by Medicare. Beneficiaries residing in relatively low cost areas do not get these added benefits, and in fact may not even have the opportunity to join a risk plan since the low payment rate discourages plan participation.

The Commission would be pleased to continue working with you as you modify and improve Medicare's managed care policies. I would be happy to answer any questions you have.

Chart 1. Managed Care Enrollment, by State and Payer (In Percent)

State	Private Sector[a]	Medicare[b]	Medicaid[c]
National average	24.1%	5.1%	17.2%
California	51.4	20.9	15.3
Massachusetts	47.8	3.2	61.0
Oregon	40.4	19.9	70.2
Maryland	37.2	0.1	23.9
Rhode Island	36.6	7.8	1.2
Hawaii	33.8	8.9	4.8
Minnesota	31.8	9.1	27.7
Utah	31.8	0.0	42.7
New York	31.4	2.9	12.5
Colorado	30.6	9.5	8.4
Arizona	29.6	23.4	100.0
Connecticut	28.4	0.0	0.0
Wisconsin	28.3	0.0	24.2
New Mexico	25.8	11.6	0.0
Delaware	25.3	0.0	4.1
Michigan	23.6	0.5	20.0
Pennsylvania	22.9	1.7	24.9
Washington	22.5	9.2	55.8
Missouri	21.5	1.8	5.2
Illinois	21.2	3.8	6.9
New Jersey	21.0	0.1	5.0
Florida	20.0	13.1	19.9
Ohio	18.9	1.1	12.7
New Hampshire	17.8	0.0	12.3
Kentucky	17.8	0.5	0.0
Nevada	16.7	15.9	29.7
Vermont	15.6	0.0	0.0
Texas	15.0	2.6	1.5
Louisiana	13.9	0.0	0.0
Oklahoma	13.0	2.1	0.0
Virginia	11.0	0.1	0.0
Georgia	10.8	0.0	0.3
North Carolina	10.5	0.0	14.0
Indiana	9.7	0.3	0.0
Alabama	9.7	0.0	0.0
Kansas	8.5	0.6	0.0
Nebraska	8.5	1.3	0.0
West Virginia	7.4	0.0	0.0
Tennessee	7.2	0.0	100.0
Arkansas	7.0	0.0	0.0
Maine	6.2	0.0	0.0
South Carolina	5.6	0.0	0.0
Iowa	5.2	0.0	8.8
South Dakota	5.1	0.0	0.0
Montana	2.1	0.0	0.0
Idaho	2.0	0.0	0.0
North Dakota	0.6	0.0	0.0
Mississippi	0.1	0.0	0.0
Alaska	0.0	0.0	0.0
Wyoming	0.0	0.0	0.0

[a] Nonelderly privately insured population in health maintenance organizations, July 1993.

[b] Medicare population in risk contracting plans, January 1994.

[c] Medicaid population in fully or partially capitated plans, July 1994.

SOURCE: InterStudy; Employee Benefit Research Institute; Health Care Financing Administration, Office of Managed Care and Medicaid Bureau; and Lewin-VHI, Inc., *States as Payers: Managed Care for Medicaid Populations* (Washington, DC: National Institute for Health Care Management, 1995).

Chart 2. Summary of Medicare Managed Care Contracts, June 1994

Type of Contract	Number of Plan Contracts	Number of Beneficiaries Enrolled
Total	268	3,280,438
Risk	133	1,996,169
Cost	27	169,495
Health Care Prepayment Plan	62	655,559
Social HMO	4	22,052
SELECT	32	435,300
PACE	10	1,863

Chart 3. Medicare Managed Care Enrollment and Payments, 1990-1994

	Combined Contracts*				Risk Contracts			
	Enrollment		Payments		Enrollment		Payments	
Year	Number (In Millions)	Percent Change	Amount (In Billions)	Percent Change	Number (In Millions)	Percent Change	Amount (In Billions)	Percent Change
1990	1.9	—	$ 4.9	—	1.2	—	$4.2	—
1991	2.1	10.5%	5.9	18.7%	1.3	8.3%	4.9	16.7%
1992	2.3	9.5	6.9	17.7	1.5	15.4	5.7	16.3
1993	2.5	8.7	8.6	24.5	1.7	13.3	7.2	26.3
1994	2.9	16.0	10.6	23.1	2.1	23.5	9.1	26.4

Note: Data are as of September each year.

* The combined contracts include risk, social health maintenance organization, cost, and health care prepayment plans.

SOURCE: Health Care Financing Administration, Office of Managed Care.

Chart 4. Comparison of 1994 Versus 1995 Aged Monthly Adjusted Average Per Capita Costs, by County Risk Contracting Enrollment

Rank*	County	State	1995 Total Rate	Total Rate Change from 1994	Total Percentage Change from 1994
1	Los Angeles	California	$558.76	$26.73	5.02%
2	San Diego	California	458.81	23.84	5.48
3	Broward	Florida	544.02	26.81	5.18
4	Dade	Florida	615.57	40.05	6.96
5	Orange	California	523.12	24.11	4.83
6	Riverside	California	464.00	18.58	4.17
7	San Bernardino	California	466.92	21.75	4.89
8	Maricopa	Arizona	440.64	22.53	5.39
9	Cook	Illinois	485.26	24.09	5.22
10	Palm Beach	Florida	473.41	21.38	4.73
11	Multnomah	Oregon	373.35	15.78	4.41
12	King	Washington	377.09	13.23	3.64
13	Hennepin	Minnesota	362.85	10.75	3.05
14	Pinellas	Florida	410.08	26.17	6.82
15	Volusia	Florida	364.96	20.90	6.07
16	Bexar	Texas	404.37	22.51	5.89
17	Monroe	New York	400.40	23.97	6.37
18	Pima	Arizona	399.81	14.14	3.67
19	Hillsborough	Florida	414.04	20.73	5.27
20	Ramsey	Minnesota	379.82	21.34	5.95
21	Worcester	Massachusetts	453.09	15.27	3.49
22	Pasco	Florida	438.80	27.27	6.63
23	Kings	New York	646.88	36.33	5.95
24	Clark	Nevada	462.83	33.01	7.68
25	Orange	Florida	433.50	21.69	5.27
26	Washington	Oregon	374.82	21.16	5.98
27	Clackamas	Oregon	350.45	23.26	7.11
28	Bernalillo	New Mexico	352.38	9.77	2.85
29	San Mateo	California	397.73	18.03	4.75
30	Ventura	California	445.67	23.33	5.52
31	Denver	Colorado	435.63	23.63	5.74
32	San Francisco	California	467.03	20.90	4.68
33	Queens	New York	592.89	32.74	5.84
34	Cuyahoga	Ohio	474.45	9.66	2.08
35	Middlesex	Massachusetts	480.33	16.84	3.63
36	Snohomish	Washington	364.28	14.08	4.02
37	Honolulu	Hawaii	352.89	14.30	4.22
38	Kern	California	444.28	29.58	7.13
39	Nassau	New York	514.93	30.12	6.21
40	Jackson	Missouri	435.32	17.33	4.15
41	Jefferson	Colorado	371.29	19.51	5.55
42	Clark	Washington	324.53	22.14	7.32
43	Philadelphia	Pennsylvania	625.81	17.48	2.87
44	Montgomery	Pennsylvania	465.04	17.57	3.93
45	Suffolk	New York	477.83	21.56	4.73
46	Marion	Indiana	418.97	18.02	4.49
47	Nueces	Texas	415.09	21.42	5.44
48	Erie	New York	360.33	9.58	2.73
49	Marion	Oregon	291.50	20.08	7.40
50	Anoka	Minnesota	342.40	29.69	9.49

* The county with the largest number of Medicare beneficiaries enrolled in risk contracting plans is given the number 1 ranking.

SOURCE: Health Care Financing Administration, Office of Managed Care.

Chart 5. Standardized Per Capita Rates of Payment for Aged Enrollees in Selected Areas, 1995

Area	Rate of Payment
Washington, DC-Maryland-Virginia	
Washington, DC	540
Prince Georges County, MD	543
Montgomery County, MD	426
Manassas Park City, VA	464
Falls Church City, VA	408
Alexandria City, VA	407
Arlington County, VA	396
Fairfax City, VA	367
Fairfax County, VA	361
Twin Cities metro area	
Ramsey (St. Paul)	$380
Hennepin (Minneapolis)	363
Anoka	342
Dakota	334
Washington	324
Carver	285
Scott	277
Southern Florida	
Dade	616
Broward	544
Palm Beach	473
Southern California	
Los Angeles	559
Orange	523
San Diego	459

Note: The 1995 U.S. per capita cost for aged enrollees is $401; 95 percent of the U.S. per capita cost is $380, which corresponds to the standardized per capita rate of payment.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 6. Monthly Value of Medicare Non-Covered Benefits Provided at No Cost to Medicare Risk Plan Enrollees, By Decile of Risk Plan Enrollees, 1994

Enrollee Decile	Monthly Value of Benefits
1	$ 0 - 10
2	10 - 27
3	27 - 39
4	40 - 45
5	47 - 52
6	55 - 63
7	64 - 75
8	75 - 89
9	91 - 110
10	111 - 139

* Each decile includes 226,800 risk plan enrollees.

SOURCE: ProPAC analysis of Adjusted Community Rate Proposal data from the Health Care Financing Administration.

Chart 7. Firms Offering Various Insurance Options, by Size, 1994 (In Percent)

Firm Size	Indemnity	Preferred Provider Organization	Point of Service	Health Maintenance Organization
All firms	46%	30%	15%	22%
Employees				
10-499	46	30	15	22
500+	60	40	25	53

Note: More than 90 percent of the sampled firms had fewer than 500 employees. This proportion reflects national employment distributions.

SOURCE: A. Foster Higgins & Co., Inc., *National Survey of Employer-Sponsored Health Plans, 1994.*

Chart 8. National Enrollment and Disenrollment Rates for Medicare Risk HMOs, 1993

Year	Enrollment Rate (In Percent)	Disenrollment Rate (In Percent)	Enrollment Ratio
1989	34%	16%	2.1
1990	35	19	1.8
1991	30	18	1.7
1992	32	19	1.7
1993	37	18	2.1

Note: Plans in operation less than two years are excluded.

SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of Prepaid Health.

Chart 9. Enrollment and Disenrollment Rates for Medicare Risk HMOs, by Region, 1993

Region	Enrollment Rate (In Percent)	Disenrollment Rate (In Percent)	Enrollment Ratio
Nation	37%	18%	2.1
Dallas	52	24	2.2
Atlanta	31	23	1.3
San Francisco	47	18	2.7
Philadelphia	65	17	3.8
Seattle	18	16	1.1
New York	33	15	2.3
Chicago	20	14	1.5
Kansas City	17	13	1.3
Boston	22	10	2.1
Denver	26	9	3.0

Note: Plans in operation less than two years are excluded.

SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of Prepaid Health.

Chart 10. Characteristics of 10 Plans with Highest and Lowest Medicare Risk Disenrollment Rates, 1993

Disenrollment Rate	Average Disenrollment Rate	Average Enrollment Ratio	Average Years in Medicare	Average Medicare Enrollment	Model Status	Type
Highest	45.6%	1.8	5.3	14,999	For Profit	IPA
Lowest	6.3	2.2	7.2	15,242	Non Profit	Staff or Group

Note: Plans in operation less than two years are excluded.

SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of Prepaid Health.

Chart 11. Hospital Per Capita Cost Growth and Private Sector HMO Enrollment for Selected States (In Percent)

Rank	State	Hospital Per Capita Cost Growth 1980-1993[a]	1993 Private Sector HMO Enrollment[b]
1	Nevada	6.0%	16.7%
2	California	6.8	51.4
3	Kansas	7.4	8.5
4	Illinois	7.4	21.2
5	Arizona	7.4	29.6
6	Minnesota	7.5	31.8
7	Colorado	7.5	30.6
8	Maryland	7.7	37.2
9	Wisconsin	7.7	28.3
10	Rhode Island	7.8	36.6
National average	All	8.8	23.8
41	Georgia	9.7	10.8
42	South Dakota	9.9	5.1
43	New Jersey	9.9	21.0
44	North Carolina	10.0	10.5
45	Louisiana	10.0	13.9
46	Tennessee	10.1	7.2
47	Kentucky	10.3	17.8
48	Arkansas	10.3	7.0
49	South Carolina	10.5	5.6
50	New Hampshire	10.9	17.8

Note: HMO = health maintenance organization.

[a] Hospital per capita cost growth is measured as annual change in hospital costs per capita from 1980 to 1993.

[b] Private sector HMO enrollment is based on 1993 plan-level data as a proportion of each state's nonelderly privately insured population.

SOURCE: ProPAC analysis of data provided by InterStudy; Employee Benefit Research Institute; American Hospital Association; and Department of Commerce, Bureau of the Census.

Chairman THOMAS. Thank you very much, Dr. Altman.

Mr. Ratner.

STATEMENT OF JONATHAN RATNER, ASSOCIATE DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. RATNER. Thank you, Mr. Chairman.

Mr. Chairman, Members of the Committee, good morning. We are pleased to be here to discuss opportunities to improve Medicare's method of paying HMOs that enroll Medicare beneficiaries.

As we stated this past February in testimony to this Committee, Medicare's dominant HMO option, known as the risk contract program, has not been able to harness the cost-saving potential of managed care. This finding takes on greater importance as health care payers, seeking to slow rapid growth in health spending, look increasingly to managed care, as we have heard.

About 7 percent of Medicare's population are HMO enrollees in the risk contract program. But recent proposals aimed at slowing Medicare spending growth call for moving a greater proportion of beneficiaries into HMOs. In view of congressional interest—and it is growing and expanding—in Medicare's HMO Program, you asked us to discuss the program's payment problems and its potential for change.

I am honored to follow Dr. Altman, Dr. Wilensky, but I confess it is a bit of a burden. I am going to be covering some of the same ground, but I will try to highlight a few things that are a little different.

In brief, HCFA needs to act promptly to correct flaws in the way Medicare sets HMO payment rates. We have heard already that enrollment growth has been very rapid. This increases the urgency of correcting rate-setting flaws that result in unnecessary Medicare spending.

As you stated at the outset, Mr. Chairman, enrollment, in fact, has been growing dramatically since 1992. In fact, in addition, enrollment growth is concentrated geographically. A rather remarkable statistic is that in 1994, 15 States, accounting for over half of Medicare beneficiaries, experienced double digit growth in HMO enrollment. Against this backdrop, let me just talk a bit about the payment problem.

How Medicare pays HMOs can be looked at from a couple of perspectives. From the perspective of Medicare and the taxpayer, there are a pair of problems. First, Medicare caps its potential savings from HMOs by setting its payment rate at 5 percent below fee-for-service costs. Now, the cost advantage of HMOs appears considerably greater than 5 percent, whether one looks at reports of specific HMOs generating great efficiencies, or HMO premiums for employees declining, or research studies.

There is HCFA-sponsored research, good research, that finds that Medicare HMOs, in caring for their enrollees, have costs at least 10 percent below fee-for-service. But as we have heard, Medicare's formula for setting these payment rates largely precludes the taxpayer and the Medicare Program from sharing in any of the HMO savings beyond 5 percent.

Now, second, by not adjusting its rates appropriately for whether HMO enrollees are healthier or sicker than average, Medicare pays more than necessary—by some estimates, about 6 percent too much; by others, about as much as 28 percent. This is the famous favorable selection or risk selection problem.

Now, these payment problems for Medicare coexist with real operational problems for HMOs in the Medicare business, and Dr. Wilensky has talked about some of those already. From the perspective of the HMOs, they see at least two problems. First, that the payment rates that Medicare has vary considerably between counties without necessarily reflecting the actual costs of providing care.

Here is an example: Medicare pays an HMO 27 percent less for serving a beneficiary living in Prince George's County, Maryland than for serving an otherwise identical person living in neighboring Montgomery County, Maryland, even if the two people are treated in the same facility by the same doctor.

Second, in some counties, the HMO rates can increase or decrease dramatically from year to year. This can deter HMOs from participating in counties with volatile Medicare rates.

Now, our work drives home two points that would make success more likely if the Congress pursues expanding Medicare managed care and better pricing of capitated health plans. One, with respect to pricing these plans in Medicare, one size does not—does not—fit all. Market conditions vary too much and in important ways, even among metropolitan areas. Two, details matter. How programs are designed and implemented often makes the difference between failure and success.

As for solutions, we believe a sensible approach would vigorously and concurrently pursue three strategies: Increase price competition among HMOs, make risk adjusters more accurate, and correct the pricing of HMO plans based on modifying the existing formula-based approach. Our written statement contains the details of these strategies.

By pursuing multiple strategies, by carefully monitoring experience, Medicare could benefit from early action, while gaining more information on how well these strategies work and how they might be better implemented.

In particular, we believe that HCFA should move quickly to implement a better risk adjuster. Last year, we recommended that they look at four risk adjusters and move quickly on demonstration projects. This year, we think they should select one of the four that is more administratively feasible and implement it as an interim fix. Meanwhile, HCFA could devote its resources to refining a more sophisticated risk adjuster.

Finally, we believe that HCFA should move forward without delay in launching demonstration projects on competitive bidding, and you have heard about that already. By trying competitive bidding in different regions, HCFA can obtain valuable information about what works and what doesn't work.

For example, demonstration projects could test different ways of penalizing HMOs that lose on the bidding. However, demonstration need not equate with delay. If a demonstration testing the competitive pricing of health plans results in savings, Medicare will reap

these gains without committing itself to a single nationwide solution immediately.

Mr. Chairman, that concludes my testimony. I will be glad to answer any questions you and the Committee Members may have.

[The prepared statement follows:]

STATEMENT OF JONATHAN RATNER, ASSOCIATE DIRECTOR HEALTH FINANCING AND POLICY ISSUES HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss opportunities to improve Medicare's method of paying health maintenance organizations (HMO) that enroll Medicare beneficiaries. As we stated this past February in testimony to this Committee, Medicare's current HMO option, known to providers as the risk contract program, has not harnessed the cost-saving potential of managed care.[1] In fact, Medicare has paid HMOs more for beneficiaries' treatment than it would have spent, on average, had those same beneficiaries received care in the fee-for-service sector.

A small portion--about 7 percent--of the Medicare population is enrolled in HMOs under the risk contract program. However, recent deficit reduction proposals aimed at slowing Medicare spending growth call for moving a greater portion of beneficiaries into HMOs. In view of increasing congressional interest in the Medicare HMO program, you asked us to discuss (1) recent trends in Medicare beneficiary enrollment in HMOs, (2) the obstacles preventing Medicare from realizing potential savings from HMOs, (3) the strategies that could enable Medicare to realize HMO savings, and (4) the Health Care Financing Administration's (HCFA) efforts to test HMO payment reforms. Our findings derive from examinations of Medicare program data, reviews of the literature, interviews with industry experts, discussions with HCFA officials, and our reports on this subject. (See the app. for a list of related GAO products.)

In brief, we found that recent enrollment growth in Medicare HMOs has been rapid, increasing the urgency of correcting rate-setting flaws that result in unnecessary Medicare spending. By not tailoring its HMO capitation payment to how healthy or sick HMO enrollees are, HCFA cannot realize the savings that private-sector payers are able to capture from HMOs. In addition, we derive two lessons from our review of ways to fix Medicare's HMO capitation payment:

-- First, with respect to rate-setting, one size does not fit all, so a multipronged approach makes sense. The large disparities in market conditions between states--from California to Maine--call for solutions keyed to market conditions. Several broad strategies--increasing price competition among HMOs, using better risk adjustors, and revising Medicare's capitation rate--show promise for enabling Medicare to realize these savings.

---

[1]Medicare: Opportunities Are Available to Apply Managed Care Strategies (GAO/HEHS-95-81, Feb. 10, 1995).

-- Second, with respect to achieving the promise of such initiatives, details matter. How these strategies would be designed and implemented could mean the difference between success and failure.

Although HCFA is planning demonstration projects to study ways to correct its HMO rate-setting method, results are likely to be years away. We believe that, in the short term, HCFA can mitigate its capitation rate problem by introducing a better health status risk adjuster. HCFA also should proceed promptly to test competitive bidding and other promising approaches to setting HMO rates that reduce Medicare costs. Given the recent acceleration in Medicare's HMO enrollment growth, we believe that correcting Medicare's HMO payment rate problems should become a HCFA priority.

BACKGROUND

In 1982, the Congress created the Medicare risk contract program to capitalize on the potential cost savings associated with HMOs. Under this program, HMOs are paid a flat fee for each Medicare beneficiary enrolled. The law sets HMO payments for comprehensive care at 95 percent of the estimated average cost to Medicare of treating the patient in the fee-for-service sector. HCFA, which oversees the Medicare program, calculates these payment rates using a three-step process. HCFA determines:

-- The base rate. HCFA calculates the projected Medicare expenses nationwide for the average beneficiary in the next year.

-- The adjusted average per capita cost (AAPCC). HCFA adjusts the base rate for differences in medical costs among the counties and multiplies the result by 0.95.

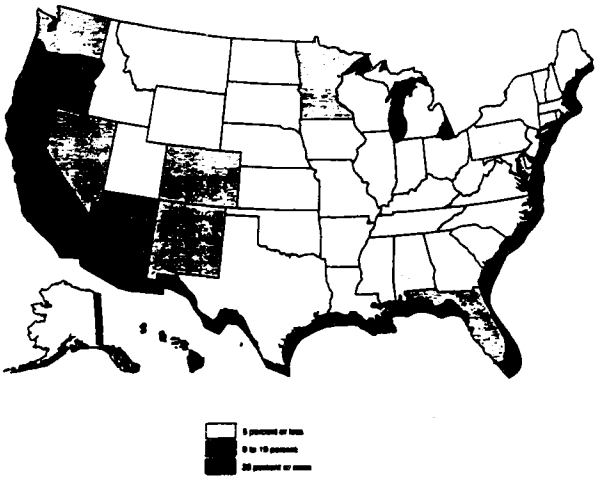
-- The capitation rate after adjusting for health status risk. HCFA adjusts the AAPCC for enrollees' demographic characteristics--age, sex, Medicaid eligibility, residence in an institution such as a nursing home. This "risk adjustment" attempts to prevent HMOs from benefiting from favorable selection of health risks, which occurs when HMOs enroll beneficiaries that are healthier--and therefore less costly to care for--than those in the fee-for-service sector.

Although in existence for over a decade, the risk contract option remains a relatively small part of the Medicare program. As of May 1995, about 7 percent of Medicare beneficiaries were enrolled in plans offered by the 164 HMOs currently participating in the program.

BENEFICIARY ENROLLMENT GROWING IN MEDICARE'S RISK CONTRACT PROGRAM

The Medicare risk contract program may be poised for substantial growth in enrollment during the next few years. HCFA reports that three-fourths of all Medicare beneficiaries now live in areas where they could enroll in a risk contract HMO. Although beneficiary enrollment in these HMOs is relatively low, in recent years the program has grown dramatically in both beneficiary enrollment and HMO participation.

Figure 1: Percent of Beneficiaries Enrolled in HMOs With Risk Contracts, By State, 1994



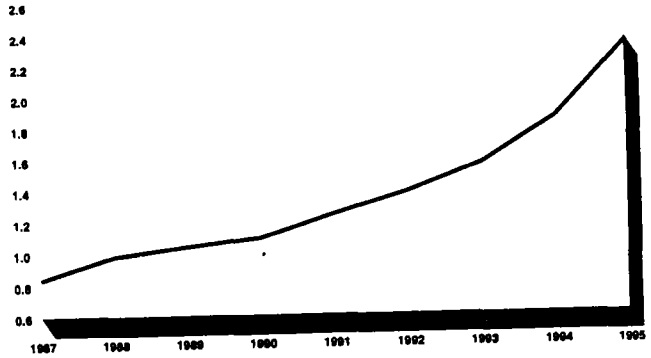
Source: HCFA, Bureau of Data Management and Strategy. Enrollment information based on computer runs using the Denominator File.

As of May 1995, about 2.6 million beneficiaries were enrolled in the risk contract program--about 7 percent of the total Medicare population.[2] Although this share is small,

[2]Another 2 percent of Medicare beneficiaries belong to HMOs that either have cost contracts or are Health Care Prepayment Plans. These programs reimburse HMOs on a cost basis and lack the financial incentives of risk contracts to reduce costs. Consequently, these cost contract HMOs are not relevant to proposals that would expand Medicare's use of capitated health plans.

recent HMO enrollment of Medicare beneficiaries has grown rapidly. From 1990 through 1992, enrollment grew by about 13 percent annually but then, during 1993 and 1994, grew by an annual average of 23 percent. Preliminary data for 1995 suggest a growth rate approaching 30 percent. Similarly, the number of risk contract HMOs, which declined substantially during the early years of the program, since 1991 has nearly doubled from 83 to the current 164.

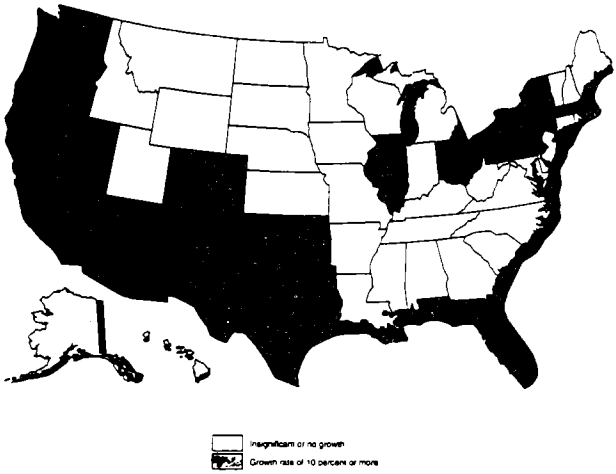
Figure 2: Number of Beneficiaries Enrolled in HMOs With Risk Contracts (in millions), 1987-1995



Source: HCFA, Office of Managed Care

In 1994, HMO enrollment in California and 14 other states--which account for 55 percent of all Medicare beneficiaries--experienced double-digit growth. The other states showed no enrollment growth. For the most part, these are states where HMO market penetration has been extremely low.

Figure 3: Fifteen States Had Double-Digit Growth in HMO Enrollment in 1994



Source: HCFA, Bureau of Data Management and Strategy. Enrollment information based on computer runs using the Denominator File.

Note: States that had 1 percent or fewer Medicare beneficiaries enrolled in risk contract HMOs were classified as "insignificant or no growth" states. Hawaii, with a growth rate of 6 percent in 1994 was also classified in that group. Ohio, with a growth rate of 9.1 percent, was classified as a double-digit growth state.

HMO RATE-SETTING METHODOLOGY THWARTS MEDICARE'S EFFORTS TO REALIZE SAVINGS

Our work suggests that Medicare's HMO rate-setting methodology does not maximize the potential of managed care to yield cost savings and, in some cases, can even discourage HMO participation in the program. By tying HMO payments to Medicare costs in the fee-for-service sector, the current methodology causes three problems. First, the rate-setting formula restricts potential savings and ignores the ability of competitive market forces to help produce additional savings. Second, the lack of adequate risk adjustors in the formula allows some HMOs to be overcompensated, given the health status of their enrollees. Third, the formula may discourage plan participation by setting payments that are too low in some areas and by causing rates to vary greatly both across geographic areas and over time.

Formula Encourages Competition Between HMOs That Primarily Benefits Enrollees

Under the present system, all HMOs in an area are paid the same capitation rate. With the payment rate fixed and independent of both HMO costs and the competitiveness of the local managed care environment, HMOs compete only for the enrollment of Medicare beneficiaries. Efficient, low-cost HMOs may be able to offer more generous benefit packages to enrollees and still prosper under the fixed capitation rate. However, because the payment rate is fixed, the government derives little benefit from either increased competition between HMOs or increased efficiency of HMOs. Moreover, Medicare beneficiaries have only limited incentives to seek care from low-cost health plans.

Medicare may be underestimating the efficiency of HMOs, and requiring an HMO "discount" from fee-for-service costs that is too modest. The HMO capitation rate is set by statute at 95 percent of the AAPCC, in other words, 5 percent below the estimated cost of serving beneficiaries in the fee-for-service sector. HMOs that can attract Medicare enrollees and provide health care for less than the capitation rate--for example, for 85 percent of fee-for-service costs--keep the difference (within limits) between their costs and the capitation payment.[3]

---

[3]HMOs are permitted to earn profits up to the level earned on their non-Medicare business--the adjusted community rate (ACR). Profits earned in excess of the ACR must either be returned to HCFA or used to provide beneficiaries with additional benefits or reduced copayments and deductibles.

The recent surge in HMO participation indicates that many organizations now view Medicare risk contracts as potentially lucrative. In addition, in caring for Medicare beneficiaries, HMOs are estimated to achieve cost savings in excess of 5 percent. Research suggests that HMO costs in caring for their enrollees are at least 10 percent less than HCFA would have spent on fee-for-service care for them.[4] Finally, some experience of private-sector employers with HMOs suggests that the 5-percent discount may be too low, especially in certain urban areas with mature managed care markets. In those markets, even a larger discount (lower capitation rate) might not significantly discourage HMOs' participation in Medicare risk contracts.

Risk Adjustment Methodology Inadequate to Prevent Overcompensation

Currently, HCFA's capitation payment to HMOs is "risk adjusted" only for four demographic factors: beneficiary age, sex, Medicaid status, and institutional status. These adjustments are designed to modify HMO payments for expected variations in medical costs. For example, the capitation payment is higher for older beneficiaries, since they are expected to require more medical care than younger beneficiaries. However, this risk adjustment is inadequate because it does not specifically adjust for the health status of enrollees. By enrolling the healthier individuals, HMOs need deliver less health care but are compensated as if they enrolled a costlier clientele--both the healthier and the sicker individuals.[5]

Our review of studies on risk selection shows that, because most HMOs benefit from favorable selection (the healthier individuals typically enroll in HMOs), Medicare has paid HMOs more than it would have paid for the same patients' care by fee-for-service providers.[6] Estimates of the excess payments range from almost 6 percent to 28 percent. Although these estimates are based on 1991 data, our review suggests that favorable selection

---

[4]Randall S. Brown and others, "Do Health Maintenance Organizations Work for Medicare?" Health Care Financing Review, Fall 1993, Volume 15, Number 1, p. 14.

[5]HCFA uses administrative means, such as prohibiting HMOs from refusing to enroll beneficiaries with pre-existing conditions and monitoring HMO marketing materials, to lessen the ability of HMOs to purposely attract healthier-than-average beneficiaries.

[6]Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs. GAO/HEHS-94-119, pp. 21-23.

persists despite HMO enrollment expansion. HCFA officials agree that the risk contract program displays favorable selection, though they believe that excess payments are at the lower end of this range.

Formula Produces Capitation Rates That Vary Considerably Within Market Areas And Over Time

Capitation rates are set separately for each U.S. county and vary considerably nationwide among regions and states, among urban and rural counties, and even among neighboring counties. This variation may discourage some HMOs from participating in risk contracts. For example, under the present system, an HMO is paid 27 percent less for serving a beneficiary living in Prince George's County, Maryland, than for serving an otherwise identical beneficiary living in neighboring Montgomery County, Maryland--even if the two individuals are treated in the same facility by the same doctor.[7] The inconsistency of payment rates across county lines leads some HMOs to enroll beneficiaries from a limited portion of the HMO's service area.

The geographic problems in the capitation rates are caused by the formula's tie to local fee-for-service spending, which reflects local variations both in the prices and volume of medical services used by Medicare beneficiaries. Much of this variation may, however, be attributable to underutilization of health care in some areas and overutilization in others instead of differences in the cost of providing appropriate health care. If fee-for-service beneficiaries use a large number of services (either because beneficiaries demand these services or because their doctors order additional services), then HMO payment rates will be relatively high in that county. In contrast, if Medicare fee-for-service beneficiaries use few services--perhaps because of inadequate transportation or a lack of providers in rural areas--then HMO payment rates will be relatively low. As a result, rates in some areas are too low to induce HMO participation in the risk contract program, while in other areas rates are too high for Medicare to realize the potential cost savings generated by capitated payments.

HMOs also can be discouraged from participating in risk contracts because payment rates can increase or decrease dramatically from year to year. This problem is most prevalent in rural counties. Because of the small number of Medicare beneficiaries in such counties, a few very expensive illnesses can drive up the following year's capitation rate, while an especially "healthy" year will have the opposite effect. HMO

---

[7]Capitation payments are based upon where the beneficiary lives, not where he or she receives medical care.

officials complain that rate instability hurts their ability to conduct long-term planning--for example, by complicating decisions about investing in new clinics and expanding physician networks--and can cause wide swings in enrollees' premiums from year to year.

STRATEGIES EXIST FOR MEDICARE TO REALIZE SAVINGS

By modifying the present payment system, HCFA could help generate savings for Medicare. Our review of the experience of the private sector, reforms in other public health care programs, and empirical research suggests that a number of strategies hold promise. These strategies can be grouped into three broad categories: increasing price competition among HMOs, developing better risk adjustors, and revising the AAPCC-based capitation rate.

In our view, potential Medicare savings will be greatest if strategies in all three categories are concurrently pursued. An attempt to address all obstacles in a uniform way across all regions of the country is unlikely to be successful. This is because the predominant challenges to saving costs in large cities are not necessarily the same ones that exist in rural counties and because the challenges vary from region to region, even for otherwise similar communities. Consequently, a variety of reforms is warranted; local conditions would determine the particular mix of solutions for any specific area.

The details of how any reform is implemented matter. Changing the Medicare policies for paying HMOs could affect their decision to participate in risk contracts and the benefits they provide. This, in turn, may affect Medicare beneficiaries' decisions to enroll in managed care plans and the quality of care they receive in those plans. Thus, estimating the potential dollar savings and determining the best method of implementing specific reforms may be possible only after quickly conducting and evaluating demonstrations.

Increasing Price Competition Among HMOs

Price competition that would enlist market forces to help contain Medicare costs could be encouraged by requiring qualified HMOs to submit competitive bids. The accepted bid would set the capitated rate at which HMOs would provide comprehensive care to Medicare enrollees in an area. This approach completely decouples capitation rates from average fee-for-service spending. Under a competitive bidding system, HMOs would have an incentive to submit bids that reflect their actual costs of providing

health care to Medicare enrollees. Low bidders would be rewarded with risk contracts. High bidders could be excluded, included if they accepted the winning bid amount, or included but subject to a financial penalty.

A competitive bidding strategy may be most effective in urban areas with well-developed managed care markets. The details for implementing such a strategy would determine the strength of incentives driving HMOs to submit low bids and the amount of choice available to beneficiaries. For example, excluding high bidders from participating in risk contracts would maximize HMOs' incentives to submit low bids, but reduce the choice of plans available to beneficiaries. Allowing high bidders to participate but with a penalty--perhaps having to charge the difference between their bid and the accepted bid as a premium to seniors--would create a weaker incentive for low bids but would allow beneficiaries a wider choice of plans.

Competitive bidding, rate negotiation, and beneficiary incentive approaches have been used successfully in other public health insurance programs. Arizona, for example, since 1982 has delivered health care to its indigent population mostly through capitated managed care organizations where the capitation rates are set through a competitive bidding process. A recent study concluded that, compared to traditional Medicaid programs (predominately fee-for-service), Arizona achieved significant cost savings and a lower rate of expenditure growth.[8] The California Public Employees Retirement System (CalPERS), serving about 1 million members, also relies upon price competition among health plans and consumer incentives to control costs. Negotiating rates with HMOs has helped CalPERS to achieve reductions in premiums in each of the past 3 years, ranging from 0.4 percent in 1993-4 to 5.2 percent in 1995-96.[9]

Designing a good competitive bidding system requires attention to many issues, such as whether beneficiaries in plans that lose the bidding must shift to the winning plan. In addition, savings may not be realized immediately because of high initial start-up costs--for example, developing the bidding process and establishing the necessary management information systems. Administrative expenses may be high as well.

---

[8]Managed Medicaid Cost Savings: The Arizona Experience, Laguna Research Associates (San Francisco: 1994).

[9]Health Insurance: California Public Employee's Alliance Has Reduced Recent Premium Growth (GAO/HRD-94-40, November 1993). Jackson Hole Group, Responsible Choices for Achieving Reform of the American Health System, eds. Paul Ellwood and Alain Enthoven, (March 1995).

Arizona's experience illustrates these points. Arizona spends on Medicaid administration an amount equal to over 11 percent of its program's acute care medical costs. This is about twice as much as comparable states spend administering their traditional fee-for-service Medicaid programs. This suggests that the effective use of managed care may require strong administrative structures that can provide adequate oversight and manage program resources efficiently.[10] Even so, Arizona's experiment with competitive bidding seems to have paid off, providing health care to beneficiaries while saving the state money.

Market forces could be introduced in other ways besides requiring competitive bidding. These include approaches that would encourage Medicare enrollees to be more price sensitive--they range from requiring newly eligible Medicare beneficiaries who choose fee-for-service to pay slightly more than those beneficiaries who choose a managed care plan, to approaches that would allow beneficiaries to "price shop" among a list of approved HMOs and share a portion of any cost savings with the government. Because they are so far untried, the extent to which these schemes would increase beneficiaries' price sensitivity and help control Medicare costs is unknown. As with competitive bidding, there is a wide variety of ways in which these Medicare reforms could be implemented. However, a fuller discussion is outside of the scope of this statement.[11]

Improving Risk Adjustors

In earlier reports, we noted that researchers have proposed several alternative risk adjustment methods to reduce HMOs' incentives to enroll only relatively healthy Medicare beneficiaries. Each of these alternative methods attempts to measure the health status of enrollees more fully than HCFA's method. These proposals can be judged according to a number of

---

[10]Our work on the Medicare risk contract program emphasizes the importance of effective mechanisms, whether administrative or market based, to ensure quality, resolve beneficiaries' complaints, and deter and pursue fraud and abuse.

[11]For example, under several proposals, beneficiaries could be given a voucher that would allow them to choose between traditional Medicare or among several qualified HMOs. HMOs would compete for enrollees on both price and benefits offered (subject to a minimum benefits requirement). Beneficiaries who choose a less expensive health plan would be allowed to keep a part of the difference between the premium cost and voucher amount; the rest would return to the federal treasury. However, neither vouchers, nor other proposals with similar consumer incentives, have been tried in Medicare.

generally accepted operational criteria. For example, a good risk adjustor would be inexpensive to administer, reduce favorable selection, create incentives for HMOs to provide appropriate care, and would not be subject to manipulation by participating HMOs. However, no risk adjustor is likely to exhibit all these positive traits because these criteria have tradeoffs. For example, a more complex risk adjustor may be more successful in reducing favorable selection but may do so only at a high administrative cost.

Recently, we evaluated 10 possible risk adjustors.[12] None emerged as the definitive solution to the problem of the current system. However, 4 of the 10 adjustors we examined were potentially superior to the current system and seemed to entail less administrative burden than the most sophisticated risk adjustors. One of these adjustors--clinical indicators--would adjust capitation rates for the presence or absence of a particular chronic health condition (such as heart disease, stroke, or cancer). Two other promising clinically-based risk adjustors include information not only on whether a beneficiary has a specific condition but also on the severity of the illness.[13] In the fourth approach, HMO capitation payments would be linked to beneficiaries' own views of their physical and emotional health.

Improving the AAPCC Capitation Rate

HCFA could require steeper discounts from HMOs than the present 5-percent discount off the estimated local fee-for-service cost. Although this would lower payments to HMOs, it may not necessarily have a large impact on their participation in Medicare risk contracts. Previous research indicates that enrollment of healthier-than-average beneficiaries, combined with an imperfect system of risk adjustment, results in excessive payments to HMOs--even after factoring in the 5-percent discount. The number of HMOs seeking risk contracts has increased from 109 to 164 in less than a year and a half. Thus, HMOs may continue to find Medicare risk contracts attractive--even at a somewhat larger discount. However, if health plans react by offering less generous benefit packages, fewer seniors may be attracted to managed care.

The method used for calculating the AAPCC could also be improved by assigning a greater weight to the influence of local medical prices and a lesser weight to the influence of local

---

[12]Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

[13]The two risk adjustment measures are Ambulatory Care Groups (ACGs) and Diagnostic Cost Groups (DCGs).

service utilization patterns in the fee-for-service sector. Modifications could also be made so that the AAPCC reflected HMO market areas, rather than artificial political boundaries. For example, defining a single capitation rate for a metropolitan area would eliminate the possibility that an HMO would receive more for serving a senior in one county than it would for serving an otherwise identical senior living in an adjacent county. These changes would also tend to reduce the volatility of the AAPCC over time and consequently increase HMO participation in the risk contract program.[14]

HCFA PLANS TESTS OF HMO PAYMENT REFORMS

HCFA is planning to conduct demonstration projects that will examine several proposals for modifying or replacing the current method of determining payment rates to HMOs. Some results of these demonstrations could emerge during fiscal year 1996, but we believe that a thorough assessment of the demonstrations is, at best, several years away. The proposals are at various stages, from solicitation of proposals from private contractors to implementation of the demonstration itself.

Specific projects that HCFA is pursuing include: (1) a study of "outlier pools" as a way of adjusting for health risk retrospectively; (2) a demonstration of competitive bidding as a means of setting the capitation rate; (3) a demonstration of a sophisticated health status risk adjustor; and (4) an open-ended demonstration project that would study one or more proposals for improving Medicare managed care.

In our view, these demonstration projects are steps in the right direction, though somewhat overdue. In light of Medicare's current losses due to the risk contract program--estimated at between 0.5 billion and 2.5 billion per year--there may be other steps that HCFA could take immediately to stem losses. For example, HCFA could increase the HMO "discount" from its current 5 percent in selected areas. These might be areas where Medicare HMO enrollment is growing rapidly or where most HMOs do not currently charge beneficiaries a premium.

CONCLUDING OBSERVATIONS

Several factors are at work that change the context of Medicare managed care:

-- the recent and anticipated growth in risk contract enrollments,

---

[14]Annual Report to Congress 1995, Physician Payment Review Commission (Washington, DC: 1995).

-- broad congressional interest in expanding Medicare's use of managed care, and

-- HCFA's recent steps toward undertaking demonstration projects on expanded managed care options and improved Medicare HMO pricing.

These factors lend a new momentum to efforts that would fix Medicare's method of paying HMOs, to stem Medicare's losses under the risk contract program, and then turn them into savings.

Our work drives home two points that would make success more likely if the Congress pursues expansion of Medicare managed care and better pricing of capitated health plans: First, one size does not fit all--at least with respect to pricing capitated health plans in Medicare. Market conditions vary too much and in important ways, even among metropolitan areas. Second, details matter. How programs are designed and implemented often means the difference between success and failure.

As a result, we believe a sensible approach would concurrently pursue the three major strategies--increasing price competition among HMOs, making risk adjustors more accurate, and correcting the pricing of HMO plans by modifying the existing AAPCC approach. Moreover, by adopting a "try and track" stance, Medicare could benefit from early action while gaining more information on how well these strategies work and how they might be better implemented.

In particular, we believe that HCFA should move quickly to implement a better risk adjustor. Last year, we recommended that HCFA promptly undertake demonstration projects on four risk adjustors that we have identified as promising in accuracy and administrative feasibility. Today the increased urgency of fixing the HMO capitation rate may argue for an alternative approach: HCFA could select one of these risk adjustors to implement as a near-term fix. Meanwhile, HCFA could devote its resources to refining and implementing a more sophisticated risk adjustor. As another interim measure, HCFA could also increase, in selected areas, the HMO 5-percent discount.

Finally, we believe that HCFA should move forward without delay in implementing demonstration projects on competitive bidding. By trying competitive bidding in different regions, HCFA can obtain valuable information about how the structure of the bidding process affects outcomes--such as the tradeoff between maximizing HMOs' incentives to submit low bids and ensuring the widest possible choice of plans for beneficiaries. Moreover, Medicare can likely reap some of the potential gains from competitive pricing of health plans.

- - - -

Mr. Chairman, this concludes my testimony. I would be glad to answer any questions you and the committee members may have.

RELATED GAO PRODUCTS

Medicare: Opportunities Are Available To Apply Managed Care Strategies (GAO/T-HEHS-95-81, Feb. 10, 1995).

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).

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, March 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, March 8, 1985).

Chairman THOMAS. Thank you, Mr. Ratner.

A portion of your testimony stimulated a question back here.

The gentlewoman from Connecticut.

Mrs. JOHNSON. I thank the panel for their excellent testimony, and as one who is particularly interested in the reimbursement of medical education, I look forward to more specific conversations with you about how we can assure that not only do we carry forward into the future the tradition of outstanding medical education that has marked American medicine, but that we do it in a way that hopefully all beneficiaries—that is, all of us—participate in, rather than just Medicare participants.

But I don't want to go to that issue right now. I want to ask a general question of the panel. I hear what you are saying about the AAPCC. I hear what you are saying about how we reimburse risk contracts, 50–50 rules for HMOs. What you are talking about is changing the current system to fix it for the future.

If we set the payment rates relative to the current Medicare payments, we are going to carry into the future the problems of that structure, which are numerous as you have just elucidated. Why can't we go around that system and base the new Medicare premium on the average premium of plans in that market that provide the Medicare basket of services? In other words, why don't we go to the market and see what they are charging for those services?

Now, I understand the problem of risk, but my impression from talking with plan operators is that if they are able to market aggressively, they are able to reach a certain critical mass of senior involvement with an established managed care plan, they don't care about risk. And I have had companies who have done this, sit across the table from me and say, here are the three ways we can medically underwrite X, Y and Z; this is how they work, and we don't use them once we get a critical mass of size.

When you look at how some seniors are being overmedicated, when you look at the costs of hospice care versus nonhospice care, when you look at the ability of managed care plans to deal with frailty, to deal with prevention, there are just extraordinary opportunities to save money around senior health care while at the same time improving the quality of health care; but they are not things we will ever be able to do from Washington.

So why not circumvent these problems? Why not end-run them and go to the market and say, what are you charging for this basket of services, and try it in a few markets and do it in a timeframe that will give us the information to move at the pace we must, or this system will go bankrupt and we will not have the choices that we need?

Ms. WILENSKY. Well, I think—if I may make the first response, Mrs. Johnson, I think it is consistent with what Stuart Altman and I have said, that the difficulty is that there hasn't been an obvious market to look to, particularly as it relates to seniors. The idea behind competitive bidding as a strategy to set the amount that you pay is not to tie it to what was spent on average under fee-for-service in an area for Medicare beneficiaries. We could protect ourselves as a program by putting an upper limit there, but otherwise basically let markets establish what they are willing to pay in

order to provide a Medicare coverage service package to the people in that area.

In some areas of the country where you have established Medicare Programs—for example, Portland, Oregon has over half of its seniors already in HMOs and managed care, there is no question in my mind, you could do competitive bidding as fast as you could put the office in place.

Mrs. JOHNSON. They do that in Oregon without our doing the Federal risk adjuster. A lot of things that are happening are happening without our fixing the problems in the system, and when 74 percent of seniors live in markets where there are managed care choices, why do we have to fix all the problems you point to? Why can't we go around them and gradually wipe them out?

Ms. WILENSKY. Competitive bidding in the areas where there are a number of HMOs is something that you ought to start quickly. There are parts of the country, of course, where you won't have enough entities to start, and there is a problem in risk selection. Let me try to explain why.

Even if HMOs are not actively selecting healthy risk—I believe Stuart, that there are a couple of bad apples out there—in general, I don't think HMOs are going out and actively shunning certain groups and attracting others. But the problem is, if it turns out that you get the healthy folk in your HMO and the HMO down the street gets the sick people, there will be financial reward or penalty if you don't make an adjustment. That is, if you get part of the 10 percent of the population that spends 70 percent of the money, or the 1 percent that spends 43 percent of the money, you will either make a bundle, if you are paid on average, or lose a bundle if there isn't some adjustment to the premium. If you have any linkage to what is going on in the fee-for-service system—which I hope you get rid of, then you get caught there in case the people who are left are either sicker or healthier than average.

So as long as you have choices around, this is not just a Medicare problem. This is a problem any time you have choices in the system.

FEHB, for example, the public program for Federal employees, faces a risk problem if disproportionate numbers go to a particular plan.

I think we can make some inroads there. I am not going to recommend you stop until we fix the problem. I think we can do better than we have if we give it a little more serious attention. But I am all with you; competitive bidding, which means going to the market, is great.

Mr. ALTMAN. Let me add a couple of things to that. I am convinced that if you don't seriously look at risk adjustment, 3 to 5 years down the pike, a new group of people are going to be sitting at this table telling you some horrendous stories; and the reason why I say that is, if you look at the insurance world, the fee-for—the private insurance world, they are very sophisticated, experienced raters. I mean, we can't be naive. There is so much money at stake here, the ability to make money in—and these are smart people. The ability to make money by carefully crafting techniques to have less sick people is such an incentive out there, it is almost too tempting.

Now, this is not saying these are bad people. This is not saying these are un-American. This is what incentives do. So I caution you as strongly as I can, do not be misled by the plans that talk to you. They honestly went into this market, many of them have been in the market for years. They had a social mission and an economic mission. They didn't experience rate. Some of them are getting badly beat up in the HMO world because they are finding themselves with adverse selection relative to the newcomers.

You can't ignore incentives. That is why we want to change, because the old set of incentives in fee-for-service killed us. You could create another set of incentives that would kill you, and then the groups are going to be here talking about profits being made and other firms going broke, and I think most managed care plans would want to have a fair risk adjuster so they don't get hurt.

Mrs. JOHNSON. Thank you. We will pursue this at other times.

Chairman THOMAS. Just two points before I recognize the gentleman from California.

Stu, you and Gail talked about the problem in the way in which teaching hospitals are funded.

Mr. ALTMAN. Yes.

Chairman THOMAS. Perhaps the HMOs are not passing through the money given to them to those institutions, like the more traditional structure. You just talked about a problem in terms of risk adjusting and rating within Medicare. It just seems to me that both of those problems are probably better addressed in the larger arena of health care reform, like fundamentally changing the way in which teaching hospitals are reimbursed. Then you don't worry about it passing through cleanly on a Medicare structure; and we deal with the way in which insurance is sold and the way in which ratings are determined. If we deal with that on the health care question, we then will have solved it. And I just am a little concerned about how much weight we have put on the back of Medicare to carry changes in the health care arena that probably would be fairer and better met on a broader based change, more fundamental change.

Mr. ALTMAN. I agree with that, but I think back to a discussion I had with Mr. Cardin several hearings ago. And he chastised me, and I think appropriately so, for a catch-22 environment, which is, OK, I buy that. But suppose you take the extra funds out of Medicare, what happens to those institutions? And so, in general, I supported where you were.

I think in the bigger picture, it is a small issue. It is not a small issue in Los Angeles and in Boston and New York; and it is not going to be a small issue when Medicare goes to 50-percent managed care.

So, yes, in a theoretical sense, I would much rather see it in broader reform, but I don't think you can ignore it in Medicare because now Medicare is becoming the dominant form of extra payment for these teaching hospitals.

Chairman THOMAS. I think your response is well taken. So what I need to do then is, in crafting a solution for Medicare, make sure that it fits into the larger health care plan that will either precede or follow it. So one or the other, the two have to be compatible. I prefer doing the larger, which gives us a broader——

Mr. ALTMAN. Mr. Cardin walked in and he hasn't heard, but I apologize.

Chairman THOMAS. The gentleman from California.

Mr. STARK. Thank you, Mr. Chairman. I will just follow up on what Stuart said.

We had—a year or two ago, Stan Jones, who was then a private consultant to insurance companies, consulting with him on how to find, within whatever was reasonable, healthy people, or how to avoid unhealthy people—and I can't remember where it was, perhaps in my own district; but as somebody said, you want to try it, try signing up one of these Medicare Select or Medicare HMO plans over the phone. Just try. Try and not go to a meeting which you have to come to before the company will sign you up. Where is the meeting? Not near public transportation. Why is it at some hotel, so that they are sure the people who get there can drive.

There are all kinds of subtle little ways that you exclude—now, they are not so crass as to put it on the third floor and not have an elevator, but—in which case I wouldn't be able to sign up—but there is a cottage industry out there which saves these insurance companies tons of money in doing it.

I would ask one question of Stuart and Gail. In all this selection, if in areas where there is wide usage—in my district, 70 percent of the people belong to staff model HMOs, 70 percent of the residents, not just Medicare. If one had community rating, open enrollment and no medical underwriting strictly enforced, would you not then, just through service, would there not be any risk selection? It would seem to me you would just get an average of people—Gail is saying no.

Ms. WILENSKY. The reason is that unless people evenly distribute themselves among the competing HMOs in your district, and for reasons that have nothing to do with what you have done, you happen to get 20 percent more of the AIDS patients or the chronic diabetics or the potential Alzheimer's or whatever, and you get paid on average, you will get hurt. As long as there is choice among plans——

Mr. STARK. Somebody said that if you got more than a couple of thousand members at some level, that this—we were discussing this in self-insurance—at some level, that selection sort of evaporates as you get to be a fairly big plan.

Ms. WILENSKY. I think that there is less of a problem the larger the group. That is why it has always been harder to do bundled payment for doctors or outpatient services than it is for the inpatient sector. Because health care spending is so concentrated, I really believe risk selection and risk adjustment, which I am a little more confident we can do, is a problem. But the bigger the group, the smaller the problem.

Mr. STARK. Is there anything wrong with requiring nonage-related premiums for seniors? It seems to me to be—well, first of all, it prevents chicanery among salesmen for lowballing seniors into coming into a plan, then kicking up the premium as they get older. But if you follow the fact that they will get sicker and more expensive as they get older, and perhaps they are on limited assets, they will dissipate that as they get older, that if the price they have going in at 65 remains the price throughout their lifetime, that

that would be a better system than allowing age bands and to kick up the premium, and also a way to prevent what I think are rather unscrupulous sales practices of starting low and then, when you get to be 70 or 75, having rather severe increases.

Does that disadvantage or does it offend any of you to say perhaps we ought to require that as a social benefit?

Ms. WILENSKY. Well, it would hurt a plan that was an established plan in an area that would get older and older people who, other things being equal, will be predictably more expensive; and that, of course, doesn't allow them any kind of package——

Mr. STARK. It seems to me—you are saying after they open up?

Ms. WILENSKY. Yes.

Mr. STARK. I am saying, when people move into Medicare, this is your largest enrollment population, the people that become 65 each year; they mature into these plans, and rather than allow—that is where the competition occurs among plans.

If you allow one plan to lowball—and in California, for instance, AARP is the only one with a nonage-related premium, and they are a couple hundred bucks higher for the same Medigap policy at 65. But pretty soon, if you sign on to some of the other plans, by the time you are 75, you are paying a whole hell of a lot more; and it really, I don't think, is—I don't think that is good for the consumers.

I don't think it hurts Medicare, and I think it prevents possible chicanery to just say, wait a minute, you set a rate. Now, if you come in later, that is OK, but it becomes the rate for the rest of your life. I mean, you don't let them kick up the rate every 5 years.

Mr. ALTMAN. I want to make a distinction between the rate the individual pays and the amount paid by the program. I think you need to risk-adjust the amount paid by the program because the plans need to be protected. I mean, I would have to——

Mr. STARK. Why do we have to protect the plans? Why do we have to protect the plans? I am not so sure.

Mr. ALTMAN. Because I think they are going to wind up having to provide more services, and you don't want to—you don't want to underpay them for legitimate needs of older seniors.

Mr. STARK. You are not into this market business story. That is not our job. They are supposed to go broke. That is what takes the inefficient ones out and the efficient ones make a big profit.

Mr. ALTMAN. This has nothing to do with efficiency. This has to do with legitimate service that an 85-year-old frail person might need that a 65-year-old doesn't.

So I think it is——

Chairman THOMAS. Go easy on him. He is new to this market concept.

Mr. STARK. I am learning.

Mr. ALTMAN. Let me jump.

Mr. Chairman, there was one piece that I don't have in my testimony that also blew my mind, and I apologize for this; but what you said, Mr. Stark, is absolutely correct.

The Medigap business is also leading to substantial distortion. If you buy fee-for-service Medigap versus buying a Medigap policy from a managed care group, you wind up paying substantially more for the same risk in the fee-for-service because in the fee-for-service

are the disabled, are the renal patients and everybody else who can buy an average Medigap plan; where in the managed care plan, they are not there.

So there are distortions that are currently building into the Medicare Program, and it varies of course by area.

I think the Medicare Program is fast moving away from its basic premise, which is to provide a national benefit package of roughly comparable rates around the country; and it is distorted twice, at the Medigap policy and at the way the government pays through the AAPCC.

Mr. STARK. Thank you, Mr. Chairman. Thank you.

Chairman THOMAS. Interesting.

Let me say that everybody has subtle ways of selecting, and the gentleman from California indicated drivability to the hotel. I would say if I was an association looking for would-be seniors I would begin mailings to individuals age 50 and up—obviously they are people who plan for the future, which, by definition, are somewhat atypical, and they have 15 years of planning for the future before they become available for the plan.

Mr. ALTMAN. Absolutely.

Chairman THOMAS. The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman.

Just a quick question to you, Dr. Altman. I think you said that when you look at seniors that are served by the VA system and by DOD, you find that their costs or their expenditures are 3 to 7 percent higher?

Mr. ALTMAN. I may not have made myself clear.

Many seniors avail themselves of services that are provided free to them by the VA and the Defense Department, so they therefore use less services from the regular Medicare fee-for-service or managed care world. But when it comes time to calculate the AAPCC in the area, they include in the denominator all of the people, including those that use the DOD and the fee-for-service. As a result, in some areas, you get a distortedly low——

Mr. MCCRERY. I see. I misunderstood.

Mr. ALTMAN. No. I didn't say it correctly. I can see why you misunderstand it.

Mr. MCCRERY. That explains it. Thank you.

Dr. Altman, you talked about distortions that are in the current system. It seems like every time we talk about Medicare, the subject of distortions comes up; and it seems to me that many of those distortions are caused by the government trying to direct one thing or another, or the government trying to create incentives, or the way the government designs a benefit package or a payment system or whatever. It is almost a catch-22. You try to fix something here and you create something over there, and you get these distortions because of government policy.

I would like to find a way to minimize the government's influence in the Medicare system; and it seems to me that in order to do that, we are going to have to follow the President's advice, which is to address the health care system at the same time you address Medicare in terms of reform.

Do any of you have any ideas on that? Do you agree with that, and if so, is there a way that we can work to blend the Medicare

system with the private system in a way that minimizes distortions and still provides quality care for our senior citizens?

Mr. ALTMAN. I support your comments in general, but I would add the caveat that it is not only the government that gets caught in this problem.

I have spent a few years on and off working with the large autos. General Motors and Ford got really beat up when they went into the managed care business because they wound up with problems not unlike what happened to the government. They had their less sick people go into the HMOs. The HMOs were collecting average premiums. They thought they were saving 10 percent. When they finally added up the bottom line, they found that they were paying a lot more because the people who weren't in the HMOs were the sicker ones and so they, too—you know, when you get—I think what we are dealing with is bigness and big averaging creates problems. So I agree with you.

My own view is, we need to move things down into the community level. We need to develop mechanisms that are much smaller, and I do believe Medicare needs to be incorporated into the broader issues of reform. How that is done is, as you know, a very complicated, not-agreed-on strategy, but basically I agree with you. I think it is bigness and averaging that creates these problems, and of course, the biggest of all is the government, so it creates the most problems.

Ms. WILENSKY. Let me try and expand a little on this issue. While there are problems outside of Medicare and Medicaid that need to be addressed, that I wish had been addressed in the last 2 years, but weren't, I think that the public programs are different because they use public moneys. We need to address them with an urgency that can't be avoided because of the pressures that they are putting on the Federal budget and attempts to reduce government spending or government involvement.

In the case of Medicare, if you wanted to try to reduce government involvement, you could try to set the amount that Medicare will pay at whatever price is available to cover Medicare-covered services as they exist now, hopefully, with some risk adjustment so you take care of those that are predictably sicker—and allow people to do as they will in buying various products—HMOs, managed indemnity plans, and regular, old, expensive fee-for-service, which means they will have to put in some more money.

But to have the Medicare amount reflect the cost of a low-cost provider of Medicare services and what other people want to buy is something they can buy and add on to that.

As I think you know, I am also intrigued by the notion of having a medical savings account catastrophic option as a one-time option when you turn 65. I think the selection gets very difficult when you get over 65, but to give people choices, Medicare should decide on a competitively bid type of model that reduces the involvement of government in those little areas.

Now, you still have to worry about risk adjustment and you will still have to worry about making information available and making sure that the plans aren't fooling around in some way. But I think that would make a huge difference in the Medicare market, whether or not you are willing to take on what is going on in the private

sector. A number of us have ideas about how we would like to improve the way the private sector works in terms of subsidies that exist and distortions; but frankly, I think Medicare is so much money and is in now a real financially fragile position that you just can't avoid trying to do fixes here, whatever it is you do elsewhere.

Mr. MCCRERY. Well, I would like to explore this more, but my time is up. Maybe we will get back to it.

Chairman THOMAS. I think that is the answer.

Mr. MCCRERY. That is the answer, Mr. Chairman, but it is only part of the answer. I mean, I don't see how we do what Dr. Wilensky said without some private sector reforms, insurance reforms, and so forth.

Ms. WILENSKY. I don't want to discourage you from doing it. I just don't want you to believe that if you can't do the second, you would have no choice with regard to the first. I think you can't not do Medicare changes because of the pressures in the budget.

Mr. ALTMAN. We are both concerned about that. You can't leave Medicare unreformed.

Mr. MCCRERY. I agree. But if we do Medicare the way you just suggested—which, by the way, is almost word for word what I have suggested to some other folks—then I think we have to do some private sector reforms. I think you have got to mesh the two; otherwise, you have the same budgetary problems that we have got right now.

Chairman THOMAS. I do think the problems with Medicare are the same in the larger health care arena, and therefore, as long as we keep the solution the same, it makes less difference to me which one moves first. I just don't want a fix for Medicare that is artificial or doesn't also address the larger concerns. You have got to keep them together, and I don't care which vehicle moves it first, as long as the solution is what is agreed upon for both.

The gentleman from Nevada.

Mr. ENSIGN. Thank you, Mr. Chairman.

To follow up a little bit on what Mr. McCrery has talked about: In Nevada, I held a Medicare task force, had HMOs at the table and hospitals, teaching hospitals, physicians, AARP was there. We had really a very, very diverse group, trying to get all the different opinions at the table at the same time, trying to come up with some possible solutions, and we will be holding these at various times during the summer.

One fairly well agreed upon problem in the whole Medicare situation is HCFA. Virtually everybody said that what would be a great place to start, is to eliminate HCFA in whatever way that we could. But I think that brings up something that Mr. McCrery talked about, and that is, the government is so involved with the system and micromanaging the system that it creates a lot of its own problems.

The reason I wanted to pursue that is to just continue the dialog on this, do we foresee perhaps assigning risk to different individuals based on their health status, which is being talked about over on the Senate side as well as talking about some vouchers.

You know, based on your risk, now you get a voucher and you go out there in the marketplace and you buy your own health care coverage. Whether that is at 65, the medical savings account, or on

a yearly basis you choose managed care. Whatever it is out there that you are choosing, the government is assigning the risk, and, therefore, an amount so that the insurance companies don't get burned by the risk when they get all the bad patients into their pool.

Do you see some kind of answers along those lines?

Ms. WILENSKY. I think it does some of it, but I would see structuring it a little different: Believe me, in the 2½ years I was at HCFA, I heard about every evil thing ascribed to it you could imagine.

I believe in having Medicare become an equivalent kind of payer. That is what I was talking about—having a bid that reflects a judgment about what it would take to have the services provided in a low-cost plan or in an efficient way. That is what the government should do. I don't know that you necessarily have to give a voucher to the individual.

What you need to do is have a way that individuals receive information about the health care plans in that area, and that is something I think HCFA could do. If it is doing less about paying line item services, it can provide information about the plans that are in the area and make sure a payment adjustment is made so that the plans that get the chronic diabetics or the serious cancer patients get an additional premium and everybody else gets a little less.

You don't have to make adjustments for all 37 million people on Medicare. What you have got to do is make some adjustments for the major classes of different users, and so it is like having an individual voucher. I don't know that you literally have to have that kind of structure.

Mr. ENSIGN. It is more of a concept.

Ms. WILENSKY. What I would see HCFA doing is providing information to seniors about satisfaction, about outcomes measures, about making sure that the plans are behaving appropriately; getting information; moving to annual or some other more structured enrollment; and getting more and more away from being the payer on a line item basis.

Even for people who want to go into fee-for-service plans, that is fine. They just get a payment from the government that probably isn't going to be enough in most areas to cover an open-ended fee-for-service. They add to it and go to their plan.

So I see a different function over time that HCFA would take on. I guess the bad news is I don't see HCFA going away for those that had that as one of their main goals.

Mr. ENSIGN. I was just dreaming out loud.

Ms. WILENSKY. Reduce the level of involvement, though, for sure.

Mr. ALTMAN. Let me add something that the private sector is doing that I think HCFA or some other agency needs to do, and that is, yesterday it was announced that many of our largest corporations, Sears and Merrill Lynch and American Express, are forming into a consortium and opening up competitive bidding nationwide for managed care plans to provide a whole battery of information—not only prices, quality of the care, availability of the care. And that seems like it makes so much sense.

As a worker, I want a company that, first, has done some screening, and second, I can go to at some point to protect myself. I don't think you would be able to withstand hundreds of thousands of seniors coming in here and bombarding you if they get really hoodwinked all over the place.

So you need—I agree with Gail. You need somebody out there to do what is now being done for enrollees in the private sector, these HEDIS reports and stuff like that. With that information, then you can have a much freer system of selection. Even the Federal employees are doing the same thing. So that is more along a model of what HCFA could do.

Mr. ENSIGN. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from Nebraska.

Mr. CHRISTENSEN. I would tend to agree with my colleagues from Nevada and Louisiana that if there is one major problem in this whole dilemma, it is HCFA.

To what degree does Medicare inform beneficiaries of the managed care options available?

Ms. WILENSKY. Not at all.

Mr. CHRISTENSEN. At all?

Ms. WILENSKY. Not at all. If you will forgive me, HCFA is administering the program that is basically in place by legislation. I agree with a lot of the complaints of your seniors and your physicians, but it is the program that was legislated in place. Excuse me.

Mr. CHRISTENSEN. We will change that.

No information at all?

Ms. WILENSKY. None. None.

Mr. CHRISTENSEN. Pretend that I am a Medicare recipient. I call HCFA. I can't find out any managed care plans in the area? I can't find out any premium information, additional benefits? I can't find out any information?

Ms. WILENSKY. Well, there is a group that has worked with HCFA, and I can't remember what it is called. There is a group that is a public group that has been working with HCFA to make information available, and of course, as a result of the changes in 1991 law, the kinds of options that are available under Medigap are severely restricted.

So HCFA doesn't have as part of its mission, or any funding, to make information in general available about the managed care plans; but there is some structure now because of the changes that were put in law about what is available. But nothing like what I think should exist.

Mr. CHRISTENSEN. What do you think should exist?

Ms. WILENSKY. What we were talking about, which is really the sort of report card notion of what is out there, what it costs, what kind of benefits you get, consumer satisfaction, enrollment, disenrollment and anything we know about outcomes.

Mr. CHRISTENSEN. How many HMOs in an area do you think it needs to put together a competitive-type structure, competitive bidding?

For example, I am from Nebraska. Two-thirds of my State is more rural than urban. How would it work in the western United

States, in the less urban areas, what you are proposing, in terms of ideas?

Ms. WILENSKY. I think what you will see happening are two things. The first is you will find some of the groups coming in that you might not expect to be in your backyard. For example, the Mayo Clinic has been running around northern Iowa setting up relationships with primary care physicians, relationships to have people go back to the Mayo Clinic and, if needed, to Methodist Hospital.

The Loveless Clinic in Albuquerque has been doing similar arrangements with regard to physicians in rural New Mexico. So for one thing, I think you may find over time you may have more company in your areas than—even in the western parts of your State than you thought.

The second thing is that a number of States have used primary case management as trying to bring together a coordinator so that you don't have completely a la carte fee-for-service medicine; and again, you can get a package of services that would then get put together and bid for.

So I think we need to recognize that for the frontier parts of the country—the Dakotas, Montana, and Wyoming—that there are different ways of structuring this than if you are in Los Angeles or the bay area. But I think that in both the entry of groups that are nearby will be greater—I mean, there are a lot of those activities, plus spins on primary case management, to allow for some level. But in areas that are sparsely populated, you know, two or three groups will be all you will have.

Mr. CHRISTENSEN. I guess one thing I will probably remember the most from this panel today, Dr. Altman, is your response to Mr. McCrery's question and saying that we are not talking about efficiency here. And I guess someday maybe we could—someday maybe we will get to a government-run program that is somewhat efficient.

Thank you.

Ms. WILENSKY. You have got to change the incentives first.

Mr. ALTMAN. You have got to change all those incentives.

Chairman THOMAS. Let me underscore a couple of points. Chairman of the Budget Committee Kasich and I sent, in February 1995, a letter to Bruce Vladeck at HCFA asking him once again to provide us with any kind of a listing of the information sent out about managed care options. HCFA has not gotten back to us on that. We are also looking at some language right now from OBRA 1990 where I think we even set aside some money.

And it just seems to me a little bit unfair to constantly point out that HMOs are out there sophisticatedly avoiding risks in the recruitment of seniors when a simple foil to that would be to provide a one-stop-shop access for information about them; when, in fact, I believe it is more simply going out there looking for customers and the manner in which you look for customers.

Whether it is a third floor hotel that you have to drive to or a sophisticated mail program to professionals at age 50, those are marketing choices that I think are, after the fact, damned as selective procedures, when I think one of the fundamental faults—and another—we have talked about the number of catch-22s we have

here—is that the Federal Government isn't actively pursuing an informational directory to have people call up an 800 number and find what is available in their area.

Ms. WILENSKY. Mr. Thomas, now that you mention it, it strikes me that there was some money set aside, and perhaps you could ask whether that is available now in the Social Security offices or not. It strikes me that that was supposed to be in place all in one stop. Of course, having the Social Security Administration no longer part of HHS is not going to make any of that coordination easier.

Chairman THOMAS. It is not easier, but we are going to run it down because as this discussion went on, in my head, I said, wait 1 minute, I thought we had done this once. We are going to follow up on that.

The last question I guess I will ask you is one that you can't answer, but I want you to begin thinking about it, and again, it is partly the chicken-and-the-egg because you spent so much time. And Mr. Ratner, if you can get in on this from the angle of your research as well.

Both of you, Drs. Wilensky and Altman, spent so much time on the failure of the AAPCC to be a reasonable tool in measuring value—and we talked about small percentage shifts into managed care—to what extent is the failure to move more rapidly—even in areas where managed care is clearly the dominant choice, to what extent is it the failure of the funding mechanism? The primary reason?

Ms. WILENSKY. No. I would put it the secondary reason. The secondary reason is that the elderly have very little reason to leave the a la carte, open-ended entitlement fee-for-service system.

I don't think the AAPCC is a trivial problem. I think that is why Medicare doesn't get much in the way of savings. But, for me, the most serious problem is the lack of incentives for the elderly, the reward to choose wisely. I don't know what——

Mr. ALTMAN. I would agree with that. We did not see a rapid buildup in managed care in the private sector until employers changed the incentive structure substantially, not marginally, so that it became more and more expensive to individuals to stay in the program that they traditionally had. It didn't force them, although now you get to some employers that your only options are between managed care A, B or C. But in the transition, it moved—it flipped in the late eighties from making fee-for-service the dominant choice for many employers to making managed care the dominant plan.

You have got to be more careful with the seniors, but I support Gail. That is the primary reason.

Chairman THOMAS. So the system that is driving us bankrupt that we are going to try to get people to move out of voluntarily is actually the wisest dollar choice that they could make?

Mr. ALTMAN. Yes.

Ms. WILENSKY. They are acting very rationally.

Chairman THOMAS. And the failure to change that system fundamentally?

Ms. WILENSKY. Make some of those changes, either because they are—in the best of all worlds, they are using a lot of other people's

money in an open-ended entitlement. That is a very nice place to be.

Mr. RATNER. There is an additional aspect of that also, which is that particularly the elderly feel what many people feel, that they are attached to their primary care physician. That becomes a more acute problem as people age, particularly if there are chronic diseases that are present.

So while the financial element, the financial choices that they face, is an important thing to consider and is going to affect some people, we do have to remember that this is a somewhat different population than the younger employee population. It is a tougher market, really, to draw people in voluntarily.

The second thing is that—what Dr. Altman said is very important, there are many things that employers do as sponsors that are much more structured than Medicare and the Federal Government have done vis-a-vis Medicare beneficiaries and, perhaps, are contemplating. That structure, while not necessarily compulsion, really gives an extra push to people in the private sector in the employee population. So there are some different things going on there.

Chairman THOMAS. I was looking at a chart in the ProPAC structure. The majority of people in California are in managed care programs. We are really negligent if we don't create a system that carries over the workplace experience, which in the sixties was fee-for-service, and create a wall to a certain extent for those people who were in the system and try to incentivize them into the newer system.

But to the degree we don't inform them, we don't have a payment system which is rational. We are, in fact, penalizing ourselves and the taxpayers by getting people into Medicare basically as a fee-for-service program, when they were in a managed care program in a place of work.

Mr. RATNER. Yes. There certainly are things that can be done—or can be considered—so that people who have been in managed care organizations as employees can age in and remain in Medicare. But part of the problem there, that again we have to recognize, is that currently the Medicare managed care program is largely an HMO program, whereas the thrust of managed care in the private sector has been heavily toward looser forms of managed care.

There are some things that we need to pay attention to in thinking about the choices that the beneficiaries have, so that if we are looking for the kinds of gains you get in the private sector, that it is reasonable then to expect them to show up in Medicare.

Chairman THOMAS. I have no interest in locking nineties Medicare into a structure which may be transitionary, as we did in the sixties. It has got to be an open-ended model to allow for movement. There is no question about that.

Let me ask you a very difficult political question. If, in fact, we are basically providing them, for want of a better term, with a chocolate sundae and the other option is plain ice cream, and we keep the chocolate sundae available and continue to try to convince them the plain ice cream is pretty good. Would you advise us to look at the possibility of closing out the chocolate sundae market on a prospective basis so that only ice cream is available?

Mr. ALTMAN. First of all, let me change your analogy just a little bit.

Chairman THOMAS. Good. I am looking for a better one, one that is 25 flavors.

Mr. ALTMAN. We will stick with the ice cream because that sort of engenders a positive——

Chairman THOMAS. Ice milk versus ice cream.

Mr. ALTMAN. No. As I mentioned in the testimony, let's think of the fee-for-service as sort of a half a sundae or minisundae. The real sundae of today is to be in a managed care environment in a high AAPCC area, because you get all of these extra benefits.

So what you have are three kinds of choices. You have the fee-for-service, which is quite attractive; and then we bribe or encourage or incent—I think it is almost bribing—to put all this extra stuff on to make people move into it. So in California and Arizona, it is not surprising they are there, because they get all these extra benefits because of the way the current system is structured.

And then you have the vanilla. What are you going to do? Take away the true sundaes from the people that are in managed care in very high AAPCC areas?

Ms. WILENSKY. This is one of the areas where I don't quite agree. I agree that it is an issue we hadn't thought about, that there is a lot more variation because spending is there, but if these people weren't in managed care plans, they would be just in that regular, old, expensive fee-for-service and that would——

Mr. ALTMAN. That is not the issue. I don't disagree.

Ms. WILENSKY. I think actually your analogy is a perfectly fine one and the issue we ought to be asking ourselves—as a government and as a taxpayer, we owe providing the cost of the plain ice cream; we promised that. Those are the benefits and we ought to make sure we do it and we do it at the cheapest place that we or—not the cheapest, at a lower priced place to be able to get it.

It is—I could understand the attractiveness to you as a politician to not have the chocolate sundae out there available, but it is the wrong path for us to take. We want people to be able to choose what they want. What we have to do is have the discipline as a government to say, our job is to pay for the basics. We will do that, and if you want to buy the chocolate sundae, we won't stop you, but don't ask us to pay for it.

That is really the change in thinking, and to take away the artificial barriers, I mean, it is ridiculous.

You said it very well. People in California are aging into Medicare in plans that they have been happy with. You can't stay in that plan because when you turn 65, you must go into the fee-for-service world. You can't stay in the plan because if your employer only allows his employees or former employees in, that disallows you from being in an HMO under Medicare rules. We absolutely stop with these foolish rules, people continuing care in a seamless way as they go from being 64 to 65. Now, that is dumb, but it is going to take more than that in order to change this problem.

Chairman THOMAS. Then not even create an informational structure to find something else and have a payment system, as Stuart says, which isn't rational at all within regions.

Ms. WILENSKY. It is not a surprise why you have got a problem here.

Chairman THOMAS. Yes, Mr. Ratner.

Mr. RATNER. Just a couple of points. First, the idea of putting fee-for-service out of reach of the beneficiaries I don't think makes sense in terms of good economic logic. What you really want to do is make sure that people have appropriate incentives to choose efficient plans. Whether that happens to be fee-for-service, HMO, PPO or some new alphabet soup that comes up in 10 years, you want to have an appropriate, level playingfield there so the incentives are right, not that somebody prejudges which delivery form is best.

Point two. If you look at Boston, Massachusetts, and compare that with New Haven, Connecticut, you will find that the level of resources devoted to medical care per person in Boston is much greater than in New Haven. You can have a managed care plan in Boston that may be having a richer, more intense practice style than New Haven.

If you set up a scheme that just says, exclude one form of delivery, a fee-for-service plan, you would be saying in effect that maybe parts of the country where they do things leaner shouldn't be doing it. I think it becomes sticky there. So I just give that as a caution.

Chairman THOMAS. Well, finally, my concern is that if we do determine what is a reasonable payment structure and different styles of delivery of care have a different cost pattern, would it be appropriate to indicate that this is what is available, and if you want a different program, you pay for the extra cost, but that you could get this under a particular style—that is, provide a wide choice, but clearly certain styles would have 100-percent coverage, and if you want a different style of delivery, it would then be out of pocket on your case.

That is an option that we would be looking at, isn't it?

Ms. WILENSKY. That is I think what you need. That is what you need to move to.

Chairman THOMAS. The gentleman from Louisiana.

For the record, I think Dr. Altman nodded his head.

Mr. ALTMAN. I did.

Mr. MCCRERY. Just a quick followup to perhaps conclude this. Is any one of you familiar with the CBO study on the amount of money that the average Medicare recipient paid into the system versus the amount that the average Medicare recipient takes out of the system?

Ms. WILENSKY. I was just looking at some figures that were HCFA, and I think ProPAC has done them. I don't know that I have seen CBO's.

But basically, what I recall is that in part A, the trust fund part, the average payment in is about $8,000. The average payment out is about $40,000. So it is roughly a 5-to-1 differential. If you include the employer's share, it is then about 2½ to 1.

You get out two-and-a-half times more than what you put in, and of course, that doesn't account for part B where somewhere between 25 and 30 percent is paid by the senior and, therefore, 70 to 75 percent is paid for by the taxpayer. So it is a heavily subsidized transfer as it exists now.

Mr. McCRERY. So the average Medicare recipient, at least under today's system, takes out about three times as much as he ever puts in in taxes when he was in the work force.

Ms. WILENSKY. Slightly more. Slightly more. It is 2½ to 1 on the hospital side and—well, I guess 3 to 1. So it is about 3 to 1.

Mr. McCRERY. Well, I think that explains where part of our problem is.

Chairman THOMAS. Any additional questions?

I want to thank all of you very much. As usual, you have been very, very helpful in focusing our attention.

I would ask the next panel to come forward and this panel will consist of Stuart Butler from The Heritage Foundation and David Kendall from the Progressive Policy Institute.

I want to announce prior to the beginning of this panel that, due to a previously arranged Ways and Means Committee function, the Subcommittee will break at noon for 1 hour and we will reconvene for the third panel at 1 o'clock. So that if the folks from Arizona want to try to get a bite of lunch, we are not going to be back in until 1. I apologize, but the Full Ways and Means Committee has a preplanned meeting and function, and we are required to participate in that.

I would tell this panel, as I have the others, that if you have any written statement, it will be part of the record, without objection, and that you may proceed to inform us any way that you see fit.

Dr. Butler.

STATEMENT OF STUART M. BUTLER, PH.D. VICE PRESIDENT AND DIRECTOR, DOMESTIC AND ECONOMIC POLICY STUDIES, THE HERITAGE FOUNDATION

Mr. BUTLER. Thank you, Mr. Chairman, for the opportunity to testify. The discussion toward the end of the last panel with regard to incentives, I think, very nicely sets up for what I wish to address, which is the basic incentive system. We see a slow pace of HMO enrollment and other innovations of delivery in the Medicare system because of the very nature of the program, which is essentially a planned, defined benefit program.

As such, it tends to be rather insensitive to the normal process of innovation and quick decisionmaking that occurs, say, in the corporate area. Similarly, it is insensitive to the introduction of services that the elderly may want and, may be more effective to treat them.

I think as a general strategy with regard to Medicare, it is important for Congress to restructure the program, moving much more to giving control of the dollars and choice of services to the elderly, and using competitive forces among competing plans to provide both quality and price for the elderly to buy.

As a model to look at for how this might be done, I think the Federal Employee Health Benefits Program, which, of course, covers you, Mr. Chairman, and other Members of the Committee, and also Federal employees and retirees from the Federal sector, is a very good basic model to examine.

It provides good information to the elderly who are in that program. It provides a range of plans. It provides different benefits within those plans. And a method of enabling elderly Federal retir-

ees to pick plans sensibly, by the use of fairs and other kinds of marketing arrangements to deal with some of the problems of marketing that Mr. Stark and others mentioned.

If you were going to move to a system like this for Medicare generally, there are two broad changes that would be necessary. One is to move toward a defined contribution system, or a voucher adjusted by age, sex and geography at the least.

Incidentally, the former and current Directors of the CBO, Mr. Reischauer and June O'Neill, both support a move in this direction.

An alternative to a simple voucher would be some kind of credit system against the cost of premiums and other expenditures, and there are various variations that can be considered there. But the important thing is to move to a defined contribution, which is essentially in the hands of the elderly themselves to make the decision over exactly what kind of plan will serve them.

The second element which is crucial is to allow Medicare-approved plans, willing to enter this market, to compete for the voucher, much as under the FEHBP. The same kind of arrangement should occur. It must be a very open-ended arrangement to allow variation of types of services, not just HMOs or fee-for-service, but a wide choice of a continually expanding range of types of delivery to be incorporated into plans that could be offered to Medicare beneficiaries.

To be Medicare-approved, I would argue that such plans would have to meet certain basic conditions very similar to those in the FEHBP. They must show basic financial security. They must have a standardized description of their costs and services and a standardized marketing method very similar to what OPM requires for the FEHBP plans. It would be possible under this arrangement for Members of Congress, say, or HCFA, to arrange all kinds of ways of standardizing information for the elderly to pick the particular plan they wanted.

Third, there should be a core set of benefits in the plans that are being offered to the Medicare-eligible population. This should be a rather leaner core than today—principally catastrophic, hospitalization and so forth—but with a wide range of additional services that could be incorporated into any plan, and a Medisave variant could be offered as well.

And, fourth, premiums in such a Medicare-approved plan, would be subject to limited underwriting, using essentially the same principle to devise the voucher—age, sex and geography. Under this arrangement, you would see two principal effects. One is that the elderly's choice of plans would be affected by the total cost of plans and out-of-pockets, not the way in which their out-of-pocket is affected, which is the case today.

So to take your ice cream sundae analogy, it would be rather like offering either ice cream or a sundae, but saying, we are going to contribute 50 cents to whichever one you want. My kids certainly react very well to those kinds of incentives. In so doing, they are looking at the total cost of the product, rather than the specific payment that you make.

And second, of course, it would mean that the elderly would be able to pick plans that are right for them in terms of the services within them, and the relative costs and benefits. Again, this is very

similar to the way elderly Federal retirees do today; and I think organizations like AARP could fulfill the same kind of role that say NARFE does for Federal retirees, which is to help grade the plans, recommend plans and so on.

So I think a lot of the concerns associated with marketing tricks could be very simply dealt with under this kind of system.

I think if you move in that direction, Mr. Chairman, a lot of the issues that were raised in the first panel would be substantially dealt with because you would have a situation where the elderly would have a much more normal set of incentives to make decisions. They would have to take total costs into account, and there would be strong incentives for the plans to innovate in terms of the services that they provide.

Thank you, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF STUART M. BUTLER, PH.D.
THE HERITAGE FOUNDATION

INTRODUCTION

Mr. Chairman, my name is Stuart Butler. I am a Vice President at The Heritage Foundation. I appreciate the opportunity to address the committee on structural reform of the Medicare system. I emphasize that the views I express are my own, and should not be construed as representing any official position of The Heritage Foundation. In addition I should note that my Heritage colleagues John Liu and Robert Moffit assisted me in the preparation of this testimony.

Designed to operate as a federally run health insurance program for America's elderly, Medicare was heralded by proponents to be a "[h]istoric measure and a fiscally responsible bill."[1] However, the Medicare program is now essentially bankrupt and the continued quality of Medicare services is in doubt. According to the 1995 Trustees Report, if Medicare is not reformed the cash flow of the HI trust fund (Part A), which finances hospital benefits for the elderly, will go into the red in fiscal year 1997 and the fund will run out of money and become insolvent in the year 2002.[2] The Report then provides some sobering information on how payroll taxes (which finance the HI program) would have rise to keep the program afloat. "To bring the HI program into actuarial balance even for the first 25 years",[3] a new 1.3 percent payroll tax would have to be added on top of the current 2.9 percent Medicare payroll tax. Based on the Trustees estimates for revenues under the current tax rate, this would raise payroll taxes — and hence raising the cost of employing Americans — by an estimated $263 billion over five years and $388 billion over seven years. For a worker earning $45,000 per year, it would mean an additional payroll tax of $585 per year.

To achieve long-term actuarial balance of the HI trust fund without reforming the program — that, is to put it on a *permanent* sound footing —an immediate additional payroll tax of 3.52 percent would need to be levied top of today's 2.9 percent rate. That would raise taxes by $711 billion over five years and $1.050 trillion over seven years. The payroll taxes of a worker earning $45,000 would increase by $1,584 per year.

Moreover, this shortfall is only for the hospital program. Part B will require a rapidly increasing subsidy from general revenues to continue paying for services. "Growth rates have been so rapid," explain the trustees, "that outlays of the program have increased 53 percent in aggregate and 40 percent per enrollee in the last five years. For the same period, the program grew 19 percent faster than the economy despite recent efforts to control the cost of the program."[4] With the trustees' "intermediate" estimates of future program growth, the annual taxpayer subsidy will grow from an estimated $38 billion in this fiscal year to an estimated $89 billion in five years time and $147 billion in FY 2004.[5]

Trying to hold down Medicare's costs through price controls on health providers and stringent regulations is no answer. Not only has this strategy failed to control costs in the program, it encourages physicians and hospitals to "game" the government to make an adequate living, rather than properly serving their patients. Moreover, price controls have

---

[1] House Speaker John W. McCormack (D-MA), during floor debate in the U.S. House of Representatives on April 8, 1965.
[2] *1995 Annual Report of the Board of Trustees of the federal Hospital Insurance Trust Fund*, pp. 2,8.
[3] *1995 Annual Report* [HI], p. 27
[4] *1995 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund*, p.3.
[5] *Ibid.*, p. 9

shifted costs over to the private sector, driving up premiums for working individuals and families.

Instead of trying to tighten the controls and regulations in the current system, the proper reform is to create a very different dynamic and set of incentives to drive the Medicare program. Specifically, the bureaucratic, standardized command-and-control structure of today's Medicare must be replaced with consumer choice of competing health plans offering different benefits. This is the same dynamic that has allowed health costs to be brought under control while improving quality in the private sector -- and in the government-sponsored health plan enjoyed by Members of Congress and other federal employees.

The way to achieve the same results in Medicare is to reform the Medicare program by patterning it after the existing Federal Employee Health Benefits Plan (FEHBP), which covers roughly ten million federal employees, families, retirees, including present and former Members of Congress. Under this new Medicare program, perhaps renamed the "Medi-Choice" program, Medicare would become a *defined contribution* program instead of today's defined benefit program. Making this change would give America's seniors unprecedented opportunity to choose their own health plan and range of benefits, just as retired Members of Congress and other federal retirees do. Under such a system, and unlike today's Medicare program, the nation's elderly and disabled could choose sound health insurance plans from a variety of different managed care and fee-for-service arrangements. And retirees could choose coverage for services not covered by today's standardized Medicare program -- such as a prescription drug benefit -- by accepting, say, higher copayments for other covered services. One of the great ironies of the Medicare debate is that those who oppose reforms are in practice denying the elderly the chance to receive many basic medical services that are available to working Americans and even the indigent.

The key financial difference is that the government would make a defined financial contribution to the plan of the retiree's choice, rather than reimbursing each Washington-approved service according to a fee schedule that defies comprehension and ignores market realities. Doing so would mean the same incentive in the reformed Medicare as it does for federal retirees in the FEHBP: encourage beneficiaries to pick plans with the best value for money, pocketing part of the savings for choosing more efficient coverage. That incentive has enabled spending in the FEHBP to increase at half the rate of Medicare. And this year, federal workers and retirees were treated to a reduction in premiums averaging 3.3 percent. Introducing that incentive system into a reformed Medicare program would save hundreds of billions of dollars over the next decade, putting the program on a sound financial footing so that it can serve both today's elderly and the next generation of Americans.

Congress in reality only has two choices when considering the future of Medicare. One choice is for Congress to make no significant change in the way in which Medicare is run by the government, and to try to pay for future trust fund shortfalls by raising new revenues through higher payroll and other taxes, or by diverting money from other programs. This means Medicare survives only by draining money away from the rest of the budget or by raising taxes.

The second choice is to change the way Medicare is run, so that benefits are delivered more efficiently, avoiding future tax increases or a diversion of money from other programs. Making the program more efficient would not reduce the financial burden Medicare will place on the next generation, but it will also improve the quality of benefits and the choices available to America's senior citizens.

HOW TO REFORM MEDICARE

In grappling with Medicare's emerging fiscal crisis, Congress should pursue both short term budgetary measures and a long-term strategy of structural change. Short-term measures are needed to deal with the injustices and glaring shortcomings of the program. But long-term structural reform is needed to deal with the structural financial problems of the program and to improve the quality of care for America's seniors. Moreover, Congress must help to deal with the public confusion about the status of the Medicare

system and the purpose of reform. So Members of Congress must educate the American people about the true dimensions of the problem, including the potential tax burden facing working Americans if action is not taken. This last task can be accomplished in two ways:

First, Congress should order the Health Care Financing Administration(HCFA) to notify America's 37 million senior and disabled citizens that their Medicare hospitalization program is facing bankruptcy as early as 2001, according to the Medicare Trustees Report. To keep the program going without reforms, HCFA should explain that billions of dollars will need to be taken from the paychecks of working Americans or diverted from other programs.

Second, Congress should order HCFA to inform the elderly that the premiums they pay for their Medicare supplementary insurance program (Part B Services) represents only 25 percent of the premium income for those services, and that their children and grandchildren, young working families, are paying the bulk of these Medicare benefits out of general tax revenues. Most elderly are under the erroneous impression that they are paying the full cost of their Medicare benefits. The truth about the financial condition and circumstances of the Medicare system will only improve the quality of the necessary public debate.

Short-term Reform of Part B

Congress should act immediately to reduce the heavy taxpayer subsidy of Medicare's Part B premiums.

Option #1: The simplest, though not necessarily the best, option would be to restore the premium to the original 50 percent level. This could be done in a gradual, phase-down of the current level of taxpayer subsidies at five percent per year over a five-year period. This change would save taxpayers approximately $74.7 billion over the next five years.[6] By financing one-half of the Part B program costs, Members of Congress would thus return to the spirit of the original 1965 "contract" with America's taxpayers.

A reduction of the taxpayers' subsidy in Part B would encourage many enrollees to compare the costs and benefits of more efficient private alternatives with the cost and benefit of the Part B program. The more the subsidy is reduced, the more level would be the playing field between the private sector plans and the government plan. The elderly would have incentives to choose more efficient plans in the private sector. The likely result: not just a reduction in the subsidy but also a significant reduction in the gross budget outlays for Medicare Part B.

One problem with simply reducing the subsidy across-the-board is that it would impose some hardship for many lower-income Americans yet it would still continue a taxpayer subsidy to the affluent (though it would reduce that subsidy). It would also raise the cost to states of enrolling in Medicare some individuals also on Medicaid.

Option #2: An alternative would be reduce the current subsidy as income rises, and perhaps raise the level of subsidy for the elderly with very low incomes. The savings achievable from such a change would vary widely, depending on what method of means-testing was introduced. At, say, $65,000 adjusted gross income for individuals and $85,000 for couples, the subsidy might be phased out in increments of three percentage points 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.

Not a Tax. Contrary to what liberals in Congress may say, an increase in the Part B premium is *not* a tax increase, but a reduction in a direct subsidy. It is not a tax increase because the Medicare Part B program is a voluntarily chosen service from the federal government that can just as easily be provided by the private sector. Part B is a subsidized commercial service provided by the federal government in competition with the private sector. If Members of Congress believe it necessary to give high levels of subsidies to enrollees in the program, those subsidies should be targeted to those elderly

[6] This, and other short term budgetary proposals for dealing with the Medicare system are discussed in Scott A. Hodge(ed.) Rolling Back Government: A Budget Plan To Rebuild America" (Washington, D.C.: The Heritage Foundation, 1995).

citizens who cannot afford an acceptable level of physician services and other services now available under Part B, not to everyone over 65.

A POSSIBLE MODEL FOR LONG-TERM REFORM -- THE FEHBP

Members of Congress searching for an alternative model for reforming Medicare do not have to look far. For well over three decades, Members of Congress and federal employees -- and federal retirees -- have been enrolled in a unique consumer-driven health care system called the Federal Employee Health Benefits Program (FEHBP). Unlike Medicare, it is not run on the principles of central planning and price controls. Instead, it is based on the market principles of consumer choice and competition. Starting enrollment in 1960 with 51 plans for the federal workforce, there are now over 400 private health insurance plans nationwide, ranging from traditional indemnity insurance and fee-for -service plans to plans sponsored by federal unions and employee organizations to various managed care plans, including Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). In the Washington, D.C., metropolitan area, half of all persons with health insurance are covered by one of the 35 plans competing in the FEHBP.

The FEHBP works on entirely different principles from those in Medicare. For one thing, Medicare is a **defined benefit** program, meaning that each enrollee has access to a specific set of health services which are then paid for in total or in part by the federal government. The FEHBP, on the other hand, is a **defined contribution** program, in that the government agrees to provide the federal worker or retiree with a financial contribution towards the purchase of the health plan of their choice.

Even more important, and unlike Medicare, the FEHBP does not attempt to constrain costs by controlling prices and specifying services. Instead it sets only very broad guidelines over how plans must be structured and marketed, and specifies only a brief set of core benefits, permitting federal workers and retirees to choose the plan and benefits that are right for them. Cost restraint is achieved not with an army of Medicare-style price controllers, but through the operation of consumer choice in a market of competing plans.

Choices for Federal Retirees. The FEHBP system is open to all congressional and federal retirees who retired after July 1, 1960. Under current rules, a congressional or federal retiree is eligible to enroll in an FEHBP plan if they retired on an annuity with at least five years of continuous service at the time of retirement, or if they retired on a Civil Service disability. A federal or congressional retiree can assure coverage for spouses if they elect such survivor benefits for their spouses. And any survivor annuitant can even request FEHBP coverage for grandchildren, under certain conditions on or after August 11, 1994.[7]

Significantly, while private sector firms in recent years have been cutting back, or even eliminating private health insurance for their retirees altogether, the FEHBP has improved its coverage. Moreover, while the number of active employees has remained fairly constant over the past ten years, the number of retirees has grown, from 1.3 million to 1.6 million.[8] Congressional and federal retirees and their dependents now make up 40 percent of the total enrollment in the program.[9] And for these fortunate congressional and federal retirees, the FEHBP offers choices and services denied to Americans enrolled in the Medicare program. Among the features of the FEHBP:

* **Wide Choice of Health Plans.** No group of Americans enjoys the same range of personal choice over health plans as do active and retired congressional and federal employees. Their private plans range from fee-for-service to managed care plans. They can even obtain plans through organizations they trust. Plans sponsored by federal unions and employee organizations are particularly popular among federal workers and retirees -- almost one-third are enrolled in such plans. In recent years, managed care plans have

---

[7] Whether or not a child will be added to a family plan of a survivor is dependent upon the family status: "The deciding factor now is whether or not the grandchild would have qualified as a family member if the retired employee were still alive." See NARFE, p. 28.

[8] Carolyn Pemberton and Deborah Holmes, eds., EBRI Databook on Employee Benefits, (Washington D.C.: The Employee Benefit Research Institute, 1995), p.278.

[9] Ibid.

become quite popular in the FEHBP. But among the managed care plans, there are a variety of different types of options. There are Health Maintenance Organizations (or HMOs), including staff model HMOs, where physicians are paid on the basis of a salary rather than a fee. But there are also "group model" HMO's, where the HMO "rents" the services of physicians; "network model" HMOs, where the insurance company contracts with physician group practices; and "Independent Practice Associations"(IPAs), where the HMO contracts with individual doctors in private practice and groups of physicians at a negotiated rate. There are also "point of service" plans, where retired federal and congressional workers can choose to use a personal physician outside the HMO network for a higher copayment.

The FEHBP is very popular among federal retirees. Indeed, it is so popular that many federal retirees who qualify for Medicare decide instead to remain in the FEHBP. And as the National Association of Retired Federal Employees states, in its 1995 guide to federal health plans for retirees, "All FEHBP plans are good.... You can't make a serious mistake in choosing a FEHBP plan unless you choose a high cost plan or option when you don't need one." [10]

* **Choice of Health Benefits**. Federal retirees do not merely have a choice of plan. Unlike virtually all other Americans, active or retired, congressional and federal retirees also have the freedom to choose the services they want. Unlike Americans enrolled in the Medicare program, congressional and federal retirees are not locked into a single, government standardized benefits package. Beyond the normal range of typical hospitalization and physicians services, congressional and federal retirees can pick from a variety of plans that cover such items as skilled nursing care and home health care by a nurse, dental care, outpatient mental benefits, routine physical examinations, durable medical equipment and prostheses, hospice care, chemotherapy, radiation , physical and rehabilitative therapy, prescription drugs, mail order drugs, diabetic supplies, treatments for alcoholism or drug abuse, acupuncture and chiropractic services. And FEHBP plans include catastrophic coverage -- in sharp contrast to Medicare.

* **Choice of Price**. Unlike the limited or non-existent choices of workers and retirees in the private sector, and unlike the rigidly controlled pricing in the Medicare system, congressional and federal employees have a wide range of options in terms of what they will pay in premiums, coinsurance or copayments. Under the FEHBP's financing formula, the federal government will contribute up to 75 percent of the cost of a plan up to a maximum dollar amount (currently $1,600 for individuals and $3,490 for families).

If congressional and federal retirees wish to choose a very expensive "cadillac" plan, with a rich set of benefits, they may do so, but they make the decision to pay extra . If, on the other hand, a retiree picks a less expensive plan, he or she saves money on their portion of the premium. Private health plans compete directly for these consumers' dollars.

Needless to say, the dynamics of a competitive market in the FEHBP have had a positive impact on premium prices for federal employees and retirees. According to the Congressional Budget Office (CBO):

> Over the past five years, FEHBP plan premiums have increased an average of 6.8 percent a year, whereas the premiums paid by medium and large firms surveyed by Hay/Huggins Company, a benefits consulting firm, increased by 10.8 percent a year. Furthermore, FEHBP premiums are expected to decline by 3.3 percent in 1995; the Congressional Budget Office projects, however, that aggregate private health premiums are likely to rise by about 5 percent.[11]

According to the CBO, Medicare hospitalization (HI) costs will rise at a nominal rate of 8.4 percent per annum between 1995 and 2000, and the Medicare supplemental medical insurance (SMI) plan costs will rise at a "nominal rate" of 12.9 percent between 1995 and 2000.[12]

---

[10] See Federal Health Benefits Information and Open Season Guide, 1995, The National Association Retired Federal Employees (Washington D.C., 1994), p. 11.

[11] Congressional Budget Office, Reducing the Deficit:Spending and Revenue Options, A Report to the Senate and House Committees on The Budget, (February 1995), p. 184.

[12] Ibid.,p.225.

Many federal retirees, but not all, have access to Medicare system, as well as their FEHBP plans. For retirees who retired from the federal government during or after 1983, and met Social Security earnings criteria, are eligible for Medicare's hospitalization program. All federal workers are eligible for Part B at age 65, whether or not they ever worked under the Social Security system. Whether it makes sense to enroll in the Medicare Part B is dependent upon one's personal needs and choice of FEHBP health plan. Retirees are given advice on these issues by consumer organizations such as the National Association of Retired Federal Employees (NARFE). Washington's Consumer Checkbook, a consumer organization, gives retirees advice on the best options, such as enrolling in plans that coordinate with Medicare. Various other groups rate plans and provide information on plan services, quality, and levels of benefits.

Deficiencies in the FEHBP The FEHBP is not without deficiencies. The most significant is that plans must offer community-rated premiums, meaning they must offer a plan to healthy 19 year-old at exactly the same premium as they charge a very sick 89 year-old. This inevitably leads to the problem of adverse selection. Still, the FEHBP functions so well that even this problem does not undermine the program. Nevertheless, it does introduce distortions and perverse incentives that prevent the FEHBP from functioning as effectively as it should. A wise reform would be to vary the degree of assistance to FEHBP enrollees at least according o their age and to permit plans to vary premiums also by age. That would allow plans to compete more effectively and to offer services with less vulnerability to adverse selection.

A REFORM AGENDA FOR MEDICARE

Congress has committed itself to curbing the growth of Medicare spending in order to restore the financial stability of the program and thus prevent out-of-control Medicare spending from swallowing up money for other programs or forcing huge increases in taxes. To carry out this wise commitment, Congress can proceed in two ways. It can, as it has done in the past, impose tighter regulation, stricter price controls and cut medical services for the elderly. But experience shows that strategy yields only short-term spending reductions at best. In the long run it does nothing to curb runaway spending, and yet undermines the quality of care for the elderly.

The other option for Congress is to achieve spending restraint by giving the elderly greater control over their Medicare dollars and greater opportunity to use their dollars to select the health care plan and services that are right for them. Such a reform, modeled after the health system serving federal retirees, would use consumer choice and competition to curb waste and improve care.

Such a reform would include three principles:

Principle 1: Medicare should be changed from a defined benefit program into a defined contribution program.

Principle 2: The elderly should be allowed to use their Medicare dollars to enroll in a plan with health services that they choose, not services that bureaucrats or politicians have chosen for them.

Principle 3: Cost control should be achieved through consumer choice and competition, not central planning and price controls. Indeed, HCFA's complex system of price control and other restrictions should be phased out.

A reform incorporating these principles would be to provide Americans eligible for Medicare with a voucher to purchase the Medicare plan of their choice. The amount

of the voucher would be the combination of two amounts, reflecting the financing of today's Part A and a reformed Part B. The two elements of the voucher would be:

Portion (A) Part of the voucher would be an amount, adjusted by age, sex and geography, intended to cover the actuarial equivalent of the hospital and other services in today's Part A of Medicare. This portion would not be means-tested.

Portion (B) The other part of the voucher would be based on an amount, adjusted by age, sex and geography, intended to cover the actuarial equivalent of the services currently in Part B. This base amount would be means-tested to determine the dollar amount of this element. And since today's Part B is voluntary, the elderly would be able to decline this portion of the voucher.

An alternative form of defined contribution, rather than a voucher, would be for the Medicare program to cover a certain percentage of the premium for the plan of the elderly's choice, with a maximum dollar amount of contribution. This structure of contribution would be more like the FEHBP, but would mean somewhat less financial assistance for lower-income elderly.

The elderly would be able to use the voucher (or the percentage contribution) to purchase a Medicare approved health plan of their choice. Medicare would distribute information on the plans to the elderly, as well as a checklist to permit the elderly to pick their desired plan. Medicare would then inform the appropriate plan of the retiree's choice.

These plans, somewhat like plans offered through the FEHBP to retired federal workers, would have to meet certain basic requirements to be marketed as Medicare-approved plans:

Plan Requirement #1 The plan would have to meet certain basic financial requirements to assure their financial strength.

Plan Requirement #2 The plan would have to specify its services and costs in a standardized manner, to enable the elderly to choose without confusion.

Plan Requirement #3 Each plan would have to offer coverage designed to be actuarially equivalent to Part A (for those declining the "Part B" portion of the voucher) and a plan with additional services equivalent to the services in Part B (for those who wanted the full voucher).

Plan Requirement #4 Each plan would have to contain a core set of benefits, including catastrophic overage. This core would be leaner than Medicare today, thereby permitting the elderly to purchase a less expensive basic plan and supplement it with other optional services, or — with the help of the voucher — buy those services directly from providers. As an option, plans could offer a Medisave option, allowing the enrollee to pay directly for services out of an account, with insurance only for catastrophic expenditures. The core benefits for those declining the "Part B" portion of the voucher would be less extensive, and focused on hospital services. If a senior declined the "Part B" portion of the voucher they could buy additional insurance or pay for benefits without any requirement that these additional services comply with any federal guidelines. Thus, just as today, the equivalent of part B coverage would not be compulsory.

An alternative would be for Congress to require that, at a minimum, each plan must contain at least the specific services available today under Medicare, yet allow plans to offer additional services — with perhaps higher copayments for services currently in the Medicare package.

Plan Requirement #5 Each plan would have to set its premiums according to limited underwriting principles. These would be age, sex, and geography, but not health status. One exception to this general underwriting limitation would be to permit "lifestyle" premium discounts for seniors willing to enroll in sickness prevention and health promotion programs.

A reform based on this consumer-choice approach would have numerous advantages for the elderly and the taxpayer.

Personal Freedom. Under a consumer choice system in Medicare, elderly Americans could choose the type of private health insurance that best meets their individual needs. With the advice and counsel of their doctors, they would be able to pick not only the level of benefits above a basic set of hospital and physicians services, but also a broad range of medical services and treatments that are available on the free market. Consulting with their doctors, rather than waiting for approval from the bureaucrats at HCFA, this means that the elderly would be able to take immediate advantage of changes in treatments, medical procedures, and service delivery innovations. The only large group of the elderly with access to similar breakthroughs today are retired Members of Congress and federal employees.

Value for Money. Like retired federal and congressional retirees, Medicare beneficiaries would be able to pocket any savings from their personal decisions. While the cost of health care for the elderly is considerably higher than the cost of health care for active workers and their families, the level of the government contribution to their health plans would also be higher, depending on differences in age, sex, and geography.[13]

Controlling Costs. While by no means a perfect market, the FEHBP, serving retired Members of Congress and federal workers, has been able to control costs better than either private, employer based insurance or the current the Medicare program. According to the Congressional Budget Office and such private econometric firms as Lewin-VHI, this success is in large part due to the ability of Members of Congress and other federal workers, families, and retirees to comparison shop among the various health plans in their geographic region for the best value for their money. In recent years, even though the FEHBP enrolls approximately 1.6 million higher-cost retirees and dependents and includes progressively higher benefits, the FEHBP's outlays have increased at a much slower rate than the Medicare program.[14] With the establishment of a Medi-Choice system, similar in structure to the current FEHBP, the powerful market forces of consumer choice and competition should produce similar dynamics and thus similar results in the Medicare program.

---

[13] As noted earlier, one central weakness of the FEHBP is that its insurance underwriting practices are outdated. It is currently a crude form of community rating, where there is no distinction in premium payments for active and retired federal workers and their families. This current FEHBP arrangement also directly contributes to the persistent problem of "adverse selection" in the FEHBP. The problems could be largely eliminated by an adjustment in the FEHBP premium structure, resulting in simultaneously higher premiums for retirees than active workers, along with an increase in the government contribution to retirees chosen plans or a tax credit for federal retirees to offset the increased cost. For a discussion of how to improve the FEHBP, see Robert E. Moffit, "Consumer Choice in Health :Learning From The Federal Employees Health Benefits Program," op. cit. pp.17-19; see also Stuart M. Butler, "Reforming Health Insurance: Analyzing Objections To The Nickles-Stearns Bill," Heritage Foundation Issue Bulletin, No.193, June 14, 1994.

[14] Source: Office of Personnel Management, Office of Actuaries, Table entitled "Federal Employees Health Benefit Program, 1992 Contracts."

Reduced Red Tape and Bureaucracy. In administering a consumer choice system in Medicare, Congress could relieve the Health care Financing Administration(HCFA) of the task of trying to dictate the minutiae of virtually every facet of health care financing and delivery for the nation's elderly. Instead of administering complex and cumbersome system of economically inefficient price controls, or promulgating an seemingly endless stream of rules, regulations and guidelines, HCFA could simply transmit defined contributions, either in the form of vouchers or through electronic transmissions, to the plans of the elderly' citizens choice, certify private plans as meeting basic hospital and physicians benefits, meet fiscal solvency requirements, and guarantee catastrophic coverage (a benefit that Medicare does not now provide). Moreover, HCFA could promulgate and enforce serious rules protecting elderly citizens from fraud by insurance companies.

An AARP Health Plan? Much like the National Association of Retired Federal Employees (NARFE), which rates and grades the quality and benefits of plans offered to congressional and federal retirees, the American Association of Retired Persons (AARP), and other senior citizens organizations, could play a similar role in a revamped Medicare system, rating and approving competing plans on the basis of price, service, quality, and benefits for Medicare beneficiaries. In fact, there is every opportunity for the AARP, and other senior citizens organizations to sponsor and market their own health care plans, entering into competition with established insurance carriers, such as federal unions and employee organizations do today within the FEHBP.

CONCLUSION

Unless Congress soon takes action, the costs of the current Medicare program will continue to rise at unsustainable rates and will become insolvent. The Medicare program is structurally unsound. It provides a false sense of security for the nation's elderly population. Attempts at holding down annual cost increases of 11% per year through arbitrary price controls have failed. The Health Care Financing Administration (HCFA) has become an entrenched, intrusive and overly bureaucratic organization. It has issued volumes of rules, regulations and guidelines that are confusing not only to the public and lawmakers, but also to doctors, hospital administrators, and patients.

The new debate over Medicare reform is one of the most important domestic policy discussion since Congress debated comprehensive health care reform last year. Congress must make decisions affecting the lives of every American, working or retired, rich or poor, healthy or ill. It is imperative that participants in this debate, particularly Members of Congress, focus their attention on not only the financial health, but also the administrative structure, including the regulatory details ,of the Medicare system. While pursuing necessary spending restraints in Medicare and many other government programs in order to secure an end to these ruinous deficits, they must also remain open to the fundamental restructuring of the Medicare program with a view towards improving the quality, availability, and the security of health services to the elderly well into the next century. If Congress fails, then the elderly will be faced with a dramatic reduction in the quantity and the quality of their health care coverage, or already overburdened working families, now paying over one third of their total income in taxes, will be forced to pay record high levels of payroll taxes just to maintain the current level of benefits. Either consequence is tantamount to fiscal and political disaster. If Congress succeeds, and takes advantage of this historic opportunity to create a new Medicare system based on consumer choice and competition, it will not only be a great comfort to our nation's elderly , it will also serve future generations of taxpayers as well.

Chairman THOMAS. Mr. Kendall

STATEMENT OF DAVID B. KENDALL, SENIOR ANALYST FOR HEALTH POLICY, PROGRESSIVE POLICY INSTITUTE

Mr. KENDALL. Thank you. My name is Dave Kendall with the Progressive Policy Institute, which is the policy arm of the Democratic Leadership Council. I thank you for the opportunity to be here today.

Let me begin by recalling one of the lessons from last year's debate. The public cannot have confidence in a program that they don't know. That was the problem with President Clinton's health care alliances. They inspired little confidence in his plan because they would have been a brandnew institution in this country. And that is the danger of bold proposals like the ones we are considering today.

The Federal Employees Benefit Program, for instance, is a good model to be using to think about the reforms that we need to do, but most Medicare participants are not familiar with it. Instead, we need to build up from what we already have.

Medicare already offers vouchers. It is in the managed care program. And the growing popularity of managed care plans offers an opportunity to create fiscal discipline for Medicare that it has never had before.

HMOs are offering participants an alternative to rapidly rising costs, better benefits at lower prices. As a result, they are growing at an annual rate of 27 percent. The dark cloud raining on this parade is that taxpayers are not gaining much of the savings from the managed care movement.

The reason is simple. Medicare pays managed care plans 5 percent less than its fee-for-service costs. Even if we solved the risk adjustment problems, we would still be saving only 5 percent. So the public will never reap the full benefits of competition as long as Medicare benefits are tied to the fee-for-service costs.

The alternative is to base payments to managed care plans and, ultimately, to the government's fee-for-service plan on the best price in the marketplace. A competitive approach like this must be enacted step-by-step in order to win public confidence during the transition.

We recommend a three-part strategy: Test, verify and adapt. Test the competitive basis for paying managed care plans and any other kind of health plan; verify access to high-quality care at lower costs; and finally, adapt all of Medicare spending to limits set by competition. Let me explain in detail.

Testing competition means opening up Medicare's program to more than just HMOs. Other kinds of health care plans like PPOs and even fee-for-service private plans should be allowed to compete. A greater range of choices would make the option of joining a private plan more attractive to Medicare beneficiaries.

The government's contribution would be set initially near the average of all plans competing that way. Medicare participants would be assured that the government's contribution to their health plan would always be worth something.

The benefits offered by health plans should not exceed the cost of the current value of Medicare benefits. That would prevent the

competitive system from breaking the bank with extra benefits. But all plans would have to offer a core set of benefits, including prescription drugs. That is important, to make the private plans more attractive to older Americans and the disabled.

I think we could build in flexibility as we move forward in the system—as Dr. Butler indicated, by moving to high-deductible plans or medical savings accounts; but, initially, they are going to attract more healthy people. So if we have a problem today in risk selection in the managed care program, it will be even worse with the medical savings account approach.

The quality of care for each plan should be carefully assessed with hard data about the performance instead of simply relying on regulations to protect consumers. Medicare should follow the lead of large employers that write report cards on health plans for their employees.

I believe that consumers armed with good information are better regulators than bureaucrats wielding rules. Every Medicare participant should have a pamphlet that compares the cost, quality and services of each choice on the menu of plans, and including the current Medicare system. I agree with the sentiment of the Committee that we should be doing so much more in just providing better information to consumers.

The next step, verifying, means checking for savings as well as for high quality. Are the health plans saving money by risk-skimming the healthy? Are the plans more efficient because providers are doing more for less and not degrading quality? If Congress cannot answer these questions with confidence, then the pace of change should be slowed until it can. The final step is to adapt all of Medicare to a competitive system. As participation in private plans rises, more of Medicare spending will be set by competition rather than regulations. Medicare's fee-for-service plan should have the authority and flexibility to manage its costs as any other health care plan should. You can almost imagine a privatized HCFA. Confidence in the private health plans would allow Medicare to limit its spending increases to market conditions, and a fee-for-service spending cap would discipline Medicare's fee-for-service system without sacrificing access and quality.

In short, the pace of change in Medicare reform should depend on the ability of the government to win confidence in the new system.

The challenge of reform is summed up by what was said last year by a Medicare participant who was alarmed by the idea of having government-run health care. He said, keep the government out of Medicare. That is the sum of the problem we have today.

Keep in mind that the beneficiaries and the taxpayers have a common interest and that is fighting the high cost of health care. We need to forge a new relationship between the government and Medicare participants. The government must ask them to accept more responsibility for key decisions about the costs and quality of their health care and, in exchange, the government must make sure that they have the resources and the information to make the right decisions for themselves.

Thank you.

[The prepared statement follows:]

TESTIMONY OF DAVID B. KENDALL
PROGRESSIVE POLICY INSTITUTE

The growing popularity of managed care plans in Medicare has created the opportunity to achieve fiscal discipline. For too long, older Americans, the disabled, and taxpayers have had little choice but to pay Medicare's rapidly rising premiums and out-of-pocket expenses. Today, private health plans—namely, health maintenance organizations (HMOs)—offer Medicare participants another choice: better benefits at a lower price. But taxpayers are saving little because Medicare's government insurance plan, which is based on fee-for-service medicine, is shielded from competition.

Under current law, payments to managed care plans are tied to Medicare's less efficient fee-for-service plan. Instead, payments to all health plans—both private and government—should be based on the best price in the marketplace. To compete, Medicare's fee-for-service insurance plan should have new authority and flexibility to manage its costs. Such competition would unleash Medicare's buying power by transforming "beneficiaries" into responsible consumers. They would have more control and responsibility for Medicare spending, thereby lowering costs for taxpayers.

Competition offers an alternative to the price controls and spending limits preferred by many Democrats and the arbitrary budget caps proposed by Republicans. On the one hand, the regulatory approach has been largely exhausted. The controls that have been developed and refined over the last thirty years do not have the potential to restrain Medicare's rising costs to available revenue. On the other hand, the proposed budget caps would reduce spending without regard to the consequences. No one knows how much and how fast to reduce Medicare spending without sacrificing quality and access to health care.

A competitive approach must be enacted step-by-step in order to assure public confidence during the transition. First, a competitive basis for paying private health plans would be widely tested. Next, access to high quality care at lower costs would be verified. Finally, all of Medicare would be adapted to limits set by competition.

Medicare's "risk-contract" program, which pays managed care plans a fixed-sum for every person they enroll, is the logical place to start this new approach. It is the only existing opportunity for private health plans to assume the financial risk of managing the costs of Medicare patients. But it has many flaws that must be fixed before competition can be effective.

Flaws in the Current System

Risk contracts already permit a limited form of competition between private insurance plans and Medicare's fee-for-service insurance. HMOs compete by offering

participants better benefits at lower prices. They combine into one package the benefits offered through Medicare's fee-for-service plan and supplemental benefits such as prescription drugs and low out-of-pocket costs. Medicare participants would otherwise have to pay more for a separate "medigap" insurance policy to get the same benefits. HMO enrollment includes 9 percent of all Medicare participants and is growing at an annual rate of 27 percent.

But the current program is poorly designed to capture the efficiencies of the marketplace. Its problems stem from an outmoded, regulatory approach to health care delivery, which is at odds with the consumer-driven marketplace taking shape in the private sector.

Meager Savings. Rather than paying managed care plans based on competition, the risk-contract program uses a rigid financial formula tied to fee-for-service costs. Specifically, a managed care plan receives 95 percent of Medicare's current fee-for-service spending level for every person it signs up, even though the plan's real costs are usually much less. The government could keep more of these savings, but instead, it requires managed care plans to spend them on richer benefits for participants. This rule means that many older Americans receive free dental care, eye and ear exams, and foot care, which they ordinarily would pay for out of their own pocket.

Long-Term Limits on Competition. Medicare's fee-for-service system limits the capacity of managed care plans to drive efficiency gains in local markets. Consider the example of the Minneapolis-St. Paul market, where the dominance of managed care plans has fundamentally altered the behavior of all doctors. Specifically, doctors have learned to get the same results with fewer tests and procedures, and these lessons have been taken by fee-for-service doctors as well as those in managed care. Yet further competition has been constrained by the fee-for-service nature of Medicare, which guarantees a minimal income to both the managed care plans and the doctors. As a result, participation in Medicare's risk-contract program has declined, and managed care plans for Medicare participants are switching to a different reimbursement system that is based on fee-for-service charges. The drive toward efficiency has come to a halt.

A related problem is that managed care payments in adjacent counties can vary by as much as three-to-one. Moreover, counties seldom correspond to natural market areas. As a result, managed care plans are reluctant to do business in an area where they could lose money by having the misfortune to sign up more people from counties with the lower payment rates.

Risk-Skimming. Many critics have accused HMOs of saving money by attracting enrollees who are healthier than average. To the extent this is true, the fault lies not with HMOs but with those managing the program. Congress and the Administration have not taken full advantage of measures to prevent risk-skimming. For example, Mathematica Policy Research, Inc., which was hired by the government to examine risk-skimming, has recommended lowering payments to manage care plans with patients whose health

history indicates they are healthier on average than the general population. This recommendation has not yet been adopted, but should be.

Restricted Choice. Medicare rules prevent managed care plans from offering patients the option to see doctors outside their network. As a result, older Americans and the disabled must agree to see only the HMO's doctors when they enroll.

Ineffective Quality Assurance. Medicare has two quality assurance programs that are weak and outdated. First, federal inspectors review each managed care plan's operations periodically without ever measuring its results. Second, a managed care plan's business must be at least 50 percent non-Medicare, which is based on a crude assumption: if it's good enough for the private sector, it must be good enough for Medicare. In contrast, employers and state Medicaid agencies are demanding sophisticated measures of managed care's performance.

Inadequate Consumer Information. Medicare does not ensure that participants have access to reliable information comparing the costs, benefits, and services of HMOs.

Step-by-Step Reform

Many of the flaws in the risk-contracting program can be fixed immediately through the following actions: 1) Expand the choice of private health plans for Medicare participants to point-of-service plans and preferred provider organizations, which allow patients to go to doctors outside of a provider network; 2) Provide comparative information to all Medicare participants about their private sector options; 3) Pay managed care on a market-wide basis rather than a county basis; 4) Permit health plans to offer cash rebates in lieu of extra benefits; 5) Assure quality through health plan report cards and satisfaction surveys instead of outdated methods; and, 6) Give the Secretary of Health and Human Services the authority and responsibility to prevent risk-skimming.

But the more fundamental problem—the lack of competition—requires broader reform. As long as payments to managed care plans' are tied to the fee-for-service system, savings will be meager and payments unstable.

To create competition, Congress should follow the path blazed by large employers. They have been successfully fighting runaway costs while keeping workers satisfied. The key has been letting workers choose their own coverage from a menu of plans that compares costs, quality, and service. Workers choose more cost-effective plans such as managed care because they see value in it. When workers become comfortable taking responsibility for their own decisions, employers limit their health care contributions to the cost of a managed care plan. But they have kept options for workers who want more expensive benefits to pay more.

The experience of large employers suggests the following strategy for Medicare reform:

Phase One: Test the Use of a Competitive System. Medicare would create a menu of private health plans from which participants could voluntarily choose annually. Private health plans would offer a core set of benefits including some not already covered by Medicare such as prescription drugs and a limit on out-of-pocket costs. But the overall value of the benefits should not exceed the equivalent value under Medicare's fee-for-service plan. This approach would ensure that the competitive system would have appeal to potential participants without breaking the bank.

Private plans could not discriminate against the sick by charging them higher premiums, but they would be free to compete using managed care or any other innovative system. Over time, more flexible benefit design should be permitted as Medicare becomes more successful in preventing risk-skimming. In the short run, however, high deductible policies, for instance, might attract only the healthy.

The government's contribution would be set on a local basis near the average of health plan premiums. Those who chose a plan that cost more than the average would either pay the higher cost themselves, and those in lower-than-average plan would receive the difference in cash. Without such a rebate, plans would have no incentive to bid below the average.

Every Medicare participant would have information that compares the cost, quality, and services for each choice on a menu of plans including the current Medicare system. The advantages of the new system would become clear: lower out-of-pocket costs, better services, and high quality.

Converting the whole country to a competitive system all at once would be precipitous and impractical. Instead, legislation should allow a competitive system to be phased in starting with the markets that could benefit the most: mature managed care markets where competition has already hit the limits under the risk-contracting system in such areas as Minneapolis-St. Paul.

Another interim measure would be to limit the HMO payment rates for those plans in the non-competitive system to increases of 6 percent, which is more in line with private sector experience.

Finally, Medicare should encourage private purchasing groups to negotiate on behalf of large groups of Medicare participants. Competition is more likely to be effective if Medicare creates purchasing systems similar to large employers, which are the most effective purchasers in the private sector.

Phase Two: Verify Access to High Quality Care at Lower Costs. If private plans perform as expected, then satisfaction surveys and report cards on patient outcomes will

reveal high marks even as costs come down. If not, additional safeguards will be necessary. But rather than relying on anecdotal information to evaluate private health plans, seniors deserve hard data to determine if lower costs come from true efficiency gains and not from degrading quality.

Phase Three: Adapt Medicare's Overall Growth Rate to the Limits Set by Competition. As participation in the competitive system rises, more of Medicare's spending will be set by competition rather than regulations. Confidence in private health plans will allow Medicare to limit its spending increases to market conditions. This market-based spending cap would discipline Medicare's fee-for-service system without sacrificing quality and access to care.

Since Medicare will need several years to develop this market-based cap, Congress will have to resort to the same stopgap actions used in the past to delay bankruptcy in Medicare's hospital insurance trust fund: moderate provider cuts and more patient cost-sharing.

In general, this approach ensures that the government's contribution to the health insurance will be restrained to the level of essential services without shifting costs on to the private sector. The marketplace, not arbitrary government limits, will establish the price at which providers are willing to care for Medicare patients.

Conclusion

The pace of change in Medicare reform should depend on the government's ability to win public confidence in the new system. An example of the challenge before Congress is the words of one retiree during last year's debate. The campaign against "government-run" health care led him to demand that his congressman keep the government out of Medicare.

The Progressive Policy Institute urges Congress and the President to recognize that taxpayers and those who rely on Medicare have a common interest: fighting the high cost of health care. Republicans must forgo arbitrary budget caps that anticipate the savings from competition before it has even begun. Democrats must acknowledge that preserving Medicare will require fundamental Medicare reform.

The real political challenge is to reshape the relationship between the government and Medicare participants. The government must ask them to accept more responsibility for the key decisions about the cost and quality of their health care. In exchange, the government must commit to make sure they have the resources and information to make the right decisions for themselves.

Chairman THOMAS. Thank you very much.

I have been sitting here trying to refine the analogy, and I came to the conclusion the difference between ice cream and a sundae is the topping. They both have the ice cream. The sundae gets the topping, and what you are saying, Mr. Kendall, is that after you test various programs, running an average price on the innovative structures, you verify they are getting quality for price, you can actually come back to the folks who are getting the sundae and say, we will provide the ice cream with your fee-for-service cap, but since you can get what we consider to be a reasonable and quality product for that same amount, if you want the topping, you are going to have to pay for it.

Mr. KENDALL. That is exactly right. That is what large employers have done. They have spent a lot of time educating and demonstrating to their employees that these new systems can work, and that is what the government is going to have to do.

Chairman THOMAS. Well, thank you both for your testimony.

The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman, and thank both of you for your testimony.

Dr. Butler, your testimony seemed to be pretty much in keeping with Dr. Wilensky's suggestion of—I think it was a suggestion—to move toward a voucher system, basically figuring out what the government can afford, based on the financing mechanism we have in place now, to provide for a base structure and then allow the elderly to decide among a number of choices in the private sector. Whether we set it up as we do in the Federal Employee Health Benefit Plan or we just let the marketplace work and provide some information, it is still basically the same approach. And that seems to be the plan that we keep coming back to, and I happen to like that plan.

Mr. Kendall, you didn't really comment directly on that approach. You kind of talked around it, and it sounded like you were talking about something very similar, but I couldn't quite tell.

Would you comment directly on the voucher and capitation?

Mr. KENDALL. It is a difference more in style than in substance. We believe that going to a defined contribution is ultimately the right goal, but the danger is that you would set the voucher at an amount that wouldn't be worth anything, or be worth something less than what would be politically acceptable and what would be good for health care policy reasons and good for older Americans and the disabled. That is the real trick, how to make sure that, as we move into this new system, we continue our commitment to making sure that everyone has good health care without reducing our financial contribution to the point where individuals can't fulfill that.

Mr. BUTLER. May I just make a point that obviously there are going to be complex issues to setting a voucher amount and also there are variations. We are not necessarily talking about a simple, voucher idea. It could be a system like the FEHBP is.

But the problems with setting a voucher are certainly no greater and probably much less than the system where we are trying to set fees and prices for every single service, to work right throughout the country, to get us the right kinds of selections and so on. I

think setting a broad voucher amount is a much simpler task than trying to set prices throughout the current system.

Mr. McCrery. It seems to me we have created kind of a dual health care system—one private, one public—and we have duplicated a lot of mechanisms that were already in the private sector for monitoring everything that is going on and checking prices and fees and peer review and all of this stuff that the government tries to do, which costs a lot of money. The private sector already does—maybe in a different way—but they do it out of their own self-interest, and if we could somehow get rid of that government responsibility and all the costs associated with it and let the private sector do that, it seems to me we might be better off.

Mr. Butler. Even within the government sector, it is very instructive to compare, say, the way the FEHBP serves Federal retiree employees and the way Medicare serves other retirees in terms of the way it operates—the things that Gail Wilensky was mentioning regarding basic information that is available and routinely provided, if you happen to be an over-65-year-old Federal worker.

There are all kinds of arrangements made for the various competing plans to provide standardized information. You can go to places and have all the plans there offering their wares in an organized situation. All these things are available.

So it is not even necessarily whether the government is involved or not. It is the basic incentive and structure of the system itself. One program depends—which is Medicare—on the government making every decision about prices and services. The other involves the government setting broad guidelines and giving a defined contribution and allowing the normal methods of the market in the nonprofit sector, in terms of providing information, to then begin to operate.

Mr. Kendall. If I could just add one point to that. I think it is easy to bash the current system because it is inefficient—and I am no fan of it. But it has provided one value, I think, among many, that needs to be stated; as a conservative businessman told me, the one thing Medicare has accomplished is defining a product in health care.

Before Medicare, there was no standardization of a product which is necessary to make a marketplace work; and albeit with a clumsy and awkward way of doing it, it has given that.

Now, we need to replace that product definition with a new product definition, but I think it is important to keep in mind that that product is still defined in many people's minds the old way as a very real thing, and we can't just get rid of it.

Mr. McCrery. Thank you, Mr. Chairman.

Chairman Thomas. Thank you.

The only concern I have in that discussion is, it is always easier to talk about it than to do it. When you talk about a defined contribution or a voucher—in essence, the AAPCC was an attempt to try to do that, and what we heard from the previous panel is, it has been a disaster, even within relatively close regions on a county basis.

So even if we went to the concept so that you would have a list of plans—we will test, we will verify, then we adapt, then we have

a list of plans that get the Medicare Good Housekeeping Seal of Approval in terms of the profile and the rest, and that the Medicare beneficiary has a debit card that is worth so much and we give them plenty of information as to which ones are 100 percent covered by the debit card and which ones are 90 percent or 80 percent, and they go ahead and do it, we still have the problem of the regionality aspect of the way in which health care is delivered and how much you get for your dollar to build in.

But I think what I am hearing you folks saying is that if we would move to that level of the problem, we will have gone a long, long way.

Mr. BUTLER. I believe so, and I totally agree with what you said. But I think, say—Mrs. Johnson's idea of saying, let's start looking at, say, a market test in the area rather than trying to microanalyze all the different things is certainly one element of the movement.

As I also said earlier, it seems to me it is much easier there—not that there is no difficulty—but it is much easier to set a broad amount in terms of a voucher in an area than to try and make decisions and try to make calculations when the recipient themselves, the beneficiary, is not motivated to make decisions on the basis of total cost. That is a crucial difference. If you see the total cost, then you have a strong incentive to look for the one that is the best value. Now, that is lacking under the current system, which is one reason why the AAPCC doesn't work too well.

Mr. KENDALL. I think the question you are asking is about regional variation. I think that is real important because fundamentally healthy markets are regional in nature. Kaiser in California is a very different animal from Kaiser in this area. We ought to rate it separately as far as its cost quality, and it should be judged that way too. So that is why you need a competitively bid system that does allow for regional competition in setting that voucher.

Chairman THOMAS. Let me thank the panel, and I will tell you, Mr. Kendall, although there may be some assumption that you are tied somewhat politically to one party, the ideas you have offered are very refreshing and, frankly, some distance from the President's health care plan. Had he listened to you folks in terms of putting together a plan, we would have had a lot more common ground to work from.

I want to thank you, and I frankly believe we will be back to both of you, not only for the specific plan structure as we move forward, but frankly for a larger problem, and that is of marketing whatever the product is that we get, given the climate and the political incentive to make political hay with this product.

If we are in agreement that we need to make change and that the change we agree on is a professionally accepted one, I am very concerned about the way in which the change is transmitted. I look forward to working with both of you in that area.

Mr. Kendall.

Mr. KENDALL. Don't sign me up for the Republican Party yet. I want to see the bottom line of the budget first.

Chairman THOMAS. I am not interested in signing you up to the Republican Party. I am interested in signing you up to a solution

to the Medicare problem, which, frankly, I think transcends partisan lines.

Mr. BUTLER. Which it should do, certainly.

Chairman THOMAS. Thank you very much. The Subcommittee stands in recess until, I think, 1 o'clock.

[Whereupon, at 12:05 p.m., the Subcommittee was recessed, to reconvene at 1 p.m. the same day.]

Chairman THOMAS. The Subcommittee will reconvene.

I want to thank the gentlemen from Arizona. Your testimony is important to us and your real world experience, which is the basis of your testimony, is important to us. This panel is Dr. Block from Phoenix, Arizona; Dr. Jacobs from Phoenix, Arizona; and Mr. Zucarelli from Tucson, Arizona.

I would tell you that any testimony that you have that is written will be made a part of the record, without objection, and you may begin to inform us in any way you see fit about your experience on HMOs and Medicare.

I guess we will start with Dr. Block and then move to Dr. Jacobs. Then to Mr. Zucarelli. Thank you very much.

STATEMENT OF MARTIN BLOCK, M.D., MEDICAL DIRECTOR, UTILIZATION MANAGEMENT AND GOVERNMENTAL PROGRAMS, CIGNA HEALTHCARE OF ARIZONA, INC., PHOENIX, ARIZONA

Dr. BLOCK. Thank you, Mr. Chairman.

My name is Martin Block and I am a physician employed by CIGNA HealthCare of Arizona in Phoenix. At CIGNA, I am the medical director of Utilization Management for the Staff Model and for the Independent Practitioner Association, as well as the medical director for Governmental Programs.

CIGNA is deeply committed to the Medicare managed care concept and believes that Medicare risk HMOs are the model for the future. In our experience, covering the Medicare population through managed care networks achieves three goals: Seniors receive richer benefits with fewer out-of-pocket costs than under traditional fee-for-service Medicare, Medicare beneficiaries express satisfaction with the quality of care they receive, and employers providing retiree coverage save time and money.

CIGNA ranks among the largest investor-owned managed care companies in the United States with 48,000 employees around the world, $86 billion in assets, and 1994 revenues exceeding $18 billion. CIGNA is a leading provider of managed medical and dental insurance with 3.3 million members in our HMOs nationwide.

In Arizona, CIGNA is one of the State's largest HMOs and provides medical services to more than 400,000 participants in Medicare, Medicaid, individual, and commercial programs. We have been providing health care services to Arizona seniors through prepaid health plans beginning in the seventies with our predecessor company, which became the State's first HMO. Today we are in two counties for our Medicare risk program and have approximately 24,000 Medicare beneficiaries.

In 1993, CIGNA HealthCare of Arizona converted from a Medicare cost contract, which we conceived in 1985, to a risk contract, in short, because our competitors were increasing market share by

offering risk contracts with benefits similar to ours but with lower premiums. More than 97 percent of our cost contract members transferred their enrollment to the risk product.

Our careful management of patient care maintains the quality of services for our Medicare population while reducing by half inpatient hospital days per thousand. We work closely with our hospital networks, which are capitated for inpatient services, including skilled nursing facilities, outpatient surgery, and home health services. We emphasize preventive care services, provide case management for complex patients, and carefully manage all inpatient admissions beginning early in a patient's clinical course.

By effectively managing utilization and expenses, we have been able to return a significant amount of the savings to our Medicare beneficiaries in the way of enhanced benefits that seniors really care about. For example, we offer richer benefits such as prescription drug benefits, routine eye and hearing examinations, and partial coverage for glasses and hearing appliances. One benefit that our members would like to have is a popular point-of-service plan but, under current Medicare regulations, it is virtually impossible for managed care plans to offer this option.

Our enrollees are assured of receiving high-quality care because CIGNA HealthCare of Arizona is subject to rigorous accreditation and quality control programs. The Federal Government, in contrast, has no similar quality control programs for its fee-for-service Medicare population.

Our Phoenix Staff Model Plan was granted a 3-year accreditation by the National Committee for Quality Assurance, a national standards board. We also are involved in cooperative efforts with other managed care plans to develop quality improvement processes and closely track patient complaints, Medicare appeals, and disenrollments with the goal of improving service.

A recent survey found that CIGNA Medicare HMO members felt that we were more patient-oriented and better anticipated their needs than traditional fee-for-service Medicare providers. During 1994, the voluntary disenrollment rate was less than 3 percent, and only 39 Medicare appeals were made to HCFA, a rate of 1.57 per thousand which is below industry norms.

In summary, Mr. Chairman, Medicare risk contracting is a win-win situation for everybody in Arizona. Acceptance by seniors of the HMO risk product is on the rise and would accelerate if certain structural and legislative barriers were removed. CIGNA is committed to a growing presence in the Medicare market and believes that seniors' choices should be expanded in the managed care environment.

Thank you very much.

[The prepared statement and attachments follow:]

TESTIMONY OF MARTIN BLOCK, M.D.
CIGNA HEALTHCARE OF ARIZONA

Thank you, Mr. Chairman. My name is Martin Block. I am a physician and am employed by CIGNA HealthCare of Arizona, Inc. in Phoenix. At CIGNA, I am the Medical Director of Utilization Management for the Staff Model and Independent Practice Association delivery systems, as well as the Medical Director of Governmental Programs. I am Board Certified in Internal Medicine, am a member of the American College of Physician Executives, and the Board of Directors of the Arizona Association of Managed Care Plans.

It is a pleasure to appear before you and your committee today to discuss the important issue of how we can deliver quality health care to our over-65 population while controlling costs. CIGNA is deeply committed to Medicare managed care and believes that Medicare-risk HMOs are the model for the future. In our experience, covering the Medicare population through managed care networks achieves three goals:

- Seniors receive richer benefits with fewer out-of-pocket costs than under traditional fee-for-service Medicare.
- Medicare beneficiaries express satisfaction with the quality of care.
- Employers providing retiree coverage save time and money with Medicare managed care.

I would first like to provide some background on our company, and then explain our success in serving the Medicare population of Arizona through our managed care programs.

BACKGROUND

CIGNA ranks among the largest investor-owned managed care companies in the United States, with 48,000 employees around the world, assets of more than $86 billion, and revenue exceeding $18 billion. CIGNA HealthCare has an extensive network of HMOs with 3.3 million members, as well as PPOs, and a nationwide managed dental care network. Additionally, we are a leading provider of managed medical and dental insurance.

CIGNA HealthCare of Arizona, Inc. is one of the state's largest HMOs, providing medical services to more than 419,000 participants. We provide coverage to Medicare and Medicaid beneficiaries, as well as individuals and commercial enrollees through a statewide network. Services are provided to Medicare enrollees through the CIGNA staff models and independently contracted providers.

In Arizona, CIGNA has a long and successful track record of providing health care services to seniors through capitated, prepaid health plans that goes back to the early 1970s. CIGNA HealthCare 's predecessor companies began providing prepaid medical care in 1972, and became the first HMO in the state of Arizona -- receiving its Federal qualification in August 1978. Today, CIGNA's efforts have evolved into a two-county Medicare-risk program with approximately 24,000 Medicare beneficiaries. By focusing on quality of care, customer service and cost effectiveness, CIGNA has been able to steadily increase its Medicare membership.

PARTICIPATION IN THE MEDICARE PROGRAM

Beginning in the mid-80s, CIGNA offered benefits to Medicare enrollees through a cost contract with the Health Care Financing Administration (HCFA). Membership peaked at approximately 22,000 in 1989. After eight years of the cost contract, however, membership began to erode due to our competitors ' offerings of risk contract products, which had competitive benefits and lower premiums. During that

eight year period, our monthly member premiums increased from $45 to $69.50 in an attempt to cover costs. However, competitor risk contract products with no premium were available. It became clear to us that seniors were attracted to the benefits of a managed care health plan, but found the expense of cost contracts prohibitive. Thus, the competitive market helped drive our decision to convert to a risk contract for Medicare in 1993 -- much as the market place has led the managed care transformation of privately funded health care.

THE MOVE TO RISK CONTRACTING

Our offering of a benefit plan under a risk contract in Arizona met with overwhelming acceptance. More than 97 percent of our cost contract members enrolled in the risk product. The average age of our Medicare membership at that time was nearly 78 years old, compared to approximately 74 years for the general Medicare population.

Originally, we offered one benefit plan option -- with a $20 monthly premium -- in our staff model facilities to individual members only. This was done, in part, for ease of administration and also to limit membership until we could determine whether we could successfully implement utilization management measures for our Medicare membership while maintaining quality. Our immediate and dramatic reduction in inpatient hospital days with the risk contract proved that our utilization management measures were successful. During our last year under the cost contract, inpatient hospital days per thousand members were approximately 2,200. After our first year in risk, days per thousand dropped to about 1,100, or nearly one-half the amount realized under the cost contract. These impressive utilization results, it should be noted, were achieved with an older population than on average, while maintaining quality of health care.

HOW WE SERVE SENIORS

The key to CIGNA's success in containing health care costs is close management of the patient 's care. This is achieved through "partnerships" we have developed with our two major hospital networks to effectively manage the Medicare risk population. The risk, as well as the potential rewards, are shared between the Health Plan and its hospital partners. The hospital systems are capitated for inpatient services including skilled nursing facilities (SNF), outpatient surgery, home health services and durable medical equipment. Risk bands have been established, based on the utilization of these components.

Additionally, through the wise use of medical resources, CIGNA is able to provide quality care at a more reasonable cost. All new Medicare beneficiaries choose or are assigned to a primary care physician who manages and coordinates their care, referring them, when needed, for specialty care or diagnostic procedures. And nurse practitioners play an important role in assuring that SNF patients get appropriate, quality medical care.

The Health Plan works hard to meet seniors ' needs in the most efficient way possible. We focus on our patients ' entire needs, not just their medical care. By offering a full continuum of care, we can begin making appropriate plans for patients ' discharge early in their clinical course. SNFs are located on the main campuses of the hospitals and are designed to accept more seriously ill patients than most other SNFs. Once patients are admitted, they are reviewed on a daily basis by utilization nursing staff who also begin the discharge planning process to ensure a smooth transition to the most appropriate level of care. The nurses work directly with the patients and their families to coordinate services.

The Health Plan also as an extensive Ambulatory Case Management program to support the ongoing needs of members. Early identification of potential cases is an important aspect of the program. Once members are in the program, the RN Case Managers, under the supervision of Health Plan physicians, are responsible for evaluating patients ' needs, coordinating care and community resources and monitoring patients ' health status. For example, a patient discharged with the diagnosis of congestive heart failure may have a home health nursing visit to ensure that they understand their medications and how to take them, to teach them how to

recognize signs and symptoms of recurrent heart failure, and to assess nutritional status and safety issues in the home environment. The case manager also stays in contact with the patient by telephone or by home visit to ensure continued compliance, offer family support, and make the patient aware of community resources. The Health Plan also uses nationally accepted guidelines in managing inpatient admissions and lengths of stay.

We are very pleased with the results to date. Inpatient hospital days are down, while skilled nursing and home health services utilization is up. When compared to a traditional fee-for-service Medicare population, readmissions within 30 days are lower and mortality rates are, similarly, lower. In summary, CIGNA has reduced inpatient utilization by partnering with its contracted hospitals, establishing financial incentives, emphasizing preventive services, providing case management for complex patients, and carefully managing all inpatient admissions. CIGNA's effective management system has resulted in high patient satisfaction and satisfactory financial performance.

From the patient 's perspective, there are a number of advantages to participating in a managed care environment. These include generous benefits and the ability of an integrated health system to continuously improve the quality of health care delivery. Let me comment briefly on these two advantages of Medicare managed care: benefits and quality.

BENEFITS

Medicare enrollees are very attracted to our benefit package. We offer richer benefits than are available under traditional Medicare coverage, particularly benefits that seniors care about. For instance, our plans provide important prescription drug benefits, and routine eye and hearing exams, with a nominal copayment charge. Partial coverage for glasses and hearing appliances also is included. None of these benefits are available under fee-for-service Medicare plans today.

By effectively managing utilization and expenses, we have been able to return a significant amount of the savings to our Medicare beneficiaries in the way of enhanced benefits. We provide several preventive services which helps avoid expenses related to costly illnesses. Preventive services include routine physical exams and immunizations. We also provide "Wellness" classes with exercises specifically designed for seniors.

Unlike fee-for-service Medicare, our benefit plans provide unlimited days of acute hospital care. We also admit patients directly to SNFs when appropriate -- foregoing the prior three-day hospital stay required for coverage in traditional Medicare. World-wide emergency coverage also is provided.

One of the enhanced benefits, which members would greatly appreciate, is a point-of-service plan. In these plans -- also known as open-ended HMOs -- patients can choose out-of-network providers at any time and still receive reimbursement, although with a higher copayment. Point-of-service plans, it should be noted, are one of the most popular benefit plans currently purchased by the under-65 population. Unfortunately, current Medicare regulations make it difficult, if not impossible, for managed care plans to offer a true point-of-service product.

(Attachment "A"provides a more detailed discussion of CIGNA Senior Coverage. And Attachment "B"provides a comparison of Medicare and coverage provided by CIGNA HealthCare for Seniors.)

QUALITY MANAGEMENT

In addition to the generous benefit package, enrollees in CIGNA HealthCare for Seniors receive another important advantage. They are the beneficiaries of rigorous accreditation and quality control programs, which ensure that they receive high quality care. In contrast, the federal government has no such quality management programs for its fee-for-service Medicare population.

CIGNA HealthCare of Arizona has been reviewed by the National Committee for Quality Assurance (NCQA). NCQA, an independent non-profit organization in Washington D.C., accredits and evaluates managed care plans across the country to ensure that the managed care industry maintains high professional standards. The Phoenix Staff Model (employed physician) plan was granted a three-year accreditation, the most favorable rating given to health plans by NCQA. Although NCQA does not specifically review a plan's Medicare performance, many of the reviewed categories impact both commercial and Medicare members alike. These include provider credentialing and recredentialing, review of the ambulatory medical record, monitoring of adverse outcomes and sentinel events, preventive health activities, outcome-focused improvement activities and utilization management.

While NCQA approval is important to us, its rating only reflects a single point in time. We at CIGNA, however, recognize that quality management is not a one-time occurrence, but, rather, it requires continuous self-assessment and ongoing improvements. Thus, we are actively engaged in several quality improvement efforts. In August of 1993, the managed care plans of Arizona (including CIGNA), the Health Services Advisory Group and the Arizona Peer Review Organization began to work cooperatively to move from a quality "assurance" focus (e.g. removing "bad apples") to a quality "improvement" focus. The goal was to improve overall performance. For example, the ambulatory medical record was reviewed for patients with diabetes, and certain quality indicators were agreed upon. Subsequent reviews will provide participating Medicare HMOs with feedback on how they are performing relative to benchmark. Arizona health plans also have collaborated on several patient-oriented publications, such as "Understanding Benign Prostatic Hyperplasia" and "Management of Localized Prostate Cancer".

Additionally, CIGNA aggressively tracks patient complaints and Medicare appeals through its Managed Care Service Center. We take patient complaints very seriously, and the information is used to improve our services. For example, we now more broadly define an out-of-area emergency to allow routine follow-up care, rather than require a beneficiary to return to the geographic service area. CIGNA also tracks the reasons why members choose to leave a plan and uses this information as the basis for additional improvements.

While member satisfaction is high, opportunities for improvement remain. Some improvements our membership has suggested include:

- A point-of-service option to allow access to specialists in the service area, which I discussed earlier.
- Coverage of routine care out of the service area (e.g. coverage for Medicare beneficiaries who live for nine months in the Sun Belt and who spend summers in their home state – "snow birds").
- Transportation for routine medical services.
- Expanded physician network.
- Expanded hospital network

MEMBERSHIP GROWTH

Realizing that we could effectively manage utilization patterns of the Medicare population, we sought to increase membership. In June, 1993 we began offering the Medicare risk product to employer groups which provide retiree coverage. These employers have generally been pleased. The risk product allows employers to see significant cost savings and lower long-term accounting liabilities for their over-65 populations, while keeping administrative expenses to a minimum. Because the government is already paying the HMO for basic services, employers can offer a Medicare risk plan for as little as $30 per month per person.

CIGNA regularly conducts focus groups to determine the potential market for the Medicare Risk product, and to assess the needs and wants of Arizona seniors. Although many seniors are not eligible or interested in a Medicare HMO due to the nature of their retirement benefits, others are underinsured, even with the purchase of a supplemental product, and see a Medicare HMO as a way to obtain richer benefits with fewer out-of-pocket expenses. Promotional activities conducted by CIGNA include television advertisements, print media, and direct mail. In addition,

CIGNA conducts meetings at places where seniors congregate (restaurants, senior centers, etc.) as part of its marketing efforts.

Other efforts to increase membership include: the development of a $0 premium benefit plan effective January 1, 1994; the expansion of the product in March, 1994 to include a limited number of CIGNA IPA providers; and the expansion of the service area in April, 1994 to include greater Tucson.

As a result of these efforts, our membership has steadily increased to over 24,000 Medicare beneficiaries today. The average age of our enrollees has decreased to approximately 74 years.

MEMBER SATISFACTION

We have found our Medicare members to be very satisfied with the Health Plan. A survey conducted by one of CIGNA's hospital partners revealed that despite shorter hospital stays, Medicare members enrolled in the risk program were likely to be more satisfied with their hospital experience than were fee-for-service medicare beneficiaries. Specifically, the survey found that CIGNA Medicare HMO patients felt that CIGNA was more patient oriented (92 percent vs. 85 percent) and better anticipated patient needs (96 percent vs. 85 percent) than traditional Medicare providers. Voluntary termination rates have been low. During 1994, the voluntary disenrollment rate was less than 3 percent. The majority of disenrollments are for non-voluntary reasons such as members moving out of the service area and deaths. Also in 1994, we forwarded only 39 Medicare appeals to HCFA for resolution. This rate of 1.57 per 1,000 members is significantly below industry norms.

It is clear that acceptance of this product among seniors is on the rise. I would observe, however, that further use by the elderly of managed care for their health care needs would accelerate if structural and legislative barriers were removed. One of the factors that has kept health benefits for Americans affordable has been the efficiencies of group purchasing by employers through the workplace. At this point in time, however, the purchase of Medicare is a one-person-at-a-time retail sale and does not contain any of the current efficiencies of scale that much of the rest of our system has. At a minimum, it should be easier for employees to join risk contractors through their employers when they retire.

SUGGESTIONS TO HCFA

I would like to suggest two other ways, in which HCFA could assist Medicare contractors in improving services to beneficiaries and easing the administration of the contracts:

- Create a climate that encourages innovation. A case in point is self-referral options (SRO). The SRO benefit is being requested by beneficiaries, yet implementation has been virtually impossible due to HCFA reporting requirements, particularly for Federally qualified plans.

- Establish one HCFA office as the contact for plans with multiple sites. This would be more efficient for both HCFA and the plans. For example, CIGNA currently must request approval of marketing material from each different HCFA regional office in which it has a health plan wanting to use the material. This results in duplicated efforts and wasted HCFA resources, and places an unnecessary burden on plans to comply with differing interpretations of the regional offices.

SUMMARY

In summary, let me emphasize that Medicare risk contracting is a win-win situation for everybody in Arizona. Compared with traditional fee-for-service Medicare plans, seniors in Medicare-risk HMOs receive greater benefits with lower out-of-pocket costs, while enjoying quality care and service. Retirees no longer have to worry about claim forms or physician fees exceeding Medicare's "reasonable and customary" limit. Providers have learned a new way of doing business which involves using the most cost-effective level of care consistent with a member's medical needs. The

resulting elimination of unnecessary services and inpatient days of care allows CIGNA to provide enhanced benefits at a lower overall cost. The competitive Arizona marketplace has encouraged innovative approaches and resulted in better benefits for Medicare beneficiaries.

Looking to the future, we are committed to being a part of the improvement and transformation in the Medicare market and believe that seniors' choices should be expanded in the managed care environment. Medicare managed care, we're convinced, is quality care.

Attachment A

The primary differences between our two benefit plans are summarized below:

BENEFIT	CIGNA SENIOR COVERAGE	
	BASIC PLAN	PREMIUM PLAN
Premium	**$0**	**$20**
Outpatient Copays	**$10 per visit**	**$5 per visit**
Prescription Drug annual Maximum benefit	**$750**	**$2500**
Hospital Inpatient Copay	**$300 for non-plan hospital admission**	**no copay for non-plan hospital admission**
Lens/frame benefit (routine)	**Not Covered**	**$100 allowance**
Hearing Services - Exams - Hearing aid appliances	**Not Covered** **Not Covered**	**$5 per visit** **$100 credit** for each hearing aid unit per year
Routine Podiatry Services	**Not Covered**	**$5 per visit**

An optional dental plan is also available for those members who desire dental coverage.

Attachment B

Following is a summary of benefits we offer that exceed those provided by Medicare.

Medicare vs. CIGNA HealthCare for Seniors

BENEFIT	MEDICARE COVERAGE	CIGNA SENIOR COVERAGE	
		BASIC PLAN	PREMIUM PLAN
Premium	Part B Medicare premium required	**$0** Part B Medicare premium required	**$20** Part B Medicare premium required
Preventive Care - Routine physical examinations - Routine Immunizations - Wellness Classes	Not covered Not covered Not covered	**You pay $10 per visit** **You pay nothing** **You pay nothing**	**You pay $5 per visit** **You pay nothing** **You pay nothing**
Prescription Drugs	Not covered	**You pay $7** for each prescription or refill up to 30 day supply. Maximum annual benefit of **$750** is based upon the average wholesale price of the drug.	**You pay $7** for each prescription or refill up to 30 day supply. Maximum annual benefit of **$2500** is based upon the average wholesale price of the drug.
Hospital Inpatient Services - Semi-private room and board, misc. charges - General nursing care - Operating room - Lab and X-ray tests - Drugs and medical supplies - Special care unit - Blood transfusions - Rehabilitation services such as physical therapy, occupational therapy, and speech pathology	You must pay a deductible of $716 for your first 60 days; for the 61st through the 90th day of a benefit period, you pay a coinsurance of $179 a day. If you use lifetime reserve days (60 total), your coinsurance is $358 a day	**You pay nothing** when admitted to our plan hospitals. (You pay copayment of $300 for admission, *including emergency admission*, to any in-area or out-of-area hospital that is not a plan hospital.) Maximum annual fee towards hospitalization is $716.	**You pay nothing** when admitted to any hospital. (All non-emergency hospital admissions will be scheduled through your primary care physician at a plan hospital.)
Physician Services For Hospital or Skilled Nursing Center Care (Inpatient) - Physician services - Specialist services - Major/minor surgery	You pay $100 annual deductible plus 20% of Medicare approved charges and non-approved charges up to the limiting charge.	Physician services are covered under your hospital benefit. **You pay nothing** for inpatient physician charges.	Physician services are covered under your hospital benefit. **You pay nothing** for inpatient physician charges.
Vision Services - Routine eye exams (once per calendar year) - Lens/frame benefit (routine)	Not covered Not covered	**You pay $10** **NOT COVERED**	**You pay $5 per visit** **$100 allowance** towards purchase of one pair of eye glasses or contact lenses annually.
Hearing Services - Exams - Hearing aid appliances (care must be received in a CIGNA HealthCare Center	Not covered Not covered	**NOT COVERED** **NOT COVERED**	**You pay $5 per visit** **$100 credit** for each hearing aid unit per year.
Routine Podiatry Services	Not covered	**NOT COVERED**	**You pay $5 per visit**
Durable Medical Equipment (medically necessary per Medicare guidelines) - Equipment - Prosthetic devices - Therapeutic shoes (for diabetics)	You pay $100 annual deductible, plus 20% of Medicare approved charges up to the limiting charge.	**You pay nothing** when you use a CIGNA HealthCare contracting provider and when prescribed by a CIGNA HealthCare contracting physician for services covered by Medicare.	**You pay nothing** when you use a CIGNA HealthCare contracting provider and when prescribed by a CIGNA HealthCare contracting physician for services covered by Medicare.
Emergency Care - World-wide emergency coverage (that meets emergency criteria)	Not covered	**You pay $50** per visit to an emergency room. You pay $300 copayment per non-plan hospital admission. (Your $50 copayment is applied to hospital admission copayment. Maximum annual copayment is $716.)	**You pay $50** per visit to an emergency room. You pay nothing per hospital admission. (Your $50 copayment is waived upon hospital admission.)

Chairman THOMAS. Thank you, Dr. Block.
Dr. Jacobs.

STATEMENT OF RICHARD JACOBS, M.D. VICE PRESIDENT, HEALTH CARE DELIVERY, FHP HEALTH CARE, PHOENIX, ARIZONA

Dr. JACOBS. Mr. Chairman, Members of the Committee, good afternoon. My name is Richard Jacobs. I am a physician, board certified in internal medicine, and also the vice president of health care delivery with FHP Health Care in Arizona, which is a division of FHP International Corp.

I received my medical degree from St. Louis University in 1976, did a medical residency program, and I have practiced medicine in both the fee-for-service setting as well as in the managed care setting and am now a physician administrator with an MBA, so I am not an expert on national health care policy. But I would like to share with you my experience and observations in managing health care to a Medicare risk population for a successful plan in a highly competitive environment, and I hope that that will be of some value to you.

FHP has been around a long time, over 30 years. We started in Fountain Valley, California with a Staff Model and we were in on the ground floor with a Medicare risk contract. We were one of the demonstration projects early on and so we have been doing this a long time.

We have over 2.3 million Americans that we take care of in 20 States, the District of Columbia, and also in Guam. We came into the Phoenix area in 1985 and then finally into Tucson in 1989. And right now the Arizona—FHP Arizona has over 182,000 members in three counties: Maricopa County, Pinal County and also Pima County, and roughly half of our membership are in the Medicare risk contract.

Arizona is a little different in that we have what we call a mixed model. Our members can choose their care from a private physician in the community, a contracted provider, if you will, and we have over 1,500 of those. We also have 17 or 18 community hospitals that we are contracting with so there is a lot of overlap between our network and the care provided by physicians in the community for Medicare, Medicare patients.

We also have a Staff Model which is an owned and operated type of thing and we have primary care physicians employed to provide services in our Staff Model, and we get very tight control of the services and quality in the Staff Model environment. We are the second largest Medicare risk contractor in the Nation and, as I said, we were the first Medicare risk contractor in Arizona.

If I could digress from my written statement just briefly to give you an observation about what that was like to start up a managed care plan in a new area, it might be of some value to you.

In 1985, when we entered Arizona, there was really—there was no Medicare risk contract at all. We lost millions of dollars in the first year trying to get this thing going. Our bed days at that point really approximated Medicare's experience in bed days. Over 2,000. Our physician costs were twice what we anticipated. And it took us over a year to really get a handle on all of that, to train the

physician network on how to manage the care, to teach them how to use the community resources in a coordinated way for the benefit of our members, and to bring the bed days down to a level that is really successful.

Right now, in an open network, not in a Staff Model, not in a group model, but in an open contracted network, we are running bed days of around 1,000 to 1,200, averaging around 1,100, which is half of what Medicare is running nationwide and represents a significant improvement in cost savings.

We get paid 95 percent of what HCFA pays fee-for-service Medicare area, and we really feel that our estimate is we save the Federal Government about $60 million nationwide because of that. We think it makes a lot of sense to manage the care. Until managed care came around, those services were provided in an ad hoc way. There was no way to coordinate the services and to bring to bear in a coordinated fashion all of the various complex services, such as social services and so on to take care of patients with many different needs. That is what managed care brings to the table.

You are going to hear—you heard from Dr. Block and you will hear from Mr. Zucarelli. Many of the different programs and methodologies that we use, in my written statement, those are really summarized as well, but what I would like to emphasize is managed care intuitively makes a lot of sense. It makes sense to plan the care. It makes sense to coordinate the services, to monitor how well you are doing and to use a TQM approach to incrementally improve the care.

Finally, we have found the 50–50 rule to be a real impediment to marketing to more and more seniors and I just might give you an anecdote.

In my church where I attend, even though we have been in this marketplace since 1988 and FHP has been around since 1985, I constantly have seniors who come up to me and say, gee, we just never heard about your plan. We wish we would have known about it a lot earlier. And it is really, I think, time to get rid of 50–50 and take the wraps off, and we can really reach a lot of beneficiaries who want this but don't know about it.

Thank you very much.

[The prepared statement follows:]

TESTIMONY OF RICHARD JACOBS, M.D.
FHP HEALTH CARE OF ARIZONA

Mr. Chairman and members of the committee, good morning. My name is Richard Jacobs. I am a physician and Vice President of Health Care Delivery for FHP Health Care in Arizona, a division of FHP International Corporation.

After receiving my medical degree from St. Louis University in Missouri nearly 20 years ago, I have practiced medicine in the United States Navy, in private practice, and in an HMO setting. My specialty is Internal Medicine and I have seen the practice of medicine evolve over the years both as a physician and as a physician-administrator. I am proud to be associated with FHP, an organization that for the past 34 years has had the best interests of its patients in mind.

Who We Are

FHP Health Care today provides a wide range of health care services to over 2.3 million Americans in twenty states, the District of Columbia and Guam. Since our entrance into the Phoenix area in 1985 and into Tucson in 1989, we have grown to serve over 182,000 residents in Maricopa, Pima, and Pinal counties. Roughly half of our membership in Arizona is comprised of Medicare beneficiaries who have chosen to receive their care through an HMO.

FHP in Arizona is a "mixed model" HMO. Our members can choose between receiving care from an independent physician in the community or from a health care professional employed by FHP. We contract with nearly 1,500 independent physicians in the state. In addition, we employ our own physicians, dentists, optometrists, nurses, and ancillary staff who are located in our fourteen medical centers in Maricopa and Pima counties. I am proud to note that FHP in Arizona received one year accreditation from the National Committee for Quality Assurance (NCQA) for both types of care delivery – through our contracted physicians and through our employed staff of health care professionals. We hope to receive full three year NCQA accreditation this year.

FHP Senior Plan

FHP is the second largest Medicare risk contractor in the nation with 370,000 Medicare beneficiaries among our members. FHP's health plan for Medicare beneficiaries is called Senior Plan. It's an important part of our diverse portfolio of products and services. As the first Medicare risk contractor in Arizona, we have a record of initiating and maintaining health plans for seniors.

Because the Health Care Financing Administration (HCFA) pays us 95 percent of what it would pay fee-for-service physicians and hospitals in a given geographic area, we estimate that the federal government saved approximately $60 million in 1992 on our Medicare patients, system-wide, alone. Our Medicare members also come out ahead because they

receive high quality, comprehensive health care, plus other benefits such as prescription drugs which regular Medicare beneficiaries must pay for. It has been estimated that FHP's extra benefits save each of our senior members about $1,200 a year in out-of-pocket costs. That comes to approximately $335 million a year for our senior members. When the individual savings are combined with the five percent government savings, we believe FHP -- company-wide -- helps eliminate almost $400 million a year in unnecessary health care costs. The Medicare risk contract program is a "win-win" proposition for all parties concerned.

The Arizona Marketplace

Between December 1992 and December 1993, commercial and senior enrollment in Arizona HMOs grew almost 11 percent -- from about 1,175,000 members in 1992 to 1,301,000 members in 1993. These numbers do not reflect the number of Medicaid beneficiaries who receive their care through Arizona's unique Medicaid managed care system, the Arizona Health Care Cost Containment System (AHCCCS). That could be the subject of another hearing like this one.

Tucson ranks 6th among the 54 largest metropolitan areas in the country for HMO market penetration -- Phoenix ranks 12th. Just over 39 percent of the Tucson population are members of HMOs. Approximately 29 percent of the Phoenix population are enrolled in an HMO.

Quality of Care in HMOs

There have been considerably more studies of HMO performance than of any other health benefit option. A comprehensive review of the literature published from 1980 to 1994 appeared in the May 18, 1994 **Journal of American Medical Association.** The study analyzed the findings of 16 studies comparing the quality of health care provided in HMOs with care provided to other populations in other settings.

It was determined that HMO quality of care results were better than or equal to results in fee-for-service plans on 14 of 17 quality of care measures. The study found that people cared for in HMOs consistently received more preventive care (such as breast, pelvic, rectal, and general physical exams) than people in fee-for-service plans. HMO members also received more health promotion counseling than members of fee-for-service plans.

How Does FHP Provide Quality Care?

In the 34 years that FHP has been providing managed health care services, one fact is continually reinforced: providing quality health care is the best way to keep costs down. Our health care professionals utilize a number of techniques, pioneered by health maintenance organizations, to coordinate the care of each member. Let me cite a few examples:

- We use computerized practice guidelines and national standards to determine whether surgery or certain tests are really necessary. Very few individual physicians have this information at their disposal.
- Physicians and nurses make daily hospital rounds to monitor the in-patient care our members receive.
- We encourage patients to become more involved in deciding their course of treatment. FHP is pioneering a unique computerized interactive video program which allows patients dealing with breast cancer or prostate cancer, for example, to learn about all the options available to them. The more informed patients are, the more cooperative and supportive they are in their treatment plan.
- We have found that six percent of our member population uses 60 percent of our health care resources. By identifying these high risk individuals, we can intervene earlier in their course of treatment, proactively manage their care, and reduce costs.
- We care enough about our members with limited or fixed incomes to help steer them to available community resources, like food stamps, social security, and long term care options.
- We sponsor annual flu immunization clinics that are open to FHP members and non-members alike. Last year, over 25,000 Arizonans received their flu shot from FHP. The goal is to reduce the incidence of flu-related illnesses and hospitalizations the next spring – and it works.
- Finally, we have adopted a continuous quality improvement approach to the way we deliver care and service. We carefully examine areas for improvement and put together Quality Action Teams to reduce or eliminate nonconformity. For example, we significantly reduced the time that members subject to blood clots received the results of their anti-coagulant medication. Our team of pharmacists help these members learn more about possible interactions of Coumadin, with their diet, exercise plan, other drugs, and other diseases.

Customer Satisfaction

Are we doing a good job? Our members think so. We regularly survey our members about the health care they receive and encourage them to tell us about the good things we are doing and the things we could do better. Using the results of these surveys, we work with our physicians, health care providers, service representatives, and staff to develop new or improved plans and programs that respond directly to what our members tell us.

In our most recent patient satisfaction survey conducted earlier this year, medical services, indicators on appointment availability, accessibility and convenience, front office personnel, and pharmacy all were found to be "better than expected."

As a iederally-qualified HMO, we must abide by the rules and regulations established by the HMO Act of 1973 and amendments. We are required to meet all statutory, regulatory, and policy requirements laid out for Medicare risk contractors. Every two years, the Health Care Financing Administration visits every Medicare risk contractor and formally audits almost every aspect of our business. HCFA carefully looks at how we are organized, our fiscal soundness, cost reporting, utilization management, incentive arrangements, the way we deliver care, quality assurance efforts, marketing activities, procedures for enrollment and disenrollment, processing claims, grievance procedures -- both internal and with Medicare, and our compliance with the Equal Employment Opportunity and Americans with Disabilities Acts.

Other regulatory bodies "looking over the shoulders" of HMOs in Arizona include the Joint Commission on Accreditation of Healthcare Organizations, the Occupational Safety and Health Administration, the Arizona physician oversight organization, the Arizona peer review organization, the Arizona Departments of Insurance and Health, and others.

Does Competition Work?

Each of the HMOs represented on this panel -- and the six other commercial HMOs in Arizona -- compete in the marketplace. But that does not mean competition is based solely on price. We are all striving to keep our current members and bring in new members by providing more value for their health care dollar. We all hope to increase value by adding new benefits, developing new or improved products and services, improving our customer service, streamlining administrative functions, or developing larger provider networks. This is all for the good of our membership and the public at large.

Through the Arizona Association of Managed Care Plans, we also come together to inform and educate the public, business community, state legislators, and our Congressional delegation on significant health care issues. Our goal is to foster a better understanding of HMOs and how they impact health care quality, accessibility, and cost.

Through The Arizona Partnership for Infant Immunization (TAPII), Arizona HMOs are leaders in the statewide effort to meet the President's goal of 90 percent immunization of Arizona two-year-olds by the year 2000. Three of the four subcommittees are chaired by HMO representatives. Many other HMO employees volunteer to serve on each of TAPII's committees. They do it because it not only makes good business and medical sense to immunize, but because they care.

Suggestions for Reform

FHP, of course, supports federal and state efforts to encourage citizens into managed care settings. There are several recommendations that we believe Congress should enact to help these efforts along:

- Require HCFA to implement a proactive program to educate Medicare beneficiaries about the Medicare coverage choices available in their area.
- Eliminate the 50/50 rule. This rule has outlived its usefulness. Other means now exist to measure and assure quality. In Arizona, there is substantial HMO competition for the relatively small commercial population. However, there are fewer HMO competitors for the Medicare population. The result is that the 50/50 rule has in many instances limited the ability of seniors to enroll with a risk contractor of their choice. Nationally, the 50/50 rule is an impediment to expansion of the risk contracting program. FHP is committed to the Medicare risk program. We would like to expand into new markets. Currently, to develop a sufficiently large commercial base to be a risk contractor takes significant time, or enormous resources must be spent to acquire an existing commercial HMO which is not a risk contractor. From our view, the quickest way to expand the number of beneficiaries choosing Medicare managed care options would be to eliminate the 50/50 rule.
- Expand health plan choices available to beneficiaries to include a point of service/self referral option, a preferred provider organization, and other managed care delivery methodologies. Plans offering a Medicare SRO should adhere to the same marketing and selection practices presently in place for the Medicare risk program. All plans should be held to the same quality and fiscal standards.
- Streamline the new application and plan expansion process by amending current Medicare contracting guidelines to allow entities to seek first time qualification for a Medicare risk contract under the terms of a Competitive Medical Plan (CMP). Federally qualified HMOs should be deemed to have met these standards. Plans with at least three years of Medicare contract experience would not be required to file full applications. For multi-state plans, there should be "national use and file" standards so that marketing materials can be approved for use nationally without subsequent review by HCFA regional offices. Private accreditation would be deemed approval of a plan's quality assurance and delivery system.
- Subject each Medicare risk contractor to an annual external independent review consistent with HCFA guidelines pertaining to the quality, timeliness, and accessibility of services Medicare beneficiaries are entitled to receive.

Closing

HMOs – like FHP – provide high quality care with more comprehensive benefits, more preventive services, and lower out-of-pocket expenses. Because of our focus on quality, administrative efficiencies, coordination of care, and purchasing power we are able to provide these services at a lower cost than the fee-for-service system. We encourage people to see their personal physician to catch small problems before they become major ones. Our members can choose from a wide variety of board certified personal physicians who meet high standards of professional training and medical practice. Based on our experience and numerous independent studies, our members like their care every bit as much and often more than people in old-style fee-for-service plans.

HMOs – organizations comprised of people just like you and me -- have grown rapidly in Arizona and across the country because a need existed. The healthy competition that has evolved in Arizona can serve as an indicator of what states with low HMO penetration can look forward to. HMOs in Arizona have been working successfully -- in the marketplace and as an industry – to solve many of the problems in our health care system that you and your counterparts at the state level are trying to address.

Thank you. I welcome any questions you may have.

Chairman THOMAS. Thank you.
Mr. Zucarelli.

STATEMENT OF PAUL A. ZUCARELLI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PARTNERS HEALTH PLAN OF ARIZONA, TUCSON, ARIZONA; AND SENIOR VICE PRESIDENT, MANAGED CARE, HEALTHPARTNERS OF SOUTHERN ARIZONA

Mr. ZUCARELLI. Thank you, Mr. Chairman, Members of the Committee. My name is Paul Zucarelli. I am the president and chief executive officer of PARTNERS Health Plan of Arizona and senior vice president of HealthPartners of Southern Arizona, an integrated health organization. The PARTNERS Health Plan is the largest health plan in the Tucson area with approximately 120,000 enrollees.

We introduced our Medicare risk product 2½ years ago and currently enjoy 13,000 customers in that product line, representing slightly over 10 percent of Tucson's Medicare population.

PARTNERS, as I said, is part of an integrated health organization which joins together both the health care delivery infrastructure and the financing mechanisms of health care. We have shared governance and ownership based upon the following members: The area's largest community hospital, a tertiary care facility; a medical group practice model with six health centers, an independent physician organization that comprises one-third of the area's physicians, and the health plans.

We are convinced that an integrated approach is the best way to continue to provide quality health care services as is demanded by the marketplace. And to contain costs, it is also simultaneously demanded.

Let me comment on our reputation for quality. A recent independent survey of decisionmakers in Tucson's managed care market ranked PARTNERS as the only major health plan to combine high rankings from employers for clinical outcomes, service outcomes, and limited cost increases. Our internal monitoring of customer satisfaction found that our senior members in the risk product were even more satisfied than our other members in general, scoring statistically higher than the mean for overall membership.

I would like to share with you some specifics relative to our customers in the Medicare risk product. We currently provide free transportation services to members who are unable to get to a hospital for outpatient visits or inpatient stays or to physicians' offices for appointments within a 10-mile radius of their home. This service provides an average of approximately 1,000 trips per month to the elderly, and 70 percent of our riders have reported that without this service, they would be missing or postponing health care, which would greatly increase the potential for adverse health outcomes and results and, therefore, increased health care costs.

Another innovative program that we have rolled out for the Medicare population is what we have called a Geriatric Evaluation and Management Program, affectionately known as GEM. I would like to share this briefly with you.

We have a team—the GEM team consists of a physician, pharmacologist, geriatric nurse practitioners, social workers, registered

dietitians, and administrative coordinators that perform intensive evaluations on Medicare beneficiaries and include histories and physicals, nutritional assessments, pharmacological assessment, functional fitness interviews, psychosocial interviews, evaluations of mental health and depression screening, and safety and health risk assessments of their actual home environment.

Let me tell you a brief story about what this has meant to two of our Medicare risk members who happen to be a couple. I will refer to them as Mr. and Mrs. A. Mr. and Mrs. A became progressively more worried about being able to stay together in their home. Mrs. A was 81, was becoming more dependent on help, and her 79-year-old husband feared they would be separated by a nursing home wall. Mrs. A has diabetes, hypertension, cancer, glaucoma, and a history of falls.

The GEM team was able to approach the patient in a multidisciplinary fashion and detect early stages of Parkinson's disease as well. This may not have been picked up in an ordinary routine office visit by the physician. The treatment plan was able to effectively coordinate the already complex mix of medications she was on so that her Parkinson's would be effectively managed, without detrimental effect on the management of her other health problems. In-home support was arranged for Mr. A through a group of care givers. Three months after this evaluation, Mr. A's progressive arthritis and vision changes resulted in a GEM evaluation for himself as well. Early stage Parkinson's was diagnosed and an increased fall danger was noted in a gait evaluation. Podiatric care was prescribed as a care for Mr. A.

In-home support is still being used by Mr. and Mrs. A. However, in the face of complex medical problems, they are still at home maximizing their quality of life together. In conclusion, innovative programs like these are the result of taking the HMO concept and moving it forward.

In Tucson, Arizona, managed care plans serve the needs of Medicare members with excellent results. With four Medicare HMOs operating in the Tucson marketplace, nearly 50 percent of Medicare beneficiaries have voluntarily opted out of traditional fee-for-service medicine and into one of the managed care plans.

I would suggest you might want to survey these people directly to assess their perceptions of the increases in service, convenience, quality, and economy which they are currently experiencing.

I also believe the integrated approach, which our HMO is a part of, is a giant step in the right direction to serve, and more directly connect the customer with providers of service of care, so true productivity and accountability is the result.

We believe we are uniquely positioned in our marketplace to significantly reduce costs and provide better quality care because of our shared vision of our elements, namely, managing our communities toward a better health and improved health status within a finite set of resources. We think we are proving it is a worthwhile effort.

I would encourage you to look for incentives to make more of this development possible rather than allowing creation of restrictions, intended or accidental, which may hinder our ability to build a healthier community. We urge you to expand managed care principles to the Medicare line.

Thank you.

[The prepared statement follows:]

Testimony of

Mr. Paul A. Zucarelli
President & CEO
PARTNERS Health Plan of Arizona
&
Senior Vice President for Managed Care
HealthPartners of Southern Arizona

My name is Paul Zucarelli. I am President and CEO of PARTNERS Health Plan of Arizona and Senior Vice President for Managed Care with HealthPartners of Southern Arizona, a community-based, integrated health organization. PARTNERS Health Plan provides a variety of managed care services for more than 120,000 members in the Tucson metropolitan area and in rural counties of southern Arizona.

The term "integrated health organization (IHO)" may be new to some, so I will briefly explain it in a moment, because an understanding of this evolving configuration of health organizations can be very important to understanding some of the advances we believe we are developing.

PARTNERS Health Plan

Allow me first to briefly introduce PARTNERS Health Plan of Arizona. PARTNERS has been providing managed care services in Arizona since 1986. We began as a cooperative effort whose principal parties were an organization of several hundred independent physicians in the Tucson area known as Southern Arizona Independent Physicians (SAIP) and TMCare, a community-owned, not-for-profit health care provider which owns and operates the area's largest hospital, Tucson Medical Center (TMC).

Following initial success in the commercial HMO marketplace and growth in our provider network, PARTNERS introduced a Medicare Risk Plan, known as Senior Choice, in 1992. Current membership in PARTNERS' senior plan is more than 13,000, which represents approximately 10 percent of the area's total Medicare membership.

We are a full-service managed care company with products for individuals, large and small groups, and point-of-service plans in place.

Like the growth of our commercial HMO options, our growth in Medicare risk membership has been steady throughout the time that we have offered this option. We believe that the reason for this is our constant attention to the needs of the patient.

Integrated Health Organization (IHO)

Many observers of the development of HMO's have, wisely, counseled that as we seek to shape a system which is more economically responsible, we must not reduce the importance of the patient or member and substitute the dollar as the center point of our efforts. We believe that as our IHO forms into a truly integrated system, which places the incentives of all service providers in alignment with what creates better health within the communities we serve, we do the maximum to enhance both better care and economic responsibility.

This IHO is **HealthPartners of Southern Arizona**, a not-for-profit, community-based organization. It joins together the following organizations:

Southern Arizona Independent Physicians, with more than 500 medical care providers, including both primary care and specialty physicians;

GHMA Medical Centers a primary care and multi-specialty group practice with five major clinics throughout the area and which is the physician group responsible for introducing managed care into southern Arizona some 20 years ago;

Tucson Medical Center a 615-bed hospital with a 50-year reputation for quality acute and tertiary care, and the other operating entities of TMCare including the area's leading behavioral health hospital;

PARTNERS Health Plan with its 120,000 managed care members; and,

Arizona Physicians, IPA, the largest participating plan in Arizona's managed care Medicaid program known as the Arizona Health Care Cost Containment System serving approximately 111,600 members (APIPA is a partnership with Samaritan Health Services of Phoenix).

The process of bringing together all these interests is complex and difficult. We are, nonetheless convinced that this is the best way to both continue to provide quality health services as is demanded by the marketplace *and* to contain costs as is also demanded. The community-based IHO brings providers of care (inpatient as well as outpatient, tertiary as well as primary) into the same organization and simultaneously finances the managed care products directly to the marketplace. All constituencies are thus linked daily to the member. We believe we are, indeed, achieving a real alignment of interests and incentives which includes payors, members and providers in a partnership which can truly minimize conflict and maximize health improvement results for our members.

We view ourselves as being in the business of managing the health status of the defined population we serve in our communities. Most HMO's are arrangers or coordinators of care through contracted networks; we, on the other hand, serve as an integral part of our communities (we are among the largest private employers in southern Arizona) and both provide care and finance it for the community.

We seek to create the best value for our customers and we understand "value" to be the optimal intersection of quality service with cost containment. By being *together* in our understanding of that mission, and in our rewards for success, we seek to remove the counterproductive wrangling that is often seen between provider and insurer or between hospital and physician. Inevitably, where such diversion is present, it is the patient who suffers. We are convinced that this new configuration of health services in a community-based IHO is capable of genuinely incorporating the customer at every level as a full partner to the benefit of the health status of the entire community.

The various organizations involved in HealthPartners have been working toward integration for two years and began to put integrated programs into place under the HealthPartners name this past November.

HMO Quality for Medicare Enrollees

The overall reputation of PARTNERS Health Plan has been built on providing high quality care while simultaneously being effective at limiting cost increases. A recent independent survey of decision-makers in Tucson's commercial managed care market ranked PARTNERS as the only major health plan to combine high ratings from employers for clinical outcomes and service as well as for limiting cost increases.

Our own internal monitoring of customer satisfaction provides an interesting extension of that data specifically as it applies to our Medicare membership. In January of this year we surveyed a representative sample of all our health plan members measuring responses in a dozen areas which are pivotal in establishing member satisfaction.

We found that *our senior members were the most satisfied of all our members.* In all twelve categories of measurement our senior members responded with scores statistically higher than the mean score for overall membership (which includes commercial HMO and Point Of Service plan members as well). In eleven of the twelve measures, our seniors were the group which gave us the highest scores and in the twelfth category, their high ranking was matched by those in one other category of membership.

Our measurement categories included such things as overall evaluation of care, access to specialty care, and time available with physician and their staff members. The survey was based on an instrument developed by the Group Health Association of America.

The strength of this expressed satisfaction in our services is perhaps best exemplified by our members telling us that they are very unlikely to switch to a different health plan, given the opportunity. When surveyed on this question (and while our overall membership response was very favorable) our members aged 65 and older were the *least* likely to express any inclination to change plans.

Extra Services for Seniors

Perhaps a part of the satisfaction our members express can be traced to some of the synergy of services which is available because of our integrated system.

TMC's hospital-based program of special services for seniors (which is available at no charge to our Medicare risk members) provides a free transportation service to members in need of inpatient or outpatient services at the hospital or to appointments at physician offices within a 10-mile radius for members unable to drive. The service provides an average of approximately 1,000 rides each month and 70 per cent of our riders report that, without this service, they would be missing or postponing medical services which would greatly increase the potential of adverse health results and increased health care costs.

This program also provides for significant discounts on classes at our FitCenter Plus, a center for exercise and wellness with a membership of more than 2,000 seniors. Staff members at FitCenter specialize in senior fitness programs and work in cooperation with members' physicians or restorative services providers. A recent 12-week study of warm water therapy demonstrated dramatic improvements in range of motion, shoulder strength and walking speed for participants. This takes place in a relatively low-cost setting which members find pleasant and productive. More than 50 classes per week are offered throughout the city at six different sites.

Our Medicare risk patients also receive free membership in another community-based program known as OASIS which offers a wide variety of classes and programs. Among them is an inter-generational tutoring program which matches trained senior volunteers with elementary school-age children with needs for assistance in reading and language skills who are not eligible for other literacy programs. Last year, 268 member volunteers provided more than 42,000 tutoring hours to 383 students from 37 schools throughout the area.

These are a few of the extra services and opportunities which come to Medicare members who chose our HMO; some are clearly and directly related to improving and maintaining their health and others work more indirectly. All are benefits which have been enthusiastically endorsed.

Innovations for Better Care

I'd like to tell you about two programs currently being piloted within the HealthPartners Network; they are of particular significance to Medicare members of PARTNERS Health Plan. These two programs literally bring together all the major components of the IHO, placing the patient's best interest at the center of the process, where it belongs. The programs are:

* a primary-care-based nurse case management system and

* an intensive geriatric evaluation and management system.

They are interrelated and complementary.

Our **primary-care-based case management**, just several months into its pilot process has already been expanded into seven physician offices from its original five. Available for our health plan patients of all ages, it tends to see predominantly a senior population. With this program we have a nurse case manager assigned to the office practice of participating physicians so that extended resources are available at the primary care level to identify and intervene in patients who are at risk for health difficulties.

Case managers work with patients identified by their primary care providers on the basis of diagnoses or risk factors. Patients with multiple diagnoses, frequent hospitalizations or multiple emergency room treatments are among those paid special attention.

The nurse case manager administers a health risk appraisal including a home environment assessment and works with the primary care physician in creating and implementing a plan of care. They identify and deal with gaps in support systems available to patients. It is an on-going process to give long-term additional support and reach to the primary care provider in bringing maximum results for each patient.

One simple example of the efficiency of this extra resource is the case of a woman who is now using night-time oxygen as a result of an extended, in-home evaluation by her nurse case manager. Because of the greater period of time available for evaluation within the case management system (compared to an office visit with only the physician) and because it can be in the member's home, a more complete picture of the patient's total health risks and needs can be gathered. In this case, an in-home visit determined that overnight oxygen monitoring was warranted, that in turn pointed to a risk from lower oxygen intake during sleep. A simple addition of night time oxygen is now working to prevent a more serious incident.

Our nurse case managers report a wide spectrum of experiences, some as simple as finding asthma patients at home with poor dust control, all of which leads to intervention and prevention at its most effective and efficient level.

The pilot study includes both independent physician practice and group physician practice settings. We are currently investigating extension of our case management system into other areas including pediatric care and working to make it more widely available.

The geriatric evaluation and management (GEM) program has been in operation for almost a full year, during which we have found substantial success in providing an unprecedented level of support for senior patients and for their primary care providers by carefully coordinating resources available within the various segments of our IHO's operating entities.

Primary care providers are offered the opportunity to refer Medicare risk patients whom they believe to need special attention into this program for evaluation. The GEM program consists of health professionals in numerous disciplines from each of our major IHO component areas: hospital, health plan and physician practice. This team (a pharmacologist, a physician, a geriatric nurse practitioner, a social worker, a registered dietitian and an administrative coordinator) performs a coordinated, intensive evaluation covering such areas as:

* history and physical
* nutritional assessment
* pharmacological assessment
* caregiver interview
* functional fitness interview
* psycho-social interview

* evaluation instruments for mental state and depression screening
* an safety and health risk assessment of their home environment
* and others.

Results and recommendations from the team's collaboration are returned to the primary care provider in an individualized plan for interventions and desired outcomes.

It's proving to be a very good system, but only to describe its intention and organization leaves the patient out of the center Allow me to tell you about a what this has meant to some of our Medicare members.

Mr. and Mrs. A had become progressively more worried about being able to stay together and in their own home. Mrs. A, who is 81, was becoming more dependent on help and her 79-year-old husband feared they would soon be separated by nursing home walls. Mrs. A has diabetes, hypertension, cancer, glaucoma and a history of falls. Progressive weakness, renewed falling episodes and memory changes caused her physician to send her for a GEM evaluation

Because this team of trained, interdisciplinary members of our staff is able to approach the patient from so many different perspectives in a coordinated fashion, information often comes together that would be unavailable to the primary care provider in a normal setting.

The team's results made it possible to diagnose Mrs. A's Parkinson's disease which had been masked by the rest of her complex condition The treatment plan was able to effectively coordinate the already complex mix of medicines so that her Parkinson's is being effectively managed without detrimental effect on the management of her other health problems. In-home support was arranged and Mr. A was introduced to a support group for care-givers.

Three months later Mr A's progressive arthritis and vision changes resulted in a GEM evaluation for him as well. Early-stage Parkinson's was diagnosed in him and is now being managed and an increased fall danger was noted in a gait evaluation. Podiatric care was provided as a preventive measure.

In-home support is still in use by Mr. and Mrs. A. The key is that, in the face of complex medical problems, they are still in their own home and maximizing the quality of life together.

Mrs. B, who is 80, has a different but also complex set of medical problems. She suffers from macular degeneration and is legally blind, she has gastric ulcers, has urinary incontinence; she was anemic and her depression was growing.

As a part of the in-home evaluation, our geriatric nurse practitioner discovered that she had been seeing several physicians and had stockpiled, and was taking, 14 different medications and using alcohol. It is not uncommon, as you may know, for older adults to get trapped into substance abuse in this fashion and they are unlikely to volunteer the information to any one of the physicians they might be seeing.

Mrs. B was admitted to a program at our psychiatric hospital to deal with her dependency and her care plan is progressing.

Finally I'd like to tell you about **Mrs. C**, 88, who chose to leave our Medicare risk enrollment.

She moved to Tucson reluctantly from her home in the northeast so that she could be cared in the home of her daughter here. Her falls and memory difficulties, vision problems and other conditions caused her to move She wanted, most of all, to remain independent and in her own home.

After medical progress from a treatment plan developed by the GEM team, and with connections to community-based resources in her home town which were arranged by the GEM team, Mrs. C chose to leave Tucson and to use the community support available allowing her to live independently in her northeastern home for the best of all possible reasons -- because she could.

Conclusion

Innovative programs like these, which don't aim at merely reducing costs but rather rearrange systems and resources into a more efficient and more patient-centered configuration, are the result of taking the HMO concept and moving forward with it.

At the core of the HMO philosophy is the belief that a policy of using resources to keep the patient well and to intervene appropriately in the earliest detectable stages of illness, disease or disability provides (considering not just finances, but lives as well) the most economical approach to better health. I am convinced that is a valid and valuable starting point. In southern Arizona managed care plans are serving the health needs of the full spectrum of Medicare members with excellent results at low cost. With four Medicare HMO's operating in the Tucson market nearly 50 percent of Medicare beneficiaries have voluntarily opted out of traditional fee-for-service medicine and into one of the managed care plans. I would suggest you might want to survey these people directly to access their perceptions of the increases in service, convenience, quality and economy which they are experiencing.

We believe that the marketplace response to our managed care plans for Medicare enrollees is strong evidence that we have taken the fee-for-service setting and improved upon what it has to offer.

While there might be individual primary care providers in a fee-for-service setting who have comprehensive resources available to them comparable to our case management and GEM systems, I am unaware of them in our marketplace. It is the combined strength, skill and commitment of the components of our IHO which can create this kind of resource on a system-wide basis and make it available to a greater portion of the population.

HMO's, I think you can agree, have not been stagnant. I submit that HealthPartners of Southern Arizona is an example of how rapidly and effectively community-based health organizations can innovate and focus on its residents in a community fashion. We can do the right thing for our customers if we continue to streamline the process. I believe the IHO configuration into which our HMO has joined is a giant step in the right direction and serves to much more directly connect the customer with the providers of service and care so that true and productive accountability is the result.

I ask you to keep in mind, as you consider legislative alternatives, that this type of progress is possible only when we are able to operate without counterproductive restrictions and cumbersome barriers.

We believe the case is strong to show that we are, in fact, paving a new path to better patient care while building a more economical system of delivery. HMO's, as integral parts of IHO's, are uniquely positioned to reduce costs significantly and provide better quality care because of the shared IHO vision of our core business as managing our communities toward better health within a finite set of resources.

I ask that you recognize that not all HMO's are the same. Some of us are community-owned and community-focused, without the need to serve the financial demands of investors seeking a purely financial return. We are, at HealthPartners of Southern Arizona, community-based and driven by a shared commitment with and to our communities. Our ultimate return is a truly healthier community.

It is an exciting and challenging prospect to extend managed care principles through a system aimed first at improved health status of patients and improved community health. We think we're proving it's a worthwhile effort and I would encourage you to look for incentives to make more of this development possible rather than allowing creation of restrictions, intended or accidental, which will slow down our ability to build healthier communities and contribute to a stronger nation.

Thank you.

Chairman THOMAS. Thank you very much.

Mr. Christensen.

Mr. CHRISTENSEN. It sounds like, Mr. Zucarelli, you are almost taking on more of a hospice care in a way. You have got a lot of the same elements of what the hospice care providers give a person who is in their last 2 to 6 months of life and—except you have taken it down to the situation where a person just enters the retirement phase of their life, meaning you have got the care givers, you have got all kinds of—you have got a social worker here. How can you afford to do that as a private sector company?

Mr. ZUCARELLI. Basically, it is a complete shift in thinking, philosophically, how you manage a patient's care. HMOs realize that there is only a finite set of resources in the system and that we will go broke quite quickly if we keep fixing people.

The early assessment portion of a person's condition regardless of their age is critically important, and to the extent we can prevent a continuation of disease progression or management of resources and enhance a person's quality of life at the same time, if they are chronically ill, but the key is to prevent chronic illness. To the extent the aging process takes its normal course, certainly we have to provide the care, but I agree with my other colleagues.

We have seen, simply in the acute care setting, days per thousand, and I would agree with the figures that my colleagues shared of roughly 2,000 days per thousand of hospital use being cut significantly. We are approximately running 1,100 days as well in our Medicare Risk Program. There is a tremendous amount of dollar savings there that you can reapply to nutritionists, some in-home care givers, and so forth.

Just a general comment. All the time we pick up safety factors in the elderly's home, like lamps, cord lamps, dust if they are asthmatic, if their house isn't clean, really, really simple things can be done that don't cost a lot of money but can save some dollars in the health care equation.

Mr. CHRISTENSEN. What is the cost that you have seen in terms of transportation? What does that average out to be? Is that something that is being widely done by your HMO managed care system as well?

Dr. JACOBS. You know, many of the benefits that you are going to see here for the three plans are very, very similar and the reason for that is we are competing in a marketplace for the same constituency.

Mr. CHRISTENSEN. Competition.

Dr. JACOBS. Yes, it is competition, it really is. I think a better question is: How can you afford not to do a proactive case management approach? Because we have discovered at FHP that 6 percent of our members incur 60 percent of the costs. It makes a lot of—there is a lot of leverage there. It makes good business sense to spend your resources on that 6 percent and proactively manage their care in order to keep them out of trouble. I mean, better, high quality health care in the long run is the least expensive health care that you can provide.

It is true that there are anecdotes of needed care being withheld in HMOs from time to time. You will hear that. But the bottom line is that an HMO that does that is going to cost you more.

Mr. CHRISTENSEN. What about the theory that the gatekeeper under a managed care system is not going to refer out to the specialists under the current, say, bonus system where a gatekeeper is provided—a primary care physician is provided a bonus if he is able to contain the costs and not refer out, and some people have said that people aren't going to receive the type of attention that they need from the specialists?

Have you experienced any of that kind of lack of specialized care for your seniors?

Dr. BLOCK. I can take that question. I know that is a concern. We have checks and balances in terms of looking at underutilization, as well as looking at overutilization, and when we evaluate our physicians, we don't look only at their cost of care, but we also look at other dimensions, and I believe probably other plans do similar things.

We review their charts, we make sure people are getting the appropriate preventive services. We look at patient satisfaction. We actually survey their members to determine if they are satisfied. And with this type of competitive market, people do vote with their feet. I mean, the risk of not providing quality care in addition to incurring later costs by not providing preventive services is that people will leave your plan and go to other plans where they perceive the quality to be better.

Mr. ZUCARELLI. Just to add to that, HMOs typically do capitate, however it gets back to the alignment of incentives issue, and we are becoming much more sophisticated whereby sometimes the specialists even share in the risk pools associated with primary care and hospital usage, and funds are commingled. So it takes the customer out of the middle, because if you look at HMOs in the eighties, we were basically a discount medicine approach with strong policing mechanisms on the front end with authorizations, and so forth.

But I think we have evolved—mature managed care plans have evolved now to more customer focus and have incentives that are aligned between primary care and referral specialists, as well as sharing in the hospital usage of resources. I am sure we all do this; we credential the providers. So that is such a value-added service.

Mr. CHRISTENSEN. Do all three of your organizations advertise for that customer? How do you go about getting your customer into the system? I asked a similar question earlier today to the panelists and HCFA has no process in place to refer out to managed care programs.

How do you all go about it?

Dr. JACOBS. Well, we have general advertising, which is image-type advertising. We also have tactical advertising in the local marketplace, and our sales is a one-on-one sales. It is very expensive to do it that way. I might comment briefly on the comparisons with the cost of administering Medicare versus the SG&A costs for an HMO.

FHP is running about 8.4 percent of revenue for its SG&A costs but it is not an apples to oranges comparison. We also have sales costs which are considerable. Also, running the gauntlet of administrative regulatory costs is very high as well, but we try to—we have general community just advertising, image advertising, and

one-on-one sales effort, and word of mouth has been the most important way of attracting members.

I can't emphasize enough the importance of competition, and competition based on something more than just on price. We compete in benefits, we compete on service and network. We compete across a broad range of program attributes and competition based just on price is a real mistake.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Following that line of argument a little bit, the point was made that—I think Dr. Block, without a point-of-service option because of the prohibition on the part of Medicare, you obviously are not able to market a product that would be as complete as your customers would like. That is primarily affecting you on the basis of a less attractive product, doing less than you could do, or do you lose people over that? How fundamental is that failure to be able to provide a point-of-service?

Dr. BLOCK. We have done——

Chairman THOMAS. Is it evolutionary? That is, more people now are more concerned about it than they were 3 years ago?

Dr. BLOCK. We have done focus groups and surveys, and what we have found is there are people that are fearful of joining an HMO and have a supplementary product or an indemnity product plus Medicare because they still want to be able to access that one doctor that they have had for 10 years, their eye doctor or their heart doctor. And when they know that they cannot access that doctor through the lock-in HMO, they are not willing to consider that as an option.

I think the commercial experience will say that one way that commercial HMOs and carriers have introduced the HMO concept has been to go with a point-of-service option as kind of an interim step so that people do have the ability to see that one or two doctors in their life who are very important to them and still have all the benefits of an HMO.

Chairman THOMAS. Dr. Jacobs, you are talking about the difficulty with the 50–50 rule, which is somewhat similar. You can't market the product the way you want to market it because of the prohibitions which like a lot of things we do in government, had a real good reason at one time to establish what folks I guess thought was a quality check but which clearly is a limitation to a certain extent, if you want to specialize in an area.

And then in response to Mr. Christensen, you talked about the kind of advertising that you do. Do you use focus group or question new enrollees as to how they found out about you? I know you mentioned several times it was by word of mouth. Is that what you find to be probably the primary reason folks looked you up?

Dr. JACOBS. Mr. Chairman, I don't have those statistics at my fingertips. I do know that word of mouth is very important to us, but I can't give you a percentage, what percentage of our leads come from word of mouth. It is a high percentage, though, and we are inhibited by 50–50 to a significant degree.

One other impact the 50–50 rule has on us is that we are unable to take on Medicaid patients because they count toward the 50–50, and I know that access in Arizona would like for us to participate.

Chairman THOMAS. Well, this is another area that we need to get into because, when you talk about Medicare, you wind up with a certain profile of patients talking about Medicaid. And when you talk about Medicaid with certain profile patients, you wind up talking about Medicare. And in Arizona, 100 percent of the folk are in managed care on Medicaid and you are moving into a managed care Medicare situation.

We did not talk about it with the first panel, but this is an anomaly that we have to focus on, and I would guess, given the profile of Arizona and managed care and the seniors there, that you are going to be one of the most heavily impacted areas.

Mr. Zucarelli, you mentioned this GEM, the geriatric evaluation management. You mentioned a couple. First, the wife was afforded the GEM Program, and then the husband. What triggers a geriatric evaluation? Have you got a profile, there are certain aspects?

Mr. ZUCARELLI. Right. We basically market the program through the primary care physician and it is really to catch at the earliest onset some of the chronically ill Medicare enrollees so that we can provide more resources to the physician. It is usually people with multiple conditions. I am not a physician so I won't speak to the clinical end.

Chairman THOMAS. For example, if you had a couple and both were enrolled and it was triggered on one, wouldn't you want to just do the other one for a profile, or do you wait for certain symptomatic aspects for a profile?

Mr. ZUCARELLI. It is based on the team's evaluation. This example happened to be a couple. But the primary care physician called into the GEM Program and said I need the team to evaluate Mrs. A. The concern was really—Mr. A, he was functioning well but he was concerned that they were going to put his wife in a nursing home. When his vision started failing and his arthritis progressed, we did a complete evaluation, we picked up his gait problem in his walk and gave him the podiatric services. But the fact is, we have kept them together.

One comment I would like to add, Mr. Chairman, concerns the point-of-service product. I view the marketplace as evolving, and one of the biggest fears Medicare beneficiaries have is this concern that they are going to lose their choice of physician. We have seen that on the regular HMO commercial side, and that is, people our age used to HMOs and health plans because our employers have migrated to them. We have a generational gap or barrier we have to deal with and I would suggest a point-of-service plan is a means to an end and a transitioning product.

Chairman THOMAS. Yes, there is no reason why we can't eliminate that barrier. That is obviously going to be one of the things we looked at.

Dr. Block, you mentioned, and I believe Dr. Jacobs mentioned, the comparison that when you began, it was a 2,000-hour bed relationship between the program and Medicare and you basically cut it in half. In terms of that kind of behavior, obviously you are probably measuring quality slightly differently than other folk who tend to measure quality by quantity.

Have you had any difficulties in either articulating or getting people to understand the way in which you measure quality within

your system? Because, clearly, a reduction like that would normally be seen as a reduction in quality by sheer reduction of hours.

How do you counter that?

Dr. BLOCK. I think one of the things we do, and I suspect the other plans do as well, is to have a large number of nurse case managers. We call them patient care coordinators. They work with physician advisors in any of our hospitals to immediately begin case management of inpatients so the patient is not surprised, and the expectation is set for approximately how long they are going to be in the hospital.

And we also work with the physician groups to try to set the expectations early. I agree with the other two panelists that this really does lead to real savings. I had the pleasure of attending a conference where Senator Rudman addressed the American College of Physician Executives and he was trying to explain why the Medicare Program was so expensive. He talked about a case where a person was in there for an infection of the inside of the heart and they were hospitalized for a total of 6 weeks for antibiotics. Then someone from the audience, this being a managed care meeting, raised their hand and said, "If they would have been with an HMO, they would have been in for 2 or 3 days and then home for 6 weeks." It turns out the Medicare Program doesn't cover the IV antibodies at home. We would do nothing but cover those antibiotics at home. So once again we have real savings.

Chairman THOMAS. Once again, it is an attempt to try to create a system and then force a fundamentally different approach into that system and we have failed to respond to it. Dr. Block, you mentioned something which intrigued me because this is one of the normal arguments against a managed care program in general and clearly for seniors.

Arizona probably has a relatively high percentage of mobile seniors. They tend to get around a lot and travel. And you mentioned that you have an emergency coverage portion of your program on a worldwide basis that if I left Arizona as part of your HMO coverage, is that true, that I can get emergency coverage?

Dr. BLOCK. We have emergency coverage and I think this is mandated by HCFA worldwide. The coverage outside of the service area for emergency or urgent situations is regulated.

Dr. JACOBS. It is a requirement for us to do that, yes.

Chairman THOMAS. Just curious.

Mr. CHRISTENSEN. Mr. Chairman, could I ask——

Chairman THOMAS. Go ahead.

Mr. CHRISTENSEN. Have you had any of your participants who were in a fee-for-service plan who had their doctor move into the managed care system and how did that transformation process go? Did the participant follow that doctor into one of your plans? Were services reduced? Were they increased?

Dr. JACOBS. Mr. Christensen, we have about 1,500 contracted providers and we have observed that a number of those patients do move to the Medicare risk contract to the plan and stay with their doctor.

Mr. CHRISTENSEN. Has anything changed for that Medicare recipient from the fee-for-service to managed care when they have been in a long relationship with that doctor? Have you seen any-

thing change? Have you seen any evidence that those recipients are not happy when they move from their fee-for-service to managed care with the same doctor?

Dr. JACOBS. No, we have not seen that trend, and in fact, we have seen a real—I think we have seen a real improvement in care quality. It does take a while for that physician to learn managed care. It is a different way of practicing medicine. But in terms of the patients, I think patient satisfaction goes up. That has been our experience in the surveys we have done.

Mr. ZUCARELLI. And the elderly certainly appreciate no filing of forms and the no confusing paperwork.

Chairman THOMAS. On that point, Dr. Jacobs, I think you mentioned that FHP was founded in Fountain Valley, which is in Orange County. Fountain Valley is one of those new towns created in a beanfield, in the sixties. You were on a sharp learning curve to understand what you needed to do. Then you mentioned dealing with doctors to understand in part the structure.

But do you believe that there is something you have learned which is transferable to other areas? Are there management skills? Is there a model that could be recreated, or does it tend to have to be shaped in terms of the area you are in? To what extent are the ideas that you have learned exportable to the other States that you now practice?

Dr. JACOBS. I think the methodologies that we use are highly transportable. The reason for that is, we are all using the same technologies that are available in medical science, meeting the same anatomical, physiological and medical needs. Those aren't differing from State to State and patient to patient, in the same regulatory environment with the same financial structure, and that is really what is driving the methodologies that we use.

What is very labor and time intensive, however, is training the physician and provider network in how to use these methodologies, managed care methodologies, because what Mr. Zucarelli talked about, what Dr. Block talked about, what is in my written testimony, is that managed care attempts to coordinate a number of complex technologies and individualize it and use it in a proactive way to meet the patient's needs up front, and you need to get the physician to cooperate with that because he or she writes the purchase orders, and that means that you—that as a medical director, we need to get out of the community and interact with them on a one-on-one basis, develop a relationship and build trust, and then use that trust as a platform to teach them managed care, and some come along, you know, gleefully and others don't and it just takes time.

Chairman THOMAS. Dr. Jacobs, you have been in the business for 10 years, 5 years in Arizona. Have you seen a different product coming out of our medical schools and residencies in the last 3 to 5 years?

Dr. JACOBS. No.

Chairman THOMAS. Do you think you could go a long way toward reshaping those programs to create a product that is a little more focused in terms of what you need?

Dr. JACOBS. Yes, I really think that the medical schools are way behind the times. It is time—I believe it is time they start offering

courses in managed care. If physicians understood managed care when they came out of medical schools, we could really expedite this whole process.

Chairman THOMAS. You think if we got more of the payment for the medical education in the hands of the students, that we could shape those trends a little faster?

Dr. JACOBS. I don't know, sir.

Chairman THOMAS. One quick question.

Dr. Block, in terms of the benefits that you offer, beyond the basic, and you went through a litany of a number of benefits, are you offering those, and this is a tough question so I appreciate it if you don't feel comfortable in answering it. Are you presenting those because you think you need to offer those to be competitive, understanding the price mechanism that we now have available to you, or are those things that you feel comfortably that you can add to fill up the gap between what it really costs you and the 95 percent that is being paid, and what would you do in terms of that benefit profile if you didn't have the fixed 95 percent? To what extent are the add-ons market driven or a function of adding to a fixed cost structure?

Dr. BLOCK. I think some of the add-ons are market driven, and I think that as we suggested, we all compete with each other and so part of it is market driven. I think part of it is that it makes good sense to provide those benefits because what you are providing could potentially avoid more expensive benefits down the line.

Chairman THOMAS. And you could do that given the funding mechanism? If we changed it to a more competitive funding mechanism, you would then probably not offer some of those?

Dr. BLOCK. It is a little hard to say exactly how that would work, but I would guess that we would have to balance the need to be competitive with the need to provide benefits that are above those that Medicare provides.

Chairman THOMAS. Would you look forward to that opportunity to produce a truly competitive market price?

Dr. BLOCK. I think we could compete very effectively in the marketplace.

Chairman THOMAS. Thank you very much. We could go on for a long time and I believe we will be revisiting Arizona as we did on the Medicaid solution. We are going to be revisiting Arizona on the Medicare solution. I want to thank you folks for your testimony very much.

The Subcommittee is adjourned.

[Whereupon, at 1:45 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

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

Mr. Chairman and distinguished committee members, millions of senior citizens who are retired from the military, the majority of them enlisted (noncommissioned), are concerned about how Medicare reform will affect them. I am testifying on behalf of the Air Force Sergeants Association's 160,000-plus members. AFSA represents the millions of enlisted active duty and retired Air Force, Air National Guard and Air Force Reserve members, and their families. Many of our members have served their nation, have entered their retired years, and are now among those currently receiving care through the Medicare system. We appreciate this opportunity to again include AFSA's views in your deliberations.

As AFSA has testified to this committee before, we are well aware of the challenge faced by this committee in finding ways to control costs within the Medicare program. The overall costs and fees for service become especially significant for our members because enlisted military retirees are the lowest-paid military annuitants. As such, significant medical bills can be devastating for this group of retirees. On behalf of our members, I ask you to seriously consider a cost-saving option that would benefit enlisted retirees.

We urge the committee to 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 either in TRICARE or at Military Treatment Facilities (MTF) (on-base medical care facilities). 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. Two bills have been introduced in the House that provide for some form of subvention: H.R. 580, sponsored by Representative Joel Hefley, and H.R. 861, sponsored by Representative Randy Cunningham.

To put the need for subvention in proper context, consider that for years, military members were told at every re-enlistment that when they retired, they and their families would have free health care for life. Enlisted retirees, especially, considered this a part of their deferred compensation package. Over the years, that promise has been broken. At age 65, they are abruptly prohibited from formally participating in military health care programs altogether. This practice must end, not just because it is discriminatory, but also because it shatters already-broken promises.

The specific method for incorporating Medicare-eligible military retirees into a managed care system is by allowing them to enroll or remain in the TRICARE program after age 65. 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. 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. Additionally, military retirees would be allowed to stay in the MHSS for life, as they were promised when they served their nation. At the same time, costs for their care would be reduced.

Another 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 on-base are derived through the military's "utilization management," which is preventive in nature. This system ensures that medical resources are used in the most efficient way possible, and care is coordinated so that more serious treatment problems are headed off, thereby holding down costs. Put another way, the right treatment is given in the right place at the right time. 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.

However, on-base care opportunities are very limited for Medicare-eligibles. 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, particularly our Medicare-eligibles, are denied space-available care because of a lack of DOD treatment funds. AFSA feels that Medicare subvention would make on-base care more likely for our older retirees when there is space available and, at the same time, save program costs by reducing the level of Medicare expenditures for military retirees. In any event, the option of TRICARE enrollment should be open to these retirees.

DOD leaders have repeatedly supported subvention for Medicare-eligible retirees. Now is the time to make it happen.

Mr. Chairman, thank you again for the opportunity to express our ideas on ways to lower the costs associated with the Medicare system. As you are deliberating this issue, we urge you to give serious consideration to AFSA's ideas on the matter. 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

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Medicare HMO Enrollment Growth and Payment Policies Hearing

Written Testimony for the Record
Submitted by the
American Academy of Actuaries'
Medicare Work Group

June 8, 1995

The American Academy of Actuaries provides technical actuarial expertise to public policy makers and maintains the actuarial profession's standards of qualification, practice and, conduct. Academy members include actuaries from all practice specialties: health, life, pensions, and property/casualty.

Academy committees and work groups offer expert testimony, provide technical information, comment on proposed legislation, and work closely with federal and state officials on insurance-related issues. The Academy's Department of Public Policy coordinates the work of committees and work groups with the needs of public policy makers.

INTRODUCTION

Over the past 20 years, the federal government has been attempting to control Medicare health care expenditures, largely by limiting increases in the fee levels paid under the fee-for-service system and by creating incentives for utilization reduction. To control hospital costs, the Health Care Financing Administration (HCFA) has reformulated hospital reimbursement to a diagnosis related group (DRG) system. The result has been a significant reduction in the length of hospital stays. HCFA has recently switched to a resource-based relative value scale (RBRVS) methodology to encourage the use of primary care over specialized care in order to reduce aggregate physician service costs.

This testimony focuses on another approach used by the federal government for cost containment—expansion of health maintenance organization (HMO) contracts for Medicare enrollees.

The testimony begins by briefly summarizing recent trends in Medicare HMO enrollment and commenting on the expected future direction of such trends. It then describes how HMOs are currently reimbursed under Medicare risk contracts and discusses issues surrounding the key element in the reimbursement calculation—adjusted average per capita costs (AAPCC). It concludes by describing a number of different approaches for addressing issues raised by the current risk reimbursement methodology. Among the suggestions made are the following:

- Competitive bidding could be used for setting reimbursement rates. HCFA could determine an average cost that it would be willing to pay, and any balance could be chargeable as a premium to individual Medicare enrollees.

- Provisions for alternative contracting mechanisms could, and probably should, be made for HMOs that are operating in areas where growth in AAPCCs are controlled.

- Adverse selection against some types of health plans and favorable selection toward others will arise when Medicare enrollees are allowed to choose among fee-for-service and managed care options. Therefore, some method needs to be devised for discriminating between risks in calculating reimbursements.

Incorporating these and other suggestions into the current reimbursement system for HMOs could result in a more competitive system with greater government and societal savings. In creating a more competitive system, however the Academy work group is also concerned that care is taken to protect Medicare enrollees' access to quality care. The group suggests that some mechanism be put in place to assure that risk-bearing providers do indeed have the required capital, either directly or through a contracting HMO, to support the risks they undertake.

PAST MEDICARE HMO ENROLLMENT TRENDS

As of April 1995, Medicare's managed care program, called Medicare risk contracts, enrolled more than 2.5 million individuals, or about 7% of the Medicare population. Medicare enrollment in HMO risk and cost contracts were authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). HCFA approval of risk contracts and enrollment did not get under way officially until 1985. Between 1982 and 1985, several risk demonstration projects were set up to establish the process of contracting and rating arrangements.

Prior to the passage of TEFRA, the federal government did hold some HMO contracts called health care prepayment plans (HCPPs), which were set up on a reimbursable cost basis similar to the Medicare hospital reimbursement system used prior to implementation

of the DRG system. During the entire operating period of HCPPs (early 1970s to present), HCFA has allowed HMOs with poor financial success under Medicare risk contracts to switch to HCPP contracts, without federal qualification, or to switch to TEFRA cost contracts. This means that the HMOs that are doing well financially with Medicare contracts can retain their current risk contract status. However, those that do poorly are likely to choose to switch to a contract where their risk is eliminated. This option tends to minimize any chance of cost reduction for HCFA. HCPPs will be mostly phased out at the end of 1995. TEFRA cost contracts will still be an option, however. In April 1995, the number of Medicare eligibles covered under various types of cost programs exceeded 500,000, or 2% of the Medicare population.

Overall, growth in the number of Medicare risk enrollees has been moderate. But as shown in Figure 1 (prepared by the Federal Office of Managed Care) growth in the risk contract market has been accelerating over the past five years.

One reason for the slow growth noted prior to 1991 was the HMO industry's relatively poor economic performance during the mid-1980s. These financial difficulties left many HMOs short of capital, prompting them to become rather non-aggressive in enrolling risky populations and to raise commercial rates substantially in order to strengthen their capital position. Some early growth occurred, however, through the conversion to risk contracts of enrollees in several of the large prepaid group practice plans which had previously been contracting on an HCPP basis.

Growth has also resulted from the many for-profit HMOs that have emerged, largely a result of conversions of not-for-profit HMOs, start-ups, and mergers. These for-profit HMOs have targeted the Medicare population as a major source of new growth and revenue, focusing their marketing efforts in areas that had high concentrations of traditional Medicare fee-for-service system participants, with very high medical costs.

Commensurate with enrollment growth, federal disbursements to Medicare managed care plans of all types exceeded $10 billion in fiscal year 1994. They are expected to exceed $12 billion in fiscal year 1995.

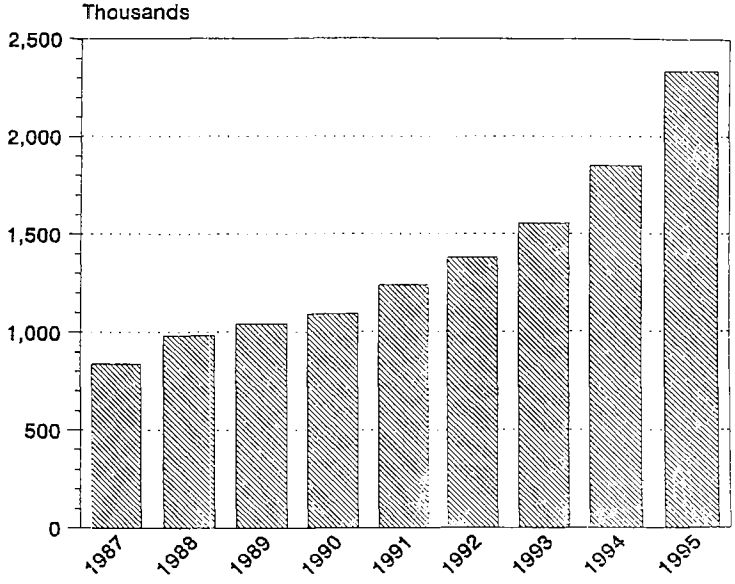
POTENTIAL FOR FUTURE MEDICARE HMO ENROLLMENT GROWTH

HMOs, in general, have been expanding rapidly. The HMO industry estimates that total HMO enrollment is now approximately 56 million, up from the approximately 50 million enrollees at year-end 1994. This growth is expected to continue at least in the near future. In addition, the Medicaid population may become a potential large source of growth. Some states envision prepaid Medicaid contracts as a potential strategy for controlling state expenditures on health care for this population.

FIGURE 1

Growth in Medicare Risk Enrollment

The largest increase in managed care enrollment by Medicare beneficiaries occurs in risk HMOs. Since the inception of the program there has been a steady increase in the number of beneficiaries enrolling in risk HMOs. From 1992-1993 there was a 13% increase; 1993-1994 showed a 19% increase; and enrollment in 1994-1995 grew from 1,848,373 to 2,339,592 - **a 27% increase**.



Rate of Enrollment Increase

1987	1988	1989	1990	1991	1992	1993	1994	1995
	17%	6%	5%	14%	11%	13%	19%	27%

In the very recent past, there has been a tremendous increase in the rate of growth for HMOs under Medicare. Moreover, Medicare HMO enrollment is likely to continue to increase substantially over the next 20 or 30 years, as many of the employees covered by HMOs during their working years retire. Very few current HMO Medicare members are individuals who "aged into" Medicare HMO coverage. The one probable exception is Kaiser Foundation Health Plans, which started with HCPPs in the early 1970s. These plans have been in business long enough to develop a relatively large aged-in Medicare population. Many of the newer HMO plans just do not have many age-ins, so they must rely on open enrollment for enrollment growth. Nevertheless, over 50 million active employees and their dependents are now covered under HMOs, and, as some of these reach retirement, it is likely that many of them will choose to stay in their HMO, or even shift to a new HMO if they retire to a different geographic location.

Another source of potential growth is smaller HMOs and PHOs. It is becoming more common for insurance-carrier owned HMOs entering into Medicare risk contracting. In addition, though, there are many smaller HMOs establishing additional sites (25 - 50 of these per year), and there is also a potential major expansion of HMO networks, through the nearly 1,000 physician-hospital organizations (PHOs) that have been formed. For example, new hospital ventures, such as in Phoenix and Tucson, have yielded rapid enrollment of great numbers of Medicare enrollees. In this competitive environment, many hospitals are striving to retain their share of Medicare enrollees by entering into Medicare risk contracts—either directly as an HMO, or by subcontracting with a federally qualified HMO or competitive medical plan.

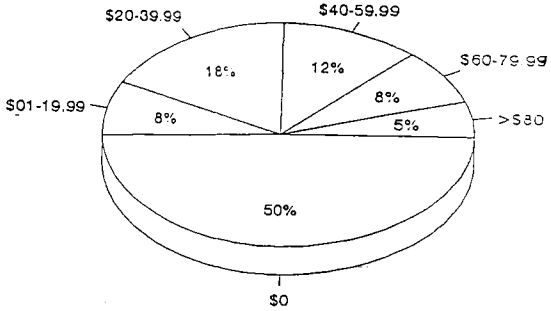
Competitive forces favor an expansion of HMOs and may encourage more Medicare enrollees. In the HMO industry, commercial premium rates have been falling for nearly two years, and many expect that rates will fail even more sharply by the beginning of 1996. Insurance carriers and HMOs are lowering rate quotes sharply on large-employer groups to increase their market share. Some analysts think that we are in the beginning of a dramatic downturn in profits for the prepaid health care industry, although the results would certainly be worse for straight indemnity plans than for HMOs, which have capitation contracts and negotiated low prices.

During the past several years, particularly in 1994-95, there have been sharp reductions in Medicare risk contract supplemental premiums. These premiums are the amount above HCFA's capitated rate that enrollees are required to pay for themselves. Figure 2 shows that approximately 50% of the contracting HMOs have a zero premium (except for supplemental benefits); 56% of Medicare enrollees are in zero premium plans. With indemnity, Medigap, or employer premiums exceeding $100 per month, it is not surprising that employers are building in incentives for their retirees to join HMOs, which have far more modest premiums.

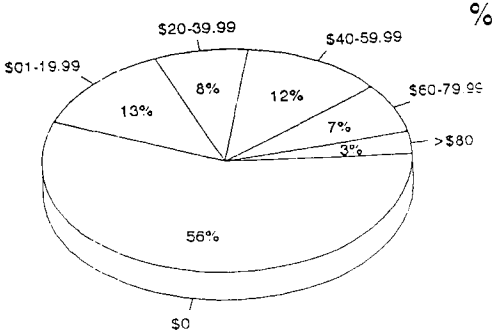
FIGURE 2

Range of Premiums for Medicare Population Covered by Risk Contracts

Premiums in Medicare risk contracts range from $0 to $110 per member per month. Sixty-six plans offer beneficiaries health care coverage for no monthly premium; 12 charge up to $19.99 a month; 26 charge $20 - $39.99; 15 charge $40 - $59.99; 11 charge $60 - $79.99, and only 6 charge in excess of $80. The majority of Medicare enrollees in HMOs incur little or no out-of-pocket expenses for HMO coverage. This coverage generally includes non-Medicare-covered services, such as preventive care, immunizations, outpatient drugs and eye exams.



% Plans



% Members

A note of caution is appropriate here. The increased competition and increased pressure for Medicare recipients to enroll in HMOs may also generate increased risk. Outcomes for the HMO industry have been favorable, and competitive pricing appears to be at its peak. However, new players who are entering the market are potentially at risk for not having sufficient knowledge about running an HMO or the capital to withstand a negative result under Medicare risk contracting.

REIMBURSEMENT METHODS FOR MEDICARE HMO CONTRACTS

Medicare risk contracts reimburse HMOs based on a capitation rate that varies for each county and is adjusted for simple risk factors, including age, sex, total disability (under age 65), Medicaid eligibles, and institutionalized members (residents of nursing homes). These capitation factors are called the AAPCC (adjusted average per capita costs) and are derived from total Medicare Part A and Part B costs for the Medicare population (excluding enrollees with end-stage renal disease).

The cost for each county is adjusted by taking the five-year average cost per capita for that county and dividing by five-year average national per capita costs, to arrive at a stable relationship. Average costs are then expressed by adjusting for the differences in the population cells, by risk factor, in each county, to produce a comparable standardized factor for the aged and disabled. There are large fluctuations in the rate of change each year in county-level costs. This makes it more difficult for HMOs to predict short-term and long-term costs accurately. Projecting AAPCCs is subject to projection error, with projections sometimes being above or below what the actual experience will be. In general, however, these projections are higher than actual experience. As a result, HMOs are, on average, reimbursed at a higher rate than their actual costs.

There are two major sets of issues with the current AAPCC method that need to be addressed. One has to do with the compensation rate and the other with geographic fluctuations.

Compensation Rate Issues

Since the amount paid to HMO risk contractors is 95% of the projected fee-for-service cost, even if the HMO were to save a great deal of money by operating at a much lower cost, it would not save the federal government any additional money. HMOs with costs below the federal reimbursement are allowed to add benefits, to an unlimited point, and to use up whatever savings it may have accrued from having lower costs than the average fee-for-service Medicare cost, thus reducing out-of-pocket costs for Medicare beneficiaries.

Each HMO is required to submit an annual adjusted community rate calculation to HCFA, which sets an upper limit on the premium that the HMO may charge. In some cases, this limit distorts the rates because HMOs are required to use HCFA's estimates for the cost of covering deductibles and coinsurance, rather than cost factors based on the HMO's own experience. In competitive areas, HCFA should consider allowing HMOs to increase their supplemental premiums without constraint.

Geographic Fluctuation Issues

The AAPCC varies considerably by geographic area. One reason for this is the large variation in fee-for-service Medicare costs. For example, there is an approximately threefold variation, with some Medicare metropolitan areas now approaching $700 per month per Medicare eligible and costs in some rural areas of between $200-$300 per month per Medicare eligible.

In areas with a high concentration of HMOs, in some cases exceeding 50% in a given county, it is not clear that the AAPCC formula will produce a fair capitation rate. Research has shown that some areas with high HMO penetration of the Medicare market experience a lower rate of Medicare spending increases, in aggregate. Major mathematical adjustments are required to calculate the AAPCCs in the normal form, when the large majority of the Medicare population in certain age/sex cells will be enrolled in HMOs. This situation seems to be particularly problematic when there is no good method of counting residents of nursing homes or Medicare eligibles also on Medicaid, who may go in and out of eligibility frequently.

METHODS OF ADDRESSING CURRENT HMO REIMBURSEMENT ISSUES

Competitive Bidding

Most HMO enrollees tend to live in high-cost areas, where effective management controls may more easily produce profits for the HMO, but little savings to the federal government. It would appear that some other basis for reimbursing HMOs is necessary, to circumvent the multiple problems that stand in the way of the two goals of equity and achieving savings for the federal government.

Many experts suggest trying competitive bidding in some area where there are three or four HMOs and a high HMO penetration of the overall marketplace. The HMOs would not be restricted to an AAPCC, but may instead bid any price they choose. HCFA could determine an average cost that it would be willing to pay, and any balance could be chargeable as a premium to the individual Medicare eligible.

If competitive bidding is used, it may be necessary to require that all HMOs in the market use risk contracts, and not be allowed to use cost contracts (This will not be an issue after year-end 1995 because most cost contracts will be phased out.). With a competitive bidding environment in high-cost areas, HCFA should consider allocating a portion of true savings to increase the payments to the HMOs in low-cost areas.

Compensation Rate

To the extent that restricting reimbursement rates in the fee-for-service sector reduces the federal government's cost, it tends to lower the amount of reimbursement that would go to HMOs under the current system. This may be problematic because HMOs may not be able to reduce their costs by a large enough margin to reduce federal government outlays for Medicare contracts. HMOs may find it difficult to renegotiate physician and employee fees and continue to reduce the current hospital reimbursement rates below the federal reimbursement rate. To the extent that the increases in AAPCCs are controlled, HMOs must be able to operate within that rate in order to enter into contracts successfully.

Adjusting for Annual Fluctuations

Attempts to smooth the income flow, and methods for retroactive adjustments, have been discussed, but never negotiated. Concern for budget neutrality and the difficulty of recapturing overpayments to HMOs appear to have stalled discussions.

Health Status Adjusters

While many HMOs have tried to implement a health status adjuster (HSA) system, the administrative requirements have proved formidable, and the HCFA capitation rates have changed frequently as medical histories are updated.

Many researchers have investigated the possible effect of factors such as prior disability, variations within geographic regions, and changes in use patterns in rural areas under HMO coverage, and adjustments for the working aged. But most studies have focused on the result of significant differences in prior hospital utilization or ambulatory care diagnoses. Because of these efforts to develop HSAs for Medicare, many states, such as Minnesota, require HSAs for populations subsidized under universal health care legislation.

Although Congress may propose other methods of controlling Medicare costs, as well as other options for enrolling Medicare eligibles, we need to bear in mind that the issue of adverse selection (or favorable selection) for one of the options will lead to more problems if more options are offered, since smaller populations will be selecting in order to maximize

their own advantage. Some studies have shown instances where there appears to be a level of favorable selection for HMOs, whether intended or otherwise. These studies also reveal that Medicare eligibles willing to join an HMO have had lower historic costs compared with similar non-HMO Medicare eligibles, or that the health status in the average Medicare population is worse than the average health status of the HMO enrollees. Other studies comparing the health status of the Medicare HMO population with the general Medicare population have not indicated that the health status of HMO enrollees is superior.

When allowing Medicare enrollees to choose from among multiple options, therefore, it may be even more crucial to devise some method, such as HSAs, of discriminating between risks. These should be set up as pilot programs until the actual pattern of selection can be determined. In addition, if a competitive bidding process is implemented, bidders may want to include some type of catastrophic reinsurance or HSA system to protect them from enrolling a high-risk population on a random basis.

HMO CREDENTIALING

One of the major elements in continuing federal regulation of HMOs is credentialing. Credentialing is intended to monitor the quality of care, grievance systems, and outcome measurements. To the extent that we are putting in place a more competitive system, we should also be concerned about protecting Medicare eligibles' access to quality care during a period of premium restraint and competitive bidding. It should also be determined that risk-bearing providers do indeed have the required capital to support this risk, either directly or through a contracting HMO. The National Association of Insurance Commissioners is developing formulas for all types of health organizations to develop risk-based capital requirements on a consistent basis.

CONCLUSION

With industry and government cooperation along the areas outlined above, the Academy work group believes that the HMO industry could greatly expand its enrollment of Medicare eligibles in a cost-effective way. This approach could produce savings to the federal government, while at the same time preserving access to quality health care at competitive cost for Medicare beneficiaries. Members of the Academy's Medicare Work Group are available to discuss these and related issues.

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
- INCREASING AND IMPROVING OPTIONS FOR MEDICARE BENEFICIARIES -

MEDICARE HMO ENROLLMENT GROWTH AND PAYMENT POLICIES

MAY 24, 1995

MEDICARE MANAGED CARE: CONSUMER PROTECTION STANDARDS

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.

The American Rehabilitation Association (formerly NARF) is the largest not-for-profit organization serving vocational, residential, and medical rehabilitation providers in the United States. The established leader in the field of rehabilitation for more than a quarter of a century, American Rehab services its more than 800 member facilities by effecting changes in public policy, developing educational and training programs and promoting research. In addition, it provides networking and communications opportunities, all of which helps to ensure quality care and access to services to more than four million persons with disabilities each year.

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.

PURPOSE

The number of people who obtain health care coverage through various types of managed care plans is growing. It is an article of faith among many policy makers that "managed care" is the appropriate, if not the only, way to slow the rate of growth in health care expenditures. Managed care plans, primarily health maintenance organizations, are replacing indemnity carriers as the insurer of choice for many corporations. State Medicaid programs increasingly are using managed care in one form or another. Various members of Congress are advocating the provision of incentives for enrollment in managed care plans by Medicare beneficiaries as a means of reducing costs (or at least reducing the rate of increase of costs) of the Medicare program.

In concept there are two reasons why managed care plans can provide care at lower cost than traditional forms of insurance and health care delivery. First, it is assumed that by hiring or contracting with providers of services to significant patient populations, HMOs and other managed care plans can achieve economies of scale (or drive hard bargains). Second, through "management" of care through gatekeeper physicians and other controlling mechanisms they can avoid delivery of ineffective or superfluous services and, thereby, avoid the associated costs.

In fact, there is a third factor, denial of services. Enrollees may find that certain services are not provided, either because they are deemed to be unnecessary or because of contract limitations, the effects of which are not appreciated until it is too late. This observation is not to suggest that HMOs and other managed care plans seek to deceive enrollees, but rather that certain specialty services which are utilized by a small number of enrollees do not receive adequate attention by either the plan or the enrollee until the service is needed.

This is often the case for rehabilitation services. Rehabilitation is designed to restore or improve physical and cognitive function after a disabling event or illness. Typically disability is produced by traumatic injury, stroke or neurologic disease or congenital problems. The ability to walk, talk and perform activities of daily living can be restored or enhanced through a coordinated program of therapies and other services. Depending on the medical condition of the patient, such services may be provided in a rehabilitation hospital or unit, a skilled nursing facility, on an outpatient basis or in the home.

This testimony provides a brief overview of the treatment of rehabilitation by managed care plans and suggests ways in which present or potential enrollees may make informed decisions about a managed care plan's coverage of same.

BACKGROUND

Managed care plans do not always fully delineate the scope and duration of covered services, explicitly state what is or is not covered, disclose incentives for or against use of various services or provide mechanisms for resolution of disputes with enrollees about the need for services. Relatively few people utilize rehabilitation services in a given year; about four million people receive some type of therapy service annually. Of this total about 400,000 are admitted to a rehabilitation hospital or a rehabilitation unit in a general hospital. Thus, the chance that a given individual will need rehabilitation services is slight.

While HMO Medicare plans are to cover all Medicare benefits, when the need for rehabilitation services does arise, enrollees find that managed care policies frequently limit or restrict access to services. To avoid such circumstances managed care plans should provide adequate information to consumers to enable them to understand what they have purchased and their rights in case of disputes about the need for services. These issues will arise in the 104th Congress as consideration is given to restructuring the Medicare program.

This means that coverage of such services is not a major consideration when a choice is made to enroll in a managed care plan. When the need for rehabilitation services does arise, enrollees find that contract limitations or managed care policies bar or limit access to services. To avoid such circumstances managed care plans should provide adequate information to consumers to enable them to understand what they have purchased and their rights in case of disputes about the need for services. These issues will arise in the 104th Congress as consideration is given to restructuring the Medicare program health insurance reform, and Medicaid and ERISA waivers.

The Association has heard repeatedly about instances where Medicare beneficiaries are not referred for rehabilitation services or where services have been limited in duration, not allowing for maximum or (even adequate) functional recovery, or, the site of services is inappropriate. Most recently the Association heard of a group of physicians who in preparing their profile in order to contract with local HMOs, refused to refer a patient with a hip fracture and prothesis to a local rehab hospital. The hospital had a critical path for such patients whereby the patient would be sent home, walking within in one week, or less. The physicians, wanting to theoretically save money, sent the patient to an alternative site where the patient never got out of bed; received only bed side physical therapy; developed serious pressure sores and the cement on the prothesis cracked. He was readmitted to the acute care hospital and receive another hip prothesis, after the complications of the pressures sores were corrected. Then he was referred to the rehab hospital. While the physician's profile may not show the readmission and subsequent rehab referral, the Medicare program had to bear the cost of this decision, the readmission and the complications that could have been avoided.

Also, an American Rehab study of HMO coverage of rehab services found that one-half of the

or 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 failure to refer for needed specialty care; not having enough contracting specialty physicians available or having financial incentives to delay or prohibit referrals to specialty physicians; and failure to refer for rehabilitation. Additional studies by MATHEMATICA, Inc. have raised similar concerns.

These issues reflect several points.

1. Managed care plans enrolling Medicare patients are required to provide at least the same coverage as the Medicare fee for service. There is no 60-day limit on inpatient rehabilitation service under Medicare, as there may be for non-Medicare enrollees.

2. Most stated coverage assumes advance approval by the managed care plan and/or "continual functional improvement". The standards to be applied in making such judgments are not stated, leaving grounds for dispute between enrollees and the plan in question.

3. There is no disclosure of incentives for gatekeeper physicians and other representatives of a plan to provide or withhold care.

Additionally, several studies have found that rehabilitation services are restricted or limited. For instances, at the request of HCFA, MATHEMATICA Policy Research, Inc. conducted a study :o assess whether this risk program proved to be cost-effective and whether the delivered care ɔf HMOS was of comparable quality to that provided by FFS providers. A report of the study, ***Does Managed Care Work for Medicare? An Evaluation of the Medicare Risk program for HMOs***, was released by MATHEMATICA Policy Research, Inc. in December 1993.

The results indicated that the risk program does not save money for HCFA and, in fact, costs are ıigher than they would have been had the enrollees not joined the HMOs. Costs under the risk ɔrogram were 5.7% higher than they would have been under the FFS because beneficiaries with :hronic health problems were less likely than healthy beneficiaries to enroll in HMOs, and the ɔayment (capitation) rates failed to reflect this favorable selection fully. Although payment rates o HMOs were set at 95% of HCFA's projected FFS cost for enrollees, these projections were oo high, by about 11% on average. HCFA's simple method of basing the payment rate for ndividuals on their age, gender, and a few other readily available characteristics fails to account 'ully for the healthier-than-average mix of beneficiaries who choose to enroll in HMOs. Thus, nstead of saving 5% as intended, HCFA spent nearly 6% more than it would have for enrollees ıad they not joined the HMOS.

\nother study, ***The Quality of Care in TEFRA HMOs/CMPs***, was released in December of 992. This study found that overall medical care for strokes and colon cancer was comparable o that in the fee-for-service sector. Any reduction appeared to be influenced by patient severity. Therefore, the researchers found that HMOs were cutting costs for these patients who needed the ervices least. In terms of speech and physical therapy visits for stroke patients, HMO enrollees ended to receive fewer services and were discharged with greater deficits than non-enrollees.

These excerpts from various managed care plans reflect three points of likely confusion.

. First, overall limitations are framed in terms of time or number of days of services per condition, leaving considerable ambiguity about what constitutes a condition.

.. Second, managed care plans enrolling Medicare patients are required to provide at least the same coverage as the Medicare fee for service. There is no 60-day limit on inpatient rehabilitation service under Medicare.

. Third, most of the coverage stated assumes advance approval by the managed care plan and/or "continual functional improvement". The standards to be applied in making such

judgments are not stated, leaving grounds for dispute between enrollees and the plan in question.

4. Fourth, there is no disclosure of incentives for gatekeeper physicians and other representatives of a plan to provide or withhold care.

DISCLOSURE OF REHABILITATION COVERAGE

For these reasons, the Association recommends that managed care plans enrolling Medicare beneficiaries fully describe coverage of rehabilitation services and that any limitations on such coverage be clearly delineated. The following principles are recommended for inclusion in any legislation designed to foster the use of managed care plans by Medicare beneficiaries and others.

1. Plan Information

Plans should provide uniform written descriptions of their benefits, services and procedures that clearly and fully disclose limitations of coverage, exclusions and out-of-pocket costs, including copayments, deductibles, coinsurance, and established aggregate maximums on out-of-pocket costs.

2. Assessment

Primary care providers should perform a rehabilitation evaluation within 72 hours of seeing patients who fall into the diagnoses most commonly treated by rehabilitation, and who have a specific functional level as measured by a common rehabilitation assessment tool.

Then if an enrollee is a candidate for rehabilitation and meets the existing Medicare inpatient rehabilitation hospital or outpatient guidelines he or she should have access to and be referred for those services.

3. Quality

Managed care plans should be accountable for the quality of care provided. They should ensure adequate access to services for all their enrollees. Outcomes, both medical and functional, should be reported by plans to the government and to enrollees.

To do so, plans should have mechanisms in place which measure quality, access and outcomes. This would include: (a) functional improvement; (b) maximum waiting periods for appointments, both initial and followup, and for referrals to specialists; (c) maximum travel distances; (d) readmission to the hospital; and (e) submission of data to the public on outcomes to assess the cost and quality of health care.

4. Specialists as Gatekeepers

Enrollees who require ongoing, specialized health services should be able to choose a specialist as a gatekeeper in order to effectively manage the services appropriate to their conditions. Relevant specialists should also be directly available to enrollees without gatekeeper approval where continued specialized care is medically indicated.

Physician referrals to physician and non-physician specialists should be based solely on the needs and desired outcomes of the patient.

5. Point-of-Service Option

This provision is critical to allowing persons with specialized health care needs to obtain care from out-of-network providers, assuming they opt to pay the extra premium and co-payments as necessary. It retains the ability of closed-panel HMOs to contain costs, but

also allows enrollees the flexibility to opt out of the provider network if they pay a little more for this option.

Consumer and Provider Due Process

Plans should set forth procedures to be followed in the resolution of disputes with enrollees about required services and the adequacy of those provided by the plan. Grievance mechanisms should be timely and fair.

Grievance and appeals procedures should:

a) be available to both enrollees and providers, including timely review of a service denial;

b) be clearly communicated to all parties;

c) require independent second opinions to be obtained promptly when covered benefits are denied for any reason;

d) require an expedited appeals process leading to a decision within 72 hours of the initial complaint.

Arrangements with Providers

Plans should enter into agreements and other arrangements to ensure an appropriate mix, number and distribution of qualified health professionals to adequately provide for the plan's benefit package.

Utilization Management Protocols

Utilization review should be performed by qualified personnel knowledgeable in the field in which a coverage decision is being made. Qualified health professionals, including rehabilitation providers and other specialists, should be involved in the development and implementation of utilization review procedures and practice guidelines.

Consistency

Plans should be consistent in the information required, i.e., data elements and methods of analysis, evaluation criteria, assurance of non-discrimination among classes of providers, uniform quality and utilization standards, outcomes assessment, assurance of access, fair and adequate reimbursement, consistency of record-keeping requirements.

Case Management

Life plans (long term care planning) should be developed for individuals with chronic or catastrophic conditions in consultation with the individual and family members.

STATEMENT OF

AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS

to the

Committee on Ways and Means
United States House of Representatives

June 8, 1995

RE: Medicare HMO Enrollment Growth and Payment Policies

The American Society of Plastic and Reconstructive Surgeons (ASPRS) represents 97% of the nearly 5,000 board certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services which improve both the functional capacity and quality of life of our patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, and cancer.

I. Background

Enacted in 1965, Medicare has proven to be a great success in improving the health status of the elderly and disabled, keeping them in the mainstream of American medical care. However, Medicare suffers budgetarily due to its fundamentally flawed financing structure and erroneous budget projections.

According to an April 3, 1995 report by the Social Security and Medicare Boards of Trustees, Medicare's Hospital Insurance Trust Fund is projected to be insolvent by year 2002 and will pay out more than it takes in beginning in 1996. This warning comes after several years of severe cuts in Medicare's physician payments. Physicians account for 23% of Medicare outlays, yet have absorbed 32% of provider cuts over the last decade. Even with these levels of cuts, for years 1991-93, physicians have succeeded in actually holding down volume increases below projected levels, thus saving the program billions in projected dollars.

In response to the recent insolvency projection and in an attempt to reduce the federal budget deficit, Congress has begun to consider restructuring the Medicare program along with further proposed reductions of $250-300 billion over the next seven years. Some are projecting as much as $100 billion in savings to come from expanding managed care into Medicare program, although the Congressional Budget Office (CBO) is skeptical about managed care programs generating any significant amount of savings.

II. Expanding Managed Care to the Elderly Population Will Not Result in Savings for Medicare

A number of policy-makers and academics have cited the potential of managed care to generate significant savings from Medicare and slow the rate of growth of the program. Managed care is premised on the notion that effective case review can lower overall costs without affecting the quality of care provided. However, it is highly unlikely that managed care will be the panacea for Medicare's financial crisis nor does it adequately serve the program's bottom line.

In the private sector, managed care has produced one-time savings through provider discounts, but has not slowed the long-term rate of growth of health care expenses. As for serving an elderly population, studies have consistently shown that Medicare managed care programs do not save the government money and do little to address the long-term problems

facing Medicare. Experience of the Medicare risk contract program confirms that the healthiest segment of Medicare beneficiaries tend to enroll in managed care, while the older and sicker beneficiaries do not appear willing to change doctors or give up their freedom to choose a particular specialist or hospital.

In testimony to the Senate in February, the CBO testified that HMOs attract healthier members of the Medicare population and "there may also be a tendency for HMO enrollees to switch to the fee-for-service alternative when severe health problems arise." When sicker beneficiaries return to the fee-for-service pool, the HMOs are relieved of the costs associated with providing the patient with advanced services and necessary equipment. This favorable selection holds down the managed care plans' expenses, but can result in major losses to the Medicare program overall.

A 1994 General Accounting Office report explains that "as more healthy beneficiaries join HMOs, the Medicare fee-for-service population on average becomes sicker, driving up Medicare's average costs of treating fee-for-service patients. When this average cost rises, so does the capitation rate HCFA pays to risk contract HMOs."

Favorable selection results in Medicare over-paying managed care to treat the healthy and then being forced to swallow the costs of the older and sicker who return to fee-for-service in the later stages of life.

There is no reason to believe that expanded enrollment in Medicare managed care programs will prevent favorable selection. The GAO concluded last year that "favorable selection is not likely to disappear once larger numbers of Medicare beneficiaries are enrolled in HMOs."

III. Managed Care Lacks Capacity to Serve Entire Nation

There are also limits to the ability of managed care programs to serve rural areas that do not contain sufficient population to sustain effective HMO competition. After all, nearly one in three Americans live in such rural areas. According to a study published in the New England Journal of Medicine, communities with less than 180,000 people may be too small to support effective competition among managed care providers.

HCFA Administrator Bruce Vladeck cautioned that "the movement toward managed care cannot outpace the capacity of managed care plans to serve large numbers of new enrollees, particularly those with expensive and special health needs of the Medicare population."

IV. Managed Care is Not Suited to Handle Unique Health Needs of Elderly

Cost is not the primary concern of the elderly. This reduces their sensitivity to pricing and their tolerance for slower, less tailored care. The special health needs of Medicare enrollees place them at higher risk for failure of managed care to provide timely access to needed care. The drive to hold down costs may threaten the health of senior citizens enrolled in the program. Numerous studies have cautioned about the adverse effects of HMO participation by the elderly. In responding to financial pressures to provide care at a low cost, HMOs may restrict care too much, leading to lower quality care. In recent years, seniors have expressed their dissatisfaction with Medicare managed care by disenrolling from the Medicare risk program in large numbers.

A study published in the May 1994 issue of the New England Journal of Medicine questions the ability of managed care to treat chronic conditions prevalent within the Medicare population. The study suggests that HMOs may be ill-suited to handle the needs of individuals with conditions that demand extended and repeated medical attention.

It is not realistic to assume that managed care delivery systems will effectively serve our seniors. As retirees grow older and sicker, they become increasingly dependent on ready access to specialists and treatment of their choice. Their expanded reliance on prescription

drugs and advanced treatments will put them at odds with organizations that are under pressure to look squarely at the bottom line. An 1994 study of HMO performance warns that little evidence exists that the performance of prepaid care in relatively healthy populations can be replicated among sicker patients.

V. Medicare Changes Should Encourage Personal Responsibility in Health Care Spending

Further short-term reductions of expenditures and the expansion of managed care will not solve Medicare's budgetary problems. The Medicare program requires serious, long-term transformation if its promise is to be preserved for future and current generations.

Any formulation of a long-term solution should include the principles of enhancing inter-generational equity in financing, reducing regulatory and administrative complexity for patients and physicians, and facilitating price competition among physicians.

Moreover, we believe that a crucial component in reducing the rate of growth in the cost of Medicare and health care in general is encouraging personal responsibility and cost-consciousness at the point of service.

In restructuring Medicare, a possible solution for Congress is to provide the same tax incentives for Medical Savings Accounts (MSAs) as given traditional employer-paid health benefits.

The enactment of MSAs, as proposed in various bills pending in Congress, would be an important step in moving away from the current system of first-dollar coverage provided by third parties, and toward returning control over health care spending to individuals and decreasing costs by lowering utilization. ASPRS welcomes chairman Bill Archer's initiative in this area and encourages the committee to develop this approach concurrent to its changes in the Medicare program.

VI. Medicare Patients Enrolled in Managed Care Should be Provided With Certain Protections

To the extent that managed care expands within the Medicare program, ASPRS strongly believes that beneficiaries should be provided with formal safeguards to ensure that the profit motive does not endanger patient care. Also, seniors should be fully informed about the coverage, restrictions and procedures of various plans.

To protect Medicare patients enrolled in managed care from potential abuses of managed care, ASPRS recommends that Congress adopt the following safeguards:

- Financial incentives should not be allowed to interfere with medical judgment. For instance, plans should be prohibited from establishing arrangements in which the gatekeeper has a financial incentive to not refer patients. The patient's first point of contact should be encouraged to make all needed medical referrals and should not feel constrained financially from doing the best job for the patient;

- Point of service options should be mandatory for all plans with limitations on out-of-pocket expenses to patients. Patients should be able to opt out of any closed system to seek the specialist of their choice. The financial penalties that accrue to such an opt out, or "point of service" should be capped. This option is the ultimate consumer protection against poorly managed health care plans, or those that unduly restrict access to necessary specialty treatment;

- Plans should be required to provide the full range of specialized care for enrollees with rare, unusual or highly complex conditions, and should provide all appropriate specialty services in accord with clinical practice guidelines established by recognized specialty societies. Direct access to specialty care is essential for patients in

emergency and non-emergency situations, and for patients with chronic and temporary conditions, as well as those with unexpected acute care episodes. Specialty care must be available for the full duration of the occurrence, and not limited by time or number of visits;

- Beneficiaries should have the ability to disenroll from managed care programs at any time. This would provide an important incentive for plans to provide high quality care;

- All plans participating in the Medicare program should be evaluated in a consumer "report card" in part on the basis of the timeliness of access to specialty care and the quality of that care as established through the credentials of the physicians and the outcomes of their treatments; and

- Plans should provide potential enrollees with clear information about the services covered and excluded, and information on patient satisfaction with the particular plan.

VII. Conclusion

ASPRS is opposed to proposals to expand managed care to the Medicare population as such a nove will not result in savings for the program, while risking the health of the elderly.

The Medicare program should be restructured to encourage personal responsibility in health care spending and decrease reliance on third-party payment. Enactment of MSAs is mportant to accomplishing this objective.

Medicare patients enrolled in managed care should be provided with safeguards protecting heir quality of care, access to necessary specialty services, and ability to disenroll from a particular managed care plan.

ASPRS appreciates the opportunity to testify on the topic of Medicare before the Senate Committee on Finance, and is available as a resource on this issue as the Committee continues its work.

Coalition of Mental Health Professionals and Consumers, Inc.
P. O. Box 438, Commack, NY 11725 Phone/Fax: 516-424-5232

Testimony

Karen Shore, Ph.D., Executive Director
1966 Ashley Place, Westbury, NY 11590
516-997-3390

A) Introduction:

I am submitting testimony on behalf of the Coalition's approximately 1250 members. The Coalition is a national, grass-roots organization, made up of clinicians from all mental health disciplines and consumers of mental health care, their family members, and their advocates. The Coalition is working with approximately 24 regional "affiliated groups" that have no legal tie to the Coalition, though some have taken out memberships. Thus, I am not officially testifying for these groups, but do want the Subcommittee to know that several of these groups are state or regional Coalitions (MA, NY, NJ, PA, DE, MD, NC, GA, TN, IL, OH, CO, CA, WA, MO) that have been inspired by our Coalition or that formed prior to our forming (November, 1992), have similar goals, and are attempting to work together. Each of these groups may have dozens, hundreds, or thousands of members.

I am testifying because of plans to increase the number of Medicare beneficiaries to be enrolled in HMO's and other forms of managed care. The Coalition formed specifically because of the decline in quality of mental health treatment brought by managed care organizations (MCO's). MCO's also have a strong impact on the ability of professionals to deliver proper care. The problems of managed care have the most impact on beneficiaries who need treatment, as opposed to those who are generally healthy. Thus, a larger percentage of the Medicare population covered by MCO's than of the general MCO population will experience these problems, as our elderly generally require more treatment than does the general population.

In this testimony, I will outline the problems we have seen in delivery of services under MCO's in the private sector and will offer recommendations. We cannot assume that Medicare beneficiaries will receive better care under MCO's than those in the private sector.

B) Problems with Managed Mental Health Care for Consumers and Providers:

1. Citizens lose the right to freely choose clinicians and treatment facilities.

a) MCO's increasingly limit their provider list to providers who demonstrate a willingness to perform short-term treatment, whether or not it is truly appropriate, and on their willingness to do so without complaint. Thus, the pool of providers available to the consumer may exclude those who would perform or advocate for quality care.

b) Primary care providers often must act as gatekeepers and may limit access to psychiatrists and to psychotherapists. Often, there are financial penalties if primary care providers make "too many" referrals. Corporate profits are often more important than the consumer and treatment. Primary care physicians are asked to do "counseling," but do not have the training to do real psychotherapy.

c) MCO panel limitations often cause the consumer to travel a great distance for their care, which could be especially burdensome for the elderly, and may prevent needed care.

d) Consumers may have to change clinicians often as plans drop providers and merge with other MCO's, or as the consumer changes health plan. Continuity of care and the building of trust in the clinician are impeded. Continuity of care and trust may be particularly important for the elderly, who often are more in need of ongoing treatment than the general population.

e) Clinicians are impeded in their ability to make the best referral possible due to panel restrictions preventing them from referring "out-of-network."

f) Generally, psychiatrists and other doctoral-level clinicians, and even master's level clinicians, may be prevented from performing psychotherapy by MCO's, as MCO's often search for the "cheapest" clinicians. One MCO reportedly has begun using bachelor's level counselors rather than professionally trained master's and doctoral level professionals. When beneficiaries cannot receive reimbursement for treatment by clinicians with advanced training, quality of care is compromised.

g) Patients hospitalized in a non-network hospital in an emergency may be forcibly transferred to a network hospital before they are well, impeding recovery and possibly increasing symptoms.

h) Even if the MCO offers out-of-network benefits (Point-of-Service Option), consumers with limited incomes may be unable to access out-of-network providers, as they are financially penalized for doing so. This may affect the elderly in large proportions due to the large percentage on limited incomes.

2. Patients lose the right to make their own treatment decisions.

a) The MCO may pre-determine that all or most patients are to receive brief hospitalizations and brief, crisis-focused psychotherapy, regardless of patients need. This is based on decisions about money, not treatment and consumer need.

b) The MCO often requires reports from the treating clinician and then takes over treatment decisions. The patient and his/her clinician may be powerless to decide the course of treatment. The sense of powerlessness and the prevention of access to proper treatment may increase a patient's symptoms, especially depression and anxiety. Hospitalization or intensive psychotherapy for a particular patient may be declared "not medically necessary," even though the standards of practice in the professions would clearly show the need for treatment.

c) What is "medically necessary" varies from one MCO to another, as it generally has more to do with costs than with care.

d) Many MCO's will only authorize three or four psychotherapy sessions at a time, leaving the beneficiary and provider unable to know how long their work will be able to continue. Anxiety often rises before each "approval" and session time is often spent on discussing the MCO, rather than on the problem for which the patient sought treatment.

e) Some MCO's deny funds for psychotherapy if the patient refuses medication. This is because medication may produce a fast relief of symptoms, even though it may actually fail to correct the actual problem. This then allows the MCO to discharge the patient without investing much money. In general, there is concern that too many of our elderly are already over-medicated. Often, they are considered too old to make changes and not good candidates for psychotherapy, which is not necessarily true. This puts the elderly at increased risk of over-medication. Further, there is a bias among some physicians and scientists toward medication and away from "talk therapies," but this may reflect little more than an honest bias and the difficulty of forcing "talk therapy" into the molds of empirical science. Patients may have a strong need to talk out their problems, yet their voices do not count under managed care.

3. Consumers lose the right to privacy under managed care.

Because reports must be submitted to the MCO by the provider in order for the MCO to determine whether or not continuing care is "necessary," information that should not leave the treatment room must be given to the MCO, which may store it in their data banks. Psychotherapy patients often require privacy over information involving personal problems. Many consumers are not at all comfortable allowing such information to be divulged, but may have to sacrifice reimbursement if they withhold this information. Under Medicare, psychotherapy providers are not permitted to treat beneficiaries outside the plan. Thus, those requiring privacy or those with paranoid conditions may be forced to forego needed treatment due to inappropriate cost-containment techniques that may be suited to "industry," but not to human services.

4. MCO's may be grossly under-treating consumers of mental health care due to cost-containment. Because it is illegal for psychotherapists to provide treatment for Medicare beneficiaries outside of Medicare, those consumers who need treatment beyond what the MCO dictates may be prevented from legally obtaining needed services.

a) Many MCO's provide a grossly inadequate model of "short-term therapy," "solution-oriented therapy," "crisis intervention," or "stabilization," or they may state that they only treat the "acute phase" of a problem, refusing to pay for proper treatment for "chronic" or "ongoing" problems. This is a standard that would never be tolerated in medical care, and should not be tolerated in mental health care. Examples of MCO literature stating these limits can be provided to the reader.

b) Many patients need time to build trust in the clinician and to tell their story. Patience and understanding from the clinician are as necessary as advice. The clinician needs to spend enough time with the patient in order to know if the problem goes deeper than the surface "presenting problem." These things are too often impossible under managed care.

c) MCO's are misusing research data by not speaking to the limits of the research in order to support their bias toward short-term treatment.

d) Even though the literature in many MCO plans may state that beneficiaries may have "up to 20 sessions" in a year, often times the companies' reviewers are told never to allow more than a few sessions (see vignettes), or providers are warned that if they average more than a few sessions per patient, they will be ejected from the panel or refused further referrals. Thus, the provider may be too afraid to give the consumer the treatment that is needed.

e) A recent Harvard study (James Hegarty, MD, at McLean Hospital, Boston, as reported in *Newsday*, "Study: Managed-Care Squeezes Hospital Stay," 5/24/95) showed that there has been a dramatic increase in re-hospitalizations of psychiatric patients under managed care due to premature discharges. The average length of stay (LOS) at McLean in 1989 was 45 days. By 1994, due to managed care, the average LOS was 15 days. There was a concomitant increase in the number of people readmitted within a month, from 0% in 1989 to 21% in 1994, and an increase in patients who were minimally improved or worse at discharge than at admission, from 4% to 18%.

f) The industry is ignoring 100 years of development in the field of psychotherapy and is creating standards for treatment that are *substandard*.

5. Many managed care provider contracts contain "non-disparagement clauses," prohibiting the provider from saying anything negative about the managed care company to the patient or anyone else, often preventing providers from making the consumer aware that he/she is not receiving proper care.

Consumers are prevented from accessing professionals who follow their ethics and refuse to sign such agreements, as these providers will not be included on the MCO's panel. Also, this can mean that if a panel provider believes that the MCO's recommendations would be harmful to the patient, the provider may not tell this to the beneficiary. The consumer should have the right to know his/her provider's opinions of treatment decisions made by the MCO, especially if the provider believes that the MCO's decision is not in the patient's best interests. Also, these clauses prevent managed care abuses from reaching the press and legislators.

6. Patients may find that they must fight for benefits when they are ill, when their energy should be spent on getting well.

Patients never know whether or not their treatment will be covered until they become ill. Since providers may be at risk if they advocate for the consumer, this leaves consumers often having to spend their energy on advocating for themselves when needed treatment is being denied. Patients who do not have the ability, self-confidence, or energy to advocate for themselves may be seriously under-treated. Often, mental health patients are too derpressed, anxious, or too humiliated by their problems to advocate for themselves. With providers being at risk for unemployment if they advocate for their patients, there may be no one left to advocate for the elderly patient, especially if family is uninvolved or lives far away.

7. Under managed care, many providers fear doing what is right for the patient, putting the consumer at risk.

Since the MCO's now decide which providers will be able to continue working, many have been frightened into silence. Many feel too powerless to protest poor treatment of consumers to the MCO, the press, or to their legislators. When New York State's Assembly held hearings on managed care in January, 1994, several providers told me they were too afraid of being identified by the MCO's to testify. Their fear was that they would be ejected from the networks, refused referrals, or that their patients would be refused future sessions. These very real threats put the consumer at risk, especially in mental health, where patients usually do not advocate for themselves, and especially with the elderly patient, who may not be able to advocate for him/herself.

8. Quality and quantity of care will always be a problem under managed care and any form of capitation, as *there is an inherent conflict of interest when an entity that is supposed to offer care, be it an MCO or an individual provider, keeps whatever money is not spent on treatment.* This is especially destructive when mental health is under-capitalized.

a) MCO's keep money that is not spent on treatment. Corporate profits are soaring while beneficiaries are prohibited from receiving care for chronic and ongoing problems and are being discharged from hospitals prematurely.

b) Even capitated contracts that are made between employers and providers directly, bypassing MCO's, are problematic. One California therapist told me that she was called by a capitated plan and told that she would receive approximately $235 for each patient they send her. Obviously, if she performs one session only, she does very well. She still does well if she performs only two. Obviously, if the patient requires 10 sessions, she is receiving poor wages (with no benefits) for someone with a doctorate or even a master's degree. If the patient requires 40, 50, or more sessions, it becomes ludicrous. Thus, there is a strong incentive to under-treat, and clinicians may simply not be able to afford to

treat patients properly due to under-capitation. It is the bias of the corporations that people should only require 1-3 sessions. This is not reality.

c) It is true that under the fee-for-service system, there was some incentive to over-treat the patient. However, not all providers over-treated, as wise clinicians knew that they would receive future referrals from patients whom they treated appropriately. Also, under a fee-for-service system, if a consumer feels that he/she is not being treated properly, he/she can easily leave that clinician and find another. Further, a system of appropriate co-payments, when used by the insurers, encouraged consumers to be cost- and utilization-conscious.

9. Despite claims that managed care and managed competition comprise a "free market solution," there is no free market for the patient, the actual consumer of health care.

a) Managed competition is really about the elimination of competition. As consolidation continues, only a few large insurers will remain.

b) In several areas, the industry already controls 90% of the market. Where managed care squeezes out fee-for-service plans, *there is no competition for managed care itself.* A lack of competition always bodes poorly for quality.

c) A free market for the patient would mean that the patient is the one who would determine what care is needed, determine the value of that care, and choose freely from all who are qualified to provide that care. Managed care does not allow the patient these liberties. As managed care becomes an arrangement between employers or governments and the insurer, and the "consumer" becomes the employer or government, for they pay the premiums, the "free market" exists between the MCO and the payor. Under managed care, the MCO determines who will receive what kind of treatment, for how long, and who can deliver it. The true consumers of care, the patients, as well as the body of professionals who could administer care, are kept out of the "marketplace."

d) The managed care industry controls both supply and demand in regard to health care services. MCO's have declared that there is an over-supply of mental health professionals. This is predicated, however, on the industry's assumption that only brief forms of crisis-oriented therapy are needed, and that few people need treatment. This is not based upon true demand, which would be based upon the citizens' requests for care. Although fee-for-service is a "subsidized" market, it is still based on a more true supply and demand than under managed care. Under a fee-for-service system which had, in recent years, seen extremely high co-payments for psychotherapy, the demand for services was far greater than what is allowed under managed care. There will soon be a drastic shortage of mental health professionals and other providers, for the number will be based on what the managed care industry "needs," not upon what our citizens need. This will affect our entire society.

C) **Recommendations:**

1. Allow Medicare beneficiaries to choose among a variety of health plans, including fee-for-service plans, Medical Savings Accounts, MCO's, and any other type of health plan that currently exists or is yet to be devised.

a) Medical Savings Accounts (MSA) are attempts to return the rights of the "free market" to the actual consumers of health care. Incentives are provided that make the consumer cost- and utilization-conscious. Up to the catastrophic limit of the MSA, the consumer retains the right to choice of provider, the right to privacy, and the right to make his/her own treatment decisions.

b) There are some problems with MSA's, however:

i) Beyond the catastrophic limit, the consumer retains freedom of choice, but loses privacy and the right to make his/her own treatment decisions, as treatment may be subject to utilization review. However, because there are no panels, and MCO's can't threaten the providers with unemployment, providers are free to advocate for patients.

ii) The standard MSA contract written by the Golden Rule Insurance Company, has a limit on mental health services of $10,000 per year per individual. This is generally adequate for a patient requiring only psychotherapy, but not for one requiring a day treatment program or hospitalization.

iii) There is some concern that MSA's will not be appropriate for those who are unable to be responsible for their funds. This may affect some of the elderly. It may be necessary to arrange for a relative to make MSA decisions or, when there is no such relative close by, for a consumer case manager (not a case manager contracted by the insurer) to do so.

c) Some MSA plans are combined with MCO's. Again, this penalizes consumers for using out-of-network clinicians, which limits their choice of providers, especially for those with a limited income.

2. Return control over health care to the citizen:

a) Phase out employer involvement in health care. It no longer works. For employees, premium money actually belongs to the employee, for it is taken from his/her wages. Return this money to the employee so that employed citizens can purchase, own, and control their own health care plans. Under Medicare, and for citizens with limited incomes, beneficiaries should be expected to pay a portion of their premiums, based on their incomes, with government paying the balance.

b) Return the three basic rights consumers have lost under managed care (choice, privacy, and decision-making). Employees lost these rights because we now expect employers to pay for insurance, and because employers needed to cut costs once the patient became separated from the consequences of their decisions under the fee-for-service system. Citizens have been separated from the fact that it is their money to begin with, and the greater the separation, the less care they take with that money.

c) In order to protect their freedom, citizens must be financially responsible for their care to whatever extent they can afford to be so.

i) Medicare beneficiaries with adequate incomes would buy their own plans, or at least pay for a portion of their premiums. Government would pay that portion of the premium which is unaffordable for the Medicare beneficiary or other citizens.

ii) Benefit design must create incentives for patients to be cost- and utilization-conscious, without restricting access to care and other freedoms.

d) Individual mandates might be considered. Car insurance is required of all who drive, not just of all who have accidents. Why can't health insurance be required of all who live, not just those who get sick? While we might wish to protect the freedom of the citizen NOT to be insured, all citizens must then pay for emergency care and follow-up treatment when an uninsured individual requires treatment he/she cannot afford out-of-pocket.

3. Protect quality care and consumer freedoms by encouraging citizens to buy and own their own insurance plans. Allow a 100% tax deduction for all citizens buying their own health care plans.

All citizens deserve the tax break now given to employers, especially those who are self-employed or unemployed, which may include a large number of Medicare beneficiaries. Also, it is important for a government to encourage people to take care of themselves, so they will be less dependent upon the government for services. The more health insurance coverage one owns, the less dependent one will be on the government for care.

4. Guarantee portability of health care plans.

5. Prohibit "pre-existing condition" barriers to treatment.

6. Guarantee all citizens in MCO's access to "Point-of-Service" options:

Unfettered access to specialists is crucial for those who are ill.

7. Guarantee the right of all citizens, including Medicare beneficiaries, to "contract privately" with providers of their choice.

In the case that a health plan denies reimbursement for a particular service, the citizen must still be allowed to purchase health care he/she believes is necessary. The MCO might be making incorrect decisions. Medicare beneficiaries cannot currently purchase psychotherapy except from Medicare providers. If Medicare comes under managed care, beneficiaries will also frequently be denied more than a handful of psychotherapy sessions, as is already happening to the general population. Most MCO's are only allowing "crisis" care, and are prohibiting true forms of psychotherapy. We cannot make it *illegal* for Medicare beneficiaries, or anyone else, to obtain genuine psychotherapy.

8. Allow the States to regulate the managed care industry.

a) With a true "free market" system, in which the citizen has the ability to make his/her own health care decisions while being given incentives to be cost-conscious, there will be less need for regulation than there is under managed care.

b) Managed care plans frequently short-change the patient, and often prevent providers from advocating for patients and from delivering the best care they know how to

provide. It is imperative that the federal government allow the States to regulate this industry. ERISA laws were not intended for health care. They were intended for pension plans. If employer involvement were phased out, employers would not object to state regulation of health insurance plans.

9. Allow states the flexibility to experiment with a variety of health care plans.

a) Encourage the States and regions to develop insurance plans that involve "freedom with responsibility." MSA's attempt to do this.

b) There are many ideas yet to be devised and written down (e.g., see "Managed Cooperation," item F, below). Please do not lock Americans into any particular form of system, as this will prevent better ideas from being formulated and implemented.

D) Summary:

There are many problems that have already occurred in the private sector under managed care. These problems generally involve the loss of consumer freedoms to make their own treatment decisions, in private, with their chosen clinician. In mental health, the industry has changed the "standards of care" to substandard care.

In general, we urge Congress to institute some insurance reform and to allow the States to regulate the managed care industry. We urge Congress to increase choice of plan for Medicare beneficiaries and others, and to pass legislation that enables the development and implementation of programs that offer alternatives to managed care and managed competition, especially those that re-institute a true free market for the actual consumers of care. We support plans which retain consumer freedom while containing costs by providing incentives for consumers to be cost- and utilization-conscious, thus expecting some financial responsibility from the consumer, according to the financial means of the consumer.

E) Vignettes from Managed Mental Health Care - see pages 7 & 8.

F) "Managed Cooperation:" A Medical/Mental Health Care Plan - see pages 9 & 10.

These pages contain ideas ("Managed Cooperation") designed by the Coalition. Many of these ideas could be helpful in designing systems of cost-containment that put the consumer of care back in charge of his/her own treatment.

COALITION OF MENTAL HEALTH PROFESSIONALS AND CONSUMERS, INC.
P. O. BOX 438, COMMACK, NY 11725
PHONE/FAX: 516-424-5232

Original Vignettes (#1)
Managed Mental Health Care
(Revised 12/18/93)

The following vignettes are summaries of managed care (MC) cases. Decisions about who can be in treatment, how long treatment can continue, what type of treatment patients can have, and who can provide it, are being made by the MC companies. While they state they are basing decisions on "medical necessity," the companies cannot be free of a need to themselves be profitable. Unfortunately, the cases below are not atypical.

1. Ten year-old "Susie" was involved in a tragic and frightening accident. She and one parent escaped, but the other parent and her sibling died. "Susie" became mute, and began drawing pictures of a little girl with a noose around her neck. The surviving parent brought "Susie" to their HMO. "Susie" began therapy, but her pictures became increasingly darker (a symbolic indication of deepening depression and increasing suicidal risk). After the ninth session, the parent found "Susie" about to make a suicide attempt. This was reported to the therapist (who had not yet earned a master's degree) at the 10th session. This HMO therapist concluded treatment with the 10th session, stating that "Susie" "should be" finished. "Susie" was still mute and suicidal. Fortunately, the parent had some money available to pay for therapy without insurance coverage. The parent asked a friend for a referral outside the HMO and found a psychiatrist who offered a reduced fee. "Susie" was seen three times/week for 18 months. It took 12 months before "Susie" began to speak again.

2. "Mary," a depressed woman with several physical problems related to her emotional disorder, was denied therapy after 8 visits, even though her policy allowed up to 20 visits. The therapist (licensed) strongly recommended further treatment, but the reviewer (not licensed) refused authorization, saying that he had been instructed not to approve any outpatient treatment beyond 8 sessions regardless of the diagnosis or provider recommendation. "Mary" was too depressed to appeal. Within a month, she was hospitalized for severe gastric distress and required surgery. The therapist believes this was caused by inadequately treated depression.

3. "Jane," a depressed and suicidal woman, had finally left her physically abusive husband. She called her MC company for permission to begin therapy and for a referral. The request was refused. The reason given was that "domestic violence is a social problem, not a psychological problem."

4. "Sean," an adolescent boy, asked to be in therapy. His mother called the MC company for permission for him to begin therapy and for a referral. "Sean" stated he would not be comfortable seeing a male therapist. No list of network therapists is published, so the mother could not find an appropriate referral herself. The company agent refused to offer the name of a female therapist, though there were many in the network in that area. Despite many protests by the mother, the agent gave only names of male therapists, stating: "Listen, if you're sick, it doesn't matter who you see. And if you don't take the names I gave you, I can't help you anymore."

5. "Rosa," a young mother with 3 young children, cuts her wrists. Her HMO approved only 8 sessions. The therapist believes her symptom is due to feelings of anger at the responsibilities of motherhood. As the oldest of 9 children herself, "Rosa" had been over-burdened with responsibility as a child, for her own mother was unable to care for the children. Without appropriate treatment, "Rosa" will not likely understand the reasons for her distress. She will likely continue to cut her wrists, possibly escalating to serious cuts. The potential for child abuse is also present should "Rosa" begin directing her anger outward instead of toward herself.

6. "Henry," a middle-aged man with a childhood history of being severely humiliated, requested treatment due to interpersonal problems, including difficulty trusting others. "Henry" refused to return to treatment when the therapist was required to submit a detailed report about him and his therapy. The therapist finally convinced him to return and they spent much time discussing what the therapist should write. The report was written and more sessions were authorized, but "Henry" never returned for treatment. When the therapist called him, "Henry" said that the experience of having to divulge information to the company was too humiliating for him.

(over)

7. "Steven" experienced increasing depression, panic attacks, and phobic anxiety that prevented him from working. His psychiatrist provided psychotherapy and medication. There was a brief admission to a local hospital for a suicide attempt. After a year of treatment, "Steven's" insurance was changed to a MC company. The psychiatrist joined the network to be able to continue the treatment. The treatment resistant depression and severe anxiety showed some improvement, but the MC company said "Steven" was a "chronic" patient who wasn't showing enough improvement. The psychiatrist had to plead for more sessions. "Steven" did show more improvement. Later, a new anti-depressant helped lift "Steven's" mood and eliminated almost all panic attacks. However, "Steven" then began manifesting increasing manic symptomatology, including spending sprees. Restarting Lithium, which had been helpful in the past, now led to an organic brain syndrome. To be hospitalized under his MC plan, "Steven" would have had to enter the MC company's "anchor" hospital, which was not in his community, and would have been required to change psychiatrists. "Steven" refused to change psychiatrists and thus refused the hospitalization, though he would have agreed to a local hospitalization with his own psychiatrist. The organic symptoms decreased, but the manic symptoms remained. However, the psychiatrist did not feel "Steven" qualified for an involuntary hospitalization. "Steven" endured a full month of manic symptoms, infuding spending sprees. The cost to "Steven" was great in terms of financial, interpersonal and emotional effects before the manic symptoms remitted with outpatient treatment.

8. "Barbara" was in individual and group therapy before a MC company took over her insurance. She had been sexually abused by her grandfather in many horrifying ways between the ages of 5 and 12. She was also abused by a neighbor at age 12. Marital sex was accompanied by terrifying flashbacks of the abuse. The therapist was told by a reviewer to "hurry it along." Unfortunately, the symptoms had worsened because "Barbara" was given a new assignment at work which required her to work with men about the same age as her grandfather. Also, she had recently undergone her first gynecological exam, which left her psychologically disorganized for several weeks. The reviewer, a psychiatrist, asked if "Barbara" was suicidal. When the therapist said she was not, the reviewer disallowed further group treatment, stating she was just "following company policy." Group treatment, in addition to individual treatment, is often extremely important for sexual abuse survivors.

9. "Linda" was in treatment for about 1 1/2 years before a MC company took over. "Linda" was unable to tolerate anti-anxiety medication, but did respond to psychotherapy. Toward the end of the second year, "Linda" witnessed her 22 year-old daughter being hit by a car, leaving her a quadriplegic. "Linda's" symptoms increased dramatically. She was likely manifesting signs of Post Traumatic Stress Disorder. The therapist called the reviewer for permission to continue treatment. The therapist was told: "Well, doctor, let me tell you something. We are going to cut you off - be prepared - its coming down the pike soon!"

10. "Allison" had been sexually abused by two of her brothers for several years during childhood. She was raped as an adolescent, and battered throughout her first marriage. She was in group and individual therapy. Group therapy was later denied by the MC company. When the therapist, a recognized expert in treatment of sexual abuse, told the reviewer that the literature speaks to the importance of individual and group therapy for optimal treatment, the reviewer said: "Listen, we are not interested in providing optimal treatment. We are interested only in providing that which is absolutely medically necessary."

11. "Bill" is usually in control of his anger, but when he loses his temper, he threatens his pregnant wife with a loaded gun. His therapist was encouraged to complete the work in 8-12 sessions. Although the reviewer agreed this was a "long-term" case, he stated that it is not the company's policy to provide long-term treatment.

12. "Jennifer," in her late 30's, noticed pain in one breast, though she found no lump on self-examination. Her HMO doctor also found no lump. "Jennifer," suspecting a problem, asked for mammography. The doctor, who also acted as "gatekeeper," stated that the HMO does not pay for mammography for women under 50 unless there is a physical finding upon examination. With this refusal, "Jennifer" had a mammogram outside her HMO at her own expense. The test showed breast cancer. She decided to sue the HMO. Distressed by the cancer and the refusal of the HMO to provide the services she deemed necessary, "Jennifer" requested psychotherapy to deal with the stress. The HMO refused to authorize psychotherapy for her.

Coalition of Mental Health Professionals and Consumers, Inc.
P. O. Box 438, Commack, NY 11725 Phone/Fax: 516-424-5232

MANAGED COOPERATION

A Medical/Mental Health Care Plan

An idea for the future

(revised 2/14/95)

1. The success of a health care plan will depend on the value system upon which it is based. Cooperation seeks solutions that enhance and are fair to all parties involved.

2. Managed Cooperation optimally balances patient choice and freedom with responsiblility, instills provider responsibility to the patient, and engenders cost- and utilization-consciousness in patients and providers.

3. Managed Cooperation can be written in both single and multiple payer versions.

4. Benefit design would encourage patients and providers to be conscious of costs. When little or no co-payment is expected at the time of service, patients may not be motivated to question a provider's fees or suggested procedures. External controls (gatekeepers, case managers, and utilization reviewers) may then be called upon to do this, reducing patient control over their care. It is important, therefore, for patients to be financially responsible for their care at the time of service to the extent that out-of-pocket expenses are significant enough to the patient that the patient questions providers about fees and recommendations, but not to the point where out-of-pocket costs are burdensome and present a barrier to treatment for those with limited incomes. Sliding scales for premiums, fees and co-payments, deductibles, and catastrophic limits are all possibilities under Managed Cooperation.

5. We suggest a gradual phase-out of employer involvement in health care. When employers buy coverage, they may, understandably, seek to control the care given, limiting the freedom of citizens to make their own treatment decisions, in privacy, with their chosen clinicians. Since the money used by employers to buy insurance really comes out of the employees' income, we encourage a return of this money to employees in the form of income so that they may buy and own their own policies. This returns control over health care choices and decisions to the individual citizen. The possibility of an individual mandate might be considered.

6. Managed Cooperation relies upon regional cooperation. Cost-containment procedures as described below would be carried out by Regional Boards made up of consumer advocates, professionals, government representatives, and insurers (if a multiple payer plan is used).

7. Annually or every other year, Regional Boards would recommend fee ranges and insurance reimbursement levels for each procedure and send this information to consumers, clinicians, and insurers (the government if single payer systems are used or to insurance companies if a multiple payer system is used). Insurers would set dollar amounts for each procedure's reimbursement. Providers would set fees, preferably on a sliding scale, starting with a fee minimally above the reimbursement, up to a reasonable "full fee." The co-payment would be the difference between the reimbursement and the fee for the patient's income level, and could be legally waived if necessary. Clinicians would provide current and prospective patients with their fee schedule

upon request. The intention is to provide true discounts for those with limited incomes. The Board's recommended fee ranges would protect wealthier patients from being over-charged. High-priced clinicians would have to be able to justify their fees to patients. Caps on fees and the mandatory use of sliding scale fees could be instituted if a voluntary sliding scale did not adequately control fees. Sliding scales might be able to be used for hospital expenses if the percentage share for costs was graduated according to income (e.g., citizens earning $30,000 might only pay 5% of hospital bills up to a catastrophic limit appropriate for their income, while those earning $300,000 might pay 50% of all bills up to an affordable catastrophic limit.

Under this system: a) the insurer's liability is limited by the fixed reimbursement, b) patients and providers, due to a co-payment scaled to the patient's income, become cost- and utilization-conscious, c) patients could "comparison shop" and have freedom of choice, and d) practitioners would be guaranteed at least a minimum payment for each procedure (the fixed reimbursement), yet would retain some independence to compete in a truly free market based upon training, talent, reputation in the community, and fees.

8. Regional Boards could regulate purchases of expensive machinery; perform outcome studies; focus on fraud and incompetence, rather than micromanagement; and settle disputes between patients, providers, and insurers.

9. Government support for building hospital-based and free-standing primary care centers would reduce emergency room visits and encourage primary care use.

10. Outpatient psychotherapy would cover individual, group, and marital/couple/family treatment, as allowing children, adults, or families to remain in distress is harmful and costly to our country. Coverage for 40-50 sessions/year is recommended, as: a) 85% of patients use less than 26 sessions, even with liberal benefits and no UR (utilization review), b) liberal outpatient benefits reduce inpatient costs and, thus, overall mental health costs, and c) preventing the 15% of patients who need long-term psychotherapy from receiving it may increase society's costs and harm patients and their families. UR can be used to provide additional sessions beyond the annual limit for those who demonstrate strong psychological and/or medical need AND financial need. UR would not intrude on session content or personal information. Inpatient treatment would require UR, but at reasonable intervals. Medication management would be given the same status as any medical visit. Partial hospitalization, half-way houses, and group homes would be supported to reduce inpatient costs and the costs to society of inadequately treated mental health needs. There would be no limit to inpatient care for the seriously mentally ill (schizophrenia, bipolar disorder, major depression, severe borderline personality disorder, etc.), but appropriate UR would be utilized. Patient education would be developed to explain mental health problems, different forms of treatment and psychotherapy, and the educational requirements of different types of clinicians.

11. UR, or at least denials of benefits, would be done by licensed, practicing professionals who are independent of the insurer, and who have training comparable to that of the treating clinician. UR would focus only on those procedures known to be over-utilized.

12. Incentives in the form of partial premium rebates could be used to encourage patients to refrain from submitting smaller claims.

13. Claims procedures would be simplified and standardized, and claims could be submitted either by patients or providers.

TESTIMONY SUBMITTED FOR THE RECORD
CONSORTIUM FOR CITIZENS WITH DISABILITIES

MANAGED CARE AND PEOPLE WITH DISABILITIES

The 49 million people with disabilities in this country include individuals with physical and mental impairments, conditions or disorders, and people with acute or chronic illnesses which impair their ability to function People with disabilities are disproportionately represented among the underinsured and uninsured in America's private health insurance system.

A sound managed care plan can offer several advantages to people with disabilities: well-coordinated care or case management; comprehensive services; the convenience of "one-stop shopping" which minimizes physical and other obstacles to obtaining care; and an emphasis on primary and preventive care. Unfortunately, these potential positive aspects of managed care are usually undermined by the economic incentives inherent in managed care and capitated health plans. Many of these incentives run counter to the interests of all beneficiaries, particularly people with disabilities and chronic health conditions. People with disabilities often have extensive, special, and complex health care needs and are often underserved in these types of plans.

Managed care plans would significantly decrease their costs over time if appropriate services were delivered to people with disabilities and chronic conditions in a timely manner. The provision of appropriate rehabilitation therapies, services, and devices today can substantially reduce secondary, expensive conditions tomorrow. The provision of home and community-based services, including personal assistance services, can greatly save expenditures on institutionally-based inpatient and long-term care. All health plans, particularly managed care plans, should consider their enrollees' long-term health status and seek to maximize their function and independence through primary and preventive care, appropriate rehabilitation therapies and services, and assistive devices and technologies. More often than not, managed care plans simply do not do this.

As managed care is increasingly utilized by both the private and public health care systems, it is imperative that consumer and provider safeguards are established and enforced under Medicare, Medicaid, and private managed care plans.

PROBLEMS WITH MANAGED CARE

Gatekeeper Inadequacies/Choice of Providers

Most managed care plans use "gatekeepers" to manage individuals' care While in theory a gatekeeper provides coordination of care, in reality a gatekeeper can create many problems for people requiring frequent or specialized health care services. Due to financial disincentives, gatekeepers may delay access to critical services which people may need immediately Gatekeepers may also be reluctant to refer patients to specialists because of utilization limits imposed by managed care plans, despite gatekeepers' unfamiliarity with the health care needs of people with specific conditions or disabilities or the medical needs of the chronically ill.

People with disabilities often require specialists with whom the managed care plan may not have a contractual relationship. Another common problem is that of insufficient numbers of specialists in the panels of some managed care plans, leading to long waits for appointments.

Many managed care plans assign enrollees to physicians and do not allow subscribers to choose their own physician who may be familiar with their medical history and health care needs. In addition, most plans do not allow specialists to serve as a gatekeeper. However, many people with disabilities, because of their complex requirements, often need a specialist to meet their primary care needs and to determine if additional specialized services are needed. Children with disabilities often need the option of pediatric specialists as the primary physician or as part of a multi-disciplinary team. In some managed care plans, children with disabilities may be limited to adult specialists who may not be familiar with the special needs of children.

Inadequate Benefits

A comprehensive benefits package is critical for people with disabilities, but all too often managed care and other private insurance benefit packages are based on an acute care model. For example

- Managed care plans typically cover only 60 days of rehabilitation and sometimes provide no rehabilitation services at all.

- Managed care plans rarely cover home and community-based health care services, such as home nursing and personal assistance services, which often prevent multiple re-admissions to acute care settings.

- Managed care plans often have annual and lifetime caps for certain conditions or treatments (usually mental health and substance abuse)

- Enrollees are often denied benefits based on narrow definitions of "medical necessity" because these definitions are based on the health care needs of the "average" person. For example, managed care plans often refuse to authorize physical therapy for people with chronic conditions because such therapy would "maintain" rather than "improve" function.

- Many plans refuse coverage of durable medical equipment, orthotics and prosthetics (orthopedic braces and artificial limbs), and certain therapies, such as respiratory and recreation therapy, which are important to maintain function and prevent secondary complications.

- Definitions of durable medical equipment and prosthetics/orthotics are often restrictive. This is a particular problem for individuals requiring customized medical equipment, such as specialized wheelchairs and seating systems, and most types of orthotics and prosthetics, which require specialized expertise and custom fitting and fabrication to the unique needs of each patient.

- Drug formularies or other restrictive lists of covered pharmaceuticals are commonly used by managed care plans. For some people with disabilities and chronic conditions, particularly people with rare disorders, effective drug therapies may not be available in managed care plans.

Access to Centers of Specialized Treatment

Some people with disabilities require highly specialized providers who may not participate in a managed care plan's network. Furthermore, continuity of providers is critical to people with special health care needs who require specialized care sporadically over time. Some people with chronic conditions, including individuals with mental illness, sustain great harm when forced to disrupt existing relationships with providers.

Many people with severe or rare conditions can often only receive appropriate care at highly specialized centers which may be affiliated with schools of medicine or teaching hospitals, or may be free-standing centers with specialized treatment expertise. Examples of these conditions include certain neurological and rare disorders, intractable pain, and a number of orthopedic impairments requiring specialized assistive technology. Many managed care plans will not cover care received at these centers.

Incentives to Underserve

Many managed care plans, particularly capitated plans, have built-in incentives to underserve patients which can place persons with disabilities at significant risk. They may --

- pay nonsalaried physicians according to the numbers of patients served, which leads to insufficient time and attention being paid to individual patients;

- provide bonuses or penalties to providers based on their adherence to utilization limits determined by the managed care plan,

- place individual physicians at financial risk for caring for patients by requiring physicians to assume the cost of out-of-plan specialty care.

RECOMMENDATIONS

Managed Care Safeguards for Consumers and Providers

To address these significant problems with health care delivery through managed care, Medicare, Medicaid, and private health insurance reforms should include safeguards for consumers and providers from certain managed care practices. Managed care plans continue to gain market power with few federal or state guidelines for the provision of quality care, particularly for people with disabilities and those with specialized or complex health needs. Managed care plans should at least be required to meet certain standards to maintain access, quality, and accountability to enrollees. Without these protections, managed care plans can be devastating to the health status and ability to function of people with disabilities and chronic health conditions.

CCD strongly encourages the 104th Congress to include the following provisions in any proposals to reform both the public and private health insurance systems. These provisions have wide support in the consumer and provider communities.

- **Consumer and Provider Due Process Protections**

  CCD strongly supports the inclusion of due process protections in Medicare, Medicaid, and private insurance reform legislation so that consumers and providers are on a level playing field when interacting with powerful managed care companies. These protections will ensure appropriate decision-making and selection procedures for providers, and in so doing, will protect consumers in their choices and access to health and mental health professionals and other providers.

- **Quality Assurance Provisions in Managed Care Plans**

  The need for appropriate quality assurance measures is particularly important for people with disabilities and chronic conditions in managed care settings. As enrollment in managed care health plans continues to increase, consumers must be informed about the nature of managed care health delivery and their rights within these plans. Consumer needs must be routinely and systematically considered and consumers must play a central role in decision-making within the managed care entity. In fact, consumer involvement is critical at all levels of health care system governance. CCD strongly supports an emphasis within public and private health plans on consumer choice, consumer involvement in the governance of the plan, consumer rights, and consumer satisfaction. We believe that this emphasis on the role of the consumer is directly related to assuring the actual quality of health and health-related services provided under managed care plans.

- **Point-of-Service Option**

  Managed care plans should provide a point-of-service option to their enrollees in order to allow persons with specialized health care needs to obtain care from out-of-network providers, assuming they opt to pay the extra premium and copayments necessary. This provision retains the ability of closed-panel HMOs to contain costs but also allows enrollees the flexibility to opt out of the network if they pay a little more for this option.

- **Specialists as Gatekeepers**

  Enrollees in network plans who require ongoing, specialized health services should be able to choose a specialist to act as their gatekeeper and to manage their condition. Relevant physician and non-physician specialists should also be directly available to enrollees without gatekeeper approval where continued specialized care is medically indicated. For instance, a person with spinal cord injury should be able to access a qualified physiatrist as a gatekeeper who would provide primary care at the primary care reimbursement rate and specialty care at the specialist rate. Similarly, a person with multiple sclerosis should be able to choose a neurologist as a gatekeeper who has authority to refer to non-physician providers of specialty care in order to manage a chronic condition over time.

- **Health Plan Arrangements with Providers**

  All health plans should enter into agreements and other arrangements to ensure an appropriate mix, number, and distribution of qualified health professionals in order to adequately provide the plan's benefit package.

- **Access to Specialized Treatment Centers**

  Managed care plans should ensure access to academic and other specialized health centers. CCD recognizes that much specialized health expertise is provided in centers that are not academically affiliated. Provision should be made in any legislation addressing health care issues to provide people with disabilities and chronic illnesses requiring specialized care access to a variety of centers of specialized treatment expertise.

- **Utilization Management Protocols and Physician Incentive Plans**

  Utilization review should be performed by qualified personnel with knowledge in the specific medical area in which the coverage decision is being made. Physician incentive plans can be extremely harmful to enrollees who require significant and/or ongoing health services due to the incentives to underserve inherent in these arrangements. In fact, all incentives to underserve managed care enrollees, financial or otherwise, should be prohibited.

Any legislation addressing the public or private health care system should include all of these important provisions.

For additional information, please contact one of the CCD Health Task Force Co-Chairs on the cover page of this testimony.

STATEMENT OF CONGRESSMAN BILL LUTHER (MN-06)
WAYS AND MEANS SUBCOMMITTEE ON HEALTH
5/24/95

Mr. Chairman:

I seek to testify today on an issue that affects many Americans, especially the citizens of states like Minnesota -- the issue of regional disparity in reimbursement for Medicare risk contracts.

I come from Minnesota, a state which is working hard to implement health care reform. For a number of reasons including efficiencies we have achieved along with bi-partisan efforts such as our MinnesotaCare health reform initiative, the people of our state enjoy among the lowest health care costs in the country while receiving excellent care. But ironically, we have been penalized by our efforts to become more efficient. Our health plans offering managed care to Medicare enrollees get reimbursements well below the average and, as a consequence, our Medicare beneficiaries are required to pay more out of pocket for less benefits than those in many other states.

The problem stems from the capitation rates under the TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) risk contracting programs, which serve approximately three million Medicare beneficiaries. Every year, HCFA calculates the capitation rate, called the Adjusted Average Per Capita Cost (AAPCC), which is the amount a health plan receives to provide Medicare coverage. This figure, however, varies widely from county to county, and herein lies the problem. This rate is calculated by first estimating a national average Medicare expenditure per beneficiary. HCFA then adjusts the rate to take into account the local trends in expenditures as well as the demographics of each particular area.

In Minnesota's case, our capitation rates are 70-80% of the average in urban areas. The 1995 Medicare payment rate per person in Anoka County, Minnesota is approximately $338. Since the rate is based on fee-for-service costs in each geographic region, and because our health care is delivered cost-effectively, our rate is lower. In states which have less effective health care systems, more money is spent per beneficiary. In calculating rates for these areas, HCFA figures a higher projected Medicare spending rate per beneficiary and capitation rates are higher. For example, the 1995 Medicare payment rate per person in Kings, New York is approximately $646.

The unfairness in this disparity is obvious. States that are keeping costs down are punished with low reimbursement rates, while those that have not controlled health care costs are rewarded with high per-person allowances. This inequity becomes even more glaring for beneficiaries of managed care plans. Because TEFRA requires that additional savings from managed care be passed to beneficiaries only as benefits, plans in areas such as Kings are able to offer more benefits yet cut out-of-pocket expenses such as premiums, deductibles and co-payments and still maintain a profit, while plans in states like Minnesota cannot afford to offer such benefits. Therefore, while people pay the same amount into Medicare during their working careers regardless of their state, some Medicare beneficiaries pay less and get more of their expenses covered than others depending simply on where they live.

Mr. Chairman, this is unfair and it is creating exactly the wrong incentive in the delivery of health care. We must adopt a new formula for setting Medicare reimbursement rates. If we are to achieve Medicare savings and yet serve the real needs of the senior population, the federal government must send a clear message. Rather than penalize reform, we must reward the efficiencies realized in a health care system like those in Minnesota. While the issue of reimbursement disparity is but one piece in the larger puzzle of Medicare, it is one that affects citizens all around the country and it has the potential to affect them dramatically in the future. It is time that the Medicare debate include discussions of efforts to achieve an improved Medicare system with a sound financial future. I look forward to working with you and other Members of the Subcommittee to address this issue.

Thank you.

TESTIMONY OF THE PATIENT ACCESS TO SPECIALTY CARE COALITION

Mr. Chairman: This statement is made on behalf of the Patient Access to Specialty Care Coalition ("Coalition"), consisting of nearly 100 patient, physician and non-physician health care professional organizations dedicated to ensuring the right of patients to consult and be treated at a reasonable cost by the specialist of their own choice, regardless of the health plan in which they are enrolled.

PATIENT CHOICE MUST REMAIN PARAMOUNT IN MANAGED CARE HEALTH CARE DELIVERY

As the presence of managed care increases in the marketplace, and as Congress seeks to further expand the role of managed care in the Medicare program, it is the Coalition's belief that Congress must preserve the patient's right to select the provider of his or her choice.

Many major changes are now taking place in the way people purchase health insurance and receive medical care. The pressures to reduce health spending continue to be intense, and health plans and providers have become more aggressive in their cost containment activities. While many health plans have developed a number of effective techniques to achieve economy and maintain quality of care, others have not always achieved that balance.

In this rapidly changing health care delivery environment, the Patient Access to Specialty Care Coalition believes that consumers of medical services must have effective protection against the potential that their access to medically necessary health care services will be inappropriately structured.

The most effective check against this potential restraint is the patient's power to seek and obtain medical services outside the provider network established by the health plan. Health plans that provide good service to their enrollees should not be troubled by this point-of-service feature. Only health plans that fail to meet the needs of their subscribers should be concerned.

THE POINT-OF-SERVICE FEATURE

The Coalition's message is a simple one. There are a number of current practices, especially in managed care settings, which impede patient access to treatment, particularly specialty care.

True freedom of choice for patients can only be achieved by making available out-of-network medically necessary treatment and services for all health care plans. All patients should have the option, at an additional but not prohibitive copayment, to seek the out-of-network treatment they desire. This feature should be built into every health care plan, and not just offered at the time of enrollment.

While offerring a point-of-service feature at the time of enrollment is a good first step in preserving consumer choice, patients sometimes act with less than perfect information when choosing a health care plan. Many times healthy patients are unable to assess their health care needs, until they actually get sick or need specialty care. Consequently, the broadest possible patient protection is to build choice of health care provider into every health care plan.

Real health security is the freedom for patients to choose their own physicians or specialty care provider, and then to continue to access these same caregivers regardless of a change of jobs or health care plans.

As Congress explores the role of managed care in controlling health care costs, it also has the opportunity to guarantee the patients' right to choose, and to make

consumers secure in knowing that the health care provider of their own choice will always be there.

Making available out-of-network treatment and services for enrollees in all health care plans provides a very good quality assurance check. It ensures that all health care plans provide the health care that their enrollees need and deserve. The ability of all Americans to seek out-of-network coverage, provides consumer protection as well. If a patient is not satisfied with care, he or she could pursue other treatment for a reasonable, but not cost-prohibitive price.

Today, one of the more popular health insurance products among consumers is a closed panel managed care plan with the availability of out-of-network coverage. Patients have been demanding this freedom to choose, and the marketplace has responded. This point-of-service feature for all health plans, therefore, is not intrusive, but rather advances a developing trend, and builds in consistency and predictability for consumers.

THIS POINT-OF-SERVICE FEATURE IS NOT COSTLY

Building a point-of-service feature into all health plans will not affect any health plans' ability to be aggressive in their cost containment activities, nor will it limit their efforts to encourage providers and consumers to use health care resources wisely. It will simply put pressure on health plans to keep patients' welfare uppermost on their agenda, ahead of dividends and the bottom line.

Consumers expect to bear some additional cost for this point-of-service feature. However, this cost is not great, and it is a simple actuarial calculation to determine a reasonable copayment. There is also no financial burden placed on the HMO.

The Patient Access to Specialty Care Coalition retained the firm of Milliman & Robertson, Inc. to study the cost impact on HMOs, if all closed-panel HMOs had to offer a point-of-service to their enrollees. A closed-panel HMO only allows patients to receive care from its own contracted providers. When a closed panel HMO has a point-of-service feature, patients have an opportunity to "opt-out" of the managed care's network of providers, and seek "out-of-network" care.

The managed care industry has consistently claimed that a point-of-service feature in all health plans would greatly increase the cost of doing business. This assertion is contradicted by the Milliman and Robertson findings.

According to this study, a built-in point-of-service feature for all managed care plans would not greatly change the cost of managed care or HMO benefits. In fact the study demonstrates that this point-of-service feature, in some instances, can actually lower the costs to an HMO.

The Milliman and Robertson study estimated the "net claim cost" for two typical health care plans in today's marketplace. These plans were developed from existing data in the HMO Industry Study, 1994 of the Group Health Association of America. Milliman and Robertson concluded that when it compared a point-of-service feature to a pure HMO (a closed panel), the expected cost ranged from a decrease of about 5 percent for a typical HMO plan to an increase of about 10 percent for a more generous HMO plan.

Analysis of this data demonstrates that the inclusion of out-of-network coverage within an HMO design does not, in itself, either increase or decrease claims costs incurred by the HMO. Instead, claims costs are increased or decreased depending upon the HMO's selection of factors (deductibles, copayments, and out-of-pocket limits)

that encourage or discourage utilization of out-of-network coverage and the nature of the discounts negotiated with network providers. (For the Subcommittee's use, the Coalition has shared with it a copy of the complete Milliman and Robertson study).

Again, the Patient Access to Specialty Care Coalition maintains that a built-in point-of-service feature provides a good safety valve for the unhappy or dissatisfied members of the closed panel HMO. Under the point-of-service feature, patients are able to go to a non-network provider of their choice. In doing so, however, the patient would incur a higher copayment for the opportunity to go "out-of-network."

This point-of-service feature provides the patient with an out when they question the quality of care they are receiving by the network's limited providers. It also provides an opportunity for the patient to seek an additional opinion from a non-partisan provider when the patient or family disagrees with the decision made by the closed panel HMO or the primary care gatekeeper to withhold treatment or deny an appropriate referral to a specialist.

EXPANSION OF MANAGED CARE IN THE MEDICARE PROGRAM

The Coalition is not opposed to managed care. It is concerned, however, that Congress may be embracing a concept of cost savings of managed care in the Medicare population without sufficient data.

Should Congress choose to go forward with expanding managed care in the Medicare program, the Coalition maintains that its recommended point-of-service feature will:

a) End the uncertainty and unpredictability of seniors moving in and out of health plans through open enrollment and disenrollment--the feature will always be there, and actuaries could easily calculate utilization of out-of-network services.

b) Give the Medicare patient effective protection against the potential for restricting access to medically necessary health care services.

c) Provide a quality assurance check on all health care plans to make sure that they are providing the full range of health care services to their enrollees.

THE POINT-OF-SERVICE FEATURE IS NOT AN "ANY WILLING PROVIDER" PROVISION

The point-of-service feature endorsed by the Patient Access to Specialty Care Coalition, differs substantially from "any willing provider" proposals. "Any willing provider" provisions deal with the contractual relationships between health plans and providers of medical services. The focus of the Patient Access to Specialty Care Coalition is on patient choice and the health care access rights of consumers and patients.

Mr. Chairman, the Patient Access to Specialty Care Coalition's point-of-service feature allowing patients to access out-of-network medically necessary care ensures real choice and real consumer protection, and is a sound quality assurance check to make certain that all plans offer the full range of quality health care.

In your continuing deliberations on managed care and the expansion of managed care in the Medicare program, we urge your Subcommittee to ensure adequate patient

protection and safeguards in this changing marketplace by instituting a point-of-service feature in all health plans.

A listing of the current membership of the Patient Access to Specialty Care Coalition follows:

Allergy and Asthma Network•Mothers of Asthmatics, Inc.
American Academy of Allergy and Immunology
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology - Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Physical Medicine & Rehabilitation
American Association for Hand Surgery
American Association for the Study of Headache
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Private Practice Psychiatrists
American College of Cardiology
American College of Foot and Ankle Surgeons
American College of Gastroenterology
American College of Nuclear Physicians
American College of Obstetricians & Gynecologists
American College of Osteopathic Surgeons
American College of Radiation Oncology
American College of Radiology
American College of Rheumatology
American Diabetes Association
American EEG Society
American Gastroenterological Association
American Lung Association
American Orthopaedic Society for Sports Medicine
American Pain Society
American Podiatric Medical Association
American Psychiatric Association
American Psychological Association
American Rehabilitation Association
American Sleep Disorders Association
American Society for Dermatologic Surgery
American Society for Gastrointestinal Endoscopy
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Pathologists
American Society of Dermatology
American Society of Echocardiography
American Society of General Surgeons
American Society of Hematology
American Society of Nephrology
American Society of Pediatric Nephrology
American Society of Plastic and Reconstructive Surgeons, Inc.
American Society of Transplant Physicians
American Thoracic Society
American Liver Foundation
American Urological Association
Amputee Coalition of America
Arthritis Foundation
Arthroscopy Association of North America
Association of Subspecialty Professors
Asthma & Allergy Foundation of America
California Access to Specialty Care Coalition
California Congress of Dermatological Societies
College of American Pathologists
Congress of Neurological Surgeons
Cooley's Anemia Foundation
Cystic Fibrosis Foundation
Eye Bank Association of America
Federated Ambulatory Surgery Association
Joint Council of Allergy and Immunology
Lupus Foundation of America, Inc.
National Association for the Advancement of Orthotics and Prosthetics
National Association of Epilepsy Centers
National Association of Medical Directors of Respiratory Care
National Foundation for Ectodermal Dysplasias
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Osteoporosis Foundation
National Psoriasis Foundation
Oregon Dermatology Society
Orthopaedic Trauma Association
Patient Advocates for Skin Disease Research
Pediatric Orthopaedic Society of North America
Pediatrix Medical Group: Neonatology and Pediatric Intensive Care Specialists
Renal Physicians Association
Scoliosis Research Society
Society for Vascular Surgery
Society of Cardiovascular & Interventional Radiology
Society of Gynecologic Oncologists
Society of Nuclear Medicine
Society of Thoracic Surgeons
The Alexander Graham Bell Association for the Deaf, Inc.
The American Society of Dermatophathology
The Endocrine Society
The Paget Foundation For Paget's Disease of Bone and Related Disorders
The TMJ Association, Ltd.

The HMO Industry Study has been retained in the Committee Files.

ISBN 0-16-053954-4