asim

american society of internal medicine

August 16, 1995

Ms. Carol Rasco
Director
Domestic Policy Council
West Wing
The White House
Washington, DC 20500

Dear Ms. Rasco:

Late last month, the American Society of Internal Medicine issued a set of proposals for reforming Medicare. An executive summary and complete set of recommendations is enclosed for your information. As ASIM states in the executive summary, our principal aim in offering this plan is to ensure that all participants in the Medicare program share the responsibility for preserving this pillar of the nation's commitment to its elderly citizens well into the next century.

ASIM continues to believe that changes in Medicare should ideally be made in the context of other health system reforms--insurance market reforms, changes in medical liability, due process for patients and physicians in all health plans -- that will promote an environment in which changes made to Medicare will not adversely affect beneficiaries. Nevertheless, as calls have grown for specific changes in Medicare, ASIM has attempted to respond to these requests by outlining those immediate changes we feel should be made in Medicare's current financing and the existing risk contracting program and those reforms we believe are necessary for the long term survival of the program.

Many of the changes we are proposing in the current Medicare system are consistent with several of the administration's policies set out in last year's Health Security Act. These include: increasing the choice of managed care plans under the risk contracting program to include preferred provider organizations (PPOs) and point-of-service (POS) plans; giving beneficiaries comparative information on risk contracting plans; improving financing of Medicare through increased taxes on tobacco products and alcohol as well as limitations on the tax deductibility of health insurance beyond an average premium cost; revising the disproportionate hospital share system of payments; and creating an all payer funding pool to finance graduate medical education and decreasing the number of residency positions funded by the federal government.

However, in light of increasing budgetary pressures and a growing Medicare population, ASIM believes that the creation of a voluntary voucher program, albeit with certain safeguards, will not only broaden the choice of coverage options now available to beneficiaries but will introduce additional market incentives that can control rising costs under Medicare. ASIM understands that the administration has expressed reservations over voucher proposals. As outlined below, ASIM has

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attempted to address in its recommendations several of the major criticisms lodged against a voucher system for Medicare.

1. Vouchers will take away the broad choice of physician and provider that beneficiaries now enjoy under tradtional Medicare.

ASIM agrees that beneficiaries should **not** be deprived of their choice of physician. Under our proposal, beneficiaries could remain in traditional, fee-for-service Medicare. The voucher program would be entirely voluntary. Indeed, a voucher program might enhance choice of physician if beneficiaries discover that the physician they wish to see is participating in a health plan that had heretofore been ineligible to contract with the Medicare program.

In addition, ASIM is recommending that voucher plans with networks of providers be required to offer to prospective enrollees the chance to buy a point-of-service rider that would allow the beneficiaries to seek care from non-network physicians. ASIM further recommends that this POS rider be priced at an actuarially-determined level because many studies have shown that the additional costs of POS are modest. Imposing this limit on the cost of POS riders would protect beneficiaries from excessive charges for going out of a health plan network.

2. Vouchers will leave beneficiaries exposed to "cherry-picking", deceptive marketing and other practices designed by insurers to avoid covering the sickest of patients.

ASIM wholeheartedly agrees that discriminatory insurance practices should be eliminated, not only for Medicare patients, but for all segments of the population. The insurance reform measure recently reported out of the Senate Labor and Human Resources Committee is a step in the right direction. Insofar as a Medicare voucher system is concerned, though, ASIM addresses problems with insurance industry discrimination by requiring voucher plans to guarantee acceptance to beneficiaries seeking enrollment, by requiring voucher plans to provide the range of benefits now covered under Parts A and B, along with preventive care services, by requiring plans to submit their marketing materials to the Department of Health and Human Services for review and by establishing a reinsurance mechanism to cushion plans with large numbers of seriously ill enrollees.

3. Vouchers will fail to keep pace with the costs of medical care, increasingly reducing beneficiaries' selection of affordable health plans and/or subjecting beneficiaries to greater and greater out-of-pocket costs.

ASIM agrees that, **if** the government's contribution is set too low, such as the lowest priced plan in a region, or at some national average, this could adversely affect the ability of many beneficiaries to buy a satisfactory health plan. ASIM believes that by setting the voucher amount according to regional health costs and adjusting it for age, sex, and disability, ESRD and institutional status, this will avoid a situation in which the voucher is set at such a level as to render it basically worthless to most beneficiaries. Furthermore, as noted above, requirements that **all** voucher plans offer the services covered under Parts A and B, plus preventive care, should ensure that all beneficiaries, no matter how modest of means, will receive the benefits to which they are now accustomed under the Medicare program.

ASIM also believes that the voucher must be updated to keep pace with the costs of providing services to beneficiaries and does not support capping or limiting the voucher according to some arbitrary formula. In the event that spending for the voucher program exceeds estimated budget goals, ASIM would prefer that an independent body be established to examine the reasons for

that cost overrun and to propose a response that does not solely rely on cuts to providers and increased costs to beneficiaries. In addition, ASIM states that Congress should commit itself to increasing funds for the voucher program if spending under that side of Medicare is deemed to have derived from provision of medically necessary services.

To the contention that a voucher system would subject beneficiaries to excessive out-of-pocket costs should they choose to remain in the traditional fee-for-service sector or if they want to go outside a plan's network of physicians, ASIM is proposing the use of its "competitive pricing, informed choices" proposal for Medicare beneficiaries who wish to remain with fee-for-service or to use a POS option. As described in item 9 of ASIM's recommendations, using the competitive pricing approach would give beneficiaries "up front" the information they need concerning physicians' charges so that they could decide for themselves how much they were willing to pay to see a particular provider.

ASIM also urges that, with regard to traditional Medicare or under voucher plans using a fee schedule either for their regular plan or for their point-of-service option, charges in excess of Medicare's payment amounts be forbidden under the following circumstances: where beneficiaries' income falls below a certain level; in emergency situations; when beneficiaries have little choice in selection of a hospital-based physician; or in areas of the country where there is little or no competition for a particular medical specialty.

I hope that you find ASIM's recommendations for Medicare reform useful and would welcome the opportunity to discuss our proposal with you further. If you or your staff have additional questions, please feel free to contact ASIM's Vice President for Government Affairs and Public Policy, Robert Doherty at 202-466-0283 or Susan Prokop, ASIM's Director, Health Care Policy at 202-835-2746, ext. 259.

Sincerely,

Alan R Nelson MD

Alan R. Nelson, MD
Executive Vice President

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ASIM TODAY

KEEPING MEDICARE AFFORDABLE

RECOMMENDATIONS OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

July 1995

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american society of internal medicine
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KEEPING MEDICARE AFFORDABLE
RECOMMENDATIONS OF THE
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EXECUTIVE SUMMARY

Thirty years ago, the Medicare program was created to ensure that the nation's elderly would not be denied medical care when they needed it. Today, almost all Americans over 65 feel secure in the knowledge that health care services will be accessible to them. The American Society of Internal Medicine, representing the nation's largest medical specialty and the principal providers of medical care to Medicare beneficiaries, is committed to preserving this contract with older Americans. However, in the face of changing demographics, burgeoning costs and the need to restrain overall federal spending, the Medicare program is facing an unprecedented challenge. Responding to this challenge will require both immediate changes in the program's financing and current risk contracting program as well as long-term reforms to broaden beneficiaries' choice of insurance options, control costs through enhanced competition and instill a sense of responsibility among all those involved with and affected by its policies.

This set of recommendations is ASIM's response to policymakers calls for proposals to address the need for fundamental changes in the Medicare program so that it may continue to be a reliable source of medical care for the nation's elderly well into the new century. For ASIM, the overarching philosophy on which these Medicare reform proposals rest is that of shared responsibility.

Physicians have a responsibility to deliver care to greater numbers of Medicare patients under health care delivery systems that will increasingly require them to accept financial risk and to be accountable for the cost and quality of their clinical decisions--and to compete within this new system on the basis of cost and quality.

Medicare patients have a responsibility to consider the costs of alternative sources of health care coverage, to be willing to contribute more in out-of-pocket costs if they choose more expensive coverage and--for those who can afford to--to contribute more to the financial support of Medicare so that those of lesser means can afford coverage.

Taxpayers have a responsibility to accept changes in the tax code that would raise revenue and introduce positive incentives into the health care system including a limit on the tax deductibility of employer paid insurance and increased taxes on tobacco.

The insurance industry has a responsibility to compete in the new system--not solely on price or risk avoidance but on benefits offered and quality--and to accept reasonable standards to protect beneficiaries who choose private insurance coverage.

And the federal government has a responsibility to assure that the government's contribution remains adequate to guarantee that all beneficiaries can obtain high quality coverage through traditional Medicare and private sector alternatives--and to provide sufficient oversight over the market to protect patients' interests.

Changing the Medicare Financing System

Steps can be taken now to reform the current Medicare program so that future efforts to change the system need not be enacted in an atmosphere of crisis. These steps include:

1. increasing the eligibility age for Medicare to align it with eligibility for Social Security.

2. increasing the amount contributed by upper income beneficiaries to financing the Medicare system.

3. applying the Part B coinsurance to home health services.

4. including in taxable income the value of health insurance benefits beyond a set value of insurance premium.

5. limiting disproportionate hospital share (DSH) payments only to those facilities that, in fact, care for a disproportionate share of Medicare patients.

6. increasing federal excise taxes on alcohol and tobacco if the revenues from changes identified above prove inadequate to finance an appropriate level of benefits.

7. creation of a national all-payor funding pool for GME.

8. increasing the direct GME weighting factor for general internal medicine and other primary care residency positions while decreasing the weighting factor for others.

9. creation of a private sector physician workforce planning initiative.

10. decreasing the number of funded residency positions to 110 percent of U. S. medical school graduates.

Instilling Market-based Incentives in the Medicare Program

Additional steps can be taken to improve the existing Medicare risk contracting program so that this mechanism designed to enhance market competition can operate as it was intended until more substantial reforms are implemented. These steps include:

1. changing the adjusted average per capita cost (AAPCC) formula used to pay health plans.

2. applying risk adjustments--such as severity of illness--in setting payments to risk contracting plans.

3. broadening managed care choices for beneficiaries to include HMOs with point-of-service and preferred provider organizations (PPOs), instead of limiting

participation only to health plans that require beneficiaries to obtain services from contracted physicians and other providers.

4. requiring that beneficiaries be provided comparative information concerning all Medicare risk contracting plans that are available to them.

5. giving beneficiaries one opportunity per enrollment year to disenroll from a Medicare risk contracting within 60 days of enrollment. Once a beneficiary has been in a plan more than 60 days, he or she should be required to wait until the next open enrollment period.

6. mandating reasonable, non-punitive increases in premiums and other cost sharing for beneficiaries who choose to remain with the traditional fee-for-service Medicare program.

Medicare Vouchers

Changing the existing fee-for-service Medicare program and improving the current risk contract program will help to stabilize Medicare for the short term. However, major restructuring of Medicare is necessary to achieve a system that relies on competition to control costs and broaden beneficiary choices, that instills individual responsibility for the appropriate use of scarce medical resources and that assures the program's long term survival. One way to accomplish this is through the creation of a voucher program.

ASIM supports creation of a voucher system and believes that the following elements are necessary to any voucher program designed for Medicare to ensure that beneficiaries have access to the widest range of cost-effective, high quality health plans, physicians and providers.

1. Medicare beneficiaries should be given the option of staying in the current Medicare program or using a voucher to buy any private health plan that meets certain conditions of participation.

If a plan purchased with a voucher becomes insolvent, or ceases operation in a beneficiary's area, beneficiaries should be able to enroll in another plan. When the annual enrollment period occurs, beneficiaries should be able to return to the traditional Medicare program at that time.

2. Under a voucher program, beneficiaries should have access to a variety of plans ranging from indemnity models to staff model HMOs. All voucher plans that restrict enrollees to the use of network providers should be required to offer at an actuarially-determined level an optional rider that would provide point-of-service access to non-network physicians for those enrollees. Enrollees should be able to select from among a network plan's panel of physicians an internal medicine subspecialist as their primary care physician and plans should be prohibited from discriminating against physicians in their selection processes based on a physician's patient population.

3. Beneficiaries should have the option of using their government contribution--e.g. the voucher--to establish a Medical Savings Account (MSA) rather than to purchase coverage through a health plan. The MSA would:

a) be coupled with a catastrophic health insurance policy purchased through a purchasing group to help preserve community rating;

b) be comprised of a fund from which a beneficiary could pay deductible medical expenses and catastrophic health insurance to cover expenses that, in the aggregate, exceed the catastrophic insurance deductible;

c) permit accumulation of unspent balances within the fund;

d) allow state and federally tax exempt distribution of funds only for medical expenses, health insurance premiums and/or long term care.

4. Voucher plans should be required to accept all applicants during an open enrollment period to minimize adverse risk selection. Beneficiaries should be required to remain in a plan after the first 60 days until the next open enrollment period. Beneficiaries should be explicitly informed of this requirement by the health plan and should be required to sign a written acknowledgement of the conditions of enrollment.

A reinsurance mechanism should be available to those plans subject to adverse risk selection or to a sudden influx of voucher enrollees whose previous plan has gone bankrupt.

5. The defined contribution--or voucher--should be set at a level that would produce incentives for beneficiaries to consider cost in choosing a health plan without forcing them into the cheapest plans that are most restrictive of choice of physician. The voucher should not be set at the cost of the lowest priced plan in a region.

The voucher amount should be adjusted according to age, sex, disability status, institutional status, and Medicaid-buy in status and applied by region. Once the regionally adjusted voucher amount was established, HHS or HCFA would accept applications from health plans to participate in the voucher program.

6. The voucher should be updated on a regular basis to keep pace with the costs of providing services to beneficiaries. In the event that spending under the voucher program exceeds estimated savings goals or targets, the voucher should not be subject to arbitrary caps. Mechanisms to keep spending within designated limits or to recoup excess expenditures, such as a "look back sequester", should be rejected. Instead, an independent board or commission should be established that would involve all participants in the health care system in devising a response to cost control that would not focus solely on cuts to providers and increased costs to beneficiaries. If spending is greater than projected due to development of valuable new technologies or increased patient utilization of services deemed medically necessary, there should be a commitment to increasing the amount of

funds devoted to the voucher program in order to ensure vouchers retain sufficient purchasing power and to assure appropriate medical outcomes.

7. A reassessment of the voucher program should be required after five years. This reevaluation should be undertaken by an agency or commission not responsible for funding Medicare.

8. Beneficiaries opting for the voucher program should be provided incentives that encourage their selection of an economically priced plan but that do not force enrollees into those plans that are most restrictive of choice of physician and that impose the strictest limits on access to services. Incentives should come in the form of additional benefits or services provided by the health plan and not in the form of a cash rebate. With rules in place to ensure that all beneficiaries have access through voucher plans to the full range of Medicare covered benefits and services, beneficiaries should pay the difference between the voucher amount and any premium charged by a plan that exceeds the voucher amount.

9. Reasonable cost sharing under voucher plans -- both fee for service and managed care -- should be imposed to assure consumer cost consciousness in utilization of services. Lower cost sharing should be imposed on clinically-proven preventive services so that people are not unduly discouraged from obtaining beneficial care. Preventive services should be subject only to copayments, not deductibles. Copayments for preventive services should be set lower than those for other services.

To avoid unjustified restrictions on choice of physician, POS voucher plans should not impose unreasonable coinsurance on services provided by out-of-network physicians. To prevent beneficiaries who seek out-of-network care from being subject to unexpected out-of-pocket costs, POS plans and physicians should be required to establish their own conversion factors to be used against an improved resource based relative value scale (RBRVS). This would determine the rates the POS plan would pay and the fees the physicians would charge for their services. Plans and physicians would be required to supply enrollees in the POS plan with information based on these conversion factors to enable enrollees to determine in advance how much they would pay in going out of the plan's network of physicians.

As an incentive to promote greater price consciousness in the traditional Medicare program and to encourage the movement of beneficiaries into the voucher system, those who choose to stay in the traditional Medicare program should be subject to reasonable and non-punitive increases in cost-sharing. As with POS plans, in order to buffer beneficiaries from unexpected costs, a requirement could be imposed under traditional Medicare that physicians must establish their conversion factor for their services each year concomitant with the announcement of Medicare's conversion factor. Enrollees in traditional Medicare would be supplied annually with information comparing the charges of physicians in their area to Medicare's fees based on their respective conversion factors. In this fashion, beneficiaries would know in advance whether or not they would have to pay out-of-pocket for services charged under traditional Medicare.

Beneficiaries should not be subject to charges in excess of Medicare's payment amounts under the following circumstances: in the case of low income beneficiaries; emergency situations; when the beneficiary has little voice in the selection of a physician or in areas of the country where there is no competition for a particular medical specialty.

10. To qualify as a voucher plan under Medicare, health plans should have to: offer a standard minimum Medicare benefits package that includes preventive services; meet certain utilization review and quality assurance standards; involve participating physicians in development of the plan's utilization review (UR) and quality assurance (QA) and provider selection policies and procedures; disclose their utilization review and quality assurance policies, restrictions on choice, risk arrangements and provider selection criteria; establish due process mechanisms in selection of plan providers; meet certain solvency standards; report certain information -- such as premium costs, out-of-pocket liability, consumer satisfaction and the percentage of premium dollars devoted to administration versus benefits -- to a central data collection entity so that this information can be distributed to beneficiaries and use uniform claims forms and standard billing and claims processing procedures.

Health plans that selectively contract with physicians should be required to offer enrollees the opportunity to buy a rider that provides point-of-service access to non-network physicians, in addition to meeting the foregoing standards.

11. Because Medicare is a federally funded program, the federal government must continue to ensure that health plans are accountable for the care they give to beneficiaries and that they abide by standards set out for Medicare plans. HCFA or another federal agency should be responsible for contracting with health plans; reviewing marketing materials; disseminating to beneficiaries objective data about each plan in a region in a standard format; ensuring health plan compliance with certain standards governing their rules and operations; and ensuring that health plans meet certain quality standards. However, private accreditation agencies should be able to achieve "deemed" status to fulfill the role played by HHS in approving voucher plans. Mechanisms should be available for patients and physicians to pursue grievances against health plans for denial of medically necessary care. Patients and physicians should retain access to fair hearing and judicial review processes at least comparable to those now available under traditional Medicare.

12. Self-referral restrictions affecting shared laboratory facilities and group practices should be removed and antitrust reforms enacted to enable physicians and providers to negotiate on an equal footing with health plans and purchasers.

KEEPING MEDICARE AFFORDABLE
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Introduction

Thirty years ago, the Medicare program was created to ensure that the nation's elderly would not be denied medical care when they needed it. Today, almost all Americans over 65 feel secure in the knowledge that health care services will be accessible to them. The American Society of Internal Medicine, representing the nation's largest medical specialty and the principal providers of medical care to Medicare beneficiaries, is committed to preserving this contract with older Americans. However, in the face of changing demographics, burgeoning costs and the need to restrain overall federal spending, the Medicare program--as well as all those affected by its policies--is facing an unprecedented challenge.

Earlier this year, the trustees for the Hospital Insurance Fund declared that the Part A fund which finances hospital care will be bankrupt by the year 2002. What few realize is that the fund has already begun to run a deficit. Bankruptcy is merely the end product of the red ink that is beginning to accumulate in the system today.

As the population of Medicare eligible individuals grows, the ratio of working Americans who support the program with their payroll taxes to beneficiaries has diminished. Whereas today there are five working-age persons for each person over 65, by 2030--when today's workers retire and their children are wage earners--the ratio will be three working-age persons for each American over 65. Without any policy changes, Medicare SMI (Part B) will grow to more than 7 percent of the payroll tax base by 2030--up from one percent today. Although beneficiaries overall continue to have ready access to physicians and other providers, disturbing trends have been identified by the Physician Payment Review Commission (PPRC) and other organizations tracking the Medicare program. For example, the PPRC notes in its 1995 report to Congress "those over age 85, individuals living in poverty areas and the disabled continue to experience access barriers" that existed prior to the latest round of Medicare reform. The Employee Benefits Research Institute (EBRI) recently issued data showing that the number of Medicare patients seen each week by internists has been declining steadily since 1989. At the same time, there has been a significant increase in internists contracting with managed care plans. In the wake of continuing cuts in Medicare reimbursement to control program costs, physicians may be entering practice environments where the degree of involvement with Medicare patients is limited.

Indeed, cuts already enacted in previous budget reconciliation measures that are now being implemented will reduce payment levels to physicians over the next seven years by 17 percent, even before the impact of inflation is taken into account. Under one of the savings options proposed by a subgroup of the House Budget Committee, the reductions in payment levels for physician services will increase to 31 percent over the next seven years. If the debate beginning now in Congress is about making sure the elderly have access to appropriate, high quality health care into the next century, continued reductions of this type will only undermine this promise and create a Medicare program that guarantees access in name only.

If no action is taken, the hospital side of Medicare will go broke in less than a decade, the supplemental medical insurance portion of Medicare will consume increasing amounts of the federal budget and beneficiaries may face increasing difficulty in obtaining needed health care. This is clearly not a viable option.

Policymakers could continue with the historical approach to attempting to reign in Medicare's costs--enacting cuts in provider payments and imposing increasing regulatory rules on the program as part of massive year-end budget reconciliation measures. This, of course, does not address the underlying reasons for increasing costs under the program and will only serve to exacerbate many of the growing problems in Medicare.

The third option is to reform the Medicare program so that its financing is placed on a sound basis and to introduce the kind of marketplace incentives that have enjoyed success in the private sector in holding down the growth of health care costs. ASIM strongly believes that this is the only option that Congress should consider.

ASIM recognizes the urgent need for reforming the Medicare program and restraining growth in spending under other federal health care programs. However, internists also believe that significant changes in these programs *ideally* should be made in the context of other health system reforms. Medical liability reform, insurance market reform, measures to broaden and protect choice of plan and physician, and steps to ensure due process for patients and providers in health plan operations and clinical decisions are important system-wide reforms that will foster an environment in which changes in Medicare will have a positive impact. Nevertheless, the following set of recommendations is ASIM's response to policymakers calls for proposals to address the need for fundamental changes in the Medicare program so that it may continue to be a reliable source of medical care for the nation's elderly well into the new century.

The recommendations propose both immediate and longer-term reforms in the following areas:

1. Immediate changes in Medicare financing and the current Medicare risk contracting program.

2. Longer term reforms to expand beneficiaries' choice of insurance options through enactment of a defined federal contribution--or voucher--program.

Changing the Medicare Financing System

Many analysts and policymakers contend that only complete transformation of the Medicare program can solve its financing problems. Any type of restructuring, however, will be the subject of considerable debate and, given the realities of the policymaking process, could take a number of years to implement. In the meantime, the red ink will grow and problems of access will be exacerbated. Steps can be taken now to reform the current Medicare program so that future efforts to change the system need not be enacted in an atmosphere of crisis.

Last December, a report on entitlement reform options was issued by staff from the Bipartisan Commission on Entitlement and Tax Reform (hereinafter referred to as the Commission). That report identified a number of measures that could be enacted in the existing Medicare program to stem the imbalance in funding. These improvements can be made with or without enactment of

other long term reforms, such as a voucher program. Among those improvements ASIM supports are:

1. increasing the eligibility age for Medicare to align it with eligibility for Social Security. By early in the next century, the eligibility age for Social Security will be 67. It would make sense, both financially and administratively, to couple the eligibility age for Social Security with that for Medicare. However, such a change must come in concert with insurance market reforms and other measures to assist those elderly under 67 with chronic, but not disabling, illnesses in maintaining insurance coverage.

2. increasing the amount contributed by upper income beneficiaries to financing the Medicare system. The Commission staff proposed reducing the Part B premium subsidy and creating a new Part A premium indexed according to growth in program costs. ASIM believes this premium should instead be indexed to income. This would avoid imposing an excessive burden on those with modest means while concomitantly calling for appropriate contributions from those with greater ability to finance their health care.

3. applying the Part B coinsurance to home health services. Current law requires no cost sharing by beneficiaries for these services. Home health care has been among the fastest growing parts of the Medicare budget and cost sharing has been demonstrated effective in stemming overutilization of services.

4. including in taxable income the value of health insurance benefits beyond a set value of insurance premium. Today, employers and workers benefit from a system that gives preferential tax treatment to high cost health plans. Placing a limit on the tax deductibility of such health insurance will promote the purchase of cost-effective but moderately priced health plans and would bring in significant revenue into the health care financing system.

5. limiting disproportionate hospital share (DSH) payments only to those facilities that, in fact, care for a disproportionate share of Medicare patients. The Commission staff report cited studies showing that DSH payments, intended to compensate hospitals for services provided to low income individuals, have been used by some states for purposes beyond its original intent. Without harming those hospitals truly in need of these payments, the formula should be changed--e.g. elimination of DSH payments for hospitals whose disproportionate share index is below the 80th percentile--to avoid inappropriate uses of federal payments.

In accord with ASIM's longstanding policy that Medicare trust fund reserves should be augmented through a combination of expenditure reductions, program efficiencies and revenue increases, ASIM also supports:

6. increasing federal excise taxes on alcohol and tobacco if the revenues from changes identified above prove inadequate to finance an appropriate level of benefits. Not only would these additional revenues help to support the program but they would discourage certain behaviors that result in increased public and personal health costs.

Historically, Medicare has served as a major source of financing for training of this nation's doctors. However, changes have been proposed in Medicare's funding of graduate medical education (GME) as another avenue for achieving significant savings in the program's budget. One proposal offered by the Health Care Working Group of the House Budget Committee would cut direct and indirect GME spending by $27.24 billion over seven years.

ASIM believes it is time to rethink Medicare funding of graduate medical education, not simply as a device to reduce federal spending, but in order to respond to the changing health care delivery environment and to ensure that all components of the health care system that benefit from highly trained physicians contribute to the cost of their education. To those ends, ASIM supports:

7. creation of a national all-payer funding pool for GME. All payers and health plans should contribute a percentage of their premiums to a financing pool for graduate medical education. With managed care plans and other health delivery organizations seeking qualified, well-trained physicians for their networks, they, as well as all payers interested in providing the best care possible for their insureds, have a stake in the education of the physicians that will contract with their plans. Until now, no one has asked these health plans and insurers to help support the cost of training this nation's physicians. However, given Medicare's financial condition, the federal government can no longer be viewed as a major source of funding for the future supply of doctors.

8. creation of a private sector physician workforce planning initiative. The American Medical Association has proposed that a taskforce be established with participation of both public and private sectors to offer recommendations to Congress about the physician workforce supply and the future of GME. If the all-payer GME pool is established, such a task force will be necessary to advise how the funds in the all-payer pool would be distributed.

9. increasing the direct GME weighting factor for general internal medicine and other primary care residency positions while decreasing the weighting factor for others. Currently, direct medical education payments are based on hospital-specific, per resident costs multiplied by the number of residents. Proposals have been offered in past Congresses to reimburse hospitals more for primary care residents than for specialty residents in order to encourage training of more primary care physicians. The need for more primary care physicians has grown with the increase in the elderly population as well as with the desire of health plans for physicians to manage the care of their enrollees. Alterations in the financing of medical education will encourage changes in training programs to meet those needs.

10. decreasing the number of funded residency positions to 110 percent of U. S. medical school graduates. The Physician Payment Review Commission has recommended that the number of funded residency positions in the United States be reduced in order to respond to the fact that the country is facing, in general, an excess of physicians. By taking this action, the U. S. would cut the oversupply of physicians while at the same time--if the other steps are taken--increase the proportion of primary care physicians relative to the population.

Instilling Market-based Incentives in the Medicare Program

The current Medicare program includes an optional program intended to use competition among health plans as a means to moderate costs. The Medicare risk contracting program--in which Medicare contracts with health plans and pays them a capitated payment based on less than 95% of the adjusted actual per capita costs of caring for Medicare patients--was intended to encourage health plans to control utilization of services and, subsequently, costs. Because of flaws in the formula for paying risk contracting plans and because healthier beneficiaries are more likely to enroll in these health-plans-than-other-beneficiaries,-the risk-contracting program has not been as successful at reducing Medicare spending as originally anticipated.

Again, steps can be taken to improve this existing mechanism designed to enhance market competition until more substantial reforms are implemented. These include:

1. changing the adjusted average per capita cost (AAPCC) formula used to pay health plans. The current AAPCC is based on historical, fee-for-service costs in an area. This has resulted in overgenerous payments to health plans in high cost areas and modest payments to health plans in regions where health care costs have been kept relatively low. Changes in the AAPCC should reward cost effective health plans in areas with historically low utilization rates instead of penalizing such plans with less generous AAPCC payments.

2. applying risk adjustments--such as severity of illness--in setting payments to risk contracting plans. This change should be coupled with other reforms in the AAPCC to avoid driving away from the program managed care plans that might attract more seriously ill patients and to make regional plan payments more equitable.

3. broadening managed care choices for beneficiaries to include HMOs with point-of-service and preferred provider organizations (PPOs), instead of limiting participation only to health plans that require beneficiaries to obtain services from contracted physicians and other providers. Under the current risk contracting program, beneficiaries have a limited range of health plans from which to choose and are precluded from taking advantage of the numerous managed care products that have arisen in recent years in the private market.

4. requiring that beneficiaries be provided comparative information concerning all Medicare risk contracting plans that are available to them. In order for beneficiaries to make fully informed choices about their health plan, they should be provided sufficient data that will enable them to compare these plans on costs, physicians and other providers, quality and benefits.

5. giving beneficiaries one opportunity per enrollment year to disenroll from a plan within 60 days of enrollment. Once a beneficiary has been in a plan over 60 days, he or she should be required to wait until the next open enrollment period. Under current law, beneficiaries may disenroll from a health plan with only a 30 days notice. This makes it difficult for many risk contracting plans to anticipate costs for a health plan year. It is also contrary to most enrollment policies effective in the private sector which call for enrollment or disenrollment during a particular "open

season". Asking beneficiaries to stay with a plan until the next open season once they have been in a plan for two months would offer additional stability to a risk contracting plan without limiting too severely beneficiaries' ability to change their minds about managed care. Such a requirement would make Medicare more consistent with the private sector in which workers are required to make an annual selection of a health plan and to stay with that plan for an entire year. Limiting the disenrollment opportunity to one per year would also prevent cases in which people jump from plan to plan every so often prior to the 60 day deadline. Medicare patients should accept the same degree of responsibility in choosing a health plan that is expected from those under 65.

6. mandating reasonable, non-punitive increases in premiums and other cost sharing for beneficiaries who choose to remain with the traditional fee-for-service Medicare program. With improvements in the risk contracting program, it is reasonable to expect that those who choose to remain with the higher cost fee-for-service side of Medicare should bear a portion of those higher expenditures.

The current risk contracting program would be repealed upon enactment of a voucher program as described below.

Medicare Vouchers

Making changes in the existing fee-for-service Medicare program and improvements in the current risk contract program will help to stabilize the program for the short term. However, to achieve a system that relies on competition to control costs and broaden beneficiary choices, that instills individual responsibility for the appropriate use of scarce medical resources and that assures the long term survival of Medicare, major restructuring of the program will be required. One way to do this is for the government to offer beneficiaries the opportunity to take a defined government contribution–or voucher–and purchase private insurance coverage with those funds.

There are a number of issues that must be addressed for any voucher plan to be successfully implemented. ASIM supports creation of a voucher system and believes that the following elements are necessary to any voucher program designed for Medicare to ensure that beneficiaries have access to the widest range of cost-effective, high quality health plans, physicians and providers.

1. Medicare beneficiaries should be given the option of staying in the current Medicare program or using a voucher to buy any private health plan that meets certain conditions of participation.

If a plan purchased with a voucher becomes insolvent, or ceases operation in a beneficiary's area, beneficiaries should be able to enroll in another plan. When the annual enrollment period occurs, beneficiaries should be able to return to the traditional Medicare program at that time.

Transition to a voucher program should be done gradually to account for the fact that some areas of the country may not have the degree of managed care penetration necessary to make competition among health plans work. Retaining traditional Medicare would provide reassurance

to beneficiaries while serving as a spur to voucher plans to make their products attractive enough to encourage enrollment by Medicare recipients.

2. Under a voucher program, beneficiaries should have access to a variety of plans ranging from indemnity models to staff model HMOs. All voucher plans that restrict enrollees to the use of network providers should be required to offer at an actuarially-determined cost an optional rider that would provide point-of-service access to non-network physicians for those enrollees. Enrollees should be able to select from among a network plan's panel of physicians an internal medicine subspecialist as their primary care physician and plans should be prohibited from discriminating against physicians in their selection processes based on a physician's patient population.

Under the present Medicare system, beneficiaries are entitled to receive all covered benefits from any provider of their choice. A voucher system could undermine this basic premise of the program. For example, depending on the amount of the voucher and other rules governing the voucher program, beneficiaries could find their choice of health plan in reality to be quite limited. Furthermore, if the voucher is inadequately funded, some beneficiaries may be compelled to select a plan that limits the physicians and providers they may see for services. Adequate choice of physician and health plan can be promoted by offering beneficiaries a wide menu of plans and by establishing the federal contribution at a level that does not force patients to choose the cheapest plan available, as discussed below. By requiring voucher plans that use a network of physicians to offer enrollees the opportunity to buy a point-of-service rider, enrollees who want the flexibility to go outside the network will be able to select this option while those beneficiaries who wish to choose a closed-panel HMO may do so. In addition, a POS rider requirement for all health plans with restricted provider networks might ameliorate adverse risk selection arising from the tendency of very ill beneficiaries in an area to gravitate toward traditional Medicare and/or one plan with point-of-service.

3. Beneficiaries should have the option of using their government contribution--e.g. the voucher--to establish a Medical Savings Account (MSA) rather than to purchase coverage through a health plan. The MSA would:

a) be coupled with a catastrophic health insurance policy purchased through a purchasing group to help preserve community rating;

b) be comprised of a fund from which a beneficiary could pay deductible medical expenses and would be coupled with purchase of catastrophic health insurance to cover expenses that, in the aggregate, exceed the catastrophic insurance deductible;

c) permit accumulation of unspent balances within the fund;

d) allow state and federally tax exempt distribution of funds only for medical expenses, health insurance premiums and/or long term care.

Since 1987, ASIM has supported the concept of medical savings accounts and the idea of integrating medical savings accounts into an overall health system in which people could choose among a variety of health plans, including medical savings accounts. These accounts are useful

as part of a continuum of health care coverage options, particularly for their impact in enhancing consumers' awareness of the costs of health care.

ASIM feels strongly, however, that MSAs should not be used as the sole source of health care coverage but should be established in concert with a catastrophic health insurance policy. Furthermore, ASIM agrees with the concerns of some MSA critics that these accounts would adversely affect community rating of insurance and diminish the potential for widening insurance coverage. Ways to ameliorate these effects include ensuring that money in an MSA be used only for health care, including long term care, and making MSAs available for purchase only through purchasing groups to address problems with community rating.

ASIM acknowledges that MSAs appear to run counter to the trend in the health care system toward managed care. On the other hand, a spokesman for the American Academy of Actuaries Workgroup on MSAs predicted that managed care plans may respond "creatively" to these savings accounts by offering managed care products compatible with MSAs. Because MSAs appeal to so many patients and physicians, ASIM believes efforts should be made to include them in the menu of coverage options available to beneficiaries. To make medical savings accounts a reality under the Medicare program, however, will require many more provisions than the outline provided above. To implement MSAs, answers will be needed to questions such as: how will the government ensure that the funds in an MSA are, in fact, used for health care purposes?; will beneficiaries be able to contribute their own money to MSAs and, if so, will there have to be separate accounts established for private funds and the federal contribution?; can the savings instrument into which the government contribution is placed be protected against adverse market downturns so that beneficiaries do not lose their medical coverage?; should copayments be required as part of the catastrophic coverage?

4. Voucher plans should be required to accept all applicants during an open enrollment period to minimize adverse risk selection. Beneficiaries should be allowed one opportunity per enrollment year to disenroll from a plan within 60 days of enrollment. Once a beneficiary has been in a plan over 60 days, he or she should be required to wait until the next open enrollment period. Beneficiaries should be explicitly informed of this requirement by the health plan and should be required to sign a written acknowledgement of the conditions of enrollment.

A reinsurance mechanism should be available to those plans subject to adverse risk selection or to a sudden influx of voucher enrollees whose previous plan has gone bankrupt.

Another set of problems related to choice of physician and plan has to do with the response of health plans to those beneficiaries holding vouchers. To avoid circumstances in which health plans sought to avoid covering the very ill, all plans should be required to enroll any beneficiary with a voucher who seeks entrance into the plan. On the other hand, mandated acceptance and the ability of beneficiaries--under current Medicare risk contract rules--to enroll and disenroll outside of any prescribed enrollment period leaves plans vulnerable to unanticipated costs. In such a scenario, beneficiaries' right to choice of plan/physician conflicts with health plans' needs to maintain their cost and utilization control. The Congressional Budget Office has suggested that an annual enrollment period with a point-of-service policy "would permit Medicare enrollees to go to providers outside [a managed care plan's] panel when they wanted to and yet it need not increase benefit costs for either the [the plan] or Medicare." To avoid circumstances in which

beneficiaries enroll in and disenroll from plans multiple times using the 60 day window, there should only be one opportunity during an enrollment year to disenroll from a plan within two months, after which the beneficiary would have to wait for the next open enrollment period. For such changes to work, beneficiaries must be given enough information at the outset to understand that, in signing up for a managed care plan, they must remain with that plan until the next open enrollment period once they have been in a plan over two months. This puts the burden of education on the managed care plan and the decision in the hands of the beneficiary. In addition, such an approach would make managed care more palatable to both beneficiaries and physicians.

5. The defined contribution--or voucher--should be set at a level that would produce incentives for beneficiaries to consider cost in choosing a health plan without forcing them into the cheapest plans that are most restrictive of choice of physician. The voucher should not be set at the cost of the lowest priced plan in a region.

The voucher amount should be adjusted according to age, sex, disability status, institutional status, and Medicaid-buy in status and applied by region. Once the regionally adjusted voucher amount was established, HHS or HCFA would accept applications from health plans to participate in the voucher program.

If the voucher is set too high it will have little impact on controlling Medicare costs. Set too low and beneficiaries choosing the voucher option may find their choice of plan and, ultimately choice of physician, quite limited. In addition, for a segment of the Medicare population, a voucher will not cover what a health plan would spend on treating them. This would seem to call for some type of adjustment in the value of the voucher through mechanisms that are reasonably simple and inexpensive to administer. Otherwise, health plans might attempt to discourage certain beneficiaries from selecting that plan by adopting discriminatory policies or marketing strategies.

A voucher set at some national average would fail to reflect the appropriate regional differences in costs of health care delivery. Setting a regional voucher amount is a more accurate way for the voucher to reflect local health care costs, would be less likely to drive people into restrictive health plans and would ensure that there would be at least one plan in a region that could serve Medicare beneficiaries for the price of the voucher. Any process used to set the voucher amount in which plans submit their premiums to the government and the government then sets the voucher on some portion of those premiums must ensure that the resulting voucher is not so low as to make it worthless to most beneficiaries.

6. The voucher should be updated on a regular basis to keep pace with the costs of providing services to beneficiaries. In the event that spending under the voucher program exceeds estimated savings goals or targets, the voucher should not be subject to arbitrary caps. Mechanisms to keep spending within designated limits or to recoup excess expenditures, such as a "look back sequester", should be rejected. Instead, an independent board or commission should be established that would involve all participants in the health care system in devising a response to cost control that would not focus solely on cuts to providers and increased costs to beneficiaries. If spending is greater than projected due to development of valuable new technologies or increased patient utilization of services deemed medically necessary, there should be a commitment to increasing the amount of

funds devoted to the voucher program in order to ensure vouchers retain sufficient purchasing power and to assure appropriate medical outcomes.

The way in which the voucher is updated will determine to a large extent how much purchasing power the voucher continues to give beneficiaries. Given too great an increase and the voucher will be ineffective in controlling health costs. Given too little, and the voucher may drive some beneficiaries into lower quality, more restrictive health plans. There is also always a risk that the voucher update could fall victim to budget politics and be "frozen" or "capped" at some point to meet deficit reduction targets.

If spending under a voucher program is higher than anticipated because valuable new technologies or treatments have become available and patients have sought to take advantage of these advances in medicine, it does not make sense to penalize physicians by cutting their payments when costs increase for legitimate reasons. Furthermore, if beneficiaries do not participate in the voucher program in numbers sufficient to keep costs down, physicians should not be held financially responsible for beneficiaries' independent decisions. In addition, across-the-board cuts in physician and provider payments do not target those areas where health care costs have inappropriately increased and penalize caregivers who may in fact have kept their costs down. Arbitrary reductions in payments will serve only to perpetuate inequities in the Medicare payment system and compel physicians to limit their exposure to Medicare patients.

Finally, a cap on spending for the voucher implies a lack of confidence in the ability of the market to control the cost of health plan premiums and may have the unintended consequence of becoming a "floor" rather than a ceiling. If health plans know that the government's contribution will be capped at a certain percentage rate of growth, this may serve as an incentive to those plans whose rates of growth are lower than that percentage to allow their premiums to rise to meet the government's growth rate.

In the event federal health program costs remain uncontrollable, some entity -- such as a commission or board -- should be established separate from any government financing office to involve all parties in the health care system in devising a response to cost control that would not focus solely on cuts to providers and increased costs to beneficiaries. If beneficiaries are to be assured of getting all the necessary care they need when they need it, the voucher amount should keep pace with the costs of providing services. If the value of the voucher is allowed to erode over time, beneficiaries may lose access to many high quality health plans offering comprehensive services or they may be forced to pay increasing amounts out-of-pocket to maintain a certain level of service. This would be especially detrimental for those beneficiaries of low and moderate-income who may be unable to bear an increasing financial burden. If the market is unable to deliver health care to patients within a predetermined cap, this should not be used as an excuse to diminish the government's commitment to Medicare beneficiaries.

7. A reassessment of the voucher program should be required after five years. This reevaluation should be undertaken by an agency or commission not responsible for funding Medicare.

Given the untried nature of a voucher program for Medicare, there should be an evaluation of the program relatively early in its life. There was little comprehensive evaluation of the original Medicare program in its early stages and many of the present troubles in the system derive from that oversight. If the voucher program does not seem to be living up to its expectations,

Congress and the administration should not merely tinker at the edges to provide short term fixes but should step back, take a hard look at the program and even consider starting all over again.

8. Beneficiaries opting for the voucher program should be provided incentives that encourage their selection of an economically priced plan but that do not force enrollees into those plans that are most restrictive of choice of physician and that impose the strictest limits on access to services. Incentives should come in the form of additional benefits or services provided by the health plan and not in the form of a cash rebate. With rules in place to ensure that all beneficiaries have access through voucher plans to the full range of Medicare covered benefits and services, beneficiaries should pay the difference between the voucher amount and any premium charged by a plan that exceeds the voucher amount.

Some analysts contend that beneficiaries should be provided incentives to select a health plan that costs less than the federal contribution amount, or voucher. These incentives typically fall into two categories--cash rebates or additional services. Giving beneficiaries a cash rebate if their premium is less than the voucher amount would remove funds from the health care system that ought to be providing for health care services. Instead, any excess value should be returned to the beneficiary in the form of additional benefits such as coverage of additional services, providing coverage for long term care or creating a health care spending account. There is also debate over whether beneficiaries should bear the full cost of a health plan more expensive than the voucher to encourage enrollees to select more economical health plans. Although there is concern that such an incentive might drive beneficiaries to select plans of lesser quality or that don't cover the full range of benefits, this is less of a problems if all plans offer the full range of Medicare-covered services.

9. Reasonable cost sharing under voucher plans -- both fee for service and managed care -- should be imposed to assure consumer cost consciousness in utilization of services. Lower cost sharing should be imposed on clinically-proven preventive services so that people are not unduly discouraged from obtaining beneficial care. Preventive services should be subject only to copayments, not deductibles. Copayments for preventive services should be set lower than those for other services.

To avoid unjustified restrictions on choice of physician, POS voucher plans should not impose unreasonable coinsurance on services provided by out-of-network physicians. To prevent beneficiaries who seek out-of-network care from being subject to unexpected out-of-pocket costs, POS plans and physicians should be required to establish their own conversion factors to be used against an improved resource based relative value scale (RBRVS). This would determine the rates the POS plan would pay and the fees the physicians would charge for their services. Plans and physicians would be required to supply enrollees in the POS plan with information based on these conversion factors to enable enrollees to determine in advance how much they would pay in going out of the plan's network of physicians.

As an incentive to promote greater price consciousness in the traditional Medicare program and to encourage the movement of beneficiaries into the voucher system, those who choose to stay in the traditional Medicare program should be subject to

reasonable and non-punitive increases in cost-sharing. As with POS plans, in order to buffer beneficiaries from unexpected costs, a requirement could be imposed under traditional Medicare that physicians must establish their conversion factor for their services each year concomitant with the announcement of Medicare's conversion factor. Enrollees in traditional Medicare would be supplied annually with information comparing the charges of physicians in their area to Medicare's fees based on their respective conversion factors. In this fashion, beneficiaries would know in advance whether or not they would have to pay out-of-pocket for services charged under traditional Medicare.

Beneficiaries should not be subject to charges in excess of Medicare's payment amounts under the following circumstances: in the case of low income beneficiaries; emergency situations; when the beneficiary has little voice in the selection of a physician or in areas of the country where there is no competition for a particular medical specialty.

If true reform is to be instituted in the Medicare system, enrollees must understand the nature of the costs of their care under that program. At the same time, policymakers should not lose sight of the fact that 83 percent of Medicare expenditures go to beneficiaries with incomes at or below $25,000 and thus their exposure to additional costs should be limited.

ASIM believes it is especially important that cost sharing on preventive services be reduced and deductibles on these services be eliminated entirely to avoid discouraging patients from obtaining necessary care. By erecting barriers to cost-effective preventive care--for example, imposition of cost sharing on mammograms--patients may avoid those services and wind up with more serious, and expensive, illnesses in the future.

In addition, ASIM supports limits on the degree to which additional cost sharing can be imposed on those enrolled in managed care plans who use a plan's point-of-service (POS) option to seek care outside the plan's network of physicians. The intent behind POS is to allow beneficiaries greater choice in physician and provider. If the cost sharing imposed on a beneficiary for going outside a health plan's physician network is excessively burdensome, then the promise of greater choice is a hollow one.

Obviously, if beneficiaries are to be encouraged to enter the voucher program, those who opt to stay in traditional Medicare must bear a greater share of the cost of remaining in the more expensive program. Nevertheless, any additional cost sharing should follow the principles stated above so that primary care and preventive services are sheltered from deductibles and are subject to cost sharing at a rate lower than that imposed on other services. Because high deductibles can act as a disincentive for patients to receive needed primary care and preventive services, ASIM does not support replacing the current coinsurance requirements under traditional Medicare with a single high deductible.

ASIM believes that its Competitive Pricing, Informed Choices proposal--issued in 1992--offers a means to instill price competition among physicians, enhance consumer cost consciousness and prevent price gouging by unscrupulous providers. If health plans that pay according to a fee schedule (POS plans, traditional Medicare, etc.) and physicians were required to set and publish the conversion factors they would use each year to determine their charges and fees, this information could be used by beneficiaries to determine what they would pay out-of-pocket, if

anything, if they joined a particular health plan or used a particular doctor. Beneficiaries would then be able to decide if the value they derived from a health plan and/or physician in terms of quality and service was worth the price of any additional costs.

For example, assume Mrs. Jones is a Medicare beneficiary who receives from HCFA a booklet listing all the health plans and physicians in her area. Among the information contained in the booklet might be the percentage difference between the conversion factors used by traditional Medicare and POS plans and the physicians listed in the booklet. Mrs. Jones might see that Dr. Smith has a conversion factor 10 percent higher than Medicare's conversion factor. If she went to Dr. Smith for care under traditional Medicare, she would know that she would pay an additional ten percent on Dr. Smith's charges beyond the payment traditional Medicare would make. Or, Mrs. Jones might see that health plan ABC has a conversion factor for its POS option 20 percent lower than Dr. Smith's conversion factor. She would then know that Plan ABC would pay 20 percent less for the services of Dr. Smith--who does not participate in her health plan physician network--and she would be responsible for the 20 percent difference between the health plan's payments and Dr. Smith's fees, in addition to any additional cost sharing required by Plan ABC for enrollees going out of the network.

While ASIM generally supports cost sharing by patients in order to enhance cost consciousness in the utilization of scarce health care resources, there are situations in which billing beyond Medicare's payment rates or additional cost sharing should not be imposed. These situations arise where beneficiaries' income is simply too low to sustain any additional out-of-pocket financial burden, where they have no opportunity to "shop around" for a physician (e.g. emergency situations), where beneficiaries have but one choice of physician (such as typically occurs during hospitalizations when patients are essentially assigned certain hospital-based doctors to deliver designated services) or where there are so few physicians in a particular specialty within a community that there is no chance for competition among physicians to operate.

> 10. To qualify as a voucher plan under Medicare, health plans should have to: offer a standard minimum Medicare benefits package that includes preventive services; meet certain utilization review and quality assurance standards; involve participating physicians in development of the plan's utilization review (UR) and quality assurance (QA) and provider selection policies and procedures; disclose their utilization review and quality assurance policies, restrictions on choice, risk arrangements and provider selection criteria; establish due process mechanisms in selection of plan providers; meet certain solvency standards; report certain information -- such as premium costs, out-of-pocket liability, consumer satisfaction and the percentage of premium dollars devoted to administration versus benefits -- to a central data collection entity so that this information can be distributed to beneficiaries and use uniform claims forms and standard billing and claims processing procedures.
>
> Health plans that selectively contract with physicians should be required to offer enrollees the opportunity to buy a rider that provides point-of-service access to non-network physicians, in addition to meeting the foregoing standards.

Health plans should play by the same rules if competition is truly to be effective in controlling costs. Given that the idea behind many Medicare voucher proposals is to enhance competition within the program so as to bring down costs, it would seem equally advisable that health plans

should be required to meet certain rules if they wish to participate in the voucher program and market themselves to beneficiaries as Medicare voucher plans.

A uniform minimum benefit policy would assure a basic level of care for all beneficiaries. In addition, it would facilitate beneficiaries' comparison of health plans. If beneficiaries are to have sufficient information to make informed choices with their vouchers, they will need data on a plan's costs, patient out-of-pocket liability, provider panels, and quality. Furthermore, disclosure of UR and selection standards benefits not only the providers involved with a health plan but helps beneficiaries as well by giving them another piece of information on which to compare health plans.

In addition, it is important that physicians have a role in developing and implementing health plan policies and procedures that directly affect clinical decision-making--e.g. benefits coverage criteria, determination of medical necessity, preauthorization of services, quality assurance standards, protocols and processes for selection and deselection of physicians. To leave decisions affecting patient care solely in the hands of health plan administrators whose concerns center largely on cost containment may jeopardize the quality of care given to enrollees and deny patients access to medically necessary services. Furthermore, health plans that involve physicians in development of these policies are far more likely to obtain the cooperation of their network physicians in proper implementation of those policies.

Finally, it is important that voucher plans be required to operate under similar billing and claims processing procedures to avoid unnecessary red tape. All plans that currently operate within the Medicare system must abide by the uniform claims form and billing rules and it would be logical to expect that voucher plans should use a standard format and follow standard claims processing procedures for this new variation of the Medicare program.

The type of standards to which ASIM refers--involvement of physicians in clinical policymaking, providing information to enrollees and prospective enrollees sufficient to enable them to make informed decisions about the plan--are, in fact, those that are being adopted by many well-run health plans in today's marketplace. In a competitive environment, those plans that pursue "patient-friendly" policies such as these are more likely to succeed than others.

11. Because Medicare is a federally funded program, the federal government must continue to ensure that health plans are accountable for the care they give to beneficiaries and that they abide by standards set out for Medicare plans. HCFA or another federal agency should be responsible for contracting with health plans; reviewing marketing materials; disseminating to beneficiaries objective data about each plan in a region in a standard format; ensuring health plan compliance with certain standards governing their rules and operations; and ensuring that health plans meet certain quality standards. However, private accreditation agencies should be able to achieve "deemed" status to fulfill the role played by HHS in approving voucher plans. Mechanisms should be available for patients and physicians to pursue grievances against health plans for denial of medically necessary care. Patients and physicians should retain access to fair hearing and judicial review processes at least comparable to those now available under traditional Medicare.

Because vouchers would require more thought and decisionmaking by Medicare recipients, some analysts question whether beneficiaries would find the voucher program truly appealing. Other policymakers argue that the basic premise of the voucher program is simple and that most beneficiaries, given the right kind of information, will be able to make proper decisions about a health plan. While this may indeed be the case for healthy beneficiaries who are mentally alert, the frail and disabled elderly, those who do not speak English very well or those with little education may find the task of sorting through health plan information daunting. To respond to some of these concerns, the voucher program should have an entity with which voucher plans would contract and which would ensure voucher plan adherence to any standards adopted governing such plans.

Given the characteristics of the Medicare population, an ombudsman's office should be created to receive, investigate and resolve complaints against voucher plans as well as to offer guidance to beneficiaries with questions about the voucher program. Finally, beneficiaries and physicians should retain access to the current Medicare appeals process.

ASIM would prefer that the health care industry voluntarily abide by the standards established for a voucher program and, indeed, supports the idea of a private accreditation body responsible for ensuring health plan adherence to voucher program standards. However, the voucher program will be funded by federal dollars and the federal government should not relinquish its responsibility for ensuring that health plans are accountable for the care they deliver to beneficiaries and for seeing that corrective actions are taken when deficiencies are found if a plan wishes to remain in the voucher program. Health plans that accept the government contributions should understand that, if they are going to compete for the business of the federal government through the voucher program, they must accept certain standards and certain reasonable oversight.

12. Self-referral restrictions affecting shared laboratory facilities and group practices should be removed and antitrust reforms enacted to enable physicians and providers to negotiate on an equal footing with health plans and purchasers.

Antitrust reforms and other modifications to statutory restrictions on physicians could improve the functioning of health plans offered under a voucher system and the ability of physicians to deliver services within their context. For example, self-referral restrictions on group practice compensation arrangements not only interfere in the internal affairs of private businesses but lead to confusion over how such practices may distribute revenue from ancillary services without indirectly taking into account the referrals made by physicians. Furthermore, subspecialists--such as oncologists and infectious disease specialists--in many group practices are barred from providing drugs and other services to their patients because of the self-referral laws.

Limitations on the ability of physicians to share information in order to form integrated service networks may impede the goals of voucher advocates who wish to foster competition that reduces the cost of care and increases benefits to attract voucher recipients. Indeed, antitrust laws developed at a time when most physicians and other providers practiced independently of one another now prevent these caregivers from organizing preferred provider organizations, health plans and other delivery networks that would enable physician-directed health care organizations to compete in the marketplace and offer beneficiaries a wider choice of health care options.

Conclusion

ASIM is under no illusion that reforming Medicare will be simple, easy, or quick. Changes of the magnitude required to place the program on sound financial footing and to guarantee that beneficiaries continue to receive the high quality health care to which they have become accustomed and to which they are entitled will require a great deal of thought and debate. For ASIM, the overarching philosophy on which these Medicare reform proposals rest is that of shared responsibility.

Physicians have a responsibility to deliver care to greater numbers of Medicare patients under health care delivery systems that will increasingly require them to accept financial risk and to be accountable for the cost and quality of their clinical decisions--and to compete within this new system on the basis of cost and quality.

Medicare patients have a responsibility to consider the costs of alternative sources of health care coverage, to be willing to contribute more in out-of-pocket costs if they choose more expensive coverage and--for those who can afford to--to contribute more to the financial support of Medicare so that those of lesser means can afford coverage.

Taxpayers have a responsibility to accept changes in the tax code that would raise revenue and introduce positive incentives into the health care system including a limit on the tax deductibility of employer paid insurance and increased taxes on tobacco.

The insurance industry has a responsibility to compete in the new system--not solely on price or risk avoidance but on benefits offered and quality--and to accept reasonable standards to protect beneficiaries who choose private insurance coverage.

And the federal government has a responsibility to assure that the government's contribution remains adequate to guarantee that all beneficiaries can obtain high quality coverage through traditional Medicare and private sector alternatives--and to provide sufficient oversight over the market to protect patients' interests.

KEEPING MEDICARE AFFORDABLE
RECOMMENDATIONS OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE

EXECUTIVE SUMMARY

Thirty years ago, the Medicare program was created to ensure that the nation's elderly would not be denied medical care when they needed it. Today, almost all Americans over 65 feel secure in the knowledge that health care services will be accessible to them. The American Society of Internal Medicine, representing the nation's largest medical specialty and the principal providers of medical care to Medicare beneficiaries, is committed to preserving this contract with older Americans. However, in the face of changing demographics, burgeoning costs and the need to restrain overall federal spending, the Medicare program is facing an unprecedented challenge. Responding to this challenge will require both immediate changes in the program's financing and current risk contracting program as well as long-term reforms to broaden beneficiaries' choice of insurance options, control costs through enhanced competition and instill a sense of responsibility among all those involved with and affected by its policies.

This set of recommendations is ASIM's response to policymakers calls for proposals to address the need for fundamental changes in the Medicare program so that it may continue to be a reliable source of medical care for the nation's elderly well into the new century. For ASIM, the overarching philosophy on which these Medicare reform proposals rest is that of shared responsibility.

Physicians have a responsibility to deliver care to greater numbers of Medicare patients under health care delivery systems that will increasingly require them to accept financial risk and to be accountable for the cost and quality of their clinical decisions--and to compete within this new system on the basis of cost and quality.

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Changing the Medicare Financing System

Steps can be taken now to reform the current Medicare program so that future efforts to change the system need not be enacted in an atmosphere of crisis. These steps include:

1. increasing the eligibility age for Medicare to align it with eligibility for Social Security.

2. increasing the amount contributed by upper income beneficiaries to financing the Medicare system.

3. applying the Part B coinsurance to home health services.

4. including in taxable income the value of health insurance benefits beyond a set value of insurance premium.

5. limiting disproportionate hospital share (DSH) payments only to those facilities that, in fact, care for a disproportionate share of Medicare patients.

6. increasing federal excise taxes on alcohol and tobacco if the revenues from changes identified above prove inadequate to finance an appropriate level of benefits.

7. creation of a national all-payor funding pool for GME.

8. increasing the direct GME weighting factor for general internal medicine and other primary care residency positions while decreasing the weighting factor for others.

9. creation of a private sector physician workforce planning initiative.

10. decreasing the number of funded residency positions to 110 percent of U. S. medical school graduates.

Instilling Market-based Incentives in the Medicare Program

Additional steps can be taken to improve the existing Medicare risk contracting program so that this mechanism designed to enhance market competition can operate as it was intended until more substantial reforms are implemented. These steps include:

1. changing the adjusted average per capita cost (AAPCC) formula used to pay health plans.

2. applying risk adjustments--such as severity of illness--in setting payments to risk contracting plans.

3. broadening managed care choices for beneficiaries to include HMOs with point-of-service and preferred provider organizations (PPOs), instead of limiting

participation only to health plans that require beneficiaries to obtain services from contracted physicians and other providers.

4. requiring that beneficiaries be provided comparative information concerning all Medicare risk contracting plans that are available to them.

5. giving beneficiaries one opportunity per enrollment year to disenroll from a Medicare risk contracting within 60 days of enrollment. Once a beneficiary has been in a plan more than 60 days, he or she should be required to wait until the next open enrollment period.

6. mandating reasonable, non-punitive increases in premiums and other cost sharing for beneficiaries who choose to remain with the traditional fee-for-service Medicare program.

Medicare Vouchers

Changing the existing fee-for-service Medicare program and improving the current risk contract program will help to stabilize Medicare for the short term. However, major restructuring of Medicare is necessary to achieve a system that relies on competition to control costs and broaden beneficiary choices, that instills individual responsibility for the appropriate use of scarce medical resources and that assures the program's long term survival. One way to accomplish this is through the creation of a voucher program.

ASIM supports creation of a voucher system and believes that the following elements are necessary to any voucher program designed for Medicare to ensure that beneficiaries have access to the widest range of cost-effective, high quality health plans, physicians and providers.

1. Medicare beneficiaries should be given the option of staying in the current Medicare program or using a voucher to buy any private health plan that meets certain conditions of participation.

If a plan purchased with a voucher becomes insolvent, or ceases operation in a beneficiary's area, beneficiaries should be able to enroll in another plan. When the annual enrollment period occurs, beneficiaries should be able to return to the traditional Medicare program at that time.

2. Under a voucher program, beneficiaries should have access to a variety of plans ranging from indemnity models to staff model HMOs. All voucher plans that restrict enrollees to the use of network providers should be required to offer at an actuarially-determined level an optional rider that would provide point-of-service access to non-network physicians for those enrollees. Enrollees should be able to select from among a network plan's panel of physicians an internal medicine subspecialist as their primary care physician and plans should be prohibited from discriminating against physicians in their selection processes based on a physician's patient population.

3. Beneficiaries should have the option of using their government contribution--e.g. the voucher--to establish a Medical Savings Account (MSA) rather than to purchase coverage through a health plan. The MSA would:

a) be coupled with a catastrophic health insurance policy purchased through a purchasing group to help preserve community rating;

b) be comprised of a fund from which a beneficiary could pay deductible medical expenses and catastrophic health insurance to cover expenses that, in the aggregate, exceed the catastrophic insurance deductible;

c) permit accumulation of unspent balances within the fund;

d) allow state and federally tax exempt distribution of funds only for medical expenses, health insurance premiums and/or long term care.

4. Voucher plans should be required to accept all applicants during an open enrollment period to minimize adverse risk selection. Beneficiaries should be required to remain in a plan after the first 60 days until the next open enrollment period. Beneficiaries should be explicitly informed of this requirement by the health plan and should be required to sign a written acknowledgement of the conditions of enrollment.

A reinsurance mechanism should be available to those plans subject to adverse risk selection or to a sudden influx of voucher enrollees whose previous plan has gone bankrupt.

5. The defined contribution--or voucher--should be set at a level that would produce incentives for beneficiaries to consider cost in choosing a health plan without forcing them into the cheapest plans that are most restrictive of choice of physician. The voucher should not be set at the cost of the lowest priced plan in a region.

The voucher amount should be adjusted according to age, sex, disability status, institutional status, and Medicaid-buy in status and applied by region. Once the regionally adjusted voucher amount was established, HHS or HCFA would accept applications from health plans to participate in the voucher program.

6. The voucher should be updated on a regular basis to keep pace with the costs of providing services to beneficiaries. In the event that spending under the voucher program exceeds estimated savings goals or targets, the voucher should not be subject to arbitrary caps. Mechanisms to keep spending within designated limits or to recoup excess expenditures, such as a "look back sequester", should be rejected. Instead, an independent board or commission should be established that would involve all participants in the health care system in devising a response to cost control that would not focus solely on cuts to providers and increased costs to beneficiaries. If spending is greater than projected due to development of valuable new technologies or increased patient utilization of services deemed medically necessary, there should be a commitment to increasing the amount of

funds devoted to the voucher program in order to ensure vouchers retain sufficient purchasing power and to assure appropriate medical outcomes.

7. A reassessment of the voucher program should be required after five years. This reevaluation should be undertaken by an agency or commission not responsible for funding Medicare.

8. Beneficiaries opting for the voucher program should be provided incentives that encourage their selection of an economically priced plan but that do not force enrollees into those plans that are most restrictive of choice of physician and that impose the strictest limits on access to services. Incentives should come in the form of additional benefits or services provided by the health plan and not in the form of a cash rebate. With rules in place to ensure that all beneficiaries have access through voucher plans to the full range of Medicare covered benefits and services, beneficiaries should pay the difference between the voucher amount and any premium charged by a plan that exceeds the voucher amount.

9. Reasonable cost sharing under voucher plans – both fee for service and managed care – should be imposed to assure consumer cost consciousness in utilization of services. Lower cost sharing should be imposed on clinically-proven preventive services so that people are not unduly discouraged from obtaining beneficial care. Preventive services should be subject only to copayments, not deductibles. Copayments for preventive services should be set lower than those for other services.

To avoid unjustified restrictions on choice of physician, POS voucher plans should not impose unreasonable coinsurance on services provided by out-of-network physicians. To prevent beneficiaries who seek out-of-network care from being subject to unexpected out-of-pocket costs, POS plans and physicians should be required to establish their own conversion factors to be used against an improved resource based relative value scale (RBRVS). This would determine the rates the POS plan would pay and the fees the physicians would charge for their services. Plans and physicians would be required to supply enrollees in the POS plan with information based on these conversion factors to enable enrollees to determine in advance how much they would pay in going out of the plan's network of physicians.

As an incentive to promote greater price consciousness in the traditional Medicare program and to encourage the movement of beneficiaries into the voucher system, those who choose to stay in the traditional Medicare program should be subject to reasonable and non-punitive increases in cost-sharing. As with POS plans, in order to buffer beneficiaries from unexpected costs, a requirement could be imposed under traditional Medicare that physicians must establish their conversion factor for their services each year concomitant with the announcement of Medicare's conversion factor. Enrollees in traditional Medicare would be supplied annually with information comparing the charges of physicians in their area to Medicare's fees based on their respective conversion factors. In this fashion, beneficiaries would know in advance whether or not they would have to pay out-of-pocket for services charged under traditional Medicare.

Beneficiaries should not be subject to charges in excess of Medicare's payment amounts under the following circumstances: in the case of low income beneficiaries; emergency situations; when the beneficiary has little voice in the selection of a physician or in areas of the country where there is no competition for a particular medical specialty.

10. To qualify as a voucher plan under Medicare, health plans should have to: offer a standard minimum Medicare benefits package that includes preventive services; meet certain utilization review and quality assurance standards; involve participating physicians in development of the plan's utilization review (UR) and quality assurance (QA) and provider selection policies and procedures; disclose their utilization review and quality assurance policies, restrictions on choice, risk arrangements and provider selection criteria; establish due process mechanisms in selection of plan providers; meet certain solvency standards; report certain information -- such as premium costs, out-of-pocket liability, consumer satisfaction and the percentage of premium dollars devoted to administration versus benefits -- to a central data collection entity so that this information can be distributed to beneficiaries and use uniform claims forms and standard billing and claims processing procedures.

Health plans that selectively contract with physicians should be required to offer enrollees the opportunity to buy a rider that provides point-of-service access to non-network physicians, in addition to meeting the foregoing standards.

11. Because Medicare is a federally funded program, the federal government must continue to ensure that health plans are accountable for the care they give to beneficiaries and that they abide by standards set out for Medicare plans. HCFA or another federal agency should be responsible for contracting with health plans; reviewing marketing materials; disseminating to beneficiaries objective data about each plan in a region in a standard format; ensuring health plan compliance with certain standards governing their rules and operations; and ensuring that health plans meet certain quality standards. However, private accreditation agencies should be able to achieve "deemed" status to fulfill the role played by HHS in approving voucher plans. Mechanisms should be available for patients and physicians to pursue grievances against health plans for denial of medically necessary care. Patients and physicians should retain access to fair hearing and judicial review processes at least comparable to those now available under traditional Medicare.

12. Self-referral restrictions affecting shared laboratory facilities and group practices should be removed and antitrust reforms enacted to enable physicians and providers to negotiate on an equal footing with health plans and purchasers.

KEEPING MEDICARE AFFORDABLE
RECOMMENDATIONS OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE

Introduction

Thirty years ago, the Medicare program was created to ensure that the nation's elderly would not be denied medical care when they needed it. Today, almost all Americans over 65 feel secure in the knowledge that health care services will be accessible to them. The American Society of Internal Medicine, representing the nation's largest medical specialty and the principal providers of medical care to Medicare beneficiaries, is committed to preserving this contract with older Americans. However, in the face of changing demographics, burgeoning costs and the need to restrain overall federal spending, the Medicare program--as well as all those affected by its policies--is facing an unprecedented challenge.

Earlier this year, the trustees for the Hospital Insurance Fund declared that the Part A fund which finances hospital care will be bankrupt by the year 2002. What few realize is that the fund has already begun to run a deficit. Bankruptcy is merely the end product of the red ink that is beginning to accumulate in the system today.

As the population of Medicare eligible individuals grows, the ratio of working Americans who support the program with their payroll taxes to beneficiaries has diminished. Whereas today there are five working-age persons for each person over 65, by 2030--when today's workers retire and their children are wage earners--the ratio will be three working-age persons for each American over 65. Without any policy changes, Medicare SMI (Part B) will grow to more than 7 percent of the payroll tax base by 2030--up from one percent today. Although beneficiaries overall continue to have ready access to physicians and other providers, disturbing trends have been identified by the Physician Payment Review Commission (PPRC) and other organizations tracking the Medicare program. For example, the PPRC notes in its 1995 report to Congress "those over age 85, individuals living in poverty areas and the disabled continue to experience access barriers" that existed prior to the latest round of Medicare reform. The Employee Benefits Research Institute (EBRI) recently issued data showing that the number of Medicare patients seen each week by internists has been declining steadily since 1989. At the same time, there has been a significant increase in internists contracting with managed care plans. In the wake of continuing cuts in Medicare reimbursement to control program costs, physicians may be entering practice environments where the degree of involvement with Medicare patients is limited.

Indeed, cuts already enacted in previous budget reconciliation measures that are now being implemented will reduce payment levels to physicians over the next seven years by 17 percent, even before the impact of inflation is taken into account. Under one of the savings options proposed by a subgroup of the House Budget Committee, the reductions in payment levels for physician services will increase to 31 percent over the next seven years. If the debate beginning now in Congress is about making sure the elderly have access to appropriate, high quality health care into the next century, continued reductions of this type will only undermine this promise and create a Medicare program that guarantees access in name only.

If no action is taken, the hospital side of Medicare will go broke in less than a decade, the supplemental medical insurance portion of Medicare will consume increasing amounts of the federal budget and beneficiaries may face increasing difficulty in obtaining needed health care. This is clearly not a viable option.

Policymakers could continue with the historical approach to attempting to reign in Medicare's costs--enacting cuts in provider payments and imposing increasing regulatory rules on the program as part of massive year-end budget reconciliation measures. This, of course, does not address the underlying reasons for increasing costs under the program and will only serve to exacerbate many of the growing problems in Medicare.

The third option is to reform the Medicare program so that its financing is placed on a sound basis and to introduce the kind of marketplace incentives that have enjoyed success in the private sector in holding down the growth of health care costs. ASIM strongly believes that this is the only option that Congress should consider.

ASIM recognizes the urgent need for reforming the Medicare program and restraining growth in spending under other federal health care programs. However, internists also believe that significant changes in these programs *ideally* should be made in the context of other health system reforms. Medical liability reform, insurance market reform, measures to broaden and protect choice of plan and physician, and steps to ensure due process for patients and providers in health plan operations and clinical decisions are important system-wide reforms that will foster an environment in which changes in Medicare will have a positive impact. Nevertheless, the following set of recommendations is ASIM's response to policymakers calls for proposals to address the need for fundamental changes in the Medicare program so that it may continue to be a reliable source of medical care for the nation's elderly well into the new century.

The recommendations propose both immediate and longer-term reforms in the following areas:

1. Immediate changes in Medicare financing and the current Medicare risk contracting program.

2. Longer term reforms to expand beneficiaries' choice of insurance options through enactment of a defined federal contribution--or voucher--program.

Changing the Medicare Financing System

Many analysts and policymakers contend that only complete transformation of the Medicare program can solve its financing problems. Any type of restructuring, however, will be the subject of considerable debate and, given the realities of the policymaking process, could take a number of years to implement. In the meantime, the red ink will grow and problems of access will be exacerbated. Steps can be taken now to reform the current Medicare program so that future efforts to change the system need not be enacted in an atmosphere of crisis.

Last December, a report on entitlement reform options was issued by staff from the Bipartisan Commission on Entitlement and Tax Reform (hereinafter referred to as the Commission). That report identified a number of measures that could be enacted in the existing Medicare program to stem the imbalance in funding. These improvements can be made with or without enactment of

other long term reforms, such as a voucher program. Among those improvements ASIM supports are:

1. increasing the eligibility age for Medicare to align it with eligibility for Social Security. By early in the next century, the eligibility age for Social Security will be 67. It would make sense, both financially and administratively, to couple the eligibility age for Social Security with that for Medicare. However, such a change must come in concert with insurance market reforms and other measures to assist those elderly under 67 with chronic, but not disabling, illnesses in maintaining insurance coverage.

2. increasing the amount contributed by upper income beneficiaries to financing the Medicare system. The Commission staff proposed reducing the Part B premium subsidy and creating a new Part A premium indexed according to growth in program costs. ASIM believes this premium should instead be indexed to income. This would avoid imposing an excessive burden on those with modest means while concomitantly calling for appropriate contributions from those with greater ability to finance their health care.

3. applying the Part B coinsurance to home health services. Current law requires no cost sharing by beneficiaries for these services. Home health care has been among the fastest growing parts of the Medicare budget and cost sharing has been demonstrated effective in stemming overutilization of services.

4. including in taxable income the value of health insurance benefits beyond a set value of insurance premium. Today, employers and workers benefit from a system that gives preferential tax treatment to high cost health plans. Placing a limit on the tax deductibility of such health insurance will promote the purchase of cost-effective but moderately priced health plans and would bring in significant revenue into the health care financing system.

5. limiting disproportionate hospital share (DSH) payments only to those facilities that, in fact, care for a disproportionate share of Medicare patients. The Commission staff report cited studies showing that DSH payments, intended to compensate hospitals for services provided to low income individuals, have been used by some states for purposes beyond its original intent. Without harming those hospitals truly in need of these payments, the formula should be changed--e.g. elimination of DSH payments for hospitals whose disproportionate share index is below the 80th percentile--to avoid inappropriate uses of federal payments.

In accord with ASIM's longstanding policy that Medicare trust fund reserves should be augmented through a combination of expenditure reductions, program efficiencies and revenue increases, ASIM also supports:

6. increasing federal excise taxes on alcohol and tobacco if the revenues from changes identified above prove inadequate to finance an appropriate level of benefits. Not only would these additional revenues help to support the program but they would discourage certain behaviors that result in increased public and personal health costs.

Historically, Medicare has served as a major source of financing for training of this nation's doctors. However, changes have been proposed in Medicare's funding of graduate medical education (GME) as another avenue for achieving significant savings in the program's budget. One proposal offered by the Health Care Working Group of the House Budget Committee would cut direct and indirect GME spending by $27.24 billion over seven years.

ASIM believes it is time to rethink Medicare funding of graduate medical education, not simply as a device to reduce federal spending, but in order to respond to the changing health care delivery environment and to ensure that all components of the health care system that benefit from highly trained physicians contribute to the cost of their education. To those ends, ASIM supports:

7. creation of a national all-payer funding pool for GME. All payers and health plans should contribute a percentage of their premiums to a financing pool for graduate medical education. With managed care plans and other health delivery organizations seeking qualified, well-trained physicians for their networks, they, as well as all payers interested in providing the best care possible for their insureds, have a stake in the education of the physicians that will contract with their plans. Until now, no one has asked these health plans and insurers to help support the cost of training this nation's physicians. However, given Medicare's financial condition, the federal government can no longer be viewed as a major source of funding for the future supply of doctors.

8. creation of a private sector physician workforce planning initiative. The American Medical Association has proposed that a taskforce be established with participation of both public and private sectors to offer recommendations to Congress about the physician workforce supply and the future of GME. If the all-payer GME pool is established, such a task force will be necessary to advise how the funds in the all-payer pool would be distributed.

9. increasing the direct GME weighting factor for general internal medicine and other primary care residency positions while decreasing the weighting factor for others. Currently, direct medical education payments are based on hospital-specific, per resident costs multiplied by the number of residents. Proposals have been offered in past Congresses to reimburse hospitals more for primary care residents than for specialty residents in order to encourage training of more primary care physicians. The need for more primary care physicians has grown with the increase in the elderly population as well as with the desire of health plans for physicians to manage the care of their enrollees. Alterations in the financing of medical education will encourage changes in training programs to meet those needs.

10. decreasing the number of funded residency positions to 110 percent of U. S. medical school graduates. The Physician Payment Review Commission has recommended that the number of funded residency positions in the United States be reduced in order to respond to the fact that the country is facing, in general, an excess of physicians. By taking this action, the U. S. would cut the oversupply of physicians while at the same time--if the other steps are taken--increase the proportion of primary care physicians relative to the population.

Instilling Market-based Incentives in the Medicare Program

The current Medicare program includes an optional program intended to use competition among health plans as a means to moderate costs. The Medicare risk contracting program--in which Medicare contracts with health plans and pays them a capitated payment based on less than 95% of the adjusted actual per capita costs of caring for Medicare patients--was intended to encourage health plans to control utilization of services and, subsequently, costs. Because of flaws in the formula for paying risk contracting plans and because healthier beneficiaries are more likely to enroll in these health plans than other beneficiaries, the risk contracting program has not been as successful at reducing Medicare spending as originally anticipated.

Again, steps can be taken to improve this existing mechanism designed to enhance market competition until more substantial reforms are implemented. These include:

1. changing the adjusted average per capita cost (AAPCC) formula used to pay health plans. The current AAPCC is based on historical, fee-for-service costs in an area. This has resulted in overgenerous payments to health plans in high cost areas and modest payments to health plans in regions where health care costs have been kept relatively low. Changes in the AAPCC should reward cost effective health plans in areas with historically low utilization rates instead of penalizing such plans with less generous AAPCC payments.

2. applying risk adjustments--such as severity of illness--in setting payments to risk contracting plans. This change should be coupled with other reforms in the AAPCC to avoid driving away from the program managed care plans that might attract more seriously ill patients and to make regional plan payments more equitable.

3. broadening managed care choices for beneficiaries to include HMOs with point-of-service and preferred provider organizations (PPOs), instead of limiting participation only to health plans that require beneficiaries to obtain services from contracted physicians and other providers. Under the current risk contracting program, beneficiaries have a limited range of health plans from which to choose and are precluded from taking advantage of the numerous managed care products that have arisen in recent years in the private market.

4. requiring that beneficiaries be provided comparative information concerning all Medicare risk contracting plans that are available to them. In order for beneficiaries to make fully informed choices about their health plan, they should be provided sufficient data that will enable them to compare these plans on costs, physicians and other providers, quality and benefits.

5. giving beneficiaries one opportunity per enrollment year to disenroll from a plan within 60 days of enrollment. Once a beneficiary has been in a plan over 60 days, he or she should be required to wait until the next open enrollment period. Under current law, beneficiaries may disenroll from a health plan with only a 30 days notice. This makes it difficult for many risk contracting plans to anticipate costs for a health plan year. It is also contrary to most enrollment policies effective in the private sector which call for enrollment or disenrollment during a particular "open

season". Asking beneficiaries to stay with a plan until the next open season once they have been in a plan for two months would offer additional stability to a risk contracting plan without limiting too severely beneficiaries' ability to change their minds about managed care. Such a requirement would make Medicare more consistent with the private sector in which workers are required to make an annual selection of a health plan and to stay with that plan for an entire year. Limiting the disenrollment opportunity to one per year would also prevent cases in which people jump from plan to plan every so often prior to the 60 day deadline. Medicare patients should accept the same degree of responsibility in choosing a health plan that is expected from those under 65.

6. mandating reasonable, non-punitive increases in premiums and other cost sharing for beneficiaries who choose to remain with the traditional fee-for-service Medicare program. With improvements in the risk contracting program, it is reasonable to expect that those who choose to remain with the higher cost fee-for-service side of Medicare should bear a portion of those higher expenditures.

The current risk contracting program would be repealed upon enactment of a voucher program as described below.

Medicare Vouchers

Making changes in the existing fee-for-service Medicare program and improvements in the current risk contract program will help to stabilize the program for the short term. However, to achieve a system that relies on competition to control costs and broaden beneficiary choices, that instills individual responsibility for the appropriate use of scarce medical resources and that assures the long term survival of Medicare, major restructuring of the program will be required. One way to do this is for the government to offer beneficiaries the opportunity to take a defined government contribution--or voucher--and purchase private insurance coverage with those funds.

There are a number of issues that must be addressed for any voucher plan to be successfully implemented. ASIM supports creation of a voucher system and believes that the following elements are necessary to any voucher program designed for Medicare to ensure that beneficiaries have access to the widest range of cost-effective, high quality health plans, physicians and providers.

1. Medicare beneficiaries should be given the option of staying in the current Medicare program or using a voucher to buy any private health plan that meets certain conditions of participation.

If a plan purchased with a voucher becomes insolvent, or ceases operation in a beneficiary's area, beneficiaries should be able to enroll in another plan. When the annual enrollment period occurs, beneficiaries should be able to return to the traditional Medicare program at that time.

Transition to a voucher program should be done gradually to account for the fact that some areas of the country may not have the degree of managed care penetration necessary to make competition among health plans work. Retaining traditional Medicare would provide reassurance

to beneficiaries while serving as a spur to voucher plans to make their products attractive enough to encourage enrollment by Medicare recipients.

2. Under a voucher program, beneficiaries should have access to a variety of plans ranging from indemnity models to staff model HMOs. All voucher plans that restrict enrollees to the use of network providers should be required to offer at an actuarially-determined cost an optional rider that would provide point-of-service access to non-network physicians for those enrollees. Enrollees should be able to select from among a network plan's panel of physicians an internal medicine subspecialist as their primary care physician and plans should be prohibited from discriminating against physicians in their selection processes based on a physician's patient population.

Under the present Medicare system, beneficiaries are entitled to receive all covered benefits from any provider of their choice. A voucher system could undermine this basic premise of the program. For example, depending on the amount of the voucher and other rules governing the voucher program, beneficiaries could find their choice of health plan in reality to be quite limited. Furthermore, if the voucher is inadequately funded, some beneficiaries may be compelled to select a plan that limits the physicians and providers they may see for services. Adequate choice of physician and health plan can be promoted by offering beneficiaries a wide menu of plans and by establishing the federal contribution at a level that does not force patients to choose the cheapest plan available, as discussed below. By requiring voucher plans that use a network of physicians to offer enrollees the opportunity to buy a point-of-service rider, enrollees who want the flexibility to go outside the network will be able to select this option while those beneficiaries who wish to choose a closed-panel HMO may do so. In addition, a POS rider requirement for all health plans with restricted provider networks might ameliorate adverse risk selection arising from the tendency of very ill beneficiaries in an area to gravitate toward traditional Medicare and/or one plan with point-of-service.

3. Beneficiaries should have the option of using their government contribution--e.g. the voucher--to establish a Medical Savings Account (MSA) rather than to purchase coverage through a health plan. The MSA would:

a) be coupled with a catastrophic health insurance policy purchased through a purchasing group to help preserve community rating;

b) be comprised of a fund from which a beneficiary could pay deductible medical expenses and would be coupled with purchase of catastrophic health insurance to cover expenses that, in the aggregate, exceed the catastrophic insurance deductible;

c) permit accumulation of unspent balances within the fund;

d) allow state and federally tax exempt distribution of funds only for medical expenses, health insurance premiums and/or long term care.

Since 1987, ASIM has supported the concept of medical savings accounts and the idea of integrating medical savings accounts into an overall health system in which people could choose among a variety of health plans, including medical savings accounts. These accounts are useful

as part of a continuum of health care coverage options, particularly for their impact in enhancing consumers' awareness of the costs of health care.

ASIM feels strongly, however, that MSAs should not be used as the sole source of health care coverage but should be established in concert with a catastrophic health insurance policy. Furthermore, ASIM agrees with the concerns of some MSA critics that these accounts would adversely affect community rating of insurance and diminish the potential for widening insurance coverage. Ways to ameliorate these effects include ensuring that money in an MSA be used only for health care, including long-term care, and making MSAs available for purchase only through purchasing groups to address problems with community rating.

ASIM acknowledges that MSAs appear to run counter to the trend in the health care system toward managed care. On the other hand, a spokesman for the American Academy of Actuaries Workgroup on MSAs predicted that managed care plans may respond "creatively" to these savings accounts by offering managed care products compatible with MSAs. Because MSAs appeal to so many patients and physicians, ASIM believes efforts should be made to include them in the menu of coverage options available to beneficiaries. To make medical savings accounts a reality under the Medicare program, however, will require many more provisions than the outline provided above. To implement MSAs, answers will be needed to questions such as: how will the government ensure that the funds in an MSA are, in fact, used for health care purposes?; will beneficiaries be able to contribute their own money to MSAs and, if so, will there have to be separate accounts established for private funds and the federal contribution?; can the savings instrument into which the government contribution is placed be protected against adverse market downturns so that beneficiaries do not lose their medical coverage?; should copayments be required as part of the catastrophic coverage?

4. Voucher plans should be required to accept all applicants during an open enrollment period to minimize adverse risk selection. Beneficiaries should be allowed one opportunity per enrollment year to disenroll from a plan within 60 days of enrollment. Once a beneficiary has been in a plan over 60 days, he or she should be required to wait until the next open enrollment period. Beneficiaries should be explicitly informed of this requirement by the health plan and should be required to sign a written acknowledgement of the conditions of enrollment.

A reinsurance mechanism should be available to those plans subject to adverse risk selection or to a sudden influx of voucher enrollees whose previous plan has gone bankrupt.

Another set of problems related to choice of physician and plan has to do with the response of health plans to those beneficiaries holding vouchers. To avoid circumstances in which health plans sought to avoid covering the very ill, all plans should be required to enroll any beneficiary with a voucher who seeks entrance into the plan. On the other hand, mandated acceptance and the ability of beneficiaries--under current Medicare risk contract rules--to enroll and disenroll outside of any prescribed enrollment period leaves plans vulnerable to unanticipated costs. In such a scenario, beneficiaries' right to choice of plan/physician conflicts with health plans' needs to maintain their cost and utilization control. The Congressional Budget Office has suggested that an annual enrollment period with a point-of-service policy "would permit Medicare enrollees to go to providers outside [a managed care plan's] panel when they wanted to and yet it need not increase benefit costs for either the [the plan] or Medicare." To avoid circumstances in which

beneficiaries enroll in and disenroll from plans multiple times using the 60 day window, there should only be one opportunity during an enrollment year to disenroll from a plan within two months, after which the beneficiary would have to wait for the next open enrollment period. For such changes to work, beneficiaries must be given enough information at the outset to understand that, in signing up for a managed care plan, they must remain with that plan until the next open enrollment period once they have been in a plan over two months. This puts the burden of education on the managed care plan and the decision in the hands of the beneficiary. In addition, such an approach would make managed care more palatable to both beneficiaries and physicians.

5. The defined contribution--or voucher--should be set at a level that would produce incentives for beneficiaries to consider cost in choosing a health plan without forcing them into the cheapest plans that are most restrictive of choice of physician. The voucher should not be set at the cost of the lowest priced plan in a region.

The voucher amount should be adjusted according to age, sex, disability status, institutional status, and Medicaid-buy in status and applied by region. Once the regionally adjusted voucher amount was established, HHS or HCFA would accept applications from health plans to participate in the voucher program.

If the voucher is set too high it will have little impact on controlling Medicare costs. Set too low and beneficiaries choosing the voucher option may find their choice of plan and, ultimately choice of physician, quite limited. In addition, for a segment of the Medicare population, a voucher will not cover what a health plan would spend on treating them. This would seem to call for some type of adjustment in the value of the voucher through mechanisms that are reasonably simple and inexpensive to administer. Otherwise, health plans might attempt to discourage certain beneficiaries from selecting that plan by adopting discriminatory policies or marketing strategies.

A voucher set at some national average would fail to reflect the appropriate regional differences in costs of health care delivery. Setting a regional voucher amount is a more accurate way for the voucher to reflect local health care costs, would be less likely to drive people into restrictive health plans and would ensure that there would be at least one plan in a region that could serve Medicare beneficiaries for the price of the voucher. Any process used to set the voucher amount in which plans submit their premiums to the government and the government then sets the voucher on some portion of those premiums must ensure that the resulting voucher is not so low as to make it worthless to most beneficiaries.

6. The voucher should be updated on a regular basis to keep pace with the costs of providing services to beneficiaries. In the event that spending under the voucher program exceeds estimated savings goals or targets, the voucher should not be subject to arbitrary caps. Mechanisms to keep spending within designated limits or to recoup excess expenditures, such as a "look back sequester", should be rejected. Instead, an independent board or commission should be established that would involve all participants in the health care system in devising a response to cost control that would not focus solely on cuts to providers and increased costs to beneficiaries. If spending is greater than projected due to development of valuable new technologies or increased patient utilization of services deemed medically necessary, there should be a commitment to increasing the amount of

funds devoted to the voucher program in order to ensure vouchers retain sufficient purchasing power and to assure appropriate medical outcomes.

The way in which the voucher is updated will determine to a large extent how much purchasing power the voucher continues to give beneficiaries. Given too great an increase and the voucher will be ineffective in controlling health costs. Given too little, and the voucher may drive some beneficiaries into lower quality, more restrictive health plans. There is also always a risk that the voucher update could fall victim to budget politics and be "frozen" or "capped" at some point to meet deficit reduction targets.

If spending under a voucher program is higher than anticipated because valuable new technologies or treatments have become available and patients have sought to take advantage of these advances in medicine, it does not make sense to penalize physicians by cutting their payments when costs increase for legitimate reasons. Furthermore, if beneficiaries do not participate in the voucher program in numbers sufficient to keep costs down, physicians should not be held financially responsible for beneficiaries' independent decisions. In addition, across-the-board cuts in physician and provider payments do not target those areas where health care costs have inappropriately increased and penalize caregivers who may in fact have kept their costs down. Arbitrary reductions in payments will serve only to perpetuate inequities in the Medicare payment system and compel physicians to limit their exposure to Medicare patients.

Finally, a cap on spending for the voucher implies a lack of confidence in the ability of the market to control the cost of health plan premiums and may have the unintended consequence of becoming a "floor" rather than a ceiling. If health plans know that the government's contribution will be capped at a certain percentage rate of growth, this may serve as an incentive to those plans whose rates of growth are lower than that percentage to allow their premiums to rise to meet the government's growth rate.

In the event federal health program costs remain uncontrollable, some entity – such as a commission or board – should be established separate from any government financing office to involve all parties in the health care system in devising a response to cost control that would not focus solely on cuts to providers and increased costs to beneficiaries. If beneficiaries are to be assured of getting all the necessary care they need when they need it, the voucher amount should keep pace with the costs of providing services. If the value of the voucher is allowed to erode over time, beneficiaries may lose access to many high quality health plans offering comprehensive services or they may be forced to pay increasing amounts out-of-pocket to maintain a certain level of service. This would be especially detrimental for those beneficiaries of low and moderate-income who may be unable to bear an increasing financial burden. If the market is unable to deliver health care to patients within a predetermined cap, this should not be used as an excuse to diminish the government's commitment to Medicare beneficiaries.

7. A reassessment of the voucher program should be required after five years. This reevaluation should be undertaken by an agency or commission not responsible for funding Medicare.

Given the untried nature of a voucher program for Medicare, there should be an evaluation of the program relatively early in its life. There was little comprehensive evaluation of the original Medicare program in its early stages and many of the present troubles in the system derive from that oversight. If the voucher program does not seem to be living up to its expectations,

Congress and the administration should not merely tinker at the edges to provide short term fixes but should step back, take a hard look at the program and even consider starting all over again.

8. Beneficiaries opting for the voucher program should be provided incentives that encourage their selection of an economically priced plan but that do not force enrollees into those plans that are most restrictive of choice of physician and that impose the strictest limits on access to services. Incentives should come in the form of additional benefits or services provided by the health plan and not in the form of a cash rebate. With rules in place to ensure that all beneficiaries have access through voucher plans to the full range of Medicare covered benefits and services, beneficiaries should pay the difference between the voucher amount and any premium charged by a plan that exceeds the voucher amount.

Some analysts contend that beneficiaries should be provided incentives to select a health plan that costs less than the federal contribution amount, or voucher. These incentives typically fall into two categories--cash rebates or additional services. Giving beneficiaries a cash rebate if their premium is less than the voucher amount would remove funds from the health care system that ought to be providing for health care services. Instead, any excess value should be returned to the beneficiary in the form of additional benefits such as coverage of additional services, providing coverage for long term care or creating a health care spending account. There is also debate over whether beneficiaries should bear the full cost of a health plan more expensive than the voucher to encourage enrollees to select more economical health plans. Although there is concern that such an incentive might drive beneficiaries to select plans of lesser quality or that don't cover the full range of benefits, this is less of a problems if all plans offer the full range of Medicare-covered services.

9. Reasonable cost sharing under voucher plans -- both fee for service and managed care -- should be imposed to assure consumer cost consciousness in utilization of services. Lower cost sharing should be imposed on clinically-proven preventive services so that people are not unduly discouraged from obtaining beneficial care. Preventive services should be subject only to copayments, not deductibles. Copayments for preventive services should be set lower than those for other services.

To avoid unjustified restrictions on choice of physician, POS voucher plans should not impose unreasonable coinsurance on services provided by out-of-network physicians. To prevent beneficiaries who seek out-of-network care from being subject to unexpected out-of-pocket costs, POS plans and physicians should be required to establish their own conversion factors to be used against an improved resource based relative value scale (RBRVS). This would determine the rates the POS plan would pay and the fees the physicians would charge for their services. Plans and physicians would be required to supply enrollees in the POS plan with information based on these conversion factors to enable enrollees to determine in advance how much they would pay in going out of the plan's network of physicians.

As an incentive to promote greater price consciousness in the traditional Medicare program and to encourage the movement of beneficiaries into the voucher system, those who choose to stay in the traditional Medicare program should be subject to

reasonable and non-punitive increases in cost-sharing. As with POS plans, in order to buffer beneficiaries from unexpected costs, a requirement could be imposed under traditional Medicare that physicians must establish their conversion factor for their services each year concomitant with the announcement of Medicare's conversion factor. Enrollees in traditional Medicare would be supplied annually with information comparing the charges of physicians in their area to Medicare's fees based on their respective conversion factors. In this fashion, beneficiaries would know in advance whether or not they would have to pay out-of-pocket for services charged under traditional Medicare.

Beneficiaries should not be subject to charges in excess of Medicare's payment amounts under the following circumstances: in the case of low income beneficiaries; emergency situations; when the beneficiary has little voice in the selection of a physician or in areas of the country where there is no competition for a particular medical specialty.

If true reform is to be instituted in the Medicare system, enrollees must understand the nature of the costs of their care under that program. At the same time, policymakers should not lose sight of the fact that 83 percent of Medicare expenditures go to beneficiaries with incomes at or below $25,000 and thus their exposure to additional costs should be limited.

ASIM believes it is especially important that cost sharing on preventive services be reduced and deductibles on these services be eliminated entirely to avoid discouraging patients from obtaining necessary care. By erecting barriers to cost-effective preventive care--for example, imposition of cost sharing on mammograms--patients may avoid those services and wind up with more serious, and expensive, illnesses in the future.

In addition, ASIM supports limits on the degree to which additional cost sharing can be imposed on those enrolled in managed care plans who use a plan's point-of-service (POS) option to seek care outside the plan's network of physicians. The intent behind POS is to allow beneficiaries greater choice in physician and provider. If the cost sharing imposed on a beneficiary for going outside a health plan's physician network is excessively burdensome, then the promise of greater choice is a hollow one.

Obviously, if beneficiaries are to be encouraged to enter the voucher program, those who opt to stay in traditional Medicare must bear a greater share of the cost of remaining in the more expensive program. Nevertheless, any additional cost sharing should follow the principles stated above so that primary care and preventive services are sheltered from deductibles and are subject to cost sharing at a rate lower than that imposed on other services. Because high deductibles can act as a disincentive for patients to receive needed primary care and preventive services, ASIM does not support replacing the current coinsurance requirements under traditional Medicare with a single high deductible.

ASIM believes that its Competitive Pricing, Informed Choices proposal--issued in 1992--offers a means to instill price competition among physicians, enhance consumer cost consciousness and prevent price gouging by unscrupulous providers. If health plans that pay according to a fee schedule (POS plans, traditional Medicare, etc.) and physicians were required to set and publish the conversion factors they would use each year to determine their charges and fees, this information could be used by beneficiaries to determine what they would pay out-of-pocket, if

anything, if they joined a particular health plan or used a particular doctor. Beneficiaries would then be able to decide if the value they derived from a health plan and/or physician in terms of quality and service was worth the price of any additional costs.

For example, assume Mrs. Jones is a Medicare beneficiary who receives from HCFA a booklet listing all the health plans and physicians in her area. Among the information contained in the booklet might be the percentage difference between the conversion factors used by traditional Medicare and POS plans and the physicians listed in the booklet. Mrs. Jones might see that Dr. Smith has a conversion factor 10 percent higher than Medicare's conversion factor. If she went to Dr. Smith for care under traditional Medicare, she would know that she would pay an additional ten percent on Dr. Smith's charges beyond the payment traditional Medicare would make. Or, Mrs. Jones might see that health plan ABC has a conversion factor for its POS option 20 percent lower than Dr. Smith's conversion factor. She would then know that Plan ABC would pay 20 percent less for the services of Dr. Smith--who does not participate in her health plan physician network--and she would be responsible for the 20 percent difference between the health plan's payments and Dr. Smith's fees, in addition to any additional cost sharing required by Plan ABC for enrollees going out of the network.

While ASIM generally supports cost sharing by patients in order to enhance cost consciousness in the utilization of scarce health care resources, there are situations in which billing beyond Medicare's payment rates or additional cost sharing should not be imposed. These situations arise where beneficiaries' income is simply too low to sustain any additional out-of-pocket financial burden, where they have no opportunity to "shop around" for a physician (e.g. emergency situations), where beneficiaries have but one choice of physician (such as typically occurs during hospitalizations when patients are essentially assigned certain hospital-based doctors to deliver designated services) or where there are so few physicians in a particular specialty within a community that there is no chance for competition among physicians to operate.

10. To qualify as a voucher plan under Medicare, health plans should have to: offer a standard minimum Medicare benefits package that includes preventive services; meet certain utilization review and quality assurance standards; involve participating physicians in development of the plan's utilization review (UR) and quality assurance (QA) and provider selection policies and procedures; disclose their utilization review and quality assurance policies, restrictions on choice, risk arrangements and provider selection criteria; establish due process mechanisms in selection of plan providers; meet certain solvency standards; report certain information -- such as premium costs, out-of-pocket liability, consumer satisfaction and the percentage of premium dollars devoted to administration versus benefits -- to a central data collection entity so that this information can be distributed to beneficiaries and use uniform claims forms and standard billing and claims processing procedures.

Health plans that selectively contract with physicians should be required to offer enrollees the opportunity to buy a rider that provides point-of-service access to non-network physicians, in addition to meeting the foregoing standards.

Health plans should play by the same rules if competition is truly to be effective in controlling costs. Given that the idea behind many Medicare voucher proposals is to enhance competition within the program so as to bring down costs, it would seem equally advisable that health plans

should be required to meet certain rules if they wish to participate in the voucher program and market themselves to beneficiaries as Medicare voucher plans.

A uniform minimum benefit policy would assure a basic level of care for all beneficiaries. In addition, it would facilitate beneficiaries' comparison of health plans. If beneficiaries are to have sufficient information to make informed choices with their vouchers, they will need data on a plan's costs, patient out-of-pocket liability, provider panels, and quality. Furthermore, disclosure of UR and selection standards benefits not only the providers involved with a health plan but helps beneficiaries as well by giving them another piece of information on which to compare health plans.

In addition, it is important that physicians have a role in developing and implementing health plan policies and procedures that directly affect clinical decision-making--e.g. benefits coverage criteria, determination of medical necessity, preauthorization of services, quality assurance standards, protocols and processes for selection and deselection of physicians. To leave decisions affecting patient care solely in the hands of health plan administrators whose concerns center largely on cost containment may jeopardize the quality of care given to enrollees and deny patients access to medically necessary services. Furthermore, health plans that involve physicians in development of these policies are far more likely to obtain the cooperation of their network physicians in proper implementation of those policies.

Finally, it is important that voucher plans be required to operate under similar billing and claims processing procedures to avoid unnecessary red tape. All plans that currently operate within the Medicare system must abide by the uniform claims form and billing rules and it would be logical to expect that voucher plans should use a standard format and follow standard claims processing procedures for this new variation of the Medicare program.

The type of standards to which ASIM refers--involvement of physicians in clinical policymaking, providing information to enrollees and prospective enrollees sufficient to enable them to make informed decisions about the plan--are, in fact, those that are being adopted by many well-run health plans in today's marketplace. In a competitive environment, those plans that pursue "patient-friendly" policies such as these are more likely to succeed than others.

11. Because Medicare is a federally funded program, the federal government must continue to ensure that health plans are accountable for the care they give to beneficiaries and that they abide by standards set out for Medicare plans. HCFA or another federal agency should be responsible for contracting with health plans; reviewing marketing materials; disseminating to beneficiaries objective data about each plan in a region in a standard format; ensuring health plan compliance with certain standards governing their rules and operations; and ensuring that health plans meet certain quality standards. However, private accreditation agencies should be able to achieve "deemed" status to fulfill the role played by HHS in approving voucher plans. Mechanisms should be available for patients and physicians to pursue grievances against health plans for denial of medically necessary care. Patients and physicians should retain access to fair hearing and judicial review processes at least comparable to those now available under traditional Medicare.

Because vouchers would require more thought and decisionmaking by Medicare recipients, some analysts question whether beneficiaries would find the voucher program truly appealing. Other policymakers argue that the basic premise of the voucher program is simple and that most beneficiaries, given the right kind of information, will be able to make proper decisions about a health plan. While this may indeed be the case for healthy beneficiaries who are mentally alert, the frail and disabled elderly, those who do not speak English very well or those with little education may find the task of sorting through health plan information daunting. To respond to some of these concerns, the voucher program should have an entity with which voucher plans would contract and which would ensure voucher plan adherence to any standards adopted governing such plans.

Given the characteristics of the Medicare population, an ombudsman's office should be created to receive, investigate and resolve complaints against voucher plans as well as to offer guidance to beneficiaries with questions about the voucher program. Finally, beneficiaries and physicians should retain access to the current Medicare appeals process.

ASIM would prefer that the health care industry voluntarily abide by the standards established for a voucher program and, indeed, supports the idea of a private accreditation body responsible for ensuring health plan adherence to voucher program standards. However, the voucher program will be funded by federal dollars and the federal government should not relinquish its responsibility for ensuring that health plans are accountable for the care they deliver to beneficiaries and for seeing that corrective actions are taken when deficiencies are found if a plan wishes to remain in the voucher program. Health plans that accept the government contributions should understand that, if they are going to compete for the business of the federal government through the voucher program, they must accept certain standards and certain reasonable oversight.

12. Self-referral restrictions affecting shared laboratory facilities and group practices should be removed and antitrust reforms enacted to enable physicians and providers to negotiate on an equal footing with health plans and purchasers.

Antitrust reforms and other modifications to statutory restrictions on physicians could improve the functioning of health plans offered under a voucher system and the ability of physicians to deliver services within their context. For example, self-referral restrictions on group practice compensation arrangements not only interfere in the internal affairs of private businesses but lead to confusion over how such practices may distribute revenue from ancillary services without indirectly taking into account the referrals made by physicians. Furthermore, subspecialists--such as oncologists and infectious disease specialists--in many group practices are barred from providing drugs and other services to their patients because of the self-referral laws.

Limitations on the ability of physicians to share information in order to form integrated service networks may impede the goals of voucher advocates who wish to foster competition that reduces the cost of care and increases benefits to attract voucher recipients. Indeed, antitrust laws developed at a time when most physicians and other providers practiced independently of one another now prevent these caregivers from organizing preferred provider organizations, health plans and other delivery networks that would enable physician-directed health care organizations to compete in the marketplace and offer beneficiaries a wider choice of health care options.

Conclusion

ASIM is under no illusion that reforming Medicare will be simple, easy, or quick. Changes of the magnitude required to place the program on sound financial footing and to guarantee that beneficiaries continue to receive the high quality health care to which they have become accustomed and to which they are entitled will require a great deal of thought and debate. For ASIM, the overarching philosophy on which these Medicare reform proposals rest is that of shared responsibility.

Physicians have a responsibility to deliver care to greater numbers of Medicare patients under health care delivery systems that will increasingly require them to accept financial risk and to be accountable for the cost and quality of their clinical decisions--and to compete within this new system on the basis of cost and quality.

Medicare patients have a responsibility to consider the costs of alternative sources of health care coverage, to be willing to contribute more in out-of-pocket costs if they choose more expensive coverage and--for those who can afford to--to contribute more to the financial support of Medicare so that those of lesser means can afford coverage.

Taxpayers have a responsibility to accept changes in the tax code that would raise revenue and introduce positive incentives into the health care system including a limit on the tax deductibility of employer paid insurance and increased taxes on tobacco.

The insurance industry has a responsibility to compete in the new system--not solely on price or risk avoidance but on benefits offered and quality--and to accept reasonable standards to protect beneficiaries who choose private insurance coverage.

And the federal government has a responsibility to assure that the government's contribution remains adequate to guarantee that all beneficiaries can obtain high quality coverage through traditional Medicare and private sector alternatives--and to provide sufficient oversight over the market to protect patients' interests.