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cc: Pat Woods

LAWTON CHILES
GOVERNOR

STATE OF FLORIDA
Office of the Governor
THE CAPITOL
TALLAHASSEE, FLORIDA 32399-0001

Jen —
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Emily

TESTIMONY

of

Governor Lawton Chiles

before the

United States Senate
Committee on Finance

A Governor's Perspective on Medicaid

June 28, 1995

I'm proud of the fact that Florida leads the nation in reforming Medicaid –

- We've cut the rate of growth by more than 50% and achieved real savings through managed care of Medicaid;
- We've imposed stringent price level controls on providers;
- We've encouraged alternatives to expensive long term care; and
- We've continued to use conservative standards for eligibility.

These approaches are creating significant savings today.

Florida already has more than 655,000 people or 40% of Medicaid eligibles enrolled in managed care. By next year we expect to have over one million of the state's 1.6 million eligibles enrolled. Only six other states have a higher percentage of their Medicaid recipients enrolled in managed care.

We have done much to control costs, eligibility, and benefits. And we've saved the state and federal government money while doing so. Between 1991 and 1992, Florida's average spending per recipient actually declined 3% while there was a nearly 8% increase nationally. Our cost per recipient was under $2,400 in 1993, that ranked us 44th in the nation.

But let's be sensible. We cannot achieve a 20% reduction in spending in this program without affecting coverage. And let's not forget who we are covering.

Medicaid is the vital life support system for our most vulnerable citizens. While most think it's mainly for poor welfare families, the fact is that two-thirds of Medicaid funds are spent on the elderly and disabled.

In Florida our fastest growing Medicaid population is people over the age of 85. They are also typically the most expensive population to serve. Middle-class families in America have become familiar with Medicaid when they seek care for parents who need home health or nursing home care.

Those middle-class families are facing the health care crisis today. And, for them, Medicaid is often the only way they can provide care for their elderly parents-in-need when the sky-rocketing nursing home bills come due.

So you can see why I am more than a little interested in how these block grants might be drawn and what flexibility I'll have to administer them.

I, like many of my colleagues here today, believe the states should have more flexibility to pursue managed care for our Medicaid population and to negotiate with our providers.

These efficiencies are important. And, I know they are supported by a broad bipartisan group of governors. But they <u>will not</u> make up for nearly the amount that the Congress is looking to <u>cut</u> out of Medicaid.

In fact, the Congressional Budget Office told the House last week that managed care reforms and repeal of the "Boren Amendment" would only save about $5 billion over 7 years. Remember, you've been instructed to cut $182 billion. So what additional flexibility would be required to make up for the remainder? I think part of the answer depends on how funds under the program are distributed.

But we should not pretend that we can manage these levels of cuts by making our programs more efficient. The Kaiser Commission on the Future of Medicaid estimates that nationwide, nearly 3 million people will lose coverage in 2002 alone. Florida would see more than 300,000 cut off the program. That's a conservative estimate, assuming that states have flexibility and are able to hold growth per person to no more than the inflation rate.

Your own CBO has already made that point, saying that, "Improving efficiency by itself almost certainly could not achieve reductions in the rate of growth of the order of magnitude being discussed. Some combination of cutbacks in eligibility, covered services, or payments to providers would probably be necessary." *CBO Testimony before House Commerce Subcommittee on Health and the Environment, June 21, 1995.*

And we should also recognize that because this is a free country and people are free to move from state-to state as they please that some states will face growth pressures they are not able to control.

Even under the most conservative scenarios, Florida's Medicaid program is estimated to grow between 10 - 12% per year over the next seven years.

These increases reflect a growing and aging population. Some of these characteristics are currently unique to Florida but many states will be facing them in the future:

- Florida has the largest percentage of elderly people in the nation;
- The percentage of our uninsured is increasing. More than 20% of our non-elderly citizens have no health insurance;

- We have the second highest poverty rate (nearly 18%) among the large states; AND
- Florida is a destination not only for thousands of migrants from other countries, but also from other states, particularly during periods of recessions. Many of these new arrivals require health, economic and other financial assistance from the state. When you factor in the certainty of recessions, the pressure on state budgets builds.

Medicaid caseloads, that is the number of people on the program, typically peak about a year after a recession hits in Florida. In the year following our last recession, in the early 1990s we saw caseload increases of more than 25%.

No amount of state flexibility can fully remedy that situation.

Clearly, a proposal that ignores growth factors in the individual states would be disastrous. And, a proposal without adequate federal standards would be equally disastrous.

I hope that this subcommittee would not endorse a proposal to let a state use federal Medicaid dollars for non-health purposes – especially when some states will be receiving far less than they'll need to meet the needs of the elderly, disabled, and kids. You'll be sending federal funds for the Medicaid program to one state that will have the ability to divert those funds over to other programs while states like Florida, Texas and California will be cutting thousands off our Medicaid program.

I think you've seen the results of that kind of gimmickry in the Disproportionate Share program.

I hope you will keep in mind three critical questions as you restructure the Medicaid program:

1. Does the program treat citizens in each of our states fairly with an equitable distribution formula, or does it favor some states over others?
2. Does the program reward those states making a real commitment to reform and improved management, or does it lock in the inefficiencies of the past and turn back the clock on reform? AND
3. Does the program set and maintain an appropriate, basic national standard for the care of children and others in need, or does it establish a new underclass in America?

Florida stands ready to share in the cuts -- and we have already gone a long way to reduce our Medicaid costs.

Now, I think the overall level of cuts proposed in the Budget Resolution are too high. And I think we'll have a disagreement over that. But, if you do need to cut $182 billion out of this program you should at least do it equitably.

I have a proposal to distribute these cuts fairly. It requires sacrifice for <u>all</u> states. It's a plan that would apply the cut fairly to all states.

I want a program that allows me to continue the reforms that show great promise for care -- as well as savings.

A true federal-state partnership for health care is one that has flexibility -- but it also recognizes the federal government's responsibility as a contributing partner.

Richard Nixon championed this approach as much as Ronald Reagan. Both argued that the federal government must share the fiscal burden and ensure equal treatment of those in need.

The states are willing to share the load. But, we want the federal government to cooperate – the way a partner should.

Thank you.

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United States Senate
Committee on the Budget

Sue A. Nelson
Director of Budget Review and Analysis
Senior Analyst for Medicare

Phone: (202) 224-0560
Fax: (202) 228-3898
Internet: Sue_Nelson@Budget.snn.senate.gov

635 Dirksen Senate Office Building
Washington, D. C. 20510

The Medicare Improvement and "Choice Care" Provision Act

Prepared by:

Senator Judd Gregg

-- Preliminary Draft, July 20, 1995 --

The Mee Improvement and "Choice Care" Provision Act

Sen. Judd Gregg

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DRAFT -- 7/20/95
Senator Judd Gregg

I. TITLE: "The Medicare Improvement and 'Choice Care' Provision Act."

II. PURPOSES:

The purposes of this Act are to:

A. Improve the quality of medical care provided to America's senior citizens, by making the Medicare program more responsive to the special health care needs of senior citizens;

B. Expand and improve the existing Medicare program to provide senior citizens with greater variety of health care options from which to choose;

C. Increase the flexibility of the Medicare program to allow health care services to be delivered in a modern fashion, and to enable the program to take swift advantage of future market improvements in the means of health care delivery;

D. Provide senior citizens with the information they need to make for themselves the best health care choices possible; and

E. Help preserve the immediate and long-term solvency of the Medicare program by beginning to alter Medicare's basic delivery structure by encouraging the provision of quality medical care at reasonable prices through enhanced competition.

III. CHOICE CARE OPTION, IN GENERAL:

This Act amends Title XVIII of the Social Security Act to establish an optional "Choice Care" program within the Medicare program, which shall operate as follows:

A. Eligibility -- All individuals eligible for Medicare coverage under Part A and enrolled (or eligible to enroll) in Part B of the traditional Medicare program (as defined in Section X(H)(1)) shall also be eligible to choose to enroll in the Choice Care program in lieu of the traditional Medicare program, or to remain in the traditional Medicare program, as specified in Sections III and VII.

B. Annual Open Season -- All individuals eligible to participate in the Choice Care program shall be able to choose to enroll in a Choice Care plan during an annual "Open Season," and newly eligible individuals shall be able to enroll in a Choice Care plan at the time of their initial eligibility, as described in Section VII.

C. Choice Care Options -- Each individual who elects to enroll in the Choice Care program, shall obtain Medicare health insurance coverage from one of the following types of plans:

1. **Indemnity/Fee-for-Service Plans** -- Private indemnity plans that reimburse hospitals, physicians and other providers on the basis of a privately arranged fee schedule.

2. **Coordinated Care Plans** -- Private managed or coordinated care plans, including but not limited to the following types of plans:

   a. Health Maintenance Organization Plans or Competitive Medical Plans already approved for participation in the Medicare program under 42 U.S.C. Sec. 1395mm.

   b. Health Maintenance Organization Plans already Federally qualified under 42 U.S.C. Sec. 300e.

   c. Preferred Provider Organization Plans, Point of Service Plans, or other coordinated care plans that satisfy the plan coverage and participation standards of Section IX.

3. **High Deductible Plans** -- Private plans that require the beneficiary to pay a minimum annual deductible for insured medical expenses equal to at least [$1500] in a given year. Individuals that select a High Deductible Option must establish a Medical Savings Account and deposit any Choice Care Value Amount rebate into such account.

4. **Other Health Care Plans** -- Any other private plan for the delivery of health care items and services which may exist or evolve in the health care marketplace, and which otherwise satisfies the requirements for participation in the Choice Care program under this Act.

5. **Medical Savings Accounts** -- Any individual selecting the Choice Care option, may also establish a Choice Care Medical Savings Account and deposit any rebate received (pursuant to Section VIII(A)(4)) into the Account, as described in this Section. Any individual selecting a High Deductible Option must establish such an Account and shall deposit any rebate received into the Account.

   a. Use of Funds -- Funds deposited into a Choice Care Medical Savings Account may only be used to pay the deductibles and copayments required under the individual's Choice Care plan, and to purchase medical care (as defined in Section X(H)(4)) for the beneficiary in whose name the account is established. Such funds may also be used to purchase insurance for supplemental coverage, such as such as long-term care, prescription drug, or expanded home health care insurance.

   b. Joint Accounts -- Married couples, both of whom are Medicare eligible, may establish a joint account or combine their individual accounts to form a joint account.

c. Supplemental Contributions -- In addition to the Choice Care rebate that is deposited into a Medical Savings Account pursuant to Section VIII(A)(4), a beneficiary may make additional deposits into his or her Account.

d. End-Year Disposition --

i. Funds remaining in a Medical Savings Account, which are derived from Choice Care rebates, may be rolled over into the account for the next year.

ii. Such funds may also be used to purchase supplemental insurance, such as long-term care, prescription drug, or home health care insurance.

d. Disposition at Death -- Any funds remaining in a Choice Care Medical Savings Account at death, shall become part of the beneficiary's estate.

D. Choice Care Plan Requirements, In General -- Each plan participating in the Choice Care program:

1. Shall enroll, accept payment for, and provide health care coverage to all eligible individuals within the plan's service area who elect to enroll in that plan, on a first-come first-serve basis, up to the plan's capacity.

2. Shall offer coverage for at least the items and services covered under the traditional Medicare program, as specified in Section IX(B).

3. May offer additional benefits (such as prescription drug or other benefits), or cash rebates as specified in Section VIII(C).

4. Shall be allowed to establish its own premium, deductible and copayment schedules, subject to the limits specified in Section IX(B).

E. Capitated Risk Contracts -- The Secretary shall enter into contracts with any eligible plan for the provision of health care services under the Choice Care program. Each such contract shall provide that such plans agree:

1. to provide coverage to each enrollee for the health care items and services described in Section IX(B);

2. in return for the appropriate capitated payment amount described in Section IV;

3. on an at-risk basis as described in Section IX(C); and

4. to comply with all other requirements of this Act.

IV. CHOICE CARE VALUE AMOUNTS; DETERMINATION OF GOVERNMENT CONTRIBUTION LEVELS:

A. In General: By September 7 of each year, the Secretary shall determine and publish a schedule of Choice Care Value Amounts to be used for plan reimbursement payments during the following year, pursuant to the provisions of this Section. (Payments of Value Amounts to participating plans shall be made in accordance with Section VIII.)

B. Choice Care Value Amounts shall be calculated with reference to the existing adjusted average per capita cost (AAPCC) schedule (published pursuant to 42 U.S.C. Secs. 1395mm(a)(1) & (4)), as follows:

1. Reimbursement Areas -- Choice Care Value Amounts shall be determined on the basis of "Reimbursement Areas") each of which shall constitute the service area for the enrollees of the plans operating within such Area), as follows:

a. For counties that do not fall within a Metropolitan Statistical Area, the Reimbursement Area shall be the county;

b. For counties that fall within a Primary Metropolitan Statistical Area, the Reimbursement Area shall be the Primary Metropolitan Statistical Area; and

c. For counties that fall within a Metropolitan Statistical Area, but that do not fall within a Primary Metropolitan Statistical Area, the Reimbursement Area shall be the Metropolitan Statistical Area;

2. Base Year Amounts -- The "Base Year" shall be calendar year 1996. For the Base Year, the Choice Care Value Amounts shall be calculated as follows:

a. For Reimbursement Areas that do not fall within a Metropolitan Statistical Area, the Base Year Choice Care Value Amount shall equal the average of the sum of the Part A and Part B AAPCCs of all such Reimbursement Areas within a state.

b. For all other Reimbursement Areas, the Base Year Choice Care Value Amount shall equal the average of the sum of the Part A and Part B AAPCCs of all the counties within that Reimbursement Area.

3. Subsequent Year Amounts -- For all calendar years subsequent to the Base Year, and subject to the Market-Based Reimbursement provisions of subsection IV(C), the Choice Care Value Amounts shall equal the preceding year's Value Amounts increased as follows:

a. If, during the preceding year, a Reimbursement Area's Choice Care Value Amount equalled or exceeded 125 percent of the average of all Choice Care Value Amounts, then that Area's Choice Care Value Amount shall equal the Value Amount of the preceding year plus 2.5 percent.

b. If, during the preceding year, a Reimbursement Area's Choice Care Value Amount equalled or fell below 75 percent of the average of all Choice Care Value Amounts, then that Area's Choice Care Value Amount shall equal the Value Amount of the preceding year plus 7.5 percent.

c. For all other Reimbursement Areas, the Choice Care Value Amount shall equal the Value Amount of the preceding year plus 5 percent.

C. Market-Based Reimbursement/Competitive Pricing --

1. Once the Secretary has developed sufficient experience in operating the Choice Care program, the Secretary may undertake a Market-Based Reimbursement/Competitive Pricing demonstration project, to determine the Choice Care Value Amount for that Area through competitive bidding by participating plans.

2. The Secretary may undertake such a demonstration project in a Reimbursement Area where at least three plans participating in that Reimbursement Area, including any national indemnity plans, have adequate aggregate capacity to service all Choice Care eligible individuals within the Reimbursement Area.

V. PLAN NOTIFICATION TO THE SECRETARY:

A. Notification In General --

1. General Notification -- Any plan that wishes to participate in the Choice Care program in a Reimbursement Area during the annual Open Season enrollment period for a given year, must notify the Secretary within 21 days of the publication by the Secretary of the Choice Care Value Amounts for that year.

2. Subsequent Notification -- A plan may notify the Secretary of its desire to participate in the Choice Care program in a Reimbursement Area at a later date. In such case, the plan shall not participate in that year's annual open enrollment process (unless the Secretary determines it is otherwise fair and administratively feasible), but shall otherwise be eligible to seek to enroll eligible individuals during that year.

B. Form and Manner -- Plan notification shall be in a form and manner prescribed by the Secretary and, with respect to each Reimbursement Area in which the plan will participate, the notification shall include the following:

1. The type of plan, as described in Section III(C), that will be offered in each Reimbursement Area in which it will participate;

2. A schedule of benefits and services that will be available under each plan being offered (including those subject to prior authorization by the plan as a condition of coverage), including the amounts of premiums, copayments, and deductibles that will be assessed;

3. The identity, locations, qualifications, and availability of the health care providers participating in the plan;

4. The appeals procedures provided by the plan in accordance with Section IX(C)(4);

5. The rights and responsibilities of enrollees under the plan;

6. The results of the plan's independent reviews or accreditation process (as described in Section IX(A));

7. Historical performance and beneficiary satisfaction information (as described in

Section IX(A)(3)); and

8. Historical enrollment and disenrollment data of the plan (excluding disenrollment by death).

C. Secretary Transmission of Information to Trustees --

Upon receipt of the information required under Section V(B) from plans, the Secretary shall promptly transmit such information to the Trustees. The Secretary shall also provide any other such information requested by the Trustees, in order for the Trustees to carry out their duties under Section VI.

VI. INFORMATION DUTIES OF THE TRUSTEES AND PLANS:

The enrollment informational materials under the Choice Care program shall be developed by the Trustees of the Medicare Hospital Insurance and Supplementary Medical Insurance Trust Funds, in accordance with the provisions of this Section.

A. In General --

1. "Open Season" Notification --

a. By January 7 of each year, the Trustees shall mail to each individual who is eligible to participate in the Choice Care program for that year, or who will become eligible to participate in the Choice Care program by the conclusion of the annual Open Season enrollment process, a notice of Choice Care eligibility.

b. Such notice shall include an informational brochure that includes at a minimum the information described this Section, as well as any other information the Trustees determine will facilitate the individual's decision making under the Choice Care program.

2. Notification to Newly Medicare-Eligible Individuals -- With respect to individuals who become eligible to participate in the Choice Care program subsequent to the conclusion of the annual Open Season enrollment process, the Trustees shall mail to each such individual a notice of Choice Care eligibility within 3 months of the date that such person will become eligible to participate, as well as the additional informational described in this Section.

B. Trustees' Materials; Contents -- The Trustees' notice and informational materials shall be written and formatted in the most easily-understood manner possible, and shall include, at minimum, the following information with respect to Medicare coverage during the following year:

1. the Part B (and Part A, when applicable) premium rates that will be charged for coverage under the traditional Medicare program;

2. the deductible and copayment amounts for coverage under the traditional Medicare program;

3. a description of any changes in coverage that will occur under the traditional Medicare program;

4. a description of the beneficiary's Choice Care Reimbursement Area, and a statement of the Choice Care Value Amount within that Reimbursement Area;

5. information on the participating Choice Care plans in the beneficiary's Reimbursement Area, including the rates that will be charged by such plans;

6. information on the amount of cash rebates that may be received, or additional premium amounts, deductibles or copayments that must be paid, for each participating plan in the beneficiary's Reimbursement Area;

7. information on beneficiary satisfaction with each participating plan in the beneficiary's Reimbursement Area, including enrollment and disenrollment rates from previous year(s) (excluding disenrollment by death);

8. performance and outcome-based information and reports, with respect to each of the plans participating the beneficiary's Reimbursement Area;

9. a simplified chart that presents and compares the benefits provided and services covered of each plan participating in a Reimbursement Area;

10. any other such information that participating plans provide to the Secretary under Section V or otherwise, that the Trustees determine will be of assistance to informed decision making by eligible individuals; and

11. the phone numbers that may be called by the beneficiary to enroll in the participating plans.

C. Use of Private Entities -- The Trustees may contract with private entities to undertake, in whole or in part, the informational duties described in this Section.

D. Plan Participation in Enrollment Process --

1. In addition to the Choice Care informational materials and brochures prepared and distributed by the Trustees, participating plans shall remain free to develop and distribute their own marketing materials and pursue other marketing strategies, provided such marketing materials and strategies conform to the guidelines described in this subsection.

2. Plan Marketing and Advertising Standards -- The marketing materials provided to eligible individuals by participating plans:

a. Shall include a comparison of the coverage available under the plan to the coverage available under the traditional Medicare program, as well as information on any rebates that may be available, or additional premium, deductibles or copayments that may be required, under the plan as compared to the traditional Medicare program.

b. Shall be provided in a form and manner that is easily understood by a typical Medicare beneficiary, and that contains accurate and sufficient information for an individual to make an informed decision on whether to enroll, or first seek additional information.

c. Shall include a telephone number that may be called to receive information equivalent to the information that the plan must provide to the Secretary under Section V, and that the Trustees should provide to the individual under Section VI(B).

d. Shall be pursued in a manner not intended to violate the anti-discrimination requirement of Section VIII(D).

e. Shall not contain false or materially misleading information, and shall conform to all other applicable fair marketing and advertising standards and requirements.

E. Plan Notification to Enrollees -- Each plan shall provide to each individual who has elected to enroll in the plan, at the time of enrollment and at least annually thereafter, an explanation of the enrollee's rights under the plan and this Act, including an explanation of:

1. the enrollee's rights to benefits from the plan;

2. the restrictions on coverage for services furnished other than through the plan;

3. out-of-area coverage provided by the plan;

4. the plan's coverage of urgently needed care and emergency services; and

5. the appeal rights of enrollees.

VII. INDIVIDUAL ENROLLMENT:

Each plan shall provide an annual "Open Season" enrollment period, and offer continuous "Rolling" enrollment, as described in this Section.

A. Annual "Open Season" Enrollment Process --

1. 45 Day "Open Season" Enrollment Period --

a. Beneficiary enrollment shall occur during a two-month "Open Season" enrollment period, which shall be January 15 through the end of February of each year.

b. During each Open Season enrollment period, each eligible beneficiary shall be eligible to disenroll from his or her existing Medicare or Choice Care option, and elect to enroll in another Choice Care plan of his or her choice (or in the traditional Medicare program).

2. Enrollment Process and Deadline --

a. To participate in a Choice Care plan for the upcoming calendar year, a beneficiary must complete and return a signed election and enrollment form to the Secretary, postmarked by February 28.

b. The Secretary, in consultation with the Trustees, shall also develop processes by which an individual can enroll by telephone to the Secretary, and through plan

notification to the Secretary after the individual enrolls directly with the plan.

3. Default Enrollment --

   a. In the first year an individual becomes eligible to participate in the Choice Care program, if the individual fails to enroll by the pertinent enrollment deadline, he or she will continue to be covered by the traditional Medicare program.

   b. In all subsequent years, default enrollment to the traditional Medicare program shall continue for all Medicare beneficiaries, except those beneficiaries who were enrolled in a Choice Care plan during the prior year, who shall be defaulted back into the plan in which they had been enrolled.

4. Annual Enrollment -- Each beneficiary who elects to enroll in a Choice Care plan, shall remain enrolled in the selected plan for a period of one year, until he or she again becomes eligible to enroll in another plan during the next applicable enrollment period.

5. "Lock In" Period -- A beneficiary shall be able to disenroll from a plan and enroll in another Choice Care option or in the traditional Medicare program only if the beneficiary moves to a new plan Reimbursement Area, or if the plan is unable to meet its service or capacity obligations as determined by the Secretary with reference to the plan participation criteria specified in Section IX. [[Longer Lock-In for High Deduct./MSA plans?]]

6. Four-year Phase-in Period: Notwithstanding the preceding provisions, for the first year that the Choice Care program is being implemented in a given Reimbursement Area, the "lock-in" period shall be three months. For the second year, the lock-in period shall be six months. For the third

year, the lock in period shall be nine months.

B. nuous "Rolling" Enrollment --

Traditional Medicare Beneficiaries -- Individuals who elected to remain in the traditional Medicare program during the Open Season period may disenroll from traditional Medicare and enroll in the Choice Care program at any time. [[??]

Newly-Eligible Beneficiaries -- Individuals who were not eligible to participate in the Choice Care program during the annual Open Season period, but who become eligible subsequent to the conclusion of the Open Season period, may enroll in a Choice Care program as of the date of their Medicare eligibility.

C. : Look" Period -- In the first year that an ·idual elects to participate in the Choice Care ·am, he or she shall have a "free look" period to three months duration, during which time the ·idual may disenroll from the selected plan and .l in another Choice Care plan or the traditional :are program, for any reason.

D.)iscrimination -- Plans may not discriminate on the : of health status or anticipated need for services ıe enrollment, reenrollment, or disenrollment of ·iduals eligible to participate in the Choice Care :am.

VIII. PREM PLAN PAYMENTS, AND CASH-BACK AWARDS:

A. ıums Payments --

Each individual that chooses to participate in the Choice Care program must pay the Part B premium in the amount and manner that would otherwise be required for such individual under the traditional Medicare program. This requirement shall apply even if the individual had otherwise elected not

to enroll in the Part B program.

2. Any premium amounts charged by a plan that exceed the Part B premium that would be paid by the plan's enrollee under the traditional Medicare program shall be paid by the individual to the plan, as mutually arranged between the individual and the plan.

B. Payments to Plans -- With respect to each Reimbursement Area:

1. With respect to each Choice Care plan selected by a given beneficiary, the Secretary shall transmit to the selected plan a payment equal to the pertinent Choice Care Value Amount. Such payments shall occur in advance and on a monthly basis.

2. Trust Fund Withdrawals -- Payments to plans under this Section shall be made from withdrawals from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The allocation of such payments to be made from each fund shall be determined each year by the Secretary, based on the relative weight that benefits from each fund contribute to the determination of the Choice Care Value Amounts.

3. Adjustments for Demographic Status --

a. The payments made to plans for each particular enrollee shall reflect the class status of that enrollee, as provided in this subsection.

b. The Secretary shall define appropriate classes of Medicare eligible individuals, and shall increase or decrease the Choice Care Value Amounts to reflect the relative distribution of beneficiaries among such classes of beneficiaries and the relative differences in average Medicare claims costs for the preceding five years among the same

classes of beneficiaries.

c. Such classes shall include the following:

i. Sex;

ii. Age, [[65-69 years, 70-74 years, 75-79 years, 80-84 years, 85 years and over;]]

iii. Medicaid or Non-Medicaid Status;

iv. Institutionalized or Non-Institutionalized Status;

v. once integrated into the Choice Care program, disabled and non-disabled status, and ESRD and non-ESRD status; and

vi. any other such classes the Secretary determines is appropriate.

C. Rebates --

1. In the event that an enrollee's Choice Care Value Amount exceeds the premium of the plan selected by the enrollee, the Secretary shall remit 75 percent of the difference to the enrollee and 25 percent of the difference to the Hospital Insurance Trust Fund.

2. Payments to enrollees under this section shall accrue only if the individual has remained enrolled in his or her selected Choice Care plan for the duration of the plan's annual enrollment period. [Such payments shall be credited against the individual's Part B premium deduction for the year immediately following the rebate's accrual.]

3. The Secretary shall make such payment from a withdrawal from the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds, in accordance with Section VIII(B)(2).

4. In the event that a beneficiary selected a High Deductible option described in Section III(C), the amount remitted to the beneficiary under paragraph 3 must be deposited into a Medical Savings Account that qualifies under Section III(C)(3)(b), within 30 days of receipt. In such event, the Secretary shall note such limitation clearly upon the rebate payment instrument.

IX. QUALITY ASSURANCE, PLAN COVERAGE AND PARTICIPATION STANDARDS:

A. Quality Assurance Requirements --

1. In General -- To participate in the Choice Care program:

a. Each plan shall have an ongoing quality assurance system or program for the health care services it provides under the Choice Care program, which ensures that the plan meets, at a minimum, the requirements of this section; and

b. Each plan shall have received independent accreditation, as described in this section.

2. Internal Quality Assurance --

a. Access -- Each plan shall provide or arrange for the provision of all medically necessary health care services required under this Act and the contract entered into with the Secretary for participation in the Choice Care program.

b. Timely Delivery of Services -- Each plan shall deliver to enrollees upon request health care services in a manner that is reasonably prompt and, when medically necessary, that is available and accessible

24 hours a day and 7 days a week.

3. Performance Measures -- Each plan shall undertake to measure and maintain data on the plan's actual performance in delivering of health care services. Such measures shall include:

   a. Patient Encounter Data -- sufficient patient encounter data to identify the health care provider that delivers services to each patient, and the type of service provided.

   b. Outcome-Based Information --

      [need to complete]

   c. Plan Satisfaction Data --

      [need to complete]

4. Independent Accreditation --

   a. Each plan shall arrange for, on an annual basis, an external independent accreditation of the plan, which includes a review of the plan's quality assurance systems.

   b. The independent review and accreditation shall be performed by an accrediting organization that:

      i. is a private, non-profit organization;

      ii. exists for the primary purpose of accrediting managed care plans or other health care plans that are offered under the Choice Care program; and

      iii. is independent of health care providers or associations of health care providers.

c. The results of such reviews shall be made publicly available upon request, and specifically made available to the plan's enrollees and potential enrollees, in a manner that does not disclose the identity of any particular patient.

d. Plans that fail to receive accreditation shall be disqualified from participation in the Choice Care program, unless:

i. New plans -- With respect to new plans, such plans are making reasonable progress toward receiving accreditation, to the satisfaction of the accrediting organization; and

ii. Previously accredited plans -- With respect to plans that had received prior accreditation, such plans are making reasonable progress toward correcting the flaws that led to the failure to receive accreditation, to the satisfaction of the accrediting organization, and such plans in fact correct such flaws within six months.

B. Plan Coverage Requirements -- Each plan participating in the Choice Care program:

1. Shall agree to provide, at a minimum, the covered health care items and services available to persons enrolled in Part A and Part B of the traditional Medicare program;

2. Shall be free to establish its own copayment and deductible levels, except such levels cannot exceed the levels being assessed under the traditional Medicare program;

3. Shall provide for coverage for its enrollees if an enrollee requires medical care out of the plan's service area;

4. May require the approval for the provision of non-emergency medical assistance or services to an enrollee for non-emergency services before such assistance is provided, provided such prior approval is given in a reasonably timely manner.

C. Plan Participation Standards -- The Secretary shall enter into a Choice Care contract with any plan that desires to participate in the Choice Care program. Such contract shall allow the plan to offer any combination or structure of benefits, covered items and services and coverage limits (subject to the minimum requirements of subsection B above), provided that the plan:

1. At Risk -- Agrees to provide all required and agreed to coverage to its enrollees for the fixed payment of the Choice Care Value Amount appropriate to each enrollee, and to assume the full financial risk of the cost of furnishing such coverage on a prospective basis regardless of whether such cost exceeds such fixed payment, except that the plan may:

   a. insure itself against such financial risk; and

   b. make arrangements with other health care providers to assume all or part of such financial risk.

2. Solvency -- Has made adequate provision against the risk of insolvency, including provisions to prevent the plan's enrollees from being held liable to any person or entity for the plan's debts in the event of the plan's insolvency.

3. Capacity -- Provides adequate assurances to the Secretary that, with respect to each service area in which it desires to participate, the plan has the capacity to serve the expected enrollment in that service area.

4. Grievance Procedures -- Establishes an internal procedure for hearing and resolving grievances between the plan and enrollees, including procedures under which an enrollee (or provider on behalf of such enrollee) may challenge the plan's denial of coverage of or payment for medical assistance or services to the enrollee.

5. Enrollee Acceptance -- Agrees to accept all beneficiaries within the plan area who select the plan (up to plan capacity), and does not refuse or cancel coverage of eligible beneficiaries except for reasons of beneficiary fraud or non-payment of amounts due the plan under the coverage policy.

6. Submission of Rate Tables -- Submits to the Secretary a table of its rates for all actuarial categories of beneficiaries prior to contract approval by the Secretary.

X. MISCELLANEOUS PROVISIONS:

[[need to complete]]

A. Other Provisions of Choice Care Risk Contracts --

1. Duration -- [[contracts last 1 year]]

2. Renewal --

3. Enrollee Disenrollment --

4. Other --

B. Appeals -- [[Procedures for plans appealing adverse rulings of HHS; and for enrollees appealing adverse rulings of plans.]]

C. Legal Guardians -- [[Rules for legal guardians of incapacitated or impaired beneficiaries making decisions on Choice Care or MSAs]]

D. The Secretary is expressly prohibited from mandating additional benefits coverage under the Choice Care program, beyond the benefits coverage expressly mandated under this Act.

E Sanctions for Plan misconduct --

F. Modification of 50/50 Rule -- [[??]]

G. Remove IME payments from Value Amount Calculation [[??]]

H. Definitions --

1. Traditional Medicare Program -- The term "traditional Medicare program" shall mean the health insurance program established under title ___ of the Social Security Act, as it exists upon the enactment of this Act (except as amended by this Act).

2. The Secretary -- The term "Secretary" shall mean the Secretary of Health and Human Services.

3. Trustees -- The term "Trustees" shall mean the Trustees of the Medicare Hospital Insurance and Supplementary Insurance Trust Funds.

4. Medical Care -- With respect to the use of Medical Savings Accounts under Section III(C)(5), the term "medical care" shall mean those items and services that qualify under Section 206 [?] of the Internal Revenue Code, and which are not eligible for reimbursement under the individual's Choice Care policy. [[deductibility section]]

XI. CHOICE CARE EFFECTIVE DATE AND IMPLEMENTATION:

A. General Rule --

1. This Act shall take effect upon enactment.

TOO MUCH, TOO FAST

The Impact on Older Americans of Medicare and Medicaid Reductions in the FY'96 Budget Resolution

Prepared by the
American Association of Retired Persons
June 29, 1995

For further information contact:
Tricia Smith
AARP Federal Affairs Department Health Team
(202)434-3770

Introduction

Older Americans support deficit reduction and they want a strong economy for their children and grandchildren. But they also understand that financial security — for themselves and their families — is dependent upon adequate and affordable health care coverage.

AARP believes that deficit reduction should be fair and balanced. We should strive to keep our economy on a steady path of deficit reduction, but we should not jeopardize the Medicare and Medicaid programs and the financial security they provide in the process.

The Fiscal Year 1996 (FY96) Budget Resolution proposes to take nearly half of the deficit reduction of the next 7 years out of Medicare and Medicaid. In both programs these are the largest cuts ever proposed, and in Medicare the proposed cuts are far more than what is needed to keep the programs solvent for the next decade.

As Congress struggles to meet its arbitrary deficit reduction deadlines and targets, hasty and ill-considered policy decisions are almost inevitable. Medicare and Medicaid beneficiaries will end up paying out-of-pocket what the programs will no longer pay.

The Medicare and Medicaid programs are not perfect. Changes are appropriate. Indeed, they must begin this year. A better approach recognizes that the Medicare and Medicaid programs will need to adapt to changing needs and budgetary constraints. But these changes should be carefully thought out, with considerable input from beneficiaries who understand fully what these changes will mean for them and for their children and grandchildren.

CONGRESSIONAL BUDGET RESOLUTION COULD DEVASTATE MEDICARE BENEFICIARIES

Congress has proposed unprecedented reductions in Medicare spending as part of the FY96 Budget Resolution. The proposal would reduce Medicare by $270 billion over the next seven years. These reductions are nearly three times as large as the reduction enacted in the Omnibus Budget Reconciliation Act of 1993 (OBRA93).(1)

This document describes illustrative increases in beneficiary out-of-pocket costs under the resolution and the impact these cuts would likely have on the average older American.

How Much More Will Beneficiaries Pay?

- AARP estimates that these proposals to reduce Medicare spending would mean that the average Medicare beneficiary would pay approximately **$3,400 more out-of-pocket** over the next seven years (see Chart 1).(2) Estimates are based on the assumption that one-half of proposed Medicare spending reductions come from beneficiaries.

What Are Beneficiaries Paying Already?

- In 1995, the average older beneficiary will spend about $2,750 out-of-pocket to cover the cost of Medicare premiums, deductibles, coinsurance and the cost of services not covered by Medicare — like prescription drugs and preventive care. This does not include the enormous cost of nursing home care, which is nearly $40,000 a year. Even without any changes in Medicare, these older beneficiaries are already projected to spend more than $25,500 out-of-pocket for health care costs over the next 7 years.(3) **Under the Budget Resolution, an average beneficiary would end up spending a total of about $29,000 over seven years — an increase of about $3,400.**

How Will Beneficiaries Be Affected?

- To achieve the Medicare spending reductions in these proposals, costs that are currently paid by the Medicare program would probably be shifted to Medicare beneficiaries in the form of higher premiums, deductibles and coinsurance.

These could include:

- **a higher Medicare Part B premium;**
- **an increase in the annual Part B deductible to $150, indexed to program growth;**
- **a new 20 percent home health coinsurance;**
- **a new 20 percent coinsurance for skilled nursing facility care;**
- **a new 20 percent lab coinsurance;**
- **a new income-related premium for higher-income beneficiaries**

All of these options have been under review in the Congress this year.

What Will These Additional Out-of-Pocket Costs Mean to Beneficiaries?

1) *A Higher Medicare Part B Premium*

Currently, the Part B premium is intended to approximate 25 percent of Part B costs. In 1995, the premium is $46.10 per month, $553.20 annually. It is estimated to grow to $60.80 per month, $729.60 annually, by 2002. The premium is deducted from most beneficiaries' Social Security checks. The remaining 75 percent of Part B costs are paid from general revenues.

When Medicare was enacted in 1965, the Part B premium was set at 50 percent of program costs. In 1973, in an effort to keep health care costs from consuming more and more of beneficiaries' income, Congress limited the percentage growth in the Part B premium to the annual increase in the Social Security COLA; the share of costs paid by premiums declined thereafter until it reached roughly 23 percent in 1982. Since 1982, Congress has set the Part B premium to equal or approximate 25 percent of program costs.

- The Budget Resolution could substantially increase the Part B premium paid by Medicare beneficiaries thereby shifting higher health care costs to Medicare beneficiaries. Under the proposal, the premium is estimated to jump to $97.70 per month, or $1172.40 annually by 2002. That is $442.80 more than the beneficiary would pay under current law. Over the next 7 years, most Medicare beneficiaries would pay an estimated additional $1,590 for the Part B premium alone.

2) *An Increase in the Medicare Part B Deductible to $150 — Indexed to Part B Program Costs*

Each year, all Part B enrollees pay the first $100 in approved charges for Part B services. This annual Part B deductible is not indexed. Roughly 80 percent of Part B enrollees meet the Part B deductible.

- Increasing the Part B deductible from $100 to $150 would present a significant barrier to access for lower income beneficiaries. Moreover, anticipated reductions and changes to the Medicaid program make it increasingly unlikely that Medicaid would pay the additional costs for low-income individuals.

- Indexing the deductible would increase out-of-pocket costs for the average Medicare beneficiary for each succeeding year. Under the Budget Resolution, the deductible could grow from $100 today to $270 by 2002 . For beneficiaries, the total out-of-pocket increase for the deductible over the 7 year period would be $384 per beneficiary. Even those beneficiaries with Medigap plans covering the Part B deductible would not be immune to the increased out-of-pocket costs, since Medigap premiums would likely increase to cover the cost of the higher deductible.

3) ***A New 20 Percent Medicare Home Health Coinsurance***

For a beneficiary to qualify for Medicare home health coverage, a physician must certify that the care is medically necessary and that the client is homebound and in need of only intermittent or part-time skilled care (skilled nursing or therapy). In 1996, about 3.8 million Medicare beneficiaries will use home health benefits. Approximately two-thirds of Medicare home health users are women; almost two-thirds are over age 75. Under current law, there is no coinsurance for persons who use Medicare home health services. This is intended to encourage the use of more effective, less costly non-institutional services.

- **A new 20 percent coinsurance would require the average home health user to pay an additional $900 in 1996 and almost $1,200 out-of-pocket in 2002.** The very frail individuals who need and use home health care the most, over 700,000 Medicare beneficiaries in 2002, would pay an annual coinsurance of over $3,800 in that year.

- Imposing a new out-of-pocket payment would be a "**sick tax**" on the most frail and vulnerable elderly and disabled Americans — those who can **least afford it.** Almost 80 percent of all Medicare home health users have annual incomes of less than $15,000 (see Chart 2). Approximately 24 percent have incomes between 100 percent and 150 percentof the federal poverty line (almost one million beneficiaries in 2002) — too high to qualify for current low-income protection under the Qualified Medicare Beneficiary (QMB) program, and too low to be able to afford a Medigap policy to cover these new out-of-pocket costs. As a result, many would lose access to these necessary services.

Under the current QMB program, individuals with incomes below 100 percent of the

Federal poverty line ($7,360 for singles and $9,840 for couples in 1994) would be eligible to have Medicaid pay the new 20 percent coinsurance. Unfortunately, the QMB program provides inadequate protection even for those who are eligible, primarily as a result of inadequate outreach. In addition, anticipated reductions and changes in the Medicaid program make it increasingly unlikely that Medicaid will continue to pay for qualified Medicare beneficiaries (QMBs) in many states.

- Since physicians are responsible for determining eligibility for Medicare home health coverage, a new beneficiary coinsurance is not an effective method for controlling potential inappropriate utilization.

- The 20 percent coinsurance proposal is "penny wise and pound foolish" because many beneficiaries who could not afford the coinsurance and, as a result, failed to receive needed services would be forced into nursing homes or hospitals. Those who could afford the new coinsurance would also spend down to Medicaid eligibility levels more quickly. As a result, states and the federal government could end up having to spend more than they would without the new coinsurance.

- There appears to be significant fraud and abuse in the Medicare home health program. Before making older Americans pay more, this fraud and abuse must be significantly reduced. It is not fair to force beneficiaries to make percentage payments based on artificially inflated costs that may have been fraudulently incurred.

CASE STUDY

Imposing a New 20 Percent Medicare Home Health Coinsurance. . . .

The typical Medicare beneficiary who needs home health care is a lower income woman over age 75. To illustrate the impact of a 20 percent home health coinsurance, let us take the hypothetical example of Mrs. Jones, who is an 80-year-old widow and has an annual income of $10,000 (approximately the median income level for home health users). Mrs. Jones currently spends about $3,000 per year out-of-pocket on her health needs (a typical amount for an 80-year old). She has too much income to qualify for QMB protection, but not enough to be able to buy a Medigap policy. If Mrs. Jones were forced to pay an additional 20 percent home health coinsurance, **her out-of-pocket health costs in 1996 would increase from $3,000 to $3,900**. This would leave her with about $6,100, or approximately $500 per month to pay for her basic needs for food, clothing and shelter.

4) *A New 20 Percent Coinsurance for Medicare Skilled Nursing Facility (SNF) Care*

Under current law, beneficiaries are eligible to receive up to 100 days of Medicare-covered skilled nursing facility (SNF) services following at least three consecutive days in a hospital. Beneficiaries must need "medically necessary skilled services" to receive coverage. No coinsurance is imposed for the first 20 days of covered care. For days

21-100, beneficiaries must pay $89.50 per day (one-eighth of the Part A Hospital deductible). On average, Medicare beneficiaries who need SNF care receive about 30 days of coverage. Typical diagnoses for SNF users are hip fracture and stroke.

- Imposing a 20 percent coinsurance amount for all covered days means that the vast majority of SNF users will have to pay more out-of-pocket to receive needed care. This is because the average length of coverage is about 30 days, and under current law, no coinsurance is imposed for the first 20 days.

- A major concern is that lower income beneficiaries will not be able to afford the coinsurance and may be denied access to needed rehabilitative services in a SNF. This is particularly true if the proposal to cap and block grant the Medicaid program is enacted, because it would seriously jeopardize the only low-income protection available under current law — the Qualified Medicare Beneficiary (QMB) program (see Medicaid section). Without this help in paying for SNF coinsurance, many low-income stroke and hip fracture victims would not be able to get the rehabilitation they need, and could end up spending additional days in the hospital or needing to be readmitted to the hospital.

5) *A New 20 Percent Coinsurance for Medicare Laboratory Services*

Currently, Medicare beneficiaries do not pay a coinsurance for laboratory services. Labs are paid on the basis of a fee schedule and are required to accept Medicare payments as full payment.

- Since physicians order laboratory tests — not beneficiaries — a 20 percent coinsurance could present a shift in costs for services over which beneficiaries have no control.

- Many lab tests are low cost — under $15.00 or $20.00. In some cases it probably will not be cost effective to collect a coinsurance.

6) *A New Income-Related Premium for Higher Income Medicare Beneficiaries*

Currently the Part B premium is intended to approximate 25 percent of Part B costs, and it is not based on beneficiaries' income.

- As a result of the Budget Resolution, Congress could impose a new, income-related premium for beneficiaries with incomes above $125,000 (singles) or $150,000 (couples). Some propose setting these threshholds as low as $55,000 for a single.

- At the highest income categories, beneficiaries would pay triple the amount they now pay for the Part B premium. If the income thresholds for the proposed high-income premium are not indexed, each year a greater percentage of Medicare beneficiaries would be required to pay the new, higher premium. In the future, Congress could simply choose to lower the income threshold, thereby increasing revenues.

- At the same time that an income-related premium would be imposed on Medicare beneficiaries, federal subsidies for health care costs for those under age 65 would continue, regardless of an individual's income. These subsidies come in the form of the tax deduction for employer-provided health insurance. As a result of the savings target under the Budget Resolution, Congress could impose higher health costs on higher-income older Americans but would continue federal subsidies for corporate executives, middle-aged millionaires, and Members of Congress. A May, 1994 Price Waterhouse analysis estimated that reducing federal subsidies for higher-income individuals under age 65 in the same manner as for Medicare beneficiaries would result in federal budget savings that are four times as large as the Medicare income-related premium savings.

7) *Beneficiary Access to Care could be Jeopardized*

Medicare beneficiaries' access to needed health care could be seriously hurt by the unprecedented reductions in Medicare spending included in the FY 96 Budget Resolution. For the average older American, the $270 billion in Medicare spending reductions will mean:

- **Increased Out-of-Pocket Costs That Could Limit *Access to Services*:** For the average beneficiary, the proposal to reduce Medicare spending could cost about $3,400 more out-of-pocket over the next seven years in the form of higher premiums, coinsurance and deductibles. For many beneficiaries — particularly those with low incomes — the additional costs are on top of the $2,750 they already pay out-of-pocket for health care in 1995. Older Americans spend roughly 20 percent of their income on health care — nearly three times as much as those under age 65. Increasing out-of-pocket costs could mean that fewer beneficiaries would be able to afford the care they need and many would be forced to wait until a condition worsens and care is even more expensive.

- **Spending Cuts That Could Limit *Access to Providers*:** As physician payments are reduced, many doctors will try to shift more costs onto Medicare beneficiaries. One likely way for this to happen is through the elimination of the Medicare balance billing limits. This change would allow doctors to charge beneficiaries significantly more than what Medicare approves. If this happens, many older Americans would no longer be able to afford to see their doctors. In other

cases, physicians may find that it is no longer profitable to treat Medicare patients, leaving beneficiaries without access to a doctor. Still other beneficiaries may have to travel long distances for hospital care since many hospitals across the country — particularly in rural areas — would be forced to close.

- **Spending Cuts That Could Limit *Access to Health Plans*:** The level of spending reductions included in the Budget Resolution could result in substantially higher premiums for beneficiaries who choose to remain in traditional fee-for-service Medicare. Some beneficiaries might no longer be able to afford to stay in fee-for-service and would be forced into managed care.

8) ***Medicare Caps could be Imposed***

- **Structure**

  Members of Congress are considering a Medicare spending "cap" as one method for achieving budget savings. Under this approach, yearly spending limits or targets would be established for the Medicare program. This cap could take one of several forms: a total spending limit for the program, a limit on the annual growth rate in the program; or a per capita spending limit. The cap could be fixed in law or determined on a yearly basis.

  Annual Medicare spending would then be measured against the cap. Under one approach, known as a "look-back," actual Medicare spending would be compared with the target at the end of each year. If actual spending exceeded the target, then Medicare spending for the following year would be reduced by the amount exceeding the target.

- **Impact on Beneficiaries**

  A Medicare cap would have a direct bearing on Medicare beneficiaries. If Medicare spending exceeds the yearly cap, automatic cuts in Medicare spending would likely translate into higher out-of-pocket costs for Medicare beneficiaries — in the form of higher premiums, coinsurance or deductibles — as well as reductions in payments to hospitals and doctors which would affect beneficiary access to services.

  Advocates of a Medicare cap claim that this kind of target is necessary to keep program spending in check. However, for the average beneficiary — who has little control over Medicare program spending — this would mean an even greater out-of-pocket burden for Medicare services.

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(1) This analysis is based on the June 22, 1995 Budget Resolution Conference Agreement.

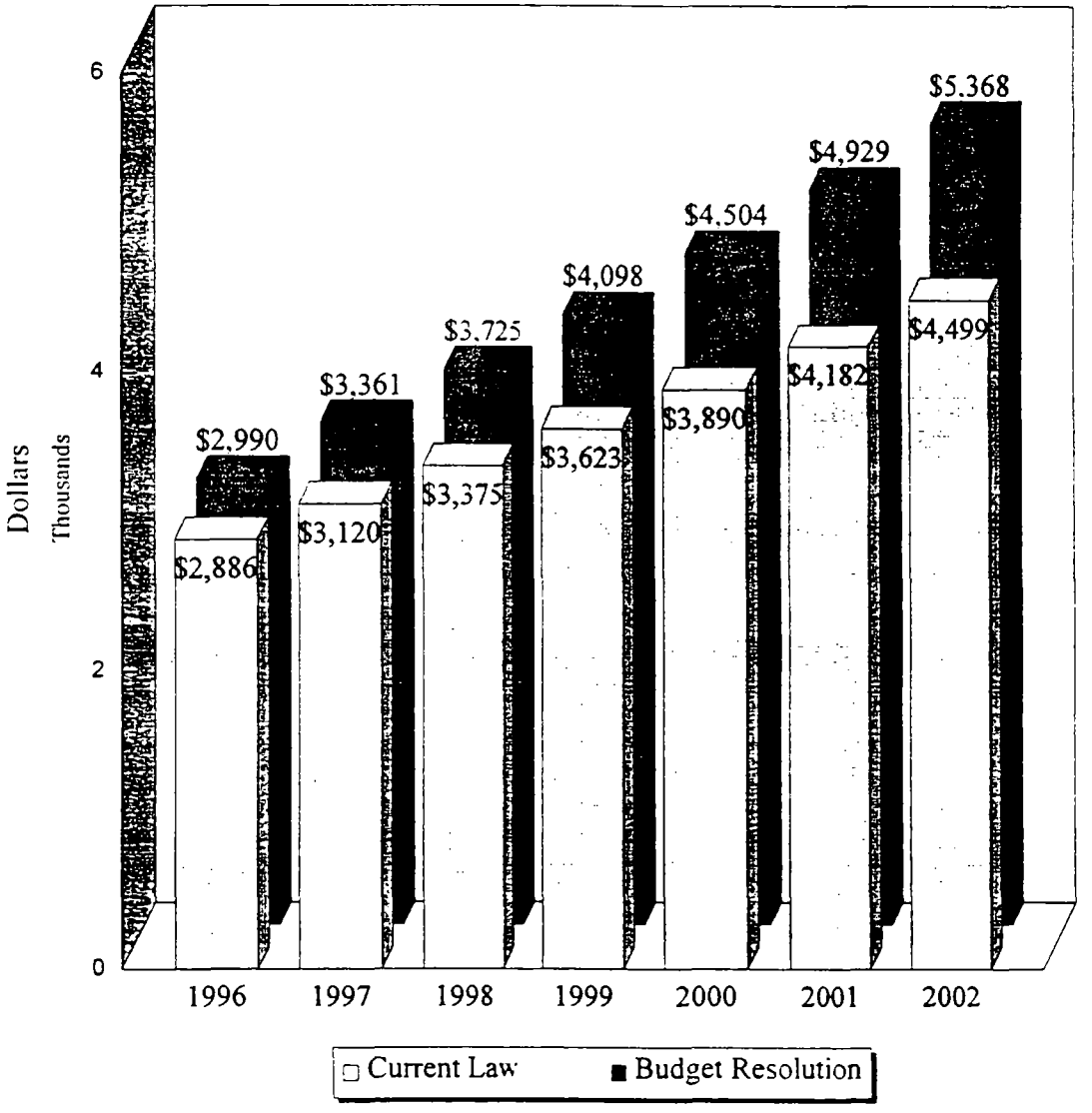
(2) Increased out-of-pocket costs are averaged across all Medicare beneficiaries.

(3) Out-of-pocket health costs include all health care expenses of non-institutionalized older individuals except those paid by Medicare. Medicare and private premiums, and prescriptions drugs, for example, are considered out-of-pocket costs. Data are based on December, 1993 CBO projections of population subgroups and National Health Accounts data by type of service and payer.

Chart 1

Comparison of Illustrative Increases in Average Beneficiary Out-of-Pocket Costs under the Congressional Budget Resolution

Over the seven year period, 1996-2002, average costs would increase by $3,400 per beneficiary.

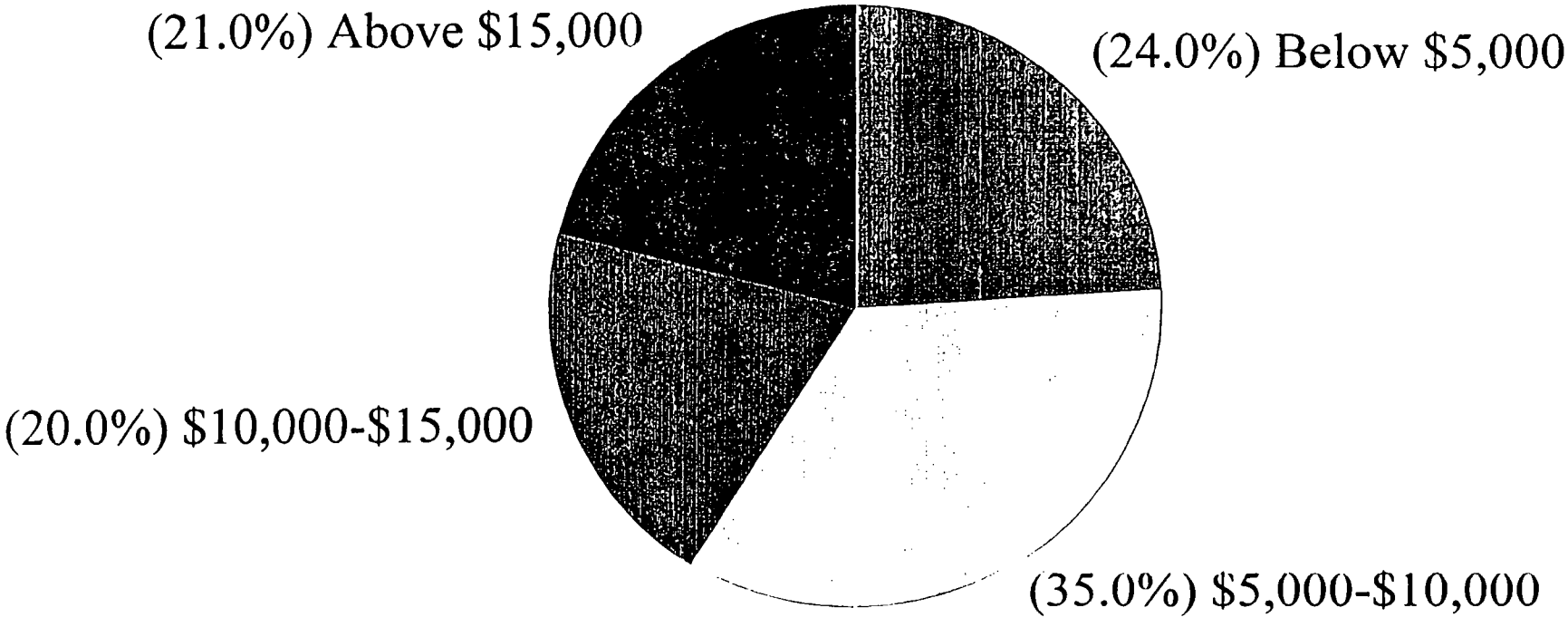


Sources:

a. "Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans." Prepared by AARP/Public Policy Institute, April 1994; Updated February 1995.

b. Prepared by AARP/Federal Affairs based on information from "Reducing the Deficit: Spending and Revenue Options," Congressional Budget Office, February 1995.

1992 Income* of Medicare Home Health Users



* Self-reported by income categories, including spouses' income.

Source: 1992 HCFA Current Beneficiary Survey, AARP Federal Affairs

AARP *JUST THE FACTS. . . .*

Medicaid Block Grants Would Threaten Essential Protections For Older Americans

The budget proposal to block grant Medicaid **jeopardizes important federal consumer protections** designed to help older Americans. These protections were enacted, in large part, because states were not doing enough voluntarily. Absent federal requirements, there is little reason to be confident that all states will continue to provide protections like spousal impoverishment and nursing home quality programs. States could reduce or eliminate some or all of these essential programs for vulnerable older Americans.

- **Low-Income Protections for Qualified Medicare Beneficiaries (QMBs)** — A block grant could allow states to eliminate the QMB program entirely, leaving vulnerable, low-income seniors without the ability to afford even the most basic Medicare services. Under current federal law, Medicaid pays the Medicare deductibles and coinsurance for beneficiaries with incomes below the federal poverty line (about $7,500 for singles and $10,000 for couples) and premiums for qualified Medicare beneficiaries (QMBs) with incomes under 120% of poverty. The governors have strongly supported federal takeover of this program, a position that suggests that they would be unlikely to dedicate adequate state funds to maintain it. Medicare and Medicaid reductions, combined with a block grant, create the very real possibility that the state and federal governments will **abandon low-income Medicare beneficiaries entirely.**

- **Nursing Home Spousal Impoverishment Protections** — A block grant could allow states to eliminate current spousal impoverishment protections. Financial protections for spouses of nursing home residents were enacted in 1988 because spouses who remained in the community were often left without income and savings to survive on as their wives or husbands entered a nursing home and spent-down to Medicaid. In some cases, the situation was causing couples married for 50 years to sue each other or get divorced to ensure that the spouse living in the community had the financial resources needed to live. Repealing this protection could lead to **bankrupting spouses who remain in the community** when their husband or wife has to go into a nursing home and spend down to Medicaid.

- **Nursing Home Quality Protections** — A block grant could eliminate successful federal nursing home quality standards and procedures, making nursing homes truly dangerous places in which to live. A 1986 study by the widely respected, independent National Academy of Sciences Institute of Medicine concluded: "A stronger federal leadership role is essential for improving nursing home regulations because not all state governments have been willing to regulate nursing homes adequately unless required to do so by the federal government." Landmark federal nursing home quality improvements were enacted in the following year. Repealing these quality protections would be a drastic step backward, and could **place millions of frail nursing home residents in jeopardy.**

AARP *JUST THE FACTS. . . .*

Unprecedented Medicaid Reductions Could Eliminate Health Insurance Coverage For Many Vulnerable Americans

The FY 96 Budget Resolution includes the **largest Medicaid reductions in the history of the program — $182 billion** in savings over the next 7 years. In the year 2002 alone, the budget proposal would reduce projected federal Medicaid spending by $54 billion, a reduction of about 30% below what the government estimates it will cost to run the program delivering the same services and benefits that it does today. The annual Medicaid growth rate would be capped, gradually reduced to a 4 percent rate of growth — less than half of the current 10 percent growth rate. In addition, the Budget Resolution anticipates that the entire Medicaid program would be turned into a "block grant" to the states.

Medicaid is the health and long-term care safety net for vulnerable children, older and disabled Americans. **More than 4 million older Americans depend on Medicaid** for coverage of preventive care, prescription drugs, nursing home and home and community-based long-term care. Medicaid also assists **over 2 million low-income qualified Medicare** beneficiaries (QMBs) by paying their Medicare premiums (if income is below 120 percent of poverty), deductibles and coinsurance (if income is below 100 percent of poverty). In addition, **more than 15 million low-income children are covered by Medicaid,** most of whom live in families where at least one adult is employed.

Budget reductions of this size will have enormous consequences for these vulnerable Americans:

- **The number of families without basic health insurance would likely increase dramatically.** How individual states would respond to the proposed cuts would vary by state, but some things are clear. It is unlikely that states will raise taxes or shift money from education or prisons to make up for the federal reductions. Some states are likely to respond by cutting their own Medicaid spending as well. According to estimates by the Urban Institute, in the year 2002, more than **8 million Americans could lose their Medicaid coverage** as a result of these proposed reductions.

- **Many older Americans would likely lose coverage for long-term care.** Medicaid is most Americans' sole protection against the high costs of long-term care. About 35 percent of Medicaid spending goes for long-term care and Medicaid pays for more than half of the nation's nursing home costs. Many who need long-

term care start off as taxpaying, middle class Americans. When chronic illness strikes, they must "spend down" their life savings until they are eligible for the Medicaid long-term care "safety net." According to estimates by Lewin-VHI, in the year 2002, **over 2 million Americans could lose their Medicaid coverage for long-term care** as a result of the proposed reductions.

Some greater state flexibility could help Medicaid — but **block grants, like the proposed reductions, go too far.** There remain substantial opportunities for simplifying the program and making coverage more rational. AARP would support greater state flexibility when it would expand coverage, improve services, or contain costs without jeopardizing access or quality. Repealing essential federal consumer protections, however, could result in great harm to older Americans.

Item I

Persons who are covered by Medicare Part A and who elect to enroll in Part B, will be eligible to select coverage provided by MediChoice health plans, the Medisave Option, or Employer, Union, or Association-sponsored health plans.

A greatly expanded choice of plan options will be made available to Medicare beneficiaries at time of initial eligibility and during subsequent coordinated annual open enrollment seasons, as follows.

Plan Enrollment Options At Time of Initial Entitlement to Medicare

Upon becoming eligible for Medicare benefits, beneficiaries may choose to enroll in any one of the following:

- original fee-for-service Medicare, hereinafter referred to as the fee-for-service (FFS) plan;
- a privately administered MediChoice health plan in their market area;
- a privately administered Medisave health plan; or
- an Employer-sponsored, Association-sponsored, or Union-sponsored health plan for which they are eligible.

Annual Coordinated Open Enrollment

Beneficiaries will have the opportunity to change their Medicare coverage once each year during a coordinated open enrollment period in which all qualified plans must participate, except Employer-sponsored plans.

Employer-sponsored plans would operate under continuous open enrollment procedures under which retired employees, also entitled to Medicare, could elect to continue in the Medicare-qualified Employer plan without a break in coverage.

During the annual open enrollment period, beneficiaries may elect to enroll in the FFS plan, any MediChoice health plan in their area, or any Association-sponsored plan or Union-sponsored plan for which they are eligible.

Enrollment Exceptions

Beneficiaries may elect the Employer-sponsored plan option upon retirement and if eligible for Medicare.

A beneficiary enrolled in an Employer-sponsored plan who subsequently elects to disenroll from such a plan and enter a MediChoice health plan, the FFS plan, or an Association-sponsored plan, would be precluded from reentering the Employer-sponsored plan in the future.

Beneficiaries may elect the Medisave health plan option only upon initial entitlement to Medicare.

Beneficiaries initially electing the Medisave health plan would have a 120 day cooling-off period during which the beneficiary could reverse the election and choose instead to enroll in the FFS plan, until the following open enrollment period. If a beneficiary disenrolls at any time from the Medisave option, the beneficiary is precluded from re-selecting the Medisave option in the future.

Special MediChoice Health Plan Disenrollment Conditions

Beneficiaries may petition the Secretary to disenroll from a MediChoice plan before the next open enrollment period, and return to the residual FFS plan or select a MediChoice plan, if the beneficiary can demonstrate that the plan committed any one of the following:

- violated the health plan's contract;
- misrepresented the health plan's benefits or operating procedures in marketing the plan to the beneficiary; or
- provided poor quality care to the beneficiary.

The Secretary must establish procedures that permit expedited disposition of such cases.

MediChoice Plans

Through MediChoice plans, a variety of new delivery system options (such as

preferred provider organizations and point of service products) will be made available to Medicare beneficiaries.

Health plans must apply to the Secretary for certification to participate as a MediChoice plan.

The Secretary will establish and administer mandatory certification standards for MediChoice plans in the following areas:

- marketing;
- enrollment;
- disenrollment;
- benefits (covered services, and premiums and cost-sharing requirements, if applicable);
- emergency and out-of-plan services;
- reporting/disclosure;
- delivery system standards
  - service areas
  - plan capacity
  - access to providers;
- solvency;
- grievances and appeals;
- sanctions;
- quality assurance standards, both internal and external programs (see additional provisions);

The federal certification standards relate only to plans' participation in the Medicare program and do not preempt state regulation of health plans.

- The Secretary may impose user fees on MediChoice plans to finance the

costs of the certification program.

MediChoice Advisory Group

The President shall appoint a MediChoice Advisory Group to offer to the Secretary recommendations on certification standards.

The MediChoice Advisory Group shall include members with national recognition for their expertise in the business of insurance, health care delivery, health economics, and related fields.

Quality Accreditation

Health plans must be accredited as meeting quality standards in order to participate in the MediChoice program.

The Secretary will determine the frequency of quality accreditation.

The Secretary may provide that private accreditation by an approved organization is sufficient to deem a plan as meeting the quality assurance portion of the certification standards for participation in MediChoice.

To allow accreditation by a private agency, the Secretary must ensure that the agency's accreditation standards are at least equal to the quality assurance standards established by the Secretary.

The Secretary shall establish quality assurance standards covering:

- quality management and improvement processes;
- utilization management;
- credentialing;
- an internal grievance process;
- patient access to written and other information about the plan, its services,

providers of care, and patient rights and responsibilities;

-- patient privacy; and

-- medical records.

Quality Measurement

The Secretary shall establish quality measurement standards based on recommendations by a Working Group on Quality Measurement.

The Working Group shall be made up of experts in health care quality, data, and consumer reports.

The Working Group shall make recommendations to the Secretary on:

- establishing computer-based patient records, including issues regarding privacy;
- standardizing clinical data collection and transmission;
- standardizing consumer satisfaction data collection;
- appropriate uses of such data; and
- the format for informing beneficiaries regarding the quality performance of MediChoice health plans.

Financial Solvency and Capital Adequacy

The Secretary shall establish financial solvency and capital adequacy standards, based on recommendations made by the National Association of Insurance Commissioners by March 1, 1996.

Consumer Protections

All marketing materials must be approved under guidelines established by the Secretary. The Secretary shall establish "one-stop" approval procedures for any plan certified to offer benefits in more than one market.

The Secretary shall establish fair direct sales guidelines, including a prohibition against agents completing enrollment forms for beneficiaries.

Benefits

Requirements for basic and supplemental benefit offerings by MediChoice plans would be established as follows:

MediChoice plans shall offer services equivalent to Medicare covered services in the FFS plan, but with discretion on delivery approaches.

MediChoice plans may establish cost-sharing appropriate to the delivery system.

MediChoice plans cannot place limitations on inpatient hospital days that are more restrictive than the FFS plan.

Any supplemental benefits offered by MediChoice plans are optional for the beneficiaries (they may elect to get only Medicare benefits).

Beneficiaries may select supplemental coverage offered by any qualified health plan.

Beneficiaries will select their supplemental coverage during the same enrollment period as for basic Medicare benefits.

Premiums and Payment Rates

A series of rules on MediChoice plans' premium development, and the development of a market-based price will be established.

Health Plan Premium Submission Rules

Health plans must submit premiums for the plan's benefit package and information on the plan's MediChoice enrollment capacity, for each market area, to the Secretary by a date determined by the Secretary.

-- The premiums submitted by the plans for Medicare benefits shall be the total premium required by the plan.

-- Once submitted, health plans may not change their premiums until the next year and must collect from the beneficiary the difference between the total premium and the MediChoice rate, if the MediChoice rate is lower.

Health plans must agree to serve all beneficiaries in a market area on a "first-come, first-serve" basis, up to plan capacity (except that current enrollees have priority over new enrollees).

Market-Based MediChoice Rates

In each market area, beneficiaries in MediChoice health plans will get a uniform MediChoice rate paid on their behalf to the plan of their choice.

The MediChoice rate will be the lower of :

- the market rate; or

- the FFS proxy premium.

The market rate will equal the average of premiums submitted by plans in the market area less a percentage of the difference between the average and the lowest priced plan.

Payments to MediChoice Health Plans

The MediChoice rate will be adjusted for demographic and risk factors before payments are made to MediChoice health plans.

MediChoice Premiums and Rebates

If a beneficiary enrolls in a MediChoice plan that charges less than the MediChoice rate, the plan will rebate the difference to the beneficiary in cash, or, at the beneficiary's option, apply the difference to supplemental coverage premiums.

If a beneficiary enrolls in MediChoice plan that charges a premium in excess of the MediChoice rate in the market area, the beneficiary must pay the additional premium to the plan.

Market Areas

The Secretary shall be required to establish the geographic boundaries of Medicare market areas according to guidelines set in legislation.

Place of Residence

Each Medicare beneficiary will be assigned to a market area based on place of principal residence.

Guidelines

The Secretary shall set the market areas in a manner that:

- creates market areas that are larger than counties, or the equivalent of counties in areas that use other designations; and

- covers all areas in the United States without overlap

In general, a metropolitan statistical area (MSA) should be included in one market area.

- However, the Secretary may make exceptions to this rule to allow smaller market areas when an MSA is large, but the sub-MSA market areas shall be set in a manner that does not segregate the Medicare population by health status.

State Boundaries

In general, the Secretary shall accept market areas that build upon boundaries established by States for private health insurance purchasing cooperatives or similar insurance purposes if:

- the State boundaries do not generally violate the rule regarding metropolitan statistical areas; and

- adopting the State boundaries will not conflict with market areas for bordering

States.

State boundaries that are used to establish Medicare market areas need not be contiguous areas.

Administration

The Secretary will be required to establish and administer a coordinated open enrollment system for Medicare beneficiaries encompassing all MediChoice and Medigap choices.

Coordinated Enrollment

The Secretary will establish a process through which beneficiaries will elect their coverage at initial eligibility and at subsequent annual, coordinated open enrollment periods.

Beneficiaries will select their Medicare and supplemental plans (including any Medigap coverage), during the coordinated open enrollment period.

Default Enrollment

Beneficiaries not submitting an enrollment form will be automatically enrolled in the same plan they were enrolled in for the prior year.

New beneficiaries not submitting an enrollment form will be automatically enrolled in the FFS plan.

Contractor

The Secretary shall contract with a neutral entity in each market area to provide information to beneficiaries about their coverage options.

- In general, the Secretary shall use existing carriers and intermediaries, unless a carrier or intermediary is offering a MediChoice health plan or Medigap insurance in the market area.

Information for Beneficiaries

Each market area contractor shall publish an information booklet that is provided timely to all Medicare beneficiaries to permit enrollment choices at initial eligibility

In general, qualified Association plans will:

-- have a primary purpose that is not the provision of MediChoice coverage;

-- not discriminate among members based on health status; and

-- offer MediChoice coverage to all members who are eligible for Medicare.

MediChoice Payments

MediChoice payments to Employer, Association, and Union-sponsored plans shall be on the same basis as payments to other MediChoice plans in the market area in which a beneficiary resides.

Alternatively, such plans may negotiate a federal payment rate certified by the Secretary as budget neutral relative to payments that would have been made on behalf of the Medicare enrollees.

Medisave, Catastrophic Plans

Beneficiaries will have an option of enrolling in a private, catastrophic medical expense plan, combined with a medical savings account.

Eligibility Criteria

To be eligible to elect the Medisave option, persons must:

- be eligible for Medicare based on age;
- maintain a qualified Medisave account;
- maintain qualified catastrophic medical expense coverage;
- self-insure for the deductible and pay all medical expenses from the account; and
- forego other Medicare coverage options permanently, after the close of the initial cooling-off period.

Cooling Off Period

Persons electing the Medisave option will have a 120-day cooling off period during which they may elect to switch to the FFS or a MediChoice plan.

The Secretary shall recoup any unspent cash payments or credits made to the beneficiary during the time the beneficiary elected the Medisave option.

Qualified High Deductible Coverage

The Secretary will establish guidelines for certification of qualified catastrophic medical expense plan coverage, including rating requirements.

- The $ deductible shall be indexed to the CPI.

Medisave Payments

Medisave payments shall be made directly to the individual's Medisave account and will equal the MediChoice rate for the market area, adjusted for demographic factors.

Medicare Review Commission

A new Medicare Review Commission is established to replace ProPAC and PPRC.

Purpose

The commission will report to the House Committees on Ways and Means and Commerce, and the Senate Committee on Finance on all aspects of the Medicare program and make recommendations to the Committees for changes.

Membership

The Commission members will be appointed on the same basis as members are appointed to ProPAC under current law.

Authorization

The Commission is authorized at $ million each year.

Required Annual Report

The Commission is required to provide a report by March 1 annually covering all aspects of the Medicare program, including analysis and recommendations.

The report should:

-- assess fee-for-service payment systems (PPS and RBRVS);

-- analyze the distribution of MediChoice payment rates across market areas;

-- recommend adjustments in payments to MediChoice health plans for relative risks;

-- recommend modifications to the MediChoice benefit package configurations;

-- provide advice on improving the quality of care in MediChoice health plans; and

-- provide advice on assuring access to care provided by MediChoice health plans.

Indexing Report

The Commission shall report by January 1, 1998 on recommendations regarding indexing the market area MediChoice rates.

The report shall include an analysis of moving to indexing instead of market-based pricing.

Transition Rules

Initiation of reform options and changes to the current HMO program will require transition periods and rules.

A transition period of three years would be established during which blended payment rates would be paid to risk and cost contractors.

Cost contractors would be required to transition to risk contracts by the close of the transition period.

Item II

Diabetic Self Responsibility

Reimburse for diabetic education and care programs.

Cardiac Disease Alternative Self Responsibility

Reimburse for coronary heart disease (CHD) education and prevention programs.

Screening Improvements

Reimburse for colorectal cancer screening. Reimburse for prostate cancer screening. Address mammography utilization issues.

Item III

Cost Sharing Under Medicare Fee-For-Service Program

Option I

A new program would be established to encourage beneficiaries to self-insure (not purchase Medigap coverage) for Medicare coinsurance liabilities. Corresponding modifications are made to current Medigap standard policies.

Beneficiaries enrolled in Part B and agreeing to self-insure for the Part B coinsurance would get:

-- a reduction in Part B coinsurance from 20% to 15%; and

-- annual out-of-pocket protection of $5000 in 1996 (indexed to overall growth in Medicare expenditures).

Beneficiaries who continue enrollment in any type of Medigap plan covering the Part B coinsurance will pay a coinsurance rate of 25% instead of 20%.

Option II

Beneficiaries who choose to enroll in any type of Medigap plan will pay a coinsurance rate of 25% instead of 20%.

Prohibit Insurance for Part B Deductible

Medigap policies would be precluded from covering the Part B deductible expense.

The Part B Deductible

Increase the Part B deductible for 1996 and index annually thereafter.

Extension of Part B Premium

Maintain beneficiary responsibility for the Part B premium at the current percentage (31%) of program costs (alternatively, increase it to 33% or 35%).

Income-Related Reduction in Medicare Subsidy

Medicare would be income-related by imposing an additional premium to cover part of the cost of Part B which is currently subsidized by the general fund. This additional premium would be collected annually with payment accompanying the April 15th filing of income taxes. All Part B enrollees would continue to pay the otherwise applicable premium in effect for the calendar year.

Coinsurance for Home Health

Impose a 20% coinsurance on home health services.

Coinsurance for Skilled Nursing Facility Services

Impose a 20% coinsurance for skilled nursing facility services for the first 20 days of a skilled nursing facility stay.

Coinsurance for Clinical Laboratory Services

Option I

Impose a 20% coinsurance requirement on all clinical laboratory services, or

Option II

Impose a 20% coinsurance requirement on bundled clinical laboratory services.

Item IV

Fraud and Abuse

Beneficiary Incentive Program

Specific qui tam ("whistle blower") provisions for Medicare beneficiaries.

Incentive program for beneficiaries reporting of overcharges in billing (non fraud) by providers, with beneficiaries sharing in savings.

Incentive program for beneficiaries' suggestions for improving program efficiency with beneficiaries sharing in savings.

Strengthening Legal Tools

Expand mail fraud statute to explicitly include Medicare and private health plans.

Expand mail fraud statute to include private mails (eg. FedEx).

Improving Program Efficiency

Establish advisory opinions.

Privatization of Medicare fraud screens.

Clarification of Current Provider and Contractor Penalties

Voluntary disclosure program for Medicare.

Clarify program exclusion provisions to include debarment periods for specific types of violations.

Clarify the "should have known standard".

Clarify intent standard and safe harbor concept.

Amend "one purpose test" to substantial or primary reason for referrals.

Clarify discount exception (include exception for capitated programs).

Amend formula for civil monetary penalties to assure that civil monetary penalties are appropriate.

Item V

Regulatory Relief

Repeal Medicare secondary payer data match.

Physician Self-Referral

Amend the Physician Self-Referral rules as follows:

- -- Moratorium on effective date;
- -- Repeal section on compensation arrangement;
- -- Eliminate the prohibition against physician's practices providing durable medical equipment and parenteral and enteral services;
- – Eliminate the "site of service" restriction on in-office service;
- – Amend the physician supervision requirement applicable to non-physician personnel to clarify that direct supervision is not required;
- – Amend the "general supervision" requirement;
- – Add a community need exception;
- – Add "shared services" exception;
- – Expand the prepaid exception to include state regulated and Medicaid plans;
- – Expand the prepaid exception to include preferred provider organizations;
- – Clarify the rural exception to include state regulated and Medicaid plans.

Clarification of Medigap Non-Duplication

Revise rules to allow coordination of benefits for long-term care, nursing home, home health, and community-based care policies.

Eliminate separate disclosure notices and require plans to outline the degree to which they may duplicate/coordinate with Medicare covered benefits.

Item VI

Medicare Sustainable Growth Adjustment

Specific growth rates in Medicare outlays for Part A and Part B would be set for each of the 7 years covered by the budget resolution.

The Secretary would estimate Medicare growth rates annually. If program spending exceeds growth rates set in law, then outlay reductions will be triggered. Growth rates for the capitated programs, MediChoice and Medisave, would be set in advance to meet the targets, so outlay reductions, if necessary, would be made only in the Medicare FFS program.

Item VII

Market Basket Update

Reduce Medicare prospective payment system hospital rate update to market basket minus [Potential range 0.5 - 2.0].

Disproportionate Share

Reduce Medicare's prospective payment system disproportionate share adjustment to hospitals by (20 - 30%).

Inpatient Capital Related Costs

Rebase Medicare's prospective payment system's federal and hospital-specific rates for capital payments.

Indirect Medical Education

Reduce payments under Medicare's prospective payment system indirect medical education adjustment

Non PPS Hospitals

Rebase the long-term care hospitals cost-based payment system.

Transitional cost reduction for rehabilitation facilities (OBRA 1993 market basket reduction formula applied for years 1996, 1997, 1998).

Establish prospective payment system for rehabilitation facilities effective 10/1/1999.

Reduction in Payment for Hospital Bad Debt

Reduce payment for hospital bad debt to 50 percent.

Extension of Skilled Nursing Facility Cost Limit

Maintain savings from skilled nursing facilities cost limits included in the President's budget.

Item VII

Process of Updating Physician Fees.

Option 1

Adopt the Physician Payment Review Commission (PPRC) recommendations to correct the many structural problems that exist with the Medicare Volume Performance Standard (MVPS).

Option 2

Repeal the MVPS and return to the Medicare Economic Index (MEI) used prior to physican payment reform for updating physician payments as a mechanism for updating physician fees.

Replace separate conversion factors for surgical, nonsurgical and primary care services with a single conversion factor.

Establish a Hospital Outpatient Prospective Payment System.

Establish a prospective payment system (PPS) for hospital outpatient department (OPDs) based on ambulatory patient groups (APGs), that would cover all hospital-based outpatient services.

Limit beneficiary coinsurance to 20 percent of the Medicare payment amount under the Outpatient PPS.

Reduce Payments to Physicians for Overhead.

Under review.

Competitive Bidding for Durable Medical Equipment

Develop a competitive bidding process for durable medical equipment contracts.

Competitive Bidding for Clinical Laboratory Services

Develop a competitive bidding process for clinical laboratory services.

Item IX

Extensions of Secondary Payer Payment Requirements.

The Medicare secondary payer proposals are extensions of provisions that are set to expire at the end of 1998 included in the President's budget. The three MSP proposals would:

-- extend the data match between HCFA, IRS, and SSA to identify the primary payers for Medicare enrollees with health coverage in addition to Medicare;

-- extend the provisions making Medicare the secondary payer for disabled employees with employer-based health insurance; and

-- extend the provision requiring non-Medicare insurers to be primary payer for ESRD patients for 18 months before Medicare becomes the primary payer.

Improve MSP Program

Develop a mechanism to prospectively identify individuals with other coverage.

Home Health Service Extension of Cost Limits

Maintain savings home health services from OBRA 1993.

Establishment of Home Health Payment Limits

Establish a per visit payment system, subject to a 120 day (not visit) per episode cap, with home health agencies sharing in any savings if total per episode payments are less than the cap.

Create an "inlier policy" excluding short term use of home health care (such as 20 days) from the cap.

Create a "volume performance standard" methodology to reduce payment if savings from payment limit system are not achieved.

Research Agenda Brief

June 1995

Reengineering Medicare: From Bill-Paying Insurer to Accountable Purchaser

Prepared by

Lynn Etheredge
Consultant

Prepared for the Health Insurance Reform Project, George Washington University, with funding from the Robert Wood Johnson Foundation

Reengineering . . . is the fundamental rethinking and radical redesign of business processes to achieve dramatic improvements in critical contemporary measures of performance, such as cost, quality, [and] service.

--Michael Hammer and James Champy,
Reengineering the Corporation

At the time of its enactment 30 years ago, Medicare was patterned on the health insurance models widely used by private employers and insurers for the under-65 population. In this model, the primary administrative function of insurance companies and of the Medicare program was simply to pay bills. Today, Medicare remains essentially a bill-paying insurance program, with the addition of national formulas for hospital and physician payment rates.

In recent years, the private sector has moved beyond this traditional insurance model. Private-sector payers are no longer simply paying bills but are using a variety of evolving *purchasing* techniques, in a competitive marketplace, to restrain costs and improve quality and service. Among these purchasing strategies are many forms of selective, competitive contracting; capitation and risk-sharing arrangements; provider performance standards, with incentives, penalties, and continuous quality improvement goals; management of high-cost cases; centers of excellence for transplants, heart surgery, cancer care, and other treatment; prevention and chronic disease management initiatives; consumer information and incentives; specialized contracting for pharmaceutical benefits, substance abuse, mental health, and other services; and specialized claims-auditing firms to deal with fraud. Individuals with benefits offered by large employers—including, through the Federal Employees Health Benefits Program (FEHBP), the nation's political leaders and federal workers—are usually able to make choices among a number of health plans on the basis of provider networks, cost, quality, service performance, and other features.

In this new purchasing environment, private-sector employers and consumers are increasingly able to make informed choices—to hold providers (and the plans that contract with them) *accountable*—through the use of tools such as the National Committee on Quality Assurance's (NCQA's) "report cards," which are based on the Health Plan Employer Data and Information Set (HEDIS), and other quality measures, such as health outcomes. The HEDIS data set includes more than 60 quality, service access, patient satisfaction, outcomes, and other performance measures, including preventive care (such as immunizations, mammography screening, and eye exams for diabetics) and signal indicators for poor quality (such as inpatient admissions for asthma and treatment following heart attacks).

In the current political climate, there is great interest in the federal government's making available to the Medicare population a broader choice of competing private health plans that use such purchasing technologies. Today, health maintenance organizations (HMOs) and other private plans enroll only about 10% of the Medicare population. Among the many measures that could open up more plan options are an FEHBP-type "managed competition" approach that would allow Medicare beneficiaries to make informed choices among a wide range of HMO, preferred provider organization (PPO), Medicare Select, medigap, and other plans during an annual open season. Other options being discussed involve workers staying with employer/association plans after turning age 65 or some use of medical IRA accounts and catastrophic coverage. Much of the attention in Congress now centers on the policy questions involved in structuring new options for Medicare enrollees.

As a complete reform strategy, such options would fall short. They do not reform the basic Medicare program. Over 90% of Medicare's spending is through the fee-for-service model. As of January 1, 1995, 19 states had no Medicare HMO enrollees and 32 states had 1% or fewer of their Medicare-eligible populations

enrolled in HMOs. A handful of states—including California (42% of Medicare HMO enrollees) and Florida (17% of Medicare HMO enrollees)—accounted for most of the Medicare HMO membership.[1] Even with an FEHBP-type arrangement and optimistic growth assumptions about private plan enrollments, many factors make it likely that most Medicare eligibles in most states will still be in the program for the rest of the decade and beyond.[2] In its traditional bill-paying mode, the Medicare program has very few tools for dealing with the volume, intensity, and quality issues that are its major cost-drivers. Thus, devising a strategy for fundamental reform of the basic Medicare program—"reengineering" Medicare—is essential not only to deal with budget issues but also to achieve improvements for the 37 million people who depend on the program.

What should be done about the basic Medicare program? What would be in the best interest of its 37 million elderly and disabled enrollees?

This paper considers the question of whether Congress should give Medicare the same types of authorities that are available to its private-sector competitors—particularly authorities to use new purchasing techniques—and require performance accountabilities for their use through HEDIS-like quality and health outcomes measures. Should not the nation's elderly and disabled, as well as taxpayers, ask for and expect a state-of-the-art Medicare program? If this approach were adopted, Medicare-eligible individuals would be able to enroll either in a Medicare program that is working hard to provide the best economy, quality, and services or in competing private-sector health plans that are paid equivalent (risk-adjusted) capitation amounts. One might expect that, over the long term, both taxpayers and Medicare-eligible persons would benefit by such competition.

At the most general level, reforming the Medicare program in this way would start with three fundamental changes:

- *A revised mission philosophy that emphasizes Medicare as a health plan.* Most importantly, Medicare would need to become accountable, not just for insurance to pay bills and protect financial assets, but for improving the health of its enrollees, by providing preventive health measures and quality medical care.[3]
- *The adoption of "report cards" that assess Medicare's performance on the basis of cost, quality, outcomes, and service so that it can be held* accountable *by enrollees and policymakers.* These measures need to reflect a wide range of criteria, including preventive care, quality of care, consumer satisfaction, and health outcomes, and should also apply to competing private health plans. Report cards should show national, state-level, and market-area performance.

The measures that could be used by a reformulated Medicare can be illustrated by comparing current official data reports with new health-related data that could be a basis for the above-described report cards. The most extensive public accounting for Medicare's operations is the *Medicare and Medicaid Statistical Supplement* published in February 1995.[4] Its more than 370 pages are filled with statistics that emphasize financial, workload, and claims-paid data, such as hospital days of care and expenditures, that are appropriate to a traditional health insurance program. Nowhere are there measures of quality of care and improved health status or reports on enrollee satisfaction.

Two recent studies highlight the kinds of health-related measures that might be used to assess Medicare's future performance as an accountable health plan. The Physician Payment Review Commission (PPRC) and the RAND Corporation have recently developed a set of approximately 50 quality measures that can be implemented, using claims data, for the current Medicare program. Several measures, which have been run against Medicare's national claims data, are shown below in Table 1. A number of them are similar to the

NCQA's HEDIS measures used for private-sector health plans. In the view of the physician consensus panels developing the measures, these are "necessary care" indicators; that is, professionally acceptable practice should be near 100% compliance.

TABLE 1

Clinically Based Indicators of Quality of Care for the Elderly

Medicare Claims Data, 1992 and 1993

Breast Cancer	
For patients with breast cancer, interval from biopsy to surgery less than 3 months	64%
Mammography every year for patients with a history of breast cancer	61%
Mammography every 2 years in female patients	39%
Diabetes	
Eye exam every year for patients with diabetes	38%
Heart Problems	
Visit within 4 weeks following discharge for patients hospitalized with MI	84%
EKG during ER visit for unstable angina	81%
Mental Diagnosis	
Visit within 2 weeks following discharge of patients hospitalized for depression	95%

The PPRC-RAND study shows several quality indicators on which the care received by Medicare elderly patients merits an "A" (95%+) on a nationwide basis. But it also highlights a number of prevention indicators, such as mammography and eye exams for diabetics, for which there should be failing grades, "D" or "F," as well as many indicators in the 60% to 85% range where care falls well below professional standards. The study also highlights particular problems for minority populations and for rural and underserved areas.[5]

Another recent study, by Lewin-VHI for the National Institute for Health Care Management, analyzed Medicare hospitalization rates for three diagnoses that are sensitive to good ambulatory care and preventive measures. For 1992, the study reported Medicare hospitalization rates for asthma to vary by more than 3:1 among states, hospitalization rates for diabetes by more than 5:1, and hospitalization rates for hypertension by more than 8:1. Even after statistical adjustments for demographic characteristics, several-fold variations still remained.[6]

Given such statistics, any presumption that Medicare has already become the "gold standard" of quality care and that it is up to its competitors to prove their superiority should be put aside. Medicare's performance needs to be measured and accountable on the same basis as its competitor plans, so its enrollees can make informed choices.

The third fundamental change that would need to occur for Medicare to become more like a state-of-the-art accountable health plan is the following:

- *Medicare should have new authorities to purchase health care on the basis of explicit quality and other criteria and competitive performance.* Within the many statutory constraints Medicare has to operate under as a government program, it has generally been run effectively, efficiently, and with continuing improvement and innovation. Given its constraints, Medicare is now about as good a program as it can be. But, in nearly every area—such as three-year-long rule-making processes, volume increases and quality assurance issues, fraud and abuse, and rapidly rising budget costs—it is clear that Medicare cannot deal as effectively as it

needs to with the complexity and pace of change in today's health system, nor can it hold physicians, hospitals, and other providers accountable for improving their performance. To improve Medicare's performance, Congress needs to provide authority to move beyond the limits of regulatory rulemaking and price-setting so that Medicare can adopt the same types of successful purchasing techniques pioneered by private-sector payers. Such evolution could build incrementally through many Health Care Financing Administration (HCFA) initiatives, but, if fully reengineered, the Medicare program would be quite different a decade hence. Such changes will require a new bipartisan political consensus.

The next section elaborates on management challenges for the Medicare program's future if it is to be an effective health care purchaser. Following that is a discussion of specific legislative changes needed to allow Medicare to be an effective purchaser and competitive health plan. A third section sketches a research agenda for developing a Medicare management strategy to use these new statutory authorities. A final section discusses issues related to competition between a reengineered Medicare program and competing private-sector health plans.

THE CHALLENGE OF MEDICARE MANAGEMENT

For the federal government, serious efforts to manage Medicare as an accountable health plan would be among the most enormous and complex tasks it has ever undertaken. To put the task on the scale of private-sector enterprises, the Medicare program, with $160 billion of spending in 1994, has passed General Motors—with $154 billion in revenues, the nation's largest private company—to become the nation's largest business-type operation.[7] In 1994, only three privately managed U.S. corporations (General Motors, Ford, and Exxon) had more than $100 billion in revenues, 11 had $50 billion or more in revenues, and 110 had $10 billion or more in revenues. Today, 37 million persons depend on the Medicare program. Within 30 years, as the baby boom generation retires, Medicare will be purchasing health care for about 70 million persons, and its annual spending will be many times greater than it is today.

An understanding of the challenges of charting Medicare's future begins with an understanding of the scale involved. Nevertheless, there is a widespread misperception about the Medicare program that must be dealt with to understand just how difficult it will be to manage the program. That is the myth of uniformity, predictability, and gradual change.

Medicare can seem to be a deceptively simple and easy-to-reform program. Its enrollments, financing, and benefits are defined in statute. It has a centralized administrative structure (DHHS/HCFA); a uniform set of regulations; payment rates for hospitals, physicians, and other services that are specified by national formulas; and a national quality assurance/peer review structure, the Professional Review Organization (PRO) system. Individuals who are not health services researchers also tend to presume that health care is enough of a science that area-to-area rates of service use will be roughly uniform and that clinical practices change gradually, primarily as a result of the steady accumulation of scientific data. A misperception that the health care system is evolving in gradual, uniform ways is also reinforced by national health expenditure and Medicare actuarial data that aggregate a vast number of complex changes and variations into single categories such as "intensity."

The following selection of data illustrates how far assumptions of uniformity and steady change are from the Medicare program's reality.

- *Hospital use.* Even on a regional basis, Medicare enrollees' use of hospital care varies by a ratio of 2:1—from 1,735 days/1,000 enrollees in the western states to 3,455 days/1,000 enrollees in the northeastern states in 1992. As they have for years, hospital

lengths of stay continue to average about 50% longer in the northeastern states (10.4 days) than for the western states (6.7 days).[8]

- *Rates of change in hospital use by diagnosis-related groupings (DRGs).* In the 1988-1992 period, hospital discharges for Medicare enrollees rose by 8.3%. Of the 65 leading DRGs, however, only 12 had increases between 0% and 20%. Seventeen DRGs had increases of 20% to 40%, 9 rose by 40% to 60%, and 5 increased by more than 60% in the four-year period. The most rapid increases were reported for DRG 88 (chronic obstructive pulmonary disease), 219%; DRG 462 (rehabilitation), 103%; and DRG 214 (back and neck procedures with complications and/or comorbidities), 75%. Discharges declined for 22 DRGs. Eleven DRGs had declines of between 0% and 20%; 8 declines were in the 20% to 40% range; 3 declined by over 40%. The DRGs that decreased most were DRG 90 (simple pneumonia and pleurisy) and DRG 96 (bronchitis and asthma with complications and/or comorbidities), which had declines of 52% and 58%, respectively.[9]
- *Nursing home use.* Rates of nursing home use varied by 6:1 across states. Minnesota residents used 1,364 days/1,000 enrollees, Connecticut residents 1,235 days/1,000 enrollees, and Indiana residents 1,067 days/1,000 enrollees in 1992. Among the low-use states were Maine (248 days/1,000 enrollees), Oklahoma (326 days/1,000 enrollees), and New Hampshire (327 days/1,000 enrollees).[10]
- *Home health use.* The rate of home health visits per 1,000 enrollees varied by more than 17:1 among states in 1992. The high-use states included Mississippi, with 11,786 visits/1,000 enrollees and Tennessee, with 11,717 visits/1,000 enrollees. At the other end of the range were Hawaii, with 668 visits/1,000 enrollees, and South Dakota, with 969 visits/1,000 enrollees.[11]
- *Growth rate in part B spending.* Over the 1986-1992 period, Medicare part B annual expenditures rose at a national average of 8.8%. Here again, substantial national diversity, rather than uniformity, is the dominant pattern. The rate of increase varied more than 3:1 among states—from 4% to 5% annually in California and Hawaii to between 13% and 16% annually in South Carolina, Delaware, Kansas, Nevada, and North Carolina.[12]
- *Growth in physician procedures.* Over the 1991-1994 period, the growth rate of Part B services averaged 3.5% annually. Behind these averages, however, were quite different and rapidly changing patterns for different services. Echocardiograms increased at a 19.3% annual rate, angioplasty at 17.1% annually, MRIs at an 11.9% rate, arthroscopy at 9.1%, coronary artery bypass grafts at 8.8%, and joint prostheses at 7.3% per year. Among the declining procedures were transurethral prostate surgery, falling 9.9% annually, and cataract lens replacements, falling 2.3% annually.[13]

A common-sense view might be that high-use areas would probably also be areas of high overuse. This assumption was rigorously tested by RAND researchers using 1981 data for three procedures: carotid endarterectomy, coronary angiography, and upper gastrointestinal tract endoscopy. The rates per 10,000 elderly varied among three sites by 3.8 times for carotid endarterectomy, 2.3 times for angioplasty, and 1.5 times for upper gastrointestinal tract endoscopy. Their findings were that rates of inappropriate use were not much different between low-use and high-use areas. However, rates of inappropriate use for all three procedures were significant, ranging from 17% to 32%.[14]

One might be skeptical about some of the Medicare-reported trends. (Were there really major epidemics of chronic obstructive pulmonary disease and complicated back and neck problems requiring hospitalization of the elderly that escaped the national media attention in 1988-92?) But Medicare has spent a

great deal of effort and money to improve its data systems. To the extent that Medicare's payments do not accurately reflect the services being provided to its beneficiaries, then far more is wrong about provider billings (and Medicare administration) than data errors.

REENGINEERING MEDICARE MANAGEMENT

The only way we're going to deliver on the full promise of reengineering is to start reengineering management.

—James Champy

If Medicare were to be operated in a more business-like way, what important changes should Congress consider making in the Medicare program's authorities? Many government-sponsored activities do have flexibility similar to that found in private-sector businesses; these activities include the Tennessee Valley Authority and other power marketing authorities, the Government National Mortgage Association, and the Federal Reserve Board. But granting Medicare, with $175 billion in purchasing power and 37 million enrollees, a freer rein will need to be done carefully and watched vigilantly.

In general terms, *Medicare needs the authority to select providers based on quantifiable measures of quality, outcomes, and service and to use competitive purchasing.* The heart of a private-sector plan's ability to improve quality and assure accountability is its capacity to decline to do business with poor performers and to move business toward better performers. In contrast, Medicare is the prime remaining example of the traditional insurance "any willing provider" philosophy. To be certified as a Medicare provider usually requires little more than state licensure or accreditation by certifying organizations that are provider-dominated. Congress has created a virtual entitlement for health care providers to participate in Medicare. Competitive procurement is a standard business method for assuring good quality, cost, and service, and it should also be available for Medicare administrators.

Among the areas for possible use of such authorities are:

- *Competitive purchasing of standardized services and supplies,* including durable medical equipment, laboratory testing, radiology, and outpatient surgery
- *Establishment of explicit quality and service performance standards and refusal to do business with providers that do not measure up.* For the welfare of its beneficiaries, Medicare needs to move beyond the minimal participation requirements that are now set in legislation. New standards for providers should include the HEDIS-type "report card" and health outcomes measures for which the Medicare program will be accountable (for example, physicians who fell below certain standards in providing mammography screening for their patients would be dropped from the program).
- *Development and use of centers of excellence and specialized services contracting.* Medicare now uses such concepts in its coverage for transplant services; private-sector plans use selective contracting even more widely for many forms of surgery, cancer care, mental health, and so forth. Major expansions may be possible to develop disease management and preventive services for patients with chronic or high-expense illnesses and for disabled enrollees. Intelligent purchasing by Medicare could call forth better quality, cost, and service competition among providers, to the benefit of Medicare beneficiaries and taxpayers. To preserve Medicare's role in assuring a broad choice of providers, Medicare enrollees might still be able to go to non-preferred providers, but with higher co-payment rates.
- *Use of case management for high-cost patients.* Most private-sector health plans have the flexibility to work with high-cost patients to develop service packages, such as home

care, that can better meet their needs. The Medicare statute does not permit such flexibility, even when it would be in the best interests of the patient and the program. With so many frail elderly and disabled patients, Medicare might be able to make good use of such authorities.

- *Elimination of notice of proposed rule-making process for purchasing.* Like Gulliver tethered by many bonds, the Medicare program's effective use of its purchasing power is held back by numerous technical constraints, some of which are appropriate to a rule-making administrative style but not to a business-type operation. Most important of these is the Notice of Proposed Rule Making requirements that now involve at least a three-year process for major Medicare policy initiatives or changes. Such rule-making is frequently, in essence, simply a statement of contractual terms, that is, what Medicare will and will not pay for, under what terms, and in what circumstances. A private business that had to go through a three-year process any time it wanted to write or revise a contract with its suppliers would probably be in the same financial predicament as the Medicare program.

- *Authorization for Medicare simply to drop providers in the best interests of the program to deal with fraud and abuse.* In recent testimony, a Government Accounting Office (GAO) official noted that the Medicare program is "overwhelmed" by fraud and abuse and that it is a "particularly rich environment for profiteers."[15] Among Medicare's many problems are the difficulties of kicking providers out of the program and the limited resources made available by the Department of Justice. A recent GAO study based on studies of claims denial rates for 74 services across 6 carriers noted that one-half of denied claims were submitted by between 2% and 11% of providers.[16] Acting as a business-type purchaser, Medicare would have authority to simply stop doing business with any supplier, at its discretion. In areas of widespread fraud, Medicare might also be allowed to engage private-sector law firms to recover on behalf of the government.

- *Authorization for Medicare to organize and contract for quality assurance at its discretion.* Since 1965, the major initiative to improve Medicare quality has been enactment of the PRO system. It is an expensive program (costing some $325 million in 1994), deals almost exclusively with inpatient hospital care, and has been of questioned effectiveness. The 53 PROs are provider-dominated organizations. Most are physician-sponsored, for example, by local medical societies, and typically have a board of directors composed primarily of physicians and other provider representatives. Medicare Part B services are largely subject to quality review by the claims-paying carriers. As noted in an Institute of Medicine report on Medicare quality improvement, the implementation of a new health-oriented mission for the Medicare program will require far-reaching administrative, contractual, and other changes that include reconsideration of PRO, carrier, and HCFA roles.[17] Would a private-sector purchaser, intent on improving quality of care, want to be constrained to contracting with a medical society or provider-dominated organization?

- *Publicity about data on quality and service.* With the advent of HEDIS and buyers insisting on accountability, provider secrecy about quality problems is being replaced by publicized reporting in the private sector. Statutory change should also allow this approach to be adopted by the Medicare program. Such publicity about where physicians and hospitals stand compared to professional benchmarks and guidelines can be important acts in themselves to encourage better patterns of care and service.

- *Improvement of customer service.* The Medicare program has never had a strong customer orientation. As an adjunct to the Social Security Administration (SSA), it started with representatives in SSA's district offices, but

it lost these community-level staff when HCFA was established. Customer service is an area in which Medicare is at a competitive disadvantage vis-à-vis competing private health plans.

- *Enactment of special authorities for Medicare in the hiring, promotion, and compensation of employees.* There is no activity which is of larger budgetary consequence or greater management challenge for the federal government over the next half century than the Medicare program. Today, Medicare is bound by government-wide civil service procedures, promotion, firing, compensation levels, and personnel ceilings. In business-type operations, such as the Federal Reserve Board, Congress has been willing to make exceptions so that federal activities can be carried out with the required professional expertise. In particular, the Medicare program may need such flexibility if it is to compete with private-sector plans.

Certainly some health care providers—and competing health plans—will question the wisdom of such new Medicare authorities. But why would beneficiaries and taxpayers want to keep Medicare from being as good a program as it can be? If Medicare is expected to compete with private plans for enrollees, why should it not have comparable purchasing flexibility?

A STRATEGIC PLAN FOR MEDICARE MANAGEMENT

If the Medicare program, as an accountable health care purchaser, is to begin to use these authorities to deal with quality, service, and cost issues, where should it start and what should it do? Given the program's scale and complexity, a great deal of work will need to be done to devise an intelligent purchasing strategy before that question can be answered in a way that has wide professional and political support. As a matter of law, Medicare cannot deal with such problems in an arbitrary or capricious manner. Beneficiaries have rights to due process and to judicial review for claims denials. Much of the needed research will be useful for competing private-sector health plans, since these plans will face the same issues and few yet have much special expertise in managing care for the Medicare populations.

Research might help Congress, the executive branch, and other interested parties in the following five basic areas:

- *A national strategy for clinical effectiveness and outcomes studies for the Medicare populations.* This strategy could be built by analyzing the Medicare data to identify procedures with wide variations that seem likely to reflect overuse and underuse or excessive rates of increase and by prioritizing a research agenda by potential payoffs in enrollee health and program costs. It also needs to include recommendations concerning funding for the effort, the appropriate methodologies to assure usefulness, and an ongoing system to automatically evaluate new technologies and clinical practices. The serious shortcomings of much of the published literature on medical treatment, well-known to clinical effectiveness researchers, was highlighted in a recent *New York Times* story of a Canadian assessment of treatment for whiplash injury that found only 62 of 10,382 studies met the evaluators' criteria for solid scientific evidence.[19]
- *Development of HEDIS-type "report card" measures* for quality/health outcomes, consumer satisfaction, and service. These data need to be collected at the state and market-area level, so that HCFA can manage its carrier/PRO contractors accountably and so that enrollees have comparable data to private-sector plans for making their enrollment decisions. These report card measures need to be selected for their validity and reliability and should include information that is important to consumers for making choices among health plans.
- *Studies of "best practices" in all major areas of costs, quality, and service.* Medicare is a vast program that has not been very amenable to

centralized, command-and-control management. Political decision-makers and the Medicare program have rightfully been extremely wary about trying to use government coercion to change medical practices. Perhaps the best way to foster desirable change in a competitive-choice market system is to make sure that patients, providers, and competing health plans are well-informed about the best practices and performance benchmark standards that they should look for in making purchasing decisions or should offer to be successful in the marketplace. The private sector's new purchasing techniques, and their applicability to Medicare's populations, need to be carefully assessed.

- *Effective communication strategies.* The development of a national research effort for effectiveness and outcomes studies, report card data, and identification of best practices need to be matched by strategies to be sure the information is effectively communicated and that it takes into account the range of sociological and other factors that need to be addressed for effective change. Good clinical research data on outcomes and effective communication seem to have been an effective strategy in the recent declines in prostrate operations and cataract surgery, two procedures that had been increasing rapidly until better information was made available to clinicians and patients.

- *Assessment of where both Medicare and competing private health plans do and do not work well, and why.* One of the important open issues for health policy is to identify market conditions where health plan competition can improve health care and where such competition does not work well. In today's market, for example, while the Twin Cities area has one of the highest national rates of HMO enrollment for the under-65 population, only 9% of Medicare eligibles are enrolled. A possible reason is that HMOs cannot make much money or provide many additional benefits for 95% of the Medicare expenditures in this area. Some analysts have also argued that managed competition will not work well in rural areas. If Medicare competition is opened up to a wide variety of options more attractive than HMOs—for example, PPOs, point-of-service (POS) plans, Medicare Select options, and other arrangements—market research on their comparative success can yield insights about how the Medicare program may need to be changed to better meet the needs and preferences of its enrollees.

In addition to these areas, there are a number of special study topics that could prove useful for devising a strategy for Medicare to operate as an accountable health plan.

- *Special studies of needs and service for Medicare's disabled populations.* Medicare's 4 million disabled enrollees have been badly neglected by health policy analysts and in Medicare policy discussions. Medicare publishes very little data on their characteristics, needs, and service use. Nevertheless, this is an important group for analysis, as its rate of growth (4.0% annually in the period 1982-1992) is more than twice that of the elderly population (a 1.9% annual increase during the same period); the under-45 disability group has been growing even faster, almost 11% annually over this period. With a benefit package focused on acute medical care, the Medicare program is not well-designed for totally and permanently disabled persons. Since this group is unlikely to be attractive to private health insurance plans, it is particularly important that the Medicare program, as an accountable health plan, make special efforts to be sure that they are being well served. Separate HEDIS-type measures may be needed for disabled subpopulations.

- *Special studies of high-use elderly populations.* As is the case with the under-65 population, Medicare's spending for the aged is highly skewed, with about 5% of enrollees accounting for about 50% of expenditures on care, 10% for about 70% of expenditures on care, and about 20% accounting for about 80% of

expenditures on care. Among the high-expense populations are important subpopulations with chronic illness. Trying to identify these groups and analyze potential improvements in their care will be of particular importance for dealing with Medicare spending issues. To the extent that such high-use groups remain with the Medicare program, it will be even more important for Medicare to have a scientifically strong clinical basis for assessing their needs and care.

- *Special studies of disease management and prevention initiatives.* It may seem unusual to think about prevention and long-term disease management for Medicare enrollees, but its elderly enrollees are in the program, on average, for over a decade, with some enrolled for up to 40 years; its disabled enrollees receive benefits for even longer. Among prevention initiatives reported by HMOs for the over-65 are activities to reduce falls, a leading cause of hospitalization in the elderly, and to identify inappropriate prescribing and potential drug-drug interactions. As an increasing number of pharmacy benefit management and other firms develop disease management expertise, it will be important to assess the potential of these developments for the Medicare population, particularly in light of the many studies that show misprescribing for the elderly.
- *Policy development for post-acute hospital care.* A particularly rapid part of Medicare's recent growth has been in post-acute hospital care. Between 1992 and 1993, Medicare spending for home health and skilled nursing care each grew by about 40%, to a total of nearly $17 billion. Rehabilitation therapy claims are growing about 30% a year.[19] This entire policy area needs careful review, in conjunction with the Medicaid program, which is the nation's largest financer of long-term care, to rationalize the service efforts. Standards of appropriateness of care are more difficult to come by in this area than for clinical effectiveness and outcomes studies of acute care.
- *Better risk-adjustment mechanisms and procedures.* It is predictable that the basic Medicare program will continue to have a less healthy population than competing private health plans, at least for the foreseeable future. This will be an ongoing area of research and policy analysis. Perhaps an independent or quasi-independent organization should manage the annual "open season" competition between Medicare and private health plans to help assure fair, well-informed choice by eligible individuals.

This is an outline for a very broad and multi-year research agenda. But such an effort is needed, by both public and private sectors. Over the past 10 years the primary focus of Medicare policy has been to design, implement, and refine its price controls—using DRGs and a resource-based relative value scale (RBRVS). Today, there is very little that is "on the shelf" that can be implemented in the short run.

CAN MEDICARE COMPETE SUCCESSFULLY?

Given new accountabilities, new management authority to purchase health care, and a strategic plan for its future, can Medicare compete successfully with private health plans for the benefit of the elderly and disabled? Why not just leave Medicare alone as a traditional bill-payer and hope that it will whither away as beneficiaries choose better-managed private health plans? There will be those who believe that privately managed health care plans will out-perform any new-model, government-run Medicare program in head-to-head competition and that trying to manage Medicare as a competitive health program is hopeless or unwise.

Nevertheless, the Medicare program is still the choice of over 90% of its eligible population (and, in a majority of states, of 99% or more of eligibles), and it seems premature to predict Medicare's demise or to make an unchallengeable case about private health plans' interest and ability to compete, on a nationwide basis, for the Medicare population,

particularly its high-expense frail elderly, chronically ill, and disabled populations. Given the current situation, it would be a high-stakes risk to ignore upgrading Medicare and place all of the nation's Medicare budgetary bets on presumptions about the success of private-sector plans that may prove to be wishful thinking. In addition, the federal government has a number of strengths to build on in trying to make Medicare a better program. Among these strengths are:

- *Good track record.* It is fashionable to disparage government competence, but, compared to much of the private insurance industry, the Medicare program has an excellent track record for innovation and efficiency, within its statutory constraints. Through the use of DRGs and RBRVS, Medicare has led private payers in reducing payments for overpriced procedures and using purchasing power to restrain inflation and rationalize payment rates. Medicare has also led in investing in medical efficacy studies and protocol development to improve clinical practices reflecting outcomes research (through the Agency for Health Care Policy and Research [AHCPR]); publicizing information on comparative provider quality, for example, hospital mortality rates and nursing home reviews; setting up standardized data systems; establishing electronic submission of claims; and overall administrative efficiency. In all of these areas, Medicare still betters the private insurance norms. Among recent innovative steps are beneficiary surveys, a consumer information strategy (immunizations, mammography), a coronary artery bypass surgery demonstration with bundled payment rates, Medicare Select demonstrations, and performance contracts with PROs. With a new statutory mandate and authorities, Medicare may also excel in new competition vis-à-vis private health insurance plans.
- *Flexible administrative structure.* Medicare is normally thought of as a government-run program, but, in fact, no federal employees actually pay claims. Federal employees oversee a system of some 74 private contractors (called intermediaries and carriers—mostly Blue Cross/Blue Shield plans or commercial insurers) that actually run the program on a day-to-day basis. These private-sector insurers—themselves now involved in developing and managing private health plans—bring administrative flexibility, staffing and subcontracting capabilities, and expertise in local markets. When Medicare was first established, its contractor system offered administrative capabilities the government did not possess and could not develop on the scale and in the time frame that was needed. A well-managed Medicare program might be able to take advantage of this flexibility, in new relations with its contractors. As discussed in a recent companion piece,[20] the Blue Cross Blue Shield Federal Employees Plan managed pharmacy benefits program offers a model for how state-of-the-art managed care programs can be developed and offered in a government-financed framework for public beneficiaries. Medicare might be able to cross-fertilize between HCFA's rule-making and bill-paying culture and the private payers' purchasing culture to produce hybrid plans through joint efforts with its primary contractors.
- *Public trust and freedom of choice.* While government, in general, may be viewed with distrust and suspicion by many voters, the Medicare and Social Security programs retain strong senior citizen support. Medicare remains the program of choice of the elderly. In the Medicare program, enrollees have much broader freedom to choose a provider than in private managed care plans. They also have legal rights and due processes that help to guarantee their benefits—and an ability to appeal to their members of Congress for assistance.
- *Enormous purchasing power.* Medicare is the nation's largest health care purchaser, with an estimated $175 billion of spending in

1995. In 1993, it accounted for 19% of personal health care expenditures, including 28% of hospital care expenditures, 20% of physician care expenditures, and 39% of home health expenditures. The price discounts Medicare has been able to achieve through DRGs and RBRVS alone—although now undercut by HMOs in some markets—and its high assignment rate (over 96%) suggest a reasonable amount of optimism should be in order about the success of future purchasing strategies. If managed purposively, Medicare should be able to strike economic terms that are at least as favorable as its competing health insurance plans, as well as use its purchasing discretion for upgrading quality and service standards.

- *Data and research capacity.* Finally, Medicare has an unsurpassed data system, including claims records on medical services use by some 37 million enrollees and a potential for service-profiling and quality-auditing most of the nation's health care providers. This is a unique resource for developing national management strategies and for rapid learning about the effectiveness of these providers. Medicare and AHCPR also have a strong tradition of health services research and can work with many professional groups in developing clinical quality indicators and improvement strategies.

How best to manage competition between competitive Medicare and private-sector plans, all trying their best to enroll Medicare eligibles with the most attractive benefits, costs, quality, and service, is a complicated topic in its own right. If reengineering Medicare, as described in this paper, is a primary challenge, another ongoing challenge of daunting complexity will be to assure that competition among Medicare and competing health plans works well. Congress is now in the midst of debating many major policy questions, including enrollee financial incentives and the potential for budget savings, and there are numerous questions which will require long-term learning agendas.

Thirty years after Medicare's enactment, a much-needed debate about Medicare's future is taking place; its focus is whether (and how) the Medicare program should be rethought in light of the private sector's transition from bill-paying insurance to accountable health care purchasing. Whether one favors Medicare reforms alone, more private plan options alone, or a "two-track" strategy that includes both approaches (the possibility raised in this paper), there are good reasons to proceed with caution in use of either Medicare's new business-type authorities or new competitive arrangements. The welfare of 37 million elderly and disabled individuals is at stake. While it is attractive to envision improving the Medicare program, it is also important to realize that discretionary authority can also be misused, and competitive forces can go awry. The Medicare program could be made worse if it is subjected to unrealistic budget pressures and its new authorities are used to ration services, or if competing plans "skim" the Medicare enrollment. As well, the American tradition of public management —based on the view that government officials should not be allowed to act in ways that are arbitrary, capricious, and unfair—has usually insisted on "a government of laws and not of men." But protection of Medicare enrollees in private plans from poor HMO practices should be no less an issue.[21] With broader administrative discretion for political appointees also comes increased possibility for the application of political pressures, from Congress and other sources, and the pursuance of personal agendas. Perhaps the Medicare program is unmanageable or will prove to be so; perhaps private plan enthusiasm about the profit potential of Medicare enrollees will abate. For many such reasons, there will need to be a great deal of oversight and vigilance about Medicare and its competitors. Just as Congress established the Prospective Payment Assessment Commission and PPRC to advise on development of Medicare price regulation, it may also wish to establish a similar advisory commission for an implementation period of market-oriented Medicare reforms.

ENDNOTES

1. *Medicare: Opportunities Are Available to Apply Managed Care Strategies*, statement of Janet Shikles, GAO/T-HEH-95-81, February 10, 1995 (Appendix I).

2. About 77% of Medicare eligibles already have medigap, Medicaid, or other supplemental coverage, so switching enrollment to an HMO may provide them few additional benefits. Individuals may also be deterred from enrolling in an HMO because they would have less freedom of choice of physicians and other providers and would not be able to re-enroll in their current plans if the HMO were not satisfactory. Insurers' ability to compete with Medicare is also lessened because Medicare pays providers well below average private market rates.

3. An Institute of Medicine committee has also recommended that Congress make quality assurance, including improved patient health outcomes, a fundamental program goal. See Kathleen Lohr (ed.), *Medicare: A Strategy for Quality Assurance*, National Academy Press, 1990. The study, chaired by Steven Schroeder, M.D., was requested by Congress in OBRA 1986.

4. *Health Care Financing Review: Medicare and Medicaid Statistical Supplement*, HCFA Pub. No. 03348, February 1995.

5. Physician Payment Review Commission, *Monitoring Access of Medicare Beneficiaries*, Report No. 95-1 (forthcoming); S. Asch, et al., *Access to Care for the Elderly Project*, Final Report, RAND Corporation, April 13, 1995 (photocopy).

6. National Institute for Health Care Management, *Health Care Problems: Variation across States*, December 1994, pp. 34-36 (exhibits 4.4, 4.5, 4.6).

7. "The Fortune 500 Largest U.S. Corporations," *Fortune*, May 15, 1995, p. F-1.

8. *Medicare and Medicaid Statistical Supplement*, p. 199 (table 25).

9. Ibid., pp. 208 (table 28).

10. Ibid., p. 232 (table 37).

11. Ibid., p. 252 (table 46).

12. Physician Payment Review Commission, *Expenditure Limits*, July 1993 (staff paper), p. 62.

13. Physician Payment Review Commission, *Annual Report to Congress: 1995*, p. 20 (table 1-1).

14. M. Chassin, et al., "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services?" *J.A.M.A.*, November 13, 1987. Jack Wennberg has been among the pioneers in Medicare area variation studies.

15. Statement of Sarah Jagger, March 22, 1995 (cited in *BNA Health Care Policy Report*, March 27, 1995, p. 479).

16. *Medicare Part B Factors That Contribute to Variations in Denial Rates for Medical Necessity across Six Carriers*, GAO/T-PEMD-95-11.

17. Lohr, *Medicare: A Strategy for Quality Assurance*.

18. "Study Finds Most Treatments for Whiplash Are Ineffective," *New York Times*, May 2, 1995.

19. *Medicare: High Spending Growth Calls for Aggressive Action*, Statement of William Scanlon, February 6, 1995, GAO/T-HEHS-95-75.

20. Lynn Etheredge, *Pharmacy Benefit Management: The Right Rx?* Research Agenda Brief, Health Insurance Reform Project, George Washington University, April 1995.

21. Complaint rates vary by more than 25:1, from 1.8/10,000 enrollees for Group Health of Puget Sound to 45.8/10,000 enrollees at Humana (Florida).

PRINCIPLES FOR THE BUDGET RECONCILIATION PROCESS

While AHA remains concerned about the magnitude of reductions being proposed in Medicare and Medicaid, now that a budget resolution has been enacted the process dictates that we move on to the next stage--reconciliation--where we all must work to ensure that the reductions are achieved in the most responsible manner.

We believe that any reductions must be accomplished based on the following principles if we are to maintain high-quality health care services to patients and the communities we serve.

- **FUNDAMENTAL RESTRUCTURING TO IMPROVE THE DELIVERY SYSTEM**

  The majority of spending reductions in Medicare and Medicaid must be achieved by improving the efficiency of the health care delivery system itself. This includes giving beneficiaries more options, such as the ability to choose coordinated care plans provided by community based organizations. And every health plan must be held publicly accountable for the quality of health care services it provides.

  Hospitals and health systems also support changes to the delivery system that eliminate excess capacity, overlap and duplication. Such changes should ease the way to a thoughtful downsizing and reengineering of the delivery system that could involve the merger, consolidation or closure of hospitals.

  To accomplish these goals, a variety of restructuring issues must be addressed which include: health plan definitions; patient referral restrictions; hospital antitrust reforms; prohibitions on the corporate practice of medicine; preventing any-willing-provider requirements; eliminating burdensome regulations; and malpractice reforms.

- **SHARED RESPONSIBILITY TO MAINTAIN QUALITY**

  Hospitals and health systems are willing to make their contribution to both a balanced budget and ensuring that the Hospital Insurance Trust Fund remains solvent. But, this must be accomplished through shared responsibility with all major stakeholders shouldering the burden in a fair and equitable manner and with no one absorbing a disproportionate share of reductions. Relying on provider payment reductions for the vast majority of savings will jeopardize the ability to provide high-quality health care services.

- **FAIRNESS IN MAKING TOUGH CHOICES**

  Tough choices will be necessary to achieve the reductions proposed and to maintain the long-term viability of these programs. That's why an independent citizens commission should oversee a fair and open process to balance available resources with appropriate services and provider payments. Congress would be held ultimately responsible by employing legislative fast-track procedures and default mechanisms to ensure accountability.

In addition, every penny saved on Medicare should be reinvested to ensure adequate financing. None of the savings should go outside the programs to finance other initiatives. At the same time, it is important to note that as the system moves toward capitated payments, the distinctions between Medicare Part A and B blurs. Therefore, the Medicare Hospital Insurance Trust Fund (Part A) and the Medicare Supplementary Medical Insurance Trust Fund (Part B) should be reorganized to make certain that financing decisions related to this program are based on maintaining fiscal viability of both Parts A and B.

- **ENSURING ACCESS FOR VULNERABLE POPULATIONS**

  Our most vulnerable citizens served by Medicaid must be protected against converting the program into block grants which can be used for purposes other than providing health care services to vulnerable individuals. States must be held accountable for using funds for the purpose in which they are intended. In addition, current law (Boren Amendment) provisions that require payments to providers be "reasonable and adequate" cannot be unilaterally repealed so that states have no accountability in providing fair payment to providers.

These principles will be used for evaluating AHA's position on specific legislative provisions as well as the legislation in its entirety.

A Proposal for Medicare Transformation

A Program in Jeopardy -- How to Rescue It

What is the Crisis in Medicare?

- Part A: Trust Fund Imbalance Imminent
- Part B: Outlays Compete for Budget
- Ratio of Workers to Medicare Population Declining

Solutions

- "Traditional" Remedies
  - Increase Taxes
  - Cut Payment Rates
- Transformation Remedies
  - Correct the Flaws
  - Create Savings for Program and Beneficiaries

Flaws in Medicare's Design

- Open-ended Liability
- Ineffective Cost Sharing
- Price Controls
- Current Taxes Fund Current Benefits

Summary: Financial Stability and Fund Solvency

Providers

- Reduce/ retarget special provider payments
- Reduce Medicare's GME funding via all payor pool

Beneficiaries

- Increase eligibility age
- Reduce subsidy to wealthy

Summary: Enhanced Choice and Market Competition

Improved Traditional Medicare

- Enhanced benefits - no Medigap needed
- Restructured cost-sharing with refundable annual deductible paid monthly
- No coinsurance
- Eliminate price controls
- "New Approach to FFS"

Medichoice (defined contribution)

FEHBP-type Plans	MSAs plus catastrophic plan

Medichoice: Enhanced Value for Beneficiaries

- Value Created by Tailored Choices
- FEHBP-type System: Informational Offering
- Choice Expanded:
  - Managed Care Plans of All Kinds
  - MSAs for Beneficiaries
- Neutral with Respect to Plan Choice
- Consumer-Driven Market

MSAs for Medicare Beneficiaries

- Coupled with Catastrophic Policy
- Self-Managed Care
- Promotes Price Competition at Point of Service
- No Additional Cost to Program

Shore Up Hospital Trust Fund

- Reduce Subsidy to Wealthy Elderly
- Increase Eligibility Age
- Reduce Graduate Medical Education Subsidies (IME and GME)
- Measures from CBO Options
  - Cease bad debt
  - Retarget disproportionate share
  - Reductions related to excess capacity
  - Other Reductions

Improved Traditional Medicare

- Enhance Benefits to Eliminate Medigap Need
- Eliminate Cost Sharing Except $500 Deductible
- Premium for Benefit Enhancement--Significant Value for Beneficiaries
- Refundable $500 Deductible
  - Deducted Monthly from SS Check
  - Indexed to Program Cost Growth
- Provisions for Poor and Near Poor
- Result: Beneficiary and Program Savings

LOW USER

DESCRIPTION: Healthy enrollee with only 2 visits for $300 total.

Out-of-Pocket Spending

Current Law		AMA Proposal	
Hospital Deductible:	$ 0	Deductible:	$ 300
Part B		Coinsurance:	$ 0
Effective Deductible:	$ 0	Total Medicare Premium:	$1,064
Effective Coinsurance	$ 0	Out-of-Pocket Spending:	$1,364
Premium:	$ 553		
Medigap Premium:	$1,011		
Out-of Pocket Spending:	$1,564		

HEAVY USER

DESCRIPTION: Ailing enrollee, several MD visits, 3-day hospital stay, 7-day hospital stay; expenses total $10,000.

Out-of-Pocket Spending

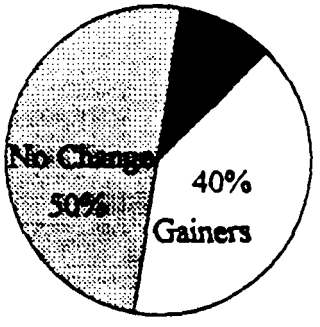
Current Law		AMA Proposal	
Hospital Deductible:	$ 0	Deductible:	$ 500
Part B		Coinsurance:	$ 0
Effective Deductible:	$ 0	Total Medicare Premium:	$1,064
Effective Coinsurance	$ 0	Out-of-Pocket Spending:	$1,564
Premium:	$ 553		
Medigap Premium:	$1,011		
Out-of Pocket Spending:	$1,564		

Summary of Beneficiary Net Savings

Case	Current Law	AMA Proposal	Net Savings
1. Non-User	$1,564	$1,064	$500
2. Low User	$1,564	$1,364	$200
3. Medium User (no Hospital)	$1,564	$1,564	$ 0
4. Medium User (with Hospital)	$1,564	$1,564	$ 0
5. Heavy User	$1,564	$1,564	$ 0
6. Catastrophic User	$1,564	$1,564	$ 0
7. Average User with No Medigap	$1,363	$1,564	($201)
8. Low-Income Average User	$1,363	$1,059	$305
9. High-Income Average User	$1,564	$2,458	($893)
10. Big Loser	$ 553	$1,064	($511)

Results of Transformation

BENEFICIARIES



PROGRAM

- Scorable Savings =$162B
- Trust Fund = Solvency

Attachment A
Policy Descriptions and Estimation Assumptions

Medicare Transformation and Modernization

Modernization of Medicare Coverage. Under the AMA proposal, the current Medicare program would be restructured so that the standard traditional fee-for-service plan would have only one deductible and no additional cost sharing requirements outside of a premium, as opposed to the current system that requires separate Part A and Part B deductibles and cost sharing requirements. The restructured fee-for-service plan has been designed to continue to cover all services currently covered under Part A and Part B as well as services covered by Medigap Plan C. The savings from restricting the fee-for-service plan is estimated to be $44.7 billion for the seven-year fiscal period, 1996 to 2002. The estimate is based on the following assumptions.

- *Effective Date.* January 1, 1997.

- *Plan Design.* The restructured fee-for-service plan would have one deductible in the amount of about half of the average Medigap Plan C premium charge (e.g. about $500 in 1995) and the remaining Medigap premium charge would be collected as a premium as would the current Part B premium charge (e.g. about $1,065 in 1995). The deductible would be collected on a monthly basis through an automatic transfer from the beneficiary's Social Security payment to their Beneficiary Escrow Account. Any remaining amount of the deductible left in the Beneficiary Escrow Account at the end of the year would be rebated to the beneficiary.

- *Estimation Methodology.* We used an actuarial estimation approach to estimate the percent of savings from restricting the fee-for-service plan in base year 1995. Benefit and cost sharing values (consistent with CBO baseline values) for calendar year 1995 were used to calculate the base year estimate of the percent savings. In the base year calculations, we estimate that the average premium charge for a Medigap Plan C is about $1,000. We assume that the percentage of savings in the base year would be an appropriate estimate of savings in future years. The percentage savings was then applied to a CBO baseline to estimate the seven-year gross savings. Net savings were computed by adjusting for the low-income subsidies and leveraging effects (described below).

- *Induction.* A prospective induction parameter equal to 0.9 (equivalent to a -0.0538 elasticity) was used.

- *Low-Income Deductible Relief.* An offset was incorporated into the estimate to take into account the amount of money not collected in the form of a deductible by beneficiaries whose income falls between 100 to 150 percent of the federal poverty level. The amount of the relief was designed to be proportional to one's poverty level. For example, if a beneficiary was at the 125 percent poverty level they would only be required to contribute half of the full deductible amount (e.g. .50 = (1.25 - 1.00)/.50).

- *Leveraging Offsets.* Leveraging offsets were taken into account and it was estimated that there was a 5.25 percent offset to the total savings.

Increase Eligibility Age to Match Social Security. The age at which individuals would be eligible for Medicare benefits would be increased to match the eligible age for Social Security benefits. This proposal would not achieve savings within the fiscal budget cycle from 1996 to 2002 because current law specifies that increases in the normal retirement age will not take effect until 2004.

Competitively Set Physician Payment Rates. Under the AMA plan, physicians will be allowed to determine their own conversion factors when setting charges for their Medicare patient. Physicians would also be allowed to balance bill their Medicare patients. Beginning in fiscal year 1997, the Secretary of Health and Human Services would recommend an update to the conversion factors using an access-based methodology. As part of that plan, this option assumes that the access-based update would be zero during fiscal years 1996 to 2002. Since the conversion factor is currently set to decline in future years, the zero update factor is estimated to cost an additional $14.5 billion over the seven-year budget cycle.

Impose 20 Percent Premium Contributions for High-Income Enrollees. Individual Medicare beneficiaries with modified adjusted gross income (AGI) greater than $50,000 or couples with modified AGI greater than $100,000 in fiscal year 1996 would pay a premium equal to 20 percent of the actuarial value of the entire federal contribution for Medicare, which would equal $987 in 1996. The income thresholds used to determine "high-income" beneficiaries would be indexed for inflation, based on the growth of CPI, for fiscal years, 1997 to 2002.

Increase Part B Premiums by 7 Percent Annually. Part B premiums would be allowed to grow at a rate of 7 percent annually. The estimates shown in Tables 1 and 2 have been lowered to account for the costs of Medicaid paying premiums for Medicaid beneficiaries as well as Qualified Medicare Beneficiaries (QMBs).

Restoration of Trust Fund Balance

Reduce Hospital Capital Payments: Rebase Rates. Payments for inpatient capital-related costs are being transferred from a cost-based reimbursement system to a prospective payment method. During the transition, hospitals are paid using either a fully prospective federal rate or a hospital-specific "hold-harmless" rate. Recent data shows HCFA overestimated the initial federal and hospital specific payment rates as growth in capital costs has been much slower than expected. As specified by the Congressional Budget Office, this option would reduce the federal rate by 5.62 percent and the hospital-specific rate by 7.13 percent to reflect current data on capital prices.

Reduce Hospital Capital Payments: Continue OBRA 1990 Reductions. OBRA 1990 set the capital prospective payment system rates during fiscal years 1992 to 1995 so that payments would equal 90 percent of estimated Medicare payments that would have been made on a reasonable cost basis for the fiscal year. As outlined in Representative Shay's proposal, this option would extend the 10 percent reduction through fiscal year 2002.

Reduce Hospital Capital Payments: Adjust Payments for Excess Capacity. This option would reduce capital payments by 5 percent to reflect low occupancy rates in hospitals. According to Congressional documents, earlier OBRAs reduced payments by 85 percent of reasonable costs, or 5 percent more than OBRA 1990. As outlined in Representative Shay's proposal, this option would recapture the 5 percent reduction for the purpose of adjusting for hospital occupancy rates.

Cease Bad Debt Reimbursements to Hospitals. Beneficiaries are responsible for certain deductibles and copayments under Part A. Currently, Medicare will reimburse providers for any unpaid amounts as long as they make a reasonable effort to collect. As outlined by the Congressional Budget Office, Medicare would no longer reimburse hospitals for unpaid beneficiary bad debt.

Retarget Disproportionate Share Payments. This option would immediately eliminate the disproportionate share payment adjustment for all hospitals, except large urban hospitals with the highest disproportionate share index. According to the Congressional Budget Office, about 1900 hospitals currently receive disproportionate adjustments; about 160 hospitals would be eligible under this option.

Bundle Hospital Acute & Post-Acute Payments. This option would make hospitals responsible for acute, all post-hospital SNF and rehabilitation services, along with 60 days of home health services. As outlined in Representative Shay's proposal, a single, prospectively determined rate would be set for all these services. Hospitals would be responsible for deciding and paying for the appropriate acute/post acute service mix for their Medicare patients.

Eliminate Sole Community Adjustments. Medicare designates hospitals as "sole community providers" if they meet certain criteria for providing acute, inpatient services in a geographic area. As outlined by the Congressional Budget Office, this option would eliminate the special payments to these hospitals, including disproportionate share adjustments and cost-based payments.

Lower Skilled Nursing Facility Cost Limits. SNFs are paid on the basis of reasonable costs, subject to a limit set at 112 percent of the national average cost per day for free-standing facilities. The limits are computed each year. OBRA 1993 froze the limits until fiscal year 1996. As outlined by the Congressional Budget Office, this option would revise the method of computing average costs to include the savings achieved from the OBRA-93 freeze. The Health Care Financing Administration estimates that this would lower the limits from 112 percent to about 100 percent of relevant average costs.

Lower Home Health Cost Limits. Home health providers are paid on the basis of reasonable costs, subject to a limit set at 112 percent of the national average cost per visit. The limits are computed each year. OBRA 1993 froze the limits until fiscal year 1996. As outlined by the Congressional Budget Office, this option would revise the method of computing average costs to include the savings achieved from the OBRA-93 freeze. The Health Care Financing Administration estimates this would lower the limits from 112 percent to about 100 percent of relevant average costs.

Restructure Medical Education Payments. Reform of Medicare payments for medical education consists of two parts: Direct Graduate Medical Education and Indirect Medical Education.

- *Direct Graduate Medical Education.* This proposal, which would take effect in fiscal year 1996, would exclude residents beyond their initial board certification in calculating Direct Graduate Medical Education (DGME) payments. For residents entering the program in fiscal year 1996 through their completion of initial board, weights of 1.0 for U.S. interns and residents and of 0.75 for foreign medical graduates (FMG's) would be used in computing the number of full-time equivalent (FTE) residents. For residents entering the program in fiscal year 1997 through their completion of initial board, we have used weights of 1.0 for U.S. interns and residents and of 0.50 for FMG's in computing the number of full-time equivalent FTE residents.

- *Indirect Medical Education Adjustment.* This proposal, which is effective in fiscal year 1996, uses fiscal year 1995 as the base year to compute indirect medical education (IME) payments for teaching hospitals. This proposal decreases total IME payments for fiscal years 1996 and 1997 by five percent over their preceding year. For fiscal years between 1998 and 2002, total IME payments are frozen at 1997 levels. This proposal does not specify how the reductions will be distributed across teaching hospitals.

Other

Modify HMO Payments. Under the AMA plan, Medicare risk contracting would be eliminated beginning in fiscal year 1997. In fiscal year 1996, HMO payments would be increased by 5 percent above fiscal year 1995 HMO rates, instead of linking payments to the growth in program costs. After 1996, the savings from the one-year reduction will be accounted in setting the payment level for Medicare's defined contribution.

Extend Secondary Payer Provision for ESRD & Disabled. OBRA 1993 provisions making Medicare the secondary payer for disabled and ESRD beneficiaries would be extended. Payment for services would be first required from a private payer, if the beneficiary has private health insurance coverage.

Sources: Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," February 1995. Congressional staff, Congressmen Shays, Hobson, Miller, and Largent, "Options for Preserving Medicare," May 11, 1995. Health Policy Economics Group, Price Waterhouse, LLP.

AMA'S PROPOSED MODERNIZATION OF THE TRADITIONAL MEDICARE PROGRAM: HOW DOES IT WORK FOR BENEFICIARIES?

SIX SCENARIOS

In order to explain how the AMA's proposal would work, think about the most common circumstance of a beneficiary. That individual is an average income person who has a Medigap insurance policy to cover the complicated cost-sharing required by separate hospital and medical insurance parts of the program. These individuals in 1996 would typically pay $1564 annually, regardless of whether they use any services or not. The $1564 is composed of two premiums: (1) Medicare's Part B premium which totals $553 and a Medigap premium, which under Plan C would average $1011 annually.

Because the AMA designed its proposal to restructure cost-sharing to improve Medicare's efficiency--not to increase the amount beneficiaries pay; AMA set out to structure beneficiary payments so that they would not exceed $1564. A major part of this modernization is to enhance benefits so that Medigap insurance is no longer needed by beneficiaries. We do that by having Medicare expand its coverage to match that of a Medigap Plan C policy with one exception. We would institute a $500 refundable annual deductible that applies to all services in the program; no other cost-sharing would be required. In exchange for these benefits, beneficiaries would pay a premium of $511 in 1996.

So under our plan, a beneficiary would pay $1064 as a Medicare premium. (Medicare would credit $553 as a premium for Part B and $511 split across Part A and B. We would have government deduct one-twelfth of $1564 (the premium plus the 500 deductible) from each beneficiary's Social Security check. The typical beneficiary who has Medigap insurance can be no worse off under our proposal because $1564 is the maximum personal expenditure under our plan.

The result of this modernization is positive for beneficiaries:

- The need for supplemental Medigap is eliminated as is complicated cost-sharing.
- 50% of beneficiaries will pay exactly what they do today for covered services.
- 40% of beneficiaries will actually pay less (those who do not spend their entire deductible).
- Only 10% will pay somewhat more. These are high income individuals who have their subsidy reduced modestly and largely healthy people who are not currently purchasing Medigap insurance.

AMA Medicare Proposal Case Studies

DRAFT

Case Study A
Mrs. Evans – Low User
Roughly 30% of enrollees spend $300 or less on medical care

Background

Mrs. Evans is a 66 year old woman working part-time as a job counselor in a suburban community located near a mid-west metropolitan area. Mrs. Evans decided to enroll in the Medicare program when she turned 65, since she did not have access to insurance coverage through her employer. A few years ago Mrs. Evans was diagnosed with a non-cancerous breast tumor. At the advice of her physician, she receives a mammogram and breast examination on an annual basis, in addition to a regular physical examination. Other than watching for changes in this condition, Mrs. Evans has good physical and mental health, enabling her to continue her professional work and spend time with her three children and six grandchildren. Her total medical bill for the year will be only $300.

Current System

Although posing no immediate threat to her health, the tumor incident left Mrs. Evans and her husband with the fear that a sudden, long-term illness could be financially devastating, especially since they used part of her income to cover household expenses. To avoid the financial risk of high medical bills, Mrs. Evans decided to purchase a Medigap policy for $1,107 to cover Medicare coinsurance and deductibles. (Mrs. Evans is not liable for the $300 in medical expenses because her examination are considered medically necessary given her prior medical history.) Since she also pays the Part B premium of $553, her total medical care spending for the year will be $1,660.

AMA Proposal

Under the AMA proposal, Mrs. Evans would continue to visit her physician twice a year for mammography and physical exams. Instead of paying a premium for Medigap and Part B coverage, she would pay a single Medicare premium of $1,064 a year, as well as the $300 in medical expenses that are considered part of the $500 deductible. Mrs. Evan's total spending for one year would be $1,364, which is a $296 savings compared with the current system.

Summary of Out-of-Pocket Spending

Current System		AMA Proposal	
Hospital Deductible:	$ 0	Deductible:	$ 300
Part B		Total Medicare Premium:	$1,064
Coinsurance:	$ 0	Total Spending:	$1,364
Premium:	$ 553		
Medigap Premium:	$1,107		
Total Spending:	$1,660		

Change from the Current System: $296

AMA Medicare Proposal Case Studies

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Case Study B
Ed Bartloe – Heavy User
About 15% of enrollees spend $10,000 or more a year

Background

Ed Bartloe has suffered from mild symptoms of heart disease for several years. Knowing that his parents enjoyed healthy, productive lives well into their eighties, and believing in the strength of his own constitution, Mr. Bartloe did not see the need to alter his habits or lifestyle to reduce the risks associated with his condition. At the age of 69, however, Mr. Bartloe was advised by a family physician to quit smoking, lose 25 pounds and retire from his sales position with a west coast hardware distribution company. At the age of 72, when the hardware company changed ownership and the new management decided to computerize its sales and inventory control system, Mr. Bartloe retired from his job of over forty years. He did not, however, take heed of his physician's other two pieces of advice.

Current System

While weeding in his backyard garden soon after retirement, Mr. Bartloe suffered a heart attack that left him hospitalized for several weeks. After the initial episode, he met with several cardiologists and revisited the hospital twice for treatment of coronary artery obstruction. Mr. Bartloe's medical expenses for doctor care and two hospital visits totaled $10,000 over the course of one year. His total medical spending, however, was only $1,543 because he is covered by Medicare and a Medigap policy that pays the Medicare coinsurance and deductibles. (Mr. Bartloe's wife, who felt more uncertain about Mr. Bartloe's condition than he did, had insisted they purchase a Medigap policy that cost them $990 a year to insure against the financial risk of an extended illness. The other portion of his total medical spending is the $553 Medicare Part B premium.)

AMA Proposal

Under the AMA proposal, Mr. Bartloe would receive the same doctor care and hospital treatment for his heart condition. Instead of paying a Medicare and Medigap premium, he would pay a single $1,064 Medicare premium for the same coverage. He would also be liable for a $500 deductible since his medical costs were so high. In terms of out-of-pocket spending, Mr. Bartloe would only pay $1,564 for his medical care, which is $21 more than he would spend under the current system.

Summary of Out-of-Pocket Spending

Current System		AMA Proposal	
Hospital Deductible:	$ 0	Deductible:	$ 500
Part B		Total Medicare Premium:	$1,064
Deductible:	$ 0	Total Spending:	$1,564
Coinsurance:	$ 0		
Premium:	$ 553		
Medigap Premium:	$ 990		
Total Spending:	$1,543		

Change from the Current System: ($21)

AMA Medicare Proposal Case Studies

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Case Study C
Ruth Hudson "Grandma Ruth" -- Low-Income, Average User
An estimated 14% of enrollees fall between 100% and 150% of the federal poverty level

Background
Everyone in this small, southern community Ruth Hudson as "Grandma Ruth." Her name springs not only from the fact that she was born in this town, where she raised her own children, grand and great-grand children, but also from the fact that she cared for at least one child from nearly every family in the town at one time or another. In her later years, after her husband died, Ruth also cared for elderly relatives and neighbors when she could.

Ruth had to curtail her caretaking activities about the time she turned 80 years old. For years, her diabetes had shown only mild symptoms, but it began to affect her more seriously. Her eyesight, for example, had deteriorated significantly, becoming apparent to her only after having missed the stop off the bus several times in one week. The swelling in her knee joints also began to make walking and climbing stairs more difficult and painful. More and more, she began to visit her physician for her diabetic symptoms, although the condition had not advanced enough to require hospitalization.

Current System
Since her caretaking income was meager, Ruth could not afford to purchase Medigap coverage. Over the years, however, her and her husband had saved a modest nest egg which she used along with her Social Security income to pay for the increasing medical expenses. In one year, her medical bills totaled $1,453, which included a $553 Medicare Part B premium and $900 in deductibles and coinsurance for physician care.

AMA Proposal
Under the AMA proposal, Ruth would continue to receive physician care for treatment of her diabetes. Since she is at 125% of the federal poverty level, she would pay a discounted Medicare premium of $809 instead of the entire $1064, as well as a $250 deductible for her medical care. Her total medical spending of $1,059 represents a $394 savings from the current system.

Summary of Out-of-Pocket Spending

Current System		AMA Proposal	
Hospital Deductible:	$ 0	Deductible:	$ 250
Part B Deductible:	$ 100	Total Medicare Premium:	$ 809
Coinsurance:	$ 800	Total Spending:	$1,059
Premium:	$ 553		
Medigap Premium:	$ 0		
Total Spending:	$1,453		

Change from the Current System: $394

AMA Medicare Proposal Case Studies

Case Study D
Edna Carter – Medicaid Eligible
About 1 in 10 enrollees are Medicaid eligible

Background

Edna Carter has lived with rheumatoid arthritis for over twenty years. At the age of 91, she lives in a nursing home that serves the long-term care needs of six rural counties in the South. Edna's son, Sam, was compelled to admit his mother when her arthritis became so debilitating that she needed assistance with nearly every activity of daily living. Sam and his wife both worked, and they could no longer attend to her medical condition adequately, as they had done for the last fifteen ten years. Even though Edna was eligible for state Medicaid assistance, the decision to move her to a nursing facility was difficult for Sam and his family. The facility was located over 160 miles away, and it was understood that they could not afford to visit more than once or twice a month.

Current System

Given her age and the advanced stage of her arthritis, Edna's health deteriorated after she entered the nursing home. She soon became completely bedridden, unable even to sit up on her own. Among other secondary health problems, Edna eventually contracted a severe case of pneumonia that required an overnight hospitalization. Over the last twelve months, Edna incurred nearly $3000 in acute-care medical bills, in addition to the medical expenses related to her long-term care. Edna's low-income status and Medicaid eligibility exempts her (and her son's family) from liability for these Medicare bills. In addition, she is not required to pay the Medicare Part B premium of $553 a year, nor any of the Part B coinsurance and copayments. Her total medical spending on an annual basis is $0.

AMA Proposal

Under the AMA proposal, Edna would continue to receive long-term care services and acute-care hospitalization when needed. Her eligibility for low-income assistance from Medicaid would not be affected. Moreover, she still would not be required to pay any Part A or Part B deductibles and coinsurance, nor would she be charged a Medicare premium. Her total out-of-pocket spending on health care would continue to be $0 a year.

Summary of Out-of-Pocket Spending

Current System			AMA Proposal		
Hospital Deductible:	$	0	Deductible:	$	0
Part B			Total Medicare Premium:	$	0
Deductible:	$	0	Total Spending:	$	0
Coinsurance:	$	0			
Premium:	$	0			
Medigap Premium:	$	0			
Total Spending:	$	0			

Change from the Current System: $0

AMA Medicare Proposal Case Studies

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Case Study E
Mrs. Alan Sachs -- High-Income, Average User
Roughly 4% of enrollees would pay a premium tax under the AMA plan

Background

Mrs. Alan Sachs, an 89 year old widow, has been financially independent and able to live on her own in her East Coast estate since her husband passed away eleven years ago. On alternating weekends, Mrs. Sachs receives a visit from one of her two daughters and their families. At other times, she entertains former colleagues or students (she and her husband both taught music at the Conservatory), or she travels into the city to hear the symphony with friends.

Current System

Recently, she fell while walking in the hallway at home. The fall severely bruised, but did not break, her hip. Other incidents, such as fainting on the patio and some difficulty with speech, has led her daughters to believe that she experiences minor strokes. Mrs. Sachs does not feel the same concern as her children do over these incidents. But to placate them, as well as her physician, Mrs. Sachs agreed after the hip incident to undergo a series of tests, which cost $3650, in order to rule out any serious condition. Her total medical spending, however, was only $1,420 for the year. Her Medigap policy (initially purchased with her husband and continued after his death) covered her Medicare Part B cost-sharing for physician care and diagnostic tests. The $1,420 in spending consists of $877 in Medigap and $553 in Part B premiums.

AMA Proposal

Under the AMA proposal, Mrs. Sachs would still receive diagnostic treatment from her physician. Instead of a Medicare and a Medigap premium, she would pay a single Medicare rate of $1,957. Because her asset and income level is high, Mrs. Sachs would pay a higher premium than other beneficiaries with low to middle incomes. (Specifically, she would pay $893 a year more than a middle-income beneficiary.) She would also be liable for the entire deductible of $500 since her medical bills exceeded this amount. In terms of total spending, Mrs. Sachs would pay $2,457 in one year, which represents $1,037 more than she would spend under the current system.

Summary of Out-of-Pocket Spending

Current System		AMA Proposal	
Hospital Deductible:	$ 0	Deductible:	$ 500
Part B		Total Medicare Premium:	$1,957
Deductible:	$ 0	Total Spending:	$2,457
Coinsurance:	$ 0		
Premium:	$ 553		
Medigap Premium:	$ 877		
Total Spending:	$1,420		

Change from the Current System: ($628)

AMA Medicare Proposal Case Studies

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Case Study F

Gilbert Torian -- Medicare Eligible, Catastrophic User

Nearly 13% of enrollees include the disabled and the end-stage renal populations

Background

Gilbert Torian, a 29-year old substitute teacher at an inner city school on the West Coast, was diagnosed with hypertension as a pre-adolescent. His condition created a more serious health problem at an early age: like many people with hypertension, his kidneys began to malfunction as a result of the disease. Soon after college, Gilbert was diagnosed with end-stage renal disease (ESRD), and he began dialysis treatment three days a week.

Current System

For several years, Gilbert received dialysis treatment at home. During this time, he maintained his work as a substitute teacher. However, his persistent hypertension had created irreversible kidney damage. Eventually, both of Gilbert's kidneys failed completely, requiring daily dialysis. Because of his youth and relatively stable physical condition, his doctors agreed the preferred course of treatment would be kidney transplantation.

Gilbert received a kidney transplant from a matching donor. The medical bills for his hospitalization and surgery totaled more than $109,000. The bulk of these catastrophic expenses were covered under Medicare's program for ESRD patients. Under his wife's employer-sponsored coverage, the Part A and Part B copayments and deductibles were also covered. Out-of-pocket, Gilbert spent a total of $1,909, which included $553 in Part B premium and $1,356 for dependent coverage on his wife's plan. (He will be liable for certain immunosuppressant drugs that are only partially covered by Medicare's ESRD program.)

AMA Proposal

Under the AMA proposal, Gilbert would receive the same treatment modality for his kidney failure. His total medical spending would be $1,564 for the same coverage. This includes $1,064 in Medicare premium as well as the entire $500 deductible (which he would be liable for because his medical expenses are so high.) This represents a $345 savings in out-of-pocket medical spending over the current system.

Summary of Out-of-Pocket Spending

Current System		AMA Proposal	
Hospital Deductible:	$ 0	Deductible:	$ 500
Part B		Total Medicare Premium:	$1,064
Deductible:	$ 0	Total Spending:	$1,564
Coinsurance:	$ 0		
Premium:	$ 553		
Medigap Premium:	$ 1,356		
Total Spending:	$ 1,909		

Change from the Current System: $345