Statement of

Martha McSteen
President of the
National Committee to
Preserve Social Security
and Medicare

Submitted to

Senate Democratic Policy Committee

Regarding

Medicare Reform

October 5, 1995

The National Committee to Preserve Social Security and Medicare, on behalf of its six million members and supporters, has a vital interest in sustaining Medicare. We support balanced, equitable measures necessary to assure Medicare's long term solvency. We oppose excessive cuts which have as their primary underlying purpose financing deficit reduction and tax cuts. The Medicare program cannot sustain the level of cuts under consideration without significant hardship to seniors, the disabled and their families.

The Republican plans to restructure Medicare are a major departure from the universal, insurance design of Medicare. What is billed as "choice" by its proponents is really the blueprint for dismantling Medicare. In effect, the proposals will individually "block grant" Medicare--providing a defined contribution toward health care and ending full comprehensive health care. I do not believe that Americans will support such a move.

The Medicare reform proposals approved by the Senate Finance Committee and under consideration in the House hold out the promise of cost savings to the Federal government and profits to the private insurance sector. For seniors, the promise is higher costs, lower quality care and restraints on services.

The Democratic leadership plan contains a more realistic target for extending the solvency of Medicare Part A without raiding Part B to pay for deficit reduction and tax cuts. The plan holds out the promise of a bill which will strengthen Medicare, not undermine it. The Democratic alternative plan recognizes Medicare' successes and builds upon them while allowing time for study of reforms for long-term change.

On the other hand, the Medicare plan approved by the Senate Finance Committee goes too far, too fast. A large scale move toward private sector options is premature and unwise. A centerpiece of the Republican proposal, Medical Savings Accounts (MSA), has not been tested for the senior and disabled population and could prove to be a financial burden for Medicare. Last week, the National Committee released a study it commissioned from Lewin-

VHI on MSAs. The study concludes that MSA proposals are likely to increase Medicare program costs, by at least $15 billion or more over the seven year budget period. In fact, the report concluded that there is no scenario under which MSAs will save Medicare money. If Medicare is really in financial crisis, why is a proposal being moved forward that is more expensive and primarily benefits upper income, relatively healthy beneficiaries?

If beneficiaries are allowed to make tax free contributions to MSAs, the combined Medicare and tax loss would be about $20 billion, according to Lewin-VHI. Even if beneficiaries are able to use tax free contributions to MSA accounts to pay for non-Medicare covered health expenses, it is estimated that only 3 to 5 percent of Medicare eligible individuals would enroll in MSAs. Enrollment would peak in 1996 at slightly over a million individuals but would drop to 346,000 by 2002 as payments to insurers and MSAs are held to a 4.9 percent rate of growth and the amount deposited into the MSA declines. If Medicare payments to insurers and MSAs are reduced to be cost-neutral to Medicare, Lewin VHI estimates that fewer than 100,000 persons would enroll.

We also have major concerns about other proposed changes. Adequate risk adjusters to compensate private sector plans for covering seniors and the disabled have not been developed. Current payment methodologies appear to overcompensate managed care plans. Extending these payment methodologies on a large scale has the potential to cost the Medicare program money, rather than improve its fiscal condition.

At the same time, the cap on program growth, set below private sector inflation, will erode the quality and benefits provided by private plans, or increase out of pocket costs, or both. If offered the opportunity to reenter the market, private insurers will undoubtedly target the healthiest seniors who, within traditional Medicare, are the least expensive to care for. To the extent that healthier seniors are enticed away, cost savings predicted by supporters will not be attained and the risk of adverse selection presents financial dangers to the traditional Medicare program.

The Republican leadership has offered little in the way of details, data, cost analysis or other technical information to justify a large scale move to private sector plans. The information provided to date amounts to anecdotal information and assurances provided by insurance company executives. For example, the claim that quality managed care can be provided at a lower cost than fee-for-service care is unsubstantiated as is the claim that quality care can be maintained with a cap on payment growth set below private sector inflation. It is ironic to hear the virtues of the private sector extolled by the current Congressional leadership. Let's not forget that the private market would not cover most seniors in the past. This is the same private sector that currently leaves a third of the non-elderly uninsured and contains costs in significant part by restricting benefits and choices, increasing out of pocket costs and dropping the very sick from coverage.

Medicare is a remarkable success story. Seniors are universally insured. They can not be denied coverage for pre-existing conditions, lose protection if they become ill, or have payment denied for medically needed services. Seniors have complete freedom to select the provider or managed care plan of their choice. Because payments to providers are at deep discounts from what private insurers pay, Medicare is, in effect, a nationwide preferred provider organization. Over the past decade, outlays per enrollee have grown more slowly than private sector outlays. All of this has been accomplished with administrative costs averaging only 2 percent of program outlays when you compare similar health care services. The private insurance large group market, in contrast, has administrative costs of 5.5 percent and the small group market 25 percent. In the private market, even the largest companies fail to meet loss ratio requirements for Medigap insurance for the elderly. The private market holds no magic bullets for Medicare-- its record on coverage of individuals and cost containment is inferior to Medicare.

Growth in Medicare's costs mirrors what is happening in the health care system generally. Medicare costs ultimately will be constrained only with a system-wide approach to health

care cost containment. Unless projected growth in overall medical care spending is controlled, Medicare cuts will be a shell game. Dollars cut at the federal level will reappear. Part B premiums, Medigap charges, copayments, deductibles and other out-of-pocket costs will rise. Cost shifting will accelerate the rise in the price of medical care to non-elderly private payers and insurers. As more non-elderly or their employers are priced out of the private insurance market, Medicaid—also targeted for excessive cuts—will face increased demand from ever more individuals and families unable to afford health care protection.

We cannot allow that to happen. The success that Medicare has achieved should be recognized. Certainly any program of this magnitude needs to be reviewed and updated from over time, not destroyed.

The proposal to end individual entitlement to Medicaid will place at risk large numbers of the elderly who rely on Medicaid for long-term care. The provisions terminating federal standards for nursing homes are tragic. These federal standards place critically important requirements on nursing homes such as nursing qualifications and staffing, and prohibitions against excessive use of physical and chemical restraints.

We believe that the budget reconciliation changes to Medicare and Medicaid are driven primarily by political promises to balance the budget in seven years and cut taxes. In the last Congress, alarms were sounded over the proposed $124 billion in Medicare reductions over seven years proposed by the President as part of health care reform. Many Republican Members of Congress predicted the cuts would destroy quality and access for beneficiaries or even the program itself. The same is even more applicable to the current budget resolution. Remember, the President's proposal maintained the Medicare program for all beneficiaries and added new benefits and attempted universal cost containment.

The current debate over Medicare costs is driven largely by the deficit problem. It is important to note that Medicare Part B has contributed a relatively small amount to the

current deficit. (See attached chart) Medicare Part A has contributed nothing to the deficit. When spending on all general revenue fund programs, including interest, is compared, Medicare Part B accounts for only 6% of deficit spending in fiscal year 1994. Yet the budget resolution targets Medicare Part A and B for 35% of the funds for deficit reduction. Similarly, Medicaid accounted for only 11% of 1994 deficit spending yet is targeted for 24% of the dollars for deficit reduction. Defense spending contributed 36% of deficit dollars in 1994, but will contribute nothing toward deficit reduction in this budget resolution. Apparently, the over two trillion dollars the government will forego over the next five years in tax entitlements will also escape mostly unscathed. We do not believe our members, or most Americans, will support a budget reconciliation bill which reflects this disproportionate and unjustified treatment of Medicare and Medicaid.

With Medicare, as with other Federal expenditures, looking for quick fixes to budget deficits can be self-defeating over the longer term. For example, by constraining funding for research into the diseases of aging, this nation may be turning its back on the most promising long-term hope for slowing growth in Medicare costs. A report submitted to the recent White House Conference on Aging documents that the entire savings which the Republicans hope to achieve in seven years would be achieved each and every year if the most common conditions of aging could be postponed by just five years.[1] Longevity does not have to be accompanied by disability and disease to the extent that it is today if we as a nation commit ourselves to the goal of holding back the diseases of aging. Medical and pharmaceutical research can make a difference. If only the onset of Alzheimer's Disease, for example, could be delayed by an average of five years, a $50 billion a year savings would be achieved. The same is true for delaying diabetes by five years. Slowing osteoporosis and reducing the hip fractures that often accompany that disease would save more than pain and

[1] *Putting Aging on Hold: Delaying the diseases of old age,* An official report to the White House Conference on Aging, Prepared by the American Federation for Aging Research and the Alliance for Aging Research, 1995

suffering, it would provide annual savings of $15 billion a year.[2] The report calls for a "a stronger national commitment to accelerate research in human aging and to alleviate aging-related diseases."[3] The National Committee wholeheartedly endorses that recommendation as the most effective and humane way to save Medicare well into the 21st century. Younger individuals would benefit from this research both in lifetime improvements in their own health and in relief from the care of parents and grandparents whose independence would be maintained years longer.

Medicare has enhanced life for millions of Americans and their families. While increasing productive years of life for beneficiaries, Medicare has also helped support the development of health care facilities and medical education. In the years since 1966, when Medicare was implemented, much has been learned about reversing life-threatening illness, relieving pain and recovering lost functional capacity. Americans of all ages and degrees of health are benefiting from this program, because it protects whole families from much of the cost of acute health care for senior or disabled family members.

Citizens want prudent spending but also want the insurance they pay for to be in place when needed. In general, large systems require continuous evaluation and refinement, and Medicare is no exception. "Innovations" may be found that will increase efficiency, hold down cost and eliminate waste, but let us not jump at just any strategy that is advertised as cutting cost. New ideas should be tested first before implementing on a wide-scale basis. We must determine "whose cost is being cut?" and "who benefits from these cuts?" Will Medicare really pay out less? What will be the level of choice, coverage and quality of care? Most importantly, does a reform plan leave Medicare as one universal program? We can make changes within Medicare to allow for more managed care options with appropriate consumer safeguards.

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[2] Ibid., p. 5

[3] Ibid.

In seeking ways to improve Medicare, this Congress must commit itself to maintaining Medicare as a federal program which guarantees comprehensive health care to all entitled seniors and the disabled. Medicare's 38 million beneficiaries are overwhelmingly satisfied with this insurance which assures portability, renewability, wide choice of providers, does not exclude preexisting conditions, does not change the ground rules of coverage when people are sick and need care and gives the individual standing to dispute decisions about coverage. Some of the changes being promoted as Medicare reforms would diminish or even end these protections. In National Committee testimony submitted to the Senate Finance Committee this year, we outlined reasonable long and short term strategies for maintaining the solvency of Part A and slowing the growth of Part B. But we also cautioned that overall health care reform is essential to a successful effort.

The National Committee endorses the following principles for any Medicare reform plan:

Universality - Medicare must remain a universal program covering all entitled senior and disabled Americans. Universality permits the pooling of risks, making insurance affordable even for the chronically ill. The National Committee opposes dismantling Medicare. Increasing choice of plans is acceptable as long as the choices are within the Medicare framework of access to a defined set of benefits. It is important that HCFA search for cost-effective means of delivering services to seniors, such as PPO's and HMO's as long as quality standards, access and comprehensive benefits are assured.

Affordability - The average senior spends over $3,000 annually for out-of-pocket health care, including premiums, deductibles and co-payments for Medicare, and uncovered care, including prescription drugs and long-term care. This amount represents a greater percentage of out of pocket costs than before Medicare was created. Increasing premiums, deductibles and co-payments will place unacceptable fiscal and physical hardships on moderate and low income seniors and the chronically ill. These types of increases are penny

wise and pound foolish solutions as they will result in seniors putting off needed medical care, which will result in ultimately higher cost medical solutions.

Quality - Medicare promises seniors access to high quality health care. The enthusiasm for managed care should be balanced with the realities of access to care and quality. Medicare beneficiaries in managed care plans should have national quality standards, clearly defined appeal rights and access to specialty care.

Means Testing - Means testing violates the universality of Medicare and singles out higher income Medicare beneficiaries for discriminatory treatment. A study by Lewin-VHI conducted for the National Committee demonstrates that the Medicare Part B subsidy for upper income beneficiaries will be more than made up by Medicare Part A taxes in excess of Part A benefits over a lifetime.[4]

Choice - Seniors should continue to have their choice of doctors, specialists and other Medical providers. Choice of managed care plans should not be coerced.

Cost Containment - Proposed reforms should not only address the solvency of the Medicare program, but should also contribute to controlling overall health care costs. Proposals that shift Medicare costs to beneficiaries or the privately insured are simply cost shifting proposals and are not real cost containment reforms. Medicare cuts alone are not real cost containment.

Fairness to Providers - Fair reimbursement to providers is the only way to guarantee access to quality health care.

The most recent report of the Medicare Trustees projects that Medicare Part A trust fund will be depleted in 2002. Such reports are not new. Seven times the Trustees have reported insolvency within a seven year time frame. In fact, Trustees predicted that bankruptcy was

[4] Paul Hogan and Matt Reilly, "Health Care Insurance Tax Subsidies and Medicare Benefits," Lewin-VHI, June 1994.

only four years away as far back as 1970, and Medicare is still here today. The reasons for this are the determination of the Congress over the intervening years to maintain the program and the full support of the public for doing so. We are convinced that large majorities of Americans of all ages still fully support preserving the Medicare program.

The report of the Trustees has been misused by some Members of Congress to convince the public that these drastic proposals are necessary. Ultimately, however, the public will have all the facts and hopefully the real debate will begin. Perhaps then we will have a national debate on priorities: What kind of health care do we want? Will we continue the guarantee of health coverage for seniors and the disabled? Can we provide a guarantee of the same for working and poor Americans? Can we take better care of our children? Can we reduce the deficit in a manner in which everybody pays their fair share, including corporations and the defense industry?

CONCLUSION

Medicare provides valuable insurance protection to millions of entitled seniors and disabled individuals, insurance that would be difficult, if not impossible, for many to obtain in the private market. The problems in the health care system in this country must be addressed, but attempting to abruptly dismantle Medicare will not solve the problem. We must continue to improve and refine Medicare as we search for a resolution to this nation's overall health care dilemma. The National Committee is committed to finding solutions which preserve Medicare as a universal, comprehensive federal health care program for all entitled senior and disabled Americans.

SPECIAL

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001
8/22/95
LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: 2377
FILE NO: 1363
Total Page(s): 4

TO: Legislative Liaison Officer - See Distribution below:
FROM: Janet FORSGREN (for)
Assistant Director for Legislative Reference
OMB CONTACT: Robert PELLICCI 395-4871
Legislative Assistant's line (for simple responses): 395-7362

SUBJECT: HHS Proposed Report RE: HR1739, Establishment of the Bipartisan Commission on the Future of Medicare

DEADLINE: NOON Thursday, August 24,1995

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President.

Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

COMMENTS: Attached is a proposed response drafted by HHS to a letter sent by Rep. Stearns to the President regarding HR 1739. HHS requests your review of the attached draft prior to its forwarding this document to WH LA. Please note that in addition to the draft letter, the incoming letter from Rep. Stearns and a copy of HR 1739 are also attached to this LRM.

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RESPONSE TO
LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: 2377
FILE NO: 1363

If your response to this request for views is simple (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet.

If the response is simple and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.

You may also respond by:

(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or
(2) sending us a memo or letter.

Please include the LRM number shown above, and the subject shown below.

TO: Robert PELLICCI 395-4871
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Branch-Wide Line (to reach legislative assistant): 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: HHS Proposed Report RE: HR1739, Establishment of the Bipartisan Commission on the Future of Medicare

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No Objection

_____ No Comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of ____ pages, attached to this response sheet

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

Washington D.C. 20201 – 0001

Draft

Date:
From: Debbie Chang, Director
Office of Legislative and Intergovernmental Affairs
Subj: Response from President to Congressman Stearns
To: Susan Brophy, Legislative Affairs, OS

Below please find suggested text for a response to Congressman Stearns from the President, regarding the congressman's introduction of a Bill which creates a Bipartisan Commission on the Future of the Medicare Program.

DRAFT LETTER FROM THE PRESIDENT TO CONGRESSMAN STEARNS:

The Honorable Cliff Stearns
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Stearns:

I want to thank you for personally notifying me of your introduction of legislation to establish a Bipartisan Commission on the Future of the Medicare Program.

We are at an historic moment. For the first time in a long time there is a willingness to try to bring the budget into balance and a willingness to try to secure the Medicare Trust Fund. I know we can do both while maintaining our commitments to the elderly and their children and grandchildren. Medicare is an integral part of the fabric of American life. It provides security not only for the elderly who receive it, but for their children as well, who otherwise would bear the worry and cost of paying for their parents' health care in addition to their own financial commitments.

We must be committed to reducing medical cost inflation and stabilizing the Medicare Trust fund through genuine reforms, not by destroying Medicare and hurting the people who are on it.

I appreciate your efforts to achieve a bipartisan approach and I look forward to working with you in the difficult months ahead.

HOUSE OF REPRESENTATIVES
WASHINGTON, D. C. 20515

95 JUN 13 A9:20

CLIFF STEARNS
SIXTH DISTRICT
FLORIDA

June 7, 1995

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

This is to advise you that I have introduced legislation to establish a Bipartisan Commission on the Future of the Medicare Program.

I am deeply committed to finding a solution to ensure that this important program, which is so vital to our senior population, can be reformed with the goal of making it an even better and more efficient system for providing health care to the elderly.

It is my hope that you will endorse my efforts and I look forward to hearing from you in this regard.

With best wishes, I am,

Sincerely,

Cliff Stearns
U.S. Representative

CS:vtc

Mr. President -
I believe this is a "win" situation for both parties ... something like the Pepper Commission on Social Security.
Best wishes,
Cliff

SENATE BUDGET COMMITTEE
QUESTIONS TO SECRETARY

Question from Senator Exon:

What is your estimate of how much of a tax shift there would be if we arbitrarily put a cap on the Medicare program?

Response:

If Medicare expenditures were limited by an arbitrary cap on the program, the excess costs above that cap would have to be borne by the health care system, both providers and consumers.

For example, the Republican plan expects to save $270 billion over seven years. If one assumes that half of this savings will be achieved by provider cuts, and half will be passed on to beneficiaries through higher out-of-pocket costs, this would translate to an increase of $2,825 in out-of-pocket costs for the average beneficiary over the seven year period. The increase would be $625 in the year 2002 alone.

Some have suggested vouchers as an alternative way of capping the program, but on a per capita basis. While a voucher can be applied to the purchase of a private insurance plan, beneficiaries will have to cover any additional costs if the plan they want is more expensive than the voucher amount. Alternatively, they may have to accept fewer benefits in order to buy a plan that is affordable with the voucher.

To protect beneficiaries, the value of the voucher would have to be indexed to actual increases in health care costs; however, Congressional Republicans' budgetary goals would not permit this rate of increase. The Budget Resolution would require a 4.9 percent per capita growth rate for vouchers under Medicare. CBO data indicate that the private sector per capita growth rate would be 7.1 percent from 1996-2002.

Constraining the costs of providing care for a much more vulnerable Medicare population to a rate of increase so much smaller than that of the private sector is, at best, unrealistic. The resulting impact would be that the value of the voucher would very quickly erode.

Given that 75 percent of Medicare beneficiaries have incomes below $25,000, the additional costs that they will have to bear through increased premiums and copayments or through a voucher system will represent a substantial additional tax on their income.

Question from Senator Frist:

Under present law, do you have the authority to expand the geographic reimbursement area or to add a health risk adjuster?

Response:

We have the authority both to modify the geographic reimbursement area and to add health risk adjustments in order to improve actuarial equivalence.

Geographic Areas: Under section 1876(a)(4) of the Social Security Act, the AAPCC is determined by the Secretary and based on the estimated cost "in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence...".

The geographic area used for the AAPCC is the county. We have examined alternative geographic areas in the past and determined that they are not superior to the county.

Health Status Adjusters: Under section 1876(a)(1)(B) of the Social Security Act, the Secretary can use any factors related to "classes of members" that are appropriate "to ensure actuarial equivalence". The Secretary can also modify the factors, for example, add health status adjusters, if she believes it will improve the actuarial equivalence of the AAPCC rates.

Health status adjuster models are currently being developed for use in the Medicare program. Two models, Ambulatory Care Groups and Diagnostic Cost Groups, should be available for testing in the spring of 1996. We intend to pilot them as part of a demonstration of alternative delivery systems and payment methods. If these health status adjuster models improve actuarial equivalence, they would be incorporated into the payment methodology.

~~JOHN HARRIS~~
~~F: 334-7576~~

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Congress of the United States
Washington, DC 20515

July 25, 1995

Attn: Chris Jennings
From: John Harris

The President
The White House
Washington, DC 20500

Dear Mr. President:

As the nation marks the 30th anniversary of Medicare this week, America's seniors are certain to be treated to a large dose of political rhetoric, and regrettably, some distortions about this program's future.

In the interest of providing the American people with the facts they need to make informed judgments about this important policy debate, we are writing to request that you direct Secretary Shalala to send to all Medicare recipients the official summary of the 1995 annual report of the Medicare Board of Trustees. As you know, the Trustees, who include three members of your own cabinet, concluded that Medicare will go bankrupt in just seven years. If Medicare goes bankrupt, no payments, by law, can be made by Medicare to pay for hospital care or for any other services paid for by the Trust Fund. The 33 million seniors and four million Americans with disabilities who depend on Medicare every year have a right to know these important facts.

It is because of this impending bankruptcy that Republicans in Congress are committed to bold and decisive action to preserve, strengthen and protect Medicare -- action that will still allow Medicare spending to increase from $178 billion this year to $274 billion in 2002.

We appreciate your consideration of this request, and we hope you share our determination to see Medicare live past 2002, its 37th birthday.

Sincerely,

Newt Gingrich
Speaker of the House

Bob Dole
Senate Majority Leader

DRAFT

STATEMENT OF

BRUCE C. VLADECK

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SPECIAL COMMITTEE ON AGING

U.S. SENATE

AUGUST 3, 1995

INTRODUCTION

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify on the Health Care Financing Administration's (HCFA) oversight of health maintenance organizations (HMOs) providing services to Medicare beneficiaries. The Special Committee on Aging has over the years played an important role in focusing attention on the issue of quality of care in Medicare managed care plans. We appreciate Senator Cohen and Senator Pryor's continued interest in this area, and we look forward to working with this Committee on further improvements.

Over the past two years, Medicare managed care enrollment has increased dramatically. In the first six months of 1995 we have already seen a 9 percent increase in managed care enrollment, an acceleration over last year's annual rate of 16 percent growth. Enrollment is growing at a rate of 75,000 per month. Currently, 9.5 percent of all Medicare beneficiaries -- over 3.5 million people -- have chosen to enroll in managed care plans. Seventy-four percent of Medicare beneficiaries have access to a managed care plan, and 57 percent have a choice between two or more plans.

More than 250 managed care organizations currently contract with HCFA to serve Medicare beneficiaries. Interest in the Medicare managed care program continues to increase. Much of the recent growth in new contracts has been in

regions that have not had a strong Medicare managed care presence in the past.

I want to describe for you how HCFA is honoring its commitment to ensuring that the growing number of beneficiaries served by managed care plans receive high quality care. First, HCFA has recently improved its monitoring and enforcement program for Medicare HMOs. Second, we have several initiatives underway to ensure quality, such as the development of performance measures and improvements in the appeals process. Finally, we are improving our efforts to inform beneficiaries about their managed care options.

MONITORING AND ENFORCEMENT

Over the past few years, we in HCFA have been involved in an unprecedented effort to review all of our activities in light of our mission and strategic plan. This review has led to a new focus within the agency on our beneficiaries as our primary customers. It has also led to a rethinking of our relationships with the providers, contractors and health care plans as our partners in serving the beneficiaries.

As the nation's largest purchaser of managed care, HCFA is committed to ensuring the quality of care for our beneficiaries. We believe that the best way to achieve this end is to work in partnership with the plans to achieve continuous quality improvement. But HCFA is not just like any private sector purchaser. We are purchasing care for Medicare beneficiaries and therefore, have to keep their interests

at the forefront of our efforts. For this reason, HCFA and its managed care contractors must be held to a higher standard of accountability. Thus, on occasion, we have to call our partners to task for not holding up their end of the bargain. This Administration has demonstrated that in instances where plans fall out of compliance with standards, we have not hesitated to take swift action.

Beginning in 1994, HCFA initiated an aggressive enforcement process to remedy the root causes of quality and access problems. HCFA has initiated eight investigations in the last two years, three in 1994 and five in 1995. These investigations identified problems with utilization management systems; quality assurance; administration and management; availability, accessibility and continuity of health care services; high rates of disenrollment; and marketing and contract management. In all eight investigations, plans have developed acceptable corrective action plans to address the findings of the investigations. As a result of these investigations and the corrective action plans implemented by plans, the number of consumer complaints has decreased and the Peer Review Organizations, which review the clinical quality of care provided by HMOs, have identified fewer problems.

Not only have we moved aggressively when we have identified compliance problems, but this Administration has significantly improved and expanded our oversight activities in three ways. First, we have brought new resources to bear on

oversight activity. Using our contracting authority, we have expanded our own review staff with private sector clinical and technical expertise when needed including physicians, registered nurses and statisticians. This had not been done before by previous Administrations.

Second, in 1993, and again in 1995, we made significant improvements to the protocol and procedures used in our monitoring process. These improvements included incorporating PRO review findings as an integral part of the quality assurance review; enhancing methods to evaluate situations in which HMOs delegate quality assurance activities to providers; and developing a score sheet which provides the reviewer with a more definitive methodology for evaluating and assessing quality assurance.

Finally, starting in January, on-site monitoring will take place on an annual, rather than biannual, basis. These improvements clearly indicate the high priority that this Administration places on our oversight responsibilities.

In preparing its recent report on our oversight activities, the GAO only fully considered enforcement cases as of June 1994. Therefore, its report does not fully reflect the new energy that this Administration has injected into enforcement activities, nor the results that we have been able to achieve. The GAO report also leaves the impression that our activities should be judged based on the number of civil

monetary penalties or intermediate sanctions we impose. We emphatically disagree that this is the appropriate standard.

First, one could argue that in a world of publicly-traded health plans and intense private purchaser scrutiny, HCFA has a more powerful enforcement tool than simple penalties and sanctions. I would ask which is more likely to motivate a plan manager, a $15,000 or even $100,000 civil money penalty or the marketplace's reaction to the adverse publicity resulting from an investigation. We believe that angry and disgruntled purchasers and shareholders are major motivators for plan managers and that plans are "sanctioned" when they have to inform shareholders of negative findings from our investigation.

Second, we believe that the time and energy spent developing the documentation necessary for a civil money penalty or intermediate sanction is better spent working with the plan to correct the particular deficiency or quality problem. I would add, however, that HCFA has obtained voluntary enrollment freezes from plans in instances where we believed such a freeze would be in the interest of beneficiaries.

ADDITIONAL INITIATIVES TO ENSURE HMO ACCOUNTABILITY

While we have made improvements to our quality assurance reviews, we would agree with the GAO that we must further remodel our methods for ensuring quality.

We are keenly interested in assuring that as the Medicare managed care program grows and evolves, we have adequate measures in place to assure and improve the quality of care plans provide to our beneficiaries.

Like other purchasers, we are attempting to develop process and eventually outcome measures of quality. Designing these measures is a challenge, as we must broaden our focus from individual, physician-based care to performance measures for entire populations. Further, unlike fee-for-service medicine, where each medical encounter results in a claim, information about specific services provided by managed care organizations has historically been limited.

Public as well as private sector purchasers have only recently begun to require plans to collect the encounter data necessary to develop plan performance measures. Little consensus has emerged, however, on what measures to assess, what types of encounter data to collect, how to ensure encounter data and performance measures are reliable and comparable across plans, and how to best present information on plan performance to consumers.

We are facing up to this challenge and working closely with the managed care industry and private sector purchasers to develop appropriate and meaningful procedures that can be relied on by HCFA, by our beneficiaries, and by the managed care plans. For example, HCFA, together with the Department of Defense and the Federal Employees Health Benefits Program, has joined private sector health purchasers, including GTE, AT&T, and PepsiCo, in an unprecedented partnership to

explore the formation of a new organization for quality improvement and managed care accountability. This new organization, the Foundation for Accountability (FAcct), will develop performance measures that will assist purchasers and consumers when choosing a health plan. This organization will also help to eliminate unnecessary duplication in individual quality improvement and HMO accountability efforts. The collective membership of this organization represents approximately 80 million covered individuals. HCFA is also convening a series of meetings with public and private purchasers of health care services, consumer groups, providers, and managed care plans to discuss issues regarding best practices for ensuring quality. Just last week, we had our first meeting with major private purchasers.

Because plan performance measures required by private sector purchasers may not always be relevant to the Medicare population, HCFA has undertaken several initiatives of its own to develop performance measures applicable to our beneficiaries. For example, HCFA plans to collaborate with the National Committee on Quality Assurance (NCQA), with the support of the Kaiser Family Foundation, to modify the Health Plan Employers Data and Information Set (HEDIS) to incorporate measures more germane to the Medicare population.

In addition, in May 1995, we launched a pilot test of the three core performance measures, developed by the Delmarva Foundation and Harvard University, to be used by Peer Review Organizations (PROs) in their external review of HMOs. The Delmarva contract was intended to help HCFA and the PROs shift from the current retrospective case review method of HMO oversight to one based on

outcomes measurement and continuous quality improvement.

As described in the GAO report, the current process through which beneficiaries can appeal HMO coverage decisions is not as effective as it could be in protecting beneficiaries against potential underservice by plans. This is the case because the current process takes too long to resolve disputes over services that beneficiaries believe are urgently needed. As the report also indicates, we have taken steps to improve the appeals process. We are planning additional improvements such as a mechanism for providing expedited appeals. We are also determining how to best educate beneficiaries regarding their appeal rights and the appeal process.

BENEFICIARY EDUCATION

Before beneficiaries can make choices among managed care plans, they must first be aware that they have a choice between traditional Medicare and Medicare managed care plans. HCFA has several initiatives underway to ensure that beneficiaries are aware of their option to join a Medicare HMO. For example, HCFA works with Social Security Administration (SSA) to ensure that SSA District Office personnel are knowledgeable about managed care options available to our beneficiaries. HCFA also publishes several handbooks, brochures and directories which includes information about managed care options. We have even placed information on Medicare managed care on Compuserve and the Internet.

We would like to do even more to ensure that beneficiaries are aware of their

option to enroll in Medicare HMOs. To this end, we are examining all HCFA publications to determine if managed care information needs to be included or if new, enhanced brochures are required. As part of this effort, we are collaborating with the Spry Foundation to interview beneficiaries on the usefulness of HCFA's managed care publications.

Finally, we are planning to modify the information included in the initial enrollment package to ensure that the beneficiaries are aware they have a choice between traditional Medicare and Medicare managed care plans. The initial enrollment package is mailed to beneficiaries six months before they turn 65.

Providing beneficiaries with reliable, comparative information on managed care plans will be a much more difficult task and will require a significant investment on HCFA's part -- one that HCFA is willing to make. As explained earlier, at this stage in the evolution of plan performance measures and their inclusion in consumer "report cards," there is no single best approach. Private sector purchasers, health plans and organizations such as NCQA have only recently begun developing information in a format that would be useful to consumers in evaluating the quality of care provided by health care plans.

We intend to continue to work with a broad range of private sector organizations, as well as pursuing our own developmental work, to move forward as quickly as possible. For example, as part of HCFA's competitive pricing demonstration, beneficiaries would receive objective, comparative information about

the plans available to them in their market areas. Accordingly, we have solicited proposals for the development of an information, education and marketing strategy to inform beneficiaries about their health plan choices. We have received several proposals in response to this solicitation and are currently reviewing them. We expect to award the contract by late September.

Through the competitive pricing demonstration and its open enrollment process, HCFA will learn what types of comparative information on plans is useful to beneficiaries and how to best communicate that information to them. It is in this context that HCFA will determine how best to use information from its monitoring visits such as disenrollment rates, the number of beneficiary complaints and enforcement activities.

CONCLUSION

As managed care enrollment continues to expand, oversight of managed care plans will become an even more important part of HCFA mission than it is today. We have made significant enhancements in this area but we recognize that we face continuing challenges.

We believe beneficiaries should have access to a wider range of managed care choices and hope to work with the Congress toward that end. As Congress considers restructuring the Medicare program, however, we believe this Committee has a special role in ensuring that beneficiary protections are not diminished while options are expanded.

Thank you for the opportunity to testify on this important subject. I would be happy to answer any questions you may have.

FINAL

STATEMENT OF

BRUCE VLADECK

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

FEBRUARY 10, 1995

Mr. Chairman and Members of the Subcommittee

I am pleased to be here today to begin a dialogue with this Subcommittee about the current state of the Medicare program and, more importantly, about its future. More than any other members of this Congress, the members of this subcommittee have long had an understanding of the complexities of the Medicare program and the vulnerable population that we serve, and have contributed to major improvements in the program over the years. Medicare is a popular and successful program. I believe we need to work together to improve on the program's success and strengthen it for its beneficiaries and the taxpayers who support it.

We in HCFA have been working very hard to make the Medicare program an effective, affordable and "customer friendly" program for beneficiaries. At the same time, we have been working to implement administrative and program improvements which maximize the efficiency and cost effectiveness of the program. I want to begin by reviewing some of our recent efforts and successes and then provide you with an overview of our efforts in the area of managed care. Finally, I would like to discuss some of our initiatives to improve the administration of the Medicare program.

I. SUCCESSES

Medicare is the world's largest health insurance program and by many measures one of the most successful. It began in 1966 as a Federal health insurance program for the elderly and was expanded in 1972 to cover disabled persons and those with End Stage Renal Disease (ESRD). The Medicare program was established because our vulnerable populations had difficulty obtaining private health insurance coverage.

Medicare is administered largely by private contractors under our supervision. In 1994, Medicare served almost 36 million persons under Parts A and B of the program. Aged Medicare beneficiaries number 32 million, 3.6 million are disabled and 77,000 have ESRD. Medicare has agreements with over 65 contractors to process beneficiary claims. In FY 1994, over 750 million claims were processed and Medicare paid more than $159 billion for medical services, treatment and equipment.

Today, we maintain Medicare's commitment to serve the most vulnerable. Medicare is the largest payor of the elderly's health care expenses. As the Subcommittee examines the future of the Medicare program, I would urge you to consider the following important facts about Medicare beneficiaries.

- Relatively few Medicare beneficiaries can be considered financially well-off. Approximately 83 percent of program spending in 1992 was on behalf of those with incomes less than $25,000. (CHART 1)

- Currently, 20 percent of our beneficiaries are either seniors age 85 and older,

most of whom are women, or persons with disabilities including End Stage Renal Disease (CHART 2).

- Third, per capita health care spending for aged beneficiaries is 4 times the average for the under 65 population.

Medicare is successfully fulfilling its mission and beneficiaries continue to express a high degree of satisfaction with the program. Millions of elderly and disabled Americans now have health care coverage and a quality of life that they would otherwise lack, thanks to the Medicare program.

Innovative Program Administration

Despite the size of the Medicare program, we have maintained a high level of consumer satisfaction with low administrative costs, less than two percent of program outlays. In contrast, private insurance administrative expenses are about 25 percent in the small group market and about five percent in the large group market.

Medicare has been a pioneer in streamlining program administration and is a world leader in fostering electronic claims submission: Ninety percent of Medicare's hospital and skilled nursing facility claims and 87 percent of its physician claims are submitted electronically. In contrast, 60 percent of Blue Cross' hospital claims and 20 percent of its physician claims are electronically submitted. For commercial carriers, the percentage is 10 percent for all claims. (CHART 3)

We have focused attention on reducing the paperwork burden on health care providers, working closely with the health care community to establish a standard uniform national Medicare claim form for physicians and another for hospitals, Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs). Many other insurers use these forms, but attach additional forms as well. These, however, are the only hospital and physician claim forms that Medicare requires.

Decline in the Medicare Baseline

During the Clinton Administration, the projections for the average annual rate of growth for Medicare have decreased. In the President's FY 96 Budget, the projected annual average rate of growth for 1996 - 2000 is 9.1 percent. In contrast, six months ago in the Mid-Session Review, the projected annual average rate of growth for the same period was 10.3 percent. The primary contribution to lower Medicare projections is slower growth in Part A Hospital Insurance expenditures. The decline in projected Part A growth results primarily from a decrease in forecasted hospital cost inflation and slower growth in the complexity of Medicare inpatient cases.

II. MANAGED CARE AND THE MEDICARE PROGRAM

Today, any discussion of the quest to enhance cost effectiveness, as well as the accessibility of quality medical care for beneficiaries, must include managed care. We are committed to working with you to improve and extend the managed care choices available to our beneficiaries so that they have the full range of managed care options available to the general insured population. The cornerstone of our policy is informed choice in a fair marketplace, in which beneficiaries have full and objective information and are not discriminated against on the basis of relative need.

Managed care is not a new concept for the Medicare program. Since its inception in 1966, a portion of Medicare beneficiaries have received care through managed care arrangements. Enrollment is increasing, and we anticipate continued strong growth as newly entitled beneficiaries, who are more familiar with managed care, enter the Medicare program.

Currently, 74 percent of Medicare beneficiaries have access to a managed care plan and 9 percent of Medicare beneficiaries have chosen to enroll in a managed care option. 1994 was a year of impressive growth in Medicare managed care, we experienced double digit increases both in plan enrollment and the number of plans participating in the program. Plan enrollment increased by 16 percent. We now have 11 counties where 40 percent or more of our beneficiaries are enrolled in managed care, an additional 30 counties with enrollment between 30 and 40 percent, and more than 44 counties with enrollment between 20 and 30 percent.

More important for future enrollment growth is the number of contracts with managed care plans. In 1994, the number of our Medicare managed care plans increased by 20 percent. Many of these new contracts are in regions beyond those that traditionally have had a strong Medicare managed care presence. In our Philadelphia region, the number of contracts increased from 6 to 16 and in the Boston region contracts increased from 4 to 9.

As we work to extend and broaden managed care options for Medicare beneficiaries, we must be aware both of the practical limitations of a rapid expansion of managed care in Medicare and of past failures of overly aggressive efforts in both the Medicare and Medicaid programs. The movement to managed care cannot outpace the capacity of managed care plans to serve large numbers of new enrollees, particularly those with the expensive and special health needs of the Medicare population.

In addition, for Medicare to benefit from the expansion of managed care, we need to improve the way Medicare pays managed care plans. Managed care currently costs the Medicare program rather than achieving savings. Our evaluations have suggested that Medicare pays 5.7 percent more for every enrollee in managed care than would have been paid if the beneficiary had stayed in fee-for-service. The reason for this is that they attract the healthier members of the Medicare population

whose health care costs are lower. Efforts are underway to improve the current payment methodology so it doesn't act as a barrier to the expansion of managed care. We have initiated several research projects and demonstrations to address this situation and we expect to have preliminary results later this year.

Medicare beneficiaries themselves must determine the pace of their movement to managed care. The emphasis must be on choice. Managed care will succeed as managed care plans are able to prove the value of their products and as beneficiaries recognize the benefit of the coordination of care and case management that high quality managed care plans can provide.

New Managed Care Options

In addition to our efforts to improve current managed care options under Medicare, we want to make available to beneficiaries a new preferred provider organization (PPO) option. This option has proven to be very popular in the commercial market, and many of us have access to PPOs. We believe that Medicare beneficiaries should have the same range of choices. Under the PPO option, our objective would be to allow beneficiaries to choose to go to any physician at any time, subject to higher cost-sharing.

In developing a PPO option for Medicare, we hope to learn from our experience with the Medicare SELECT demonstration. As you know, Medicare SELECT was designed to create a hybrid of managed care and Medigap that it was hoped would be beneficial both to beneficiaries and to Medicare. However, our experience under the demonstration has been that while premiums for traditional Medigap benefits are reduced, Medicare does not share in the savings.

The reason for this apparent anomaly is that the lower Medigap premiums in Medicare SELECT plans are generally the result of hospital discounting arrangements rather than the active management of care or the efficiency of the SELECT networks. The basic problem with Medicare SELECT is that there are limited incentives for plans to manage the total costs. As a result, Medicare does not participate in any savings, and beneficiaries do not receive the benefits of coordinated care that they would receive in efficient networks. In fact, if proposals to expand SELECT discounting to Part B services are enacted, Medicare costs would actually increase, as physicians increase utilization to recoup their discounts.

A second issue with Medicare SELECT deals with the adequacy of beneficiary protection. We feel strongly that beneficiaries should not have to worry about the quality and access provisions of their Medicare choices. We look forward to working with the Subcommittee on this important issue.

We also hope to be able to work with the Subcommittee on the PPO option in

the months ahead. In addition, given the impending deadline for expiration of the SELECT authority and the need to examine the demonstration experience before the program is expanded to all states, Congress may wish to consider a 6 month extension of the demonstration for existing plans. This would alleviate the uncertainty for existing plans, and provide time to make appropriate changes to SELECT based on demonstration experience.

Beneficiary Education

We need to do a better job of informing beneficiaries about the managed care and Medigap choices that are available. The current lack of information in the face of such a variety of choices generates confusion which works against managed care options. To understand their choices, beneficiaries have to negotiate through differences in benefit packages, cost-sharing structures and premium amounts. Beyond this need for information, beneficiaries are also be faced with enrollment periods that vary by plan and, in the case of Medigap, with health screening and underwriting. Beneficiaries who initially enroll in a managed care plan lose their one time option for open enrollment in Medigap.

We would like to do everything possible to make managed care options very attractive to beneficiaries. We think we can do a better job of helping them to understand the advantages of these plans.

Quality and Managed Care

Today, managed care organizations providing services to Medicare and Medicaid beneficiaries are required to have internal quality assessment and improvement programs to identify ways to improve the delivery of health care services and the health care itself. We also require independent external review of quality of care delivered to our beneficiaries.

HCFA is working in collaboration with the industry on a long term effort of developing a single set of measures that could be used by all payors to address the full range of a health plan's membership and performance.

The first phase of this effort centers on major performance measurement projects underway in both Medicare and Medicaid. These are designed to help us develop measures that are focused on the special needs of our diverse populations.

In Medicaid, we are working collaboratively with National Committee for Quality Assurance (NCQA), State Medicaid agencies, consumer advocates and managed care organizations to adapt the commercial sector's state-of-the-art performance measurement tool HEDIS (Health Plan Employer Data and Information Set) to the needs of the Medicaid program.

We chose HEDIS as the template for our Medicaid effort for several reasons:

- HEDIS is viewed by most of the leading state managed care programs as the appropriate model for Medicaid. Some states are already adopting HEDIS. We feel it is important to provide some national leadership.

- We want to coordinate with the private sector and take advantage of the significant analytical groundwork already produced by NCQA, so as to minimize potential reporting burdens on our managed care plans, many of which are adopting HEDIS.

In Medicare, we are beginning to pilot test a new, performance based approach to Peer Review Organization (PRO) review of HMOs developed under contract with the Delmarva Foundation. These measures reflect the special health needs of an elderly and disabled population, for example, in management of chronic conditions. These measures will them be considered in conjunction with the broader HEDIS effort.

Payment/Competitive Bidding

As I discussed above, concerns about the payment methodology for risk contractors has been long standing. Currently, we determine rates on a yearly basis, and plans decide whether or not to enter into a contract each year based on the rates. These rates, called the Adjusted Average Per Capita Cost (AAPCC), are developed for each county and are based on fee-for-service costs in the area. County rates are then adjusted for age, sex, institutional and Medicaid status; no adjustment is made for health status per se. Plans have been concerned with the adequacy, stability and equity of the AAPCC. Early on, when I became Administrator of HCFA, I invited the industry to come up with alternatives to the AAPCC. We still have no significant alternatives.

One concept that has recently received widespread support and attention from industry, academia and commercial payers is that of "competitive bidding." Proponents of competitive pricing models claim that the methodology will result in payments that more accurately reflect the true costs of doing business, in addition to promoting efficiency through greater competition among health plans.

We think that this is a promising idea, and we would like to test variants of it as demonstrations in a number of geographic areas. In order for the demonstrations to be useful, we believe that competitive bidding should become the payment methodology for all Medicare managed care plans in the demonstration areas. As always, beneficiaries will still have the ability to choose to enroll in managed care plans or remain in fee-for-service. We would be interested in working with the Subcommittee on the structure of a competitive bidding demonstration.

III. IMPROVED PROGRAM MANAGEMENT

Managed care options while of growing importance to the administration of the Medicare program are not the whole story. We are actively working to improve management throughout the program and to make continued innovations in the fee-for-service program.

Customer Service Initiatives

Under the leadership of President Clinton, Vice President Gore and Secretary Shalala, we at HCFA have focused our efforts on making sure that our nearly 70 million beneficiaries (Medicare and Medicaid) receive the health care they need when they need it. This means that beneficiaries come first in all that we do. HCFA has undergone significant internal and external changes to insure that the "customer first" philosophy becomes a reality. Throughout the agency, we are working to improve communications with beneficiaries -- whether it be one-on-one in person, on-line through the computer, over the telephone, through our numerous publications or through the media.

The nature of the Medicare program is such that there are numerous other people and organizations that have closer contact with beneficiaries than HCFA. They are also our customers and our partners in providing health care services - providers such as hospitals, nursing homes, home health agencies, physicians and medical suppliers; contractors (carriers and intermediaries) that process and pay Medicare claims; and, Peer Review Organizations that assure the quality of health care services.

We have developed a set of customer service standards that apply to our interactions with beneficiaries and our partners. These standards apply to all of our communications, claims processing activities, customer satisfaction, consumer choice, health care quality and program administration. For example, we are working with our customers to make our publications and notices easier to understand. We are simplifying Medicare claims administration so that claims determinations will be more consistent. We are placing a premium on measuring and improving customer satisfaction through the use of surveys, focus groups and meetings.

We also believe that the need for integrating delivery systems will become more and more critical as our population becomes increasingly diverse and older with more chronic care needs. In order to meet these needs, it is clear that HCFA must maintain a collaborative relationship with its partners in the provider community and assist them to improve their focus on customer service. Several such initiatives are already underway. HCFA is examining all of the long-term care services provided by both Medicare and Medicaid and is considering ways that these services can be better coordinated with one another and with the acute care system. A similar review of home health care programs has also been undertaken.

Fraud and Abuse

Starting at the Office of the Administrator and at every level of HCFA, we have expanded and strengthened our efforts to root out fraud and abuse against Medicare and Medicaid and to vigorously pursue those who commit such illegal activities. We operate in a partnership, not only with the Department's Office of the Inspector General, but with the Department of Justice, including the FBI, state and local law enforcement agencies, and our contractors. Further, HCFA is increasingly exercising its authority to suspend payments to providers and suppliers when evidence of fraud exists.

In addition, HCFA is reviewing and changing programs and policies that have been found most vulnerable to abuse. For example, in order to better monitor fraud and abuse related to durable medical equipment (DME), HCFA has changed the procedures for claims processing. Four carriers are now responsible for DME claims processing rather than the previous 33 carriers, a system which provided DME suppliers opportunities to submit claims to the carrier whose payment policy was most liberal. The new system of using four regional carriers reduces the chance for fraudulent billing because suppliers must submit claims to the carrier in the region where the beneficiary resides.

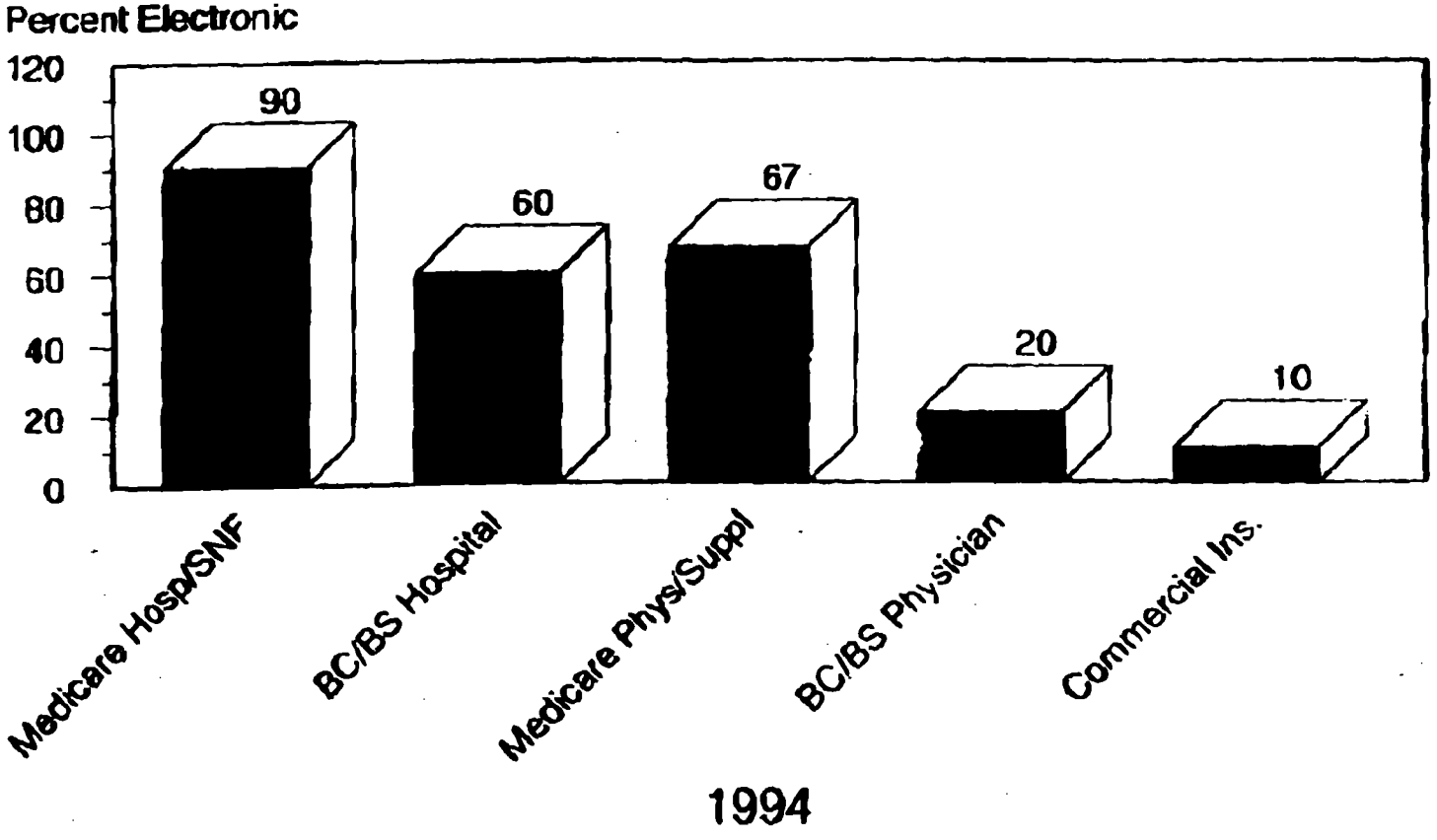
The use of more sophisticated data processing systems, such as the MTS system, that I discussed earlier, further increases the chances of detecting aberrant patterns that might indicate abusive behavior. The MTS system will greatly improve HCFA's ability to screen Medicare claims for errors and fraud.

IV. CONCLUSION

For thirty years, Medicare has been insuring the nation's elderly and disabled. We know from our focus groups, and I think you are all aware from interactions with your constituents, that beneficiaries feel a certain ownership of the program. This feeling is justified. Through their payroll contributions and those of their employers, during their working lives, and through their own premium payments, beneficiaries in fact contribute 70 percent of their insurance costs. We want to work with you to make responsible decisions in planning the next steps for the future of the Medicare program. We look forward to working with this Subcommittee as we expand choices available to beneficiaries without compromising quality, access or value.

Electronic Submission of Claims

Medicare vs. Private Insurance

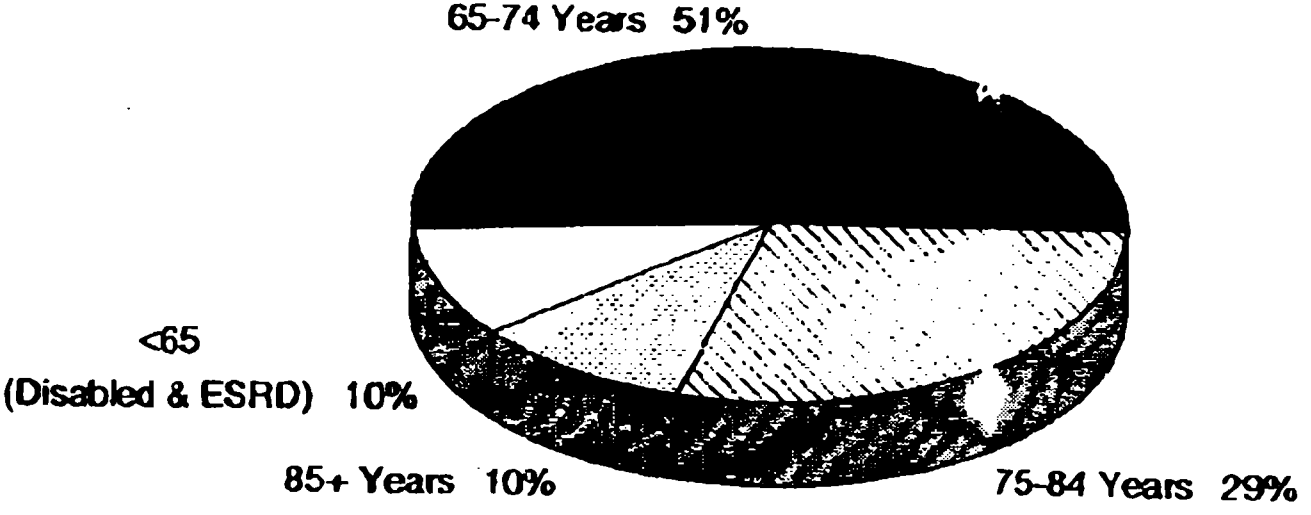


Source: HCFA/BPO; Blue Cross Assoc.

P78 HCFACHT2

The Composition of the Medicare Population, 1992

Elderly, Disabled and ESRD



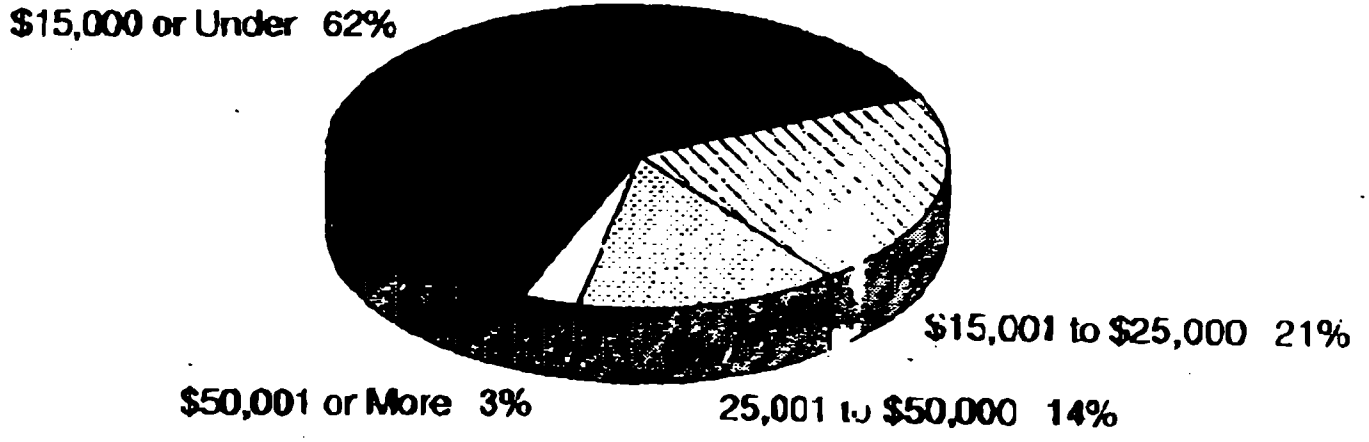
Total Beneficiaries=35.6 Million

Source: HCFA/BDMS

P78 HCFACHT4

Share of Program Expenditures by Income

Of Medicare Individuals or Couples, 1992



83% of Expenditures: Annual Income of $25,000 or Less

Excludes 2.2% not reporting income.
Also Excludes HMO enrollees (5%).
Source: HCFA/OACT

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

2/24/95

LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: 452

FILE NO: 491

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Legislative Assistant's line (for simple responses): 395-7362

SUBJECT: HEALTH AND HUMAN SERVICES Proposed Testimony on the status of the Medicare Program

DEADLINE: 5:30 p.m. Friday, February 24,1995

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President.

Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

COMMENTS: Hearing is before the Senate Committee on Finance on Tuesday, February 28th. HCFA Administrator Vladeck is the witness.

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RESPONSE TO
LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: 452
FILE NO: 491

If your response to this request for views is simple (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet.

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Please include the LRM number shown above, and the subject shown below.

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SUBJECT: HEALTH AND HUMAN SERVICES Proposed Testimony on the status of the Medicare Program

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No Objection

_____ No Comment

_____ See proposed edits on pages _____

_____ Other: _____

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draft 2/23

STATEMENT OF

BRUCE C. VLADECK, Ph.D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

FINANCE COMMITTEE

UNITED STATES SENATE

FEBRUARY 28, 1995

Mr. Chairman and Members of the Committee

I am pleased to be here today to discuss the Medicare program, its extraordinary success in providing health care to the elderly, and the challenges the program faces in controlling expenditures without jeopardizing the services Medicare offers its beneficiaries. Medicare has fulfilled its promise of providing access to basic health care for elderly and disabled Americans. As Medicare enters its thirtieth year, however, we face a world quite different from that in which the program began. We will face continuing challenges in assuring access to care, in assuring the quality of that care, in responding appropriately to technological advances in medicine, and in helping to reform the health-care delivery system.

Background

Before Medicare was created, in 1965, over half of the elderly population had no health insurance. Now over 95 percent of the elderly are insured. In 1972, Congress expanded Medicare to include disabled individuals and those afflicted with end stage renal disease. Today, these individuals have basic health insurance and need no longer fear massive bills or having to do without basic care they need. We should not lose sight of the importance of this achievement: it justly ranks as one of America's major accomplishments of the past several decades.

Medicare is administered largely by private contractors under our supervision. In 1994, Medicare served almost 36 million persons under Parts A and B of the program. Aged Medicare beneficiaries number 32 million, 3.6 million are disabled and 77,000 have ESRD. Medicare has agreements with over 65 contractors to process beneficiary claims. In FY 1994, over 750 million claims were processed

While sustained by our program, many of our beneficiaries could safely be described as vulnerable.

- Relatively few Medicare beneficiaries can be considered financially well-off. Approximately 83 percent of program spending in 1992 was on behalf of those with incomes less than $25,000 (see Chart 1). Fifty-nine percent of senior citizens rely on Social Security for 50 percent or more of their income (see Chart 2).

- Currently, 20 percent of our beneficiaries are either seniors age 85 and older, most of whom are women, or persons with disabilities or end stage renal disease (see Chart 3).

In the first full year of operation, Medicare served 19.1 million elderly Americans, with Federal spending totalling approximately $4.5 billion. Today, Medicare meets the health care needs of approximately 36 million beneficiaries, with annual

expenditures of approximately $160 billion in 1994.

Early projections of Medicare participation did not take into account the fact that good medical care has helped contribute to the increased life expectancy for the elderly. However, good care also translates into greater demand for services.

This growth in spending has resulted from a variety of factors, including improvements in benefits, expansions in eligibility, and increases in the costs of health care. Ironically, part of the growth may also be traced to Medicare itself: Medicare's case load has quietly risen because life expectancy has improved significantly, partly because of the improved medical care paid for by Medicare.

The Medicare program consists of two distinct parts.

- Part A covers services furnished by hospitals for inpatient care, home health agencies, skilled nursing facilities, and hospices. Medicare Part A services are financed by the Medicare tax, paid by both employees and employers.

- Medicare Part B is voluntary and is offered to all Medicare Part A beneficiaries for a monthly premium, now $46.10. The premiums collected are required by statute to finance 25 percent of the Part B program; the rest is financed through general Federal revenues.

  Part B covers a wide range of medical services and supplies including physician services, outpatient hospital services and some home health services. Part B services also include diagnostic laboratory tests, x-rays, and the purchase or rental of durable medical equipment.

  In recent years, Medicare has witnessed substantial increases in spending for home health services and outpatient procedures. In 1994, Medicare spent 15 percent on these services (See Chart 4).

  The Medicare program has helped the nation achieve a high standard for quality health care.

- Medicare pays almost 30 percent of the nation's hospital expenditures, and this solid base of support had a major role in permitting the modernization of the nation's hospitals.

- The training of physicians at hospitals is extensively subsidized through Medicare's graduate medical education and indirect medical education payments.

- Medicare has also pioneered the expansion of at-home

medical care through home health agencies.

- Medicare has improved access to medical treatments through special funding for rural and frontier areas.

- Lastly, Medicare, to help assure the quality of health care delivered to Medicare beneficiaries, pioneered the first utilization and quality review program, which served as a model for the rest of the country. Most importantly, all suppliers and providers that serve Medicare beneficiaries, must meet the HCFA standards for health and safety. In addition, I will later describe our Health Care Quality Improvement Program, under which the Medicare Peer Review Organization (PROs) program is setting the standard for modern quality assurance activities.

Medicare's Strengths

Medicare continues to have high levels of customer satisfaction and physician participation. Recent studies have shown that the majority of Medicare beneficiaries are highly satisfied with their medical care and coverage.

Medicare also boasts a high participation rate among physicians and other providers of health care services, which helps assure access to medical treatment and services for Medicare beneficiaries. Over 578,000 physicians, or 65 percent of those physicians who bill Medicare, have signed up to be participating physicians, meaning they forgo extra billing on all claims for Medicare beneficiaries. In addition, 6,473 hospitals participate in Medicare.

Medicare continues to lead the health insurance industry in the effective use of high technology for program administration. We operate the Medicare system with administrative costs of less than two percent of program outlays (see Chart 5). In contrast, private insurance administrative expenses are about 25 percent in the small group market and about five percent in the large group market.

Medicare has been a pioneer in streamlining program administration and is a world leader in fostering electronic claims submission. Ninety percent of Medicare's hospital and skilled nursing home facility claims and 70 percent of its physician claims are submitted electronically (see Chart 6). In contrast, 60 percent of Blue Cross's hospital claims and 20 percent of its physician claims are electronically submitted. For commercial carriers, the percentage is ten percent for all claims.

We have also focused attention on reducing the paperwork burden on health care providers, working closely with the health

care community to establish a standard uniform national Medicare claim form for physicians and another for hospitals, skilled nursing facilities and home health agencies. Many other insurers use these forms, but attach additional forms as well. These, however, are the only hospital and physician claim forms that Medicare requires.

For thirty years, Medicare has been insuring the nation's elderly and disabled. We know that beneficiaries feel a certain ownership of the program. This feeling is justified. Through their payroll contributions and those of their employers during their working lives, beneficiaries directly contribute a significant fraction of their insurance costs. The average worker turning 65 and becoming eligible for Medicare today will contribute about 10 percent, on average, of what Medicare Part A will eventually pay.

Medicare Successes in Controlling Costs

Medicare has been successful in slowing the growth of expenditures for hospitals and physicians. From 1984 to 1993 Medicare's annual rates of expenditure growth were 6.1 percent for hospitals and 7.9 percent for physicians. In the same time period, private insurance experienced rates of 7.7 percent for hospitals and 11.2 percent for physicians (see Chart 7).

During the Clinton Administration, the projections for the average annual rate of growth for Medicare have decreased. In the President's Fiscal Year 1996 Budget, the projected annual average rate of growth for 1996-2000 is 9.1 percent. In contrast, six months ago in the Mid-Session Review the projected annual average rate of growth for the same period was 10.3 percent. The primary contribution to lower Medicare projections is slower growth in Part A Hospital Insurance expenditures. The decline in projected Part A growth results primarily from a decrease in forecasted hospital cost inflation and slower growth in the complexity of Medicare inpatient cases (see Chart 8).

Medicare has experienced a slower growth rate of expenditures per enrollee than private health insurance: from 1984 to 1993, Medicare per enrollee expenditures grew at 6.3 percent versus 9.8 percent for private insurance. While there was a temporary reversal of this relationship from 1991 to 1995 (see Chart 9), our actuaries project a resumption of the trend beginning in 1996 and continuing into the 21st century.

This record has been due, in part, to Medicare's prospective payment system (PPS) for hospitals and the physician payment fee schedule, both of which have helped slow the rate of expenditure growth.

The Prospective Payment System

In 1984, Medicare began paying hospitals on a prospective basis for inpatient care of beneficiaries. Prior to PPS, hospitals were paid on a reasonable cost basis for all charges in treating a patient on an inpatient basis. Under PPS, each patient stay is categorized into a Diagnosis Related Group or DRG. The DRG payment is calculated to represent all the costs associated for treating a patient with a given diagnosis and is made as one bundled payment for the hospital.

This prospective payment gives the hospital the incentive to provide cost-effective treatment and reduce waste while providing quality care to the patient. The system has worked largely as intended: cost increases have been curbed and the quality of patient care has been maintained. Hospitals have played a significant role in helping the prospective payment system work as envisioned.

In addition, in 1992 we extended the prospective payment system to incorporate Medicare's share of capital expenses of hospitals. Until 1991, Medicare was making payments to hospitals on a reasonable cost basis. This cost-based system did not provide incentives for hospitals to make prudent capital investments. Under the old cost-based system hospitals were engaged in a race for technology, often competing for high technology pieces of equipment, such as MRIs and CAT scans, that cost the Medicare program millions of dollars. Under PPS, hospitals now have the incentive to make prudent investment decisions without burdening the Medicare program with paying for excessive purchases of unnecessary medical equipment.

Physician Fee Schedule

Medicare physician payment reform also provides better incentives for appropriate use of health care services. The reform package in the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) had three key elements. First, the law set a goal for the rate of Medicare physician expenditure growth, called the Medicare Volume Performance Standard (MVPS). Second, a resource-based fee schedule replaced Medicare's antiquated customary, prevailing, and reasonable charge system. The last element included provisions for financial protection for Medicare beneficiaries by establishing uniform limits on extra billing by nonparticipating physicians.

The fee schedule refocuses current incentives by generally increasing payment for primary care and reducing payment for surgery and other procedures. At the same time, the Medicare Volume Performance Standards help restrain overall spending for Medicare physicians' services. Further, beneficiaries are protected from extra billing charges under the fee schedule.

Since implementation of the fee schedule in 1992, we have seen a slower rate of growth in physician expenditures.

Other Areas for Payment Reform

Medicare currently covers four major services that are not paid prospectively: skilled nursing facilities (SNFs), home health, hospital outpatient departments and PPS-exempt hospitals. We are working on developing prospective payment systems for all of these services.

- Technically, we are closest to being ready to implement a PPS system for SNF services, at least for routine costs.

- We are conducting demonstrations on prospective payment for home health services on per episode basis and expect to be able to develop a system after the demonstrations are completed.

- We are ready to implement a prospective system for some of the major services in hospital outpatient departments. We will shortly submit a report to Congress on the policy issues involved.

- Finally, we are still working on developing the classification systems necessary to implement PPS for currently exempt hospitals.

Recent Developments

Over the past few years, HCFA has improved the oversight and efficiency of Medicare claims processing; strengthened prevention and detection of fraud and abuse; simplified paperwork; expanded beneficiary outreach efforts; assured improved quality of health care; strengthened managed care options; and enhanced the coordination and integration of health care.

Simplifying Program Administration

As I mentioned earlier, Medicare is a leader in streamlining program administration and fostering the use of electronic claims. We are continuing our efforts in this area by increasing our use of electronic technology for all phases of claims processing to reduce administrative costs. In fact, Medicare has experienced a significant reduction in administrative costs for processing both Part A and Part B claims. For example, Medicare's bottom line cost to process claims has been reduced by 24.6 percent per physician claim and by 21.1 percent per Part A claim since Fiscal Year 1990.

In order to continue efforts at streamlining our current

claims processing systems, we recently signed a contract with CTE to develop the Medicare Transaction System (MTS). MTS will improve communication, data capabilities, and information sharing among our contractors.

MTS will replace 11 automated systems currently operated by 73 insurance companies under contract to Medicare at 62 sites. The new system will be able to process over 1 billion claims per year as projected by the turn of the century. MTS will be phased-in over two years, starting in 1997.

In partnership with suppliers, providers, and Medicare beneficiaries, HCFA has sought to re-engineer our business processes. For example, in the durable medical equipment (DME) area, we concluded that we should concentrate all processing for durable medical equipment and supplies in a small number of specialized carriers. This step was intended to achieve more sophisticated and uniform coverage policies, to improve claims processing, and to help prevent fraud and abuse. Greater efficiency would be achieved because each carrier would have a trained pool of experienced personnel able to handle the DME claims more effectively and to process claims more quickly and accurately.

Starting in October 1993, we have gradually transferred the processing and monitoring of durable medical equipment and supplies from 34 Part B carriers to four durable medical regional carriers (DMERCs).

This consolidation also allowed for standardized submission of electronic claims. All suppliers are now able to use a single format to submit their claims to Medicare. This format results from a major redesign of the previous process, which had well over 30 different electronic formats.

Combatting Fraud and Abuse

Medicare is administered largely by private contractors under our supervision. Medicare has agreements with over 65 contractors to process beneficiary claims. In 1994, over 750 million claims were processed and Medicare paid more than $159 billion for medical services, treatment and equipment. With such a vast network in place the potential for fraud is very real. Although the majority of our providers and suppliers are legitimate, a few disreputable actors are responsible for a significant amount of fraud and abuse.

HCFA is expanding and strengthening efforts to root out fraud and abuse and to vigorously pursue those who commit such illegal activities.

- We have taken an active lead on establishing separate fraud

units in 22 Medicare intermediary and carrier sites.

- HCFA has strengthened relationships not only with the DHHS Office of the Inspector General, but also with the Department of Justice (including the FBI), State and local law enforcement agencies, and our contractors.

- We are increasingly exercising our authority to suspend payments to suppliers or providers when we discover reliable evidence of fraud.

- We are also working with State Medicaid offices to share new technology and approaches to detect fraudulent activities. Some states have state of the art technology available and are quite willing to provide assistance in determining approaches that will benefit our present and future needs.

To better monitor fraud and abuse in a particularly problematic area, HCFA has changed the way durable medical equipment claims are handled. Suppliers no longer can game the system by sending claims to the carrier that paid the highest amount or subjected them to the least scrutiny. They must now bill the regional carrier that services the area where the beneficiary lives.

The consolidation of claims processing for durable medical equipment mentioned above has significantly increased our ability to deal with fraud and abuse in this area. We now have much improved ability to track specific providers and suppliers, to check on questionable claims, and to stop payment on claims that are not legitimate.

The Statistical Analysis DMERC (or SADMERC) has the added function of conducting statistical analyses of data provided by all four carriers. This arrangement provides a quick and efficient way to detect aberrant patterns of claims that could not have been easily discovered and investigated in the past.

HCFA has also moved to eliminate the use of multiple billing numbers by DME suppliers. Starting in October 1993 we established a new supplier number application process for 120,000 DME suppliers through a National Supplier Clearinghouse (NSC). The NSC maintains a national file on DME suppliers.

In order to be able to obtain a new supplier number and bill the Medicare program each supplier must complete a uniform supplier number application which must be approved by the NSC. Through this process, we are able, for the first time, to have comprehensive information about our supplies that can be used to reliably detect abusive suppliers who attempt to relocate their operations under a different name. For example, the NSC can

provide information to carriers about aberrant suppliers and those who do not have valid supplier numbers. The carriers can then stop payment on falsely billed claims and suspend billing numbers.

Upon signing the application, the supplier attests that it will comply with the Medicare Supplier Standards. Any failure to comply with these Standards is grounds for termination from the Medicare program.

Beneficiary/Provider Outreach

We have made great strides in improving beneficiary and provider relations by listening to them and identifying their needs. After identifying the problems we went to work to create solutions. In 1994, HCFA provided simplified forms to both beneficiaries and providers in order to reduce the amount of paperwork hassle. The revised "Explanation of Medicare Part B Benefits" made it easier for Medicare's elderly and disabled populations to understand what was happening to their claims. The form is also being further refined to consolidated Part A and Part B benefits information into one form. For physicians, Medicare now requires them to sign only one form at the time admitting privileges are granted rather than signing a form each year. This one action simplified participation in Medicare for some 300,000 physicians and over 6,000 hospitals.

Part of our responsibility to beneficiaries and the general public is to provide public education on specific health issues. Accordingly, HCFA has created and developed a Consumer Information Strategy. This initiative is coordinated with our partners which include the Public Health Service, National Institutes of Health and varied consumer and advocacy groups. We have alerted Medicare beneficiaries about our coverage of the influenza and pneumococcal vaccines, and mammography. We are currently developing future campaigns on breast and prostate cancers. We strongly encourage beneficiaries to become educated and better health care consumers.

Growth in Managed Care

Medicare is certainly not immune to the managed care revolution, and HCFA is responding on a number of fronts. Our managed care agenda has two priorities: (1) to ensure the provision of quality services by HMOs that put the beneficiary first; and (2) to expand our beneficiaries' choices of managed care products, similar to those available in the private sector. We are working with HMOs as partners to meet our goals of expanded choice and quality services. We expect as much as 20 percent growth in Medicare managed care enrollment this year -- a clear signal that beneficiaries are changing the face of the

Medicare program by their own choice.

At present, 74 percent of Medicare beneficiaries have access to a managed care plan, and nine percent of all Medicare beneficiaries have chosen to enroll in a managed care option (see Chart 10). 1994 was a year of impressive growth in Medicare managed care: we experienced double digit growth both in plan enrollment and the number of plans participating in the program. Plan enrollment increased by 16 percent. We now have 11 counties where 40 percent or more of our beneficiaries are enrolled in managed care, an additional 30 counties with enrollment between 30 and 40 percent, and more than 44 counties with enrollment between 20 and 30 percent.

More important for future enrollment growth is the number of contracts with managed care plans. In 1994, the number of our Medicare managed care plans increased by 20 percent (See Chart 11). Many of these new contracts are in regions beyond those that traditionally have had a strong Medicare managed care presence. For example, in our Philadelphia region, the number of contracts increased from 6 to 16 and in the New York region contracts increased from 11 to 14.

Experience with Medicare SELECT should be part of our efforts to improve current managed care options under Medicare. We believe, however, that any expansion of SELECT should be preceded by a serious examination of our experience under the 15-State demonstration. We have looked at this experience and have two areas of concern. One major concern is with the adequacy of beneficiary protections under Medicare SELECT. Our second concern is whether Medicare SELECT will make any contribution to increasing the efficiency of the Medicare program.

Given the impending deadline for the expiration of the authority for Medicare SELECT demonstration and the need to examine the demonstration experience, the Congress may want to consider a temporary extension of the demonstration for existing plans. This extension would address the current uncertain state of the existing Medicare SELECT plans and provide ample time to examine the experience under the demonstration and to determine the changes to SELECT that should be made based on demonstration experience.

We also want to make available to beneficiaries a new preferred provider organization (PPO) option. This option has proven to be very popular in the commercial market, and many of us have access to PPOs. We believe that Medicare beneficiaries should have the same range of choices. Under the PPO option, would face nominal copayments if they stayed in plan but have the option to go to any physician at any time, if they were willing to pay the cost-sharing. A PPO option represents the ideal choice for those beneficiaries torn between staying in the fee-

for-service program and joining a Medicare risk plan. We look forward to working with this Committee on the PPO option in the months ahead.

As we work to extend and broaden managed care options for Medicare beneficiaries, we must be aware of the practical limitations of a rapid expansion of managed care in Medicare and of past failures of overly aggressive efforts in the Medicare program. Steps need to be taken to ensure the provision of quality health care to beneficiaries, in partnership with managed care leaders. The movement to managed care cannot outpace the capacity of managed care plans to serve large numbers of new enrollees, particularly those with the expensive health needs of the Medicare population. A challenge we face as more and more beneficiaries enroll in HMOs is one or monitoring, data collection and plan accountability. Like any other health care purchaser, we want a quality product.

Payment/Competitive Bidding

Concerns about the payment methodology for risk contractors has been long standing. Currently, we determine rates on a yearly basis, and plans decide whether or not to enter into a contract each year based on the rates. These rates, called the Adjusted Average Per Capita Cost (AAPCC), are developed for each county and are based on fee-for-service costs in the area. County rates are then adjusted for age, sex, institutional and Medicaid status; no adjustment is made for health status per se. Plans have been concerned with the adequacy, stability and equity of the AAPCC. Early on, when I became Administrator of HCFA, I invited the industry to come up with alternatives to the AAPCC. We still have no significant alternatives.

One concept that has recently received widespread support and attention from industry, academia and commercial payers is that of "competitive bidding." Proponents of competitive pricing models claim that the methodology will result in payments that more accurately reflect the true costs of doing business, in addition to promoting efficiency through greater competition among health plans.

We think that this is a promising idea, and we would like to test variants of it as demonstrations in a number of geographic areas. In order for the demonstrations to be useful, we believe that competitive bidding should become the payment methodology for all Medicare managed care plans in the demonstration areas. As always, beneficiaries will still have the ability to choose to enroll in managed care plans or remain in fee-for-service. We would be interested in working with the Committee on the structure of a competitive bidding demonstration.

Quality

Insuring high quality care for Medicare beneficiaries is a high priority for HCFA. The cornerstone of Medicare's quality assurance efforts rests with peer review organizations (PROs). PROs are charged with assuring that care is appropriate, provided in the correct care setting, and meets professionally recognized standards of quality. PROs, along with our program to inspect health care providers and to monitor their compliance with Federal requirements, provide an assurance that care meets quality standards.

Our knowledge and expertise in measuring and improving quality of care has evolved rapidly in the last decade, and we have been making corresponding changes in the Medicare Peer Review Organizations (PROs) and End Stage Renal Disease Networks. Two years ago we announced the Health Care Quality Improvement Program (HCQIP) to bring modern principles of quality management to PRO activities, particularly the focus on patterns of care rather than individual cases of questionable care The HCQIP forms the heart of our efforts to improve quality of care for Medicare beneficiaries over the next decade.

HCQIP embodies the major quality themes: development of quality indicators or measures, support for continuous quality improvement, development of information to promote informed consumer choice, and increased consumer protection. The most important achievement of the HCQIP is redirecting our attention from individual cases to improving quality in the mainstream of care. The HCQIP seeks to stimulate the proactive involvement of plans, providers and practitioners in quality improvement activities.

Our programs for inspecting and monitoring providers have been enhanced to improve their effectiveness at assuring the delivery of quality health services. We are reassessing and revising our standards of performance to make the focus one which is primarily directed at patient outcomes, reducing process and structure requirements for facilities. The development of quality indicators for home health agencies and skilled nursing facilities is nearing completion. These indicators will improve the health care industry's ability to continuously improve the quality care provided and enhance our ability to assure quality of care for all patients in the care of a skilled nursing facility or home health agency.

Managed Care Quality

Today, managed care organizations providing services to Medicare and Medicaid beneficiaries are required to have internal quality assessment and improvement programs to identify ways to improve the delivery of health care services and the health care

itself. We also require independent external review of quality of care delivered to our beneficiaries.

HCFA is working in collaboration with the industry on a long term effort of developing a single set of measures that could be used by all payors to address the full range of a health plan's membership and performance.

The first phase of this effort centers on major performance measurement projects underway in both Medicare and Medicaid. These are designed to help us develop measures that are focused on the special needs of our diverse populations.

In Medicaid, we are working in collaboration with the National Committee for Quality Assurance (NCQA), State Medicaid agencies, consumer advocates, and managed care organizations to adapt the commercial sector's state-of-the-art performance measurement tool, the Health Plan Employer Data and Information Set or "HEDIS," to the needs of the Medicaid program.

We chose HEDIS as the template for our Medicaid effort for several reasons:

- HEDIS is viewed by most of the leading state managed care programs as the appropriate model for Medicaid, and some states are already adopting it.

- We want to coordinate with the private sector and take advantage of the significant analytical groundwork already produced by NCQA, so as to minimize potential reporting burdens on our managed care plans, many of which are adopting HEDIS.

In Medicare, we are beginning to pilot test a new, performance based approach to Peer Review Organization (PRO) review of HMOs developed under contract with the Delmarva Foundation. These measures reflect the special health needs of an elderly and disabled population, for example, in management of chronic conditions. These measures will then be considered in conjunction with the broader HEDIS effort.

Coordination and Integration of Health Care

HCFA is constantly looking for new approaches to providing high quality care at a lower cost than traditional approaches to medical care. Starting in 1990, a demonstration project, the Program of All-inclusive Care for the Elderly (PACE), was developed to provide an integrated system of care for frail elderly beneficiaries.

PACE is the congressionally authorized replication of the health care delivery system pioneered by On Lok, Inc. PACE

provides integrated acute and long-term care financed through capitation. The program provides community-based care that integrates comprehensive medical, restorative, social and supportive services to address the client's multiple, interrelated needs. Preliminary data seems to indicate that this integrated care approach is successful in providing high quality, cost-effective health care to the frail elderly population.

Another demonstration that is now undergoing a second phase of operation is the Social HMO demonstration. The Social HMO offers Medicare beneficiaries the opportunity to receive a wide range of services to meet both acute and long-term care needs. This model of care combines the features of HMOs with those of long-term care in demonstration projects.

The first Social HMO demonstration included a fully-integrated structure to provide a range of services to enrollees, a coordinated case management system, enrollment of a cross section of the elderly population, including the functionally-impaired and the well elderly and financing methodology comprised of prepaid capitation from Medicare and member premiums.

The second generation Social HMOs will focus on refining the targeting and financing methodologies and benefit design, with an emphasis on geriatric care and the extension of the model to special populations. Six provider organizations from across the country have been selected to participate in the second phase of the demonstration.

I am optimistic that through demonstrations such as these, new models of care can be tested and successfully implemented to serve the long-term health care needs of Medicare beneficiaries.

Additional Challenges Facing the Medicare Program

As we continue to work with tighter budgets and growing needs, the Medicare program seeks to serve its beneficiaries in the best possible ways. The aging of our population, changes in morbidity and mortality, and technological advances in medicine will continue to contribute to the changing needs of the people Medicare serves.

Access and Quality Concerns

HCFA is committed to finding new ways to assure quality health care and access to medical services in more efficient ways. We are developing enhanced performance standards and quality indicators to assure that the quality of service and treatment of Medicare beneficiaries continues to improve.

We have funded grant programs to provide access to health care in rural areas, and we support the availability of managed care

options across the country. We strongly encourage beneficiaries to make educated decisions about their health care by providing choices. Despite those efforts access to quality health care is sometimes difficult for those beneficiaries living in rural, frontier or inner-city areas. Our goal is make basic quality health care easy to receive.

Improved Beneficiary Outreach

In addition to cost containment and quality goals, we are committed to improving communication with beneficiaries. HCFA is striving to make Medicare more understandable for beneficiaries. Communication with beneficiaries must be improved to ensure that the information they receive is comprehensible. We have been working to create new channels to extend our beneficiary outreach efforts. One project is 1-800-MEDICARE, a national toll-free service that will provide immediate on-line assistance for beneficiary inquiries. We are currently working with various industry, private sector, consumer, and beneficiary groups to accomplish this ambitious task. I am confident that this effort will provide a new level of beneficiary service and access to information never seen before.

Medicare's Trust Funds

While we strive to expand and change the way we do business, financial realities must be acknowledged. The most recently available optimistic estimate of the Trust Fund exhaustion date from the April 1994 Trustees report, indicate that the Hospital Insurance (HI) Trust Fund would be solvent until 2004. Changes made by OBRA 93 had the effect of extending the date of solvency reported in the April 1993 report by about three years.

While OBRA 93 made various cuts in provider payments, the largest part of this effect resulted from revenue provisions. The HI tax of 1.45 percent is now applied to all earnings; previously earnings above $135,000 escaped this tax. In addition, the percentage of Social Security benefits subject to the income tax was raised from 50 percent to 85 percent. The additional revenues generated by these provisions were dedicated to the HI Trust Fund.

The Board of Trustees will be issuing its report in April 1995. I will be happy to discuss these options with the Committee in greater detail once the report is released.

Medicare's Benefit Package

As I mentioned earlier, through better access to medical services, improved medical care and advanced technology our beneficiaries' quality of life has increased and they are living longer. These factors have made more obvious what many consider

gaps in our health care system. The long-term care or prescription drug needs of the elderly are not addressed in our current Medicare program.

While Medicare does cover temporary stays in skilled nursing facilities and provides limited coverage for home health care these benefits do not adequately address needs for long-term care. In 1987, Medicare covered only 2 percent of all nursing home expenditures (for short-term stays), while 58 percent was financed through private sources, which include direct out-of-pocket expenditures by the elderly (see Chart 12). Only 17 percent of Medicare beneficiaries have any private insurance coverage for nursing home services. This gap will continue to grow as our "baby boom" population reaches age 65 shortly after the turn of the century.

Conclusion

Although there are many approaches and views on how to provide cost effective accessible health care, the effect will be keenly felt by Medicare beneficiaries. The move towards better coordination and cooperation with our partners both in the private and public sectors will help make Medicare a stronger and more responsive program.

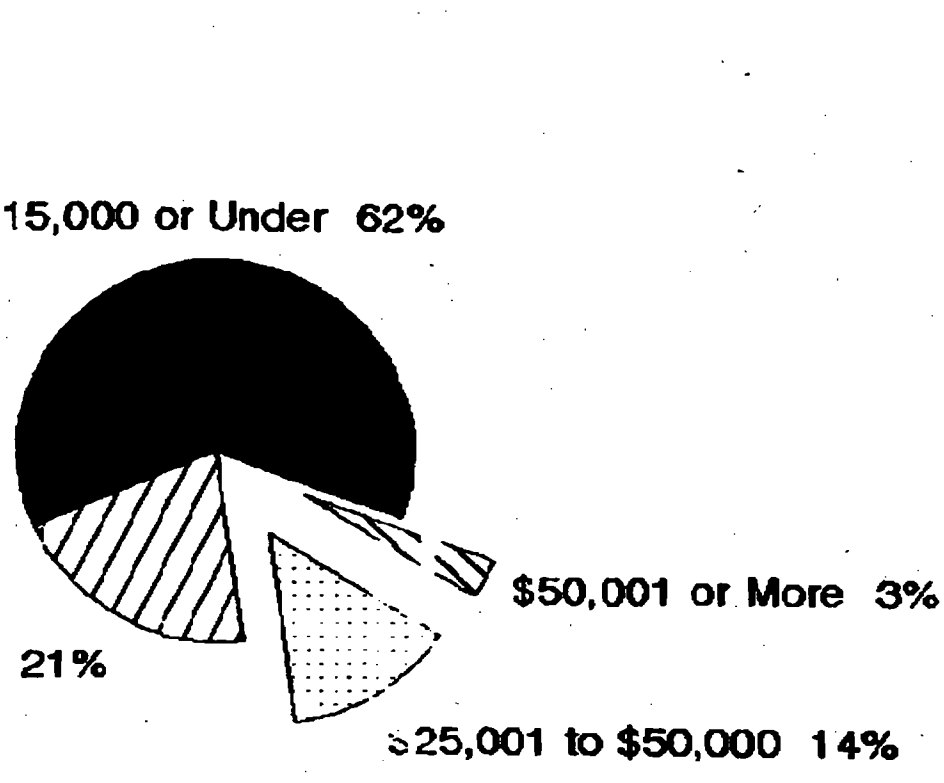
The Medicare program continues to be an extraordinary accomplishment. The vision started thirty years ago has proven to be revolutionary and has helped make the quality of life for the nation's elderly better. The steps taken by this committee has helped provide more comprehensive health benefits for millions of Medicare beneficiaries. In turn, the steps taken by Medicare has often provided the leadership for private insurance companies to offer the same types of benefits and coverage for medical treatments for all Americans.

However, this Committee or HCFA's responsibilities are not completed, they are just beginning. The challenges that we face to provide basic health care to the vulnerable populations in this country in addition to all Americans is formidable. I look forward to working with the members of this Committee to addressing these issues.

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

Share of Program Expenditures by Income
Of Medicare Individuals or Couples, 1992

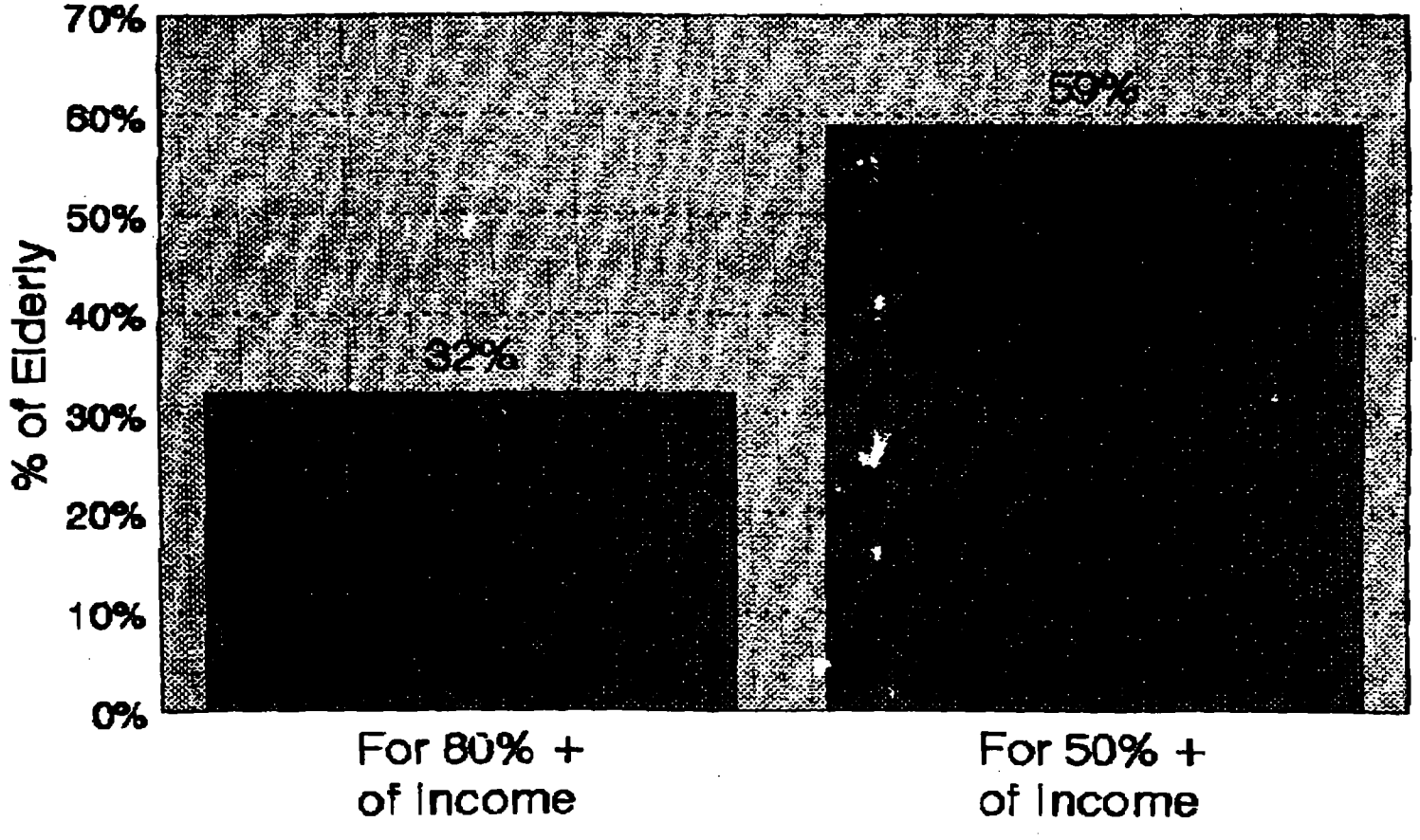
83% of Expenditures: Annual Income of $25,000 or Less



Excludes 2.2% not reporting income. Also excludes HMO enrollees (9%).
Source: HCFA/OACT

Chart

Percent of Elderly Relying on Social Security
1992

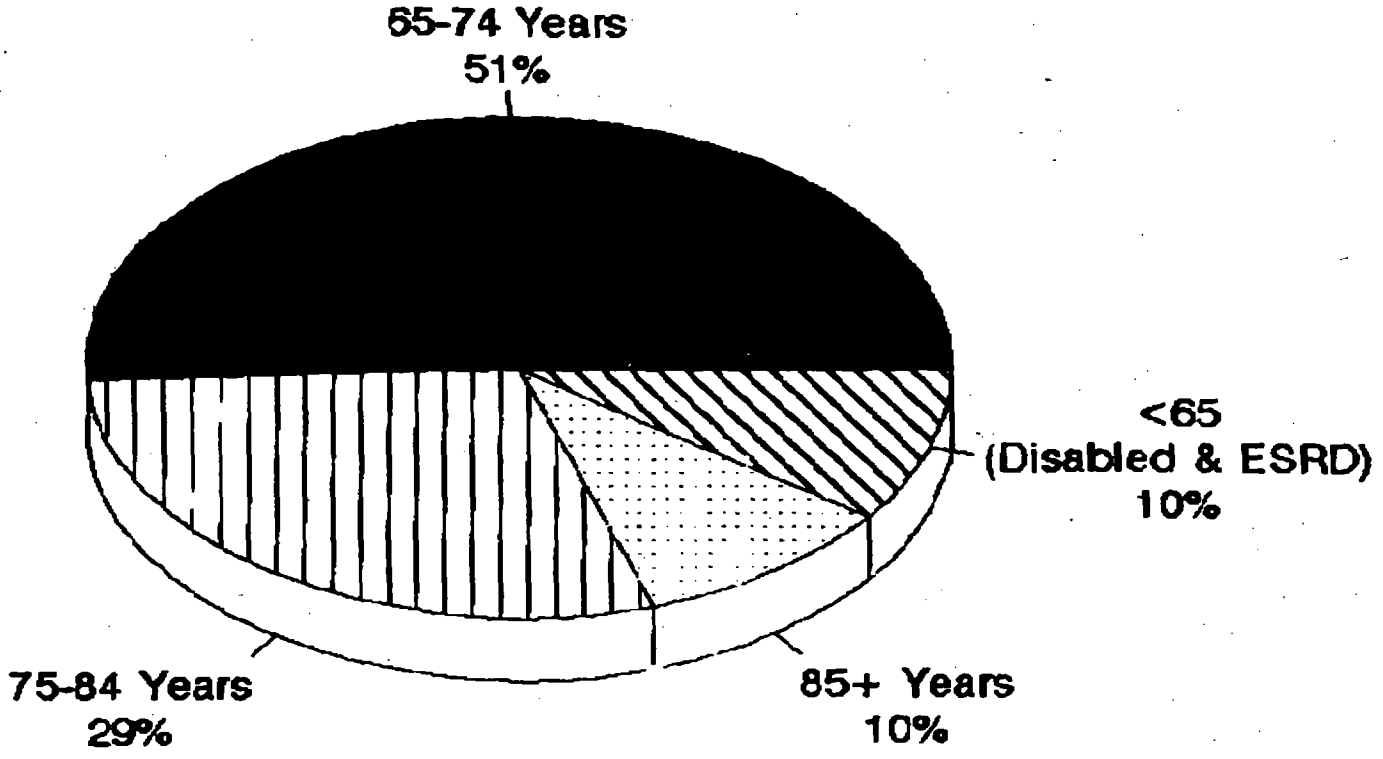


Source: Income of the Population, 55 Years or Older, 1992, SSA, Office of Research & Statistics

Chart

The Composition of the Medicare Population, 1992

Elderly, Disabled & ESRD

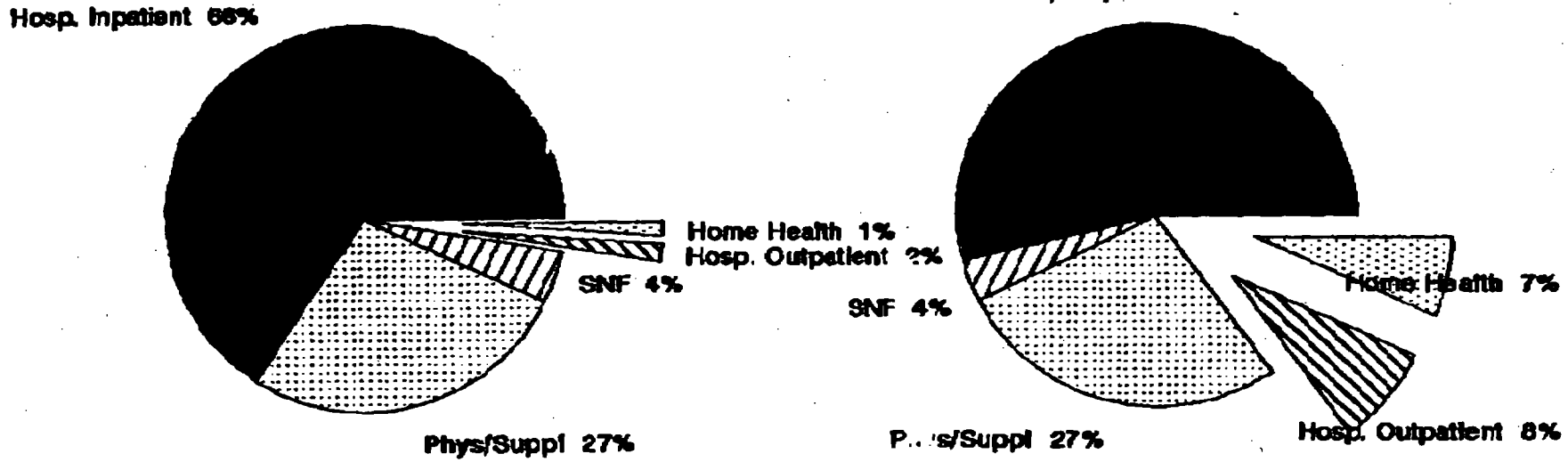


Total Beneficiaries = 35.6 Million

Source: HCFA/BDMS

Chart

Where the Medicare Dollar Goes



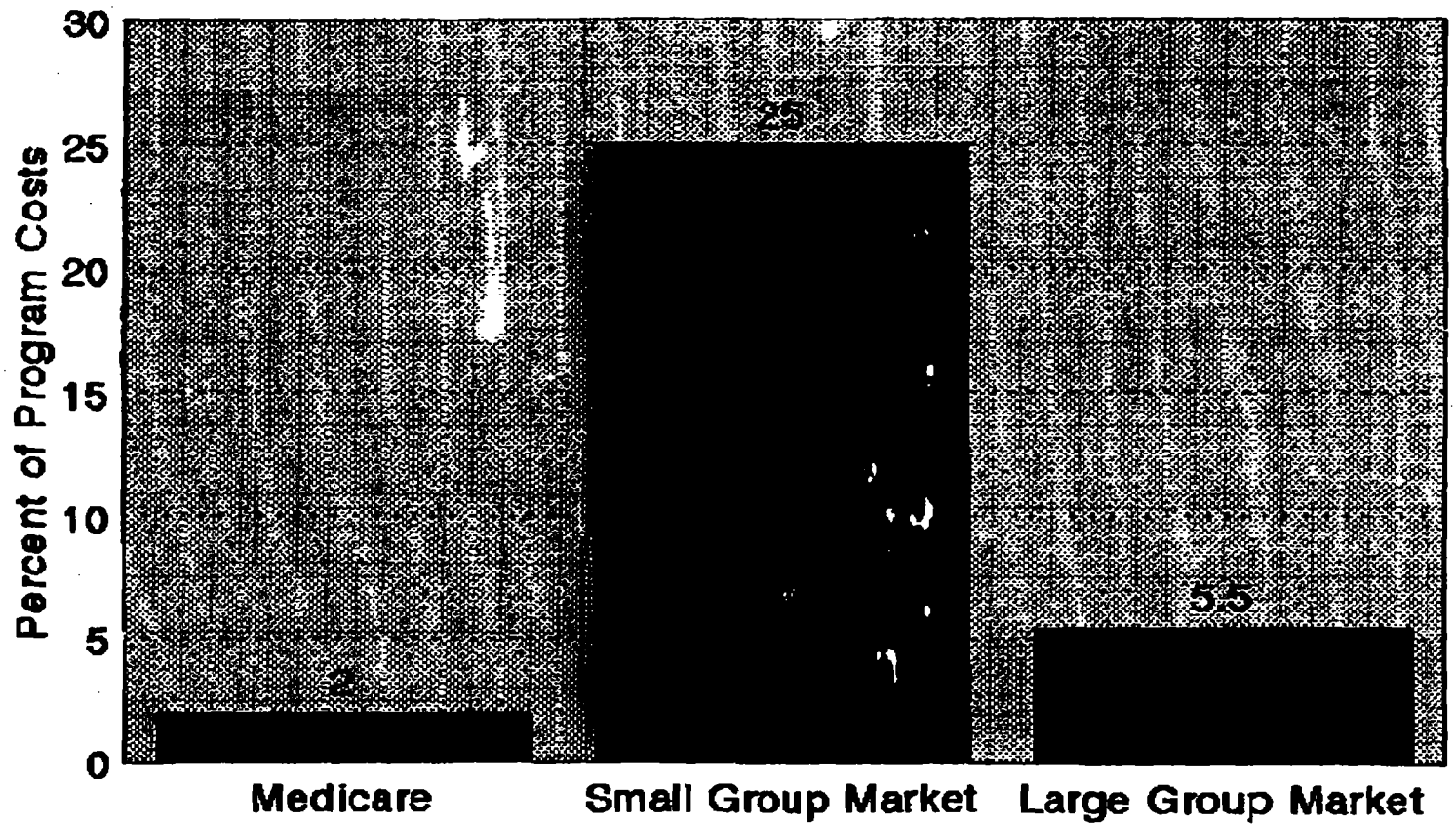
1980
Total $33.9B

1993
Total $142.9B

Source: HCFA/OACT

Chart

Administrative Costs
Medicare vs. Private Plans

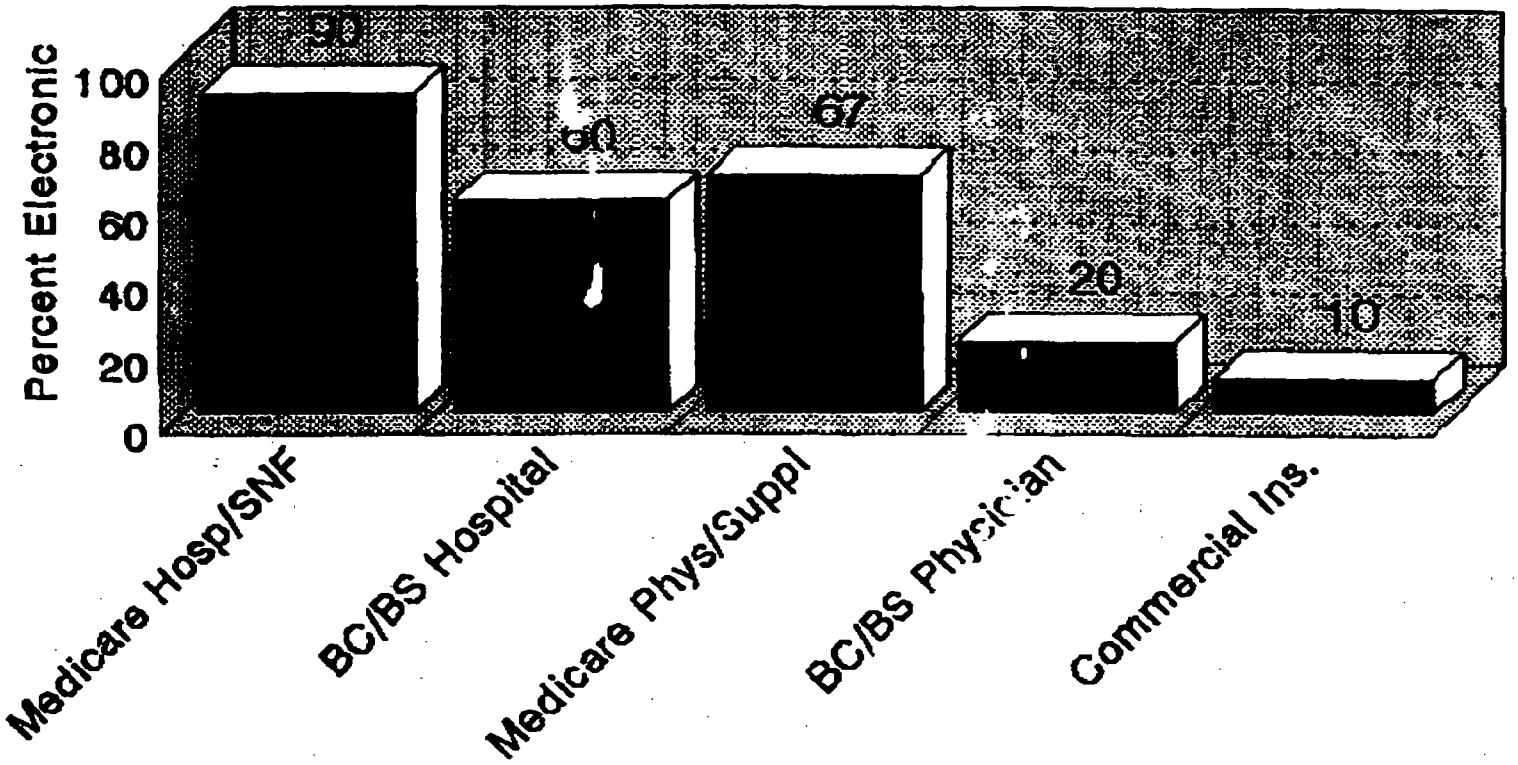


Small group market = firms <50 employees; Large group market = firms 10,000+ employees
Sources: HCFA/OACT and CRS, "Costs and Effects of Extending Health Insurance Coverage," 1988

Chart

Electronic Submission of Claims

Medicare vs. Private Insurance



1994

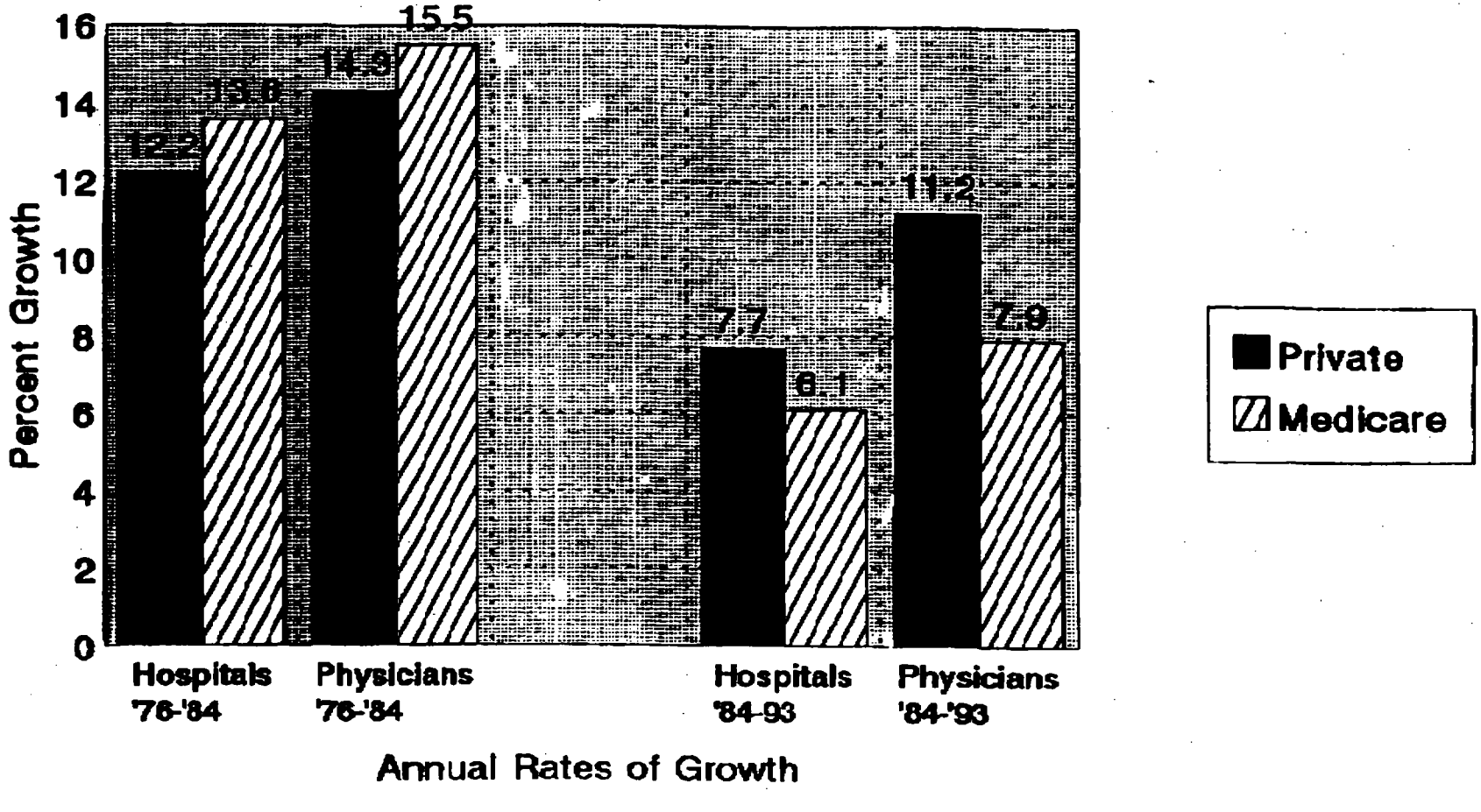
Sources: HCFA/BPO; Blue Cross Assoc.

Chart

Comparison of Growth in Hospital and Physician Expenditures

Per Enrollee

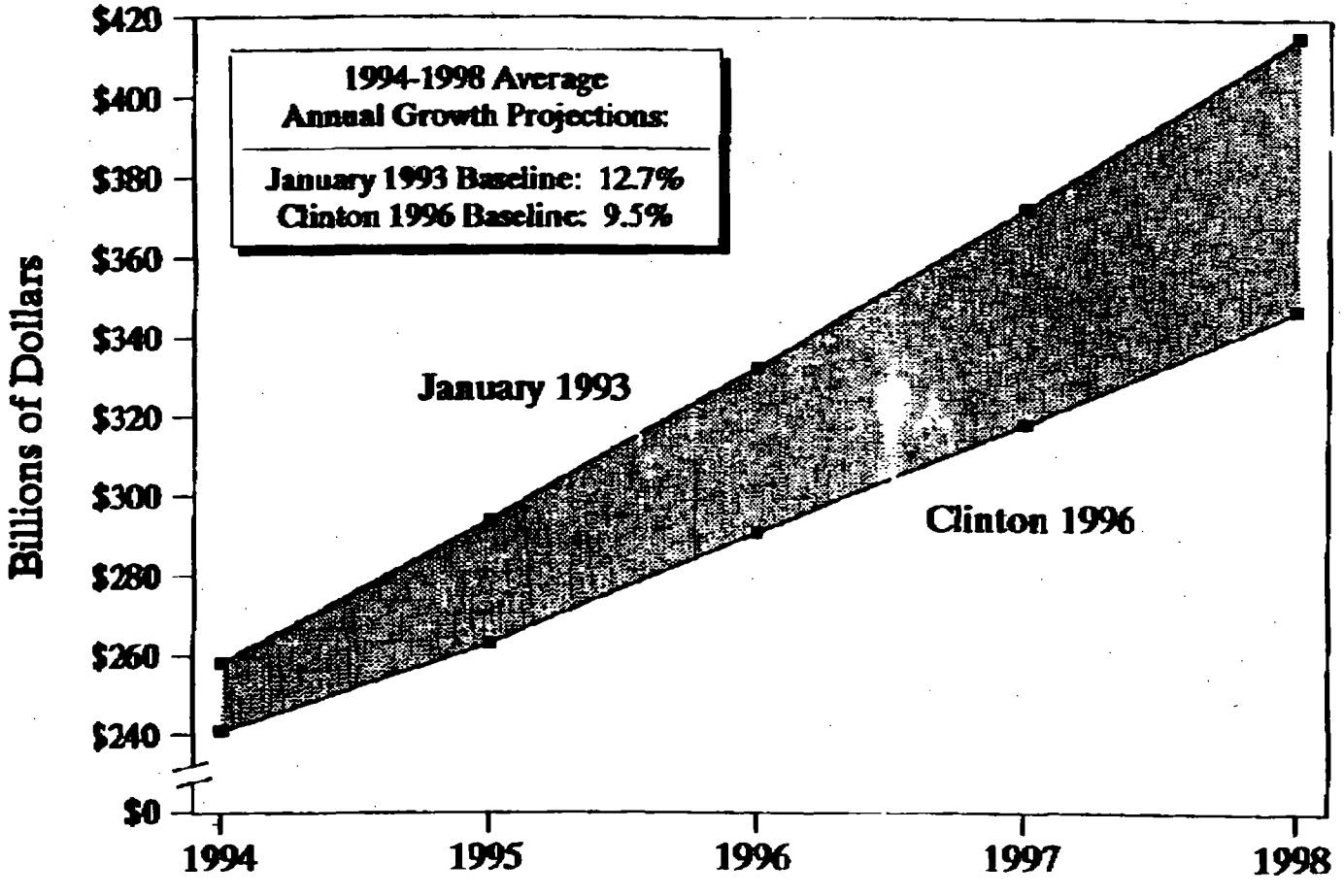
Private Health Insurance vs. Medicare



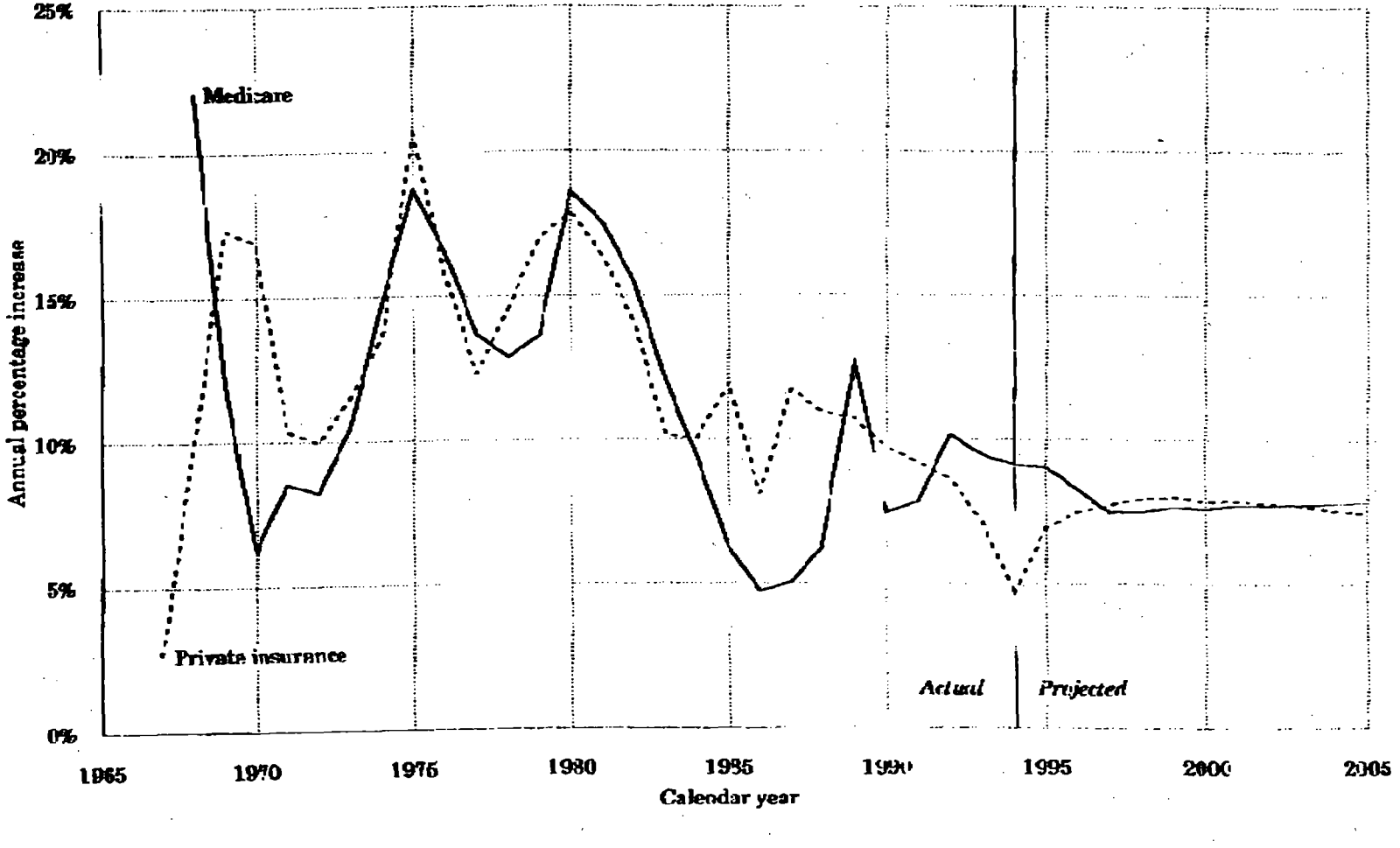
Source: HCFA/OACT

Chart

Medicare and Medicaid Growth Slows Under the Clinton Administration



Annual percentage increase in Medicare expenditures per enrollee versus private health insurance expenditures per insured person

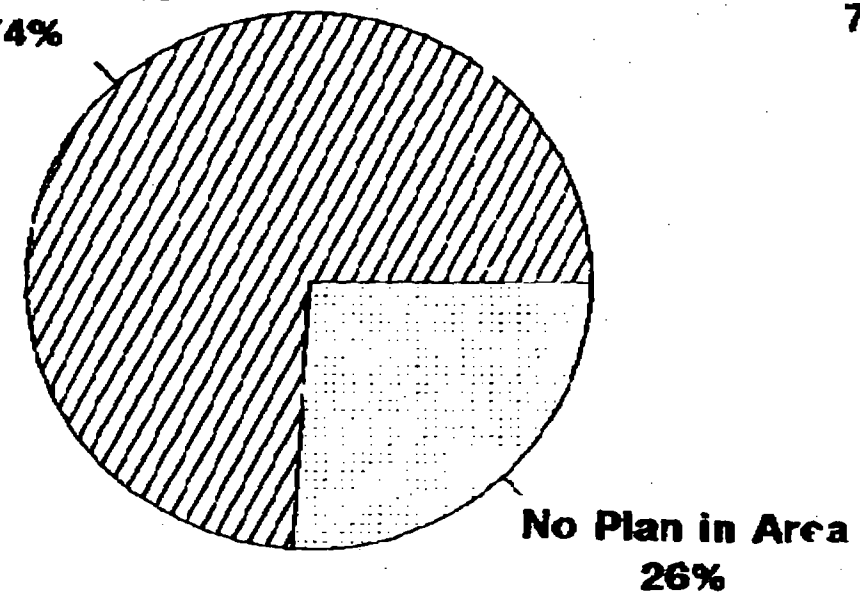


Notes: 1. Historical data shown for private health insurance are estimates based on limited data on the number of insured persons.
2. Values shown for 1994 are preliminary estimates.

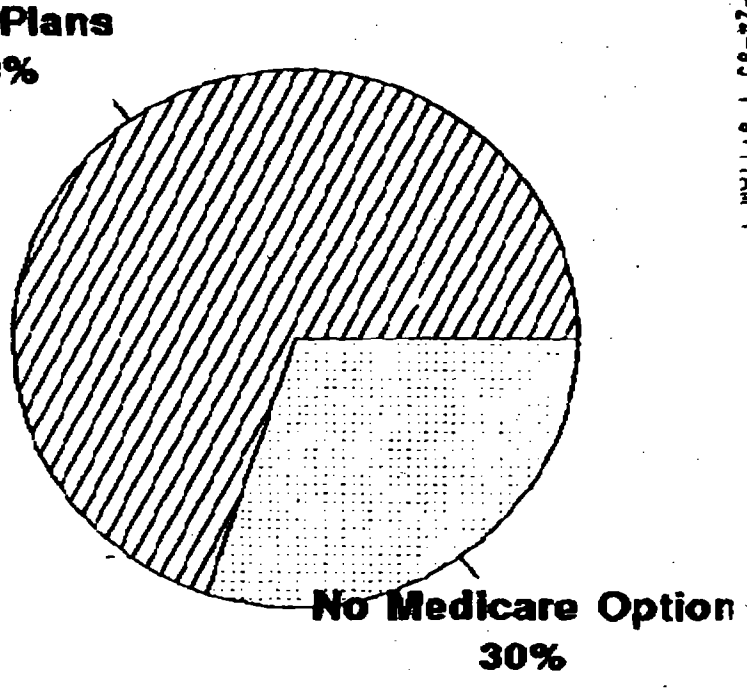
Office of the Actuary
Health Care Financing Administration
February 6, 1995

Availability of Medicare Maraged Care Products

Percent of Beneficiaries With Plans Available (1994)



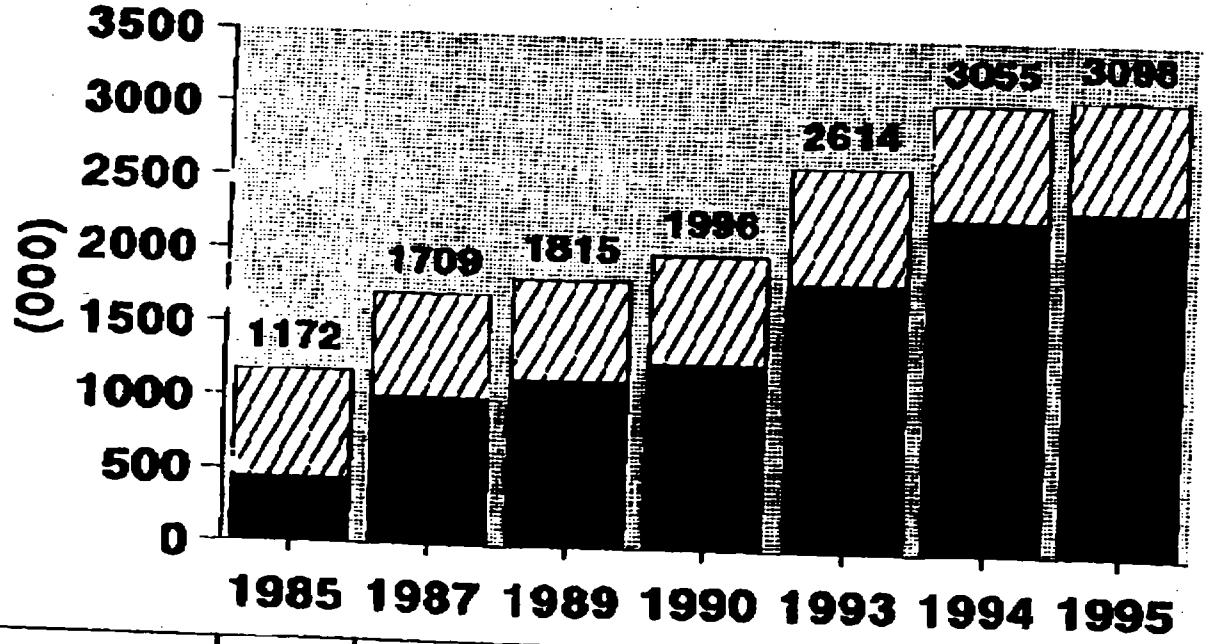
HMOs Offering a Medicare Product (1995)



Source: HCFA OMC, Group Health Association of America

Chart

Medicare HMO Enrollment, 1985 to Present
(In Thousands)



Cost HMO Enrollment	731	706	681	732	799	787	758
Risk HMO Enrollment	441	1003	1134	1264	1815	2268	2340

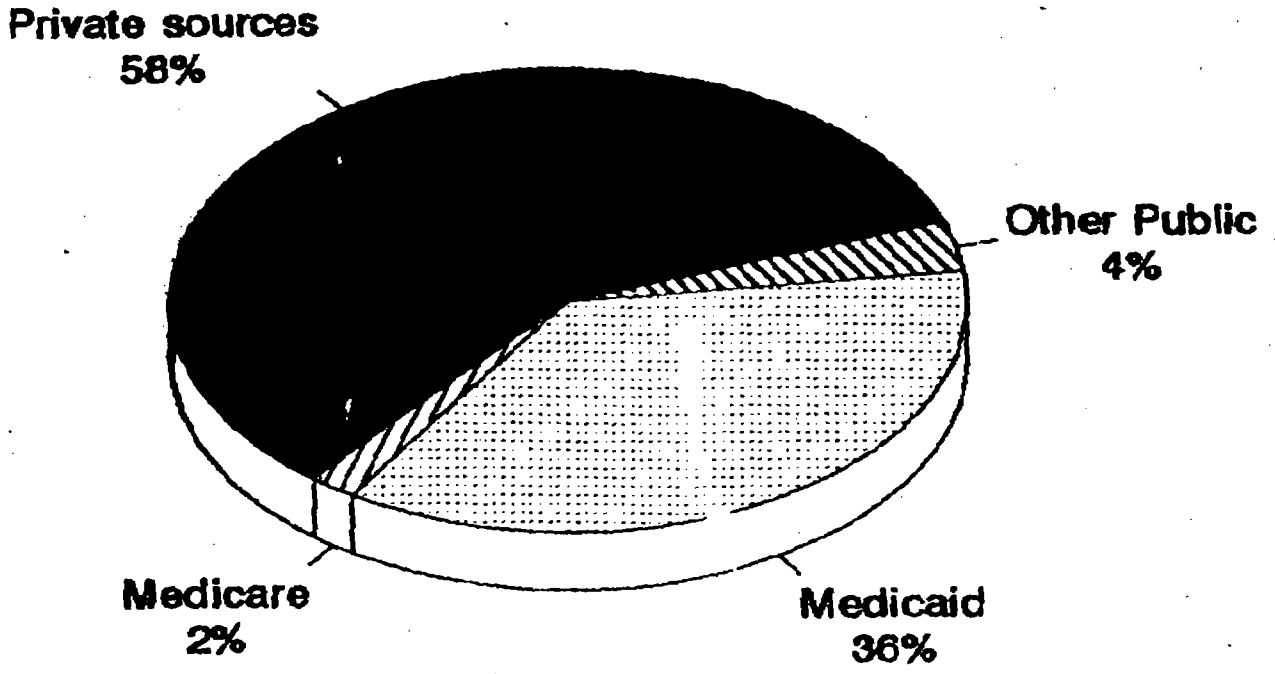
■ Risk HMO Enrollment ▨ Cost HMO Enrollment

Cost HMO Enrollment Numbers Include Cost HMOs and Health Care Prepayment Plans
Source: HCFA OMC

Chart

vvnat share do the elderly pay?

Nursing Home Expenses



1992

Source: HCFA/OACT

Chart