

THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AS A MODEL FOR MEDICARE REFORM

HEARING

BEFORE THE
SUBCOMMITTEE ON THE CIVIL SERVICE
OF THE
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GOVERNMENT REFORM
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SATURDAY, MAY 22, 1999

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON THE CIVIL SERVICE,
COMMITTEE ON GOVERNMENT REFORM,
Sanford, FL.

The subcommittee met, pursuant to notice, at 9:20 a.m., at Sanford City Hall, 300 North Park Avenue, Sanford, FL, Hon. Joe Scarborough (chairman of the subcommittee) presiding.

Present: Representatives Scarborough and Mica.

Staff present: John Cardarelli, clerk; and Ned Lynch, senior research director.

Mr. SCARBOROUGH. We call this committee meeting to order.

Good morning, and welcome to this field hearing of the Committee on Government Reform's Civil Service Subcommittee. Today, the subcommittee is going to hear from people concerned about the ways in which Americans will pay for the future costs of health care. Since it was established in 1965, Medicare has provided the primary means of insuring proper medical treatment for Americans over 65 years old. Like many Federal programs—Social Security, Medicaid, and Federal retirement benefits among them—Medicare has operated on a "pay-as-you-go" basis from the start. And, like each of those programs, the costs of past commitments are now coming home to roost.

Medicare's problems result from many of our genuine achievements in the medical treatment and improved lifestyles of our people. For multiple reasons, including important advances in medicine, people live longer. When Medicare was established in 1965, the lifespan of the average American was barely over 70 years old. Today, people who reach 65 can often look forward to an additional 20 years of life. We have not, however, been especially effective in planning for both the private and the public challenges facing us if we are to provide for our needs in those additional years.

The money coming into Medicare will no longer pay the full cost of health care that Medicare provides, while medical care costs continue to outpace inflation. In fiscal year 2000, President Clinton's budget forecasts that Medicare payroll taxes and premiums will fall \$92 billion short of the expenses that they are intended to cover. By 2010, Medicare's receipts are projected to be \$261 billion less than our anticipated expenses. Without effective corrective actions, the program will be insolvent.

In response to Medicare's deteriorating finances, Congress created a Bipartisan Commission on the Future of Medicare in the Balanced Budget Agreement of 1997. The Bipartisan Commission was charged with assessing the problems that we face and recommending solutions to extend the solvency of Medicare for the coming years. It was co-chaired by Senator John Breaux, a Louisiana Democrat, and Representative Bill Thomas, a Republican from California. After reviewing the Medicare program's financial and operational challenges, the Commission looked to the Federal Employees Health Benefits Program as a model of reform.

The Bipartisan Commission did not issue formal recommendations; 10 of the 17 commissioners agreed on an approach modeled after the Federal Employees Health Benefits Program, but the Commission's rules required 11 votes to issue recommendations. The Commission's majority reported its findings, however, and those findings will be the basis of both congressional and public discussion as we develop the laws and policies necessary to provide more secure health care for senior citizens. The Bipartisan Commission recognized that the current course of increasing deficits is unsustainable, and the majority identified sound principles that should guide Congress in shaping Medicare's future.

The majority concluded that the Federal Employees Health Benefits Program provided the most attractive model of reform available, and it was the most attractive because it relies heavily on market forces to develop responses to needs for health care services. Federal employees have an open enrollment season each year that enables them to choose from a variety of options to meet their health care needs. People seeking more extensive and expensive treatment options pay higher premiums, but all Federal employees' health insurance premiums are supported by a Federal payment. As a result of the Bipartisan Commission's report, some form of "premium support" is the emerging foundation of Medicare's future.

This approach is a marked departure from the Government's previous efforts to administer Medicare. So far, Medicare has established a history of command and control medicine. One witness today is going to report that this system has produced 111,000 pages of regulations while angering and threatening doctors and jeopardizing important health care services. As a result, Medicare has become a morass for both patients and providers. This welter of complex and confusing regulations has saddled doctors and hospitals with bureaucratic burdens that impede, rather than improve, health care for seniors. They have also added to the nightmares of our oldest and frailest citizens as they seek essential medical treatment.

The reforms outlined by the Commission majority seem to offer a promising alternative to the bureaucratic burden. We are going to learn more about those reforms today and the Commissioners' thinking on the issues. We invite you to join us in carefully examining different approaches to addressing Medicare's financial problems and providing a brighter future for Americans seeking health care in their senior years.

And now, I'd like to ask Congressman John Mica, who was the chairman of this committee last year, if he would, to please give us an opening statement.

Mr. MICA. First of all, Mr. Chairman, I want to welcome you to the 7th Congressional District of Florida. You're here in the heart of my district, and I appreciate your holding this hearing today, conducting it, and also giving an opportunity for our community and local hospitals, health care individuals, Federal retiree groups and Federal employee groups to hear a little bit more about proposals from the National Bipartisan Commission on the Future of Medicare and also how the Federal Employees Health Benefits Program can serve as a model for future reform measures that are being considered.

I have always been impressed with the Federal Employees Health Benefits Program. When I chaired Civil Service I was incredibly impressed with the fact that we have less than 200 employees administering a program that serves 9 million people—over 4.2 million Federal employees and retirees and nearly 5 million dependents—and doing so in a very cost-effective manner.

The heart of the Federal Employees Health Benefits Program, however, is based on competition and the ability to fairly compete, the ability to have a certain set of benefits prescribed and then allowing many vendors and health care providers to compete in an open and fair system, a very basic principle that has served us well for nearly four decades in providing health care benefits to our Federal employees and Federal retirees and their dependents. I think it's great to look at that as a model. I think that we do need to also be concerned about some of the problems that we've had, particularly of late, with the program, and that is that we have experienced some substantial increase in costs. But our previous hearings have revealed, in fact, that many of the costs are brought about by additional Federal mandates, additional Federal requirements, and additional Federal regulations where the Federal Government and the Congress, sometimes very well intended, has imposed additional requirements of the providers.

Not to say that we do not have problems that need to be addressed. For example, one of the greatest areas of costs, increased costs, not only to FEHBP but to health care, is prescription drugs. We've also had the experience of having imposed patients' bill of rights on the program by Executive order and have seen also that it has increased costs without providing any specific medical benefit.

So I think we need to use this as a model to look at the successes, the failures, and the problems of the system and adopt the good parts as we look for an alternative to Medicare, which is so important. I say that and repeat that as we continue to provide Medicare and many folks may want to participate in Medicare, but look at alternatives that can take pressure off of the system and provide an alternative, here's an alternative that's based on competition, based on experience, and based on a record of success.

So I salute you and the subcommittee in reviewing our good model and our good points and also the problem areas of FEHBP as we search for a model to provide good access and quality care to those who've worked so hard for this country to make it a success, our retirees and others who are taken into account by our Medicare program. I'm pleased that we are doing this hearing and, again, in my district.

So I thank you.

And one final note, Mr. Chairman, possibly later depending on your time and ability to hear requests, we have a statement from our National Association of Retired Federal Employees. Some of our NARFE folks I introduced you to are here today and I'd like to ask unanimous consent that their statement be made a part of the record.

Mr. SCARBOROUGH. Well, I'm not going to object. Without objection it'll be entered into the record. Certainly that and all this important testimony will be part of our record.

I thank you, Mr. Chairman, for your statements today.

I'd like to ask our witnesses if they would to please stand up and take the oath. If you could raise your right hands.

[Witnesses sworn.]

Mr. SCARBOROUGH. Please have a seat.

Today we're very pleased to have as witnesses Mr. Jeffrey Lemieux, who is staff economist for the Bipartisan Commission. He had previously worked in the Congressional Budget Office as health care policy analyst. He's going to be providing a discussion of the Bipartisan Commission's findings and discuss their majority position.

We also have with us today Ms. Grace-Marie Arnett, of the Galen Institute in Alexandria, VA. It's a research organization. Ms. Arnett has followed the health care issue as a journalist and as a policy analyst and she's written about the Bipartisan Commission's recommendations for several newspapers.

Our third panelist this morning is Ms. Becky Cherney, president of the Central Florida Health Care Coalition. She was recently recognized as central Florida's business woman of the year by the Orlando Business Journal and has been a tireless advocate of consumers in the health care industry.

I thank all three of you for showing up today to testify. If you would like to start, Mr. Lemieux.

STATEMENTS OF JEFFREY LEMIEUX, STAFF ECONOMIST, BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE; GRACE-MARIE ARNETT, PRESIDENT, THE GALEN INSTITUTE; AND BECKY CHERNEY, PRESIDENT, CENTRAL FLORIDA HEALTH CARE COALITION

Mr. LEMIEUX. Thank you. Thank you, Mr. Chairman, can you hear me OK with this mic?

Mr. SCARBOROUGH. Sure can.

Mr. LEMIEUX. I very much appreciate the opportunity to come down and meet you and talk to you about this issue. We on the Medicare Commission worked very hard and furiously to get an agreement and came very close. I think even though the formal report was not issued by the Commission, the plans that resulted are very powerful and very helpful. I want to spend a few seconds talking about the basics of the Medicare Commission plan. Then my statement goes into a fair amount of detail which I don't intend to talk about, but you can use as a reference if you wish. Instead of going through those details I'd like to talk about how the Commission evolved its position over the last 4 or 5 months. And I'll be happy to answer any questions you have.

The goal of the Breaux/Thomas Commission was to create a new Medicare that was new and modern and flexible. This program has been in place now for 30 years and it still, in some respects, seems 30 years old and in need of updating.

The Breaux/Thomas plan for beneficiaries has the impact of offering more reasonably priced drug coverage. It has the possibility of reducing the need for supplemental coverage. And it holds out the promise for lower premiums for the government and, of course, by extension, the taxpayer. It would aid the budget, we think. And it would gradually reduce the need, we think, for Federal micro-management of Medicare.

For health plans this system is designed to create more stability and less business risk in their operation so that they can cover Medicare beneficiaries with more of a sense of assurance that they'll be operating in a stable, fair, and competitive system. It might make a tougher competition for some of them, but we think it'll be fairer and more attractive.

And finally, for hospitals and health providers the hope is that this approach would lead to a less heavy-handed system of cost control than has been used in the past, lurching between cost control measures that can be quite difficult for providers to face.

The proposal would minimize the disruption to current beneficiaries. It's designed to remake Medicare, under new incentives, to be more competitive and more market-oriented, but at the same time, not to disrupt the current program. Now, what that means is that beneficiaries who are currently in the Medicare fee-for-service program or who are currently in a Medicare HMO, when this new system is implemented they shouldn't notice much of a difference. What that also means is that this proposal doesn't try to go through and rectify every Medicare problem or answer every question in Medicare all at once. This is a broad conceptual proposal that's intending to get Medicare right, not for the next year or the next 2 years or the next 5 years, but for the next decade or the next two decades or the next three decades. And as a result there will still be a great need for congressional oversight, for public input, and for continuing evolution of the program.

The Medicare Commission decided to take Medicare and move to a new entity to control the operations of all health plans. They call that the Medicare board, for lack of a better term. The Medicare board would control the competition between the fee-for-service plan, which would still be run by the Government, and all the private plans. They had many objectives with this Medicare board. They wanted it to create a fair competition. They wanted to reduce conflicts of interest. And they wanted to create stability. I'm going to tell you how we got there.

When we started in the Commission we broke up into two groups, one to study incremental reforms of Medicare, mainly by changes to the payment rates and changes to the compensation we give to health plans, and another task force to study more radical restructuring proposals.

We quickly decided that the first task force on incremental reforms didn't have much momentum or support. Nobody wanted to just say, well, let's reduce hospital payments, fees, a little bit. They

wanted something that was more long-term and more lasting. Few commissioners supported the incremental approach.

On the other hand, few commissioners supported a more radical restructuring, like a voucher plan or a defined contribution plan. "Defined contribution" is the term in Medicare for the Government deciding how much it's going to make available for Medicare and growing that by some index like CPI or GDP or something. And that was quickly rejected also as being probably too far-reaching and too risky.

They settled on a premium support proposal like FEHBP as an alternative between incremental tinkering with payments and of broader radical restructuring. The premium support proposal allows us to continue on Medicare in its current setup but also changes the incentives quite a bit. And here's how that works.

Under Medicare now, everybody has to pay a Part B premium, it's about \$500 a year now. It's expected to go up to about \$700 over the next several years. Nobody has a choice about that. I take that back. Most people don't have a choice about that. Almost everybody pays the Part B premium.

We took a look at the FEHBP formula, which instead says, if you choose an expensive plan you pay more than average and if you choose an inexpensive plan you pay less, and thought that that was a good start. Further looking at FEHBP, the commissioners and the majority decided that a powerful Medicare board would be a good thing to regulate the operations of the competition to make sure it was fair, to make sure that there wasn't risk segmentation, to make sure that there wasn't unfair competition or benefit packages that were designed not to help people with their medical needs, but rather, to attract the healthiest beneficiaries. And with a powerful Medicare board the commissioners decided that they could update the FEHBP premium formula to be more generous to beneficiaries.

So what they said was for a premium that's about average the beneficiary premium would be about what it is now under Part B. If it's for a premium higher than average they would have to pay the full difference. For a premium lower than average based on a schedule their entire premium could be phased out all the way down to zero.

Now, most people don't see their Part B premium now. It's in their Social Security check. They might not be too aware of it. But \$500 to \$700 a year is a significant amount of money, and the economists and others who studied this felt as though that would provide an incentive for people to be quite careful about the plans they select each year. And it would also provide an incentive for the government-run fee-for-service plan to be very careful with its costs, because beneficiaries would be more aware of how uncontrolled cost growth would be costing them and preventing them an opportunity.

After we settled on the competitive aspects, which are pretty widely agreed among commissioners, including beyond the 10 who voted for the plan, the next tough question was prescription drugs. There were several intentions there. The first thing was we wanted to get prescription drug coverage for low income beneficiaries just as soon as possible. And the plan includes a full subsidy for pre-

scription drug coverage for beneficiaries under 135 percent of poverty, which is a threshold that's used for some other reasons in Medicare.

The second way we wanted to get prescription drug coverage to beneficiaries is by requiring all plans to have a high option including prescription drugs. And that includes the government-run plan, the fee-for-service plan.

The third thing that was very important to the commissioners was limiting the expense and not creating a new very expensive entitlement and not substituting too much for the drug spending that people currently undertake privately. And I think that they intended to create a start on a drug benefit here, they intended to fund it for the poor and at least make it a fair deal for everyone else and make it available for everyone else.

In the final days of the Commission, when we were negotiating with the administration, there were some other items that aren't in the plan itself. We considered a high income premium; high income beneficiaries would have to pay an extra premium, and the intention of that was to provide additional financing for subsidies for high option plans to make high option plans a little bit cheaper. So in addition to just being fairly priced, to try and make them better than fairly priced with government subsidy. We couldn't get an agreement on that, and that was dropped out of the final plan.

Let me just say that as economists and policy analysts we are very pleased by the progress here and we're also pleased by the focus. I mean, we always focus on Medicare's financial crises. That's helpful, I guess, politically, to force Members of Congress and the public to address the issue. But what's more important is trying to create a better Medicare taxpayers, future beneficiaries and current beneficiaries. This program could use that second look, and we think that the Breaux/Thomas plan provides a good starting point.

I'll be happy to answer your questions.

[The prepared statement of Mr. Lemieux follows:]



Hearing on FEHBP and Medicare Reform

Testimony of Jeff Lemieux
Senior Economist
Progressive Policy Institute

United States House of Representatives
Committee on Government Reform and Oversight
Subcommittee on Civil Service

Saturday, May 22, 1999

Introduction

Thank you for this opportunity to testify on the Medicare Commission's efforts to use the Federal Employees Health Benefits Program (FEHBP) as a model for Medicare reform. This presentation includes a brief overview, a more detailed explanation of the proposal advanced by Senator Breaux and Representative Thomas, a discussion of some of the issues that divided the Medicare Commission, and a commentary that argues for a step-by-step process for Medicare reform using the Medicare Commission's work as a guide.

Summary—The Breaux/Thomas Proposal for Medicare Reform

The federal employees' health system has been successful in controlling the growth of enrollees' premiums and taxpayers' obligations. It has also successfully balanced innovation and standardization in health benefits. Each year, federal employees choose from a wide variety of plans, ranging from fee-for-service plans to HMOs to everything in between. They receive clear comparative information about the available plans. If they choose expensive plans, they pay more. Inexpensive plans have lower premiums both for the enrollee and the government.

Senator John Breaux (D-La.) and Representative Bill Thomas (R-Ca.), the co-chairmen of the National Bipartisan Commission on the Future of Medicare, propose to use the Federal Employees Health Benefits Program (FEHBP) system as a model for the future of Medicare. On the 17-member Commission, the proposal received 10 yes votes—all from members of Congress and Congressional appointees. That was one short of the eleven-vote supermajority needed for a formal recommendation and report.

The intention of the Breaux/Thomas proposal is to get the basic design of the Medicare program right, not for the next year or two, but for the coming decades. It is a broad conceptual proposal that does not prescribe every specific rule in advance. All plans serving Medicare beneficiaries, including the traditional fee-for-service plan, would compete under the supervision of a new entity, dubbed the Medicare Board. The Board would have some latitude to adapt Medicare to changing times, and the proposal would allow the Health Care Financing Administration (HCFA) additional flexibility in operating

the traditional fee-for-service plan.

The proposal is designed to encourage all types of plans—national, regional, or local, HMO, fee-for-service, or everything in between, and public or private—to serve Medicare beneficiaries. Recognizing that the plans of the future may be different from those available now, the proposal envisions a fair and even-handed system, called premium support, under which all types of plans could compete.

The premium support system in the Breaux/Thomas proposal is based on these principles:

- ▶ fair competition between the government-run fee-for-service plan and private plans
- ▶ minimal disruption for current beneficiaries in either the fee-for-service plan or private plans
- ▶ fair competition between local, regional, and national plans
- ▶ real opportunities for national and other wide-area plans to enter the Medicare market
- ▶ enhanced stability in the service areas and benefits of private plans
- ▶ a competitive fee-for-service plan

The Breaux/Thomas plan would create a viable prescription drug benefit in Medicare, fully subsidized for the poor, and available to all beneficiaries. The drug benefit proposal would:

- ▶ ensure drug coverage for beneficiaries up to 135 percent of poverty,
- ▶ allow more reasonably priced drug coverage for all beneficiaries via high option and Medigap plans, and
- ▶ limit the substitution of government-paid benefits for privately-paid benefits.

The goal of the Breaux/Thomas plan is to create a more flexible and modern Medicare program. For beneficiaries it offers more reasonably-priced drug coverage, a reduced need for supplemental coverage, and the promise of lower premiums. For the government (and by extension, the taxpayer) it would aid the budget and gradually reduce the need for federal micromanagement. For health plans, it offers greater stability and a more businesslike atmosphere, with fairer, but tougher, competition. For hospitals and health providers, it would bring a less heavy handed approach to cost control than has been used in the past.

The proposal would minimize disruption to current beneficiaries even as it remakes Medicare and its incentives. That means that beneficiaries remaining in the fee-for-service system or in a current Medicare HMO would not notice a dramatic change when the proposal was implemented. That also means that the proposal does not attempt to answer every question or rectify every perceived inequity in Medicare. Important operational questions would be left to future Boards and the political and oversight responsibilities of future Congresses would certainly not disappear.

Exhibit 1 summarizes the proposal and compares it with current Medicare law.¹ The following sections highlight the key elements of the proposal and discuss some issues of concern to Commissioners.

Proposal Basics

Premiums. The Breaux/Thomas proposal would change the Medicare entitlement from the government paying 100 percent of Part A (mostly hospital care) and 75 percent of Part B (mostly outpatient and physician services) to the government paying 88 percent of a combined Medicare. The 88 percent figure approximates the government's share of overall program costs under current law when the new system would be implemented.² The combined Medicare spending would grow at the average rate of growth in the premiums of plans beneficiaries chose, including the traditional Medicare fee-for-service plan and private plans. By contrast, current Medicare spending is based only on the fee-for-service program.

Each year, beneficiaries would have significant financial incentives to choose efficient plans. On average, beneficiaries would pay 12 percent of the premium for a standard plan. But beneficiaries choosing costlier-than-average plans would pay the full extra cost themselves and beneficiaries choosing plans with premiums less than 85 percent of the average would pay no premium at all.³ Currently, all beneficiaries must pay at least the Part B premium. (This year, 25 percent of Part B is equal to about \$500. When the transfer of home health spending from Part A to Part B under current law is completed, the Part B premium will be about \$700 annually.)

Exhibit 2 shows an example of a Breaux/Thomas premium support schedule. In the example, the average premium for standard benefits is about \$5,700. Therefore, a beneficiary would pay an annual premium of about \$700 (12 percent) for a plan priced at the national average.

Benefits. Parts A and B would be combined, but Medicare's standard benefits would not change. The current Part A per-admission hospital deductible (currently \$768) and the annual Part B deductible of \$100 would be replaced by a combined annual deductible of \$400. Coinsurance of ten percent would be charged for home health and laboratory services. No coinsurance would be charged for inpatient hospital stays and preventive care.⁴

The standard benefits specified in law would consist of all services covered under the existing Medicare statute. As under current law, private plans could establish their own rules on exactly how the benefits would be provided. Board approval would be required for all benefit design offerings and changes.

Every plan (including the fee-for-service plan) would offer a high option that would include Medicare's standard benefits plus drug coverage⁵. Drug benefits would be fully subsidized for beneficiaries under 135 percent of poverty.

The minimum drug benefit for high option plans would be based on standards and examples set by the Board. In the fee-for-service plan, HCFA would contract with or enter joint marketing arrangements with private insurers offering prescription drug benefits. That would create a public/private high option plan or plans, with HCFA providing

coverage for the standard benefits and its private partner(s) providing coverage for drugs. HCFA's share of the premium in a public/private high option plan would simply be the premium for its standard option plan. In the longer run, the proposal allows HCFA to contract more completely with private plans for its standard benefits as well, although no transition steps or timetables are specified and HCFA is not necessarily required to pursue that option.

Competition. Under current law HCFA runs the fee-for-service plan and controls the terms of competition between that plan and private plans. Under the Breaux/Thomas proposal, the Board would administer the competitive environment. HCFA's role in Medicare would be focused on administering the fee-for-service plan, and the fee-for-service plan would be treated as any other plan by the Board.

As under current law, the fee-for-service plan would set a national premium and its enrollees would pay one flat amount, regardless of where they live or move. The fee-for-service plan's large enrollment guarantees that its premium would be very close to the national average when the premium support system was implemented. Therefore, in both method and amount, the initial fee-for-service premium under the Breaux/Thomas proposal would be similar to the Part B premium under current law.

Payments to all plans would be adjusted for the demographics, risk, and geographic location of their enrollees. The payment adjustments are needed to ensure that plans serving more or less expensive enrollees are paid fairly, and that in their premiums reflect real value differences. The geographic adjustments would allow fair competition between local and national or wide-area plans.⁶ If early versions of the risk adjuster would otherwise fail to prevent excessive premium differences between high and standard option plans, the Board's actuaries could require that differences in premiums reflect the difference in value of benefits offered for private plans with multiple benefit options.

Under current law, HCFA sets reimbursement rates for private plans by county. Private plans decide whether or not to offer Medicare options at that rate. If the rate is insufficient, they may collect an additional premium from beneficiaries. Because many hesitate to charge additional premiums, plans sometimes adjust to changes in costs or HCFA reimbursements by changing their service areas or benefits.

The premium support system in Medicare would provide a more stable environment to ensure plan participation. Rather than adjusting to administratively-set reimbursements, they would set their own combination of benefits and premiums through negotiations with the Board. All enrollee premiums would be collected by the Board, freeing plans from collection costs. Although Medicare law now allows private plans other than HMOs, its reimbursements and regulations focus on local areas. PPOs and other types of plans that often serve wider areas are unlikely to proliferate in Medicare under those rules. Like the Federal Employees Health Benefits program, the premium support system proposed by Senator Breaux and Representative Thomas is designed to encourage the full variety of plans to serve Medicare beneficiaries.

The proposal envisions that Congress would prevent payment rates in the fee-for-service plan from increasing to levels that would make its premium uncompetitive with private plans. It would allow HCFA to manage its payments and contracts in areas where its rates were uncompetitive.

Trust Fund. The Breaux/Thomas plan would create a combined Medicare trust fund that would include all three sources of funds: payroll taxes, premiums, and general revenue contributions. Without further Congressional action, general revenue contributions would be allowed to grow only as fast as program spending if they otherwise would exceed 40 percent of Medicare's finances.

Other Items. The proposal would gradually raise the normal age of Medicare eligibility from 65 to 67. Policies to soften the blow for affected beneficiaries could include adding a new category of eligibility based on need and instituting a voluntary buy-in.⁷ Direct subsidies for teaching hospital would be carved out of Medicare; that funding would be placed elsewhere in the budget.

The proposal would significantly remake the Medigap market to conform with the combined Medicare program, to require Medigap coverage or prescription drugs, and to allow varying degrees of coverage of Medicare coinsurance and deductibles. Although the proposal does not address it, the transition policy to a remade Medigap market would be very important, especially with respect to the newly-required prescription drug coverage.

Items Left on the Table. One item considered by the Commission, but not included in the Breaux/Thomas proposal, was an income-related premium. For implementation reasons, the income related premium would have been retrospective, handled by or in conjunction with the income tax system. Although that sort of extra premium would have a negligible impact on beneficiaries' health care consumption, it was proposed for fairness reasons and for the savings it would bring.

Also considered in the waning days of the Commission were extra subsidies for high option plans. Those subsidies could have been included in the final premium schedule. An extra subsidy of 10 or 15 percent of the average additional cost of high option plans would have provided an additional incentive for beneficiaries to choose high option plans without greatly affecting the market for employment-based supplemental coverage or too greatly exposing the government to the fast-growing costs of prescription drugs.

Key Issues in the Medicare Commission

Premiums in Fee-For-Service and Private Plans. Some Commissioners expressed concern that if HCFA and Congress could not control the cost of the fee-for-service plan, beneficiaries in that plan could have higher premiums than under current law. That concern is valid since the premium support system would put the fee-for-service plan in direct competition with private plans. Although the average enrollee premium would be pegged at 12 percent of standard option premiums under the proposal, there is no guarantee that the fee-for-service premium will remain at 12 percent. Over time, if its premium grew faster than those of private plans, its enrollees would pay more. That in turn, would put considerable pressure on both HCFA and Congress to keep its costs in line.

Over the next 25 years under current law, however, Medicare Part B premiums are expected to rise to about 14 percent of overall Medicare costs (see Exhibit 3). The baby boom generation will enter Medicare in large numbers beginning in about 2010. In their

first 10 or 15 years on Medicare, the baby boomers will be heavy users of Part B (outpatient) services, driving up Part B costs relative to Part A and raising the percentage of overall program costs that the Part B premium represents.

Pegging the premium at 12 percent, therefore, will lower average beneficiary premiums compared with current law. Whether or not the fee-for-service premium would be higher under premium support than under current law will depend on how well the fee-for-service plan can control its costs.⁸ In any case, because the fee-for-service plan will hold a large market share for some time to come, premium changes relative to current law would probably be very gradual. That should give HCFA or Congress ample time to bring fee-for-service payments in line with those of private plans if fee-for-service premiums would otherwise grow too fast.

Prescription Drugs. Some Commissioners decried the absence of large government subsidies for prescription drug coverage. The Breaux/Thomas plan would create a viable prescription drug benefit in Medicare, fully subsidized for the poor, and available to all beneficiaries.

The proposal would explicitly subsidize drug coverage for the poor. In the short run, that coverage would be provided through the Medicaid program. When the premium support system was implemented, the coverage would be provided through special subsidies for high option plans in Medicare. The new drug subsidies would probably increase the participation in subsidies available under current law (for premiums and cost sharing). Ultimately, all such subsidies could be combined into a generous premium support schedule for low-income beneficiaries.

The Breaux/Thomas proposal does not explicitly subsidize drug coverage for those above 135 percent of poverty. The Board would have the power, through risk adjustment and negotiation with plans, to ensure that plans' high option offerings would be available at a fair price. Therefore, additional subsidies would not be necessary to prevent risk selection from driving up the cost of high option plans. Furthermore, large additional subsidies could spur employers to drop retiree wrap-around coverage, which often includes drug benefits. Although employer coverage for retirees will probably continue to weaken, the Breaux/Thomas proposal would not accelerate that trend.

Financing. Since most Commissioners agreed that the merger of Parts A and B of Medicare was desirable, the financing question boiled down to how best to create a combined Medicare trust fund. (The Commission did not address the more fundamental question of whether or not trust fund financing should be used for Medicare.)

Trust funds for entitlement programs are created more for political than economic reasons. Economically, trust funds have little meaning. The entitlement alone determines the government spending obligation, and dedicating certain revenues to that obligation does not change the overall federal budget surplus or deficit. Furthermore, all Medicare trust funds, current and proposed, are cash-flow funds. Their balances would not be sufficient to pay benefits for much more than a year if their revenues ceased.

Politically, however, trust funds can send very important signals. A dedicated source of revenue can reassure or comfort future beneficiaries. Dedicated revenues make the program seem permanent—a social or generational contract. Trust funds can also add

an important discipline against unrestrained program spending. The impending insolvency of a fund signals the public and Congress that action must be taken.

For reassurance, trust funds work politically only if beneficiaries believe that the government would not "spend" the "fund" on something else. For discipline, a trust fund can only work if the consequences of the fund's insolvency seem serious. Whether or not benefits would be paid without disruption must be murky enough that politicians and beneficiaries alike think that insolvency should be avoided.

Currently, the Medicare Part A fund emphasizes discipline as much as reassurance. Its dedicated revenue is mostly from payroll taxes, which are not expected to rise as fast as Medicare spending in Part A. The Part A fund is expected to go broke soon after the baby boomers begin to retire. The Part B fund is mostly a comfort fund. Its sources of revenue are split between beneficiary premiums (25 percent) and general federal revenues (75 percent). Since neither the premiums nor the general revenue contributions are limited, both will rise indefinitely to match Part B spending. The Part B fund cannot go broke.

The Breaux/Thomas plan is more of a reassurance fund than that current Part A fund, since it would allow general revenue contributions to grow at the same rate as overall program costs, even after the 40 percent cap was reached. But it would impose more fiscal discipline than the current Part B fund because, combined with payroll taxes and beneficiary premiums, the combined fund could still run out of money.

All of the policies in the Breaux/Thomas plan would probably reduce the growth of Medicare spending by about 1 percent a year-enough to squeeze another 4 or 5 years out of a combined trust fund without additional taxes, premiums, or spending restraints.

The estimates are highly uncertain, however, and they are far from vital to the Medicare financing debate. The question of the degree of fiscal discipline in a combined Medicare trust fund should be answered politically-it is not fundamentally a economic or estimating issue.

Estimates. The staff estimates of the Medicare Commission's plan were based on the assumption that spending in the unrestrained fee-for-service program (which would determine Medicare spending under current law) would grow faster than the blend of fee-for-service and private plan premiums that would determine Medicare spending under premium support.⁹ Therefore the premium support plan would slow the growth of Medicare spending. The estimated savings were roughly in line with those used by CBO during the debate on health reform proposals that would have spurred competition among health plans. Exhibit 4 shows the short-term cost estimate I prepared for the Medicare Commission.

The estimates used CBO's projection for the growth of private health insurance premiums as a guide to the likely growth of premiums for private plans under a premium support system for Medicare. CBO assumes that competition among health plans, and careful purchasing by the employers who arrange most private health insurance, will help hold the growth of private premiums to a slower rate than that seen prior to the early 1990s. A premium support system in Medicare would create a competitive purchasing environment similar to that expected in the market for private insurance for workers.

In all probability, the fee-for-service plan will continue to hold a large market share under premium support. In the absence of restraints in the fee-for-service plan, therefore,

savings from the premium support system would accrue slowly. A modest sustained reduction in the growth of Medicare spending, however, can compound to significant savings for the program in the long-run.

HCFA's estimates of the premium support plan, which started from a more optimistic (lower) baseline for fee-for-service and a more pessimistic (higher) baseline for the growth of private premiums, showed less savings than the staff estimates in the long run.¹⁰ Based on more aggressive assumptions about beneficiary switching behavior, however, HCFA estimated that the shorter-run savings would be higher than those estimated by the staff.

Some Commissioners argued that the estimates were too optimistic about Medicare savings. In a sense they were disagreeing with other Commissioners who argued that the premium support system would drive fee-for-service premiums above those of private plans. The two effects—Medicare savings and the performance of the fee-for-service plan—are directly linked. If private premiums fell below that of the unrestrained fee-for-service plan under premium support, Medicare outlays would be reduced compared to current law. If the fee-for-service plan found new ways to keep its costs in line with those of private plans, then everybody would win. That, ultimately, is the goal of premium support.

But even if the premium support system did not work to slow the growth of Medicare spending and there were no savings, beneficiaries would be no worse off. The fee-for-service system would still be in place, and its premiums would be no higher than they would otherwise have been.

Perspective

The primary motivation for Medicare reform should be the search for value, not the crisis in Medicare's finances. For significant reforms to work, both political parties and most people, working and retired, taxpayers and beneficiaries, must understand that the reforms are valuable to them. Although economists preach against the undue hope for free lunches, efficiency gains that would offer the hope for both better benefits and lower premium and tax burdens are probably possible in Medicare. Efficiency gains in Medicare could free up national resources for any number of important purposes.

The premium support system proposed by Senator Breaux and Representative Thomas has the potential to unlock efficiencies in the fee-for-service plan as well as in private plans. Fee-for-service beneficiaries in a competitive system, seeing the connection between cost control and lower premiums, could prod HCFA to work more carefully to control costs. Pressure from direct competition could aid HCFA's management, and management successes would help build the political trust necessary for HCFA to gain more and more flexibility from a skeptical Congress.

The Breaux/Thomas proposal can be viewed as a blueprint for a series of reforms. The first steps should be moving the oversight of Medicare's private plans from HCFA to the newly-created Board and launching the prescription drug subsidies for low-income beneficiaries. The Board should then work with Congress and the Administration to transition from the current system to premium support. That work would include performing detailed studies of alternative bidding and payment adjustment techniques and

building the logistical capability to run a premium support system. In anticipation of greater administrative flexibility and responsibility, HCFA should begin searching for high-option partners and reporting its plans for a more businesslike management of the fee-for-service plan to Congress in detail. The specific legislative authority for the changes could proceed in stages.

The challenge for the Board would be to raise the comfort level of current and future beneficiaries, HCFA and the Administration, Congress, health plans, and health providers as the new system takes shape. Medicare is too important to reform in any but the most careful ways; to meet the challenge, the preparations must be rigorous.

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Endnotes

1. Because the proposal contains few details, this paper is at best an interpretation, not a definitive explanation.
2. Based on current projections, all of Part A and 75 percent of Part B would equal 88 percent of Parts A and B combined if the home health transfer (enacted in 1997) was completed. If the projections changed prior to implementation, the percentage could change as well.
3. In areas where only the government-run fee-for-service plan operated, the beneficiary obligation would be limited to the lower of 12 percent of the fee-for-service premium or 12 percent of the national weighted average premium.
4. Although their final proposal does not mention it, I believe the authors' intention was to eliminate the current-law limitation on the number of hospital days covered by Medicare.
5. Private plans in Medicare generally have out-of-pocket maximum projections (stop-loss) for covered services. That would be a requirement for high option plans under the proposal.
6. To minimize disruption to current HMO enrollees, the level and type of geographic adjustments initially would be similar to those anticipated under current law. For illustrative purposes, the Commission used a 50-50 blend of historical fee-for-service payments and an input price index. That was meant to approximate the level of geographic adjustment in current law when provisions of the Balanced Budget Act of 1997 are fully implemented. Geographic adjustment for high option plans could differ from those used for standard option coverage.
7. Although the buy-in was intended to be budget neutral, a budget neutral buy-in policy may be impossible to devise. The cost estimates attached to the Medicare Commission's proposals did not include the cost of a buy-in.
8. My simulations of fee-for-service and private premiums for the Medicare Commission showed that with modest cost control in fee-for-service, premiums remained lower than under current law. With no cost control, however, fee-for-service premiums would exceed those expected under current law by 2020.
9. Staff and other estimates are available on the Medicare Commission's web site: medicare.commission.gov.
10. For its estimates, HCFA's uses a baseline for Medicare spending that assumes the growth of fee-for-service spending will slow in the future, even absent changes in Medicare law. The Commission used two current-law baselines for fee-for-service spending in Medicare: one more optimistic like HCFA's' and one that did not assume the growth of fee-for-service spending would slow in the years ahead. HCFA's baseline for private insurance assumes a growth rate of about 3 percentage points above the growth of nominal GDP. The Commission used CBO's baseline, which assumed a growth rate of one percentage point above GDP. That baseline was adjusted proportionately to be consistent with either baseline for fee-for-service spending.

Exhibit 1. Comparison of Current Medicare Law and the Breauz/Thomas Proposal

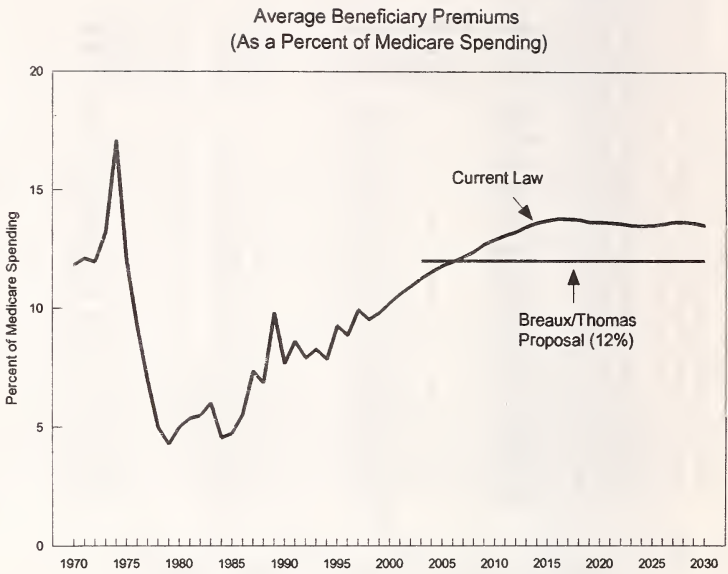
Current Law	Breauz/Thomas
<p>Entitlement: All of Part A benefits, 75% of Part B benefits. Based on fee-for-service.</p>	<p>Entitlement: 88% of combined Parts A and B benefits based on weighted average cost of fee-for-service and private plans.</p>
<p>Premiums: Premium is 25% of Part B. Same premium paid by all. Extra premium for some private plans.</p>	<p>Premiums: 12% of national average premium (combined Part A and B) on average. Inexpensive plans could have no premium; those choosing expensive plans would pay higher percentage.</p>
<p>Prescription Drugs: Only available in certain HMOs.</p>	<p>Prescription Drugs: All plans (including gov't fee-for-service) have a high option with standard benefits plus drugs.</p>
<p>Deductibles and Coinsurance in Fee-for-Service Plan: \$768 hospital deductible (per admission). \$100 Part B annual deductible. Limits on hospital days. No coinsurance for lab and home health.</p>	<p>Deductibles and Coinsurance in Fee-for-Service Plan: \$400 annual combined deductible. No limit on hospital days. 10% coinsurance for lab and home health.</p>
<p>Choice of Plans: Mostly HMOs and gov't-run fee-for-service plan. Locally-based payments and regulations not likely to attract PPOs, POS plans, and private FFS plans.</p>	<p>Choice of Plans: FEHB-style system (with risk and geographic adjustment) would encourage wide-area private PPOs, POS plans, and FFS plans as well as local HMOs.</p>
<p>Assistance for Low-Income: Medicaid pays for Medicare premiums up to 135% of poverty and cost sharing up to 100% of poverty. Dual eligibles (generally well below poverty) get drugs.</p>	<p>Assistance for Low-Income: Full subsidy for prescription drugs up to 135% of poverty, initially through Medicaid. Federal responsibility for all additional cost (incl. higher participation) with state maintenance of effort.</p>
<p>Trust Funds: Part A fund based on payroll tax receipts. Part B fund is 25% premiums and open-ended general revenue for other 75%. Part A and B funds affected by transfer of home health from A to B.</p>	<p>Trust Fund: Combined fund with payroll tax, premium, and general revenue receipts. General revenues cannot grow faster than overall Medicare spending if they would otherwise exceed 40% (without further Congressional action).</p>
<p>Education and DSH: Administered as part of Medicare entitlement.</p>	<p>Education and DSH: Carve out direct medical education, fund that activity through normal appropriations process—raise caps on appropriated spending to accommodate. Study long-term appropriation for DSH and IME funding outside of Medicare.</p>
<p>Retirement Age: 65</p>	<p>Retirement Age: Gradually raised from 65 to 67 to conform with Social Security normal retirement age. Possibly new disability or need-based eligibility for those 65-67 or waiting period reduced. "Budget neutral" buy-in for 65-67.</p>
<p>Medigap: A-J plans generally cover deductibles and coinsurance. Drug coverage is an add-on, usually expensive due to self-selection.</p>	<p>Medigap: Federal directive to NAIC to develop new model plans. All plans to include coverage for prescription drugs. One plan drug-only. Plans to vary on the degree they cover Medicare coinsurance.</p>

Exhibit 2.
Premium Support Schedule

Annual Premium (in dollars)	Premium as a Percent of the National Avg.	Enrollee Share	Enrollee Share (in percent)
4500	79%	0	0%
4600	81%	0	0%
4700	82%	0	0%
4800	84%	0	0%
4900	86%	78	2%
5000	88%	156	3%
5100	89%	234	5%
5200	91%	312	6%
5300	93%	390	7%
5400	95%	468	9%
5500	96%	546	10%
5600	98%	624	11%
5700	100%	702	12%
5800	102%	802	14%
5900	104%	902	15%
6000	105%	1002	17%
6100	107%	1102	18%
6200	109%	1202	19%

Note: In this example, the National Weighted Average Premium is about \$5700

Exhibit 3.



Note: Part B premium under current law vs. 12 percent of national average under the Breux/Thomas proposal.

Exhibit 4. Breaux/Thomas Proposal, March 14

(by calendar year)

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2000-2004
2004 2009

Cost (+) or Savings (-) in Billions of Dollars

Premium Support	0	0	0	-2	-4	-6	-9	-11	-15	-19	-23	-29	-35	-42	-5	-65
Drug Coverage up to 135 Percent of Poverty ¹¹	2	2	2	3	3	3	3	4	4	5	5	6	6	7	12	31
Extra Participation in Current Low-Inc. Programs ¹²	2	2	2	3	3	3	3	4	4	4	4	5	5	5	5	12
Cost Sharing Changes and Medigap	0	0	0	-1	-2	-3	-3	-4	-5	-5	-6	-7	-8	-8	-4	-24
Removal of DME ¹³	0	0	0	-4	-5	-5	-5	-5	-6	-6	-6	-7	-7	-7	-9	-36
Age of Eligibility	0	0	0	-1	-1	-1	-1	-2	-2	-3	-4	-4	-5	-5	-1	-11
Slowdown of Growth in Govt FFS Plan ¹⁴	0	0	0	-1	-2	-4	-5	-7	-9	-10	-12	-14	-17	-19	-4	-39
Premiums	0	0	0	-2	-1	0	1	2	4	5	7	9	11	13	-4	9
Limit Enrollee Share to 12% in Areas Where There is no Alternative to the FFS Plan	0	0	0	0	0	0	0	0	1	1	1	1	1	1	0	3
Total	4	4	5	-6	-9	-11	-10	-20	-24	-29	-34	-41	-48	-55	-1	-102
Average Monthly Premium:																
Government-run FFS plan	\$76	\$60	\$64	\$69	\$63	\$68	\$63	\$68	\$103	\$108	\$108	\$114	\$119	\$125		
Government-run plan in no alternative areas	\$75	\$79	\$64	\$68	\$62	\$66	\$62	\$66	\$90	\$101	\$106	\$111	\$116	\$120		
Private plans	\$75	\$79	\$62	\$66	\$60	\$64	\$60	\$62	\$92	\$102	\$106	\$110	\$114	\$114		
Average of all plans	\$75	\$79	\$64	\$68	\$62	\$66	\$62	\$66	\$90	\$101	\$106	\$111	\$116	\$120		
Monthly Part B Premium under Current Law	\$71	\$77	\$64	\$61	\$66	\$60	\$66	\$60	\$100	\$115	\$123	\$132	\$141	\$151		
Items Not Included (Cost + or Savings - in billion of dollars)																
Premium Subsidies in High Option Plans	0	0	0	1	1	1	1	2	2	2	2	2	3	3	2	10
Option: 10 Percent of Private Drug Cost	0	0	0	3	3	4	5	6	7	8	8	10	10	12	6	33
Option: 25 Percent of Private Drug Cost	0	0	0	3	3	4	5	6	7	8	8	10	10	12	6	33
Option: 50 Percent of Private Drug Cost	0	0	0	4	5	6	8	10	10	11	13	14	16	18	10	55
Income-Related Premium	0	0	0	-4	-5	-6	-6	-10	-10	-11	-13	-14	-16	-18	-10	-55

Source: Medicare Commission Staff

Notes: Stacking order is from top to bottom. Except for premium interaction, can peel off from bottom to top without affecting other items (estimate assumes enactment in 1999, with implementation of the premium support system and most other policies in 2003).

Estimate assumes avg. drug cost in private high option plans was about \$675 in 2003, growing to \$1,690 in 2013.

That is consistent with lightly managed drug coverage with \$500 deductible, 25% coinsurance, and \$2,500 out-of-pocket maximum (stop loss).

The estimate assumes that 30% of beneficiaries were in areas where FFS was the only alternative in 2003.

Over time, that percentage would gradually fall. If national private plans developed, it would fall to zero.

In this line method, the results are approximately the same using either of the Commission's baselines.

¹¹ Assumes 100% federal funding with a state maintenance of effort for dual-eligible beneficiaries. Participation rate assumed to be about 60 percent.

¹² Assumes 100% federal funding for the cost of expanded participation in current assistance (premiums and cost sharing).

¹³ Savings to Medicare, but not necessarily to the overall budget.

¹⁴ Follows the method of the non-traditional estimate of Feb. 17, which assumed that the fee for service plan would compare to some extent

Mr. SCARBOROUGH. Thank you for your testimony.

Ms. Arnett.

Ms. ARNETT. Thank you very much. How's this? Can you hear this OK? Hold it closer? Good.

Thank you, Mr. Chairman, Mr. Mica, for inviting me to testify before your committee today.

My name is Grace-Marie Arnett; as you've said, I am president of the Galen Institute. We focus on promoting a more informed public debate over individual freedom, consumer choice, competition, and diversity in the health sector.

The Galen Institute also facilitates the work of the Consensus Group, which is composed of about 20 other health policy analysts, who have been meeting together since 1993 to promote public education about free-market health reform ideas. We have a couple of principles that we have developed on Medicare reform as part of a longer statement, but basically we believe that the reform of the Medicare system should expand private sector options for beneficiaries. They should be able to either elect to participate in current Medicare or to purchase health coverage or medical services of their choice in the private competitive health sector.

We also believe that Medicare benefits should be defined in terms of a dollar amount, rather than in terms of an open entitlement to covered services.

We hope that these principles also might be useful in guiding the congressional debate as well.

This morning I would like today to do two things: First, to do a brief overview of why Medicare needs to be reformed, not only because of the future insolvency of the program, but also because of restrictions being placed on today's beneficiaries. And then I would also like to talk about FEHBP as a model for Medicare reform.

In 1998, as you all know very well, Medicare spent \$214 billion to provide health services for 39 million beneficiaries. The bi-partisan Medicare Commission was created because virtually everybody in the policy community, economists and anyone who studies Medicare, realizes that the current system is unsustainable as 77 million baby-boomers start to hit eligibility for Medicare.

The tax burden on today's college students, if nothing is done to change Medicare, would triple from the current 5 percent of gross domestic product to 14 percent by the time they would retire.

As you mentioned in your statement, Mr. Chairman, Dr. Robert Waller, who is the former head of the Mayo Clinic Foundation, which runs the Mayo Clinics, had his staff count the number of pages of rules, government rules, that his facilities must comply with in order to treat Medicare patients. They counted 111,000 pages of Medicare rules and regulations. That's three times more pages than in the Federal tax system. It's impossible for any physician or even an organization like the Mayo Clinic to know what is in those regulations. It's certainly impossible for any physician to try to treat a Medicare patient and not fear they're running afoul of Medicare rules.

I'd like to offer a few examples of why Medicare is a bad deal for today's beneficiaries. Two years ago there was an article in the Washington Post which reveals where a centralized, government-

run health care program can lead. The lead of the news article—this is not a commentary, it's a news article—said,

People in hospice programs are not dying fast enough to satisfy Federal Government auditors. Washington is conducting special reviews of hospice records and calling for repayment of money spent under Medicare for people who live beyond the expected 6 months that they had enrolled for hospice care. This get-tough policy is part of the government's Operation Restore Trust, a special program designed to combat waste, fraud, and abuse in Medicare.

Apparently Federal auditors believe that Medicare patients who are living too long represent waste, fraud, and abuse.

The waste, fraud, and abuse regulations, however, are having a serious impact on today's beneficiaries. Let me tell you a little bit about a couple of doctors in Idaho trying to comply with these 111,000 pages of rules.

Dr. Kenneth Krell found himself targeted by Federal auditors who came in and looked at 15 of his Medicare patient's records. And they found that Dr. Krell had overcharged Medicare by \$2,355. This was primarily a dispute over whether or not what he had done either was medically necessary, according to the Government, or whether or not he had coded it properly. The Federal agents then multiplied that number by the number of Medicare patients that Dr. Krell had seen in the whole year and charged him with a bill of \$81,390 as a fine.

He protested loudly, and apparently the Federal Government did back down.

Three other doctors in nearby Idaho Falls were also the subject of an audit, and they were told that the next time if they did not do a better job of complying with Medicare rules, which they're trying very hard to comply with, that they would then be subject to \$10,000 fines for each one of their miscodings. They dropped Medicare patients altogether. Now patients in Idaho Falls have to drive 45 minutes to Pocatello to see a doctor.

Other doctors in Idaho—and I think Idaho is particularly worrisome because there are not a lot of options, it's a rural State—other doctors are really considering dropping Medicare patients altogether.

Section 4507 has also been of great interest to a lot of patients because this provision prohibits individuals from privately contracting from doctors if they're on Medicare to receive medical services. That's been a big dispute. It's really an example of what happens in government-run systems.

And finally, privacy intrusions. The Health Care Financing Administration, as you know, is currently considering a rule that would force 9,000 home health agencies to begin collecting very sensitive data on their patients to make sure they are, in fact, qualified for home health care. Everything from their daily habits to their feelings of a sense of failure, thoughts of suicide, whether they use excessive profanity. The home health agents are to write these questions and answers down without necessarily consulting with the patients. Then these answers become part of the patients' permanent records, which are accessible to other government agencies. These are the kinds of things, as you well know, that result when doctors and hospitals and patients are subject to the Medicare regulatory system.

This is the reason, I believe, that anyone who's studied this program in-depth winds up saying we've got to change this. This is not sustainable. We've got to wind up with a better system. And the system that Chairman Breaux and Congressman Thomas of California, in consultation with the expertise of Jeff Lemieux, the Consensus Group, John Hoff, and others, have come up with.

The plan that they developed is a solution that would put more control in the hands of beneficiaries and less in the hands of bureaucrats. Traditional Medicare patients receiving financial assistance that they could use to purchase their own health coverage in the private market is a much better solution. The premium support model would move away from the current crushing system of price controls, regulatory bottlenecks, and restrictions on coverage, to give seniors much more choice in making their own health care arrangements.

And the Federal Employees Health Benefits model really is a proven model, and your committee deserves a lot of credit for continuing to operate a hands-off approach to really let competition work in this sector. I will not go into the details again of the plan, certainly Jeff Lemieux can present it much better than I, and my testimony does describe this in detail.

I would like to enter into the record a statement that I read, actually after I'd produced my testimony, by Walt Francis, who used to run the Federal Employees Health Benefits Program, who talks a lot about the details on how you could transform Medicare into a Federal Employees Health Benefits model. He said, I think interestingly, in his statement that if Medicare as it's currently constructed were offered as one of the options in the FEHBP today, to nearly 10 million beneficiaries, it would have no clients, because there are so many gaps in coverage, it's so expensive, and it puts people through so many unnecessary hoops. If it were competing with other private sector plan's customers, it would wind up not having any.

Mr. SCARBOROUGH. Without objection we will put that statement in the record.

[The information referred to follows:]

**The Federal Employees Health Benefits Program as a Model for
Medicare Reform**

Walton Francis

The purpose of this analysis is to examine the Federal Employees Health Benefits Program (FEHBP) as a potential model for Medicare reform. Is the program a good model, a bad model, or irrelevant? What Medicare problems might it solve, exacerbate, or leave unchanged?

These questions are relevant for three reasons. First, it is widely agreed that Medicare is both an antiquated and inadequate insurance program, and likely to become insolvent in about a decade. Second, the FEHBP is widely recognized as a program which has not only performed well but also avoided many difficulties by relying substantially on competitive choice among private sector health insurance plans rather than legislative and bureaucratic fiat for its evolution, design and workings. Third, the bipartisan Medicare Commission appointed by the President and the Congress is actively considering a "premium support" reform option proposed by co-chair Senator John Breaux that is explicitly "patterned after the Federal Employees Health Benefits Program ... that provides health insurance for nine million federal employees, retirees, and dependents" (National Bipartisan Commission 1999b). Of course, this is not a new idea. The first Medicare proposal modeled substantially after the FEHBP came from Alain Enthoven (Enthoven 1980). Professor Enthoven's proposal, which was remarkably similar to that now proposed by Senator Breaux, had an even catchier title, "Freedom-of-Choice", referring to the proposal's empowerment of beneficiaries to choose plans with lower premiums or better benefits, or both. More recently, Stuart Butler and Robert Moffit of the Heritage Foundation made a similar proposal (Butler 1995), as did the American Medical Association (AMA 1995).

The analysis proceeds as follows. First, it describes the workings of the FEHBP in some detail. Second, it provides information on overall FEHBP performance, particularly compared to Medicare. Third, it provides suggestions for design features of

the FEHBP that should be considered, or avoided, in reforming Medicare. For example, plan by plan flexibility in benefit design has been crucial to FEHBP success. Variations in benefits among plans provide a crucial dimension (along with cost competition and service quality) both in meeting short term consumer needs and in providing long term dynamic reforms. Freezing benefits in a "one size fits all" design that can only be changed by the political process is one of Medicare's greatest weaknesses. This flexibility has come at some cost in risk selection, but there are features that could be added to the FEHBP that would reduce undesirable risk selection. (As I argue below, having consumers pay extra for better benefits and sorting themselves into plans that provide particular benefits is in most respects a desirable form of risk selection.)

What the FEHBP model alone cannot do is provide a rescue from the seemingly inexorable dynamics of more Americans turning age 65, increasing longevity among the elderly, and technology-driven medical care costs that seemed destined to increase in perpetuity faster than the overall price level. The FEHBP model depends on and cannot perform better than the underlying medical care market.

Of course, it can influence that market to perform better and save a great deal of money in the process. But if the underlying costs continue to grow exponentially, then no reform model can deliver a complete solution to the long term problem.

In this analysis the term "beneficiary" is generally used to describe a Medicare enrollee, consistent with long-standing usage.

"Traditional Medicare" is used to describe the current fee-for-service program.

Rhetoric and Reality. In the past and present debate over Medicare reform there are deeply held positions that resonate to varying degrees for or against the idea of using the FEHBP as a model. For example, five years ago one opponent was quoted as saying that allotting a lump sum to each Medicare beneficiary and having them negotiate with insurance companies would be "throwing people to the wolves" (Firman 1995). In the rhetorical debate, "defined benefit"

is seen as generous and preserving guarantees, "defined contribution" as a mean-spirited attempt to increase the cost burden on the elderly over time, "vouchers" as a symbol of unconstrained competition, etc. Presumably Senator Breaux uses the term "premium support" to describe his plan as a way to avoid some of this baggage. Of course, no terminology can avoid the underlying reality that someone has to pay for the ever-burgeoning cost of Medicare.

As discussed in detail in various sections below, the FEHBP model is essentially neutral in the context of this debate. It is compatible with benefit reductions and increases in beneficiary premiums and cost sharing, or with benefit increases and reduced beneficiary premiums and costs. For example, the model provides one way to introduce prescription drug coverage into Medicare. Who bears the primary burden of that benefit increase is a function of premium design and payment sharing. The FEHBP model also provides a way to modify cost sharing by beneficiaries in a relatively painless and gradual way. Specific design choices would determine whether on balance the reformed program would be relatively more or less generous to each of the various parties involved--payroll taxpayers, income taxpayers, beneficiaries, private sector pension plans, States (as Medicaid payers of premiums and deductibles for low-income elderly), and providers.

The essential point is that the FEHBP model involves a potential opportunity to reduce the costs to all affected interests, IF it succeeds in improved cost reduction over time. Thus, it is potentially a "win-win" approach from the perspective of all participants.

The FEHBP--How it Works

Background. The FEHBP is unique among government health insurance programs in relying primarily on the private market for almost all of its functions, including many "policy" decisions on benefits design and coverage. This is because it is an accidental program.

During World War II, private employer health insurance grew rapidly because the government's wage control program exempted health insurance from its strictures. But the Federal government

itself eschewed using this loophole for its own employees, and a range of insurance plans sponsored by unions and employee associations grew up to fill this void. By 1959 the Executive Branch decided to act, and initially proposed a system under which the Federal government would determine benefits and payments in a single fee-for-service plan that all or most employees would join.

This proposal was modeled after large employer practices of the time. However, unions and employees did not want to abandon their own plans, and the Congress responded. A compromise was reached under which existing plans would be "grandfathered" and compete with two "government-wide" plans in an annual Open Season (Anderson 1971). New HMO entrants would be allowed--a prescient decision--but new fee-for-service entrants would not be allowed. (In 1980, the Congress enacted a time-limited opportunity for new fee-for-service plans affiliated with unions or employee organizations to join. Of the half dozen that accepted this offer, only one survives today.)

To allow multiple plans to co-exist, the annual Open Season had to be invented to allow employees to switch from plan to plan and, in a deliberately planned invitation to risk selection, from "high" to "low" (now called "standard") options within the same plan. For Open Season to offer a real choice among plans, pre-existing condition exclusions are banned. In the FEHBP, any employee or annuitant, no matter how ill, may join any plan. It is Open Season competition which forces plans to respond to consumer preferences for benefits, service, and economy.

The Mechanics of the Program. There are about 300 health insurance plans that participate in the FEHBP. Most of these are HMOs that cover self-defined geographic areas (e.g., southern California, eastern Ohio, metro DC). In 1999, every Federal employee or annuitant can choose from about a dozen fee-for-service/PPO plan options and most can choose from almost two dozen options, depending on the number of local HMOs. For example, there are 11 HMOs serving the DC metro area, 10 serving New York City, and 10 serving Los Angeles. In contrast, there are no participating HMOs serving Alaska or Wyoming, and only one serving Montana or South

Dakota (Francis 1998).

Choices include nationwide plans sponsored by Blue Cross/Blue Shield and by unions and employee associations, such as the American Postal Workers Union (APWU), Mail Handlers, and the Government Employees Hospital Association (GEHA); and almost 300 HMOs, such as the Aetna US HealthCare and Kaiser plans. The nationwide plans are all nominally fee-for-service, but in fact virtually all of them have evolved into preferred provider (PPO) plans over the last decade. Employees are free to join most union and association plans, regardless of their agency and whether they are General Schedule or Postal employees. At most they must pay annual dues, which are generally near \$30. However, some plans restrict enrollment. For example, the SAMBA plan is open only to FBI and other law enforcement agents, and the CIA, Foreign Service, and Secret Service plans are similarly restricted. There are almost 3 million covered employees and over 1 1/2 million covered annuitants, for a total of 4 1/2 million contracts. Taking into account dependents, there are some 9 million covered lives.

Employees are free to switch plans during the annual Open Season, scheduled from November 9 to December 14 in 1998 and in a similar period each year. They are also free to switch among plans at certain other times -- for instance, if they marry or move out of an HMO's service area.

Many employees and annuitants are enrolled in plans that are much more expensive than average. In each Open Season almost all of these persons will be able to reduce premium costs while maintaining or even improving benefits. However, most of these do not change plans, and overall only 5 per cent of enrollees switch plans in most open seasons.

Implementation. The Office of Personnel Management (OPM) sets financial, administrative, and benefit terms and conditions for every plan participating in the program. Most of these standards are informal and subject to negotiation. For example, its annual "call letter" in 1997 OPM asked insurance companies to expand mental health benefits consistent with recent legislation and to go

even further to achieve full parity with physical health benefits. Most plans improved benefits, but none promised unfettered parity. After negotiation in the summer, insurance companies and OPM agree each year on contracts setting forth both benefits and premium costs.

The mechanics of enrollment are handled by hundreds of government personnel offices for active employees, and by OPM directly for annuitants. New hires and employees or annuitants who change plans fill out a simple one page form. Agency payroll computers and OPM's retirement computer are programmed to deduct the correct amount for each plan. Payments for both employee and government share are transferred electronically to OPM for payment to plans. Annuitant procedures are handled almost entirely by mail, but OPM maintains an "800" number for annuitants, provides a comprehensive World Wide Web site for all (www.opm.gov/insure), and publishes an annual *Guide* for employees (OPM, 1998)

The program relies on a number of strong mechanisms to protect enrollees: clear and complete descriptions of benefits and limitations, Open Season, use of plans that are available in the open market and not limited to Federal enrollees, and an independent appeal process.

OPM Role. The Office of Personnel Management operates in a fiduciary capacity in administering the program. Its antenna focus on a wide range of issues including: status of the trust funds, status of government and plan reserves, trends in the health care market that affect either plans or enrollees, effects of plans' benefit decisions on future premiums, and, for each plan: financial viability, overall actuarial value, general benefit structure, specific benefits of special concern, general competence, clarity of brochures, and appeal procedures and their adequacy.

While there are some matters, such as brochure design, on which OPM insists plans meet specific standards, in general OPM operates in a management "by exception" role. If a plan is not doing something drastically wrong, OPM's role is passive and

accepting. Plans are presumed to understand that their decisions on premium, benefits, and services affect their ability to attract enrollees, and that their competitive position is at risk. OPM is, in essence, a referee with limited responsibility.

OPM administers the program with approximately 150 government employees, compared to the many times larger numbers involved in managing comparable functions in Medicare, TriCare/Champus, and Medicaid (counting State employees). Interestingly, almost half of the OPM effort is devoted to processing appeals of plan coverage decisions, rather than overall policy setting and direct administration. This, of course, is largely made possible by the decentralization of decision-making to plans and enrollees.

Premiums. The total premium for each plan for a given calendar year is calculated from the estimated costs for that year, as forecast by the plan and reviewed and agreed by the government in the preceding summer. There are no controls or limits on this estimate, except various reasonableness standards. For community rated plans, the government asks that the plan give the government the best group rate available to any employer. All the fee-for-service plans, and some HMOs, are experience rated. Experience rating covers about two thirds of all enrollees.

The government pays a set amount toward the total premium of each participating plan, based on a percentage of the weighted average premium for all plans estimated for the ensuing plan year.

As a consequence, as costs rise or fall, the government contribution rises proportionally. For calendar 1999 the maximum government contribution amount is about \$1870 annually for a self only enrollment, and \$4170 for a family of any size. The enrollee pays the rest. Under standard economic theory regarding employee compensation, of course, the enrollee pays the entire amount. The "government share" is a fiction with one practical effect: the government share is paid in tax free dollars and the enrollee share in before tax dollars.

More precisely, for General Schedule (GS) employees and retirees, the government pays 75 per cent of the total premium cost

up to a maximum contribution at the amounts above. Thus, a plan with a total premium cost of \$2400 for self only would have a government contribution of \$1800, and the enrollee would pay \$600.

For a plan with a total premium cost of \$3600, the government would pay \$1870 and the enrollee would pay \$1730. (The great majority of Federal employees are General Schedule or come under that rate. However, Postal Service and FDIC employees get more favorable cost sharing, and some eligibles such as former employees must pay the entire premium.)

The premium contribution is calculated as a percentage of the average premium for all plans. Thus, the \$1870 maximum contribution reflects a program-wide average premium of about \$2600 for a self enrollment.

Enrollee share of premiums varies widely. In 1999, the GS employee share of the annual premium ranges from about \$500 to over \$3,000 for individuals, and from about \$1,000 to over \$6,000 for families. What explains these vast premium differences?

First, plans vary in the kinds of enrollees they attract. The plans with smaller coinsurance and deductibles or larger provider networks tend to attract families who expect higher expenses. These plans face higher costs that have to be made up by higher premiums. Premiums reflecting these higher costs exceed the value of the benefits compared to plans that attract lower risk enrollees (Merlis 1999). Risk selection has been substantial in some fee-for-service plans, as discussed below. However, it has generally not led to a "death spiral" and some plans have maintained their enrollment at substantial levels despite having premiums significantly higher than other competing plans with similar benefits. For example, the Blue Cross High Option plan, traditionally viewed as the "Cadillac plan" in the system, had enrollment of about 90 thousand persons (mostly aged) in 1998 compared to 135 thousand five years earlier. During these years the premium cost to these enrollees was \$1000 or more higher than the premium for the almost equal benefits in the Standard Option, which has many younger enrollees.

Second, plans differ in the benefits they offer. Variations

include coverage of different expenses, coinsurance, and deductibles. Some deductibles apply to all services. Others apply only to hospital or prescription drug costs. Some plans have three deductibles. Some of these benefit variations have a major effect on the value of a plan's benefits and some do not. For example, the lifetime maximum payment in some plans has no little real effect as long as employees are allowed to switch plans every year.

Deductibles have an almost dollar for dollar effect on plan premium. By and large, benefits are very similar on an actuarial basis. For example, the worst HMO in the DC area reimburses about 88 percent of medical and dental costs; the best about 95 percent.

For national fee-for-service/PPO plans, the range is about 74 percent to 88 percent (Francis, 1999). Excluding the two outliers in each group, the range is under 10 percent.

Third, plans vary in how well they manage health care costs. A well run HMO may be able to reduce the frequency and length of hospital stays by 25 percent or more compared to traditional fee-for-service insurance. Plans vary in their effectiveness in bargaining with providers. And cost sharing creates incentives to reduce waste. Large deductibles discourage unnecessary visits, while 100 percent reimbursement encourages overuse of ``free'' services. Also, plans with deductibles achieve a saving because the time and trouble to file claims for expenses just a little bit above the deductible may discourage enrollees from applying for them. Reflecting both risk selection and plan management, fee-for-service plans have a self only total premium for 1999 averaging about \$2720; in contrast HMOs average only about \$2330, a \$400 difference (Francis, 1999). The total cost difference is even greater, since most HMOs have no deductibles.

Last, the government's formula for the share of the total premium it will pay magnifies the percentage differences in what enrollees pay. The enrollee pays all of the cost of any premium amount above the government's share. This employee share is far higher for the more expensive plans. For example, in 1999 the total premium cost of the Blue Cross High Option for self-only is about \$3,530. The government pays the maximum contribution of about

\$1,870 for GS employees and enrollees pay the extra \$1,660. In contrast, under the Blue Cross Standard Option enrollees pay only about \$720 after the government contribution.

Thus, enrollees pay modestly for insurance from a well run plan, but pay more for a plan's inefficiencies, its unusually generous benefits, or its large share of high risk enrollees. The ability to switch among plans gives enrollees a major tool for obtaining the best deal. Some of the difference reflects more intensively managed care in HMOs; some of it reflects relative age of enrollees (Merlis, 1999). According to unpublished OPM data, the average age of enrollees in HMOs is about 45 years; in fee-for-service/ PPO plans about 5 to 9 years older (Thorpe, 1999 forthcoming).

Premium Management. Each year's government premium contribution is determined by the bids of all participating plans for that same year. OPM generally accepts these bids. After all, each plan must decide on the optimal bid taking into account not only its costs and potential profits, but also its price in competition with other plans' likely bids. And OPM requires that each plan's premium either reflect the actual experience of covered enrollees adjusted for expected changes or, in the case of most HMOs, reflect the best "community" price that the plan offers any employer. However, a number of factors influence OPM decisions to intervene selectively in benefit and premium proposals from the plans.

First, if there is a question of financial viability of a plan (a not infrequent issue), OPM has an interest in assuring that the plan remains solvent at least for the contract year. In some cases, this has led the plan to propose, and OPM to accept, premiums that are not actuarially "fair" but that assure solvency until the plan exits the system.

Second, OPM has an interest in keeping premiums low, both on behalf of enrollees (a fiduciary goal) and on behalf of the Federal budget. For example, since the Blue Cross Standard Option plan accounts for about 40 per cent of total enrollment, its bid accounts for 40 per cent of the weighted average in determining the

overall premium for the current year. If Blue Cross adds a \$10 item to its benefit package, then to a first approximation this will have about a \$13 million dollar effect on next year's government contribution ($\$10 \times 4.5 \text{ million enrollees} \times 42 \text{ percent} \times 72 \text{ percent}$). A \$10 benefit reduction will save an equal amount. In contrast, the decision of an HMO with 1,000 enrollees to add a \$10 item is inconsequential. As a result, OPM has a strong incentive to "meddle" in benefit decisions for the larger plans, despite the fact that enrollees pay all marginal costs once the government contribution is set. Moreover, "fairness" virtually forces OPM to treat plans equally in what it allows, encourages, or prohibits.

Third, OPM has an interest in promoting good benefits for its employees. In the past, a number of fee-for-service plans had grossly inadequate prescription drug coverage. Over time, OPM has pressured the less adequate plans to improve coverage. This has premium implications and, hence, budgetary implications for both the Federal government and enrollee wallets. OPM is thus in the position of trading off competing objectives--frugality and beneficence.

Another implication of the FEHBP methodology arises from the fact that as plan costs change for existing benefit packages, there is a dollar-for-dollar effect on government costs. If Blue Cross and every other plan keeps its existing benefit package intact, but its payments to providers rise by 5 percent, then next year's total premium, government contribution, and employee share will all rise by 5 per cent. Thus, each year's premiums, and allocation of costs, is driven by the health insurance market. In this respect, OPM is a passive price taker--getting the best deal that it can, but like any other purchaser accepting the dictates of a more or less competitive market.

Benefits. All plans must offer a solid core of comparable benefits. In contractual bargaining, OPM seeks to limit variations in the actuarial value of plans. But on the margin, benefits are not identical among the plans. For example, most fee-for-service plans have a deductible of several hundred dollars. Most HMOs have no

deductible at all. Thus, a given employee premium for most HMOs is a considerably better dollar buy than the same premium for a fee-for-service plan. There are numerous other benefit differences. For example, only some plans provide mail order prescription drugs, chiropractic coverage, or dental coverage. Almost all fee-for-service plans now vary benefits depending on whether preferred providers are used.

The statute governing the FEHBP contains only one paragraph on benefits, which simply states that plans must cover hospital and medical costs (prescription drugs are not mentioned). Health policy analysts accustomed to hundreds and hundreds of statutory and regulatory pages exhaustively describing the minutia of Medicare benefits are often perplexed. What assures that each plan will in fact cover major types of benefits adequately and without significant loopholes? There are several answers. First and foremost, the plans themselves do not operate in a vacuum. They are ongoing businesses in an environment in which health insurance plans typically cover (for example) hospital costs without significant exceptions or loopholes. They are subject to OPM stewardship. And they are subject to market pressures. A plan which significantly departed from the kinds of benefits expected by enrollees and available in other plans would rapidly lose enrollment. Short run gains from benefit loopholes or reductions are possible due to the inertia of some enrollees, but over time the plan could not survive.

Interestingly, FEHBP benefits have significantly improved over time. From 1983 to 1992, estimated out of pocket costs for self only enrollees in HMO plans went from 22 percent to 12 percent of total medical and dental cost, and in fee-for-service plans from 33 percent to 22 percent (Francis 1993a and 1993b). Since then, benefits have improved even further, particularly for enrollees willing to use preferred providers. For example, in 1992 the Blue Cross Standard Option, then as now the largest plan in the program, required enrollees to pay for outpatient care 25 percent of usual, customary and reasonable charges after a \$250 deductible. In 1999, a reformed Blue Cross Plan requires enrollees to pay only \$12 after

a \$200 deductible, no matter how high the usual charge, provided that they use preferred providers. Taking into account inflation, this is a substantial benefit improvement. (However, enrollees who do not use preferred providers can in some cases pay half or more of the provider's charge). HMO benefits have improved less because they were so good to start.

A crucial aspect of benefit variation is that it allows plans to experiment, and evolve over time. Thus, in designing prescription drug benefits plans are free to use almost any combination of a wide range of policy instruments to hold down costs while meeting the market test of consumer acceptance. These include whether or not to have a drug deductible, how high the deductible, whether to use coinsurance or copayment, rate of coinsurance or amount of copayment, whether to use a formulary that reimburses more for drugs the plan believes to be more cost-effective, whether and how much additional copayment to charge for name brand drugs, how wide a range of pharmacies to designate as preferred providers, whether or not to use mail order, and how much financial incentive to provide to use mail order. These benefit structures change over time in each plan as the prescription drug market evolves, as consumer expectations change, and as experience accumulates.

Similar but fewer variables are used for hospital, medical, and other experiences. For example, each plan decides whether or not to charge a separate hospital deductible, how high is the deductible, and whether to waive the deductible for admission after an accident. Some plans charge coinsurance for hospital stays, some do not.

The setting of these deductibles and coinsurance rates is tied, in turn, to decisions on where to set the catastrophic stop-loss limit. Where the catastrophic limit is low, the plan is more likely to be willing to impose charges on hospital visits, because the enrollees' cost exposure is limited.

Reimbursement. Nothing in the FEHBP law or regulations prescribes any particular method of reimbursement. Historically, HMOs have

tended to use capitated approaches to both inpatient and outpatient care, and they continue to do so. Fee-for-service plans used to rely primarily on "usual, customary, and reasonable" methodologies, and in some cases on surgi-schedules and other fee schedules that were not negotiated with physicians or providers (i.e., the plan would pay \$500 towards a particular procedure, and the patient would pay the remainder of the bill, however high). Today, fee-for-service plans rely primarily on negotiated fee schedules with providers and physicians, similar to those used by HMOs. Both historically and at present, there has been no uniformity across plans in any of these payment methods. Plans simply cut the best deals they could, in the context of the health care marketplace as it existed each year. Both fostering and relying on the growth in capitation and discounting in the private market, the FEHBP has evolved with the managed care revolution of the 1990s.

Provider Access. The FEHBP has no requirements as to the terms and conditions each plan sets for deciding which providers to allow to participate at all, or to reimburse, and at what rate. Historically, the Blue Cross plans have paid better for "participating" providers who agree to accept a fixed rate set at a lower level than many would otherwise charge. More recently, it has added "preferred" providers who accept an even lower rate (about one-half of physicians, hospitals, and pharmacies are "preferred" under Blue Cross). Meanwhile, reimbursement to the few providers who are neither preferred nor participating has been reduced and relies on a parsimonious fee schedule (borrowed, as it happens, from Medicare). HMOs, of course, have historically used several models, including employee providers, affiliated group practices, and individual practice associations. The numbers and kinds of arrangements are almost as diverse as the number of plans. Point-of-service or "opt-out" arrangements have been encouraged by OPM in recent years, but fewer than one in ten HMOs have adopted these.

Decisions on provider access are obviously inextricably connected with reimbursement decisions, and also with benefit

design decisions. For example, the decision on whether to use mail order pharmacies, and if so with what preference structure, has been of intense concern to both providers and patients, particularly those elderly accustomed to a Medicare coordination benefit allowing 100 percent coverage of drugs at local pharmacies.

Several years ago, the decision of Blue Cross to add a preferential mail order benefit created great controversy. In fact, the State of Maryland went so far as to enact a statute to prohibit discounts for using mail order drugs. This statute has no effect on the FEHBP Blue Cross plan, since this plan is exempted from state regulation by OPM, but forced the Kaiser plan headquartered in Maryland to end reduced copayments for its mail order program (OPM requires HMOs to meet state mandates in the state in which they are headquartered).

Geography. Almost all the fee-for-service plans operate nationally, with a single premium. The HMOs all operate locally, typically covering a metropolitan area, but sometimes a substantial number of counties or an entire State. The statute does not allow any geographic distinctions in premiums. Thus, the government contribution is the same everywhere, in both "high cost" and "low cost" areas. This seems odd to those who believe that there are large differences in health care costs by geographic area. In fact, it is arguably a major strength. When FEHBP premiums are averaged across all plans in a service area, it turns out that there is no major difference in the cost of providing HMO care among most parts of the country (Schmid 1995). What differences there are may reflect the strengths and weaknesses of those plans that are relatively dominant in particular areas (e.g., Harvard in the Boston area, Group Health Coop in the Seattle area) as well as competitive pressures (premiums are somewhat lower than average in major cities with many HMOs, such as New York, Chicago, and DC). As a consequence, geographic distortions of consumer decisions are relatively attenuated, and arise largely because the fee-for-service plans are not allowed to vary premiums by geographic area (Thorpe 1999 forthcoming). As a result, the FEHBP has avoided the

major geographic distortions that have plagued the Medicare program and dominated the "distributive politics" of Medicare (Vladek 1999)

Costs. The essential mechanism used by the FEHBP to control costs is market competition. The program, while large in its entirety, is not large enough in market share to rely on monopsony power in most of the United States. Furthermore, cost controls (e.g., procedure by procedure limits on payments, as used in Medicare), would be antithetical to the nature of the program. If, for example, a particular method were prescribed by payment for prescription drugs, then most of the flexibility in benefit decision and evolution of benefits would be taken away.

There are both short and long run implications of relying on market forces. The long run is addressed below in comparing performance to Medicare. As to the short run, there is dramatic evidence of the effects of a competitive season. Each fall, OPM publishes the enrollment-weighted average premium for the forthcoming year, using the assumption that enrollment remains the same. During the Open Season, enrollees change plans, some selecting more expensive plans but on balance switching to relatively lower cost plans. The results show almost a 1 percent saving on average during each Open Season:

Year	Before Open Season	Open Season Result	Difference
1994	3.0%	2.7%	-.3%
1995	-3.4	-3.9	-.5
1996	.4	-.2	-.6
1997	2.4	3.1	+.7
1998	8.5	5.4	-3.1
Average	2.2	1.4	-.8

Source: OPM enrollment and premium data (Francis 1999). A similar calculation using a slightly different methodology appears in National Bipartisan Commission

1999a.

In earlier years, when insurance costs were rising much faster, Open Season savings were even larger. In theory, such effects might reflect risk selection rather than real savings, with migration each year tending to raise premiums in the next. In fact, risk selection effects are minimal, as shown by inspection of migration patterns and the long term analysis below. Also, savings from plan switching behavior might be much larger if the underlying premium formulas provided greater rewards to enrollees.

In practice, the government usually recoups 75 percent of the premium difference when a lower priced plan is selected, particularly for self enrollments. (This issue is analyzed in detail in Thorpe, 1999 forthcoming). Also, plan switching behavior is attenuated because about one-third of enrollees are annuitants, and most of these on Medicare. Special Medicare wraparound benefits allow enrollees who have both Parts A and B and who select one of several reasonably priced fee-for-service plans (but not HMOs) to have 100 percent coverage for all medical expenses, including prescription drugs, with no preferred provider restrictions of any kind. Thus, these enrollees are largely insulated from the cost-benefit calculus faced by employees.

Comparative Medicare and FEHBP Performance

Over time, the FEHBP, viewed as an insurance package, has dramatically outperformed Medicare. Overall program costs, benefits to enrollees, administrative costs, and complexity have all been visibly superior. Risk selection is more problematic.

Cost Performance. As to program costs, the program consistently surpasses Medicare. Using simple 10 year rolling averages to compare, the program's rate of increase in average benefits paid per enrollee is around 1 percentage points less than Medicare, depending on the comparison period selected:

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Sources: The Green Book, United States Budget and OPM and HHS enrollment data (Francis 1999). The National Bipartisan Commission has made a similar calculation which differs in periods selected and perhaps in methodology (National 1999a) The Commission's calculation also shows the FEHBP outperforming private sector employers, but not outperforming the most similar competitive program, operated by the State of California for its employees.

The earlier calculation, covering the period 1986 through 1995, reflects years when Medicare had just implemented the prospective payment system for hospitals. Medicare was, according to the Congressional Budget Office and the Prospective Payment Assessment Commission, paying hospitals well below actual cost, and shifting hospital costs onto private sector plans, including those in the FEHBP (see Francis, 1993a). Also, both plans and OPM overestimated future cost increases in the early 1990s and raised premiums too high (excess revenues went into trust fund reserves).

The later calculation, covering the period 1990 through 1999 estimated, reflects years during which the FEHBP radically shifted towards managed care, with HMO enrollment reaching 40 percent for employees, and preferred provider enrollment rising from near zero to almost all remaining employees (but not annuitants on Medicare).

During all these years three major trends have affected results, one favoring the FEHBP and two favoring Medicare. First, the number of expensive Federal annuitants over age 65 who do not have Medicare coverage has been falling significantly as the oldest

cohort of retirees dies (Medicare did not cover Federal employees until 1983). Second, FEHBP plans have significantly improved benefits, while Medicare has not. Third, the Federal work force has aged substantially, probably by several years on average. Despite the adverse effect of the latter trends on cost containment, the FEHBP has overcome Medicare's monopsonistic advantage and greatly reduced the rate of cost increase.

Clearly, some of this better performance reflects one-time savings accruing from the conversion to managed care. If, as some believe, managed care has reached the limit of possible savings, then the difference between the two programs would be expected to narrow over time. If, however, managed care plans continue to realize additional savings through improved service delivery (e.g., large case management), efficiency (e.g., switching to generic drugs), and payment policies they select, programs like the FEHBP may have a semi-permanent and increasing cost advantage over relatively unfettered fee-for-service medicine as practiced in Medicare.

Benefit Performance. As to benefits, it is hardly fair to make the comparison. Traditional Medicare remains a relic of insurance design vintage 1960, with an artificial distinction between in- and out-patient care, an antiquated benefit structure, a huge hospital deductible, and coverage gaps so large that, were it offered to employees in the FEHBP as if it were just another plan, it would scarcely attract an enrollee. In remarkable contrast to Medicare, the FEHBP has modernized deductibles, added and improved prescription drug coverage, and added and improved catastrophic limits virtually without controversy.

Implementation and Administration. For whatever reasons of institutional, statutory, and political setting, there are few aspects of these programs in which OPM has not performed well or excelled, and many aspects in which HCFA has stumbled (Francis 1993a). As a simple example, after a dozen or more years of active HMO participation in Medicare, the program did not have such simple

necessities as factual, organized, plain-English, or even available materials to enable beneficiaries to compare their choices of plans (U.S. GAO, 1996). This problem is rapidly being remedied, but many others persist.

Premium Cost Sharing. Under the FEHBP, consumer incentives to select the "best buy" plans, and plan incentives to restrain costs, are substantially attenuated because OPM cannot pay more than 75 percent of the cost of any plan. Thus, even if a plan can deliver care at less than the maximum government contribution, as some do and perhaps many more could, there is little incentive to do so because the government captures 75 percent of any saving. Interestingly, Medicare offers much higher incentives to many beneficiaries. For the one-third who pay their own Medigap premium, at an average cost of \$1300 a year (U.S. House of Representatives, 1988), enrolling in an HMO with better hospital and medical benefits and prescription drug coverage represents a major saving.

Risk Selection and Risk Management. There are several kinds of risk selection. First, there is the arguably desirable kind in which consumers sort themselves out by their differing preferences for different benefit packages and for tradeoffs between scope of access, benefits, and costs. A useful analogy is purchasing a car (or breakfast cereal, or any other good in a market economy). Different individuals have very different tastes and needs for size, acceleration, transmission system, color, number of seats, etc. And the willingness to pay for these differences is disciplined by their cost. This is natural and desirable variation in any kind of product, including health insurance. To be sure, selecting among a range of choices imposes some cognitive burden on consumers but consumers somehow manage to cope with such choices. Tradeoffs between product attributes, cost, and service are ubiquitous. The alternative, a single "one size fits all" product is inferior on many grounds, and unnecessary to prevent deception or products that do not perform as advertised.

When health insurance consumers sort themselves out by differing preferences, a felicitous result occurs: they naturally pool themselves and each group pays the excess marginal cost of its preferences. I don't want to pay for your sports utility vehicle, and you don't want to pay for my air conditioning. Those who want a plain vanilla car can find it, and in the FEHBP those who want a plain vanilla health plan can find it. So long as plans are priced fairly for the benefits they provide and protect against catastrophic expense and meet other standards, why should government care what specific benefits they offer?

Equally importantly, plans that can vary benefits can adapt to changing circumstances and evolve over time. At a time of rising drug prices, many HMOs are raising copays from \$5 to \$10. Others are holding the line but introducing formularies. Writing into law a \$5 copay for all drugs necessarily prevents such adaptations and forces premium increases.

A second form of risk selection arises when differences in plan features, plan enrollment, and premiums reflect people sorting themselves out into more sick and less sick groups. HMOs have traditionally sought and attracted younger persons because they cover pregnancy and well baby visits at 100 percent, while older and sicker persons tend to stay in fee-for-service plans to get better provider selection and access to specialists. Such selection is believed by many to be ethically offensive, but accepted by others as natural and desirable. Certainly we tolerate risk segmentation in most forms of insurance. For example, young persons pay much lower premiums for life insurance but much higher auto insurance premiums than older persons. Age rating for premiums is ubiquitous in the individual health insurance market.

A third form of risk selection involves issues of moral hazard, where information asymmetries can lead to market failure.

What about FEHBP and Medicare performance? The traditional Medicare program insists on identical benefits for all and identical premiums for all (leaving aside subsidies for the very poor through the Medicaid program). There is no product variation. Likewise, there is no risk segmentation or moral hazard. The

addition of HMO options has encouraged a great deal of study over whether and to what extent risk selection is occurring, and evidence for minor but not major effects.

In the FEHBP, however, there is a great deal of minor product variation, leading to a wide range of choices for consumers. There is also risk segmentation. Part of the continuing differential between HMO and fee-for-service prices, for example, reflects the willingness of older and statistically sicker persons to pay more for greater provider choice. Destructive risk selection has, however, been almost absent from the program. Some plans have gone out of business in circumstances involving risk selection, but this has been a rare event. In fact, the program is quite stable in that large and continuing premium disparities even among fee-for-service plans with similar benefits have continued for many years without "death spirals." This record is all the more remarkable because there are several large and distinct risk groups within the program, such as a once large cohort of elderly retirees without Medicare coverage. A good part of the Open Season movement of the 1980's was certainly due to the efforts of younger employees to join plans that did not attract these retirees.

It is also important to note that the FEHBP has not been given tools for dealing with risk selection. For example, the badly flawed AAPCC formula did at least allow Medicare to vary its contribution to HMO premiums by age of enrollee. In the FEHBP, the existence of statistically predictable high-cost elderly persons without Medicare coverage cried out for a differential payment to plans, depending on how many of these were enrolled. The FEHBP had no power to adjust its payment.

The only power the FEHBP has to control risk selection lies in bargaining over potential benefit changes that might disadvantage specific higher risk groups (e.g., plans refusing to pay for insulin to discourage diabetics). To the credit of the plans and OPM, virtually no invidious benefit distinctions of this kind have been present in the program. (Probably the worst is that several HMOs in areas with high concentrations of HIV-infected persons have put ceilings on prescription drug payments. These ceilings may

have been needed for plan financial survival.)

There is one major adverse consequence of the FEHBP's failure to have mechanisms to control for risk selection. The ability of enrollees to choose among plans based on benefit characteristics is distorted and compromised by the effects of risk sorting on premiums. For example, the Blue Cross High Option has the most generous outpatient mental health benefit in the program. However, because most enrollees in that plan are elderly persons without Medicare coverage, a potential enrollee has to choose both the coverage and the adverse cost experience.

Locus of Decision. There is a more fundamental distinction between the programs, which cost, benefit, and risk comparisons merely reflect. In the FEHBP, the locus of decision making lies, ultimately, with individual consumers making purchasing decisions. The plans, and hence the program, adjust dynamically to these decisions, in an almost transparent fashion. Nothing dramatic happens in any one year, but over a period of years the program transforms itself. In Medicare, the locus of decision-making is the political process. It lurches, stumbles, seeks to avoid inflicting transitory pain, and moves only when forced to by budgetary exigency or other political event. By preserving what exists, it precludes real improvement. The examples are legion, most notably the enactment and rapid repeal of the Medicare Catastrophic Coverage Act, and the decade-long failure to fix the flawed AAPCC system whereby HMOs were reimbursed at rates that had little or no relationship to the cost of managed health care delivery in particular areas. The failure to reform HMO reimbursement (finally addressed in the Balanced Budget Act of 1997) delayed by years the ability of millions of elderly beneficiaries to obtain low cost prescription drug coverage and gap-free catastrophic coverage. Interestingly, the FEHBP's failures are most acute where it is most constrained by law, e.g., in risk management, denying new fee-for-service plan entry, and (until a recent reform) erroneously calculating the all-plan average premium.

Further, because the FEHBP allows benefit variations, there is

no simple target for the political process to seize upon and change (or, more likely, refuse to change) through political rather than market processes. Precisely because the FEHBP does not have a "one size fits all" deductible, coinsurance rate, payment mechanism, provider participation, and set of coverage and provider participation parameters, there are relatively few points of leverage for parochial interests to either attack or defend.

Moving Medicare Towards the FEHBP Model

Medicare is already well down the road towards a competitive system. Particularly with the reforms enacted in the Balanced Budget Act of 1997, HMOs have realistic opportunity to compete for enrollment throughout the country, with sufficient stability of payment rates, stability of enrollment decisions, availability of comparative information, and other essential ingredients of working markets. The rapid growth in HMO participation and enrollment of the last several years, up to about 300 plans and 14 percent of beneficiaries in 1997, is testimony to the desire of beneficiaries for such choices (U.S. House of Representatives, 1988). Even the recent pullout of some 50 HMOs, in a rate dispute with HCFA, would seem to reflect teething pains rather than any real slowing in the program's evolution. However, the reported failure of any fee-for-service or PPO plans to enlist in the program suggests that the statutory and regulatory barriers are too high for these plans. The main statutory impediment is a requirement that these plans meet the benefit structure of traditional Medicare. As a very imperfect measure of regulatory burden, the interim final rule for the Medicare+Choice program, published June 26, 1998, is 148 *Federal Register* pages long, and about triple that in typed pages).

Regardless, in statutory, political, institutional and behavioral terms the traditional Medicare program remains so preeminent that it is unlikely that anything like the FEHBP will emerge soon under existing law. What then, can be learned from the FEHBP about how a more fundamental reform would or could work? What pitfalls lurk and how might they be avoided or ameliorated?

How could the elderly be assured that neither benefits nor premiums would change substantially to their disadvantage?

Premium Cost Sharing. At present, most Medicare beneficiaries pay only one-fourth of the Part B premium--\$550 in 1999. This is about 10 percent of the total Part A and B cost. However, Medigap coverage of one kind or another (through enrollee, employer, or Medicaid) is paid for almost 90 percent of beneficiaries, at an average cost of \$1300 (U.S. Congress, 1988), rising rapidly. Hence, the direct taxpayer portion of total insurance costs is about 75 percent or slightly less, roughly the same as in the FEHBP.

Complicating the issue is the peculiar role of Medigap plans. (Benefit supplementation, except for dental care, isn't needed in the FEHBP and virtually does not exist.) It is hard to imagine reforming the program so imperfectly that Medigap plans would still meet a real need or have a viable role.

These data suggest that creativity will be needed in premium design if Medicare were to attempt to implement a competitive system that placed the marginal cost of decisions on enrollees without changing underlying contribution shares in a major way. For example, should Medicare provide for rebates if, as may well be the case, some HMOs can deliver care for less than the average Medicare cost? How can premium shares be structured to avoid artificial windfalls or penalties for enrollees in plans with different cost structures (Merlis 1999)? Can employer subsidies for Medigap be grandfathered into the program rather than returned to employers as a windfall saving? As a heavy-handed example, could ERISA status be tied to maintenance of effort for employer contributions toward the cost of post-retirement insurance? Regardless, the 75-25 formula used in most of the FEHBP is flawed for competitive purposes and would appear virtually unworkable in the context of Medicare parameters.

Premium Growth. Both the FEHBP and Medicare tie growth to actual changes in the cost of health care delivery for enrollees.

However, the FEHBP approach of tying premium growth to changes in next year's insurance costs creates a huge incentive for the government to tinker with benefits to meet budgetary goals. This has not proven to be a major problem in the FEHBP but Medicare is more than ten times the size of the FEHBP in dollar terms, and has a tradition of budgetary tinkering that does not augur well for reform. Ideally, in a choice system the government share of premium growth should be decoupled from benefit decisions by enrollees and plans. Unfortunately, doing so would counter another important goal: assuring that a reformed system does not tilt unduly over time towards placing higher costs on enrollees. One way to resolve this dilemma may be to adjust premiums based on a rolling average covering several years of costs. Hence, plan changes in benefits would have an attenuated effect on the next budget.

Another way would be for only a portion of the benefit package to count towards determination of the program-wide average premium.

For example, the required minimum actuarial benefit discussed below might be set at 80 percent, with 90 percent as a maximum allowable for premium determination. This would let plans add benefits without affecting the program's budget. A related solution, used by the FEHBP, is to allow plans to add certain benefits (e.g., hearing aids, dental care) with the entire cost born by enrollees "off-budget" and not as part of the negotiated premium.

Defining the Benefit Package. Perhaps the single most vocal concern of defenders of the present Medicare program has been the prospect of losing particular benefit guarantees that are exhaustively described in law. Freezing benefits in law, however, prevents consumer-driven plan evolution, innovations in cost control, and plan responsiveness to consumer preferences for coverages. This apparent dilemma should, however, be one of the easiest concerns to address. Benefits could, by law, be tied to actuarial measures of performance, similar to those used informally by OPM in administering the FEHBP. For example, each plan could be

required to have a benefit package that actuaries agree would pay not less than X percent of overall hospital, medical, and prescription drug costs faced by Medicare enrollees, where X would be better than traditional Medicare. (Special exceptions could be allowed to accommodate Medical Savings Accounts or other unique cases, if desired.) The administering agency could also be empowered to reject plan benefit gaps that were likely to penalize enrollees unfairly or that would foster undesirable risk selection.

Risk Management. Age-adjusted capitation rates as used in Medicare improve over the non-existent adjustments used in the FEHBP. There are, however, additional mechanisms that could be used. For example, retrospective adjustments in government contributions to each plan could be made by pooling very high cost cases and allocating costs based on actual distribution of such cases. Such a reinsurance mechanism would be particularly important for smaller plans, but would also help with the problem that no risk adjustors predict costs with great precision. And, of course, benefit gaps that encourage invidious risk segmentation should be discouraged. If there were great concern over a particular plan feature (e.g., very high deductibles), enrollment could be deliberately limited until risk selection in that plan had been studied.

The main lesson of the FEHBP in this context is that the system as a whole will tolerate minimally adequate risk adjustors and a good deal of risk segmentation without destructive death spirals or real or perceived inequity. Past Medicare experience with AAPCC suggests that over-compensating for risk differences may be as big a problem as the opposite.

The Future of Traditional Medicare. Senator Breaux's proposal contemplates that traditional Medicare would continue, competing with other plans for enrollment. The fear of opponents is that this plan would become overpriced through risk selection, and the only option available in rural areas, to the detriment especially of the neediest elderly. Further, unless it were modified to include prescription drugs, it is feared that it could not compete.

(Another problem may be the inability to use panels of preferred providers, exchanging limitations on freedom of choice for enriched benefits; and yet another may lie in its uniform Part B premium throughout the country.) There is no simple answer to these concerns.

For example, the difficulty that millions of impoverished elderly have in paying premiums today is an issue in its own right, regardless of what program model is used. Perhaps the income tax system would offer a preferred approach to the imperfectly operating approach used today, which relies on Medicaid agencies to find and subsidize needy elderly. But that decision does not rest on the program model.

As argued below, the simplest remedy to malfunctioning in a newly redesigned program is to monitor it carefully and make further changes if needed to maintain access, hold down premium cost, or deal with any other problem. For example, suppose that the reformed program did not attract competing fee-for-service/PPO plans, and that risk selection raised the cost of traditional Medicare. One solution might be to amend the program to make the entrance of new plans even easier. Another might be to impose a premium cross-subsidy to attenuate adverse trends. Absent actual experience, it seems foolish to build in protections against problems that may never arise. If better alternatives become available to all enrollees, the withering away of the traditional program may be a welcome event.

However, it would be possible to give traditional Medicare limited authority to enrich some benefits while reducing others, within circumscribed limits. For example, a higher deductible could be combined with limited prescription drug coverage. Concerns over price controls on prescription drugs could be met by requiring reliance on third party contractors to administer the program. Premiums could be allowed to vary modestly by geographic area. The basic idea would be to allow traditional Medicare to compete flexibly with other plans without an Act of Congress to authorize each benefit decision.

Implementation and Administration. The Breaux proposal would set up the new program under the auspices of a new "Medicare Board", empowered to set standards, approve benefits, and negotiate premiums (National Commission, 1999b). This reflects the view that HCFA would be too conflicted if it were simultaneously in charge of the traditional program and the referee for its competitors. A further jurisdictional problem arises because HCFA has evolved over the last two decades into a major regulatory agency with broad powers over most sectors of the health care system, quite apart from its responsibility for administering traditional Medicare. It is beyond the scope of this paper to deal with the pros and cons of alternative administrative models. Suffice it to say that HCFA, unlike OPM, has a record of failing to handle its responsibilities for competitive plan oversight with careful attention to problems and rapid development of solutions that facilitate constructive program evolution. Of course, an immense increase in responsibilities and in the complexity of the program have been imposed on HCFA in recent years without attendant resources increases.

Conclusion--Evolution over Time. If the test for adoption of an FEHBP model for Medicare is that design decisions made today must be demonstrably capable of avoiding any major problem over a period of decades, then the test must inevitably be failed. If the problem is approached from the perspective that the reformed program can be further modified over time, if and when particular problems emerge and prove to have practical importance, then the FEHBP model--suitably improved to correct known defects--offers a reasonable path to achieve at least modest and possibly substantial gains in equity, efficiency, and adequacy of benefits. Of course, the government's track record as a forecaster, problem solver, and manager in all major health insurance programs is less than stellar. But this risk remains under any option, including the status quo.

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Ms. ARNETT. Thank you very much.

And finally, Mr. Chairman, I'd like to commend your committee for the work that you're doing on long-term care insurance for current Federal employees. I think that your committee can serve as a model for the right way to do this in providing people with maximum flexibility, maximum choice in the long-term care insurance market, thinking ahead about how important that is to Medicare in the future but today just setting up a very competitive model like FEHBP and the long-term care insurance model. So I commend you on that.

In conclusion, I would hope that serious consideration would be given to using the FEHBP model for Medicare reform to give seniors much more choice and freedom in attaining health care and to save taxpayers \$500 to \$700 billion a year, by the year 2030 under a modernized Medicare. Instead of appeasing regulators and health police, patients would be free to make their own choices of doctors and care arrangements.

Thank you, Mr. Chairman and Mr. Mica, for inviting me here, and I look forward to your questions.

[The prepared statement of Ms. Arnett follows:]



**GALEN
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**The Federal Employees Health Benefit Program
as a Model for Medicare Reform**

**Testimony presented before the Civil Service Subcommittee
of the House Committee on Government Reform**

The Honorable Joe Scarborough, Chairman

**Field hearing
Sanford, Florida
Saturday, May 22, 1999**

**Presented by:
Grace-Marie Arnett
President, Galen Institute, Inc.**

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The Federal Employees Health Benefit Program as a Model for Medicare Reform

Grace-Marie Arnett
President, Galen Institute

Thank you, Mr. Chairman, and members of the committee for inviting me to testify at this important hearing today. I am honored by the invitation and hope today to present ideas that will be useful as you and your colleagues address the considerable financial challenges facing the Medicare program.

My name is Grace-Marie Arnett, and I am president of the Galen Institute, a not-for-profit health and tax policy research organization based in Alexandria, Virginia. The Galen Institute was formed in 1995 to promote a more informed public debate over individual freedom, consumer choice, competition, and diversity in the health sector. Our goal is to expand public education about free-market ideas to invigorate a consumer-driven market for health services and increase access to affordable, privately-owned health insurance.

The Galen Institute also facilitates the work of the Health Policy Consensus Group, which is composed of more than 20 health policy experts from the major free-market think tanks. My colleagues in the Consensus Group and I believe two critical principles should govern changes to Medicare:

- 1) Reform of the Medicare system should expand private-sector options for beneficiaries. Beneficiaries should be able to elect to participate in

traditional Medicare or to privately purchase health coverage or medical services of their choice.

2) Medicare benefits should be defined in terms of a dollar amount, not in terms of an open entitlement to covered services.

I would hope that these principles might also be useful as a guide for your deliberations as well.

I would like today to begin with a brief overview of why Medicare must be reformed, not only to solve its looming financial insolvency, but also to address the growing restrictions on coverage for today's and tomorrow's beneficiaries. Then I would like to address innovative reform proposals, especially one offered by the Chairmen of the National Bipartisan Commission on the Future of Medicare that uses the Federal Employees Health Benefit Program (FEHBP) as a model for reform.

Danger signs ahead

Congress and the White House established the Medicare Commission last year to provide recommendations on how to save the troubled program. In 1998, Medicare spent \$214 billion to provide health services for 39 million beneficiaries, mostly Americans over age 65. The commission was created because virtually all who seriously study the program admit that Medicare's entitlement to covered services is unsustainable. The coming influx of 77 million baby-boom beneficiaries will bankrupt the system unless it is modernized.

Medicare's unfunded liability is nearly double that of the Social Security Trust Fund. If nothing is done to Medicare now, by the time today's college students reach retirement age, the tax burden created by Medicare alone will nearly triple, from the current 5.35 percent of gross domestic product to almost 14 percent.¹

But it is not only Medicare's future financial collapse that must be addressed. Already today, doctors and even beneficiaries are running into walls of restrictions in Medicare. Dr. Robert Waller, former chairman of the Mayo Foundation which operates the Mayo Clinics, asked his staff to count the number of pages of government rules and regulations his facilities must follow in treating Medicare patients. Jaws dropped when he testified before the Medicare Commission that they counted 111,000 pages of rules governing every detail of what doctors can and cannot do and how they must record and report patient information. I'd like to give you a few examples of what is happening today in the Medicare program to illustrate how important it is to modernize Medicare.

Hospice care

An article in the Washington Post two years ago² reveals where a centralized, government-run Medicare program leads. The lead of this *news* article reads:

¹ Saving, Thomas R. and Rettenmaier, Andrew J. "Saving Medicare." National Center for Policy Analysis, Dallas, TX. January, 1999.

² Rosenblatt, Robert A. "Government auditors question Medicare payments for Long-Term Hospice Care," Washington Post, March 16, 1997.

People in hospice programs are not dying fast enough to satisfy federal government auditors. Washington is conducting special reviews of hospice records and calling for repayment of money spent under Medicare for patients who lived beyond the expected six months after they had enrolled for hospice care.

The get-tough policy is part of the government's Operation Restore Trust, a special program designed to combat waste, fraud, and abuse in Medicare.

Apparently federal auditors believe that Medicare patients *living too long* represents waste, fraud, and abuse in Medicare. I think that Medicare patients, and the American people, would strongly and vociferously disagree.

Fraud and Abuse investigations

Certainly Medicare fraud is a major problem, and no one would condone fraudulent schemes that steal money from the program – and ultimately from beneficiaries and taxpayers. But the government's fraud and abuse enforcement is creating problems of its own.

The big dragnet for "health care criminals" is threatening innocent doctors as well as creating an unhealthy climate of fear and defensiveness in the medical profession.³

An example will reveal where enforcement of the government's 111,000 pages of Medicare rules and regulations is leading.

³ Arnett, Grace-Marie. "How bureaucracy invites health care fraud and why complex rules guarantee the abuse of physicians," Forthcoming.

In Idaho, Medicare inspectors audited the practice of physician Kenneth Krell last year, reviewing 15 charts. The auditors charged that Dr. Krell had been overpaid by Medicare by \$2,355.52 for some of these 15 patients whose charts they reviewed. Medicare then demanded that Dr. Krell return \$81,390.02, a figure arrived at by multiplying the alleged overpayment by the total number of Medicare patients the doctor had seen in 1997.

Dr. Krell and the Idaho Medical Association protested loudly and publicly, and the federal government backed down, limiting the fines to only to the original \$2,355.52. But this episode has put a chill on Idaho physicians, and on doctors everywhere. Another group of Idaho Falls internists decided after a similar audit that the risk of treating Medicare patients was too great. They were warned that another audit could lead to \$10,000 fines for every instance in which they miscoded a diagnosis or treatment. The doctors decided that to save their practices, they would stop seeing Medicare patients, meaning that their former patients now must travel 45 miles to the nearest city to see a doctor. These doctors are not crooks. They are trying, as AMA President Nancy Dickey recently said, to do their best to treat their patients under Medicare rules but are finding the rules so incomprehensible, contradictory, and onerous that compliance is virtually impossible.

Dr. Russell Snow, an eye, ear, nose, and throat doctor from Caldwell, Idaho, says his colleagues are so frightened by federal enforcement provisions that many more are considering heading for the exits.

Section 4507

One of Medicare's worst features is a provision enacted in the Balanced Budget Agreement of 1997 which has the effect of keeping persons over age 65 from

contracting privately with a personal physician to receive medical services. Even British citizens in their country's socialized health care system can see doctors and pay privately for services if they choose, but not so American seniors in Medicare.

Under the 1997 legislation, so named because it is located in Section 4507 of the law, a doctor who wishes to contract privately with a patient enrolled in Medicare Part B must remove him or herself completely from the Medicare program for a period of two years. That means that to treat one Medicare patient one time privately, that the doctor must stop seeing all of his or her Medicare patients for two years. This financial hardship effectively prohibits private contracting by all but a small number of physicians. The result: Most Americans over the age of 65 cannot spend their own money to secure the medical services or treatments they want on terms mutually agreed upon with a physician of their choice.

Privacy Intrusions

Under the pretext of regulating prices and assuring "quality" services, the Health Care Financing Administration which administers Medicare has proposed a rule that would force 9,000 home health care agencies to collect and report sensitive personal information on their patients. This information – to be collected without the patient's knowledge and transmitted to a federal database – would include such data as patient history and personal characteristics, including race and ethnicity, living arrangements, and financial, behavioral, and psychological profiles. The detailed record also would include whether the patient had expressed "depressive feelings," a "sense of failure," or "thoughts of suicide," or had used "excessive profanity" or made "sexual references."⁴ Further, the clinician's assessment would

⁴ Moffit, Robert E. "HCFA's latest assault on patient privacy," Executive Memorandum #580, The Heritage Foundation, March 22, 1999.

become part of the patient's file and available to other government agencies for review.

Such abuse of the patient's right to privacy is rooted in the top-heavy structure of the Medicare program.

Why Chairman Breaux is right

These and other danger signals finally have convinced some political leaders that it is time for a change in Medicare. The chairmen of the Medicare commission, Democratic Senator John Breaux of Louisiana and Republican Congressman Bill Thomas of California, lived up to the name of the "bipartisan" commission in crafting a joint plan, one designed to leverage the powerful forces of market competition and consumer choice to save the program.

But politics trumped policy. Despite heroic efforts by both chairmen, the final tally in March was one short of the 11-vote super-majority that the 17-member commission had set as its threshold to issue recommendations. None of President Clinton's appointees voted for the reform plan. The commission therefore disbanded, unable to agree on any advice for Congress and the White House.

But the plan they developed, with very competent advice of policy experts, including my colleague in the Consensus Group John Hoff, was sound and deserves consideration by Congress.

FEHPB as a model for free-market reform

Not acting, as you know so well, Mr. Chairman, is not an option. But unfortunately, Medicare is being used as a political weapon. That is bad for today's senior citizens, for tomorrow's retirees, and for young families who face the prospect of dramatically higher taxes into the next century for a program with an insatiable appetite for taxpayer dollars.

President Clinton has proposed earmarking one-sixth of the federal budget surplus to extend the program's life by a few years. This may seem politically expedient, but it's no solution. The Congressional Budget Office and the General Accounting Office both have dismissed the administration's proposal. "The president's proposal could introduce a sense of false complacency," GAO head David Walker warned, adding that the White House plan would improve the "paper solvency" of Medicare "without reforms to make the underlying program more sustainable."

The solution endorsed by the majority of the members of the bipartisan Medicare commission and by virtually all of my colleagues in the market-based health policy community is to restructure the program to put more control in the hands of beneficiaries and less in the hands of bureaucrats. We believe that citizens will get the best quality and services at the best price through the competitive marketplace. Getting there means redefining Medicare in terms of a fixed dollar amount for each individual instead of the current entitlement to a list of government-determined products and services.

Under the proposal offered by Chairmen Breaux and Thomas, beneficiaries would have the choice of staying in traditional Medicare or receiving financial assistance that they could use to purchase their own health coverage in the

private marketplace. The “premium support” model they offered would move Medicare away from the current crushing system of price controls, regulatory bottlenecks, and restrictions on coverage to give seniors money they could use to choose their own health care arrangements in a competitive system.

Their plan was modeled after the successful Federal Employees Health Benefit Program, over which your committee, of course, has jurisdiction and which provides health coverage for members of Congress and their staffs, the White House staff, and 10 million other federal employees, retirees, and their families. This very popular program has been extremely successful in providing a wide array of choices for participants, while holding down premium costs. You and the members of your committee are to be congratulated for demonstrating the effectiveness of a light-handed approach to legislative direction of FEHBP.

This viable, successful program can serve as a model for transformation and modernization of Medicare to provide a broad array of private-sector choice of health plans for Medicare beneficiaries. Under FEHBP-style Medicare reform, the government would negotiate with participating private insurers – as it does now on behalf of federal workers – to ensure that each private plan offers a core set of benefits, possibly including prescription drugs. As my Consensus Group colleague, Bob Moffit of the Heritage Foundation points out, seniors would be empowered to “hire” or “fire” a particular health plan. They would be free to select anything from an inexpensive basic plan to a more costly option with broader benefits. Health insurers would have a greater incentive to tailor their plans to meet the needs of seniors. Free-market pressures, namely consumer choice and competition, would control program costs without compromising high quality care.

Under the premium support system, Medicare beneficiaries would receive a contribution to the cost of their chosen plan, but that contribution could be adjusted – or indexed – each year to reflect the market price of plans providing the core set of benefits. In this way, the elderly would be assured that they could afford the costs of standard coverage, but they would have a strong incentive to choose a cost-effective plan because the premium support they receive would be limited.

Stuart Butler of the Heritage Foundation describes how the new premium support mechanism contrasts with the current system of allowing Medicare beneficiaries to participate in managed care plans:⁵ Medicare today uses a complex formula to determine its payments to managed care plans serving beneficiaries. Through legislation and regulation, the government tries to create a payment schedule that will work in all parts of the country and that takes into account local conditions. But as is typical of attempts by government to set payments by formula, these schedules rarely match the actual market, which is constantly changing. As a result, policymakers and health care providers grumble constantly that the formula systematically and wastefully overpays some plans and underpays others. As we have seen, many managed care plans have opted out, saying that they would lose money under federal payment schedules.

By contrast, in the FEHBP, a "call letter" is sent each spring to health plans to ask them to submit proposals for providing a broadly defined set of benefits to federal workers, their dependents, and federal retirees. The plans must state the services they propose to cover as well as the premium they intend to charge. After these proposals are received, the White House's Office of Personnel Management

⁵ Butler, Stuart. "Principles for a bipartisan reform of Medicare," Backgrounder No. 1247, The Heritage Foundation, Washington, D.C., January 29, 1999.

(OPM), which is responsible for running the FEHBP, engages in rounds of negotiations with plans until a final proposal is made and accepted.

The negotiations between the OPM and the plans involve the design and scope of benefits, the premiums, the geographic area in which the plan will operate, and other conditions under which services will be delivered. Through this negotiation system, a set of benefits and prices is determined. After the negotiations are complete, the OPM sends out standardized information on all plans to federal workers and retirees late in the fall each year, and individual FEHBP beneficiaries choose the plan in which they wish to enroll for the following year.

In this system, plans feel pressure to compete with one another; they also feel pressure from the government and federal workers to provide the best services for the price. Unlike a system of pricing based on formulas, plans cannot easily profit by exploiting a regulation or a poorly designed pricing formula; neither is the government required to overpay or underpay simply because of a legislated rule.

If Medicare were run on similar principles, the government could negotiate payment levels for plans that reflected local market conditions and avoid the chronic overspending or underpricing (which leads to poor quality or fewer plans) that is endemic to the current formula system. The government also could negotiate special prices and services for particular categories of special-needs beneficiaries and in other ways provide a better and more cost-effective service to seniors.

The negotiation approach would allow Medicare gradually to modify benefits in line with medical developments. Moreover, it would permit experimentation with

"risk adjustment" mechanisms to raise or lower total payments to plans depending on the health status of beneficiaries choosing each plan.⁶

FEHBP as a model for long-term care insurance

On a related matter, you also are providing leadership, Mr. Chairman, in using FEHBP as a model for long-term care insurance. The legislation you have introduced, cosponsored by Mr. Mica, could lead to similar policies in the private sector.

Your Civil Service Long-Term Care Insurance Benefit Act would direct the Office of Personnel Management to establish and administer a program through which Federal employees and annuitants may obtain group long-term care insurance for themselves, a spouse, or, to the extent permitted under the insurance contract terms, any other eligible relative. Your legislation takes a blessedly hand-off approach, letting beneficiaries, and not bureaucrats, decide the shape of the insurance policies.

Tomorrow's senior citizens must begin thinking today about coverage for their own non-acute medical needs. Your proposal would go a long way toward establishing a program in the FEHBP that could guide the development of these products in the private marketplace.

⁶ This is a crucial feature of a negotiation model, according to Butler. There are legitimate concerns about giving flexibility to plans to vary benefits for fear that this would allow plans to "cherry-pick" good health risks. But "correcting" that risk with standardized benefits would lead to rigidity and discourage plan innovation. Negotiation, however, would permit varied benefits to be subjected to review--to check for cherry-picking--before they could be offered to seniors.

Choice and freedom in Medicare reform

In conclusion, I would hope that serious consideration would be given to using an FEHBP model for Medicare reform. This approach would give seniors much more choice and freedom in obtaining health care, and it would save taxpayers \$500-\$700 billion *a year* by 2030. I understand that Senator Breaux and Congressman Thomas are working to gain congressional consideration of their proposal in this Congress. It failed to gain the endorsement of the full Medicare Commission because of political, not policy, considerations. The American people deserve to hear the details of this attractive option and to participate in the debate.

But members of Congress should be forewarned as the legislation moves forward: Free-market reform can be derailed in the legislative process through hostile amendments that seek to impose on private insurers the same excessive rules and regulations that the Clinton administration tried to impose on private-sector health plans. There's no point to introducing patient choice for seniors if lawmakers allow that choice to become meaningless. For serious Medicare reformers, though, the path is clear. If a superior system of patient choice and competitive private plans is good enough for Congress and the White House staff, it should be good enough for America's seniors.

Under a modernized Medicare, instead of appeasing regulators and health police, patients would be free to make their own choices of doctors and care arrangements. Seniors looking out for their own interests and pocketbooks will spend much more wisely the \$6,000 Medicare spends on the average beneficiary each year. The market will provide more attractive options for a variety of products and services.

If allowed to function without government shackles, competition will facilitate continued innovation in products and service delivery. The result: taxpayers will be protected, consumers will get better value, and Medicare would become solvent for decades to come.

Thank you, Mr. Chairman and members of the Committee, for the opportunity to make this presentation today, and I look forward to your comments and questions.

Mr. SCARBOROUGH. Thanks for that testimony.

Ms. Cherney.

Ms. CHERNEY. Thank you, Mr. Chairman and Congressman Mica.

My name is Beckey Cherney, and I'm president of the Central Florida Health Care Coalition, a non-profit coalition of large public and private employers in central Florida. The Coalition is 15 years old, and its main focus is on improving the quality of health care. I am also a consumer representative on the Florida Board of Medicine.

I speak with you today as a health care "utilizer," not a consumer. When we achieve the convergence of information technology and evidence-based medicine, I will become a health care consumer. But at the present time, the financing, clinical care delivery system, and health plan designs are so complex, no ordinary citizen has the information required to be a true health care consumer.

All doctors are not created equal.

The greatest predictor of the health care you receive is the year your doctor graduated from medical school.

The problem in health care is that it is the most inefficient major industry we have in our country. That is the disease that must be treated. Our ongoing efforts to focus on the symptoms of financing and managed care are a placebo that will never have a measurable impact until we treat the disease.

While I applaud your efforts to look at the Federal Employees Health Benefits Program as yet another "financial fix," I think the inevitable damage from attaching Medicare to that program is unfair to the people covered by that program and the people responsible for administering it. In our considerable experience with this, the almost inevitable implosion of the Medicare coverage has a terrible impact on the non-Medicare enrollees as well. Unreimbursed Medicare expenses will be shifted to the non-Medicare enrollees.

Central Florida has the demographics that will exist nationally by 2010—the ethnic diversity, percentage of senior citizens, and so on. We are a microcosm of what is happening across the Nation. California's managed care market is more mature than ours; New York's is less.

Let me quickly tell you the sad tale of Medicare in our market. Under the Balanced Budget Act, our two major hospital systems will each lose over \$100 million on Medicare from now until the act expires in 2003. Some of these losses will necessarily be shifted to employers, because the hospital cannot make widgets to replace that lost revenue. Our hospitals have acted responsibly and with restraint as they waited for the chaos created by Medicare to resolve.

As a result of that, I want to be certain I do not say anything that might shock any of you. You see, I would not want you to have a heart attack here in central Florida. We no longer have any extra capacity in our emergency rooms. Our hospital margins have been slashed so drastically by Medicare's failure to reimburse appropriately, the hospitals have not been able to expand to meet the growing demand.

One of our hospitals took on a Medicare demonstration project. Before they could extricate themselves from the project, they suf-

ferred financial losses that will hamper their operation for the next decade. As a faith-based, not-for-profit-hospital, they entered into the project simply to serve their community. Thousands of Medicare enrollees had to find new plans, and many of them even had to change doctors. That is patently unfair and unsafe. The physician-patient relationship and the continuity of care are critical, and Medicare beneficiaries should never be denied that.

I'm responsible for purchasing my mother's Medicare. I have had to change her twice in the last 18 months; with the pending PRU Care-Aetna merger, it's highly likely that I will have to change her again in the next couple of months. If my broker tried to churn my investments the way my mother's health care is being churned, the Securities and Exchange Commission would respond. But we don't have that protection for our Medicare recipients.

Remember again that with our demographics, we look like the rest of the Nation will look in 2010. The managed care plans in our market are the same as those in the Federal Employees Health Benefits Program. We have the Prudentials, Aetnas, Cignas, and so on. When Medicare+Choice arrived, they all quickly participated. Right now, to the best of my knowledge, every single one of them has either stopped enrollments or has immediate plans to do so. They're losing too much money.

Tinkering with the financial mechanism will not solve this problem. And that is being said by someone who admits that she thought she could save the world with second surgical opinions 15 years ago. Plan designs will not solve it. We must address the efficiency or more correctly, the inefficiency of the health care delivery system to correct it. And that is very doable. Working in partnership with our doctors and hospitals, we have made great strides in central Florida by linking information technology and evidence-based medicine. The greatest impediment to our advancement of that is Medicare. For the most part, we do not think doctors are overpaid; we think basketball players are overpaid. But I will tell you that Medicare is every bit as out of kilter financially as the National Basketball Association.

The health care train is rambling rapidly down the track toward a large wall. The reason Congress does not see the wall is because they are always glancing to the side at some new, but not really new, financial mechanism like we are discussing today. I would like to suggest that you do not put another Band-Aid on this wound. It is going to bleed our health care industry to death unless we force those responsible to look at the real disease of inefficiency and stop treating only the symptoms. Creating the inevitable chaos in the Federal Employees Health Benefits Program will simply be another problem, not a solution.

Mr. SCARBOROUGH. I thank you for your testimony. Mr. Mica is going to need to be leaving in the next 15 to 20 minutes for another important meeting across the district, but I wanted to ask each of you a question briefly, then I'll turn it over to Mr. Mica, and then I'll be asking some more questions.

I'm just curious, Ms. Cherney, if I want to get the best doctor I can, you said the best predictor of health care coverage depended on what year my physician graduated from medical school. I'm just

curious: Do I look for a young doctor, an older, more experienced doctor, or somebody in between?

Ms. CHERNEY. Well, it depends on what your condition is. But, for the most part, the younger doctors have had the recent education and they're aware of the technology and the new things that are available to them. It's not the fault of the older doctors that they're not, and when you're practicing medicine there isn't a place for them to go to stay up to date. But if we had a central repository, if we had systems like I have here where I can profile the physician and I can show them how well they practice in the hospital by diagnosis, and I can show them how well they practice in their office by diagnosis, they can see where their deficiencies are.

And so, if you were treating upper respiratory infection in central Florida, and your cost per episode is more than \$100 and you graduated from medical school 10 years ago, so you're giving Cephalosporin and colds and cough medicine, you will quickly see by outcomes that you should be using Ampicillin and you will have better outcomes and it will be a much lower cost to the community. But the outcome is the issue, not the cost.

Mr. SCARBOROUGH. OK. Great. So a younger doctor—I've been trying to convince Mr. Mica the same holds true with Members of Congress.

Mr. Lemieux, I'm just curious, if you could give us some background, people of the audience, because I think it would be very instructive about the board, the Bipartisan Commission. I'm interested in the makeup of that Commission. You said there were 17 people. Could you just instruct everybody and myself also, exactly what that makeup was, who appointed those members, how many from the administration, how many from Congress, et cetera.

Mr. LEMIEUX. I'll try to get this right. I can name the members and I'll have to think about exactly who they were appointed by. It was chaired by Senator Breaux as the statutory chairman, Representative Thomas was the administrative chairman. That was sort of a power sharing arrangement that was predetermined.

Mr. SCARBOROUGH. Right.

Mr. LEMIEUX. There were four appointees from the President. The rest of the appointees were from the leaders of Congress, from both sides of the aisle. The Members were—the congressional appointees were Congressman McDermott from Washington; Congressman Dingell from Michigan. There was Congressman Ganske from Iowa, who then left the Commission and was replaced by Colleen Conway-Welch, a nurse practitioner from Tennessee. Sam Howard was appointed by Speaker Gingrich at the time. He's an HMO executive in the midwest.

In the Senate side, Senator Frist was on the Commission, Senator Rockefeller, Senator Gramm of Texas, Senator Kerrey of Nebraska. They were all appointees of the leadership. Debbie Steellman, a Republican policy analyst, was an appointee of Senator Lott.

The Presidential appointees were an HMO executive from New York, Tony Watson; Bruce Vladeck, former HCFA Director—

Mr. SCARBOROUGH. Mr. Bilirakis also?

Mr. LEMIEUX. That's right, I missed Mr. Bilirakis, who is a congressional appointee. Mr. Altman, a health economist, and Laura Tyson, who is an economist, were also Presidential appointees.

Mr. SCARBOROUGH. OK. I'm just curious what was the breakdown of the people that supported Senator Breaux's recommendations and the board's?

Mr. LEMIEUX. They were all congressional appointees. Of the congressional appointees who were opposed it was Representatives McDermott, Dingell, and Rockefeller. All the other congressional appointees were in favor. None of the Presidential appointees were in favor.

Mr. SCARBOROUGH. So you had the administration actually going against the recommendation of Senator Breaux?

Mr. LEMIEUX. Whether it was going against or not supporting, yes.

Mr. SCARBOROUGH. Did you have legal training in the past also? I'm just curious.

All right. Ms. Arnett, I wanted to ask you, you touched on an issue that I've got to tell you I've heard more complaints about and I think the first time most Americans were made aware of it was after a Wall Street Journal editorial talking about how senior citizens could not go to whichever doctor they wanted to go to. If they went and actually paid for the medical service that was provided for them then that physician would be kicked out of Medicare for 2 years and face financial ruin. I wanted some clarification on that.

The Wall Street Journal says that came about as a result of the Balanced Budget Act of 1997. I have talked to every chairman on every committee that has jurisdiction over this and every one of them says that was the case before the 1997 Balanced Budget Act and as I find in Washington, DC, you know, it's sometimes hard to nail down exactly the bottom line. Can you clarify, for the record, right now, what your understanding is on when that ban came about?

Ms. ARNETT. Well, you're absolutely right, Mr. Chairman, there has been a big controversy over whether or not seniors could, in fact, pay privately for health care on their own outside of Medicare. HCFA, the Health Care Financing Administration, had said they could. Doctors were afraid they couldn't. The lawyers were all over the map.

And so this was actually Senator Kyl's, of Arizona, way of trying to put something in there that said seniors could. And the administration apparently got very upset about this and in one of these, you know, 11 o'clock at night controversies said, OK, we will let seniors contract privately with a physician for health care if that doctor agrees to get out of Medicare for 2 years and not see any Medicare patients at all for 2 years just for treating that one patient. And somehow or another it wound up being part of the bill, starting out as a fix and winding up making it much worse.

And we were told that this was a big issue with the White House and that they were ready to go to the mat to make sure that they didn't open the door to more freedom and privacy in the health care system.

Mr. SCARBOROUGH. It's just remarkable to me in 1999 in the United States of America that the people out here—my mom, my

dad, your parents—can't go to the doctor of their choice. That is about as repugnant to me and to what I thought America stood for as anything. I'm just absolutely dumbfounded as to why that got shoved in the Balanced Budget Act of 1997 and why somebody on the congressional side didn't put a red flag up before the Wall Street Journal.

Ms. ARNETT. Well, if more members had known that that was in there, you would absolutely not have voted for this. But it was in there. Not knowing it was there, that was the problem.

Mr. SCARBOROUGH. I voted against it anyway because I thought it spent too much money.

Mr. Mica.

Mr. MICA. Thank you, Mr. Chairman. A couple of questions, Mr. Lemieux. Do you think it's better that we totally replace Medicare or provide an alternative for a phase? One of the problems you have is many of the seniors become very concerned when there's something sort of new on the block, and unknown, untested, and I hear a great deal of apprehension about completely replacing the system. Had you given consideration to that, and how do you think it should be approached?

Mr. LEMIEUX. The Commission gave very little consideration to completely replacing Medicare. They wanted to remake Medicare with better incentives. But they didn't want to jettison the current HMOs that we have, they didn't want to jettison the fee-for-service plan. They wanted all those plans to compete in a better way and in a fairer way and with possibly better benefits. But there was very little consideration in the committee, and I would have known because I did the cost estimate, for something that would have been a complete change of Medicare.

Mr. MICA. One of the other areas, and I think I mentioned it in my opening statement, that we've seen dramatically increased costs is the prescription drugs, and I think you talked a little bit about that. Maybe you could elaborate some more. One of the questions that always comes up is always the copays, how that operates. Could you tell us what your recommendation might be to deal with the cost of rising prescription drug costs?

Mr. LEMIEUX. The commissioners were very concerned about the costs. They were also very concerned that prescription drugs are very important in medical practice now and that it's especially important to make sure that lower income people were taken care of.

The idea of a high option drug benefit is that all plans have to have drug coverage. Now the level of that coverage was left undetermined. The idea was that the Medicare board would set up standards or examples for what would be acceptable drug coverage but that that would be left flexible so that the board and plans could evolve how things were. They were very concerned that it not all be predetermined, the copayments and which drugs were covered and which weren't.

So one of their concerns with Medicare is that it hasn't been flexible to evolve over time, and they wanted to back away from prescribing exactly how it should be done. So that was left fairly open, exactly how good drug coverage had to be in these high option plans.

Mr. MICA. The other item would be just premium cost and developing some scale possibly based on income or resources. What would be the fairest way? With the Federal Government employees health care plan we basically have the Federal pay and the employee copay. You have a little bit different situation with Medicare because you have people of varying means, and that would be the first part of my question. The other part would be: Was there any consideration to even expanding this to Medicaid? Because at some point if you paid 100 percent of the premium on a competitive basis you might be able to provide Medicaid assistance on a competitive basis at a lower cost. Could you answer those questions?

Mr. LEMIEUX. When the commissioners set out to ensure drug coverage for persons under 135 percent of poverty they wanted to implement that even before the premium support and the FEHBP-style system would be ready for Medicare. We all think it would take at least 4 or 5 years to get an FEHBP-style system up and running. But they wanted the subsidies for the low income persons to start right away, and so they presumed that that would happen via State Medicaid programs, although they also wanted the States not to be required to pay more. So they added 100 percent Federal funding for that.

After premium support is up and running, I think that their idea was to create a special schedule of premiums for low income persons so that they could get a high option plan at no cost to them. And they wanted the competitive aspect to still work for people under that percentage of poverty but they wanted also to ensure that they would be able to afford a good high option plan at no premium cost to them.

Mr. MICA. Ms. Arnett, you described a big government system or big government program that was on the verge of collapse, and you cited the demographics that we're looking at as far as the coming recipient, potential recipient. What are our dates of concern and how quickly do we see this new mass of eligible recipients coming on board?

Ms. ARNETT. Originally Medicare had been projected to start spending more than it took in within the next year or two. But as you know, that has been moved forward by putting in more taxpayer funds into the system. So the date of bankruptcy keeps moving forward because the amount of taxpayer dollars continue to go into the system.

But when the first baby boomers start to become eligible in 2012, a relatively short time, especially in just observation that even if changes were made today, it would take some number of years to begin implementation so that seniors have choices. And, again, Medicare as it currently is constructed should be one of the options, but let's put some more options out there. It's going to take awhile to get that machinery in place, and there's just not a lot of time. We have maybe a decade to get everything up and running.

Mr. MICA. You also cited some interesting figures, the 111,000 pages of regulations which I think your testimony also outlined very graphically how it's almost impossible to comply. One of the things we tried to do in Congress since there was so much fraud, waste, and abuse, is put additional regulations on, and monitor. And some of that—you also described scenarios of how that's back-

fired, and I hear the same thing from physicians. I guess FEHBP, a plan adopted in that pattern, would pretty much scrap all of those and we'd have defined benefits and then I guess a series of add-ons. Could that eliminate most of these 111,000 pages?

Ms. ARNETT. I believe so. I understand the legislation enabling FEHBP is one paragraph long, and that's a huge difference from 111,000 pages, and it's because beneficiaries would then be in charge of making those decisions. Not either the legislation or the regulation. Yes, I believe so.

Mr. MICA. The other thing you mentioned, which is something we tried to initiate and, OPM is a little slower than molasses in January, but that's on the question of providing long-term care and model FEHBP competitive system to provide—to find those vendors and health care providers that would provide plans and competition. One of the problems we ran into is that OPM says that there's just not enough folks willing to compete and also that the premiums are very high. I tend to think that if you had this open and available we'd have more people interested, participating and create a larger resource. Is that something you think would help get more competition in this area, and how should we approach long-term care, at least from a Federal employee standpoint?

Ms. ARNETT. Ned Lynch called a meeting with some of my colleagues from the Health Policy Consensus Group and other policy experts, and we're working closely with your committee in trying to do that.

But, again, I think you're absolutely right. The FEHBP is the model to really take a hands-off approach and to allow the marketplace to provide options, to provide the resources, some basic funding level, that the consumers can use to purchase their coverage, and over time the insurance will become better and cheaper, as it has in FEHBP on a relative scale for health care.

Mr. MICA. I noticed that you raised your eyebrow, Ms. Cherney; did you want to comment on any of the questions I've posed to the other panelists?

Ms. CHERNEY. Well, the FEHB Program went up 9.7 percent last year. The numbers are due out in a few weeks. But it's going to be at least that much. Is that sustainable in our marketplace? Having seen the competitors, the Cignas, the PRU Cares, and the other people trying to do this in a marketplace that represents the demographics of 2010, it has not worked. Those plans are not competitive. They did come out with programs that were too rich. I mean, I don't know why they chose to come up with \$1,200 in pharmacy benefits to start with. They should have started lower and tried to scale them up, depending upon what they could afford. But, at least in this marketplace, it hasn't worked: It hasn't created competition. It has created chaos both for the non-Medicare and the Medicare beneficiaries. It just simply hasn't worked.

Mr. MICA. Ms. Arnett.

Ms. ARNETT. Can I just say one last thing? There have been a lot of regulations imposed on FEHBP over the last couple of years which are, in fact, forcing premiums to go up, just as State regulation is forcing up the costs on individual and group health insurance. So the model for FEHBP in how things should be done is actually being distorted by a lot of administrative direction.

Mr. MICA. I think that's something that I pointed out in my opening statement and I've observed the more mandates, the more regulations, the more constraints that are put on it—and we've also lost a number of carriers. When you lose carriers you lose competition. And we've seen price increases. So the more tinkering and the more requirements we impose, again, the higher costs that we see, and it just seems to be a simple pattern. Maybe that's a simple explanation, but that's what I've seen in the past 4 years.

Mr. Chairman, I thank you for allowing me to participate today. I apologize. I'm going to have to leave at this point. But a very interesting panel, and hopefully we can provide FEHBP at least the way it was intended and started out as a model for some Medicare reform, and I appreciate you coming to our district today.

Mr. SCARBOROUGH. Thank you, Mr. Mica. I appreciate you taking time out of your schedule to come on by, too.

I wanted to get back to this—this is a number that I think I'm going to be using an awful lot for the next couple of years, 111,000 pages, that's absolutely remarkable regarding the regulations. It really helps to explain why you have physicians and medical providers in Idaho Falls, that are just saying the heck with it, we're not going to work under this system any more. I suspect as this continues it's going to get worse and worse and it's not going to be just Idaho Falls, ID. It's going to be Sanford, FL down the road.

Obviously from Ms. Cherney's testimony it appears that none of these regulations have anything to do with making sure the doctors get paid on time or making sure that health care providers get paid in time. Is this an oversight of the regulations, what about one or two pages that we add on making sure that physicians are paid on time and the health care providers are paid on time?

I say that because we've got to keep as many health care providers in this system as possible to help us get through rocky times. Unfortunately if they're not getting paid for months or even years then they're going to do what the doctors in Idaho Falls did and just leave the program.

What do you all recommend? I know it's going to be very hard for you all to recommend adding new regulations to 111,000 pages. But what can be done to make sure that Medicare is a bit more responsive to medical providers?

Ms. ARNETT. Well, one of the provisions could be to at least allow doctors that have been subject to audits and that are being slapped with these \$81,000 and higher fines at least due process in challenging these. And they're not—they're currently really guilty until proven innocent. The way the IRS has treated taxpayers is how doctors are now being treated under these Medicare audits. So just allowing them some due process would help so that they don't feel so threatened. I spoke with one of the women who administers HCFA, and she said doctors are "hysterical" over this. And what's going to happen is they are going to start leaving the profession, and they've got to have some legal protections and they don't now.

Mr. LEMIEUX. Mr. Chairman, a little bit larger picture on that. What we're trying to do with a more competitive Medicare is also make the government-run fee-for-service plan, which is the source of these regulations and the difficulties with providers, more responsive, more businesslike. As opposed to being a government bu-

reaucracy that's used to running its program by dictate, instead run it more by partnership. And that sort of cultural change will take years. But we think the competitive environment will aid that and it'll reward managers, government people in HCFA who take the initiative to be very responsive and to closely work with the providers for beneficiaries' benefit.

Mr. SCARBOROUGH. OK. In talking about this partnership, I want to ask you all to followup on this. I'm sure you have a response, but I just wanted to followup on something you said. I've been arguing and I'm sure that Mr. Mica and many others have been arguing that really the hope of Medicare in the future is providing partnerships between the patient and the physician and the hospital and doing this through provider service organizations—some call them PSOs, some call them PPOs. But I want to ask Ms. Cherney if you looked into provider service organizations as one type of partnership that could help the system.

Ms. Cherney.

Ms. CHERNEY. On the kinds of things you could do, in our community, our physician community is forced to provide short term financing for Medicare for 90 to 100 days. That's how long it takes them to get reimbursed. So in effect they're providing the short term financing for Medicare and it's breaking their back.

But the other part of that is, if you were to take a sixth of the budget surplus, as the administration was proposing for some things, and used a piece of that to create a place where best practices could be identified and communicated to physicians, that could change things. When we sat down for the first time with our data base with cardiologists and showed them which cardiologists had the best outcome down to the one who had the lowest outcome and then showed them what the national average was so you could see who really was providing inferior medicine, that helped the hospital to know who they needed to mentor and get up.

But also just looking through on anticoagulants that you use, there was a big issue there because the outcome was the same except some of them cost up to \$2,000 per case more. That was new, and so that resolved itself.

But arterial blood gases. A surgeon who had finished school 5 years previously had been taught to do arterial blood gases before the surgery, one after, two a day until the patient went home. The same with x rays. The doctors who had been out for 2 years had been taught that if there wasn't a change after surgery in the first arterial blood gas, don't do any more. It's a very expensive procedure. It's a very painful procedure. There are a lot of side effects from it. In that 2-hour meeting they eliminated those. We cut the cost of open heart surgery here \$4,000 for every open heart surgery that's been done since then. We have that forum of communication here. But we don't have any way for the rest of the world to know that. And the President's own Commission concluded last year that anywhere from 30 to 40 percent of the medical care that's given is unnecessary. But it's because it's outdated, not because doctors are bad. They are competitive and they are bright. And if you give them good information they will make good decisions. But there is no platform for the information, and I believe that the government

is probably the only one large enough to be able to create that platform and communicate it effectively.

Mr. LEMIEUX. Mr. Chairman, before I answer your question I'd like to make two points. And that is that almost all economists, actuaries, and clinical practitioners support the sorts of things that we're talking about here as far as outcomes, research, and best practice. We feel as though it was the surge of competitive searching for value among employers over the last 7, 8, or 9 years that has helped spur some of this, and the idea in Medicare is that a more competitive system might help. Certainly these sorts of things are a key, and I think that there's broad consensus that that sort of information-gathering about how to do things right in health care is the right way to go.

The second thing is when we were talking about the trends in FEHBP costs I think it's more than just the mandates that have driven up costs in recent years. There's historically always been a fairly volatile cycle of premiums in health care and in FEHBP in particular, and some of the rate increases that we're seeing now probably reflect the fact that rates were cut too much 5 and 6 years ago when we had a negative 3 percent increase.

The thing that's been heartening to economists is that the payments for benefits have been growing more moderately now than they did 10, 15 years ago. So we're cycling around a little bit lower point, which we think will be nice.

And the other thing is in FEHBP, a lot of the plans are having trouble with their prescription drug costs, so without having to be told they're working very hard to manage those costs better by adjusting their co-insurances, working harder with the manufacturers to create a formula that will be a better value and so on. And that can be confusing, and tumultuous; that's always the case. But the price of innovation is that things do change, and that there's hope that this is a self-correcting sort of situation.

Ms. ARNETT. Just one more quick fact, a paper that will soon be coming out from the Heritage Foundation reports that the Health Care Financing Administration reported that almost one-fourth of all physician and supplier claims are being either denied or challenged. So that means even when doctors are doing what they need to do to treat a patient they then have to fight a major battle with the bureaucracy. And if a Medicare beneficiary wants to challenge whether or not they felt that they were getting proper treatment, the typical administrative appeal takes 500 to 700 days to challenge. It's a little late to get prompt treatment.

May I ask also if you'd like me to include this statement in the record as well?

Mr. SCARBOROUGH. That would be great if you could do that, without objection.

[The information referred to follows:]

WHY AN UNREFORMED MEDICARE SYSTEM IS HAZARDOUS TO YOUR HEALTH

SANDRA MAHKORN, M.D., M.P.H., M.S.¹

Link to:

| [Executive Summary](#) | [PDF \(395k\)](#) |

Note: PDF version contains both the Executive Summary and the Full Text.

Too many Medicare patients are unaware that the quality of their health care is in jeopardy. The almost 40 million older adults and disabled persons who are covered by Medicare are subject to the most aggressively managed and overregulated health plan in the United States. In fact, the federal health care regulations, rulings, and paperwork pertaining to Medicare consume over 111,000 pages, many times more than even the federal income tax code.² The complexity of the Medicare system makes it difficult for both patients and their health care providers to understand what procedures and treatments will be covered, and which ones will be ruled medically unnecessary.

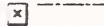
Members of Congress determine in legislation what can be covered under Medicare and at what price. They avoid making the tough decisions affecting patients, however, by shifting responsibility for Medicare coverage to the Health Care Financing Administration (HCFA). HCFA, in turn, regulates the delivery of health care by imposing voluminous rules, regulations, and guidelines on doctors,

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hospitals, and other health care providers. But it is a profound mistake to think that Medicare patients are insulated from the negative effects of this huge regulatory system in Washington by their physicians and providers. Their treatment is often at the mercy of distant federal bureaucrats and Medicare contractors.

If Members of Congress want to find ways to improve health care for all Americans, they should examine the many roadblocks to quality care that Medicare imposes on those who provide health care to senior citizens and disabled Americans. For example:

- **Medicare's standards for determining "medical necessity" are arbitrary and ill-defined.** Curiously, Members of Congress are considering private-sector health care legislation that would shift the responsibility of determining medical necessity to physicians, not bureaucrats.
- **Doctors who treat Medicare patients face the dilemma of choosing treatments based on their best professional judgment, and risking fraud and abuse charges if the Medicare bureaucracy says the treatments are "unnecessary," or if it prescribes the treatments.** This *Catch-22* undermines the professional independence of physicians and imposes a de facto gag rule.
- **The many complicated Medicare provider payment schemes include perverse incentives that interfere with the provision of medical services.** The complex "resource-based relative value scale" (RBRVS), for example, is a method of determining physician payment based on a statistical calculation of the "value" of factors that go into a medical service, outside the normal forces of supply and demand or patient benefit.
- **Patients who challenge Medicare denials of their claims face an arduous review and appeals process.** HCFA concedes that, in 1998, the average processing time for appeals of claims denied under Medicare Part A, which pays for hospital services, was 310 days. For Medicare Part B claims, which covers physicians' services, the average time for administrative law judges to render a decision was 524 days.³
- **Even if an appeal is decided in their favor, Medicare beneficiaries can hope to recover only the cost of the benefit itself, regardless of the extent of injury that resulted from the claim's original denial.** Yet in the context of private health plans, Senator Edward M. Kennedy (D-MA) has declared, "Health plans should not be allowed to escape responsibility for their actions when their decisions kill or injure patients."⁴

HCFA is not a user-friendly institution. Medicare policies and procedures stand as a regulatory gate between patients and quality care, with HCFA bureaucrats and HCFA contractors functioning as gatekeepers. Patients and doctors are poorly informed about issues as basic as the services that are covered and the financial disincentives doctors and hospitals face. Almost 24 percent of all physician and supplier claims were denied in 1997. Even excluding those denied for "reason of statutory exclusion," the rate of Medicare carrier denial is more than 1 in 10 claims.⁵ And patients or doctors who can afford the inordinate time and energy involved in filing appeals of denied claims recoup

only the cost of the service or benefit.

Although Members of Congress and HCFA officials routinely give lip service to quality, practical experience with the Medicare program tells a different story. Today's problems with Medicare are minor compared with what they are likely to become with the retirement of the 77 million-strong baby-boom generation and the corresponding demand for medical services. Shortsighted reimbursement and coverage decisions, poor communication with doctors, and intimidation of providers combine with intermittent managerial crises, invasion of patient privacy, and restrictions on patients' liberty to make the program a national concern. More than three decades' worth of circuitous and contradictory policies confuses doctors and patients alike. And Medicare has no competition to force it to improve. If Medicare beneficiaries want alternative health insurance coverage for their physicians' services, for all practical purposes they are stuck, for better or for worse.

In early 1999, 10 of the 17 members of the National Bipartisan Commission on the Future of Medicare, chaired by Senator John Breaux (D-LA) and Representative Bill Thomas (R-CA), endorsed a serious proposal that would reform Medicare substantially.⁶ That proposal would give Medicare beneficiaries roughly the same types of choices enjoyed by millions of government workers and retirees in the Federal Employees Health Benefits Program (FEHBP).⁷

If Congress is serious about improving America's troubled health care system, it should offer expanded personal choice to all Americans, regardless of whether they are enrolled in a federal plan, private plans, or the Medicare program. In the private sector, expanded choice should be accompanied by personal selection and ownership of health plans, and portability of benefits when workers change jobs. In Medicare, it would mean that patients could keep the traditional plan if they wanted to do so, but it also would mean that they could pick and choose superior private plans or bring their private health plan with them into retirement for primary coverage and get a government contribution to offset its cost.

MEDICARE: THE MOTHER OF ALL MANAGED HEALTH CARE

Medicare originally was designed in 1965 as a program to provide health insurance for the elderly. It since has evolved into a huge, financially troubled, overly bureaucratic system of rules and regulations governing virtually every facet of financing and delivering medical services to senior citizens and disabled patients. Medicare's tight control of benefits and providers is secure, with its burgeoning regulatory morass and unintelligible payment schemes.

Medicare is administered by the powerful Health Care Financing Administration. The regulatory history of HCFA has been a series of failed attempts to control and manage all aspects of medical practice, from the numbers and types of providers and the frequency of treatments and tests to the rates of reimbursement. Medicare's missteps have resulted in new layers of regulations to "correct" the unintended consequences of prior attempts. In study after study, the U.S. General Accounting Office (GAO) finds that Medicare frequently pays providers too much or too little.⁸

Testifying before the National Bipartisan Commission on the Future of Medicare, Dr. Robert Waller, President of the Mayo Foundation, pointed out that federal health care regulations consume over 132,000 pages. The vast majority of these rules, regulations, and related paperwork--more than 111,000 pages--pertain to Medicare. Between 1994 and 1998, 30,000 more pages were published in the *Federal Register*, compared with 2,000 the previous four years.⁹ This explosion of health care regulation is occurring despite White House promises in 1995 to simplify the regulations governing Medicare.¹⁰ The ever-growing pile of Medicare paperwork dwarfs that of any other government agency, including the Internal Revenue Service (IRS), which accounts for 17,000 pages of laws and regulations in the tax code. As a result, Medicare rules are becoming increasingly unintelligible to doctors and patients alike.

HCFA's regulatory regime is far more aggressive and intrusive than ever before. The Medicare bureaucracy has gone so far as to extend its regulatory reach into private transactions taking place *outside* the confines of the Medicare program, such as its private contract agreements between doctors and patients in which no taxpayer dollars are involved.¹¹ Even worse, HCFA now proposes to collect detailed and sensitive personal information from Medicare patients served by home health care agencies and transmitting it to a huge federal data base without the knowledge of the patients.¹²

Micromanaging Treatment

Federal and state legislators often chide private insurance plans for payment or reimbursement schemes that appear to reward doctors for withholding expensive tests or treatments. For example, in some managed care plans, a portion of "capitation" allotments are "withheld" until the end of the provider's contract year. Payment of these withholdings is contingent on the managed care plan's achieving certain medical spending targets. Curiously, Congress has allowed HCFA to utilize financial and punitive disincentives for expensive care and treatments for more years than most managed care plans have been in existence.

HCFA's Prospective Payment System is a case in point. Hospitals are paid a set amount on the basis of a patient's final diagnosis at the time of discharge instead of the actual number of services, tests, and treatments the patient may require. For example, HCFA reimburses a hospital more generously for the inpatient costs to treat one type of pneumonia over another, even when the patient with the lower-cost pneumonia may require more care and services and longer hospitalization.

The prospective payment methodology for hospitals encourages strict, sometimes draconian, utilization reviews for sick, hospitalized patients. It is not uncommon for admitting physicians to order unnecessary intravenous lines or urinary catheterizations--placing the patient at unnecessary risk for such problems as phlebitis or urinary tract infections--to prevent the patient from being discharged when they believe it is not in the patient's best medical interest. The reason: Hospitals have an economic incentive to "evict" patients as quickly as possible to avoid financial loss or to maximize monetary gain.

HCFA is notorious for developing elaborate payment schemes to influence the care-

giving behavior of physicians and other providers by using a series of rewards, punishments, and even threats of punishment. It is doubtful that private-sector managed care plans, faced with even minimal free-market competition, could have imposed most of HCFA's highly aggressive cost-containment measures without hearing a resounding public and political outcry. Medicare's large and growing captive membership provides effective immunity from the consumer pressures regularly experienced by private-sector plans. There is no existing private insurance market for seniors outside Medicare, a fact admitted by the Clinton Administration's counsel in recent litigation over the rights of Medicare patients.¹³ Today, American seniors have no real alternative to Medicare for private coverage. The lack of real choice for Medicare beneficiaries makes congressional attentiveness to a patient's right to quality care in Medicare even more important.

Managing "Medical Necessity"

HCFA and its contractors routinely deny payment for covered care and services that doctors say are "medically necessary." Despite its lengthy list of "covered" services, giving the impression that Medicare has a generous benefits package, Medicare's rate of payment denial is high.

Although the Medicare statute provides for payment for services that are "medically necessary," in practice just because Medicare formally "covers" a medical treatment does not mean it must cover it or will pay for it. Under certain circumstances, HCFA and Medicare contractors may determine that the medical treatment or procedure is not to be covered for purposes of payment. Consequently, doctors and patients never really can know whether a treatment will be covered. In typical bureaucratic doublespeak, the Medicare patient/provider "helpline" gives this definition of "medical necessity" to callers: "Medically necessary treatment is medical treatment thought to be needed before the carrier or insurer will pay claims."¹⁴

Congress largely ignores this problem. In perhaps the most exhaustive examination ever published, Timothy Blanchard, a California-based specialist in Medicare law, concludes,

The process of Medicare decision-making about coverage, and in particular medical necessity determinations, has been shrouded in mystery since the inception of the Medicare program.¹⁵

Blanchard reports that HCFA's notices on the topic reveal a profoundly disturbing pattern:

[T]hese notices reflect HCFA's tenacious effort to maintain to the greatest extent possible what is one of the most expansive bodies of secret law ever developed for application against a broad segment of the American population.¹⁶

In January 1989, Medicare proposed a rule to define "medical necessity" for patient care,¹⁷ but this rule never has been finalized. Despite this fact, lack of "medical necessity" is a common reason for payment denials. According to HCFA's 1997 statistics, over 19 percent of all denied physician and supplier claims were for services

deemed "medically unnecessary."¹⁸ And subtracting 1997 claims denied for "reason of statutory exclusion" causes the percent denied for lack of medical necessity to increase to 45 percent.¹⁹ Auditors for the U.S. Department of Health and Human Services' (HHS) Office of Inspector General (OIG) reported in February 1999 that, if HCFA rules and regulations were followed in all cases, even more claims would be denied for lack of "medical necessity." In fact, OIG auditors claim carriers should have denied almost \$7.5 billion of additional claims in 1997 for "lack of medical necessity."²⁰

HCFA's definition of "medical necessity," and the definition of its Medicare carriers, is a rolling one, both vigorous and arbitrary in its application and often contrary to "accepted principles of professional medical practice," a standard proposed in the Daschle-Dingell Patient's Bill of Rights.²¹ Moreover, Medicare coverage, based on definitions of "medical necessity," varies from state to state. Such major medical groups as the Mayo Clinic that operate in more than one state often are faced with conflicting coverage policies about what is, and what is not, "medically necessary."

Numerous examples abound:

- **Treatment of precancerous lesions.**²² **Removal of precancerous skin lesions²³ is considered the standard of care among dermatologists trying to protect patients against skin cancer.** Medicare's insurance carrier in Florida, as an agent of HCFA, refuses to cover the removal of these lesions in some instances. The very same insurer, however, administers a Medicare health maintenance organization (HMO) that does pay to remove these same precancerous dermatoses. And most other state Medicare carriers, even those outside the Florida Sunbelt, pay for the same procedures not covered in Florida.
- **Pre-surgical testing.**²⁴ Some Texas physicians complain that Medicare no longer covers certain routine preoperative tests, such as an electrocardiogram (EKG), which surgeons order when they believe it is medically necessary and consistent with generally accepted principles of medical practice.
- **Preventive medical services.** In Florida, the Medicare carrier published a coverage policy for blood lipid tests, which states that diabetes is not among the approved covered diagnoses for the test.²⁵ As Dr. William G. Plested III, a member of the Board of Trustees of the American Medical Association, testified before Congress,

This policy is in direct conflict with published guidelines from the American Diabetes Association, and, in 1999, physician claims for lipid tests are still being routinely denied for diabetic patients in Florida.²⁶

- **Prostate cancer.** Dr. Plested also testified that it is "standard clinical practice" to give a man suffering from lower urinary tract symptoms a prostate-specific antigen test.

But in many localities patients have no idea whether the test

will be covered because Medicare's coverage policy depends on the test result. Moreover, nearly half the carriers will not pay for the test if the diagnosis turns out to be an enlarged prostate.²⁷

- **The use of anesthesia.** Anesthesiologists favor use of "monitored anesthesia care" for certain of cases in which sedated patients may have to be revived. Says Dr. Plested,

Coverage was denied for a number of important services for which anesthesia is clearly a requirement, such as breast biopsies and pacemaker insertions. Although some carriers have subsequently abandoned the policy due to concerted informational campaigns by anesthesiologists, uneven coverage across localities is likely to persist.²⁸

- **Psychiatric care.** As Dr. Plested observed in his testimony,

In many localities, carriers establish arbitrary limits on psychotherapy services, even though the Congress has not limited the number of Medicare covered psychotherapy services for psychiatric patients.²⁹

Curiously, Members of Congress are considering legislation for private-sector, employer-based insurance plans that would ensure that doctors, not bureaucrats, determine medical necessity.³⁰ The legislation would define "medically necessary or appropriate services" as treatments "consistent with the generally accepted principles of medical practice." And the proposed legislation would prohibit a private plan from interfering with

the decision of the treating physician regarding the manner or setting in which particular services are delivered if the services are medically necessary or appropriate for treatment and diagnosis.³¹

Although politicians in Congress and state legislatures routinely chastise private-sector health plans for arbitrary payment denials, the evidence in fact suggests that such denials are not excessive. For example, data gathered under a state reporting law indicate that denials of care among the six largest New York health plans are "strikingly low"—only 2.5 appeals for every 1,000 patients. And reports from other states suggest similar coverage denial rates.³² A survey of over 2,000 physicians, published in the fall 1997 issue of *Inquiry*, reports denial rates of 3 percent or less, with lower rates for many individual procedures. Even such expensive tests as magnetic resonance imaging are denied in only 2 out of 100 cases.³³

Consider also the experience of the FEHBP, the consumer-driven system that serves Members of Congress, congressional staff, and federal employees. Out of a dozen plans surveyed in the 1999 *Checkbook's Guide to Health Insurance Plans for Federal Employees*, the number of disputed claims filed with the Office of Personnel Management (OPM) ranges from 0.58 per 1,000 beneficiaries for the Mailhandlers' plan

(a large union plan), to 2.99 per 1,000 beneficiaries for the Foreign Service plan (an option restricted to foreign service employees).³⁴ The FEHBP, administered by the OPM, offers a choice of private health plans that are rated by consumers and consumer groups annually on quality, price, and benefits. Medicare reformers would do well to consider the merits of such a consumer-driven system as the FEHBP, in which patient satisfaction with quality and service are crucial to the plan's competitive position. The FEHBP is also the model for reform chosen by Senator Breaux and Representative Thomas, the chairmen of the National Bipartisan Commission on the Future of Medicare, and the majority of the commission's members.

The effective Medicare definition of "medical necessity," as applied by HCFA and HCFA carriers, is decidedly more restrictive than, say, that proposed in the Daschle-Dingell Patient's Bill of Rights. In sharp contrast to reports indicating extremely low HMO denial rates, HCFA carriers report that they denied almost 24 percent of all claims from physicians and suppliers in 1997. As noted, over 19 percent of those denied claims were for a supposed lack of "medical necessity."³⁵ If OIG auditors had their way, even more claims would have been denied--another \$20 billion in 1997 and \$12.5 billion in 1998.³⁶ Moreover, if Medicare carriers followed HCFA rules and regulations, more than 16 percent of all the claims paid in 1998 would not have been paid.³⁷ The OIG says that lack of "medical necessity" was the most common reason for payment "errors" in 1998 (over 55 percent) and the second most common reason in 1997 (over 36 percent).³⁸

Doctors on the front lines of medical care often become demoralized by pressures to practice medicine backward--that is, compliance with reimbursement-based guidelines becomes more important than care for patients. They must devise ways to fit the patient to the care plan rather than fitting the care plan to the patient. For example, one Wisconsin physician advised an elderly patient to continue to take aspirin, which can cause gastrointestinal bleeding, prior to administering a test to check for blood in the stool. This would ensure the doctor could document the blood in the patient's gastrointestinal tract. Without that crucial finding, the patient would not fit HCFA's criteria for a colonoscopy even though, in the physician's best clinical judgement, it was the medically necessary and appropriate course of action.³⁹

Such absurd developments are, of course, a direct result of bureaucratic benefit setting. Medicare law, as noted above, ensures patients access to what are called "reasonable and necessary" medical services. Beyond the broad categories set forth in Medicare law, such as hospital, nursing home, and physician services, the Secretary of Health and Human Services is legally entitled to specify the allowed medical treatments and procedures. In practice, this means HCFA determines treatments and procedures. Unfortunately, HCFA standards are not necessarily the standards of medical practice, and so HCFA's decisions periodically set the stage for inappropriate medical micromanagement by Congress.

Because HCFA was considered so out-of-touch with standards of practice for the treatment of cancer, Congress in 1997 stepped in to mandate Medicare coverage for certain cancer screening. Since 1998, Congress has mandated coverage for many screening procedures for such common cancers as breast, colon, and prostate. More recently, for example, Representative Pete Stark (D-CA) introduced a bill to mandate coverage of retinal eye examinations for Medicare patients who suffer from diabetes and

thus are threatened with blindness.⁴⁰ An unfortunate feature of the existing Medicare system is that crucial medical treatments often are held hostage to such political and bureaucratic decision-making.

Hindering the flow of information in Medicare has a chilling effect on the free-flow of information between patients and doctors. Politicians harangue private health plans for interfering with the patient-doctor relationship by restricting a physician's communication with a patient about the diagnosis and test and treatment options. Fears of such "gag rules" persist, despite a GAO review of 1,500 health plan contracts that failed to find even one example of such a provision.⁴¹ Senior citizens do not know that inherent in the carrot and stick-laden maze of Medicare is an insidious gag rule. Open communication between physicians and patients about the right course of action is inhibited by the doctor's fears of payment denial and prosecution for fraud and abuse. As Dr. William Plested recently reminded the Health Subcommittee of the House Ways and Means Committee,

In its management of the Medicare program, HCFA seems to approach virtually every issue, whether it involves national or local coverage policy, payment, coding, or quality, as an issue of waste, fraud and abuse. This singular focus on fraud has become even more pervasive among Medicare part B carriers than it is within the HCFA central office.⁴²

This obsession with fraud affects patient care. Doctors who recommend tests or treatments considered by HCFA carriers to be "medically unnecessary" now must worry about not getting paid for services provided and avoiding charges of fraud and abuse when they talk to a Medicare patient. A July 1998 GAO report indicates that provider concerns about overzealous enforcement are justified.⁴³ Such "hot-button" issues as home health care have had an especially chilling effect on patient-provider communications. For a doctor, certifying the need for home health care is akin to an IRS red flag on a 1040 tax return. But this may change in light of reports of high percentages of emergency room visits and hospitalizations among home health patients in Tennessee⁴⁴ and an October 30, 1998, HHS-proposed rule that expands the definition of fraud and abuse to include providing "medically unnecessary" services.⁴⁵

Consider this dilemma: A doctor believes a simple blood test is important for ruling out a diagnosis of temporal arteritis in an elderly patient who has a headache. Failure to diagnose temporal arteritis, an inflammatory condition of the temporal artery, could have serious consequences, including blindness. Testing a patient's blood sedimentation rate determines if the patient suffers from temporal arteritis. The doctor must recommend the blood test to the patient, but at the same time explain that Medicare believes the test is not "medically necessary" and will not pay for it. When the patient gets the bill for the procedure, HCFA sends a note about the Medicare "HOT-TIPS" line, from which the patient may get a monetary reward for reporting fraud and abuse.

Fortunately, most doctors will place the patient's well-being first and compliance with potentially harmful bureaucratic mandates second. But an increasingly "big stick" approach to physicians threatens to compromise health care by making doctors fearful of recommending the appropriate care because HCFA or its carriers claim it is not

medically necessary. Congress should reverse this practice and require HCFA to develop a more reasonable definition of fraud and abuse.

HOW HCFA INFLUENCES TREATMENT DECISIONS

Few seniors are aware of Medicare's provider disincentives and how payment schemes often influence doctors' treatment decisions. Medicare has a large captive patient audience--the portion of the U.S. population that needs health care the most--so it has, for the most part, a captive provider audience as well. In a significant portion of employer-based health insurance plans, Americans have at least some choices.

According to the consulting group KPMG, 57 percent of employer-based health plans serving 200 or more employees provide at least two options to their workers, and 32 percent offer three or more plans.⁴⁶ So even in employment-based insurance, many people have a choice that does not exist for Medicare patients. Surveys show a variety of reimbursement arrangements for doctors and other providers. Providers who contract with a plan are at liberty to negotiate reimbursement and payment schemes and can choose to contract with some health plans but not others. At least for physicians, even in a distorted health insurance market, there is the possibility of a modicum of market-based competition.

In Medicare, however, doctors and other providers have no negotiating power. Medicare offers a stark "take-it-or-leave-it" proposition. Reimbursement is dictated by federal regulations and spending caps.

As it is, Medicare is a tangled web of incentives devised by HCFA to modify the type, amount, and manner of medical treatment for seniors. Cost control ultimately means control over the supply of Medicare services. Take the immensely complex RBRVS, a method to determine physician payment based on a statistical calculation of the "value" of the factors that go into a medical service completely outside the normal forces of supply and demand or patient benefit.⁴⁷ The RBRVS, and the price controls that accompany this strange Medicare fee system, is replete with incentives and disincentives for performing the entire range of medical tests and procedures. Even contracting doctors who are quite knowledgeable of the intricacies of the Medicare program would be hard-pressed to explain the complex calculations and models designed to encourage or discourage physicians from performing specific diagnostic and therapeutic services for beneficiaries. Seniors should know that as well.

Likewise, few Medicare patients grasp the complexity of Medicare's hospital payment schemes. The problem becomes acute in medical technology, an area in which payments for hospital services designated under a specific diagnostic-related group may not reflect the real cost of the services; indeed, they may be less than the cost of the services. As Terry Coleman, a Washington-based specialist in Medicare law, recently reminded the Subcommittee on Health of the House Ways and Means Committee,

When payment amounts are significantly less than the costs incurred by hospitals, they may refrain from using the new procedures, to the detriment of Medicare beneficiaries. For example, when Medicare first decided to cover bone marrow transplants for certain conditions, they were assigned

DRGs [diagnostic-related groups] for the underlying conditions, which had average payment levels of about \$5,000 to \$10,000.... [T]his amount was far below the actual cost of a bone marrow transplant, but HCFA adhered to its policy of making no changes until actual claims data were collected. Eventually, that data became available, in 1990 HCFA created a new DRG for bone marrow transplants and assigned it the average payment amount of about \$45,000.⁴⁸

As discussed above, Medicare's hospitalization payment system gives hospitals a financial incentive to provide fewer inpatient services and days of care. In many cases, the faster a patient with a specific diagnosis is discharged, the better the bottom line for the hospital. Seniors should know that, too.

Managed care reimbursement schemes have been criticized for resulting in inappropriate care. Politicians have bandied about anecdotal horror stories and such slogans as "drive-by" deliveries and mastectomies to portray officials of private-sector health plans as interested only in money. If those concerns are genuine, and not just fodder for press releases, lawmakers should note that most outpatient mastectomies occur in the traditional fee-for-service Medicare program, and not in Medicare managed care. For example, in New York in 1996, 72 of 74 Medicare outpatient mastectomies were performed on women in the fee-for-service Medicare program. These 72 mastectomies made up the majority (58 percent) of all outpatient mastectomies in New York that year.⁴⁹ Similar data from the Maryland Health Services Cost Review Commission show that all outpatient mastectomies were performed on Medicare beneficiaries enrolled in the fee-for-service plan; and none were enrolled in the Medicare HMO plan.⁵⁰

Curiously, in addressing the problem of financial incentives in private-sector health plans, Members of Congress are considering legislation to require private health plans to tell patients how they pay providers and to disclose related financial incentives.⁵¹ Medicare patients also deserve this information.

INCENTIVES FOR BUREAUCRATIC "ERRORS"

Medicare gives carriers and professional review organizations (PROs) economic incentives to detect billing "errors" that are broadly defined and that include providing "medically unnecessary" services as well as detecting mistakes in billing and shortfalls in documentation. Incentive payments for finding reasons to deny payments retroactively can be formidable. As reported in an article in *American Medical News* in 1998,

PRO's that cut their state's 'error rate' by at least 10 percent will be eligible for incentive payments totaling up to 2.5 percent of their overall contracts.⁵²

HCFA insurance carriers (intermediaries contracted by HCFA to process Medicare claims) also dissuade physicians from contesting payment denials. Alice Gosfield, a Philadelphia attorney who specializes in helping physicians to comply with HCFA regulations and to avoid fraud and abuse charges, warns physicians, "Don't call the carrier to find out what to do. Carriers don't know the answers, and they view questions as good targets for investigations."⁵³

HOW HCFA MAKES IT DIFFICULT TO APPEAL DECISIONS

Medicare patients and providers who challenge the bureaucracy's coverage decisions face a mesmerizing process of reviews and appeals. Medicare recipients already have the right to an external review--a right now being aggressively promoted in Congress for patients in private, managed care programs. But this process of review in the traditional Medicare program is anything but timely or user-friendly.⁵⁴ Notes Walter M. Rosebrough, Jr., President of Hill-Rom Company and a spokesman for the Health Industry Manufacturers Association,

Data obtained from HCFA show that in Fiscal 1997, on average for a part B carrier claim, it took 119 days for a beneficiary to get through the carrier review and fair hearing. HCFA has previously testified before Congress that it takes 664 days, on average, to receive a decision from an administrative law judge, measured from the date the hearing is requested. Thus, combined, it takes an elderly patient on average 783 days, well over two years, to obtain a decision from an [administrative law judge] after initiating the appeals process. That is simply too long to be an effective option for most beneficiaries. Moreover, most small medical device companies could not afford to take assignment of claims in these circumstances, and survive long enough to be paid.⁵⁵

This cumbersome and lengthy process is an old story for Medicare patients who take the time to challenge adverse decisions on their claims.⁵⁶ Current Medicare law does allow a patient to take a case disputing a national coverage decision to federal court, although there are no federal judicial appeals for Medicare's coverage decisions in states and localities.⁵⁷ After exhausting this bureaucratic appeals process, if Medicare patients wish to file an action in federal court, all they can recover is the cost of the denied benefit, not other damages inflicted on them by virtue of the adverse decision.

CONCLUSION

Unless it is substantially reformed, the existing Medicare bureaucracy threatens the quality of health care for the growing millions of Americans who depend on Medicare for their primary coverage. Medicare patients and doctors alike are ill-informed about what really is covered. Bureaucratic doublespeak results in arbitrary payment denials. Expanded definitions of fraud and abuse and circuitous definitions of "medical necessity" create a *Catch-22* situation for doctors and result in a de facto gag rule. The many Medicare contractors and professional review organizations that are supposed to promote care quality have become bounty hunters. Few Medicare patients know or understand what really is going on within the program. And worse, those who want better treatment have no real choices.

The real fix for Medicare is not more rules and regulations, another insufferable pile of paperwork, some palliative treatment, or tinkering at the edges. Radical surgery of the program's heavy bureaucratic control is needed. The best approach to the problem of patient care in both the private and public sectors is the expansion of patient choice,

which would enable individuals and families to pick the kinds of plans and benefits they personally want and need. The National Bipartisan Commission on the Future of Medicare came close to a formal recommendation of expanding choice when the majority of its members supported a model for reform that is similar to the consumer-driven system enjoyed by federal employees, Members of Congress, and White House staff--the Federal Employees Health Benefits Program.

Real Medicare reform is medically necessary, and it should put patients first. Members of Congress should create a new and better system based on patient choice and market competition, one that respects the personal liberty and privacy of Medicare patients as well as the medical expertise of their physicians.

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1. Robert E. Moffit, Director of Domestic Policy Studies at The Heritage Foundation, contributed to this paper.
2. Dr. Robert Waller, President of the Mayo Foundation, in testimony before the National Bipartisan Commission on the Future of Medicare, on August 10, 1998.
3. Mike Hash, Deputy Administrator, Health Care Financing Administration, "Medicare Coverage Decisions and Beneficiary Appeals," statement before the House Ways and Means Health Subcommittee, 106th Cong., 1st Sess., April 22, 1999, pp. 8-9.
4. Senator Edward M. Kennedy, *Press Release*, September 2, 1998.
5. Information supplied to Sarah E. Youssef, then Research Assistant for The Heritage Foundation, from the Health Care Financing Administration, Office of Financial Management, July 1998.
6. The proposal fell one vote short of the supermajority necessary to proceed as a recommendation to Congress and the Administration. See <http://medicare.commission.gov>.
7. On the potential elements of a major Medicare reform, see Stuart M. Butler, Ph.D., "Principles for a Bipartisan Reform of Medicare," Heritage Foundation *Backgrounder* No. 1247, January 29, 1999.
8. See, for example, William J. Scanlon, Associate Director of Health Care Financing and Policy Issues, U.S. General Accounting Office, "Medicare: High Spending Growth Calls for Aggressive Action," testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, 104th Cong., 1st Sess., February 6, 1995, p. 5.
9. *Ibid*. This itemization of Medicare regulations and supporting documents was compiled in support of the testimony of Dr. Robert Waller, President of the Mayo Foundation, before the National Bipartisan Commission on the Future of Medicare. on

August 10, 1998.

10. Press Release, The White House, July 11, 1995.

11. For a comprehensive discussion of this issue, see Robert E. Moffit, Ph.D., "How Congress Can Restore the Freedom of Senior Citizens to Make Private Contract Agreements with Their Doctors," Heritage Foundation Background No. 1209, August 3, 1998; see also John S. Hoff, *Medicare Private Contracting: Paternalism or Autonomy* (Washington, D.C.: AEI Press, 1998).

12. See Robert E. Moffit, Ph.D., "HCFA's Latest Assault on Patient Privacy," Heritage Foundation *Executive Memorandum* No. 580, March 22, 1999.

13. Thomas Bondy, an attorney for the Clinton Administration, told the U.S. Court of Appeals in the District of Columbia, "I don't think there is anything out there that's in anyway a meaningful equivalent to Medicare," Transcript of oral argument, *United Seniors Association v. Shalala* (Case No. 98-5142), U.S. Court of Appeals for the District of Columbia Circuit, October 23, 1998, pp. 17-19.

14. Information obtained by calling the Medicare patient help line at 1-800-MEDICARE on April 19, 1999.

15. Timothy P. Blanchard, "Medical Necessity Denials as a Medicare Part B Cost-Containment Strategy: Two Wrongs Don't Make It Right or Rational," *Saint Louis University Law Journal*, Vol. 34, No. 4. (1990), p. 981.

16. *Ibid.*, pp. 981-982.

17. The Secretary of Health and Human Services has the authority to make determinations of the "reasonableness and necessity" of medical services under 42 U.S.C., Sec. 1395u(1).

18. Information supplied via telephone to The Heritage Foundation from the Health Care Financing Administration Office of Financial Management, July 1998.

19. *Ibid.*

20. U.S. Department of Health and Human Services, Office of the Secretary, Office of the Inspector General, "Improper Fiscal Year 1998 Medicare Fee-for-Service Payments," Report No. A-17-99-00099, February 9, 1999, Appendix 1.

21. S. 6, sponsored by Senator Thomas Daschle (D-SD). The House version (H.R. 358) is sponsored by Representative John Dingell (D-MI).

22. Information from the American Academy of Dermatology in discussions with the author in October 1998.

23. Clinically known as actinic keratoses.

24. Information provided by the Texas Medical Association, April 9, 1999.
25. William G. Plested III, statement on Medicare Coverage Decisions and Beneficiary Appeals, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, 106th Congress, 1st Sess., April 22, 1999, p. 5.
26. *Ibid.*
27. *Ibid.*
28. *Ibid.*
29. *Ibid.*
30. See the Patient's Bill of Rights Act of 1999 (S. 6/H.R. 358), introduced by Senator Thomas Daschle and Representative John Dingell (respectively).
31. See Section 151 of Patient's Bill of Rights Act of 1999.
32. Michael Weinstein, "Managed Care's Other Problem: It's Not What You Think," *The New York Times*, February 28, 1999.
33. R. Dahlia et al., "What Do Managed Care Plans Do to Affect Care? Results from a Survey of Physicians," *Inquiry*, Vol. 34 (Fall 1997), pp. 196-204.
34. Francis Walton, ed., *Checkbook's Guide to 1999 Health Insurance Plans for Federal Employees*, 20th edition, (Washington, D.C.: Washington Consumers' Checkbook, 1999), p. 73.
35. Information from HCFA's Office of Financial Management, supplied to The Heritage Foundation via telephone, July 1998.
36. U.S. Department of Health and Human Services, Office of Inspector General, "Improper Fiscal Year 1998 Medicare Fee-for-Service Payments."
37. *Ibid.* (Auditors report that 915 of the 5,540 records reviewed contained payment "errors.")
38. *Ibid.*, Appendix 1.
39. This real-life example of the impact of Medicare regulations on physician treatment decisions was reported to the author in a personal conversation.
40. Representative Fortney "Pete" Stark (D-CA), "Medicare Coverage of Diabetic Retinal Exams," Extension of Remarks in the House of Representatives, 106th Cong., 1st Sess., April 22, 1999.

41. U.S. General Accounting Office, "Managed Care: Explicit Gag Clauses Not Found in HMO Contracts, But Physicians' Concern Remain," GAO/HEHS 97-175, August 29, 1997.

42. Plested, p. 2.

43. U.S. General Accounting Office, "Application of the False Claims Act to Hospital Billing Practices," GAO/HEHS-98-195, July 1998, p. 14.

44. G. Sasser and C. King, "Tennessee's Venipuncture Patient Outcome Study," report prepared for Tennessee U.S. Legislators, Tennessee Association for Home Care, November 1998.

45. Department of Health and Human Services, Office of the Secretary, Office of the Inspector General, "Health Care Fraud and Abuse Data Collection Program: Reporting of Final Adverse Actions," Notice of Proposed Rulemaking, *Federal Register*, Vol. 63, No. 210 (October 30, 1998), pp. 58341-58342.

46. KPMG, Health Benefits 1997, at <http://www.us.kpmg.com>.

47. For a discussion of the theory underlying the Medicare physician payment system, see Robert E. Moffit, Ph.D., "Back to the Future: Medicare's Resurrection of the Labor Theory of Value," *Regulation*, Vol. 15, No. 4 (Fall 1992), pp. 54-63.

48. Terry Coleman, "The Medicare Process for Coverage Decisions and Beneficiary Appeals," statement before the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, 106th Cong., 1st Sess., April 22, 1999, p. 9.

49. American Association of Health Plans, "Mastectomy Length of Stay: Information and Analysis," *Issue Brief*, February 1997, p. 1.

50. *Ibid.*, p. 1.

51. The Patient's Bill of Rights Act of 1999.

52. "PROs Arm to Help Curb Payment Errors," *American Medical News*, December 7, 1998, pp. 1, 58, 59.

53. "What Washington Plans for Doctors," *Medical Economics*, April 15, 1996.

54. The situation is different, interestingly enough, with the Medicare+Choice program, which allows private plans to participate in a highly restricted form of competition within the Medicare program. Those plans are required to respond within 72 hours to appeals of care denials that could jeopardize life, health, or the "ability to regain maximum function" within 14 days for initial decisions and within 30 days for reconsideration of appeals.

55. Walter M. Rosebrough, Jr., "Medicare Coverage and Beneficiary Appeals," statement

on behalf of the Health Industry Manufacturers Association before the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, 106th Cong., 1st Sess., April 22, 1999, p. 5.

56. U.S. General Accounting Office, "Medicare Statistics on the Part B Administrative Law Judge Hearing Process," HRD-90-18, September 1989.

57. Rosebrough, p. 5.

Mr. SCARBOROUGH. Let me ask you all, again following up on the regulations that really have totally strapped not only patients but also doctors in the system: What would you all say to a defender of the system regarding the elimination of 111,000 pages of regulations, when they came to you and said, well, if we do that, obviously, you're going to see excessive costs going up and you're going to see the quality of care plummeting? What do you say in defense of such an argument?

Ms. ARNETT. The only thing they could do is add more pages, and we see how price controls have not worked for 4,000 years. Regulation winds up meaning that physicians have to cater to the regulators, not to the patients. So I think that's why, as just said, the Medicare Commission when it really looked at this said, we can't fix this system with more regulation. We have to provide an alternative system with a lot more choice, a lot less rules. Let this one stay there if people want to stay under that system, that's fine. But there has to be a choice of a different system, and that's this competition, freedom of choice, where individuals and not regulators are in charge.

Mr. SCARBOROUGH. Would both of you agree with that, that you are not proposing a radical departure from this current program but also suggesting, as Ms. Arnett said, that if people want to stay in the program as is they can, but instead provide them other viable alternatives? Would that be a fair statement on what the Commission concluded?

Mr. LEMIEUX. Yes, and I think there's some reason for optimism that even the government-run plan could do a much better and more cleanly managed job. I don't think there's reason to presume that more competition would necessarily do away with the government-run fee-for-service plan. I think there's room for optimism. Maybe I'm too much of an optimist. Certainly these things would take time. But I think there's plenty of room for the fee-for-service plan, and it has potential to do much better.

Mr. SCARBOROUGH. OK. I don't want to keep you all much longer and I know we have a statement that's going to be read for the record. I could keep asking you questions all day—I've got a captive audience here—but they won't be captive here much longer.

Let's talk very quickly about the costs of the program. Obviously, with regulators and bureaucrats and a lot of politicians' ideas in Washington, any time you have a problem just increase taxes. We're now even seeing people suggesting the taxes for Medicare be doubled in the coming years and yet you all know that even if we double taxes, the system still goes belly up. We cannot tax our way out of this mess. So what do we do? What hope do we have to provide our constituents that this system can be saved or that health care systems can remain solvent in the coming years?

Mr. LEMIEUX. Well, the Commission assumed, and I estimated, that new incentives under the Breaux/Thomas plan would save some money. Not gigantic amounts of money and not really soon. But that over time it could slow down the growth rate of Medicare spending. Even a small reduction in the growth of Medicare spending can compound to a significant amount when you starting looking out 10, 20, 30 years.

There were other provisions of the plan that really weren't related to the new competitive system. They were just there to save a little money. And those, of course, were very controversial.

The Commission wanted to create a new trust fund system to help the public and Congress monitor how Medicare was doing. They decided to create a combined trust fund instead of having a part A fund, which is the one we always talk about, and part B, which is virtually meaningless. They wanted to create a combined fund where people's premiums would come into that fund, payroll taxes would come into that fund and general revenue contributions would come into that fund, but it would be structured so that we'd have to keep a very close eye on those general revenue contributions and if they had to be increased it would force a congressional vote above a certain growth rate.

That seems to make some sense as a compromise to help us keep a close eye on Medicare spending. Is this going to be the last time we ever have to think about Medicare spending, even if we did this? Very hard to say. Very uncertain. Probably not. But it's meant to be a step in a plausible direction that has the potential to save us money as well as to help beneficiaries. It's unclear whether it really would, but it has the potential.

Ms. CHERNEY. I don't propose that throwing more money at it will fix it. But I go back to saying that we need some help on the efficiency side of it. No physician can do that. I think we have a unique window in the next 10 years because we're going to have a surplus of physicians; that will be somewhat helpful. But failure to deal with some of that inefficiency will also create an opportunity for the surplus of physicians. They will find a way to make money, and that might be bad.

But there are just the smallest things that don't cost money. For example, I cannot understand why HCFA has to have an EOB, why a Medicare recipient has to get a form that says "Explanation of Benefits." It might as well be Spanish for most of them. It would say, Mr. Scarborough, you had an appendectomy. The hospital charge was this. Medicare paid this. You owe nothing. Your physician charged this, it's what's on the EOB but it's in a format people don't understand. No one is looking. All of those things cost money. That's the inefficiency. It's not just the clinical delivery, but it's the whole thing of people doing it their way and not looking at what works for that customer. That's why we don't have a consumer, because no one has thought about that customer. It isn't that at all. They are a beneficiary, not a customer. We've got to change that.

Ms. ARNETT. I think that's really right. One of the wonderful things that a competitive marketplace does is focus on how can I get this consumer to take their money and buy what I'm selling. And, therefore, they have to provide information that resonates with that consumer and right now the information they provide has to cater to the bureaucrats. It's written so a bureaucrat can understand it. That's why the consumer focus is so important, and the only way to get that is to get money in the hands of individuals.

One of my mottos is: whoever controls the money controls the choices. Right now it's bureaucrats in Washington. They are controlling the choices because they control the money. If individuals control the money they're not only going to control the choices but

they're going to demand more efficiency and better information on what they're getting.

Ms. CHERNEY. We call that the golden rule. We implemented the golden rule here 15 years ago in health care, and that is that he who has the gold makes the rules. It's our right and our responsibility.

Mr. SCARBOROUGH. While you all are still here, let me recognize Cliff Rustia of NARFE. He has a statement that he's going to read for us, and I'd like to ask him to do that now.

Mr. RUSTIA. Thank you, Congressman Scarborough, for this opportunity. Before I read the statement from NARFE, I'd like to make a brief personal statement, since I'm the first person with enough gray hair to qualify as a consumer of both Medicare and the Federal Employees Health Benefits Program. I've learned a lot of interesting information from the witnesses here, and I thank you for it.

By the way, as an IRS auditor, we don't hold you guilty. We did civil audits and you had to prove your deductions. Guilt reply was the criminal people, and I only had three of them in 20 years.

But getting back to Medicare and the availability of private physicians. When I was up north and still working, my cardiologist told me that when I qualified for Medicare, if I should live that long, and thankfully I did, he does not accept Medicare, and at that time he was allowed to charge 120 percent I think of the Medicare amount, and that was being reduced to 110 percent. He said when that happened he wouldn't take Medicare people at all. Of course, this was up north. We had a relatively small proportion of Medicare recipients. I'm down here in central Florida since 1992 and if you go into the doctors' offices there's nothing but gray hair and if they refuse Medicare patients they wouldn't have any patients. None of them are open at nights or Saturdays for working people. I don't know how working people get to see a doctor. But they're pretty busy with us old gray heads.

Now, if I may read the statement from NARFE.

Mr. Chairman, I am here today to express the National Association of Retired Federal Employees' views on the use of the Federal Employees Health Benefits Program [FEHBP] as a model for Medicare reform.

I wish Medicare would pay for glasses, I might have better ones.

Before Congress and the President created Medicare in 1965, nearly half of all older Americans were uninsured and a third lived in poverty. Today, only 1 percent of the Nation's senior citizens are uninsured and the number living in poverty has been reduced by almost two-thirds. As a result, far fewer older persons have to choose between buying food and going to the doctor. Our quality of life has significantly improved, and we are living longer.

There is no question that the large numbers of retiring baby boomers will begin to place demands on Medicare starting in 2010.

Hal, maybe you could read this better than I.

Mr. KELTON. May I, Congressman? I'm from NARFE, too.

Mr. SCARBOROUGH. You may.

Mr. RUSTIA. If you'll excuse me, I think—I'm having difficulty with these glasses.

Mr. SCARBOROUGH. That's fine.

Mr. RUSTIA. This is Mr. Kelton, president of the New Smyrna Beach chapter, up north.

Mr. SCARBOROUGH. Great.

Mr. KELTON. Thank you, Congressman.

There is no question that the large numbers of retiring baby boomers will begin to place demands on Medicare starting in 2010.

Public policymakers would be irresponsible if they failed to review the program before this development. But at the same time, Congress and the administration must ensure that Medicare continues to guarantee basic health security for older Americans at affordable and predictable prices.

In response to this challenge, some have proposed to replace Medicare with something similar to FEHBP. We can appreciate interest in emulating our program. For 39 years, FEHBP has minimized costs, encouraged insurance carrier competition, and provided a wide choice of comprehensive health insurance plans to Federal employees, retirees, and their families. Although the FEHBP performs well as an employer-sponsored health plan, its use as a substitute to a public insurance system that guarantees health security to the Nation's elderly raises many questions.

The FEHBP-inspired "premium support" proposal made by Senator John Breaux and Representative Bill Thomas would provide beneficiaries with vouchers—or a government contribution—that they would use to purchase private health insurance. The dollar amount paid by the government would be determined by a calculation similar to the "fair share" formula used to set the employer contribution for FEHBP plans. Indeed, the premium support model would use a program-wide weighted average of each Medicare plan to set the maximum government contribution.

However, the premium support model differs from FEHBP since it does not limit the government contribution to 75 percent. Under FEHBP, enrollees always have to pay at least 25 percent of their health plan premiums. Absent this cap in the Breaux/Thomas proposal, the beneficiary share of Medicare premiums could be zero if enrollees select the lowest cost plans. As a result, the proposed formula would act as a powerful incentive for beneficiaries to enroll in the lowest cost and most basic managed care plans. Since the government contribution formula is weighted to the number of enrollees, a low cost plan that attracts a large share of beneficiaries would reduce the overall dollar amount of the maximum government contribution under the premium support model. Consequently, such costs would be shifted to beneficiaries.

It is also important to ask which beneficiaries would choose the most basic managed care plans. Healthy beneficiaries have the least to fear from such a choice since they are low utilizers of health care. They trade quality of care and physician choice for lower premiums since they are less dependent on doctors and hospitals. Because these plans are designed to enlist healthier seniors, sicker beneficiaries would tend to remain in traditional Medicare. Adverse selection will occur as a result, and taxpayer and beneficiary costs would increase.

Although current managed care plans have not created significant risk segmentation in Medicare, the incentives for healthier enrollees to join them under the proposed voucher system are far

greater. That is because current Medicare managed care enrollees pay 25 percent of the Part B premiums just like participants in the traditional fee-for-service program. However, under the proposed voucher system, beneficiaries might not have to pay anything for a basic managed care plan designed to draw in healthy enrollees.

Premium support proponents suggest that the incentives to cherry pick beneficiaries could be countered if Medicare pays plans less for healthier patients and more for sicker ones. Unfortunately, no one seems to have overcome the complexities of creating such a risk adjustment system. What's more, nothing will stop participating plans from running to Congress any time a risk adjustment formula decreases their payments from Medicare.

As a single insurance pool, the present Medicare fee-for-service program avoids risk segmentation because it spreads individual beneficiary health costs across the full population. NARFE believes that the proposed financing scheme of the premium support model could compromise this fundamental principle of group health insurance.

In addition, NARFE is concerned that the creation of a Medicare voucher system could open the program to a cost-shifting proposal that has been repeatedly suggested for FEHBP.

Despite the enactment of the fair share formula in the Balanced Budget Act of 1997, the House Budget Committee sought to replace it by including a proposal in the fiscal year 1999 budget resolution to limit the annual growth of the government share of FEHBP premiums to the consumer price index [CPI]. At the request of Representatives Tom Davis, Frank Wolf and Connie Morella, Budget Committee Chairman John Kasich said on the House floor June 5, 1998 that he would not support inclusion of this proposal in the conference agreement on the budget resolution. Fortunately, the cost-shifting plan failed to receive further consideration in the 105th Congress.

According to the Congressional Budget Office's [CBO] "Options Book" published this April, the Federal Government would cost-shift \$600 in added annual cost to Federal annuitants and employees in 2004 and more in later years if this artificial limitation became law. Indeed, Federal employees and annuitants would pay an ever-increasing percentage of premium costs each year FEHBP rate hikes exceeded general inflation as measured by the CPI. CBO estimates that the average FEHBP enrollee share would grow from 29 percent to 40 percent by 2004.

Given this experience, NARFE would oppose any scheme that limits the government's portion or reduces its proportional share of Medicare premiums through a formula that does not accurately reflect the updated costs of providing health care to eligible beneficiaries. Shifting costs from the government to beneficiaries would be particularly hard on older Americans who have insufficient income to further supplement their health care costs.

While we realize that the Breaux/Thomas approach would not limit the government's contribution to a predetermined rate, NARFE believes that budgetary pressures could tempt Congress to accept such a cost-shifting plan.

Mr. Chairman, we have several other concerns that I will not go into today, including the coordination of coverage between Medi-

care managed care plans and employer-sponsored plans, the ability to select the physician of your choice, prescription drug coverage, means testing, increasing the eligibility age, and copayments for home health care. As you know, the Senate Finance Committee is presently considering the totality of Medicare reform issues, and we have expressed these concerns to members of that panel.

In closing, I would like to say that the guarantee of health security provided by Medicare has dramatically improved the quality of life for older Americans. While the demographic realities of the baby boomers will place new demands on this program, most Americans agree that Congress and the President must honor the commitment made in 1965 to ensure the health security of senior citizens. NARFE strongly believes that the present benefits, protections, financing responsibilities and principles of insurance must be preserved if this promise is to be kept.

Thank you.

Mr. SCARBOROUGH. Thank you very much. I appreciate it.

Let me ask the panel if you all have any response to the statement from NARFE's national office.

Ms. ARNETT. I'm sure, Jeff, that you especially do. If I may just make one quick comment. The statement that you have graciously allowed me to enter into the record by Walt Francis, who is really the preeminent expert on FEHBP, addresses many of these issues. Obviously, too many to go into here. But in particular and just to read one quick passage about risk segmentation, he says:

In fact, in FEHBP there is a large and continuing premium disparity among fee-for-service plans with similar benefits that have continued for many years without debt spirals. There are several large and distinct risk groups within the programs, such as the large cohort of elderly retirees without any Medicare coverage.

The FEHBP tolerates this. They have 300 different plans competing that spreads risk and that really does not wind up causing the kinds of risk segmentation that many fear. Competition and the free market has a marvelous ability to tolerate and to even out many of these risks.

And I'm sure, Jeff, you have many other—

Mr. LEMIEUX. We were concerned in the Medicare Commission that risk adjustment be done. That it would be more necessary in Medicare than in FEHBP. FEHBP doesn't have it and FEHBP gets along OK without it. But we thought it would be very important in Medicare. So we think your point is well taken. And I'm not so pessimistic as the statement that it can't be done acceptably well in the next 5 or 10 years. We're getting closer. And we do have to look forward to the future of Medicare and what we can do 5 and 10 and 15 years from now when we're making our plans to get started now.

And so I appreciated your statement. I think that was very helpful.

My only other thing is that you compared the premium support to the fair share formula. And we usually don't call the fair share formula in FEHBP a voucher. That tends to confuse people. It makes them think they're going to be left all out on their own with a sheet of paper or a coupon, and that's really not the intention. I think there needs to be a better word than that for how the FEHBP and how the Breaux plan would work.

Mr. KELTON. I will certainly point that out to the writer of this. I didn't write this. This comes from the national office of NARFE, one of the legislative assistants up there. We didn't get notice of this hearing. I didn't hear about it. I was at a convention in Ft. Myers until Thursday afternoon and at the convention, somebody said people from Sanford should be aware that there's a hearing taking place at Sanford and some of you who are near there should try to get there and hear what goes on.

Cliff and I really appreciate the chance to speak at this hearing.

And then when I got home from the convention I did have a letter from Mr. Mica that arrived while I was gone. So I did a little bit of homework last night. And one of the things that I would like to point out—I think it's covered in this but I would like to say it in plainer language—one of the big differences between the Medicare risk pool and the FEHBP risk pool is that the FEHBP risk pool represents a very healthy kind of cross-section of the population. It includes both employees, 20 and 25-year-old people, and it includes people like me, I'm going to be 73. Now, when I was in the Federal employment I didn't call in my health benefits for decades. I literally did not go to a doctor for decades. Now, I'm going to five doctors a year. Last week I had a cancer cutoff my leg. So we're really concerned about health care and the premiums involved in it.

Medicare, the risk pool is all elderly people. There are no young people in Medicare, and that's something that ought to be taken into consideration. One of the concerns that we have in FEHBP is that many of us also have Medicare. See, my wife worked all of her life and she's been able to make us eligible for Medicare. And we need it. If these premium support models don't work with Medicare and it becomes necessary for Medicare to start finding a way to save money through deductibles—or increasing deductibles and changing the premiums and the benefits my supplemental, Blue Cross and Blue Shield, has already indicated they're not going to participate in it. You see, it's a complicated situation.

So thank you very much for considering these things. It's not simple.

Mr. SCARBOROUGH. No. It's certainly not. I appreciate the statement you read. And as I said to them, it did come from the national office. But I think what we do see, though, through that statement, through the testimony today, is that we're going to be on a high wire and we're going to have to balance the commitment made in 1965 and make sure that commitment is made and kept into the 21st century but at the same time recognizing that there are just absolutely incredible strains that are going to be placed on the system over the next 10 to 15 years with the baby boomers moving toward retirement.

Ms. Cherney, I believe, you had a statement?

Ms. CHERNEY. I just wanted to make a comment with regard to the opening remarks that the gentleman made, before he began to read the statement where he mentioned that his cardiologist, when Medicare reimbursement got to 110, said that he would no longer treat him. In our market, and we're not different than other places, most of these managed care programs you were talking about that you want to participate are reimbursing at 83 percent of Medicare.

Remember, they've got to have marketing money and they've got to have profit, and so if physicians didn't want to provide the care at 110 percent, you can believe there's a whole bunch of them going to get out when it's at 83 percent. They're getting out now.

Mr. SCARBOROUGH. Let me say it's 5 until 11 and we're coming up on 2 hours. I'd say that they will be turning the microphones off in 5 minutes, at 11 o'clock, but I don't think they've really turned them on. But if somebody wants to get up here, we've got about 5 minutes for any statements—I've seen a couple hands go up—and ask our panel any questions. Come on up, sir, if you'd like.

Mr. DURANTI. Good morning.

Mr. SCARBOROUGH. And if you could, state your name, for the record?

**STATEMENT OF PETER DURANTI, AGENT EMERITUS,
PRUDENTIAL INSURANCE CO. OF AMERICA**

Mr. DURANTI. Yes. Good morning, my name is Peter Duranti and I'm agent emeritus with the Prudential Insurance Co. of America and I am on Medicare. And I believe that we need to address fee-for-service, because competition lowers rates. And competition is what America is built on. Not on government bureaucracy. I pay \$44 a month for Medicare. Now, the average cost of a health plan is about \$150 to \$200 a month. So we are running behind on the whole plan of Medicare. And Social Security was never designed to pick up Medicare. It was for retirement.

Now, I would say this, I would recommend this in a sincere way that we could calculate what the average cost of Medicare for a recipient was over the past 5 years, then issue an annual benefit statement to that person, to the Medicare recipients, for what that amount would be. And have it available in a Medicare recipient fund under their Social Security number and they could go to any doctor they wanted to.

Now, we could measure what the cost of a recipient was in the past 5 years, let's say it was \$30,000, let's say it was \$100,000, whatever it was, we could then as I say, issue a statement to the new people in the future of what is available to them. They could go to any doctor they want to at that time. Then we could also say if people are well off they don't have to go on Medicare. They could choose their own plans. Why should we have to pick Medicare? If I'm a wealthy man, which I'm not, but if I were a millionaire I would say, I don't want Medicare. I don't want to pay \$44 a month. I'll pick my own plan.

We've got to get back to basic economy, fee-for-service. Thank you very much.

Mr. SCARBOROUGH. I appreciate your statement, and I would guess that Ms. Arnett's group actually wrote that for you. You'll find no opposition, I'm sure, from her organization.

Any quick statements as we conclude this hearing?

Ms. ARNETT. One of the things that really upsets me about Washington is that they think they're smarter than you are. I think you're smarter. And I think that this \$6,000 a year that Medicare pays for the average beneficiary, that if you had control of that \$6,000 you'd make much better decisions and you would not tolerate some physician having to jump through 111,000 pages



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worth of regulations to give you medical care. You want health dollars.

Mr. DURANTI. I'd like to go to the doctor that I wish, you know, and I'd like to pay for it. Thank you.

Mr. SCARBOROUGH. Thank you very much.

This hearing is adjourned.

[Whereupon, at 11 a.m., the subcommittee was adjourned.]



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