HAS MEDICARE+CHOICE REDUCED VARIATION IN THE PREMIUMS AND BENEFITS OFFERED BY PARTICIPATING HEALTH PLANS? A REVIEW OF MEDICARE+CHOICE PLAN PAYMENT METHODOLOGY

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

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THURSDAY, MAY 31, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Levittown, PA.

The subcommittee met, pursuant to notice, at 9:23 a.m., in Bristol Township Senior Center, Levittown, Pennsylvania, Hon. James C. Greenwood (chairman) presiding.

Members present: Representatives Greenwood and Deutsch.

Also present: Representative Hoeffel.

Staff present: Joe Greenman, majority counsel.

Mr. GREENWOOD. Good morning, everyone. I am Jim Greenwood, and I have the honor of representing the 8th Congressional District, which consists of all of Bucks County and some of the better parts of Montgomery County in the District. I also have the honor of chairing the Oversight and Investigations Subcommittee of the U.S. House of Representative's Energy and Commerce Committee. And I want to thank you all for attending this official field hearing of the Oversight and Investigations Subcommittee.

We are here, as I suspect you know, to learn about a problem that affects senior citizens, Medicare beneficiaries, and disabled Medicare beneficiaries with regard to the premiums that they pay and the benefits that they receive under the Medicare+Choice plan, which is, of course, the managed care option under Medicare. I will make a few statements about that in a moment.

To begin with, I want to thank the Bristol Township Senior Center for hosting us this morning, and I want to thank all of the local members of the Senior Citizen Center for joining us, as well as seniors from around the region.

I want to also thank and introduce, as I will in a moment, my colleagues who have come here to attend as well. We have to my immediate left, Congressman Peter Deutsch. Peter Deutsch is the ranking member of this subcommittee. That means that, as a Democrat in the minority, he is the most senior member of the minority party. He covets this gavel. As soon as he can push us into the minority, then he will be the chairman. But he has driven up; he left Washington this morning at 6 a.m. to get here on time, and we are glad that he is here. To his left is Congressman Joe Hoeffel. Con-

gressman Hoeffel represents the 13th Congressional District of Pennsylvania, which is, I guess, best described as the balance of Montgomery County, most of Montgomery County. Mr. Hoeffel is not a member of the Energy and Commerce Committee, nor of this subcommittee, but Mr. Hoeffel represents constituents who have the exact same problem that my constituents have, as they do in all of the suburbs of Philadelphia, as well as elsewhere in the country. So I asked Mr. Hoeffel if he would come and help out with this hearing and listen to the testimony this morning.

The Chair asks unanimous consent that the record remain open for 1 week so that additional documents and testimony may be entered. And without objection, that is so ordered. The Chair recognizes himself for 5 minutes. And it has been suggested by my trusty staff that I turn on the microphone. I will not start over. I am hoping that everything I said prior to this is either heard or not worth repeating.

The reason that we are here is to look at inequities in the Medicare system in our region. Medicare was created in 1965. It was one of the most important things that the Congress and the Federal Government has ever done. It has put a safety net under retirees and disabled Americans in terms of their healthcare for 36 years now. It has been a tremendous boon to the health, and the longevity, and the wellbeing of our seniors.

Of course, when the program was created, it did not have a prescription drug benefit, and I have been asked by the local AARP folks to at this moment put on this little pin here, which says, Pennsylvania Needs Affordable Prescription Drugs Now. Wear this ribbon to show your support. So I am going to put this pin on while Hal Lefcourt takes my photograph. He is the AARP maven here. And as I showed Hal when I walked in, as of 1 week ago, I now carry an AARP card in my wallet. I am officially the youngest member of the AARP in the country.

Medicare began as what we call a fee-for-service system. Recipients receive their benefits card, they go to the doctor and the hospital of their choice, and their bills are reimbursed. Over time, Medicare developed a managed care alternative so that seniors had a choice. They could choose a plan that would instead of having Medicare, the Federal Government, directly pay the bills, insurance companies would serve as intermediaries and a flat fee would be paid to those insurance companies, who would then pay the bills for the recipients within the network.

Over time, we improved that system. We created—and you will hear this from some of our witnesses—Medicare+Choice. And that was to improve that system, to ensure the longevity of Medicare, managed care, and it was, initially, a tremendous opportunity for beneficiaries. I encouraged my mother and father, who are still members of the Medicare+Choice Plan to join because suddenly, when they did, they no longer had to pay Medigap insurance. They were able to get a very good prescription drug benefit at no premium. And additionally, had better dental care, better eye care, access to hearing aids and so forth that was not available to them under the traditional Medicare fee-for-service system.

The problem has been that in the last several years, the payments made by the Federal Government to the Medicare plans in

our region have not been sufficient. That has been partly the problem of the Congress, it has been partly the problem of the previous President of the United States. We had lots of tough negotiations about that, and there is plenty of blame to go around. The bottom line is that the plans have had to reduce their benefits over time, and virtually, eliminating the premium-free prescription drug plans, and they have had to increase premiums.

To make matters worse, and to add insult to the injury, in our region what has happened is that beginning in the first of this year, the plans have charged a significant premium. I think it is at least $59 in some cases, per month, to the beneficiaries who happen to reside in the suburbs of Philadelphia—in Bucks County, in Montgomery County, in Delaware County, in Chester County—as well as across the river in New Jersey, while beneficiaries in Philadelphia will not have to pay this additional premium. That is not fair, that is not right, and that needs to be fixed, and that is why we are here this morning.

If it were fixable with a wave of a wand, we would have done that when the first complaints started to come into our offices some months ago. It is a complex problem and we are going to try to understand that problem better than we do this morning by hearing from our expert witnesses. And then we will take that information back to Washington and try to fix this. As I told one gentleman, we will not fix this any earlier than January 1 of next year. That is, virtually, impossible. The plans set their premiums and their benefits in the latter part of the year. They go into effect in January 1. If we work very hard, if we are very successful and somewhat lucky, we may be able to improve this system throughout the course of this year so that when the new fiscal year begins on October 1, the plans will have enough funds to increase the benefits, and reduce premiums by next year. No guarantees of that. It is going to depend upon a lot of cooperation in the House and Senate and with the President.

That is what we are here for this morning. A question has been asked as to whether there will be questions allowed or comments from the audience. I should tell you that that is normally not possible in a Congressional hearing when those hearings operate in Washington. We have a finite amount of time and a finite list of experts from whom we can hear and then ask questions. We have to be out of here in almost exactly 2 hours from now, at 11:30, because lunch is served here then, and we will need to do that. If there is time, if we have heard from all of our witnesses, if the Members of Congress here at the panel have had opportunity to ask all of the questions and have them answered, and we have time, I will try to set up a system where we can entertain for the balance of our time here this morning questions and comments from the audience.

With that, I will now yield 5 minutes for an opening statement to the gentleman from Florida, Mr. Deutsch.

Mr. DEUTSCH. Thank you, Mr. Chairman, and I won't take 5 minutes. I want to thank you for inviting me to your district. I went to school not that far from here. I was an undergraduate in Swathmore College in Delaware County. Representing south Florida, those of us in south Florida, those who are from Florida, I

would like to say that there are two types of Americans, those that live in Florida and those that want to live in Florida. So I am sure some of your constituents will become my constituents in the not too distant future.

This is, obviously, a very important issue. I am looking at the numbers. I represent three different counties in south Florida and we have the same sorts of disparities, so it is a national issue. And I think it is, clearly, something we can work together on, and Congress has been working together on it.

I want to thank the Chairman, and I think this community is really very blessed to have, really, two outstanding Members of the U.S. Congress who are the epitome of bipartisanship and working together to try to solve the problems of America. And knowing the constraints on time, I yield back the balance of my time.

Mr. GREENWOOD. I thank the gentleman and recognize for an opening statement, the gentleman from Montgomery County, Mr. Hoeffel.

Mr. HOEFFEL. Thank you, Mr. Chairman. I want to start by thanking Jim Greenwood for inviting me. This is an unusual occasion. I am not a member of this committee, and this is not my District, and Jim has reached out in a bipartisan way to include me, to ask me to provide a witness, and we will hear from Lois Dudley in a minute, from Montgomery County. And I am very grateful, and I am impressed, and this is the way Congress ought to work, and it does not always work this way.

So I am glad to be here and glad to be here with Peter Deutsch as well. And I was going to say before he did, that many of my constituents will end up his constituents. I didn't know you were smart enough to have gone to Swathmore, Peter. I am very impressed with that.

Mr. DEUTSCH. I was a wrestler so——

Mr. HOEFFEL. Oh, he was a wrestler, he says. All right.

Mr. DEUTSCH. I didn't get there on my brains.

Mr. HOEFFEL. I am delighted to be here in Bucks County. I want to acknowledge someplace in the back, State Representative Matthew Wright.

Mr. GREENWOOD. Oh, I didn't know Matt was here.

Mr. HOEFFEL. Yes. Wave your hand. I said hello to Matt when he came in. I served with his father, Jim Wright, when I was in the State Legislature, the same when Jim Greenwood was in the State Legislature, and we are in the Jim Gallagher Memorial Senior Center here, and I served with Jim as well. So I am delighted to be here today.

My constituents have complained to me just as Jim Greenwood's have complained to him, and Peter Deutsch's to him, about the different premiums that they are charged by the Medicare+Choice providers. I am sure we will hear today of the disparity in the amount that Medicare pays the providers for each Medicare beneficiary. In this region, effective March of 2001, Medicare pays providers in Montgomery County $560 per month per beneficiary; they pay in Bucks County $623 per month per beneficiary; and in Philadelphia County, $762 per month per beneficiary, over $200 more than they pay for Montgomery County.

Now, that may be a very legitimate difference in payments based upon the cost of providing the service. Philadelphia has a larger low income population, more teaching hospitals, hospitals that have more poor people going there, and there may be legitimate differences that require Medicare to reimburse differently, county by county.

What Jim Greenwood is saying with his leadership today by calling this hearing is let us see if we cannot level out the premiums that are, in turn, charged to the beneficiaries. It is fine for the Government to pay different rates to the providers based upon the provider's costs, but it is not so fine in, for example, the service area of Independence Blue Cross, or any other healthcare insurer, for the beneficiaries, the customers, to pay different premiums simply based upon where they live. We ought to be able to figure out a way in Washington so that a health insurer charges the same premiums every place within that insurer's service area, whether it is one county or five counties, when they are delivering the same product throughout that entire service area. I think that is the focus of our concern.

I, again, compliment Chairman Greenwood for holding this hearing and inviting me, and I yield back the balance of my time.

Mr. GREENWOOD. The Chair thanks the gentleman, and we are delighted to have him join us. I was not aware that State Representative Matt Wright is here, but I am delighted that he is. The rules—I have checked with the counsel. The rules of the House do not permit Mr. Wright to ask questions of the witnesses, but I have checked; there is no objection to his coming up and joining us at the panel. So Matt, if you would like to, you are welcome to come on up here and have a seat at the front table or you can—or not, as——

Mr. WRIGHT. I am going to stay back here.

Mr. GREENWOOD. You will stay back with the real people? Okay.

Mr. HOEFFEL. That means he might heckle.

Mr. GREENWOOD. Okay. With that, we welcome our first of two panels of witnesses. And they are Ms. Ila M. Kirsch from Langhorne; Ms. Lois Dudley of Hatboro; Mr. William Blacknell of Ben Salem; and Ms. Lynn Kopacz, who is a Resident Insurance Manager of Wood River Village in Ben Salem, as well. We thank you all for being with us.

You have probably been informed that the committee is holding an investigative hearing, and when doing so, has had the practice of taking testimony under oath. I need to ask you, do you any of you have objections to taking testimony under oath? So you are all going to be honest with us. That is good. The Chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today? Usually, we are investigating bad guys; that is why we have to ask these questions.

In that case, if you would please rise and raise your right hand, I will swear you in.

[Witnesses sworn.]

Mr. GREENWOOD. Thank you. You are now under oath, and I would invite, beginning with Ms. Kirsch, you to take 5 minutes to summarize your testimony. Do the witnesses have microphones?

Ms. KIRSCH. Is this okay?

Mr. GREENWOOD. This is perfect. Thank you very much for being with us this morning. Can you hear back there now? Okay.

TESTIMONY OF ILA M. KIRSCH; LOIS DUDLEY; WILLIAM BLACKNELL; AND LYNN KOPACZ, RESIDENT INSURANCE MANAGER, WOOD RIVER VILLAGE

Ms. KIRSCH. I went with Aetna U.S. Healthcare 7 years ago, and my premium was $30. That was fine. I had to get notice from another doctor to see another doctor, but they canceled all that out. And gradually, it built up to this year, which is $50. Now, I can handle that; that is not bad. It is the prescriptions that is giving me the problem. The first of the year, Healthcare deleted it entirely. I have to pay 100 percent. It is $111 for 30 pills, and I take two different prescriptions. It is quite a dig into my check and I can't see any reason for it to be so high. I mean, it is just awful. I just hope, you know, that our Government will help us—all the seniors, not just me, but all of us—to try to get the drug companies to realize, you know, what a problem this is. And with your help, maybe it can be done. That is all I have to say. It is not 5 minutes, but I am sorry.

Mr. GREENWOOD. When we are in Washington, no one has ever spoken for less than 5 minutes before so we are delighted and we will have some questions for you as we proceed.

Ms. KIRSCH. Okay.

Mr. GREENWOOD. Thank you. Ms. Dudley, you are now recognized for 5 minutes, or so much time as you choose to use.

TESTIMONY OF LOIS DUDLEY

Ms. DUDLEY. Thank you. Hopefully, mine will not be that long either. As you can see, I have a tape here. When I was asked to represent our district, I went back to my records. I kind of keep a very detailed budget, and I went back and took last year. And as I have written on this, you know, I started out with a zero fee, as you had said, and now we are up to $50, also, my husband and I. And when I spent over what I was allowed—we always had a bank. It was $1,500 the first year, of which it would be reduced as I used it. Then it got to $1,000, then it got to $500, then it got to nothing. So we are doing the total cost also. And I just looked, and I would have been spending $675 for the prescriptions that we are using at this point. We are now spending $2,973, along with the $1,200 fee now for the two of us, and the $1,200 coming out of our Medicare. So we have jumped extremely, you know, in our budget. We are on a fixed income, and it is really very difficult.

Let me show you the problem I had. I said, all right. Now, I am going to go out and see where I can get the least expensive drugs. Well, as I wrote on my thing, the pharmacies will not divulge the cost of the various medicines and is preventing us from getting the best price. What happened is when I would call the different pharmacies, they say, well, I have to have your prescription. Well, I described everything from the ones I already had. I didn't have a pre-

scription at that point to take to them, and to run to every pharmacy with this prescription, then they would tell me what the cost was. I had no way to prepare. So therefore, I am stuck with whoever I am getting my medicine from.

Also, the experience my husband had was we went to—we do not get the company. In other words, we do not have our Medicare—I am with U.S. Healthcare, also, Aetna U.S. Healthcare. It is not a company backed where some of my friends are in it and they do get prescriptions. I do not and neither does my husband. And so what happens is, not being able to get the best price, we went with one drug company and they, literally, told our doctor to change his prescription. Now, you have a pharmaceutical company, or a prescription company, telling my doctor what to give my husband. They wanted to change it. Now, my husband was not able to take that particular medicine, but it was one they made. And that is a problem when your doctor is being told—to turn down the doctor's note, that he could not use theirs, it was accepted, but there is a problem. It could be sometime where maybe it wouldn't.

So I feel that—I hope I am not going over my 5 minutes, but I do feel that it is very important that Congress realize that where there is so much pharmaceutical power, and lobbying, and money going into campaign, and all that sort of thing, and they say, well, we need the money for research—let us get a lot of money into the research and not into this false campaigning, and let us get some prescription help from Congress.

Mr. GREENWOOD. Thank you very much, Ms. Dudley. Mr. Blacknell. Oh, I am sorry. Let me also recognize—I have been just notified that State Representative Tony Melio has joined us. Tony, where are you? Welcome. Thank you for joining us and thank you for your interest. Mr. Blacknell.

TESTIMONY OF WILLIAM BLACKNELL

Mr. BLACKNELL. Last December, Congress voted $11 billion for Medicare HMO's. We saw a rate decrease in our Keystone 65 premiums of $6. "Congress was assured that every penny would go to increase benefits and reduce premiums," says Representative Pete Stark of California, a leading Democratic spokesman on healthcare. With no formal amendment and just before the bill was brought to the final vote, the wording changed to allow HMO's another option for spending money. They would be able to pay more to networks of hospitals and doctors that provide care for their beneficiaries.

On average, plans can devote 70 percent or more to this added option. To add to the mix, Keystone 65 says that providing healthcare for Philadelphia compared to the four surrounding counties, there is very little difference. Philadelphia residents who are enrolled in Keystone 65 pay only for the prescription part of the plan, which amounts to $35 for generic brands or $65 for brand names. The surrounding counties may pay an additional $59 per month on top of the 35/65 fee paid by Philadelphia Keystone members. The HCFA, which administers the program, has never explained why there is such a disparity in funding. For example, HCFA funds $762 for each Philadelphia Keystone member as opposed to only $559 for each member in the suburbs.

I have been in contact with Representative Greenwood's office over the past few months and have been told that they are working on the problem. Why is there a difference in the way HCFA funds Philadelphia versus the suburbs? Why after years of zero cost to seniors enrolled in Keystone 65 do we now pay $89 per month for a generic drug plan and Philadelphia pays only $35 for the same plan?

Show us the formula that justifies the fee difference because HCFA's imbalance of funding. This affects myself as well as other seniors in the following examples. As of January 2001, the annual premium for an individual went from zero to $1,068. the annual premium for a married couple went from zero to $2,136, or as high as $2,556 if the brand name plan is necessary. Not to mention, having a co-pay for doctor visits and prescriptions.

I have a seasonal job. I am concerned about how I will manage this financial burden if the day comes when I no longer am able to work. I would be reduced to a fixed income and having also to meet the obligations of paying almost $4,000 in local property taxes. As of now, I don't qualify for State programs such as PACE, et cetera, unless parameters are changed to include seniors in my similar situation.

Thank you for allowing me to voice my concerns and opinions on this very serious matter.

Mr. GREENWOOD. Thank you very much, Mr. Blacknell, for your testimony. We appreciate it.

Just to explain the process here, you have asked a lot of questions about why things are the way they are. In the next panel, we will begin to get those answers as we ask those questions of the Health Care Financing Administration and the insurance company themselves.

Ms. Kopacz. And please speak as directly into the microphone as you can so everyone in the back can hear.

Ms. KOPACZ. How is this?

Mr. GREENWOOD. That is great. Thank you.

TESTIMONY OF LYNN KOPACZ

Ms. KOPACZ. Good morning. My name is Lynn Kopacz. I am an insurance manager at Wood River Village, a retirement community in Ben Salem. What I do is help all the seniors at our facility with their health insurance problems, issues with bills, premiums, and different plans, which is the best for their particular physical needs.

With U.S. Healthcare, with the difference in the premiums, comparisons in premiums, I did find yesterday in Bucks County, Aetna U.S. Healthcare cost $50 per month. That includes no prescription drugs. In Philadelphia County, the same plan is a zero dollar premium. In New Jersey, Mercer County, the same plan is $93 a month. I did find out in Philadelphia they offer an additional plan for $40 a month that will give you $500 in annual prescription costs. However, if you multiply the $40 a month times the 12 months, you are, actually, paying $480 for them to give you $500 worth of coverage.

Mr. GREENWOOD. Less postage.

Mr. KOPACZ. Right. When you add in your co-pays, you are actually paying them. So that is part of the problem. I didn't get the Keystone premium difference information, unfortunately.

One of the issues I wanted to talk about was the impact of the decreased prescription benefits and the effect on seniors. I have one resident that was paying a $30 co-payment for a non-formulary brand name prescription. When her prescription benefit was exhausted in April this year, the cost went up to $130.28 for that one prescription, which was just one of maybe seven or eight prescriptions she takes. Her total bill did go to $827.21 for the month.

Another issue we have with the HMO's is the communication problem. While these seniors here are—I consider them barely even seniors. They are very young and capable. The average age at our——

Mr. GREENWOOD. We are the politicians up here.

Mr. KOPACZ. Sorry. The average age at our facility, I know, last year was 88 years old. So what happens with an 88-year old person is many other complications. For example, when they need referrals or they need to compare prescription drug costs, they cannot hop into their car and drive to Target, and CVS, and K-Mart, and all the different areas to find different cost differences. They are, basically, at our facility and have to get the different pharmacies that we have that deliver to our facility.

We also have an issue with safety with the many different number of prescriptions that some of the seniors take. We use a pharmacy that prepackages medications for them, and that way, if they need help with their medications, a nurse can come up on an a.m. and p.m. basis, give them the proper amount of dosage and pills that they are supposed to take, which also is an added cost to the seniors, too. And also, it doesn't allow them to use mail order pharmacies, which can also be a big savings.

The other issue I wanted to talk about was the communication issue. Poor vision and poor hearing create confusion when trying to deal with automated telephone systems, voice mail, referrals, and pre-authorization requirements. A situation I had when I was trying to help a resident was I called Keystone 65, and I was told that all their representatives were busy, I would have to leave a message, and I would receive a call back within 24 hours. Three days later, I got the call back. I was unable to take the call at that time. They told me this is, basically, your chance, and if you don't take it, you miss your opportunity, which, unfortunately, I did. I had to go back through. They told me I had to call the member services number again and go back through the whole situation again, leaving frustration. Many of them are very frustrated, as well as myself. I find it is very frustrating to have to leave a voice mail message and hope that someone gets back to you.

Also, there is questionable knowledge of the insurance company representatives. I have found a situation where I have called one of the particular HMO's four times on the same issue and received four different answers. Keystone 65, one of the problems is they don't have the automated referral system, so the members are supposed to go to their doctor's office and pick up their referrals, which is another problem.

And the last thing I wanted to say—I could go on, and on, and on, because there are so many problems that the seniors are having with this, with the HMO's. One is the ability to understand the benefits and make an educated choice based on the plan comparisons provided by the insurance company. The information mailed out is lengthy, confusing, and overwhelming. And I find that I know—I, at one time in my job I did, I used to interpret contract language for different insurance plans for union and salaried members, and the information in the language that they send out in the packets of information does not include a lot of the information that you need to know, and there is a very big gray area regarding what is covered, what is not covered, how to get it, and how to be eligible for the benefits that you are guaranteed.

I know I have an issue with Keystone 65, someone that had a hearing aid purchase, and they had to call through to get to the phone. You first had to get on the phone to get somebody to mail you out the form that had to be completed to send back in to get reimbursed. And this took at least three phone calls for me to get the form to be sent out.

And just one other thing I want to mention, too. I had a resident who was 90 years old, was informed by her company she was covered as a retiree for a company she worked for 30-something years. She was informed this year that they can no longer afford to supply their retirees with health insurance benefits, that she would have to find new coverage. She was paying $87 a month for coverage with prescription costs. We sat down and went through all of the different Keystone plans and U.S. Healthcare plans, got a prescription printout from her pharmacy listing all of her brand name medications, her generic medications, figured out the actual cost, if we had co-pays, if they are on the formulary, if they are a preferred brand name or a non-preferred brand name, and figured out with each particular plan what the cost would be per month. I don't think that this 90-year old woman would have been able to do it if I had not helped her do it.

But interestingly enough, what I did find out as the actual cost between all of the plans, with U.S. Healthcare included, not paying any prescriptions was a difference of maybe $20 over the whole month. So that is, you know—thank you.

Mr. GREENWOOD. Thank you very much for your testimony.

The Chair recognizes himself for 5 minutes for inquiry, and let me address my question to you, Ms. Kopacz, if I may. A few years ago, three or 4 years ago, it seemed to me to be a very—as I said in my opening statement, a very excellent choice to choose a Medicare+Choice plan because you saved the money that you might may a Medigap policy. You get the prescription drug plan you didn't have access to otherwise, and other health benefits as well. As the prescription drug benefit has vanished for most intents and purposes, and as the premium has now climbed to $50 a month, help me with the math. At what point—is it still advantageous for most beneficiaries to remain on the managed care plan as opposed to going back to fee-for-service where they would have no—they wouldn't pay the premium but, of course, they would either have to go out and buy a Medigap policy or take the risk of paying out of their pocket for what Medigap covers should they need it? How

do you advise your residents as to whether they are better off on a fee-for-service plan or a Medicare+Choice plan?

Ms. KOPACZ. Well, actually, what I found is that each individual person differs. And like I said, with this particular woman, we had to—and this is what I have done with everyone. I get a printout of all of their pharmacy costs for the month. You have to compare how many generic they have, how many brand name they have, what is the actual cost, are they on the formulary, will it cost them $25, $10, $15, is there unlimited coverage. Every person really differs based on the amount of brand name prescriptions that they actually take. Actually, it gets to the point of even how many specialists you have to go to, a $20 co-pay versus a $10 co-pay. When you are on a fixed income, $3 makes a big difference. And I find that people are willing to change their insurance plan based on a $3 co-pay extra per month.

What I found with this particular one, like I said, that she, even with no prescription coverage, the cost of her—which is minimal. She takes a minimal amount of prescriptions. What I am finding is the average cost per month with no insurance is $500, I would say, average that seniors are paying. This woman, in particular, only has seven medications. Her total was $190.29 per month. So adding in the premiums, deducting her co-pays, figuring out if it is generic formula, or nonpreferred, or preferred, it came to a difference of $20 between plans. However, with people that are on a high cost brand name prescription usually exhaust the benefit in the first 2 months of the year and end up, they are paying the additional premium of $90, $130 in some cases, a month, plus they end up paying for the last 10 months of the year the actual cost of the plan—I mean, the actual cost of the prescriptions.

Mr. GREENWOOD. Thank you very much. And obviously, your residents are very fortunate because they have you to, with all of your experience and ability, to come and walk them through this very complex process. The average senior out there may find that an overwhelming process to make all of those calculations and decide what is the best choice.

Let me direct a question to Ms. Kirsch, and I am going to ask Ms. Dudley and Mr. Blacknell to answer as well. Can you give us a sense of now that you are having to pay these additional burdens, both for your premium and prescription, what has that done to your budget at home? What are you doing without that you might have enjoyed otherwise?

Ms. KIRSCH. Well, what I do is I put it——

Mr. GREENWOOD. Before you respond, I am going to ask that the microphone be sent down to you, and if you will speak directly into it, some of my staff are hard of hearing and I want to make sure that they can hear.

Ms. KIRSCH. Okay. What I do is I put it on my credit card, because with the two of them, it comes up to $254 a month.

Mr. GREENWOOD. What do you put on the credit card, the——

Ms. KIRSCH. My prescriptions.

Mr. GREENWOOD. The prescriptions.

Ms. KIRSCH. At the drugstore, I give them my credit card, and then when my bill comes in, I pay half of it. And then the next

month, I pay the other half. That is the only way I can see to do it. Then I don't put out all that money at one time.

Mr. GREENWOOD. But if I do the math then, what happens is your credit card balance is going to grow month by month by month.

Ms. KIRSCH. Exactly.

Mr. GREENWOOD. So you are, basically, plunging yourself into debt just to take the medications.

Ms. KIRSCH. I just started doing that. I don't like to do it. I hate it. It worries me. But what else can I do? I can't expect my kids—I won't let my kids do this, you know. They have their families, and I just won't do it. So I just try to go along and do it that way. And also, I went with three different mail order companies. And right now with Pace, the price has not dropped one cent. It is still up to $101 for one prescription. I thought with Pace I would get a break. NO.

Mr. GREENWOOD. Well, do you qualify for the Pace program or the Pace net program?

Ms. KIRSCH. Yeah, I have the card. I sent in my form. I sent in everything that they needed, and I don't understand that. Of course, there is no generic for what I take. I take cholesterol and high blood pressure, and the doctor said I have to take it, but there is no generic so I don't get a break on the cost.

Mr. GREENWOOD. Okay. Ms. Dudley, can you comment? If you—it is a fairly personal question, but I am trying to get a sense of what this has meant to your lifestyle.

Ms. DUDLEY. Yes, it has changed mine, but I have taken it out of many other funds and switched it into the medical fund. And we don't know—I don't know if I have enough in there. I have to wait until the end of the year to see how I am coming up. But I agree with what you are saying, if you can't get the generic—and I was on Brocardia and there was no generic. It has just become generic, and so there is a huge difference in the money on that particular—but I did want to answer when you said about is it still advantageous to say in the managed care versus going to fee. My husband told me that on his visit that he has to take twice a year because he has a heart problem, it is $250. So now, you take $250 twice, you have $500. He is paying $600 into managed. And so that is just for those two visits. That is not for anything when he goes to the heart doctor. And so you can see, we stay in it just only for that reason at this time. We haven't found that it would be—to drop out. Otherwise, everything else is gone, the help for all kinds of aid. Dental is definitely gone. There is nothing in that line. So we do pay quite a high fee for that.

But that is what I had to do with my budget. I had to really take from other things that I have allotted and put it into the medical. And with the fuel, it is going to happen with utilities also. So it does come out of food, it does come out of entertainment, which we do very little of, and you wonder where it is going to come from. And I am sorry to hear that you have to put that on a credit card, because it is going to snowball with the interest.

Mr. GREENWOOD. Thank you. Mr. Blacknell—would you pass the microphone over—and could you respond to the same inquiry as to how this has affected your family budget?

Mr. BLACKNELL. Well, as I mentioned, I have a seasonal job, approximately, I work 6 months to 6½ months. What I tried to do is I went to the Veterans Administration, and there you can get 90 days supply for $6, except that they don't carry all drugs. My cholesterol is great, but my good cholesterol is low—it is always something. So anyhow, they don't have it, so you have to go out and pay for it. And I won't mention the two stores, but one was $76 for a month's supply and the other was $65. So there is a disparity there, which sort of ties in with what they are saying. And that is, basically, it for now. But as I mentioned, when I stop working, I will be in a different category.

Mr. GREENWOOD. That is great to shop around, but I think it was one of these ladies—was it Ms. Dudley—said that if they won't give you the information over the telephone, it is an impossible task to drive to ten different pharmacies to find out which one has the best price.

Mr. BLACKNELL. Well, as it happened with me, I just went to one, and I paid for the prescription, and I just happened to go to another one after the usage of that and found out it was more advantageous to go to that drugstore.

Mr. GREENWOOD. Very well. Mr. Blacknell mentioned the Veterans Administration. Of course, the problem is that if you go to the, or call the VA in this area to schedule an appointment at the Willow Grove Base, for instance, so that you can qualify, because you have to get a physical, you are told there is almost a year's wait before you can even get it. And I want to let you know, let everyone know here, that this is something I am very involved in. We have a meeting at 2, I think it is this afternoon, or tomorrow afternoon at 2, with the VA and with the Captain at the base, and some others, and we are going to try to find a location where we can expand the facilities at the base so that we can bring more nurses and other personnel in there so we can get these physicals done more quickly so we can get those who qualify for the VA benefits on that prescription plan sooner rather than later.

Thank you all. And now we will turn to Mr. Deutsch for 5 minutes for his questions.

Mr. DEUTSCH. Thank you, Mr. Chairman. I am trying to get a sense in this community, and I guess what I have heard is that there are no Medicare+Choice providers that provide any type of prescription drug coverage in this period?

Ms. DUDLEY. Unless you are with a company.

Mr. DEUTSCH. And when, just for whoever can answer, when did that change?

Ms. KOPACZ. The first of the year.

Mr. GREENWOOD. Don't forget to—I am sorry that we don't have four microphones, but if you would just always pass the microphone back so that the folks in the back can hear, please.

Ms. KOPACZ. In our particular area, Keystone 65 does offer four different plans, and each increase is, you know, premium increases with the actual amount of benefit they give you for your prescription drugs.

Mr. DEUTSCH. So that changed as of January 1, but what are the four plans?

Ms. KOPACZ. There are four different plans. The first plan has no prescription coverage, is $59 a month. Drug Option 1 is $89 per month, covers unlimited generic drugs with a $10 co-pay, no brand name prescriptions. Unfortunately, most people need the brand name prescriptions. Drug Option 2 is $124 per month, unlimited generic, $10 co-pay, brand name prescription. Here is the catch on this. $750 brand name prescription, $10, $15, $25 co-pays with a formulary. It is limited to $375 every 6 months. Drug Option 3 is $136 per month. They give you unlimited generic with a $10 co-pay, $1,000 in brand name coverage, $500, broken down into $500 every 6 months, with the $10, $15, $25 co-pays with the formulary. Formulary is very confusing, it is very hard to understand. I, myself, cannot even find half of the medications that the doctor orders on there. I don't know if there is different names, or if they are generic, or what the situation is with that.

Mr. DEUTSCH. So I guess the bottom line, though, is that if you live here in this community, and you have high prescription drug cost, and you are a middle class senior, you are in serious trouble.

Ms. KOPACZ. Yes, that is exactly——

Mr. DEUTSCH. I mean, that is the bottom line.

Ms. KOPACZ. Yes.

Mr. DEUTSCH. And I mean, prior to January 1, you did have an option, but you really don't have that option anymore?

Ms. DUDLEY. No.

Mr. DEUTSCH. And so I mean, as a practical sort of thing, you know, what are you telling your friends, what are you doing as choices? I mean, you are making the choice. You talked about less entertainment, less food, putting things on credit cards. I mean, are those the options that seniors—is practical? And let me tell you again, I mean, one of the—in Philadelphia, if the people here lived in Philadelphia, what would the choices be?

Mr. BLACKNELL. It would be $35 for the generic or $65 for the brand name.

Mr. DEUTSCH. And would that be total coverage for brand name drugs, similar to prior to January 1?

Mr. BLACKNELL. Well, that is the question.

Mr. DEUTSCH. I mean, I don't want to, you know, recommend anyone do something improper or illegal, but do you have friends who are using addresses in Philadelphia to get prescription drug coverage?

Mr. BLACKNELL. No, not that I know of.

Ms. DUDLEY. We don't like to do that.

Mr. DEUTSCH. I wouldn't recommend it to anyone but, you know, given the choice of survival—I mean, I think seniors start doing things that maybe we don't want them to do.

Ms. KIRSCH. They catch up with you then.

Mr. BLACKNELL. Anything is possible.

Mr. DEUTSCH. Let me talk about that in a direct sense also, because one of the things Congress is, in fact, you know, addressing—and our committee, actually, has jurisdiction over it—is the idea of having prescription drug coverage as a benefit of Medicare, you know. Just to give people some sense of that, you know, there are some interesting statistics about Medicare. One is that prior to when it was created 36 years ago—and there are two interesting

statistics that I like to mention, occasionally. One interesting statistic is the average life expectancy for Americans 36 years ago was 65 years old. The good news is 36 years later, it is over 80 years old. So in a period of 36 years, we have had a real high class problem, people living a lot longer. One of the reasons they are living a lot longer is prescription drugs, as a variety of other things as well. But one of the things that is clear is if we were today creating a Medicare system, it is 100 percent certain we would include prescription drug coverage. You couldn't conceive of a healthcare system without prescription drug coverage today.

I think the truth of the debate of what is going on is who should that prescription drug coverage cover, and there have been different proposals. And this is where I think, you know, a real debate is going on in Congress because, unfortunately, the President has made a proposal that limits that coverage to, really, low income seniors. And the threshold level in many cases is $15,000 a year as total income. Mr. Blacknell mentioned, you pay $4,000 a year in property taxes. And whatever else—if you are talking about your premium and other things, I don't think—you know, at what level, you know, is it appropriate. I mean, you know, what level is appropriate for—my perception is that it should apply to all Medicare beneficiaries, and I think that is really the debate.

So maybe if you can comment—I mean, if Congress does implement the prescription drug plan, do you think there should be an income standard for that or, I mean, should it be part of Medicare as a whole?

Ms. KOPACZ. I just want to comment that, actually, when President Bush was running for president, he was stating that they didn't feel that Government wanted—or the people didn't want Government involved in their prescription drug plans. I went back to Wood River Village and did a spreadsheet on how many people, the people that lived at Wood River Village, which is a retirement community. You have to have a little bit of money to get in there. I did a comparison of how many people actually did have prescription drug coverage. What I found was that not including the HMO's, because they were at that time giving prescription coverage, the people without coverage worked out to about 65 percent of the people, of seniors, had no coverage; 4 percent actually qualified for Pace; 22 percent did have coverage through a private company, and they were all government workers. It was the Federal employees, teachers, and Bell Atlantic. And besides that, the majority of the people did not have any prescription coverage.

Mr. DEUTSCH. Does anyone else want to comment? I mean, if we are going to implement prescription drug coverage for Medicare, do you believe there should be income standards?

Ms. DUDLEY. Absolutely. It should be every—and that is my opinion. Because what happens when they put this cap on your income, it is never in with the middle. It is always for some very poor, which I would hope that they would be able to get their prescriptions, period, without having to pay if they have no money. And I am not asking for a free ride, and I don't think many of us are. We don't mind contributing toward prescriptions, but it has to be a reasonable, and it needs to be to cover all the drugs. And I can understand how people are running to Canada. I mean,

Ananan printed their address, and believe me, I saved it, of where in this country we can join this group to go to Canada if it gets that bad. I don't want to do that; we shouldn't have to.

Mr. DEUTSCH. I could tell you you can come to Florida, because the HMO's there still provide a prescription drug coverage. That is one more reason to move.

Let me mention, though, one final thing, and that is, you know, this threshold amount of $15,000. I mean, do you consider that, you know, a threshold amount that is appropriate in terms of, you know, seniors. I mean, it is sort of if you have more than $15,000, can you afford to pay for your prescription drugs in terms of income? And it is actually—I think it is $17,000 for a couple. I mean, what does that mean in the real world of seniors living in this community?

Mr. BLACKNELL. The VA, their threshold is $27,000. So there is a $10,000 difference; they are in the real world.

Mr. DEUTSCH. Okay. All right. Thank you very much.

Mr. GREENWOOD. The Chair thanks the gentleman for his questions. If I may insert an editorial opinion, what we are likely to do in the Congress, and what the House of Representatives did last year and the Senate didn't get to, is pass legislation that would provide at the lower tier, 130 percent of poverty or thereabout, that it would, basically, pay for everything. There would be no co-pays, there would be no premiums, and the drug benefit would be covered. What we are fortunate—and then above that, there would be more of a sharing between what the Federal Government pays and what the beneficiary pays. We are fortunate here in Pennsylvania because we do have this very strong Pace program that right now is focused entirely on the lower income folks of Pennsylvania. The idea is that if the Medicare Program steps in and covers entirely the lowest income residents of Pennsylvania, then the Pennsylvania legislature and our Governor will be able to use the lottery monies that are now used for the Pace to now pay for the middle class to help make up the difference between what Medicare pays and what the beneficiaries pay. So because we have such a strong program in Pennsylvania, no matter what we do in Washington, Pennsylvanians will probably fare better than most.

The Chair recognizes for 5 minutes the gentleman from Montgomery County, Mr. Hoeffel.

Mr. HOEFFEL. Thank you, Mr. Chairman. I wanted to ask Ms. Kirsch, Ms. Dudley, and Mr. Blacknell to respond to some of the comments of Ms. Kopacz, who seemed to strike quite a nerve—I saw lots of heads nodding up and down when she was talking—regarding when you try to compare Medicare+Choice plans, you get confusing information, automated messages, it is difficult to communicate, bureaucratic hurdles, confusing differences in plans. Have the three of you experienced something like that?

Ms. DUDLEY. We were in, as I said, Aetna U.S. Healthcare. We wanted to make a change because we weren't—we were told we weren't going to get the prescription coverage, or we were having a reduced prescription coverage. So the man from Keystone came out. He had his whole spread. None of my husband's medications were on that, none of them. So that ended Keystone.

Mr. HOEFFEL. And most of the difficulty is over the prescription coverage?

Ms. DUDLEY. That is absolutely right.

Mr. BLACKNELL. My wife is with Aetna, and on prescriptions, she takes Libertore, and she received a letter asking her to take the generic two times, and her doctor insists that Libertore does the job for her. And the formulary and——

Mr. HOEFFEL. What was the upshot of that? How did you resolve that problem?

Mr. BLACKNELL. Well, it is still the same. She is taking Libertore. They never got back again and said, you know—it is a must.

Ms. DUDLEY. That wasn't even on Keystone.

Mr. BLACKNELL. Well, she is Aetna.

Mr. HOEFFEL. And is that being covered?

Mr. BLACKNELL. Pardon?

Mr. HOEFFEL. Is Aetna covering that?

Mr. BLACKNELL. Yes, but she had received two letters from them stating she should be taking whatever, the generic or whatever brand it was.

Ms. DUDLEY. Well, are they covering it now with the no prescription——

Mr. BLACKNELL. Yes, they——

Ms. DUDLEY. Oh, then you have something different.

Mr. BLACKNELL. They never got back to her and said, you know, you must change.

Mr. HOEFFEL. So you felt some pressure from them, but they have continued to cover it?

Mr. BLACKNELL. Right.

Mr. HOEFFEL. All right. Ms. Kirsch?

Ms. KIRSCH. I just take two pills, Flexeril and high blood pressure. They are both over the counter drugs. And my doctor, I asked him. I said, can I go generic? He said, I will tell you the truth, there is no generic, so I had no choice. That is what it has to be.

Mr. HOEFFEL. Have you had problems trying to figure out what coverage is best for you?

Ms. KIRSCH. No. I only take the pills, I have no fatal disease.

Mr. HOEFFEL. I am glad to hear that.

Ms. KIRSCH. I just went along with what they said.

Mr. HOEFFEL. Let me ask the panel this question regarding prescription coverage. There were two basic plans offered in Congress last year, one that would have extra dollars given to the insurance industry to encourage them to offer drug policies that seniors could then evaluate and choose the policy that provided them with the best prescription coverage. The other plan was to simply put a prescription drug plan into Medicare where it would be a universal plan, the same for everybody, with significant co-pays. I don't want you to respond to the differences in cost here. I am trying to determine what the best method is, whether we should be encouraging the private insurance industry to be providing drug only policies that you could evaluate and choose or would you prefer a Medicare prescription coverage that you would take your card to the pharmacy and pay your share of that plan based upon the economics,

but not have to deal with private insurance companies? Do the three of you have a view of that choice?

Ms. DUDLEY. I definitely have a view on that. Definitely, absolutely, no question, it should be through the Congress because, first of all, you have the profit making institutions, and some how or other, that gets deteriorated. The money gets allotted to things that it shouldn't be allotted to and it is going to go and it is going to change. If it is mandated in Congress for everybody, at least you have a chance.

Ms. KIRSCH. Yes, I heartily agree with that.

Mr. BLACKNELL. I have never been in Medicare, so I don't know as far as that. But I think if it was administered by the Government, it would probably be better.

Mr. HOEFFEL. All right. Thank you. I thank you very much and I yield back my time.

Mr. GREENWOOD. The Chair thanks the gentleman, and we thank the witnesses very much for coming here this morning and for your testimony. It is very helpful and we will take it to heart. You are excused and we call forward the next panel.

And they are Ms. Judy Berek, who is the Administrator for the Northeast Consortium of the Health Care Financing Administration; that is HCFA, Medicare; William F. Haggett, Senior Vice President, Government Programs, Independence Blue Cross; Dr. Sandra Harmon-Weiss, the Head of Government Programs for Aetna U.S. Healthcare; and Dr. Scott Harrison, who is Research Director for Medicare+Choice of MedPAC.

Thank you all for being here. I appreciate your presence this morning. Let me, as I did with the first panel, note that I am sure that you are aware that the committee is holding an investigative hearing, and in doing so, has had the practice of taking testimony under oath. Do any of you have objections to taking testimony under oath? Hearing none, the Chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony? The answer is no. In that case, would you please rise and raise your right hand, and I will swear you in.

[Witnesses sworn.]

Mr. GREENWOOD. So saying, you are now under oath, and you will be recognized to give a 5-minute summary of your written statement, and we will begin with Ms. Berek from the Health Care Financing Agency. Thank you for being with us this morning.

Oh, and let me, before I take your testimony, let me ask unanimous consent to enter into the record the letter that I sent to the Health Care Financing Agency requesting reimbursement data in Bucks and Philadelphia Counties, and HCFA's response to me, and the chart that I prepared on Medicare+Choice spending to my left. Without objection, those documents will be entered into the record.

[The documents follow:]

U.S. House of Representatives
Committee on Energy and Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515–6115

February 28, 2001

Michael McMullan
Acting Deputy Administrator
Health Care Financing Administration
200 Independence Ave., S.W.
Washington, D.C. 20201

Dear Acting Deputy Administrator McMullan:

I am writing today to inquire about the Health Care Financing Administration's (HCFA) methodology in setting reimbursement rates for Medicare Part C, also commonly referred to as the Medicare+Choice program. Of specific concern to me are the reimbursement rates in the Philadelphia area paid by HCFA to health plans participating in the Medicare+Choice program. It has come to my attention that reimbursement rates paid to health plans in Philadelphia County, Pennsylvania are nearly 18 percent higher than they are in neighboring Bucks County, Pennsylvania. This discrepancy has led health plans to offer widely different health care benefits to Medicare beneficiaries participating in the Medicare+Choice program in these counties. In many instances, these beneficiaries live only a matter of miles from one another and are even served by the same health care providers.

In light of this, I personally contacted HCFA last fall and requested documentation of the materials and data used by HCFA to determine the reimbursement rates in Bucks County and Philadelphia County. Having not received a response from HCFA, in January, 2001, upon assuming the chairmanship of the Subcommittee on Oversight and Investigations, I asked investigative staff with the Energy and Commerce Committee to begin looking into this issue. I understand that Committee staff have contacted HCFA and requested information regarding the setting of Medicare+Choice reimbursement rates in Philadelphia County and Bucks County and HCFA's methodology for setting reimbursement rates generally.

To date, HCFA has produced documents explaining its methodology for Medicare+Choice reimbursements and more specifically, its methodology for computing the Adjusted Average Per Capita Cost (AAPCC) which, as you know, has been the underlying component for Medicare+Choice reimbursement in Bucks County and Philadelphia County.

Unfortunately, despite repeated requests, HCFA has not provided me with the documents and data that have been used to set Medicare+Choice reimbursement rates in Philadelphia County and Bucks County. Accordingly, pursuant to Rules X and XI of the U.S. House of Representatives, I am now requesting that HCFA provide the following information to the committee by March 9, 2001:

1. Please identify and explain the geographic adjustment factors in Philadelphia County and Bucks County that HCFA used to convert the national per capita costs to the county level in calculating the AAPCC. Specifically address how HCFA calculated the historical and expected future cost relationship both between these counties and the nation as a whole. Provide all records relating to determinations made by HCFA regarding geographic cost factors for Philadelphia County and Bucks County.

2. Please provide a summary of the fee for service claims data used by HCFA to calculate the 1997 AAPCC for Bucks County and Philadelphia County that are used as the base line for counties receiving the minimum increase from the previous year as their Medicare+Choice payment rate.

3. Please provide a comparison of utilization rates for Medicare services in Philadelphia County and Bucks County.

4. Please identify and explain how the redetermined county per capita cost, which reflects demographic variables, may have affected the 1997 base line AAPCC in Bucks County and Philadelphia County.

5. Please provide any information on the extent to which health status differences could have affected the difference between the 1997 AAPCC payment rate in Philadelphia county and Bucks County.

6. Please explain how HCFA accounts for Bucks County Medicare+Choice beneficiaries who obtain health care services from the same providers as Philadelphia County Medicare+Choice beneficiaries. Provide a description of how HCFA ascribes all costs of Bucks County beneficiaries to the appropriate county.

7. Please explain the internal process undertaken by HCFA for determining the Medicare+Choice payment rates in the more than 3000 counties nationwide. Specifically describe how HCFA collects claims data from each county and how HCFA has used that data to determine payment rates. Include descriptions of any formulas used to adjust claims data to determine the AAPCC.

I am concerned that the large reimbursement discrepancy between Bucks County and Philadelphia County may be emblematic of other problems with the Medicare+Choice program that have come to my and other Members of Congress attention in recent years. In addition to providing answers to the above questions, I also request that HCFA arrange a briefing between

a briefing between Committee staff and staff from the office of actuary or any other divisions within HCFA responsible for setting reimbursement rates in Philadelphia County and Bucks County. My objective in making this request is to have HCFA outline the underlying reasons for this large reimbursement discrepancy and provide Committee staff with a more general overview of HCFA's guidelines and procedures for crafting Medicare+Choice reimbursement policies.

Please note that, for the purpose of responding to these requests, the terms "records" and "relating" should be interpreted in accordance with the Attachment to this letter. Thank you for your assistance. If you have any questions, please contact me or have your staff contact Joe Greenman of the Committee staff at (202) 226-2424.

Sincerely,

James C. Greenwood
Chairman
Subcommittee on Oversight
and Investigations

Attachment

cc: The Honorable W.J. "Billy" Tauzin, Chairman
The Honorable John D. Dingell, Ranking Member
The Honorable Peter Deutsch, Ranking Member
Subcommittee on Oversight and Investigations

ATTACHMENT

1. The term "records" is to be construed in the broadest sense and shall mean any written or graphic material, however produced or reproduced, of any kind or description, consisting of the original and any non-identical copy (whether different from the original because of notes made on or attached to such copy or otherwise) and drafts and both sides thereof, whether printed or recorded electronically or magnetically or stored in any type of data bank, including, but not limited to, the following: correspondence, memoranda, records, summaries of personal conversations or interviews, minutes or records of meetings or conferences, opinions or reports of consultants, projections, statistical statements, drafts, contracts, agreements, purchase orders, invoices, confirmations, telegraphs, telexes, agendas, books, notes, pamphlets, periodicals, reports, studies, evaluations, opinions, logs, diaries, desk calendars, appointment books, tape recordings, video recordings, e-mails, voice mails, computer tapes, or other computer stored matter, magnetic tapes, microfilm, microfiche, punch cards, all other records kept by electronic, photographic, or mechanical means, charts, photographs, notebooks, drawings, plans, inter-office communications, intra-office and intra-departmental communications, transcripts, checks and canceled checks, bank statements, ledgers, books, records or statements of accounts, and papers and things similar to any of the foregoing, however denominated.

2. The terms "relating," "relate," or "regarding" as to any given subject means anything that constitutes, contains, embodies, identifies, deals with, or is in any manner whatsoever pertinent to that subject, including but not limited to records concerning the preparation of other records.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

APR - 3 2001

The Honorable James C. Greenwood
House of Representatives
Washington, D.C. 20515-6115

Dear Mr. Greenwood:

I am writing in response to your letter of February 28, in which you requested information on AAPCC rates in Bucks and Philadelphia Counties. In that letter you requested seven items of information. We have also provided this information informally to your staff in materials delivered March 9 and March 13. With respect to Item 3, as we have advised your staff, the process for determining county level utilization rates will require an additional two or three weeks. We will provide this information to your staff as soon as it is available.

Attachment 1 provides our response to six of the seven items. Attachment 2 is a description of the AAPCC methodology, which was used to determine payment rates for 1997 and earlier. Attachment 3 is a description of the Medicare+Choice payment methodology, which was used for determining payment rates for 1998 and later.

You also requested that we set up a briefing with your staff to discuss Medicare+Choice reimbursement. As you know, we have been in contact with Mr. Greenman of your staff since we received your letter. We have indicated that we would be happy to provide the briefing whenever it would be helpful. If you have any questions, please contact Peter Hickman in HCFA's Office of Legislation at 202-690-5950.

Thank you for your interest in the Medicare program.

Sincerely,

Michael McMullan
Acting Deputy Administrator

Enclosures

Attachment 1

The attached data sheets contain most of the background data for the calculation of the 1997 AAPCC for Bucks and Philadelphia counties. The first 2 sheets are for Bucks county, the first page is Part A data and the second page is Part B data. The second 2 sheets are for Philadelphia county, again the first being Part A data and the second being Part B data.

Item 1: The upper left-hand part of each page contains the 5 years of historical data (labeled 1) used in the calculations of the geographic adjustment for each county. The column labeled reimbursement is the expenditures paid through intermediaries or carriers. The enrollment is the total Medicare enrollment in the county. The GHP amount is the amount paid in direct payments to managed care plans. The GA or geographic adjustment is the yearly index of the per capita amount for the county (reimbursement – GHP amount divided by enrollment) divided by the corresponding amount for the nation as a whole. A couple of lines below this geographic data is the AGA or average geographic amount which is the 5-year average of the GAs.

Item 2: The 5-years worth of data listed under reimbursement is the historical fee-for-service claims data.

Item 3: As we have advise your staff, the process for determining county level utilization rates will require additional time.

Item 4: The enclosed description of the AAPCC methodology (attachment 2) describes how the AAPCC was calculated. Specifically, the CNHPCC (county non-HMO per capita cost) shown labeled as 2 on the data sheet is divided by the AVG-DF (average demographic factor) to get the standardized (the "redetermined amount") or the NCNHPCC. The demographic data used to calculate the average demographic factor is shown in the bottom half of each page.

Item 5: As a comparison of the difference in the demographics and relative health status, below is the average demographic factors and the average risk scores for each county. The average demographic factors come off of the data sheet. The average risk scores were determined from special runs of the risk model used in implementing the new risk adjustment methodology in 2000. The average risk scores are calculated from 1994 to 1996 data for the fee-for-service population. The average risk scores were used to restandardize the 1997 AAPCCs for use in calculating the risk adjustment payment ratebook used in 2000. (Ten percent of payments for individuals enrolled in managed care plans are paid based on the risk rate book in

2000 to 2003). The average risk scores are developed on a Part A and Part B combined basis only.

A score of 1.0 means the county population's health status or demographic status is equal to the national health or demographic status. A score of more than 1.0 means the county population's health or demographic status is more costly than the national average while a score of less than 1.0 means the county population's health or demographic status is less costly than the national average.

Note that the risk scores are tied to an interim risk adjustment method that uses only data from inpatient hospital admissions. We plan to implement a risk adjustment method that also uses physician and outpatient hospital data, referred to as a comprehensive method, because it measures health status based on both inpatient and outpatient use of medical services. Use of this system will require new county risk scores linked to the elements of the comprehensive system.

County	Part A AVG-DF	Part B AVG-DF	Average Risk Score
Bucks	.901140	.957224	.9829
Philadelphia	.981360	.999031	1.1178

Item 6: The data used in the calculation of the geographic adjustments is tabulated based on the county of residence of the beneficiary. The expenditures for people who live in Bucks county but use services in Philadelphia county will show up in the Bucks county data. A more detailed description of how costs are attributed to counties is included in the attached description of the AAPCC methodology.

Item 7: Process of Collecting Fee-for-Service Data for Inclusion in the National Claims History

1) A beneficiary visits a physician, receives a home health visit, stays in the hospital, etc.

2) The provider (physician, home health agency, hospital, etc.) submits a claim or bill to their Medicare carrier or intermediary, specifying which services the beneficiary received. Carriers and intermediaries are health insurance companies with which HCFA contracts to process Medicare claims.

3) The carrier or intermediary checks to make sure the claim is appropriate (proper formatting, beneficiary eligibility from internal records, service is appropriate for the beneficiary's condition, etc.).

The carrier or intermediary then sends the claim information along with its payment determination (pay, reduce, deny) to HCFA's Common Working File (CWF).

4) The CWF checks beneficiary eligibility against HCFA's master database and also checks to make sure the claim is appropriate (e.g., ensures a claim for the same service for the same beneficiary on the same day hasn't been paid previously, etc.). The CWF alerts the carrier or intermediary whether it confirms the carrier or intermediary's payment determination. The carrier or intermediary then carries out the payment determination.

5) In the meantime, the CWF sends the claim information to HCFA for inclusion in its National Claims History. Based on information on the claim itself, or information HCFA has stored in its databases (master beneficiary database, etc), HCFA can aggregate claims information in a variety of ways. This includes compiling payment information for all beneficiaries in each county.

COUNTY = 39140 BUCKS.....PENNSYLVANIA

RUN DATE: 96/09/04

PART A

yearly geographic indices

*** AGED ***

YEAR	REIMBURSEMENT	ENROLLMENT	GHP AMT	GA
90	$124,287,450	55,668	$4,613,884	1.1850303
91	$132,627,787	57,614	$5,803,304	1.1404568
92	$154,309,615	59,728	$7,588,648	1.1409850
93	$171,154,758	61,596	$10,815,838	1.1556600
94	$183,284,796	63,131	$16,734,155	1.1383348

TOTAL HMO REIMB	MEMBERS	NON-MEMBERS	USPCC RATIO
$16,236,169	68,367	57,435	1.2620

average geographic

AGA	CPCC	CNHPCC
1.1520934	343.10	348.12

NUMERATOR	NCNHPCC	EXPOSURE	AVG-DF
51757.00	367.00	69,775	.901140

* DISABLED *

REIMBURSEMENT	ENROLLMENT	GHP AMT	GA
$11,540,225	4,593	$245,497	1.3321937
$12,011,704	4,713	$283,853	1.2966372
$13,904,441	4,952	$373,588	1.3004291
$15,056,969	5,364	$553,719	1.2457174
$17,501,058	5,791	$790,650	1.2691434

TOTAL HMO REIMB	MEMBERS	NON-MEMBERS	USPCC RATIO
$778,370	2,997	5,544	1.2245

AGA	CPCC	CNHPCC
1.2888242	324.68	324.38

NUMERATOR	NCNHPCC	EXPOSURE	AVG-DF
5552.10	307.71	2.874	1.001461

NON-HMO	INSTIT	** MALE ** MEDICAID	NON-MEDICAID	WORK-AGED	INSTIT	** FEMALE ** MEDICAID	NON-MEDICAID	WORK-AGED
85 & OVER	308	0	1,145	3	1,357	0	3,408	4
80 - 84	207	0	2,099	20	665	12	4,004	10
75 - 79	166	0	4,010	71	425	157	5,925	63
70 - 74	130	57	6,381	290	194	354	7,931	195
65 - 69	98	123	7,550	500	123	401	8,701	348
60 - 64	28	54	620	0	20	110	378	0
55 - 59	24	45	352	0	27	94	242	0
45 - 54	63	124	574	0	66	166	387	0
35 - 44	74	313	368	0	78	211	281	0
UNDER 35	66	301	136	0	50	218	74	0

WITH-HMO	INSTIT	** MALE ** MEDICAID	NON-MEDICAID	WORK-AGED	INSTIT	** FEMALE ** MEDICAID	NON-MEDICAID	WORK-AGED
85 & OVER	46	7	790	24	129	50	1,687	108
80 - 84	19	12	1,846	112	66	93	2,754	120
75 - 79	51	0	4,507	249	87	117	5,944	261
70 - 74	30	16	9,360	735	52	142	10,246	613
65 - 69	3	7	12,972	531	23	61	13,971	418
60 - 64	0	0	614	0	0	22	444	0
55 - 59	0	0	413	0	0	19	286	0
45 - 54	0	0	396	0	0	1	262	0
35 - 44	0	37	175	0	0	12	141	0
UNDER 35	0	1	61	0	0	8	105	0

(1)

(2) Compare CNHPCC with NCNHPCC to get effect of standardizing for demographic variables (and 5-yr dimension)

AGA = average geographic factor, i.e. 5-yr average

CPCC = projected county per capita cost

C-NHPCC = projected fee-for-service per capita cost

AVG-DF = average demographic factor for fee-for-service

NCNHPCC = [illegible] (and 5-yr dimension)

COUNTY = 39140 BUCKS.....PENNSYLVANIA

RUN DATE: 96/09/04

PART B

	*** AGED ***				* DISABLED *			
YEAR	REIMBURSEMENT	ENROLLMENT	GHP AMT	GA	REIMBURSEMENT	ENROLLMENT	GHP AMT	GA
90	$78,004,293	54,014	$4,126,154	1.2295240	$5,995,144	4,107	$205,164	1.3683677
91	$86,867,118	55,757	$5,210,729	1.2384862	$6,513,214	4,169	$213,269	1.3791134
92	$93,274,017	57,645	$6,239,680	1.2705392	$6,873,072	4,362	$274,622	1.3190061
93	$98,740,093	59,258	$7,916,349	1.2540521	$7,565,414	4,681	$341,328	1.2610503
94	$105,231,615	60,699	$11,102,560	1.2304034	$8,458,309	5,029	$454,501	1.2254417

TOTAL HMO REIMB	MEMBERS	NON-MEMBERS	USPCC RATIO	TOTAL HMO REIMB	MEMBERS	NON-MEMBERS	USPCC RATIO
$11,609,563	68,380	55,002	1.2813	$512,350	2,997	4,780	1.2401

AGA	CPCC	CNHPCC	AGA	CPCC	CNHPCC
1.2446010	210.51	210.22	1.3105958	195.35	194.07

NUMERATOR	NCNHPCC	EXPOSURE	AVG-DF	NUMERATOR	NCNHPCC	EXPOSURE	AVG-DF
52649.25	208.64	69,777	.957224	4861.55	181.28	2,874	1.017061

	* * M A L E * *				* * F E M A L E * *			
NON-HMO	INSTIT	MEDICAID	NON-MEDICAID	WORK-AGED	INSTIT	MEDICAID	NON-MEDICAID	WORK-AGED
85 & OVER	332	0	1,098	3	1,473	0	3,252	3
80 - 84	220	0	2,076	18	713	0	3,964	9
75 - 79	179	0	3,981	62	461	137	5,904	57
70 - 74	141	51	6,186	185	212	355	7,800	123
65 - 69	107	126	6,731	332	134	420	7,957	200
60 - 64	24	54	539	0	18	110	317	0
55 - 59	20	45	296	0	22	94	182	0
45 - 54	54	124	477	0	55	164	293	0
35 - 44	67	313	301	0	64	212	196	0
UNDER 35	59	301	91	0	42	218	28	0

	* * M A L E * *				* * F E M A L E * *			
WITH-HMO	INSTIT	MEDICAID	NON-MEDICAID	WORK-AGED	INSTIT	MEDICAID	NON-MEDICAID	WORK-AGED
85 & OVER	46	7	790	24	129	50	1,687	108
80 - 84	19	12	1,846	112	66	93	2,766	120
75 - 79	51	0	4,607	249	87	117	5,944	261
70 - 74	38	16	9,360	735	52	142	10,246	613
65 - 69	3	7	12,972	531	23	61	13,972	418
60 - 64	0	0	614	0	0	22	444	0
55 - 59	0	0	413	0	0	19	286	0
45 - 54	0	0	396	0	0	1	262	0
35 - 44	0	37	175	0	0	12	141	0
UNDER 35	0	1	61	0	0	8	105	0

COUNTY = 39620 PHILADELPHIA.....PENNSYLVANIA

RUN DATE: 96/09/04

PART A

	*** AGED ***				* DISABLED *			
YEAR	REIMBURSEMENT	ENROLLMENT	GHP AMT	GA	REIMBURSEMENT	ENROLLMENT	GHP AMT	GA
90	$770,403,976	231,852	$13,387,532	1.7300847	$80,724,439	23,302	$562,234	1.8110640
91	$794,111,443	234,381	$15,620,919	1.6454967	$81,076,257	23,302	$614,720	1.7424030
92	$861,013,823	232,667	$19,207,353	1.5924754	$91,295,764	24,046	$760,391	1.7266688
93	$943,041,953	229,142	$35,571,830	1.6706598	$105,819,033	25,205	$1,630,542	1.8247537
94	$928,446,742	225,180	$71,091,769	1.5948185	$113,910,387	26,448	$3,646,429	1.7859323

TOTAL HMO REIMB	MEMBERS	NON-MEMBERS	USPCC RATIO	TOTAL HMO REIMB	MEMBERS	NON-MEMBERS	USPCC RATIO
$68,554,980	225,531	206,389	1.3620	$3,396,657	10,533	25,574	1.2245

AGA	CPCC	CNHPCC	AGA	CPCC	CNHPCC
1.6467070	490.40	496.79	1.7781644	447.95	449.20

NUMERATOR	NCNHPCC	EXPOSURE	AVG-DF	NUMERATOR	NCNHPCC	EXPOSURE	AVG-DF
202541.85	480.92	208,902	.981360	28558.35	382.15	10,141	1.116695

	** MALE **				** FEMALE **			
NON-HMO	INSTIT	MEDICAID	NON-MEDICAID	WORK-AGED	INSTIT	MEDICAID	NON-MEDICAID	WORK-AGED
85 & OVER	499	401	5,926	21	2,653	2,998	14,454	19
80 - 84	353	733	8,144	61	1,289	3,599	15,623	56
75 - 79	336	1,237	13,191	213	767	5,319	21,553	155
70 - 74	306	2,344	17,711	710	453	7,685	23,971	489
65 - 69	294	3,296	17,845	1,007	255	7,678	22,010	745
60 - 64	123	687	2,322	0	105	1,381	1,113	0
55 - 59	137	708	1,600	0	139	1,030	722	0
45 - 54	323	1,484	2,100	0	286	1,464	919	0
35 - 44	341	2,127	991	0	266	1,216	470	0
UNDER 35	294	1,889	67	0	187	843	240	0

	** MALE **				** FEMALE **			
WITH-HMO	INSTIT	MEDICAID	NON-MEDICAID	WORK-AGED	INSTIT	MEDICAID	NON-MEDICAID	WORK-AGED
85 & OVER	66	75	3,906	70	116	526	6,815	122
80 - 84	38	99	7,674	176	79	612	12,116	313
75 - 79	13	104	16,684	650	61	857	22,008	680
70 - 74	30	282	26,928	1,430	55	1,164	35,220	1,349
65 - 69	10	525	36,020	1,432	0	1,381	44,790	1,055
60 - 64	11	70	2,273	0	0	106	1,614	0
55 - 59	0	48	1,256	0	0	119	917	0
45 - 54	0	92	1,259	0	0	47	1,034	0
35 - 44	0	84	617	0	0	98	438	0
UNDER 35	0	63	153	0	0	55	179	0

COUNTY = 39620 PHILADELPHIA.....PENNSYLVANIA

RUN DATE: 96/09/04

PART B

	*** AGED ***				* DISABLED *			
YEAR	REIMBURSEMENT	ENROLLMENT	GHP AMT	GA	REIMBURSEMENT	ENROLLMENT	GHP AMT	GA
90	$393,387,149	228,268	$10,718,463	1.4314922	$32,408,907	21,695	$413,051	1.3712577
91	$396,424,031	225,737	$12,175,874	1.3876121	$32,864,780	21,565	$377,514	1.3176054
92	$411,800,672	224,450	$13,757,476	1.3954238	$35,906,602	22,205	$438,861	1.3175465
93	$422,068,377	220,527	$22,308,291	1.4039930	$39,168,568	23,051	$772,320	1.2936043
94	$419,284,031	216,403	$38,488,747	1.3580271	$43,554,336	24,159	$1,500,518	1.2895027
	TOTAL HMO REIMB	MEMBERS	NON-MEMBERS	USPCC RATIO	TOTAL HMO REIMB	MEMBERS	NON-MEMBERS	USPCC RATIO
	$40,632,419	225,690	197,597	1.2813	$1,645,567	10,533	23,284	1.2401
	AGA	CPCC	CNHPCC		AGA	CPCC	CNHPCC	
	1.3953096	236.00	234.85		1.3179033	196.44	196.27	
NUMERATOR	NCNHPCC	EXPOSURE	AVG-DF	NUMERATOR	NCNHPCC	EXPOSURE	AVG-DF	
197405.55	223.33	208,975	.999031	25614.30	169.50	10,142	1.100082	

	* * M A L E * *				* * F E M A L E * *			
NON-HMO	INSTIT	MEDICAID	NON-MEDICAID	WORK-AGED	INSTIT	MEDICAID	NON-MEDICAID	WORK-AGED
85 & OVER	537	393	5,074	18	2,880	2,914	12,924	16
80 - 84	377	746	8,022	51	1,382	3,645	15,486	40
75 - 79	362	1,287	12,953	188	820	5,462	21,323	137
70 - 74	331	2,435	16,923	468	493	7,932	23,284	319
65 - 69	320	3,502	15,363	666	279	8,126	19,669	450
60 - 64	112	687	2,058	0	98	1,382	958	0
55 - 59	123	708	1,374	0	125	1,030	548	0
45 - 54	290	1,483	1,730	0	257	1,465	671	0
35 - 44	311	2,127	724	0	238	1,217	295	0
UNDER 35	274	1,409	415	0	173	843	159	0

	* * M A L E * *				* * F E M A L E * *			
WITH-HMO	INSTIT	MEDICAID	NON-MEDICAID	WORK-AGED	INSTIT	MEDICAID	NON-MEDICAID	WORK-AGED
85 & OVER	66	75	3,907	70	116	526	6,841	122
80 - 84	38	99	7,691	176	79	612	12,129	313
75 - 79	13	104	16,685	650	61	857	22,022	680
70 - 74	30	282	26,945	1,430	55	1,164	35,253	1,349
65 - 69	10	525	36,055	1,432	0	1,383	44,790	1,055
60 - 64	11	70	2,273	0	0	106	1,614	0
55 - 59	0	48	1,256	0	0	119	917	0
45 - 54	0	92	1,259	0	0	47	1,034	0
35 - 44	0	84	617	0	0	98	438	0
UNDER 35	0	63	153	0	0	55	179	0

ATTACHMENT 2

ADJUSTED AVERAGE PER CAPITA COST METHODOLOGY FOR RISK-SHARING CONTRACTS

The Medicare program pays monthly per capita payments in advance to eligible organizations with a risk contract for each Medicare eligible individual enrolled with the eligible organization under the risk contract. The eligible organizations are prepaid health plans referred to as health maintenance organizations (HMOs) or competitive medical plans (CMPs). In order to determine the appropriate payments, each enrollee is assigned to a demographic class based on age, sex, Medicare entitlement status, institutionalization, and Medicaid status. The annual rate of the payment for each enrollee is then set at 95 percent of the Adjusted Average Per Capita Cost (AAPCC) for the demographic class to which that enrollee is assigned.

The AAPCC applicable to a demographic class is a prospective estimate of the average per capita amount that would be payable by Medicare in the contract year for a group of similarly classified Medicare eligibles in a geographic area if services were to be furnished by other then an eligible organization in the same geographic area. Thus, the AAPCC is a prospective estimate of Medicare cost levels, by demographic category, in the fee-for-service (that is, noneligible organization) sector of the geographic area.

A set of AAPCC rates is estimated at the county level for all Medicare insureds except those having end-stage renal disease (ESRD), in which case the calculation is performed at the state level because of the relatively small size of this segment of the population. The calculation of the AAPCC rates applicable to a future calendar year is developed in four conceptually basic steps:

1. Medicare national average calendar year per capita costs are projected for the future year under consideration.

2. Geographic adjustment factors which reflect the historical relationship between the county's and the nation's per capita costs are used to convert the national average per capita costs to the county level.

3. Expected Medicare per capita costs for the county are adjusted to a fee-for-service basis by removing both the reimbursement and enrollment attributable to Medicare beneficiaries in eligible organizations under contract with HCFA.

4. The fee-for-service Medicare per capita cost is disaggregated into its demographically defined component parts to produce a set of county AAPCC rates.

These four steps are discussed in greater detail below.

Step 1.--The national average per capita costs to the Medicare program are prospectively determined for the future calendar year (the contract year) under consideration. These prospectively determined numbers are known as United States Per Capita Costs (USPCC's) and are the estimated average incurred benefit costs per Medicare enrollee, loaded for intermediary and carrier expenses. Intermediaries and carriers are private insurance organizations that contract with HCFA to make coverage decisions and pay Medicare claims.

For each of the Hospital Insurance (Part A) and the Supplementary Medical Insurance (Part B) programs of Medicare, USPCC's are developed separately for the aged, the disabled, and those beneficiaries having end-stage renal disease (ESRD). The estimates that are used as the basis for the USPCC's generally are recent Medicare cost estimates prepared for the President's budget submission cycle by actuaries at the Health Care Financing Administration (HCFA). These estimates are adjusted, if necessary, for the effects of any legislation passed or regulations implemented between the time of the budget submission and announcement of the AAPCC rates.

Intermediary and carrier expense loadings are determined separately for Part A and Part B as the ratio of cash administrative expenses to cash benefits. The administrative expense amounts are obtained from reports of HCFA's Division of Contractor Financial Management. The cash benefits amounts are obtained from reports of the U.S. Treasury's Division of Financial Management. Monthly USPCC's are determined for the future contact year as:

$$\frac{1}{12} \times \frac{\text{(annual incurred benefits)}}{\text{(projected enrollment)}} \times (1.0 + \text{loading factor}),$$

where the

$$\text{loading factor} = \frac{\text{(cash administrative expenses)}}{\text{(cash benefit outlays)}}.$$

Later in this description we make a distinction between "retrospective" and "prospective" USPCC's. Retrospective USPCC's are more accurate measures of the actual claims cost than prospective USPCC's. This is because retrospective USPCC's are calculated at a point in time after the calendar year has passed and a great majority of the actual incurred claims cost is already known. Consequently there is far less need for the actuaries to use estimation techniques in determining the claims cost as must be done when calculating prospective USPCC's which are calculated at a point in time prior to the beginning of the calendar year in question and before any actual claims cost have been incurred.

In addition, a distinction is made between the "contract year" and the "base year." The contract year is a future calendar year for which AAPCC's are being calculated. The base year is a past calendar year for which AAPCC payments have already been made. In the calculation of the AAPCC's, we normally use demographic data and eligible organization cost data from a base year which is three years prior to the contract year.

Step 2.--Once the prospective USPCC's have been developed, they must be adjusted from a national to a county level. An adjustment is made for each county in the nation. For each of Parts A and B, a five-year historical relationship between the county per capita cost and the national per capita cost is used to make this adjustment which is determined separately for the aged, the disabled, and the ESRD beneficiaries. The historical per capita costs are developed from the entire Medicare enrollment and the aggregate amount of claims data collected for each of the five years. Use of this historical relationship to adjust the national USPCC's implies there will be little or no change in the cost relationship between each county and the nation as a whole.

Nonetheless, in addition to the above adjustment which reflects the historical cost relationship between each county and the nation as a whole, the USPCC's can also be adjusted to account for differences between the actual historical relationship and the expected future relationship (in the contract year) between the county and the national costs. For example, since the implementation of the prospective payment system (PPS) in fiscal year 1984, the payment provisions for hospitals have been changing. Before fiscal year 1984 hospitals were paid the cost of providing care, but under PPS hospitals are paid a pre-determined rate. Thus, the payment provisions differ between the five-year historical period, and the contract year for which AAPCC rates are being determined.

Consequently, an adjustment based solely on a historical cost relationship would not be sufficient to estimate the contract year cost relationship between the county and the nation. Since the AAPCC should be the best estimate of fee-for-service reimbursements in the county in the contract year, another adjustment is made for changes in the hospital payment provisions. PPS provisions are applied only under Part A, so the Part B USPCC is not affected by this additional adjustment.

To calculate the historical county and national per capita costs, the claims data collected in Medicare's statistical information system must be combined with payments made by HCFA's Office of Prepaid Health Care (OPHC). The payments made by OPHC are amounts paid directly by HCFA to risk-sharing and reasonable cost prepaid health plans, and consequently are excluded from

Medicare's statistical system which only includes reimbursements made by intermediaries and carriers on behalf of the Medicare program.

The statistical system beneficiary claims data is aggregated by county of the beneficiary's residence as well as by coverage (Part A or Part B) and Medicare eligibility status (aged, disabled, or ESRD). A vast majority of the OPHC payments to prepaid health plans are also aggregated likewise. However, because some prepaid health plans are unable to provide detailed data, some OPHC payment data is available only by coverage and by the prepaid plan to which it was paid. Consequently, an approximation method is used to allocate these payments in the same manner in which the statistical system claims data is aggregated. Allocations are performed separately for each plan. The allocation is based on the number of enrollees residing in each county and the relative cost of providing services in each county. Once all the payments made by the OPHC are determined for each county, they are added to the statistical system's reimbursement amount giving the total reimbursement for the county.

Next, the PPS adjustment is calculated by modeling hospital payments in the contract year and in each of the five historical years using the same hospital admissions. We then aggregate the modeled payments for each county. The PPS adjustment factor for each county and each historical year is computed by dividing the modeled contract year payments by the modeled historical year payments. The adjustment factors are applied to the portion of the Part A reimbursement attributable to hospital payments reimbursed under PPS.

County per capita costs for each of the five most recent available years are then estimated as follows:

$$\frac{\text{(statistical system reimbursement + OPHC reimbursement)}}{\text{(statistical system enrollment)}},$$

where, for Part A, the reimbursement has been adjusted for PPS.

National per capita costs for each of the five years involved are similarly calculated using reimbursement and enrollment data applicable to the entire nation.

If CPCC and NPCC respectively represent the county and national per capita costs in year i, then the geographic adjustment for year i is:

$$GA_i = CPCC_i / NPCC_i .$$

The adjustment factor to be applied to the prospective USPCC is the average of the geographic adjustments for the five years.

This factor is known as the "average geographic adjustment" (AGA):

$$AGA = (GA_1 + GA_2 + \ldots + GA_5) / 5 .$$

Application of this factor to the contract year prospective USPCC is used to adjust the projected national per capita cost, derived in Step 1, to the county level:

$$PCPCC = \text{PROJECTED COUNTY PER CAPITA COST} = AGA \times USPCC .$$

For that portion of the population having end-stage renal disease, the relationship between the state per capita cost and the national per capita cost is used to make the geographic adjustment. State data rather than county data are used because of the relatively small size of this segment of the population.

Step 3.--At this point, six projected per capita cost figures have been determined for each county. For each of Parts A and B, there is a separate cost for the aged, disabled, and renal disease populations. These costs are averages for the entire county (or state for the renal disease beneficiaries) and, therefore, include the reimbursement and enrollment totals of eligible organizations. The third step is to remove, from the county (or state) per capita cost, the projected incurred cost and enrollment of any eligible organization that serves the county and is under contract with HCFA. This is accomplished by subtracting the combined total of the organizations' projected incurred costs and enrollments from the entire county's (or state's) Medicare cost and enrollment, respectively.

The method used to determine the organizations' projected incurred costs depends on the type of contract an organization has with HCFA. For organizations having reasonable cost contracts the projected costs are estimated by adjusting the base year cost to the contract year by means of an inflation factor. This inflation factor takes into account differences in benefits, utilization and cost of services over the three year period that separates the base year from the contract year. The factor is calculated as the ratio of the prospectively determined contract year USPCC to the retrospectively determined base year USPCC. Thus for cost reimbursement contracts the

$$\text{Projected Cost in Contract Year} = \text{Base Year Cost} \times \frac{\text{Prospective Contract Year USPCC}}{\text{Retrospective Base Year USPCC}}$$

For risk-sharing contracts a similar approach is used. However an additional adjustment is made to the base year costs, which are simply the total AAPCC payments made in the base year. The additional adjustment has to be made because the AAPCC payments in the base year were estimates that necessarily deviated from

the actual incurred costs in the fee-for-service sector. The amount and direction of the deviations depends largely on the value of the prospective USPCC originally used to calculate the base year AAPCC's. By retrospectively determining the USPCC in the base year, one can estimate the amount and direction of the deviation of the projected costs (the AAPCC's) from the actual incurred costs. If the AAPCC's are found to be less than actual fee-for-service costs, an upward adjustment can be made to the organizations' base year payments before attempting to inflate these payments to the new contract year. On the other hand, if the AAPCC's are found to be more than the actual fee-for-service costs, a downward adjustment can be made to the organizations' base year payments before attemping to inflate these payments to the new contract year.

The adjustment is performed by use of a factor calculated as the ratio of the retrospective base year USPCC to the prospective base year USPCC. Thus for risk-sharing contracts

$$\text{Projected Cost in the Contract Year} = \text{Base Year Cost} \times \frac{\text{Base Year Retrospective USPCC}}{\text{Base Year Prospective USPCC}} \times \frac{\text{Contract Year Prospective USPCC}}{\text{Base Year Retrospective USPCC}}$$

Since the denominator of the second ratio is identical to the numerator of the first ratio, the formula for risk-sharing contracts simplifies to

$$\text{Projected Cost in Contract Year} = \text{Base Year Cost} \times \frac{\text{Prospective Contract Year USPCC}}{\text{Prospective Base Year USPCC}}$$

The above projected incurred costs, for each reasonable cost and risk-sharing eligible organization operating in the county, are summed to obtain the incurred costs for all eligible organizations operating in the county. Then using the following formula, these costs are subtracted from the projected county per capita cost determined in Step 2:

$$\frac{\text{(PCPCC) x (number of enrollees in county) - projected HMO incurred costs}}{\text{number of enrollees in county excluding HMO members}}$$

to give a fee-for-service county per capita cost.

Occasionally the base year cost data for cost reimbursement organizations is found to be unsuitable for projecting costs in the contract year, as the resultant per member per month cost is not reasonable when compared to the projected county per capita cost. When this occurs the calculation of the AAPCC rates can yield extreme values that are unlikely to reflect the fee-for-service costs in the county. Therefore the base year costs for these eligible organizations are tested for reasonableness prior to using them for making projections.

The data for each plan is tested separately, by county. The ratio of the base year HMO per capita cost to the base year county per capita cost is the primary indicator used to determine reasonableness. Other factors are sometimes considered, such as the number of enrollees in the plan as compared to all Medicare eligibles in the county, or the amount of reimbursement involved. However, for the most part, if the above calculated ratio is not between the range of 0.75 and 1.20, the county data for that plan is not used to project costs in the contract year. The value of these testing points are reviewed annually for appropriateness and may be changed from time to time.

Step 4.--In the final step, the redetermined county per capita cost is converted into rates that vary according to certain demographic variables: age, sex, Medicare status, and institutional status. (For purposes of this methodology, an institutionalized individual is a Medicare beneficiary who has been a resident for at least 30 days of a nursing home, sanitorium, rest home, convalescent home, long-term care hospital, or domiciliary home, and a Medicaid individual is a Medicare beneficiary who has been determined by the Medicaid agency of the State in which he or she resides to be eligible for Medicaid). For each of the aged and disabled, there are thirty cells for each of Parts A and B, corresponding to different combinations of these variables (see Table 1).

The factor shown in each cell is the ratio of the cost for a Medicare beneficiary having that particular demographic characteristic to the average per capita cost. These cost factors are referred to as demographic factors. The relative effects of age and sex on the demographic factors are updated annually based on the same Medicare cost experience used to develop base year costs. An adjustment for the institutional and Medicaid populations is made using the last three years (1974-76) of the Current Medicare Survey, incorporating roughly 20,000 Medicare beneficiary-years of observations.

Through the use of these demographic factors, rates are developed from the county per capita cost as described below. The updated demographic cost factors for 1990 are shown in Tables 1 and 2. For the county, there will be thirty rates for each of Parts A and B, for the aged and disabled populations separately. For each Medicare eligible enrolled under the risk-contract, Medicare will pay the organization 95 percent of the rate corresponding to the demographic class to which the beneficiary is assigned.

DEVELOPMENT OF RATES FROM COUNTY PER-CAPITA COSTS

The AAPCC methodology adjusts for age, sex, Medicaid status, and institutional status of the Medicare beneficiaries in a given county.[1] Tables 1 and 2 show the demographic cells used in this adjustment. The adjustment process depends upon on the demographic factors (DF_i for each demographic cell i). Each factor relates the Medicare cost for a person in that demographic cell to the cost for the average Medicare beneficiary (factor = 1.00). Because of rounding and shifts in the demographic distribution of the Medicare population, it is possible that the average demographic factor for the entire Medicare population would not be exactly 1.00, although it should be close to that value. Demographic distributions for a given county could lead to an average demographic factor other than 1.00. The problem of county demographic variations is addressed by adjusting the county fee-for-service per capita costs (PCC_{fs}) to the theoretical level, K, that would result if the county demographic distribution were such as to give an average demographic factor of 1.00. This is accomplished simply by dividing PCC_{fs} by the average demographic factor for the county calculated by using the actual fee-for-service county population ($_{fs}P_i$ for each demographic cell i):

$$K = PCC_{fs} \times \frac{({}_{fs}P_1 + {}_{fs}P_2 + \ldots + {}_{fs}P_{30})}{({}_{fs}P_1 * DF_1 + {}_{fs}P_2 * DF_2 + \ldots + {}_{fs}P_{30} * DF_{30})}$$

This calculation (and, in fact, the entire AAPCC calculation) must be done separately for each of aged Part A, aged Part B, disabled Part A, and disabled Part B beneficiaries. Demographic adjustments are not made for Medicare beneficiaries with end-stage renal disease because demographics do not have a significant affect on the cost for people having this condition. After the county fee-for-service per capita cost has been standardized for demographic variables, yielding a value for K as defined above, it is possible to estimate the amount that those in a given demographic cell would have cost Medicare had they not been enrolled in a prepaid health plan, simply by multiplying K by DF_i for each cell i. This procedure allows 95 percent of the AAPCC to be prepared as a set of rates, $R_i = .95*K*DF_i$, varying according to the demographic cells shown in Tables 1 and 2.

[1] This adjustment does not apply to ESRD beneficiaries.

TABLE 1
DEMOGRAPHIC COST FACTORS FOR THE AGED

Sex and Age Group	Institutionalized	Noninstitutionalized	
		Medicaid	Non-Medicaid
Part A -- Hospital Insurance			
Male:			
65-69.....	1.95	1.30	.70
70-74.....	2.40	1.75	.90
75-79.....	2.40	2.05	1.10
80-84.....	2.40	2.30	1.20
85 & Over..	2.40	2.40	1.25
Female:			
65-69.....	1.60	.90	.55
70-74.....	1.85	1.10	.70
75-79.....	1.95	1.40	.85
80-84.....	1.95	1.60	1.00
85 & Over..	1.95	1.85	1.05
Part B -- Supplementary Medical Insurance			
Male:			
65-69.....	1.55	1.10	.75
70-74.....	1.85	1.40	1.00
75-79.....	1.90	1.60	1.10
80-84.....	1.90	1.65	1.15
85 & Over..	1.90	1.65	1.15
Female:			
65-69.....	1.50	1.05	.70
70-74.....	1.70	1.20	.85
75-79.....	1.70	1.25	1.00
80-84.....	1.70	1.25	1.00
85 & Over..	1.70	1.25	1.00

TABLE 2
DEMOGRAPHIC COST FACTORS FOR THE DISABLED

Sex and Age Group	Institutionalized	Noninstitutionalized	
		Medicaid	Non-Medicaid
Part A -- Hospital Insurance			
Male:			
Under 35	1.60	1.00	.55
35-44	1.25	1.05	.60
45-54	1.15	1.30	.70
55-59	.90	1.55	.80
60-64	.55	1.80	.95
Female:			
Under 35	1.80	1.25	.55
35-44	1.40	1.25	.60
45-54	1.25	1.25	.80
55-59	1.00	1.40	1.00
60-64	.65	1.50	1.25
Part B -- Supplementary Medical Insurance			
Male:			
Under 35	1.45	.95	.40
35-44	1.35	1.00	.50
45-54	1.30	1.20	.65
55-59	1.15	1.35	.80
60-64	.95	1.50	.95
Female:			
Under 35	1.70	.90	.65
35-44	1.70	1.05	.80
45-54	1.65	1.25	1.00
55-59	1.45	1.45	1.15
60-64	1.15	1.55	1.25

Addendum

Recent Changes in the AAPCC Methodology

A. Projection of HMO Payments

The following change dealing with the projection of HMO payments which are carved out of the county payments to get fee-for-service costs was made beginning with the 1993 AAPCC ratebook: The prior methodology used directly the HMO reimbursement in the county for the base year (last year of the 5 year historical period), inflated it to the contract year, then subtracted it from the county payments to get the projected county fee-for-service costs. The change uses the HMO reimbursement in each year of the 5 year historical period and inflates it to the contract year by the USPCC ratio. An average of the 5-years of inflated HMO costs is calculated and subtracted from the projected county reimbursement to get the projected fee-for-service county costs. This change principally affected county rates for high penetration counties where an HMO changed status in the base year, i.e. a plan changed from risk to cost basis, etc. and where the change in status resulted in a significant change in per-enrollee payments to the HMO. In counties where no HMO changed status, the impact was minor.

B. Resource Based Relative Value Scale (RBRVS) Adjustment to the AAPCC

I. Background

Prior to 1992, Medicare payments to physicians were based on a statutorily defined system of "usual, customary and reasonable" charges (UCR). In OBRA '89, Congress passed a physician payment reform package by adding section 1848 to title XVIII of the Social Security Act. This section contains three major elements: (1) a Medicare volume performance standard (MVPS); (2) limits on charge levels for nonparticipating physicians; and (3) a fee schedule for the payment of physician services.

The physician fee schedule is composed of three schedules of factors: (1) nationally uniform relative value units; (2) geographic practice cost indices which vary by payment localities; and (3) nationally uniform conversion factors for surgical and for non-surgical services.

II. Calculation of the Fee Schedule Adjustment to the AAPCC

The geographic factor used in determining the AAPCC is based on a five year historical period. The physician fee schedule will cause payment changes which are not reflected in the

historical period prior to 1992 when the fee schedule was first effective. There is a transition to the full fee schedule over a four year period. The full fee schedule will be in effect on 1/1/96.

Beginning with the 1994 AAPCC ratebook, an adjustment was made to each of the five years of historical data to put payments on the same basis as that used for the fee schedule in the contract year. To determine the adjustment in 1994, the anticipated price and volume impact of changing from UCR payments to fee schedule payments for physician services in 1994 were calculated. Since the physician fee schedule does not apply to other Part B services such as lab tests, equipment and supplies, or outpatient facility charges, these impacts were reduced to reflect the percent of total Part B services which are paid on the physician fee schedule. The final step was to modify the historical data by applying the 1994 adjustment to the expenditures in each of the five years used in the geographic factor of the AAPCC. Similar adjustments will be mad for future AAPCC ratebooks.

The payments under the physician fee schedule vary according to the Medicare locality of the performing physician. Localities are areas defined by carriers which reflect the geographic differences in costs. Payments to HMO's, however, are made according to the county of residence of the beneficiary. Due to data and sample size considerations, analysis showed that the most credible results were obtained by calculating the fee schedule adjustments according to the locality of residence. The locality impact was then used for each county in that locality. Appropriate adjustments were made for counties that were contained in more than one locality by prorating the impacts according to population data.

C. Working Aged Adjustment to the AAPCC

Beginning with the 1995 AAPCC ratebook, there is a new demographic class added to the AAPCC ratebook. The prior demographic class for the Non-Institutionalized Non-Medicaid beneficiaries is now divided into two distinct classes, i.e. the "Working Aged" and the "Non-Working Aged." The working aged class consists of Medicare beneficiaries over age 65 for whom Medicare is the secondary payor because these beneficiaries have coverage under an employer sponsored group health plan that is, by law, the primary payor.

Previously there were 20 individual demographic cells for aged non-institutionalized non-Medicaid beneficiaries, 10 each under Part A and Part B for the various age/sex groups. Since these cells are divided into two distinct classes, there are 20 additional cells.

Although Medicare can also be the Secondary Payor for disabled beneficiaries under age 65, HCFA has not implemented changes to the disabled AAPCC demographic classes due to the unavailability of the requisite data.

Medicare aged beneficiary enrollments in the fee-for-service and HMO sectors are disaggregated between working aged and non-working aged on the basis of information gathered from the SSA/IRS/HCFA Data Match for Tax Years 1987 to 1989. The Data Match information is combined with data from HCFA's central enrollment files to complete the development of the demographic enrollment counts.

The new table of demographic cost factors were, in part, derived using data from HCFA's Current Beneficiary Survey (CBS). The CBS is a study that gathers data about the health, use of medical services, and costs of receiving care for people on Medicare. More than 12,000 Medicare enrollees who have been scientifically selected to represent the Nation as a whole are participating in the study. Information from the study was used to determine cost differences between working aged and non-working aged individuals. Following are the demographic cost factors as of January 1, 1995 for the aged Non-Institutionalized Non-Medicaid AAPCC rate cells.

Demographic Cost Factors for Non-Inst Non-Medicaid

	Male		Female	
Age	Working Aged	Non-working Aged	Working Aged	Non-working Aged
		Part A		
65-69	0.55	0.70	0.30	0.55
70-74	0.50	0.85	0.40	0.70
75-79	0.65	1.10	0.50	0.85
80-84	0.80	1.20	0.70	1.05
85+	0.85	1.30	0.75	1.15
		Part B		
65-69	0.40	0.80	0.35	0.70
70-74	0.60	1.00	0.50	0.85
75-79	0.80	1.10	0.70	0.95
80-84	0.90	1.15	0.75	0.95
85+	0.90	1.15	0.80	1.00

HEALTH CARE FINANCING ADMINISTRATION
ADJUSTED AVERAGE PER CAPITA COST RATEBOOK FOR CALENDAR YEAR 1997

TABLE 1 -- DEMOGRAPHIC COST FACTORS FOR 1997

AGE GROUP	****** MALE ****** INSTITUTIONALIZED	NON-INSTITUTIONALIZED MEDICAID	NON-INSTITUTIONALIZED NON-MEDICAID	NON-INSTITUTIONALIZED WORKING AGED	****** FEMALE ****** INSTITUTIONALIZED	NON-INSTITUTIONALIZED MEDICAID	NON-INSTITUTIONALIZED NON-MEDICAID	NON-INSTITUTIONALIZED WORKING AGED
PART A - HOSPITAL INSURANCE								
AGED								
85 & OVER	2.25	2.60	1.35	.90	2.10	2.10	1.20	.80
80 - 84	2.25	2.35	1.20	.80	2.10	1.70	1.05	.70
75 - 79	2.25	1.95	1.05	.70	2.10	1.45	.85	.55
70 - 74	2.25	1.50	.85	.45	1.80	1.05	.70	.45
65 - 69	1.75	1.15	.65	.40	1.45	.80	.55	.35
DISABLED								
60 - 64	.60	1.85	1.00	N/A	.70	1.55	1.30	N/A
55 - 59	.90	1.60	.85	N/A	.95	1.35	.95	N/A
45 - 54	1.10	1.30	.65	N/A	1.15	1.20	.75	N/A
35 - 44	1.45	1.20	.70	N/A	1.40	1.20	.60	N/A
UNDER 35	1.80	1.10	.60	N/A	1.80	1.20	.55	N/A
PART B - SUPPLEMENTAL MEDICAL INSURANCE								
AGED								
85 & OVER	1.95	1.70	1.15	1.00	1.65	1.25	1.00	.85
80 - 84	1.95	1.70	1.15	.90	1.65	1.25	.95	.75
75 - 79	1.95	1.55	1.10	.80	1.65	1.25	.95	.70
70 - 74	1.80	1.35	.95	.65	1.65	1.15	.85	.55
65 - 69	1.80	1.10	.80	.45	1.50	1.05	.70	.40
DISABLED								
60 - 64	.95	1.45	.95	N/A	1.15	1.55	1.20	N/A
55 - 59	1.10	1.30	.75	N/A	1.35	1.35	1.05	N/A
45 - 54	1.25	1.15	.60	N/A	1.60	1.25	.95	N/A
35 - 44	1.50	1.15	.55	N/A	1.85	1.15	.85	N/A
UNDER 35	1.70	1.10	.45	N/A	1.95	1.05	.75	N/A

ATTACHMENT 3

Medicare+Choice Capitation Payments

I. SUMMARY

Medicare Managed Care Payment Prior to the Balanced Budget Act (BBA) of 1997.

Prior to the BBA, Medicare's capitated payments to risk contracting organizations were set using an Adjusted Average Per Capita Cost (AAPCC) methodology. Under this methodology, the base rate for capitated payments reflected Medicare fee-for-service expenditures (minus 5 percent, because health plan costs are believed to be lower due to managed care efficiencies). The average fee-for-service costs were estimated at the county level to account for local variation in provision of health care. These costs were also adjusted based on demographic factors, in particular age, sex, institutional status, Medicaid status, "working aged" status (i.e., whether the beneficiary or the beneficiary's spouse had insurance coverage through an employer), and whether or not the enrollee has End-Stage Renal Disease (ESRD). These adjustments were made to account for variations in health care costs due, for example, to higher rates of illness among older beneficiaries.

Several criticisms were made of this payment system. One major criticism was that the disparity of payment rates that resulted from the use of local fee-for-service costs was unjustifiably large. It was difficult, for example, to explain why the 1997 rate (Aged, Parts A and B) in Dade County, Florida (Miami) was $748.23, while the rate in Multnomah County, Oregon (Portland) was only $386.82. Another criticism was that the payment rate adjustments were not accounting sufficiently for variations in health status. Studies of Medicare managed care enrollment produced considerable evidence of "selection bias," that is, disproportionate enrollment of lower risk beneficiaries in managed care plans compared to fee-for-service Medicare. The payment adjustments based on demographic factors proved weak in accounting for these differences. The BBA responded to these criticisms by replacing the AAPCC rate methodology with a new methodology designed to reduce the wide disparity in payment rates, and by mandating that the Health Care Financing Administration (HCFA) develop a risk adjustment system that adjusted capitation payments directly to reflect variations in the health status of individual beneficiaries enrolled in each plan.

II. CALCULATION OF PAYMENT RATES

The New Methodology for Developing Medicare Managed Care Capitation Rates.

The BBA eliminated the old payment methodology and directed HCFA to implement a new methodology starting with the 1998 contract year for payment to plans under the new Medicare+Choice (M+C) program. The BBA stipulated that the new methodology would use 1997 (the last year of the old method) as the base year for the new system. In short, the AAPCC has been eliminated, but it continues to influence the new payment methodology. This section

will first describe the calculations used to set rates for 1998 and then summarizes the calculations for subsequent years.

Under the new methodology, payment rates are developed separately for the aged, people with disabilities, and people with ESRD. The new calculation is based on the 1997 standardized county rates that were used for 1997. The BBA does not stipulate any adjustment to this base, other than to "carve out" a specified portion of the rates representing medical education expenses. For 1998, this meant carving out 20 percent of the medical education costs (both graduate medical education and indirect medical education) that were contained in the 1997 base rate, and making these payments directly from Medicare to hospitals.

The 1997 base rates were then inflated by the national average per capita Medicare growth rate less an amount specified in the law, i.e., the national rate of growth reduced by 0.8 percentage point for 1998. This step defines the area specific rates for each county.

The BBA further provides for blended payment rates based on specified proportions of local and national rates. To calculate the blend, a national average input-price-adjusted capitation rate is determined for each county. First, a national average rate was calculated as a weighted average of the area-specific amounts, using the product of the total Medicare enrollment in the county times the average demographic/risk factor for the county as the weights. This national average was separately calculated for Part A and Part B. Second, these two national averages were adjusted to reflect differences in the prices of inputs from county to county. (For Part A, 70 percent of the amount was adjusted by the Medicare hospital wage index. For Part B, 66 percent of the amount was adjusted by the Medicare geographic practice cost index for physicians, and of the remaining 34 percent, 40 percent was adjusted by the Medicare hospital wage index.) Finally, once the input-price-adjusted national average was calculated for both Part A and Part B in each county, the two were added together to get a combined, national average input-price-adjusted capitation rate for the county. This rate was then used with the area specific rate to calculate the blended payment rate for the county. The blended rate for each county 1998 consisted of 90 percent of the area specific rate plus 10 percent of the national input-price-adjusted capitation rate for the county.

The preliminary payment rate in 1998 for the county is the larger of:

- The blended rate for the county;
- The 1997 standardized county rate (as published in the 1997 rate book) increased by 2 percent; or
- $367.[1]

1 Or, if lower, 150 percent of the 1997 standardized rate for areas outside of the 50 States and the District of Columbia.

Once the preliminary payment rate was determined for each county, as described above, a budget neutrality adjustment was required to determine the final payment rate for the county. This adjustment provides that the aggregate payments that were estimated for 1998 using the greater of the blends, the minimum increase, and the floor must be equal to the aggregate payments that would be made if payments were based solely on the area specific rates. The budget neutrality adjustment was to be made only to those county rates that were based on the blended payment rates. If the budget neutrality adjustment would lower a county rate to a point where the minimum increase or floor amount was larger, the county rate was to be set at the minimum increase or floor, respectively.

After the budget neutrality adjustment was made and the final county rates were determined, the county rates were separated into Part A and Part B amounts based on the relative weights of Part A and Part B services for total benefits on a national level.

The methodology for years after 1998 is essentially the same. The carve-out for medical education increases 20 percentage points per year until those costs are completely removed from the capitation rates. The blended formula shifts 8 percentage points from the area specific to the national rate each year until it reaches a 50/50 split. The annual increase in the area-specific rates and the floor amount is indexed in future years by the national average per capita Medicare growth rate (but then reduced by 0.5 percentage point for each year 1999 through 2001, and 0.3 percentage point in 2002).[2] These factors are summarized in the table below. In addition, beginning with the rates for 1999, adjustments will be made to compensate for differences between actual and estimated Medicare growth rates used in the 1998 and later calculations.

Calendar Year	Growth rate: national increase less	Medical education carve-out	County/National blending percentage
1998	0.8%	20%	90%/10%
1999	0.5%	40%	82%/18%
2000	0.5%	60%	74%/26%
2001	0.5%	80%	66%/34%
2002	0.3%	100%	58%/42%
2003 and later	0.0%	100%	50%/50%

This section has described only the BBA changes that affect the computation of the county capitation rates. The BBA also made a significant change to the way in which those rates are adjusted to account for variations in the expected costs of beneficiaries due to factors such as age and health status. This new risk adjustment system is described in Section IV.

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2 Section 517 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (P. L. 106-113) revised the adjustment for 2002 from 0.5 percentage point to 0.3 percentage point.

SECTION III THE INTENDED IMPACT OF THE BBA PAYMENT RATE REFORMS

These M+C payment changes were intended to promote the availability of M+C plans in lower payment areas, reduce the wide disparities in payments between higher and lower payment areas, and establish a fairer payment system.

Promote the Availability of M+C Plans in Lower Payment Areas

The introduction of a floor on the payment rates for M+C Organizations was intended to make the risk-based managed care more viable financially in areas where the AAPCC appeared to be too low for any organization to recoup its costs. The floor was set at $367 for 1998. Counties receiving the floor rate of $367 in 1998 experienced rates of increase in their rates that varied from 2 percent (the minimum rate of increase for all counties) to 66 percent. The floor amount is adjusted annually by the rate of growth of the overall Medicare program. By providing this floor payment level, M+C organizations in the lowest cost counties would be paid *more* per enrollee, on average, than would otherwise be spent on beneficiaries in original Medicare.

Reduce the Wide Disparities in Payments between High and Low Payment Areas

By changing how payment rates are calculated, the BBA sought to even out the wide disparity in Medicare managed care payment rates across counties, an issue that had been a concern for lower-payment areas. As described in Section II, blended rates are developed by mixing together an area specific rate and a locally adjusted national rate. The basic idea is to reduce the geographic variation by bringing the high payment rate counties and the low payment rate counties closer to the national rate. Over time, this can be expected to occur as the rate of increase for the blended rates exceeds the minimum 2 percent update most years, and the weight applied to the national rate portion of the blend increases.

The table below illustrates how the county rates through 2000 were already beginning to shift from the floor and 2 percent rates to the blended rates:

Percent of Counties Receiving Floor, Blend, or 2% Increase			
Year	Floor Counties	Blend Counties	2% Counties
1998	33.8%	00.0%	66.2%
1999	39.7%	00.0%	60.3%
2000	29.1%	63.1%	7.8%

Preliminary estimates for 2001 suggest an interruption in this trend. Because of corrections to the national per capita growth percentage estimates for prior years, the national per capita rate of increase for the blended rates is expected to be negative in 2001, while the floor is expected to increase by about 3.3 percent. (For more information on these updates, see the January 14, 2000, Advance Notice of Methodological Changes for the CY 2001 Medicare+Choice Payment Rates.) As a result, most counties that had received the blended rates in 2000 are expected to receive the 2 percent minimum update in 2001 to their 2000 blended rate. Floor counties in 2000 will also be floor counties in 2001.

While national numbers show the trend, the impact on the specific payment rates and increases in different counties is revealing. The chart below shows the effect of the payment changes in three different States: Oregon, Louisiana, and Florida. Oregon is a low payment States that has significant M+C penetration. Louisiana and Florida are two high payment States.

The BBA's payment changes narrow the regional difference. In 1997, Florida's average payment rate (weighted by the number of M+C enrollees) was 150 percent higher than that of Oregon. (Florida's statewide average payment rate was 114 percent of the US average, while Oregon 's was at 76 percent.) In the year 2000, Florida's rate will be 124 percent of Oregon's (111 percent and 83 percent of the national average, respectively) because blended payments rates are included in the 2000 rates. Lower-paid States such as Oregon will receive relatively much higher rates of payment increases than higher-paid States such as Louisiana and Florida. The six counties with the highest year 2000 payment rates in Florida and Louisiana will receive only the minimum 2 percent update. In Oregon the top six counties will actually receive a rate increase higher than the average in the State. (This result partly stems from the number of "floor" counties in Oregon, where the payment increase between 1999 and 2000 for floor counties will be 5.7 percent -- the State has 22 blend counties and 14 floor counties but no minimum update counties.) These results take into account only changes to the methodology for setting the rates. They do not take into account changes in the methodology for adjusting the rates, as explained in Section IV below.

BBA M+C Payment Effects in Selected Areas

Area	Medicare Eligibles	M+C Enrollees	% Penetration	YR 2000 Rate	99-00 Growth Rate	Weighted Average Increase
Oregon	496,628	132,973	26.8%	$419.52	8.1%	9.1%
Oregon Top 6 Counties	**53,102**	**23,437**	**44.1%**	**$457.36**	**9.6%**	**9.7%**
Louisiana	619,822	106,064	17.1%	$539.79	3.7%	3.1%
Louisiana Top 6 Counties	**29,169**	**8,156**	**28.0%**	**$715.40**	**2.0%**	**2.0%**
Florida	2,832,650	773,256	27.3%	$520.84	4.3%	3.6%
Florida Top 6 Counties	**831,031**	**348,975**	**42.0%**	**$673.06**	**2.0%**	**2.0%**
Nation	39,302,687	6,236,353	15.9%	$452.06	6.0%	5.0%

SECTION IV RISK ADJUSTMENT

The BBA also mandates the introduction, by the year 2000, of risk-adjusted payments in M+C payment adjustments based on the health status of enrollees. Risk adjustment will have the effect of increasing payment to plans for enrolling sicker individuals, and decreasing payments for enrolling healthier beneficiaries. This section discusses the impact of implementing risk adjustment after the description of the model that will be implemented.

Description of the Inpatient Risk Adjustment Model

Prior to the BBA, Medicare's payments to risk contracting plans were adjusted based on demographic factors alone. The purpose of these adjustments was to account for variations in health care costs due, for example, to the higher rates of illness among older beneficiaries. A major criticism of this payment system was that the payment rate adjustments did not account sufficiently for variations in health status. Studies of Medicare managed care enrollment found considerable evidence of "selection bias," that is, enrollment of lower risk beneficiaries in managed care plans compared to fee-for-service Medicare.

The BBA mandated implementation of risk adjustment on January 1, 2000, and set the timetable for allowing HCFA to collect the diagnosis data on which to base risk adjustment. Specifically, the legislation provided the Secretary with broad discretion to develop a risk adjustment methodology that would "account for variations in per capita costs based on health status and other demographic factors." The legislation (section 1853(a)(3)(B) of the Social Security Act) allowed for the collection of hospital data on or after July 1, 1997, and for collection of data other than inpatient hospital data only on or after July 1, 1998. This latter date was too late, and known to be too late, to permit use of data other than the inpatient data in time for the January 1, 2000 implementation. The BBA provision thus envisioned that a hospital-only risk adjustment system would be implemented initially.

Given the BBA mandate and the availability of data, HCFA determined that the risk adjustment approach most feasible for implementation by 2000 was the Principal Inpatient Diagnostic Cost Group, or PIP-DCG, model. Briefly, under this model, diagnostic codes (ICD 9 codes) from inpatient hospital settings are used to place individuals in one of 15 diagnosis-based payment groups, each corresponding to a range of expected health expenditures. Although the number of diagnostic groups is small, hundreds of specific diagnoses are contained in these groups. Individuals are assigned to a single PIP-DCG group based on the principal diagnosis, that has the greatest future cost implications (and thus highest PIP-DCG score), from a discharge they experienced in the data year. The model also uses age, sex, original reason for Medicare eligibility (i.e., disability), and Medicaid entitlement as factors in determining a risk score. While the PIP-DCG model uses only inpatient diagnoses in creating the risk adjustment classification system, the model *predicts total expected costs* for the following year across multiple sites of services.[3]

Because the PIP-DCG model was developed and calibrated using a year of inpatient diagnoses, a full year of data is essential for assigning beneficiary risk factors. The model uses a "time shifted" approach, in which diagnostic information from the 12 month period ending six months before the payment period is used to determine risk scores, e.g., data from July 1, 1998 through June 30, 1999 were used to assigned risk factors that take effect January 1, 2000. This allows final payment factors to be assigned to beneficiaries by the start of the payment year.

HCFA uses the demographic information and diagnostic information from all Medicare+Choice organizations a beneficiary may have joined and from Medicare fee-for-service (FFS) to determine the appropriate risk factor for each beneficiary. A risk factor is computed for each individual beneficiary for a given year, whether or not a beneficiary is enrolled is a Medicare+Choice plan, and that factor follows the beneficiary. When a Medicare+Choice organization forwards beneficiary enrollment information, HCFA sends the organization the appropriate risk factor for the beneficiary, as well as the resulting payment. Because all

3 Payments for beneficiaries "new" to Medicare (for whom no prior diagnosis information exists) are based on the average expenditures for their age group. Medicare does not have prior diagnosis information for new disabled beneficiaries and beneficiaries who age-in to the program (e.g., new 65 year olds). Predicted cost estimates were derived for these groups of beneficiaries using only demographic factors.

beneficiaries have risk factors, information will be immediately available for payment purposes as beneficiaries move from original Medicare and among Medicare+Choice organizations.

Some critics have contended that the PIP-DCG model provides an incentive to hospitalize beneficiaries unnecessarily. There are several reasons why plans cannot just hospitalize patients unnecessarily. First, it would be very difficult, if not impossible, to implement a medical management program that differentiates among certain patients. In order to game the risk adjustment system successfully, a plan would have to identify those patients who have not been hospitalized in the past year and try to get them hospitalized for a condition, which under normal circumstances is treated on an outpatient basis. Second, unless the plan games the system only late in the year, there is a possibility that the patient would have been hospitalized later in the year anyway. Third, since one-day stays are included in the base payment category, the unnecessary hospitalization would have to last at least two days, which is likely to increase direct costs even more. Finally, there is no guarantee that a beneficiary that is hospitalized will be enrolled with the same plan the following year. Thus the plan must take the risk of paying for the direct costs associated with the unnecessary hospitalization while having no guarantee that the beneficiary will be enrolled in the plan the following year.

Others have also noted that the PIP-DCG model, which relies on inpatient hospital data, may not sufficiently recognize the health status of managed care enrollees if health plans are successful in preventing hospitalizations. In particular, HCFA has received many comments raising concern about the need to reimburse plans for the outpatient management of certain chronic conditions, especially Congestive Heart Failure (CHF). As one of the most frequently billed inpatient diagnoses, CHF is unique in its prevalence and the degree to which it can be successfully managed on an outpatient basis. In response to comments we have received on this matter, HCFA has consulted with experts in CHF, disease management, and risk adjustment on whether and how payments could be refined to recognize outpatient management of CHF until a comprehensive risk adjustment model is ready for implementation in 2004. We are working to develop an approach to this issue, which could be implemented for payment in CY 2002. HCFA will meet with industry and CHF experts during 2000 to identify specific criteria for recognition of outpatient management of CHF. Any changes in the Medicare+Choice payment methodology will be announced in the January 15, 2001, Advance Notice of Methodological Changes for the CY 2002, and would apply only to payments in 2002 and 2003.

Nevertheless, the PIP-DCG model offers a significant improvement over the previous payment system by identifying a relatively small group of high cost, seriously ill beneficiaries for additional payment. In addition, although HCFA will continue to study the effects of the PIP-DCG model and consider appropriate measures to further promote the goals of risk adjustment, the PIP-DCG model is intended to be an interim step toward implementation of comprehensive risk adjustment. Under comprehensive risk adjustment, health status will be based on diagnosis information from ambulatory sites of care (such as physician offices, hospital outpatient departments, and other ambulatory settings) as well as inpatient hospital diagnoses. Because a system based on more comprehensive diagnosis data is preferable, HCFA intends to implement a comprehensive risk adjustment system in 2004, the earliest feasible date.

Medicare+Choice Risk Adjusted Payment Model

To determine risk adjusted monthly payment amounts for each Medicare+Choice enrollee, individual risk factors are multiplied by the appropriate payment rate for the county. To make this calculation appropriately, an adjustment to these rate book amounts (described in the first section) is required before applying the risk adjustment factors. This adjustment, or rescaling factor, is necessary in order to account for the fact that the existing county rate book is already scaled to the set of demographic factors used under the current system, but not to the risk factors under the new system. Applying risk factors to rates that are scaled for use with the demographic factors would result in inaccurate payments.

As a result of rescaling, payment using the risk-based rate book for a person with the average risk factor in a county would be the same as the payment for a person with the average demographic factor in that county using the original demographic-based rate book. (However, a person with the average demographic factor does not necessarily have the average risk factor.) In this sense, the rescaling process by itself is payment neutral. (This is not the same as budget neutrality. Budget neutrality would imply that payments -- either payments to a single plan or aggregate payments -- are the same under the new payment methodology as the old methodology.) Whether aggregate payments to a plan increase or decrease depends upon the plan's risk profile, i.e., the distribution of the health status of the beneficiaries enrolled in the plan. The published rate books show the demographic rates and the rescaling factors that are used to "translate" those rates into use in determining the risk-adjusted portion of payment under the transition mechanism described in the next section.

Transition Policy

HCFA decided to include a transition period as a component of our risk adjustment methodology, initially using a blend of payment amounts under the current demographic system and the PIP-DCG risk adjustment methodology. Under a blend, payment amounts for each enrollee are separately determined using the demographic and risk methodologies (i.e., taking the separate demographic and risk rate books and applying the demographic and risk adjustments, respectively). Those payments amounts are then blended according to the percentages for the transition year.

HCFA adopted a transition in order to provide a safeguard against abrupt changes in payments to plans. The blend methodology does so in particular by providing initially for a low blend percentage of the risk-adjusted payment amount. We also decided to implement a five-year transition, which will culminate in full implementation of comprehensive risk adjustment in the fifth year. On January 15, 1999, HCFA announced the following transition schedule:

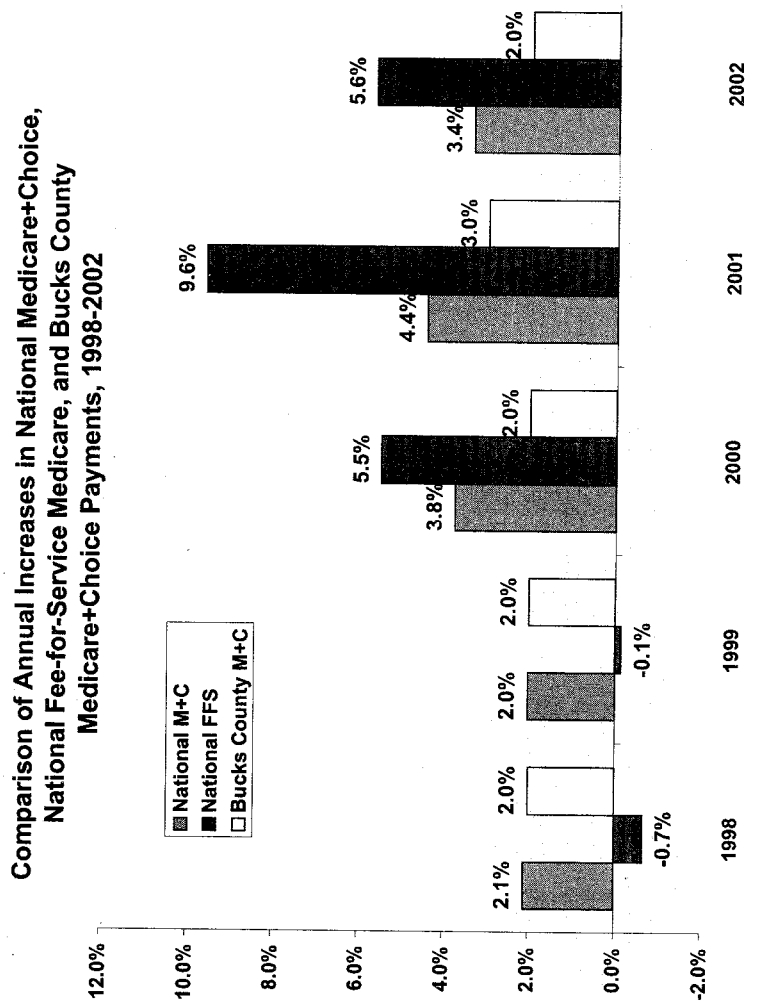
	Demographic method	Risk method
CY 2000	90 percent	10 percent PIP-DCG
CY 2001	70 percent	30 percent PIP-DCG
CY 2002	45 percent	55 percent PIP-DCG
CY2003	80 percent	20 percent PIP-DCG
CY 2004	100 percent risk adjustment, using comprehensive model (encounter data from all sites of care)	

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (P.L. 106-113), however, has revised the transition schedule. Specifically, this legislation provides that the blend percentages will be:

	Demographic method	Risk method
CY 2000	90 percent	10 percent PIP-DCG
CY 2001	90 percent	10 percent PIP-DCG
CY 2002	at least 80 percent	not more than 20 percent

In order to prepare for comprehensive risk adjustment, HCFA has initiated discussions with plans related to the requirements for submission of outpatient, physician, and other non-inpatient hospital data.

In the aggregate, payments to M+C organizations will decrease less than one percent in the first transition year as a result of risk adjustment. The impact on specific organizations will, however, vary, depending upon the health status of the organization's Medicare enrollment. While some organizations may see an increase in their payment (due to enrollment of sicker than average beneficiaries), other organizations may see as much as a two percent decrease in payment from risk adjustment alone. This maximum reduction will be offset by the minimum two percent update guaranteed under the BBA. payment methodology, so that plans would not experience a reduction in payment in 2000 relative to payments in 1999. These reductions in aggregate payments to plans are consistent with the research findings that have suggested "selection bias" in the enrollment of healthier than average beneficiaries in Medicare managed care plans. If there is no change in the enrollment profiles of Medicare+Choice plans, the impact of risk adjustment will increase through the transition as the percentage of the risk-adjusted payment amount increases. If plans react to the incentives of the risk-adjusted payment method by enrolling individuals with higher risk, this impact will be mitigated. We will continue to monitor the impacts on organizations throughout the transition period.


Comparison of Annual Increases in National Medicare+Choice, National Fee-for-Service Medicare, and Bucks County Medicare+Choice Payments, 1998-2002
National M+C
National FFS
Bucks County M+C
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
-2.0%
2.1%
-0.7%
2.0%
2.0%
2.0%
-0.1%
2.0%
3.8%
5.5%
2.0%
4.4%
9.6%
3.0%
3.4%
5.6%
2.0%
1998
1999
2000
2001
2002

Medicare 1997 Claims for Bucks and Philadelphia Counties

Bucks County PA (Medicare HI&/orSMI Population = 75,157)

	Claims	Enrolled	Persons Served	Services	Service Rate (#Services/ Persons Served)	Services per 1000 Beneficiaries (#Services/ EnrolledX1000)
Inpatient	20,976	74,985	11,775	20,976	1.78	279.74
SNF	3,566	74,985	2,587	3,566	1.38	47.56
Hospice	2,127	74,985	862	39,568	45.90	527.68
HH	20,967	74,985	6,414	263,509	41.08	3,514.16
Part B	1,019,257	71,343	46,645	4,219,475	90.46	59,143.50
DME	49,095	71,343	9,340	1,893,892	202.77	26,546.29

Philadelphia County PA (Medicare HI&/orSMI Population = 245,725)

	Claims	Enrolled	Persons Served	Services	Service Rate (#Services/ Persons Served)	Services per 1000 Beneficiaries (#Services/ Enrolled X 1000)
Inpatient	86,806	244,362	45,464	86,806	1.91	355.24
SNF	14,211	244,362	10,009	14,211	1.42	58.16
Hospice	6,334	244,362	2,800	112,009	40.00	458.37
HH	96,735	244,362	25,377	1,376,754	54.25	5,634.08
Part B	3,682,513	232,567	156,936	14,301,418	91.13	61,493.75
DME	198,109	232,567	36,033	9,263,372	257.08	39,830.98

ATTACHMENT B

	Bucks County -- Services per 1000 Beneficiaries	Philadelphia County -- Services per 1000 Beneficiaires	Philadelphia/ Bucks County
Inpatient	279.74	355.24	1.27
SNF	47.56	58.16	1.22
Hospice	527.68	458.37	0.87
HH	3514.16	5634.08	1.60
Part B	59143.5	61493.75	1.04
DME	26546.29	39830.98	1.50

Mr. GREENWOOD. You are recognized for your testimony, Ms. Berek. Thank you.

TESTIMONY OF JUDITH BEREK, ADMINISTRATOR, NORTHEAST CONSORTIUM, HEALTH CARE FINANCING ADMINISTRATION; WILLIAM F. HAGGETT, SENIOR VICE PRESIDENT, GOVERNMENT PROGRAMS, INDEPENDENCE BLUE CROSS; SANDRA HARMON-WEISS, HEAD, GOVERNMENT PROGRAMS, AETNA U.S. HEALTHCARE; AND SCOTT C. HARRISON, RESEARCH DIRECTOR, MEDICARE+CHOICE, MEDPAC

Ms. BEREK. Thank you, Chairman Greenwood, and Congressmen Deutsch and Hoeffel, for holding this hearing. And thank you for inviting me to discuss the Medicare managed care program, Medicare+Choice.

Medicare+Choice offers Medicare beneficiaries a range of health plan options and allows them to choose the types of health plans that bet suit their individual needs. Both Secretary Thompson and the new HCFA Administrator, Tom Scully, will be placing a high priority on working with you and other Members of Congress to revitalize the Medicare+Choice program. Just this week, Secretary Thompson gave Medicare+Choice plans the extra time they have been asking for to prepare and submit benefit proposals and to make their participation decisions for next year.

The Balanced Budget Act of 1997, which is often just called BBA, and subsequent amendments to that law, have reduced the substantial geographic variation in county payment rates that existed under the previous Average Adjustment Per Capita Cost, or AAPCC, which is the classic jargon term for how we pay managed care plans methodology.

In the first chart, which my Vanna White has put up there, you will see that in 1997, the county with the highest payment rate in the country was Richmond County. And for those of you who would like that decoded, that is Staten Island. Richmond County is Staten Island, New York for those of you who want to know where it is. And the lowest payment rate in the country was Arthur County in Nebraska. And you will see that in 1997, the ratio was 3.47. In other words, the rate was 3.47——

Mr. GREENWOOD. That microphone is very directional. You might want to hold it in your hand, take it from its stand and hold it in your hand, and that should make it——

Ms. BEREK. Is it working now? Okay. Richmond County was 3.47 times higher than the rate in Author County. Now, in 2002, we have reduced that variation so that although it is now $856 in Richmond, it is $500 in Arthur County. And one of the goals of the BBA was to reduce that difference. This chart also highlights how reductions within States were reduced, and you will notice that in Nebraska, in 2002, the very highest rate in Nebraska was $433, and the lowest rate in Nebraska was $221, and it has now been narrowed so there is only a $53 difference. And if you look at New York, you will see that the lowest county, which is Lewis County, where the rate was $303 in 1997, is now $500, and so the difference, again, was dramatically reduced.

Although the BBA reduced payment variation in the Medicare+Choice payment, the payment between counties still var-

ies. The second chart that Paul, AKA Vanna, is putting up, shows you the difference between Bucks and Philadelphia Counties and the underlying utilization difference between the counties. And I hope this hopes to answer some of the questions raised.

And if you look at in 2002, we have two ways of calculating the rate. One is based on the demographics, which looks at the age rates in the county, and if you look at Bucks and the utilization, the cost in that way would be $629, and in Philadelphia it would $769, where the difference is 22 percent. We are, gradually, modifying the way we pay using a risk rate where, if you look at Bucks County, the cost would be $586 if it were risk adjusted and in Philly, it would $671, and the difference is 14 percent. And those two rates are blended, actually, in the payment rate.

But to look at the underlying reason for some of that difference, you need to look at the lower half of the chart, which shows you the utilization rate in terms of—and this answers the question of why we pay more money in Philadelphia County, because the formula requires us to pay based on the historic costs, which are driven in this case by utilization. And in fact, people in Philadelphia County use hospitals 27 percent more, they use home health agencies 60 percent more, skilled nursing facilities 22 percent more, physicians 4 percent more, DME, Durable Medical Equipment, 50 percent more, and interestingly, hospice services 13 percent less. But in everything but hospice services, you will notice that the costs are much greater than Philadelphia, and that is the underlying reason.

The difference—we know the differences in payment rate can be very frustrating for Medicare beneficiaries, but this is the way the law is written. We have to use the data that produces this in order to calculate the rates.

Before I conclude, I would like to briefly highlight some of the resources available to help beneficiaries understand health plan options. We have a wealth of resources available, including a Medicare+Choice handbook, which is sent to all of you annually. We have a toll free number, 1-800-MEDICARE. We have information on our web site, which is an award winning website called www.Medicare.gov, and all of those locations will provide information to you. I know that our new administrator is very committed to improving the quality of our 800 number and making it a 24-hour-a-day number, if possible.

We also have a State Health Insurance Counseling program, which is run by grants from HCFA to the State of Pennsylvania, and there are individuals available who will counsel people one on one. For those of you who are here who have individual personal questions, we have two people here from the Beneficiary Services Branch in HCFA. They are Pamela Bragg and Sue Pellella, and they are here to handle any questions you may have, individually, after this hearing is over. We have two people here from our managed——

Mr. GREENWOOD. Would those individuals identify themselves in case there are questions? Okay. These two ladies in the front row.

Ms. BEREK. And we have two people here from our Managed Care Branch, John Waylan and Sharon Graham, and they will also be available to help anyone with any individual problems. And to

those of you who have some really technical questions that I can't answer, Bob Donnelly, who is the Director of our Division of Program Policy for Medicare Managed Care is also here with me today. So if any of us can help you, we will be happy to.

[The prepared statement of Judith Berek follows:]

PREPARED STATEMENT OF JUDY BEREK, REGIONAL CONSORTIUM ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Chairman Greenwood, Congressman Deutsch, other distinguished members of the Subcommittee, thank you for inviting me to discuss the history and current status of the Medicare managed care program, Medicare+Choice. Medicare+Choice offers Medicare beneficiaries a range of health plan options, including the traditional fee-for-service Medicare program, and allows them to choose the types of health plans that best suit their individual needs, according to the options offered by the plans. It provides valuable alternatives to traditional fee-for-service Medicare, and we are committed to strengthening this program.

Our new Administration, both Secretary of Health and Human Services Tommy Thompson and Health Care Financing Administration (HCFA) Administrator Tom Scully, will be placing a high priority on protecting and improving Medicare+Choice. For instance, this week, Secretary Thompson gave Medicare+Choice plans the extra time they have been asking for to prepare and submit benefit proposals and to make participation decisions for next year. Health care costs in recent years have been less predictable, as have decisions by providers to contract with Medicare+Choice plans. This action will allow plans more time to collect information on their costs and determine the viability of their provider networks before having to make decisions about their benefit offerings and service areas for next year. We are committed to working with you and health plans toward our goal of making more health plan options available to our beneficiaries in all parts of the country, while helping beneficiaries to better understand these options.

Medicare has a long history of offering alternatives to the traditional Medicare fee-for-service program to our beneficiaries. In the 1970's Congress authorized Medicare risk contracting with managed care plans, and in the 1980's Congress modified the program to make it more attractive to managed care companies. Under that program, HMOs contracted with Medicare to provide the full range of Medicare benefits in return for monthly "per person" or "capitated" payment rates. In the Balanced Budget Act of 1997 (BBA), Congress created the Medicare+Choice program to correct perceived flaws in the risk contracting program, including payment differences. Since then, Congress has refined the Medicare+Choice program through the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).

Today, 64 percent of all Medicare beneficiaries have access to a Medicare+Choice option; and about 5.5 million, or about 15 percent of all Medicare beneficiaries, have chosen to enroll in a Medicare+Choice plan. As was the case with the risk contracting program prior to the BBA, payments under the Medicare+Choice program vary by county, and plans have the option of varying their additional benefits or premiums from county to county. The differences in benefits across the country and between adjacent counties was an issue with the risk contracting program, and remains an issue with the Medicare+Choice program today.

BACKGROUND

Medicare pays for the health care of almost 40 million beneficiaries, involving nearly one billion claims from more than one million physicians, hospitals, and other health care providers. As the administrator of this program, the Health Care Financing Administration (HCFA) oversees Medicare's various health care plan options, including the Medicare+Choice program. For beneficiaries in Medicare+Choice, we ensure access to providers, approve promotional materials, and calculate capitated payment rates. Before the BBA became law in 1997, Medicare calculated capitation rates under a methodology known as the Adjusted Average Per Capita Cost, or AAPCC.

Under the AAPCC methodology, we determined, for each county, the average per person cost for fee-for-service Medicare beneficiaries living in that county. Health expenditures were not attributed to the county where services were provided, but to the county in which the beneficiary lived. For example, if a beneficiary living in Bucks County received a service in Philadelphia, that expenditure was included in the AAPCC for Bucks County. The per capita amounts were then "standardized" to account for differences between the demographic characteristics of Medicare bene-

ficiaries in the county and the demographic characteristics of Medicare beneficiaries across the nation. Additionally, capitation rates were set at 95 percent of the AAPCC, with the 5 percent reduction reflecting the assumption that managed care plans could achieve savings through discounts and more efficient management of health services. The following example illustrates how payment was made:

Example: Beneficiaries in Bucks County, PA, CY 19975	Demographic Factor, Part A	Demographic Factor, Part B	Monthly county capitation rate * factor	Monthly payment per person
Male, non-institutionalized, Age 65 to 69 Medicaid eligible	1.15	1.10	Part A: $ 422.05 Part B: $ 229.50	$651.55
Female, non-institutionalized, Age 80 to 84 Medicaid eligible	1.70	1.25	Part A: $ 623.90 Part B: $ 260.80	$884.70

Under the AAPCC method, Medicare capitation rates varied widely. Since county fee-for-service costs were used to calculate county capitation rates, the rates reflected differences among counties in fee-for-service health service usage and payment levels. In addition to the substantial variation in rates across the country, there were a number of other concerns with the AAPCC payment method, including:

- Payment rates changed unpredictably from year to year in each county, based on fee-for-service costs in each particular county;
- Payment rates could vary widely across adjoining counties;
- Generally, rates were lower in rural areas; and
- Hospitals were concerned that HMOs did not compensate them for medical education like fee-for-service Medicare.

RECENT CHANGES TO AAPCC

In the BBA, Congress replaced the risk contract program with Medicare+Choice. The BBA modified Medicare+Choice payment rate calculations to address a number of concerns with the AAPCC methodology. It broke the direct link to fee-for-service spending in a county, and moved to reduce wide disparities in county capitation rates by bringing both high and low payment rates closer to the national average payment rate. In addition to adjusting the payment rates based on demographic factors, the BBA required payment rates to be adjusted for beneficiary health status, sometimes referred to as a "risk adjusted method" of payment. It also provided direct payments to teaching hospitals for Medicare+Choice patients to ensure these hospitals were receiving appropriate medical education payments for their Medicare managed care patients. The BBA also mandated that the 1997 AAPCC rates would serve as the basis for the Medicare+Choice rates, and the rates for particular counties would be equal to the largest one of three amounts:

1. **Minimum 2 percent increase over the prior year's rates,** which protected high payment areas as the medical education reductions and reductions in geographic disparities took effect.
2. **Minimum amount or "floor" amount** that increases rates in historically lower-rate counties where Medicare managed care plans generally have not been offered. Beginning in 1998, the BBA set the floor rate at $367; this floor has been adjusted annually by the rate of growth of the overall Medicare program.
3. **Blended amount,** which is calculated by blending county and national rates, thus increasing rates in historically lower-rate counties while reducing rates in historically higher-rate counties. Each year, from 1998-2003, a greater percentage of the payment amount is based on the national rate, until a 50/50 blend is reached. The blend percentage for 2001 was 66 percent county and 34 percent national rates. The "national rate" for each county is calculated by adjusting the national rate by each county's Medicare hospital wage index and geographic physician practice cost index.

ADDITIONAL BENEFITS AND PREMIUM REDUCTIONS

As was the case under prior law, the BBA requires plans to compute whether their projected Medicare revenues, based on Medicare capitation payments, will exceed their projected costs for providing Medicare services (excluding Medicare deductibles and coinsurance). If revenues exceed costs, the plan must use those funds to provide additional (non-Medicare) benefits to enrollees at no additional cost to the enrollee. In 2001, on the national level, Medicare+Choice plans are using an average of about 19 percent of their Medicare revenues to provide these additional benefits, such as routine vision care, dental care, and prescription drugs, which are not available through fee-for-service Medicare.

As was also the case under prior law, the BBA mandated that plan premiums or other charges, such as copayments, for services covered by Medicare may not exceed the actuarial value of fee-for-service beneficiary cost sharing. For 2001, that amount is $100.66. Medicare+Choice plans may also offer supplemental benefits that Medicare does not cover, such as prescription drugs, and may charge premiums for those benefits. Depending on the supplemental benefits that a plan offers, this plan premium may exceed $100 per month.

Congress revised the BBA changes in 1999, through the BBRA, and again in 2000, through BIPA. The BBRA included changes to the Medicare+Choice program to make it easier for beneficiaries and plans to participate, including giving plans more flexibility in their benefits and cost-sharing, and increasing payments. The BBRA also included incentives for plans to offer plans in areas without a Medicare+Choice plan already in place. Similarly, BIPA increased Medicare+Choice payments and expanded the incentive program for managed care plans to offer Medicare+Choice in areas without such options. Congress increased both the minimum percentage payment rate increase for 2001 only (from 2 percent to 3 percent), as well as the payment rate floor amount, to $525 in Metropolitan Statistical Areas with a population of 250,000 or more, and to $475 in al other areas.

REDUCTION IN GEOGRAPHIC VARIATION

The BBA and subsequent amendments have reduced the variation in payment rates at the national level. In 1997, the county with the highest payment rate was Richmond County in New York and the county with the lowest payment rate was Arthur County in Nebraska; their rates were $767 and $221, respectively (Chart 1). The ratio of the Richmond County rate to the Arthur County rate was 3.47, that is, the rate in Richmond County was about 250 percent higher than the rate in Arthur County. In 2002, the rates in Richmond and Arthur counties will be $856 and $500, respectively. The ratio of the rates will be 1.71, a dramatic reduction from 1997.

This chart also highlights how variation within states was reduced. In 1997, in Nebraska, the ratio of the highest to the lowest county was 1.96, that is, the rate in Douglas County was about 100 percent higher than the rate in Arthur County. In 2002, that ratio will be reduced to only 1.11. There will be a similar reduction in New York, from 2.53 to 1.71 in 2002. Thus, the BBA changes effectively reduced both national and state level variation in payment rates.

PHILADELPHIA AND BUCKS COUNTY

The second chart (Chart 2) looks specifically at Medicare payment rates and utilization rates in Bucks and Philadelphia Counties. The Medicare law requires payments to Medicare+Choice organizations in 2001 to be based 90% on the demographic method and 10% on the risk adjusted method. The first row in the chart indicates that under the rates used in 2001 for the demographic portion of payments, the rate for the average beneficiary in Philadelphia County is 22 percent higher than the Bucks County rate. The next row on the table shows the percentage difference for rates under the risk adjustment method. For the risk adjusted portion of payments, the rate in Philadelphia County is 14 percent higher than the Bucks County rate. The difference between the risk method rates in the two counties would indicate that, on average, beneficiaries in Bucks County are healthier than beneficiaries in Philadelphia.

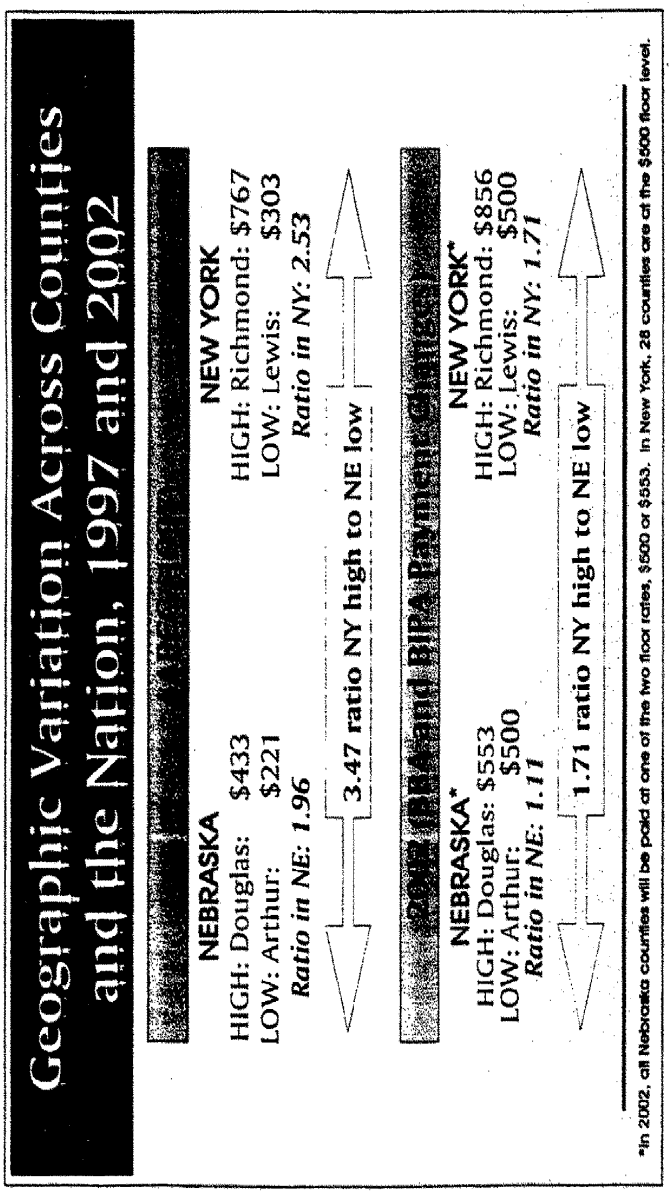
Turning to the comparison of the utilization of services in the two counties, the table shows that beneficiaries in Philadelphia County utilize more services than those in Bucks County. In particular, they use more hospital, home health, skilled nursing facilities, and durable medical equipment services than beneficiaries in Bucks County. The greater use of these relatively costly services would be associated with a population that is sicker and therefore has a greater need for medical services. This higher use of services corresponds with the higher 1997 base rate for Philadelphia County.

Differences in payment rates as well as in benefits and premiums between adjacent counties were an issue prior to the BBA and remain an issue today. These premium and benefit differences are influenced not only by Medicare payment rates, but also by the ability of the Medicare+Choice organization to negotiate favorable payment rates with providers and the presence of other Medicare+Choice options in the market area.

CONCLUSION

We are working hard to ensure that Medicare beneficiaries receive high quality health care, and have a variety of options to choose from so their health plans most

closely meet their individual needs. The Medicare+Choice program is one important way we accomplish this goal. As the name suggests, Medicare+Choice offers many beneficiaries a guarantee of traditional Medicare fee-for-service benefits, as well as a choice of other options, which vary from plan to plan. Congress has made several important improvements to Medicare+Choice over the last few years, and our new Administrator is strongly committed to working with you and health plans to expand and revitalize the Medicare+Choice program. Thank you for the opportunity to discuss this with you today, and I am happy to answer your questions.



	Bucks	Philadelphia	% by which Philadelphia rate is higher
2001 Demographic Rate	$629.20	$769.77	22%
2001 Risk Rate	$586.27	$671.04	14%

Service	% by which utilization in Philadelphia exceeds utilization in Bucks
Hospital	27%
Home Health	60%
Skilled Nursing Facility	22%
Physician	4%
Durable Medical Equipment	50%
Hospice	(13%)

Mr. GREENWOOD. Thank you for your testimony. If you will pass that highly directional microphone to Mr. Haggett, he will now try to——

TESTIMONY OF WILLIAM F. HAGGETT

Mr. HAGGETT. Good morning, Mr. Chairman, Congressman Deutsch, Congressman Hoeffel. Thank you very much for the opportunity to represent Independence Blue Cross at this hearing. It is also a pleasure to see many of our members of Keystone 65, and Personal Choice 65 are here with us this morning as well.

Just by way of context, I want to just underscore the longstanding commitment that our company has to the Government business, Medicaid, Medicare, and CHIP. We currently enroll, through our various companies, a total of 900,000 Medicaid managed care beneficiaries, 250,000 which are located in this region, 25,000 CHIP members and, currently, about a little over 150,000 Medicare+Choice members. It has been a longstanding series of programs that our company has offered. It is something that we feel very strongly about. It is part of what Independence blue Cross stands for. We are concerned, however, about our ability to continue, specifically, the Medicare+Choice program given the current trends and direction in which we are heading.

One other point I would like to make is that under the legislation that created the Medicare+Choice program, Congress was looking for the opportunity to present choices to beneficiaries. We have, since 1997, offered a PPO product, Personal Choice 65, in this marketplace. It was the first PPO that was brought in under the Medicare+Choice program. It still continues to be a very viable—or popular product, I should say. The viability of that product, however, is something that we are very concerned about given the current rules and direction.

I do and have submitted written testimony, so I won't focus on some of the context and background beyond what I have just mentioned, but would like to get to the heart of the matter. January 2001, for us, was a very difficult time. We, at that point, instituted significant price increases and benefit adjustments related to the funding limitations that had been put in place over the last several years. What that meant was that many of our members no longer had as part of their base medical plan prescription drug coverage that was available to all of our members. However, it was available at an additional cost. Annual limits on the drug program continued over the last several years to be decreased, and the co-pay limits that were passed onto our members have been increased as well.

We spent a lot of time last fall talking to our members. We posted over 125 meetings in community centers such as this throughout the five-county region, reached and talked to about 7,000 of our members. We serviced over 500,000 phone calls from our members during the 4-month transition period. We provided members with information about the State PACE program, about the VA program, to make them aware of other programs that were available, are available, and can assist them in meeting all of their needs, not just those that are related to their specific healthcare needs. But given the disproportionate and growing portion of their budget that has to be allocated to either prescription drugs, premium pay-

ments, and so forth, we feel an obligation to provide as much information to our members as possible to assist them in all of the aspects that are converging on their tight budget dollars.

This marketplace has been one of the so-called 2 percent markets. Since 1998, our increases in premium have been limited to 2 percent during that period of time. Contrast that, though, on the cost side of the equation, and specific to our Medicare members in this market, the average increase in costs over that same period of time was 12 percent each year. So during that, and even with the additional bump that we got through the BIPA dollars, a total of 9 percent increase in Federal funding, contrasted with a 48 percent increase in cost of providing services. That gap is what has caused the reduction in benefit levels, the increase in co-payments, and most recently, the significant increases that we have had to impose with regard to monthly premium.

Additionally, this year we made the decision and struggled with the decision to make a differentiation, or create a differentiation, between pricing between Philadelphia County and the four suburban counties. I think some of the members who—beneficiaries, rather—who were up before, pointed to this concern and to this issue, and you will hear, certainly, more about that. For us, the published AAPCC's for this region are Philadelphia to Bucks County, for example, an 18 percent differential. For 2002, the specific dollars are $144 less for Bucks County residents than they are for Philadelphia County; there is an 18 percent differential. For our members in our marketplace, the price differential, the cost of providing services to our members is 8 percent. So it cost us 8 percent, an aggregate 8 percent less for Bucks County residents than it does for Philadelphia County. However, the Federal formula says that that should be 18 percent; it is not for this marketplace for our members. That has and continues to be the driving reason for the differentiation in the Philadelphia/Bucks County payment issues.

Another somewhat more technical issue has to do with the extraction of the graduate medical education dollars. We are fortunate in this region to be the location of a number of medical schools, training programs, tertiary care facilities, all of which receive additional dollars for the—to help support these programs with the Medicare program. Those dollars have been gradually extracted from the Medicare+Choice payment levels, and the thought, I believe, was that our plans, plans such as ours, would go back and work with hospitals to renegotiate lower payment rates on a gradual basis, along with—to coincide with, rather, the differentiation that was being pulled out of the rates.

I can tell you that for us, that has not happened. In talking to plans throughout the country, that has not happened. Hospitals have not been willing to adjust their payment levels to us based on these additional dollars. So they are able to collect it directly from Medicare, it is being extracted from our rates, and yet, we are not in a position to be able to renegotiate with them to, you know, see a commensurate situation. Again, our estimates put that impact for our Keystone 65 business about over $30 million now since it is fully phased in that is off the table as a result of that.

Just to give you an order of magnitude, the BIPA dollars for us represented about a $7 million increase. The GME is almost four

times, a little bit over four times, that amount so it is a significant issue that is specific to this marketplace and many other similarly situated marketplaces throughout the country.

The last point that I would just like to make, and I know it is not the particular focus of this hearing, but the regulatory burden and oversight imposed by HCFA continues to be a burdensome one. And I think there has been, certainly, recognition within the agency. There have been many steps moving forward, but some of it is in statutes, some of it is in regulations, some of it is trying to fit managed care into a deeper service environment, and to require some of the same of managed care, some of the same things which are in effect in the fee-for-service program. The one size fits all approach doesn't work in this case.

Again, we are very committed to this program. We are committed to Medicare beneficiaries in this region. We also offer Medigap coverage and we are concerned and believe that managed care does continue to offer a viable alternative and significant value added to our members. However, as we extend and we look a year or 2, 3 years, out, it is going to be more expensive to be in a managed care program than it will be to be in a Medigap program. We are very concerned about that eventuality and don't think it serves the best interest of the Medicare beneficiaries, especially, in this region, and likewise throughout the country. Thank you.

[The prepared statement of William F. Haggett follows:]

PREPARED STATEMENT OF WILLIAM F. HAGGETT, SENIOR VICE PRESIDENT, GOVERNMENT PROGRAMS, INDEPENDENCE BLUE CROSS

Mr. Chairman and Members of the Sub-committee: I am William Haggett, Senior Vice President for Government Programs with Independence Blue Cross (IBC). As a participant in the Medicare+Choice program since 1993, IBC is pleased to have this opportunity to present testimony to the committee on the current state of Medicare+Choice in the southeastern Pennsylvania region.

By way of background, Independence Blue Cross is a Pennsylvania non-profit hospital plan corporation licensed to provide financing for health care coverage to residents in this region. IBC has a subscriber base of 2.8 million members in southeastern Pennsylvania and another 1.6 million subscribers in other regions. Our company has a long-standing history as an active participant in government business—Medicare, Medicaid and CHIP.

Through our family of affiliated companies, IBC currently provides healthcare coverage to 900,000 Medicaid members, 24,000 CHIP members and 152,000 Medicare+Choice members. In short, our company has a long-standing and active commitment to these government programs and the members they serve.

With regard to the Medicare program, IBC offers coverage to 277,000 beneficiaries—125,000 through Medigap coverage and 152,000 through Medicare+Choice products. The first and largest Medicare+Choice product is Keystone 65, an HMO program which enrolls 122,000 in southeastern Pennsylvania. The second is Personal Choice 65, a preferred provider organization product, which has 18,000 members in southeastern Pennsylvania. This is the first PPO offered through the Medicare+Choice program. The third product is offered in southern New Jersey under the name of AmeriHealth 65. Approximately 12,000 are enrolled in that HMO product.

Our membership enrolls voluntarily in our products. The average length of enrollment is nearly four years and growing each month. Disenrollment by members on a voluntary basis has been well below national averages for many years. More than 80% of our members reside in households with annual incomes under $25,000.

Members of our plans repeatedly rank our programs as providing high quality and value and producing high satisfaction levels. The results of formal surveys such as the Consumer Assessment of Health Plans (CHAPS), Health Outcome Studies (HOS), Health Employer Data Information Set (HEDIS) and various self-assessments completed as part of national accreditation processes, all document this high level of satisfaction and quality of care.

Our members, too, enjoy wide access to a substantial network of providers in this region. More than 10,000 physicians and 65 hospitals are participating providers. Members with congestive heart failure, diabetes, respiratory illness and complex medical conditions have access to and participate in successful care management programs. Here are some examples of those programs:

—Congestive Heart Failure Care Management Program—Studies have shown that for members enrolled in this program, the numbers of inpatient hospital days decreased and members reported higher daily living indicator scores—Several hundred of our Medicare members received $150 reimbursement for health facility dues as part of their wellness program benefit.

—Pre Surgical Outreach Program—Members whose physicians request authorization for surgery are contacted by our care management nurses. In cooperation with the member's surgeon, a comprehensive readiness review is completed. For example, discharge planning and placement is completed prior to the admission to assure that appropriate care is in place.

—Health Risk Assessments—All new members receive, and more than 75% return, health risk assessment questionnaires. The data from the questionnaires allow us to identify high risk members who are contacted by our care management nurses. Assessments are completed and coordinated care plans are developed in conjunction with the member, their family and their physicians.

I want to also note that these value-added services are an integral part of the managed care approach our company takes. They are not available in a fee for service environment.

Keystone 65 and AmeriHealth 65 are both accredited at the excellent level by the National Commission on Quality Assurance (NCQA). Additionally, Personal Choice 65 was recently reviewed and granted full accreditation as a PPO by NCQA. The significance of these ratings cannot be understated—they represent the highest ranking possible from the national accreditation agency for our industry.

In short, our members report high satisfaction levels, our outreach efforts and specialized programs are well subscribed and proven effective and the national accreditation agency has awarded our programs with the highest level of recognition. Strong programs—satisfied members.

Our ability to continue these products, however, is at significant jeopardy. The challenges we now face are several. The most urgent, however, relates to funding levels afforded under the current law and regulation governing the Medicare+Choice program.

January 2001 saw significant increases in monthly premiums paid by our members. The increases were unlike any we have had to institute since the program inception. Since the enactment of the Balanced Budget Act in 1997, we have also been forced to reduce the level of benefits offered to our members, most specifically related to prescription drug coverage. Annual coverage limits have been decreased, copayments for each prescription have increased, and most recently, prescription drug coverage has been dropped from our basic medical plan. These changes are the result of the limitations placed on federal funding for the Medicare+Choice program.

Those decisions made about 2001 premium increases were not easy ones. We worked very long and hard at fully explaining the reasons for these increases to our members both through annual notification mailings as well as more than 120 community meetings hosted by IBC last Fall. These meetings provided an opportunity for our Medicare staff to fully explain and take questions from our members on the changes necessitated in 2001. The number one question asked was why the significant premium increases and why the difference between Philadelphia and the surrounding counties.

Because of the impact health care premiums are having on their tight budget dollars, we found it even more important than in past years to provide information to our members regarding other sources of support for prescription drugs, assistance in premium payments, and other general needs (e.g., utility payments).

Even with this assistance, several thousand of our members have had to cancel their membership with IBC and transfer back to fee for service Medicare. They are not able to afford the new 2001 premium payments. We are concerned about these members as most report that they will have to take their chances with traditional Medicare coverage, not sure how the copayment and coinsurance amounts will be paid. With the current trends, more and more Medicare beneficiaries will be impacted like these vulnerable members.

With the implementation of the provisions of the Balanced Budget Act of 1997, IBC has received 2% increases in funding since 1998. With the onetime increase to 3% provided by the Benefits Improvement and Protection Act (BIPA) of 2000, that totals 9% over four years. During that same period of time, the cost of providing our members with the care and services they are entitled to increased an average

12% each year. For the same four year period, that represents a 48% increase in the cost of providing care. The substantial gap between funding levels and costs is having a significant impact. This gap has resulted in lower benefit levels and higher member copays and monthly premium payments.

Reimbursement to Medicare+Choice plans is based on county level average adjusted per capita cost (AAPCC) figures and, more recently, risk adjustment factors. The payment amounts are determined by HCFA each year. Prior to the Balanced Budget Act of 1997, the AAPCC calculation was the government's estimate of 95% of the projected Medicare payments for the fee for service costs in a given county. Since the 1997 AAPCCs are the basis of the current payment levels in the 2% counties, this reduction is built into the base figures. The adjustments made since 1997 have been national percentage adjustments, not actual cost adjustments.

In addition, since plans are paid based on the AAPCCs which were established in 1997, this does not take into account marketplace conditions—provider consolidations, dramatic changes in patterns and sources of care.

Additionally, the impact of legislation since 1997 has distorted even more the relationship between Medicare+Choice and Medicare fee for service payments. By way of example, with Congress' action, the floor payment levels paid in any county throughout the country was raised several times and will be $500 for 2002. When compared to the fee for service costs in many of those counties, the new Medicare+Choice payment level is 119% of the cost of fee for service members (according to the Medicare Payment Advisory Commission). Contrast that with the so-called 2% counties (those who have been limited to annual increases of 2% since 1998), where the Medicare+Choice payments are less than fee for service costs. This means that plans like Keystone 65 are being paid less than what it would cost the Medicare program if those members received their services through the fee for service program. Alternately, Medicare+Choice plans in floor counties would be paid 19% more than the fee for service costs.

An additional complication for this and other similar markets is the significant variation in payment levels from county to county. The current Medicare+Choice payment methodology uses counties as the unit of payment. In this region, there is a significant discrepancy in the AAPPCs of Philadelphia County and the four surrounding suburban counties. By way of illustration, the 2002 AAPPC for Philadelphia is $785. The 2002 AAPPC for Bucks County is $641. The Bucks County rate is $144 or 18% lower than that of Philadelphia.

(Note: These figures are the aged AAPCCs. The AAPCCs for disabled members also differ by county, but the difference is 10% rather than 18%.)

On the cost side of the equation, the variation between Bucks County and Philadelphia County is 8%. That means for our Medicare members, the cost of providing care is 8% less for Bucks County members than it is for Philadelphia County members. The payment we receive for Bucks County members, however, is 18% less.

The unfortunate result is that our Bucks County members are forced to pay higher monthly premiums than their Philadelphia counterparts do. That is why in 2001, for identical products, Bucks County residents pay $59 per month compared to $0 per month for Philadelphia County members.

Historically, there has been some level of variation between those counties. However, with the changes and adjustments made by Congress to the Medicare+Choice program over the past several years, the variations have grown.

These payment issues are urgent to our members and to the future of IBC's ability to participate in the Medicare+Choice program. So where do we go from here?

First, **attention needs to be paid to the 2% funding limitations in place in many parts of the country.** Specifically, there are hundreds of counties, which have been kept at the 2% funding increase level since 1998. Our entire marketplace fits into that category. Unless there is relief provided, Medicare+Choice will be eliminated from this market within the next two years. Companies will be unable to support even the most basic Medicare benefits at the funding levels provided. We support the establishment of payment levels which are not lower than an established percent of a county's fee for service costs (e.g., Medicare+Choice payments will not be less than a specified percent of fee for service payments).

Second, **the disparity between urban and surrounding suburban counties needs to be remedied.** The 18% variation I mentioned earlier between Philadelphia and Bucks County payment levels is problematic when imposed on a health care system that is a regional enterprise. In all other lines of business, our pricing and costs are blended across the natural healthcare delivery marketplace. The funding approach currently in place for Medicare+Choice plans runs counter to marketplace conditions and establishes artificial pricing arrangements to the detriment of members in suburban counties. We strongly support a regional funding approach,

which accounts for the cost of providing care in the actual marketplaces (e.g., SMSA) in which Medicare+Choice plans operate.

Third, **the Philadelphia region enjoys a rich fabric of health care facilities, medical schools and training programs.** As such, this region has been disproportionately impacted by the elimination of graduate medical education from the Medicare+Choice rating structure. The initial intent in removing this category of expenditure was, we believe, to allow providers to recoup the costs of these educational programs costs directly from the Medicare program. Plans would then recoup, through negotiations with those facilities, the dollars lost in their federal reimbursement. This has not happened—neither here in the Philadelphia region nor in other parts of the country. This GME "take away" needs to be corrected.

Fourth, **HCFA's regulatory oversight is unnecessarily burdensome.** Since last fall, our company alone has undergone four audits, six surveys conducted by HCFA contractors, three biennial comprehensive site visits and responded to several hundred assorted HCFA inquiries. This is in addition to our transitioning our members to the 2001 level of benefits and premiums, which resulted in an unprecedented number of phone calls, enrollment transactions, and inquiries. We are fully appreciative of the oversight role HCFA is required to play, in fact we support that oversight function.

Much of the Medicare+Choice program is inextricably woven to the fee for service program. In fact, many of our requirements are based upon those in place in the fee for service program. Acknowledgment needs to be made that a managed care program is very different than a fee for service program. We strongly urge that the national managed care industry standards be acknowledged as viable approaches to achieving the needed beneficiary protections, quality outcomes, and provision of services beneficiaries deserve and should depend on. A one-size fits all approach has not and cannot work going forward.

Our concern is not with the what but rather the how and how much. Significant organizational energy is diverted to responding to the numerous, often overlapping regulatory requirements and requests. That energy would be better spent on educating and servicing our members.

In summary, I want to reiterate our company's strong commitment to and hope that we are able to continue with the Medicare+Choice program. We are fully cognizant that Medicare+Choice is not the answer for all beneficiaries. However, we strongly believe that a viable Medicare+Choice program provides significant value to the beneficiaries who have made that choice. It is a choice that needs to be maintained and extended to even more Medicare beneficiaries throughout this country.

Mr. GREENWOOD. Thank you very much, Mr. Haggett. And now for her testimony, Dr. Harmon-Weiss, I will remind the audience, who is the Head of Government Programs for Aetna U.S. Healthcare.

TESTIMONY OF SANDRA HARMON-WEISS

Ms. HARMON-WEISS. Thank you, Mr. Chairman and members of the committee. I am Dr. Sandra Harmon-Weiss, a family physician and geriatrician, working for Aetna as Head of Government Programs and Medicare Compliance Officer.

I am testifying today on behalf of Aetna. Aetna is the Nation's largest health benefits company and offers Medicare+Choice plans in five States, covering 278,000 Medicare beneficiaries. Aetna has offered a Medicare managed care plan in Pennsylvania since 1985. Currently, there are more than 100,000 Aetna Golden Medicare Plan enrollees in Pennsylvania and more than 15,500 enrollees in Bucks County, some of whom we heard from this morning. I am pleased to have served Medicare beneficiaries in Pennsylvania as a geriatrician and family physician in private practice, as well as in my role at Aetna since 1985, when the Medicare managed care plan began.

The Medicare+Choice program was created by the Balanced Budget Act of 1997, replacing the former Medicare Risk contracts. The Medicare+Choice program was adjusted with legislation in

1999, the Balanced Budget Refinement Act, BBRA, followed by BIPA in 2000, the Benefits Improvement and Protection Act. I want to share some of our principal concerns with the Medicare+Choice program in its current state.

Aetna is concerned about the low Medicare+Choice Organization payment rate increases, the limits on the annual increases in capitation rates to plans, even though approved by BIPA, continue to pose a threat to the continued success of Medicare+Choice program. Program rules must allow payment rates that recognize and adjust for the actual costs of providing healthcare and complying with the increased administrative burden stemming from BBA. The payment options of the blended capitation rate, minimum county rate, or the 2 percent increase in the AAPCC rates, despite the additional 1 percent for 10 months only in 2001 do not meet the current threshold of medical expenses in 2001, which are expected to increase approximately 10 percent from our viewpoint.

The practical result, based upon actual Medicare+Choice enrollment, is that the organizations serving the majority of the Medicare beneficiaries receive rate increases of 2 percent per year, with the exception as noted in 2001. Aetna suggests that the annual increases in Medicare+Choice payment rates be sufficient to cover medical inflation as experienced in local markets.

Aetna has concern about the risk adjuster impact. The risk adjuster impact was introduced in 2000. It reduces payments to Medicare+Choice Organizations. HCFA has released data on the risk adjuster impact on health plan payments with a phase-in of a 10 percent risk adjusted rate and 90 percent demographic rates. The net impact was a reduction of, approximately 1 percent in premium for health plans in 2000 and a reduction in payment for health plans in 2001 of 1 percent. The risk adjuster is based upon inpatient hospital encountered data projected on a model based in Medicare fee-for-service experience in 1995. This model is not reflective of the current managed care experience of providing access to the most appropriate care in the most appropriate setting.

The BBRA clearly noted in the report language in Section 511 the Congress intent that the risk adjuster be implemented in the budget neutral basis for 2000 and beyond. To date, HCFA has chosen to ignore the direction of Congress reflected in this report language. This takes medical benefits away from Medicare+Choice enrollees.

In my written testimony, I describe concerns about the requirements to collecting counter data on all beneficiaries in outpatient hospital settings and for physician-related services. I applaud the responsiveness of the Government to our concerns. On May 29, 2001, we received a letter from HHS Secretary Thompson, suspending collection of outpatient encounters and physician encounter data until July 2002. Secretary Thompson further promised to examine the risk adjustment methodology with interested parties to find a better system for this purpose. Aetna is extremely pleased with this positive move on the part of the Government to work collaboratively with the managed care industry.

The low payment rate increases for Montgomery for Medicare+Choice impact Medicare beneficiaries in Bucks County. In 1998, Aetna was able to offer a zero premium plan in south-

eastern Pennsylvania, which included a $5 co-pay for primary care physicians and for specialist visits. The comprehensive benefit package included pharmacy coverage of $1,800 in prescriptions with a nominal co-pay of $12 per script. Other benefits included eyewear coverage of $70, as well as a hearing aid allowance of $500—and those of you know, Medicare doesn't cover hearing aids, wellness programs for healthy eating, healthy breathing, and fitness.

Because of cutbacks in reimbursement attributable to BBA, including legislated user fees, and added regulatory burden over the past 3 years, Aetna has had to move in the opposite direction. Member premium has been introduced in Bucks County; currently, it is $50 per month. Primary care physician co-pays have risen to $10, and specialist co-pay visits have risen to $20 per visit. There is no pharmacy program available, except for discounts on prescription drugs of up to 40 percent off retail. Aetna can no longer offer eyewear reimbursement to those who need glasses or lenses.

The average rate of monthly HCFA capitation payment in Bucks County in 2001 is $554, a scant 3 percent greater than in 2000. This lags far behind the real medical inflation rate of, approximately, 10 percent.

Aetna has additional concerns about Medicare+Choice oversight, as you heard from my colleague. The current oversight infrastructure for Medicare+Choice plans by HCFA includes three separate HCFA centers, which often results in fragmented unnecessarily complex policymaking. Consolidating Medicare+Choice program administration within one HCFA division would go a long way toward improving partnerships between HCFA and the plans.

Aetna, last, strongly encourages repeal of the enrollment lock-in. BBA provided that beginning in 2002, beneficiaries are allowed to switch Medicare plans outside the annual enrollment period only one time per year. Previously, there were no limits on switching. Allowing beneficiaries to switch plans when they are dissatisfied allows market forces, rather than increased layers of regulation, to encourage Medicare+Choice Organizations to provide coverage for quality care and quality service. It also allows beneficiaries to continue with their chosen physician if their physician leaves the plan's network, thereby, impacting continuity of care.

In closing, Aetna believes that the opportunity exists now to create a regulatory framework that will assist Medicare+Choice in fulfilling its promise of preserving and expanding healthcare choices for all Medicare beneficiaries. If Congress is to make adjustments to the program, it really has to act now; time is wasting.

Thank you for the opportunity to appear today. I will be happy to answer questions.

[The prepared statement of Sandra Harmon-Weiss follows:]

PREPARED STATEMENT OF SANDRA HARMON-WEISS, HEAD OF GOVERNMENT PROGRAMS AND MEDICARE COMPLIANCE OFFICER, AETNA, INC.

Mr. Chairman and members of the Committee, I am Dr. Sandra Harmon-Weiss, a family physician and geriatrician working for Aetna, Inc. as Head of Government Programs and Medicare Compliance Officer. I am testifying today on behalf of Aetna.

Aetna is the nation's largest health benefits company and offers Medicare+Choice plans in 5 states, serving 278,000 Medicare beneficiaries. Aetna has offered a Medicare managed care plan in Pennsylvania since 1985. Currently, there are more than

100,000 Aetna Golden Medicare Plan enrollees in Pennsylvania and more than 15,500 enrollees in Bucks County. I am pleased that I have served Medicare beneficiaries in Pennsylvania as a geriatrician and family physician in private practice as well as in my role at Aetna since 1985 when the program of Medicare managed care began.

In March, 1999, I had the opportunity to testify before the House Ways and Means Subcommittee on Health on the implementation of the Medicare+Choice program. I am pleased to have this opportunity to discuss further the Medicare+Choice program and the developments in this program over the past two years. I want to share a few of our principle concerns. Aetna believes that the Medicare+Choice program represents an essential component of the government's effort to help ensure the financial survival of the Medicare program and to meet the health care needs of the baby boom generation as we move into the 21st century. However, our experience with Medicare+Choice up to the present suggests that Congress has additional work to guarantee a viable Medicare+Choice program. To ensure the promise of the reform in the Balanced Budget Act of 1997 (BBA), the Balanced Budget Refinement Act of 1999 (BBRA), and the Benefits Improvement and Protection Act of 2000 (BIPA), and to facilitate beneficiary choice under the Medicare program, additional legislation and policy modification must be made.

CONCERNS ABOUT LOW MEDICARE+CHOICE ORGANIZATION PAYMENT RATE INCREASES.

1. Limits on Annual Increases in Capitation Rates and Concerns Regarding the New Risk Adjustment Methodology Threaten the Continued Attractiveness of the Medicare+Choice Program to Beneficiaries and Providers.

a. Most Plans Have Experienced Cost Increases From Medical Inflation That Exceed Payment Increases During the Coming Year.—Perhaps the greatest threat to the success of the Medicare+Choice program is the collective impact of changes in Medicare's payment methodology enacted by the BBA. In order to achieve a successful partnership between the federal government and Medicare+Choice organizations, program rules must: (1) allow payment rates that recognize and adjust for the actual costs of covering quality health care services and complying with the increased administrative burdens imposed by the BBA, BBRA and BIPA, and permit necessary investment in clinical and operational improvements, and (2) incorporate financial incentives to reward those Medicare+Choice organizations that achieve the government's economic, quality and operational objectives.

As set forth in Section 1853(c) of the BBA, Medicare+Choice organizations will be paid the greater of:

(a) a blended capitation rate, which is the sum of a percentage of the area-specific capitation rate and a percentage of the national Medicare+Choice capitation rate (the percentage balance will change over time until it reaches a 50/50 blend in 2002); or

(b) a minimum amount, which is $475 per enrollee per month in 2001 (from BIPA); or

(c) a minimum percentage increase equal to an increase of 2 percent of the 1997 Adjusted Average Per Capita Cost (AAPCC) rate for the particular county for 1998, with increases of 2 percent in each subsequent year.

The practical result, based on actual Medicare+Choice enrollment, is that Medicare+Choice organizations serving a majority of Medicare beneficiaries enrolled in such organizations receive rate increase of the minimum 2 percent. For most, if not all, of these organizations, this 2 percent increase is not sufficient to cover the increased cost of covering basic Medicare and additional services, given projected medical inflation.[1] This, combined with the fact that many Medicare+Choice organizations experienced significant losses in 1998, 1999 and 2000, forecasts continuing trouble for the program.

Indeed, inadequate reimbursement rates for 1999, 2000 and for 2001 largely were responsible for the retrenchment of Medicare+Choice plans over the past three years. Congress passed the BIPA legislation in 2000 which added 1% to the payment rates for 10 months of 2001. Most health plans (70%) used this money to ensure or stabilize access to services for beneficiaries by paying additional money to contracted providers for this purpose.

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[1]The budget for fiscal year 2000 included funding for original fee-for-service Medicare that reflects anticipated increases in medical costs over a five year period of 27% and an increase in the Federal Employee Health Benefit Program of about 50%. Estimates of the likely growth for Medicare+Choice plan payments in high paying counties for the same period is less than 10%.

Since Medicare+Choice began in 1999, numerous health plans have terminated or reduced their contracts. Of 309 Medicare+Choice plans serving Medicare beneficiaries at the end of 1999, 99 plans terminated their contracts or reduced the number of counties they served in 2000 and 118 plans terminated or reduced service areas for the 2001 contract year. These withdrawals affected approximately 328,000 enrollees in 2000 and nearly 1 million enrollees in 2001.[2] These withdrawals can mean higher out-of-pocket costs and be disruptive for those beneficiaries who lost access to relatively inexpensive drug benefits or must switch health care providers. To put this into perspective, HCFA averaged two Medicare risk contract cancellations per year from 1993 through 1997.

Aetna strongly believes that additional adjustments beyond BIPA are necessary to attract and maintain the number and diversity of Medicare+Choice organizations necessary to establish a sound and attractive market-based alternative to the traditional Medicare fee-for-service program.

Accordingly, Aetna urges Congress to reconsider the artificial and arbitrary limits on capitation rate increases set forth in the BBA and BIPA. Specifically, Aetna suggests that annual increases in Medicare+Choice payment rates be sufficient to fully cover medical inflation experienced in the local markets. Because local employer health plans and other commercial customers have a tremendous incentive to keep costs down, they will positively affect the inflation rate in each market. Under the current structure, more Medicare+Choice organizations have found it necessary to withdraw from areas served and beneficiaries enrolled in the remaining plans will again experience premium increases or reduced benefits. Finally, as Medicare+Choice plans leave the market, the original Medicare program (with its higher per capita costs) will have more beneficiaries and put additional strain on both the Part A Trust Fund and the budget.

b. The New Risk Adjustment Methodology Will Substantially Reduce Payments to Medicare+Choice Organizations.—Change in the Medicare+Choice payment methodology is all the more necessary because the risk adjustment process which HCFA is implementing will substantially reduce aggregate payments to Medicare+Choice plans while adding additional administrative requirements and expenses. According to HCFA estimates, total Medicare+Choice revenues for the year 2000 were $200 million less than they would have been under the Average Adjusted Per Capita Cost (AAPCC) payment method. As a result, most plans saw even their minimum two percent increase eroded in 2000 as the risk adjustment methodology was phased in. Thus, what began as a well-intended effort to compensate plans for the health care costs of their particular members did, in reality, result in an overall reduction in funds to Medicare+Choice organizations.

This development runs counter to Aetna's understanding of Congressional intent, i.e., that the savings resulting from the percentage reduction in plan payments for years 1998 through 2002 was intended to be in lieu of any net program savings from risk adjustment. (Indeed, the Congressional Budget Office did not score any projected savings in connection with the risk adjustment program under BBA 97). The new methodology, and huge projected revenue reductions, underscores Aetna's concerns regarding the inadequacy of plan payments under Medicare+Choice. To the extent that the proposed HCFA risk adjustment methodology translates into a significant overall decrease in payments for the Medicare+Choice program, it is an additional deterrent to program participation. Accordingly, Aetna urges Congress to require HCFA to modify the risk adjustment methodology so that aggregate payments to Medicare+Choice plans for 2000 and beyond are based on aggregate BBA adjustments, making the risk adjustment process budget neutral.

c. The User-Fee "Tax" on Medicare+Choice Organizations for Beneficiary Education is Inequitable and Reduces Even Further Payments to Medicare+Choice Organizations.[3]—Aetna strongly supports educating and informing Medicare beneficiaries about all coverage options, including the Medicare+Choice program, and supplying beneficiaries with straightforward, unbiased information to help them choose appropriate coverage. That said, we are concerned that the BBA, to support beneficiary education activities for all 37 million beneficiaries, placed a "user fee tax" on Medicare+Choice organizations only. The educational campaign is a benefit to all Medicare beneficiaries. Indeed, initial information suggests that the toll-free number HCFA established in 1999 with funds from the $95 million dollar "tax" assessed upon Medicare+Choice organizations primarily fielded calls from beneficiaries seeking information about the fee-for-service program. Considerations of eq-

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[2] Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings (GAO/HEHS-00-183), September 2000.

[3] Medicare+Choice organizations essentially pay a "head tax" (i.e., an amount based on the number of Medicare+Choice enrollees in their plan) to support the public information program.

uity dictate that the educational program which informs beneficiaries about basic program benefits and requirements be funded from the Medicare Trust Fund, or another broad-based source of revenue, as are other such essential program functions.

This "user fee tax" equaled .355% of the total monthly payments to each Medicare+Choice plan in 1999 and .34% in 2000. While BBRA reduced the "user fee tax", it remains a factor in the erosion of monthly payments to Medicare+Choice organizations.

d. The Bucks County Experience and the Pennsylvania Experience.—Aetna examined the type of coverage we provided previously to Medicare beneficiaries. As recently as four years ago (1998), Aetna was able to offer a "Zero Premium" plan in Southeastern Pennsylvania which included a $5 copay for Primary Care Physician and Specialist visits. The comprehensive benefit package included pharmacy coverage for $1800 in prescriptions with a nominal copay of $12. Eyewear coverage of $70 was included as well as a $500 hearing aid allowance (not covered by Original fee-for-service Medicare) and Wellness Programs for Healthy Eating, Healthy Breathing and Fitness (not covered by Original fee-for-service Medicare). This was a great plan for more than 14,400 seniors and disabled Medicare beneficiaries in Bucks County.

Because of cutbacks in reimbursement attributable to the Balanced Budget Act of 1997 (BBA) and new legislated fees on Medicare+Choice organizations and added regulatory burdens over the past three years, Aetna has had to move in the opposite direction. Aetna has been forced to introduce premium in Bucks County ($50 per month), raise Primary Care Physician copays to $10 and Specialist copays to $20. There is no pharmacy program available except for discounts on prescription drugs of up to 40% off retail. Aetna no longer can offer eyewear reimbursement to those who need glasses or lenses. As such, the Aetna Golden Medicare Plan™ is less attractive to Medicare beneficiaries and the enrollment has dropped by 500 over the past year.

Aetna has been forced to withdraw from certain areas in Pennsylvania. The counties where we withdrew were those where our medical expenses, not even counting administrative expenses, exceeded the reimbursement provided to us by the Health Care Financing Administration (HCFA) and where we determined that we could not offer a plan with sufficient benefits at a competitive price. No Medicare+Choice organization, or any company in any sector of the economy for that matter, can keep doing business as usual when there is not enough revenue even to start covering administrative expenses. In the areas where we have remained, we had to increase premiums and reduce benefits in order to try to cover those basic medical and administrative costs. We do not make these changes lightly, nor do we make them without the involvement and approval of HCFA.

It is a useful exercise to examine more closely the monthly HCFA premium in Bucks County for 2000 and 2001 for each Medicare beneficiary enrolled in Aetna. The chart below outlines the HCFA premium payment rates on a per member per month basis. Following the multiple adjustments to the rates, the final average rate of monthly payment in Bucks County for 2001 is $554, a scant 3% greater than in 2000. This lags far behind the real inflation percentage reflecting the true medical trend which is approximately 10%. From 2000 to 2001, it was necessary for Aetna to raise the member premium in Bucks County from $10 to $50, raise co-payments for Primary Care Physician visits (from $5 to $10) raise co-payments for Specialist visits (from $10 to $20) and eliminate the pharmacy benefit (except for discounts on each covered prescription). This benefit package remains more valuable than an equivalent Medicare with Medigap coverage package. The Medicare with Medigap coverage includes fewer benefits with higher premiums.

Bucks County—HCFA Premium Per Member Per Month

	2000 Jan-Dec	2001 Jan-Feb	2001 March-Dec
Published HFCA monthly payment rates	611	623	629
Aetna monthly payment rates as a result of demographic adjustments (age, sex)	544	554	560
Aetna monthly payment rates as a result of Risk Adjustment	539	548	554
Aetna monthly payment rates as a result of "user tax."	537	548*	554*

*Assessment of user fee is less than $1 per month ($0.42) as a result of new methodology.

One of the important changes in HR 3075 (the Balanced Budget Refinement Act of 1999 "BBRA") was a change that could lead to lower premiums and better benefits for seniors. In the report language to Section 511, it clearly notes that Congress intends the risk adjuster to be implemented in a budget-neutral fashion; that is,

that money taken away from plans with younger, healthier populations be kept within the Medicare+Choice program and be channeled directly to plans with older, sicker populations. The language goes on to urge HCFA to revise the risk adjuster to implement it on a budget-neutral basis in 2000 and beyond. HCFA has, to date, chosen to ignore the clear direction of Congress reflected in this report language, thereby, taking medical benefits away from Medicare+Choice enrollees.

IN MANY PLACES THE REGULATIONS ARE OVERLY RIGID AND DEMANDING SO THEY BECOME AN IMPEDIMENT TO ALL MEDICARE+CHOICE ORGANIZATIONS.

1. The Proposed Risk Adjustment Policy is Ill-conceived.

On March 1, 1999, HCFA reported to Congress on its methodology for implementing the risk adjustment mandate set forth in BBA. While Aetna believes that improved risk adjustment is an appropriate and essential long-term goal for the program, we have serious concerns regarding the current HCFA proposal, which calls for the initial use of only inpatient hospital data. During the Administration's proposed phase-in period, plans would receive capitated payments based on a blend of payment amounts under the current demographic system and the interim (PIP-DCG) risk adjustment methodology. For the year 2000, for instance, the HCFA plan included separate capitated payment rates for each enrollee based 90% on the demographic method and 10% on the risk adjustment methodology.

By 2004, payment rates would be 30% based on comprehensive risk adjustment using full (i.e., inpatient and other) encounter data and 70% on the demographic method. By 2007, payment rates would be based solely on comprehensive risk adjustment from encounter-based data with no demographic adjustments. HCFA estimates a much greater negative impact on Medicare+Choice plan revenues, on average, with the switch to full encounter data risk adjusters. Aetna's concerns are both practical and programmatic.

First, the practical. The timeframe for implementation outlined by HCFA is simply far too short. Given the significant technological considerations involved, it is unreasonable for the agency to require that all Medicare+Choice organizations be able to provide physician, outpatient hospital, skilled nursing facility and home health data beginning as early as October 1, 2000. The collection, verification, transmission, acceptance and analysis of "representative" encounter data is a complicated endeavor. Capturing these data in a valid, accurate and transferable manner is a major challenge for M+C organizations.

The process by which information is communicated to, and received by, HCFA presents significant technological problems as well. Aetna has experienced, and continues to experience, problems in ensuring that accurate inpatient hospital data is transmitted via Medicare fiscal intermediaries to HCFA. Long delays in uploading information into the Common Working File, poorly responsive fiscal intermediary contractors, technical difficulties because of using a system meant to pay fee-for-service claims to collect HMO data, all have added enormous expense and resource consumption to Medicare+Choice plans.

Difficulties have occurred as HCFA attempts to manipulate significant amounts of data for the PIP-DCG risk adjustment model. The methodology developed by HCFA is complicated and requires numerous steps. HCFA faces a monumental task in getting the PIP-DCG system to work. To date, HCFA is unable to accept all inpatient encounters for current Medicare+Choice enrollees.

As if all this were not reason enough to delay implementation, Aetna has significant programmatic concerns regarding the proposed risk adjustment model. First, Aetna is concerned that variations resulting from excessive payments under the original Medicare fee-for-service program have been incorporated into the risk adjustment calculation. Additional, unnecessary hospitalizations that have occurred within the original Medicare Part A fee-for-service program, despite HCFA's attempt to fight this, are still significant. As a result, Medicare+Choice organizations will receive lower payments through the proposed risk adjustment methodology. HCFA should not penalize the managed care portion of Medicare for the program's failure to limit certain false or fraudulent claims and medically unnecessary hospitalizations. One approach to avoid this would be to limit the use of risk adjustment so that the total amount paid to all Medicare+Choice plans is not reduced but instead redistributed among Medicare+Choice plans only.

Second, recognizing the fact that most federal agencies rely on sampling, HCFA's expectation of reported data on all individuals seems excessive. Given that even the more comprehensive risk adjuster will not be able to fully reflect all differences, Aetna believes that Congress should require HCFA to re-examine the use of plan-based sampling to reduce the administrative burden on the plans, reduce the poten-

tial for errors in the early phases, and increase the privacy of each individual's sensitive medical information.

Third, Aetna strongly believes that is poor public policy to base risk adjustment, even temporarily, on inpatient hospital data only. Such an approach rewards Medicare+Choice plans that, through inferior utilization management or poorer quality, experience excessive hospital use, and penalizes plans that have more effectively reduced inpatient hospitalizations and focused on providing more care on an outpatient basis and improving quality through preventive care. The incentives created by a risk adjustment methodology based exclusively on inpatient hospital data would inevitably result in increased inappropriate hospital use, increased avoidable costs, and a setback in the effort to realize greater efficiency and quality in the health care system. Beneficiaries enrolled in plans with a relatively high proportion of members who receive care for expensive chronic illnesses outside the hospital setting would be particularly harmed.

For all these reasons, Aetna urges HCFA to consider less burdensome alternatives that meet the goals of risk adjustment.

2. Improve Partnerships Between HCFA and Medicare+Choice Organizations by Establishing Single Administrative Unit for Medicare+Choice Program Oversight.

Aetna recognizes that HCFA has many competing demands and responsibilities. However, the current oversight infrastructure for Medicare+Choice which involves three separate centers has often resulted in fragmented and unnecessarily complex policy making which has been problematic for Medicare+Choice organizations and beneficiaries. We believe that consolidating Medicare+Choice program administration within one HCFA division, which has a Director who reports directly to the HCFA Administrator, would go a long way toward improving the partnerships between HCFA and plans.

3. Create Consistency Between HCFA Central and Regional Offices.

Medicare+Choice organizations across the country frequently receive different instructions and policy interpretations for the ten HCFA Regional Offices and the HCFA Central Office. This has a large impact on national plans such as Aetna with Medicare+Choice organizations overseen by three HCFA Regional Offices. HCFA Regional Office Administrators and HCFA Center Directors report directly to the HCFA Administrator with no direct authority on the part of the Centers to require consistent implementation of Central Office policies in the Regions. HCFA should establish communication procedures to help ensure that the Agency and its regional offices speak with one voice.

4. Set Priorities for Policy Making Based on the Costs and Benefits of Different Regulatory Options.

The costs of compliance are opportunity costs borne directly by Medicare beneficiaries. For every dollar Medicare+Choice organizations spend on regulatory compliance, there is one dollar less to spend on enrollee benefits. Adding or changing program regulations should be considered in this context. Also, periodic assessments should be made to ensure that the benefits of compliance requirements exceed their costs.

The frequency and content of new regulatory and policy changes has increased staff time and resources considerably. In 2000, HCFA issued 15 new Operational Policy Letters (OPLs) two revisions of one OPL, and the final Medicare+Choice regulations. Inconsistencies between HCFA Regional Offices and Central HCFA add to the strain of regulatory interpretation, particularly for national health care organizations such as Aetna.

5. Improve the HCFA Review of Marketing Materials.

The new marketing and member communication requirements, particularly the 45-day review period, make it very difficult to get materials finalized in a timely manner. This can prove particularly problematic for employer group marketing materials. The 45-day period has had a particular impact on our ability to communicate product changes with our members in a timely manner, often leading to confusion for those who hear about changes in media reports, but then fail to receive notice until much later. In some markets, we hear from the reviewers that they do not plan to comment on the materials until the end of the review period. If they ask for changes on day 44, the 45-day review period begins all over again. Moreover, the prescriptive nature of the review often requires the materials to be very generic, taking away our ability to make statements reflecting our unique attributes.

6. Repeal the Enrollment Lock-In.

Congress should immediately repeal the enrollment lock-in provision of the Balanced Budget Act of 1997.

BBA provided that, beginning in 2002, beneficiaries are allowed to switch Medicare plans outside the annual enrollment period only one time per year. Previously, there were no limits on switching.

Allowing beneficiaries to switch plans when they are dissatisfied allows market forces, rather than increasing layers of regulation, to encourage Medicare+Choice organizations to provide coverage for quality care and quality service. It also allows beneficiaries to continue with their chosen physician if their physician leaves the plan's network, thereby impacting continuity of care.

Enrollment rules in the Medicare+Choice program are extremely complex. HCFA's regulatory guidance exceeds 100 pages! Adding lock-in rules to the current rules will significantly increase the confusion of beneficiaries, beneficiary advocates and the Medicare+Choice organizations. It will, without doubt, result in unhappy beneficiaries, pressure for more and more "special enrollment" opportunities, an even more complex and bizarre set of enrollment rules. In addition, implementing the enrollment lock-in will require both Medicare+Choice organizations and HCFA to make system changes and adopt costly and burdensome new administrative procedures, all for little or no gains in enrollee well-being or Medicare+Choice program functioning.

SUMMARY AND CONCLUSIONS

If the Medicare program is to be sustained for the next generation of beneficiaries and beyond, it is crucial that the federal government employ every strategy appropriate to enhance quality health care options for beneficiaries and encourage the development of lower cost options rather than relying on burdensome regulations which will reduce choice and funnel more people into the highest cost option, fee-for-service Medicare. The Medicare+Choice program already is at a crossroad where improvements can allow it to flourish but neglect of necessary change will doom it to failure. It would be wiser, in the long run, for the government to employ market-oriented strategies to ensure that there are Medicare+Choice options available to beneficiaries and to create incentives for private health insurers and providers to deliver value in the context of the Medicare program. Because it is a critical building block in this market-based strategy, Medicare+Choice must be successful.

In summary, Aetna believes that the prospect for success will be greatly improved if the following steps are taken with respect tot he Medicare+Choice program:

- Adjust the payment structure so that increases cover medical inflation;
- Delay and revise the proposed risk adjustment model to reduce the cost of reporting and system development;
- Modify the role of risk adjustment so that overall revenues to the Medicare+Choice program are not reduced, but simply reallocated among Medicare+Choice plans based on the health status of enrollees;
- Issue revised regulations to reduce costly administrative burdens on all Medicare+Choice plans;
- Streamline the HCFA oversight on Medicare+Choice organizations; and
- Repeal the enrollment lock-in.

The opportunity exists now to create a new regulatory framework that will assist Medicare+Choice in fulfilling its promise of preserving and expanding health care choices for all Medicare beneficiaries. If Congress is to make adjustments to the program, it should act now.

Mr. GREENWOOD. Thank you for your testimony. We now turn to Dr. Harrison. For those in the audience, let me explain who he is, because it may be a little confusing. Several years ago, 3 or 4 years ago, the Congress created MedPAC, which is the Medicare Payment Advisory Commission. It is a group of experts that we rely upon to study the cost of Medicare and the policies involved and give us, the Congress, some advice as to what is the best policy. And we are delighted to have you with us, Dr. Harris.

TESTIMONY OF SCOTT C. HARRISON

Mr. HARRISON. Thank you, Chairman Greenwood, Congressman Deutsch. I am Scott Harrison, Research Director at MedPAC. I am

pleased to be here this morning to discuss the Medicare+Choice program. My testimony draws on the recommendations and analysis in MedPAC's march 2001 report to Congress.

MedPAC is concerned about the sometimes large differences in payment to Medicare+Choice plans between adjacent counties within healthcare markets. The situation here in the Philadelphia Metropolitan area is a good example of local county payment rate differences. In Pennsylvania's five-county area, the highest county payment rate is about $200 per month higher than the lowest rate. Many of the residents of the lower rate suburban counties, as you have heard today, are concerned about having to pay an extra $700 a year for a plan compared to their follow beneficiaries across the county line in Philadelphia.

These payment rate differences arise from differences in Medicare per-beneficiary spending under the traditional fee-for-service Medicare program. In our March report, we recommended that the Secretary of Health and Human Services study the differences in spending under the traditional Medicare program to determine its causes and to make recommendations on how and whether the differences should be incorporated into Medicare fee-for-service and Medicare+Choice payment rates.

Also in the report, we recommended that the Secretary consider using payment areas with more Medicare beneficiaries than are typically found in counties in order to raise the reliability of the spending data on which the payment rates are calculated. However, the Commission did not feel it was ready to recommend using metropolitan areas, specifically, because of concerns that such areas might be too large to represent homogenous healthcare markets. Instead, MedPAC is interested in seeing the results of ongoing work dedicated to finding better criteria to delineate healthcare market areas.

Despite all of the recent changes to the Medicare+Choice rate-setting formula, the percentage differences in the payment rates among Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties remain as they were in 1997. All five counties have received the annual minimum update since then, and thus, the relative payments have not changed.

While there is a lot that MedPAC does not know about the reasons why Philadelphia rates are least 19 percent higher than the rates of most of the suburban counties, some factors are known. Between $35 and $55 of the difference in rates can be traced back to the higher spending for graduate medical education related to stays in Philadelphia teaching hospitals. Half of these differences will be removed as counties move to blended rates, but the removal may yet take several years, as none of the counties have received blended rates yet. Another factor that partially explains why Philadelphia has higher spending is its health risks, according to the risk adjustment model that HCFA uses. If that risk adjustment model were fully implemented, the payment rate differences between Philadelphia and the rest of the area would shrink by $45 to $75 per month.

And what effect do the higher payments in Philadelphia have? Clearly, there are differences in plan availability and benefit packages between Philadelphia and the suburban counties. There are

seven plans available in Philadelphia and only three plans available in most of the other counties. In Philadelphia, there are several plans that do not charge a premium, including some that cover prescription drugs. The lowest premium charged by a plan in Bucks County is $50 per month, and the only basic plan that offers prescription drug coverage there charges a premium of $114 a month.

However, the differences are not always consistent. Of the three plans operating in Bucks County, all have the same benefits across the county lines. One plan, actually, does charge the same premium in Bucks and Philadelphia, and the other two charge, as you have heard, $50 and $59, respectively, in Bucks, while not charging anything in Philadelphia.

MedPAC has recommended that Medicare+Choice payment rates be set equal to fee-for-service spending in the local market. The best way to define these local markets, however, awaits further research. If local interest felt that the local rate differences were not appropriate, they could petition their State's Governor, who has the power under current Medicare law to redefine payment areas. Allowed options include a single statewide payment area and a metropolitan based system where each metropolitan area would be a separate payment area, and all rural counties in the State would be grouped together in one payment area.

Any redefinition, however, must be budget-neutral across the State as a whole. Now, if we took, as an example—if the five-county area had been designated as a single payment area for 2001, the rate would have been about $670 per month. That would have meant an increase of about $100 per month for Chester and Montgomery Counties, an increase of about $25 to $40 for Delaware and Bucks Counties, and about $100 decrease for Philadelphia. So you have your work cut out for you.

Thank you, and I look forward to your questions.

[The prepared statement of Scott C. Harrison follows:]

PREPARED STATEMENT OF SCOTT C. HARRISON, RESEARCH DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

Chairman Greenwood, members of the Subcommittee. I am Scott Harrison, research director for Medicare+Choice issues at the Medicare Payment Advisory Commission (MedPAC). I am pleased to be here this morning to discuss the Medicare+Choice (M+C) program. My testimony draws on the recommendations and analysis in MedPAC's March 2001 report to the Congress.

MedPAC is concerned about the sometimes large differences in payments to Medicare+Choice plans between adjacent counties within healthcare markets. The situation here in the Philadelphia metropolitan area is a good example of local county payment rate differences. In Pennsylvania's five-county metropolitan area including Philadelphia, the highest county Medicare+Choice payment rate is $200 per month higher than the lowest rate. Many of the residents of the lower-rate suburban counties are upset at having to pay an extra $700 a year for a plan compared with their fellow beneficiaries across the county line in Philadelphia.

These payment rate differences were created by differences in the Medicare per-beneficiary spending on behalf of county residents in the traditional fee-for-service Medicare program. MedPAC, in our March 2001 Report to the Congress, recommended that the Secretary of Health and Human Services study the variation in spending under the traditional Medicare program to determine how much is caused by differences in input prices and health risk and how much is caused by differences in provider practice patterns, the availability of providers and services, and beneficiary preferences. He should report to the congress and make recommendations on whether and how the differences in use and preferences should be incorporated into Medicare fee-for-service payments and Medicare+Choice pay-

ment rates.Also in the Report to Congress, the Commission recommended that the Secretary consider using payment areas that contained larger numbers of Medicare beneficiaries than are typically found within counties to raise the reliability of the spending data. However, the Commission did not feel it was ready to recommend using metropolitan areas specifically because of concerns that such areas might be too large to represent homogenous healthcare markets. Instead, MedPAC is interested in seeing the results of ongoing work dedicated to finding better criteria to delineate healthcare market areas.

Setting Medicare+Choice payment rates

Before the Balanced Budget Act of 1997 (BBA), county payment rates (per beneficiary per month) were based on the fee-for-service (FFS) costs of Medicare beneficiaries in that county. The BBA established a new payment method, under which the county Medicare Choice(M+C) rate is the maximum of:

- a floor rate
- a minimum update applied to the previous year's rate
- a blended rate

The **floor rate** was set at $367 for 1998 and is increased by an update factor based on the projected growth in Medicare expenditures per capita each year thereafter. As a result, the floor payment was $380 in 1999 and $402 in 2000. The Medicare, Medicaid, and SCHIP Benefit Improvement and Protection Act of 2000 (BIPA) raised the floor rate to $475 for 2001, and established a new floor rate of $525 for counties in Metropolitan Statistical Areas (MSAs) with a population greater than 250,000. The **minimum update** is 2 percent, with BIPA adding a one-time increase to 3 percent for 2001. The **blended rate** combines a national rate and the local rate. (The local rate is the 1997 payment rate trended forward by a national update factor.) The intent of blending was to reduce the variation in payments across the country by lowering the highest rates (subject to the minimum update) and increasing the lowest rates. Blended rates are being phased in over six years. In 1998, the blend was 10 percent national and 90 percent local. As of 2003 and thereafter, the blend is 50-50 national and local. The actual computation of blended rates is complicated by several factors and the application of those rates is limited by a budget-neutrality provision. The provision limits total payments in the M+C program to what total spending would have been if county payments were based on strictly local rates. Because the floor payment rate and the minimum update percentage are set in law, total projected payments may nonetheless equal or exceed the budget neutrality limit. When this happens all counties either receive the new floor rate or last year's rate raised by the minimum update and no county receives a blended rate. The budget neutrality provision resulted in no blended rates being applied in 1998, 1999, and 2001. Other factors that complicate the blend calculation are:

- The graduate medical education (GME) adjustment. Local rates are decreased by a percentage of 1997 GME spending beginning with 20 percent in 1998 and increasing by 20 percent a year to 100 percent by 2002. (Teaching hospitals will be paid separately for the teaching costs associated with M+C admissions).
- The update factor. Local rates for each year are calculated by multiplying the previous year's local rate and the update factor mentioned above. The BBA decreased the update factor by 0.008 in 1998 and by 0.005 from 1999 to 2002. The Balanced Budget Refinement Act (BBRA) changed the reduction to 0.003 for 2002.

The national rate is the average of the local rates weighted by the number of Medicare beneficiaries in each county. According to the phase-in schedule, that national rate is input-price adjusted and blended with the local rates to come up with the blended rate per county. If the budget neutrality provision permits, that rate becomes the blended rate per county that is then compared with the floor rate and minimum update to determine the actual county M+C payment rate.

Differences in payments across the five-county-area

Despite all of the changes to the Medicare+Choice rate-setting formula, the percentage differences in the payment rates among Bucks, Chester, Delaware, Montgomery, and Philadelphia counties (as high as 36 percent) remain as they were before the Balanced Budget Act of 1997 created the Medicare+Choice program. All five counties have received the annual minimum updates of 2 percent (3 percent in 2001), thus relative payments have not changed. None of these counties have yet received a blended rate update because their local rate components are above the national rate components that would be used for the blend.

While there is a lot that MedPAC does not know about the reasons why the Philadelphia rates are at least 19 percent higher than the rates of the suburban counties, some factors are known. Between $35 and $55 of the difference in rates can be

traced back to the higher spending for graduate medical education related to stays in Philadelphia teaching hospitals. Half of these differences will be removed as counties move to blended rates, but the removal may yet take several more years. Similarly, some of the difference may reflect higher disproportionate share (DSH) payments to Philadelphia hospitals, which are more likely than suburban hospitals to get those payments for treating low income patients.

The special teaching and disproportionate share payments to hospitals follow the patients who use the hospitals. Because beneficiaries are most likely to use hospitals in their counties of residence, counties that have these facilities are more likely to have higher spending associated with the special hospital payments. For example, MedPAC staff found that residents of Philadelphia overwhelmingly went to Philadelphia hospitals. Medicare beneficiaries who live in Levittown, however, went to Philadelphia hospitals only about 10 percent of the time.

The health risk of the Medicare population is another factor that partially explains why Philadelphia has higher per capita spending than its suburbs. According to the risk-adjustment model that HCFA uses to adjust payments to Medicare+Choice plans, the per capita Medicare spending in Philadelphia would be expected to be 10%-13% higher than in the suburban counties because the Medicare beneficiaries in Philadelphia tend to have greater health risk.

What effect do the higher payments in Philadelphia have?

Clearly there are differences in plan availability and benefit packages between Philadelphia and the suburban counties. There are seven M+C HMO plans available in Philadelphia, and only three HMO plans available in most of the other counties. In Philadelphia, there are several plans that do not charge a premium (in addition to the standard Part B Medicare premium), including some that cover prescription drugs. The lowest additional premium charged by a plan in Bucks County is $50 per month, and the only plan that offers prescription drug coverage there charges a premium of $114 per month.

However, the differences are not always consistent. Of the three plans operating in Bucks County, two have exactly the same benefits and premium that are offered in Philadelphia, even though the plans receive $140 less per month in Bucks County. The third plan charges no premium in Philadelphia and a $59 premium in Bucks County.

If the plans did not face different costs in the different counties in relation to the payment rates they receive from the Medicare program, how could they afford to offer the same benefits for the same price? One way is for the plan to set the price higher in Philadelphia so that the higher profits there would offset lower profits (or losses) in the suburban counties. Another way is for the plan to become more efficient in managing the benefit by serving a larger number of beneficiaries than it could attract if it were only in Philadelphia. Or, the plan may simply view the entire five-county area as one market instead of five.

MedPAC staff briefly examined the Medigap market in the five-county area and found that the insurers generally charged the same rates across all five counties. This suggests that they viewed the area as one market with similar costs. One should remember, however, that Medigap insurers are not responsible for the special payments associated with teaching and DSH hospitals because they only pay the standard hospital deductible, not the DRG payments made by the Medicare program.

Options

MedPAC has recommended that Medicare+Choice payment rates be set equal to the expected Medicare fee-for-service per capita spending in the local market. The best way to define local markets, however, awaits further research. State governors may redefine payment areas in the state under a provision of the BBA. Allowed options include a single statewide Medicare+Choice payment area, and a metropolitan-based system where each Metropolitan Statistical Area is a separate payment area and all rural counties are grouped as one payment area. Any redefinition must be budget-neutral across the state as a whole. If the five-county area had been designated as a single payment area for 2001, the rate would have been about $670 per month. That would have meant an increase of about $100 per month for Chester and Montgomery counties, an increase of about $25-$40 for Delaware and Bucks counties, and about a $100 decrease for Philadelphia.

Mr. GREENWOOD. Thank you very much for your testimony.

The Chair recognizes himself for 5 minutes for questions. And let me turn my first question to Ms. Berek from the Health Care Financing Administration. We have heard from Mr. Haggett of Inde-

pendence Blue Cross that yes, it is more expensive to provide healthcare to Philadelphians. They tend to be less healthy than the beautifully robust healthy people that we have here in Bucks County. They tend to demand more healthcare, and that healthcare is more expensive per unit, the doctors charge more, the hospitals charge more, the home health services providers more. What he tells us, though, is that the difference is 8 percent, that it costs on average 8 percent more to provide healthcare to someone from Philadelphia than it does from Bucks County. Yet, the payments to Philadelphia are 18 percent more rather than 8 percent more. I am not blaming HCFA for that because Congress, essentially, locked that formula in, and you haven't had time to adjust it.

My question is isn't the theory of adjusting these payments, having a different payment for different counties around the country, supposed to result in, basically, no apparent difference to the beneficiaries. Isn't it the case the beneficiaries should all, basically, be, in a region like ours, ideally, and in theory, should be getting the same benefits, the same prescription drug benefits, for instance, paying the same premiums. The only difference is that we would—that Medicare would pay insurance companies a little bit more to make up the difference in providing those benefits. Isn't that the way this thing is supposed to work?

Ms. BEREK. That is the theory of the original formula for calculating the AAPCC. I mean, that was what it was supposed to bring us in terms of information. That, at this point, is a 1997 number, and we are in the process, and I know June is only tomorrow, but we hope early in the month of June to have definitive data on what 1998 and 1999 information would be for calculating what the actual costs were. Now, again, that is still formula driven and it is not going to be perfect, but we will have more current numbers.

Mr. GREENWOOD. Is that nationwide, you are doing that?

Ms. BEREK. Nationwide, yes. We are about to—one of the things that was asked for in BIPA was that we recalculate those numbers, and we are a little bit behind schedule.

Mr. GREENWOOD. And when do you expect to have those calculations completed?

Ms. BEREK. In briefing me for this hearing, I was, actually, told that they might be able to tell them to me yesterday, and my answer was, if they are not public, don't tell them to me. But my guess is they will be public sometime next week, or at the latest, the week after. And I think that will help us look at the question.

The other thing which HCFA doesn't calculate and look at is the difference in the actual structure of the healthcare system in a locality, which is the difference in a managed care plan's ability to negotiate rates. And depending on how competitive the marketplace is, the managed care plan can or cannot negotiate discounts and rates, and depending on their penetration in the market. And our formulas don't account for that at all, and that is one of the variables which—and I can't speak to this region, but I know if the New York Metropolitan area, which has similar problems between the urban center, Richmond, as was on the chart, and Nassau, Suffolk, and Westchester, which are suburban, it has exactly the same rate problems. And a lot of that is based on the ability to negotiate

rates and market penetration in terms of not just cost. So I think those are the two factors.

Mr. GREENWOOD. Thank you. I want to address another question, and I am going to ask our other three witnesses to respond to this. There are a couple of ways we can fix this problem. One of them is to update the formula, and we just heard that we are going to have new calculations on the average area per capita cost, and if Congress wanted to, Congress could go back to that system and we would probably get the 8 percent variation between Bucks and Philadelphia instead of the 18 percent, and we would have an equalization in benefits and premiums throughout the region, which would be good.

There is another way to go about this. And the reason it has been suggested is because what we really want to guarantee is we want to guarantee the availability of Medicare+Choice managed care Medicare throughout the country, and we want to make sure that the payments to the companies are sufficient so that the beneficiaries can go back to the good old days of just a few years ago where they had really excellent coverage at really low premiums, or no premiums, and were very happy there.

The way that has been suggested, one way has been suggested to do that, is instead of using these very complex formulae, where you have to gather all this data and hope that it is accurate, and then make a different calculation for every county, is as was suggested under the Breaux-Frist proposal, would basically be say to the companies, you come in and bid on these plans. What do you need in terms of premiums in order to provide benefits, and we are going to have several companies come in and compete against each other, and then Medicare will, essentially, decide what is the best deal, and then pay the premium based on that competitive bidding as opposed to this formula.

Could each, Mr. Haggett, Dr. Harmon-Weiss, and Dr. Harrison, comment on what do you think is the better of those two fixes or a third fix if you think it is best yet?

Mr. HAGGETT. I believe the whole competitive bidding issue is one that we have looked at and are, I guess, conceptually, not opposed to. We are concerned about what the details are, as you would expect. One of the issues that is in play in this marketplace, and I suspect many other marketplaces throughout the country, is really the competitive aspect of the Medicare+Choice marketplace. When you have a county like Philadelphia County, and four suburban counties where there is a significant difference in payment rates, you also have companies—we have got competitors that operate only in Philadelphia. So they are at an advantage to that extent, that their service area is different than ours. And I am not sure if that would be a concern when you go into a competitive situation, you know, would it be a county by county type of situation, and would we, in effect, use a different methodology to get to the same results, where, you know, unless the underpinning fee-for-service, or whatever the base costs are, were modified to acknowledge that type of thing.

I think, also, one of the aspects in terms of updating the formula, the data that is currently being used is 1997 data. Significant changes have happened, certainly, in this marketplace, other mar-

ketplaces throughout the country, provider consolidations, you know. There are many more separate hospitals, many more of the physician practices were independent. They are now all wrapped together and our ability to negotiate is very different than it was 5 years ago when this data, upon which we are paid now, was collected and used.

So to your point, I think the concept of competitive bidding is something, you know, that we are not necessarily opposed to. It is something, however, that there are a lot of component parts to that that really need to be thought through to really get to the result that looks at more natural regions. To us, when we look at the—and we rate any of our other business, it is on a regional basis. Healthcare in this community is a regional enterprise. The pricing structure that is in place right now is artificial to the detriment of suburban Medicare beneficiaries. I can think of, virtually, no other marketplace, no other product line that we operate in, that is similar. Medicaid contracts are done on a regional service area basis, not on a specific county basis, and I think some acknowledgement of what is real in the marketplace being factored into whatever approach is taken is an absolute must.

Mr. GREENWOOD. Dr. Harmon-Weiss.

Ms. HARMON-WEISS. Thank you. We, certainly, as both Mr. Haggett and I have emphasized, there needs to be a way for the Medicare+Choice rates to be raised, reflective of the medical cost inflation that we are experiencing. We, certainly, do have issues with the rates being so disparate in Philadelphia versus Bucks and Montgomery County, and we would like to see some resolution on that issue.

As far as moving to a competitive bidding system, I would have similar reservations that Mr. Haggett has expressed, and that is as long as it is not based upon some draconian formula reflecting arcane data. We feel that this would be of great interest because it should be able to be reflective of the true cost of providing healthcare in this market. We feel that the market based forces are really important in setting health insurance rates. So for example, our plan sponsored commercially insured members are the bulk of our business. There are 10 or 20 times the number of beneficiaries in the market that are commercially insured. The plan sponsors have no intention of spending more money than they have to. They, actually, drive the business and they, actually, drive the health plan to get the lowest rates possible with the limitations that my colleague has expressed within this market. So we really feel that using market based forces is far to the benefit of every Medicare beneficiary in this country.

Mr. GREENWOOD. Dr. Harrison.

Mr. HARRISON. MedPAC has recommended, basically, going back to the old system.

Mr. GREENWOOD. The old system being the AAPCC?

Mr. HARRISON. The AAPCC, where we look at the county-based rates, although, we are not wedded to stay with the counties, and issues do come into play as they would in competitive bidding as to what you want to make the market areas, and I think we need some more work. I know HCFA, some people at HCFA, have been

doing some work to try to better define the market areas, and I think we need to do that.

Mr. GREENWOOD. I have a question for Mr. Haggett and another question for Dr. Harmon-Weiss, and I am, obviously, exceeding my 5-minute limit. I will do the same for the other gentlemen.

Can you tell us what your profit margin is in this region here? And if you could include what were your administrative costs and your profit margin on these products in the Philadelphia region?

Mr. HAGGETT. Yeah. For the—maybe take it by product by product. Keystone 65, by far, our largest program, has generated a margin between the 2 and 3 percent range over the last 5 years. That has, progressively, declined and this year is projected to be less than 1 percent.

Our administrative costs have run over the last 5 years between 5.5 and 6 percent of the total revenue dollars, which when we look at the State, or even the national standard, is extremely competitive. On the commercial side, you would expect to see anywhere from 10 to 12 percent, so it is significantly lower.

Personal Choice, the margins have been lower, less than 2 percent since the beginning of that program, and that continues to be the case. Our administrative cost there, likewise, in the 6 percent range. And our product in New Jersey, and while I know we are focusing on Pennsylvania, but we do offer product in New Jersey that is very comparable to the Keystone 65 product. We have never made any money in that market. We have been in it for 4 years.

Ms. HARMON-WEISS. I have been advised by my financial colleague who accompanied me today that we are seeing the same trends that have been expressed by my colleague.

Mr. GREENWOOD. A final question, and then I will ask—let us be mannerly here in Bucks County, please.

An interesting—to me, an interesting phenomena occurred here this morning. That is when our first panelists were, the beneficiaries, were asked questions that had to do with is it a better deal for you to be on a Medicare+Choice plan administered by a private insurance company or is it better for you, financially, to be on regular fee-for-service Medicare, most of the beneficiaries' responses were, oh, we are still better off, financially. And Ms. Kopacz said in terms of advising her clients, in many cases, you are still better off, financially, to be with a private insurer than on the Medicare fee-for-service. And yet, when I think Mr. Hoeffel asked a question, which was when it comes to prescription drugs, would you rather be in a Medicare regular fee-for-service system or would you rather see that constructed in the private insurance system, I think they all, unanimously, said, oh, we don't want to be with the private company, we want to be with regular old Medicare. So you have this sort of irony here, and that is, when you look at what people are receiving, even though they are unhappy with it, they think—they don't believe you when you tell them you are making 1 or 2 percent profit. They don't really love you very much if you haven't noticed. And yet, they are still better off with you than they are in Medicare fee-for-service, for the most part.

Why do you think it is that even though, theoretically, you can offer better option in many instances than the regular Medicare fee-for-service, people don't really trust the companies and don't

really believe that they are going to get a better deal when, for instance, it comes to prescription drugs? Why do you think they have this credibility issue?

Mr. HAGGETT. In today's environment, over the last couple of years, we have been the ones on the front line cutting back on the benefits and increasing the premiums. I am the one who signs the letters for our Keystone members; it doesn't come from Congress, it doesn't come from HCFA. So we are, to a certain extent, the face that is put on the adjustments that need to be made.

I would counter that, however, by looking at our company's and program's disenrollment rates, which on a voluntary basis, annually, run less than 5 percent, which is significantly lower than the national average. We look at the satisfaction results that come through the standardized surveys and so forth that are done. More than 85 percent of our members report high levels of satisfaction with the plan. We look at our outcomes, clinic outcomes data, we look at the accreditation agencies and so forth, and frankly, I am very proud to offer—to continue to offer the product.

Can we get it right all the time? No, we don't. I get concerned when I hear any member saying they can't get through, they can't get an answer to the question, and believe me, that is something that we take very seriously. I, personally, monitor phone calls from our members. I, personally, was out and did about 30 of these community meetings, as did other people within our management team. We try in every way to help support and make it as easy and financially affordable, however, the game in which we are playing is a tough one right now, as we all acknowledge. So that is, hopefully, the response to your question.

Mr. GREENWOOD. Dr. Harmon-Weiss?

Ms. HARMON-WEISS. I agree that we are on the front lines and we have been in the very painful position of having to decrease benefits. And the citizens of Bucks County and Montgomery County were very pleased with our benefit package, and they complained bitterly, including my own relatives, that we are not providing the same benefits. At the same time, we do, in fact, provide them the opportunities to switch plans if they are unhappy. If they are dissatisfied, they can switch plans, they can join another plant. They always have the opportunity to go back to fee-for-service Medicare, and we find that they don't do that.

There were 308 individual members who are effective with our health plan on November 1, 1985; 47 of them in Bucks County remained enrolled to this day. They have been with us through the thick and thin, even though we have had to change the benefit package and change the premiums. Similarly, in Montgomery County, there were 142 members who were enrolled with us on 11-1-85, who have been continuously enrolled. We have kept them healthy, and they still remain enrolled at this time. That is a great deal of loyalty. We have a great deal of loyalty out there with our members.

Also, as my colleague was emphasizing, we provide coordinated care to Medicare beneficiaries. We provide services and make sure that Medicare beneficiaries have their preventative care. We, currently, can show that 80 percent of the Medicare enrollees in our plan have received mammography, whereas when you look at the

fee-for-service data in Pennsylvania, for example, only 40 percent of the Medicare beneficiaries in Pennsylvania received the service even though it has been covered by Medicare for several years. That is just one example. There are many, many examples of the benefits that we can bring to the beneficiaries under managed care by coordinating their care.

Mr. GREENWOOD. Thank you all. I now yield 10 minutes to the gentleman from Florida, Mr. Deutsch.

Mr. DEUTSCH. Thank you, Mr. Chairman. One of the things that is interesting, I guess, if you can, when January 1 rolled around for the two plans, how many people actually dropped coverage? How many people dropped out based upon the change in premium?

Mr. HAGGETT. For Keystone 65, the total number through the first quarter of the year, through the 1st of March, which we really view as our transition period, a total of about 7,000 members dropped coverage from our plan. However, at the same time, about 5,000 new members joined. And part of that 7,000 are people who are not eligible for Medicare any longer, people who died, so it is not just the voluntary folks. I mean, that is the reality of our business, every month that is there.

Mr. DEUTSCH. Okay. Dr. Harmon-Weiss?

Ms. HARMON-WEISS. I have the information for you in Bucks County. With the change in benefits for 2001 and the introduction of the higher premium, we have a decrease in our enrollment of 500 members in Bucks County. And as I mentioned before, that is against a 16,000 member enrollment previously in Bucks County.

Mr. DEUTSCH. One of the, you know, sort of interesting issues, you know, you mention, I guess, you have been providing Medicare+Choice since 1985, and Keystone——

Mr. HAGGETT. 1993.

Mr. DEUTSCH. 1993. I guess at some point, there was the sort of glory days, you know, where you were really providing the type of service that you felt you really wanted to. You know, could you describe—I mean, what was the glory year, I mean, when you felt you were really providing the benefits that you wanted to provide for your beneficiaries? And then sort of, how much more would it cost to get to that level? I assume you are not providing hearing aids anymore. Is that accurate for both of you?

Mr. HAGGETT. We do.

Ms. HARMON-WEISS. We do.

Mr. DEUTSCH. All right. And prescription glasses, are you——

Mr. HAGGETT. We do.

Mr. DEUTSCH. They are not your—are there other benefits that you have dropped, or the main dropping was prescription drugs?

Mr. HAGGETT. Correct.

Mr. DEUTSCH. All right. So were there other cutbacks on any other benefits you provided? You provided glasses at one point and then you chose not to?

Ms. HARMON-WEISS. In 2001, we have a discount vision program, but no benefit coverage dollar limit for glasses.

Mr. DEUTSCH. No healthcare memberships?

Ms. HARMON-WEISS. Pardon me?

Mr. DEUTSCH. Healthcare memberships.

Ms. HARMON-WEISS. Fitness benefit? We had a fitness benefit previously that provided healthcare memberships. We had a dental benefit, and now we have a discount dental program. Dental, as you be aware, is becoming much more of an important issue to Medicare beneficiaries. Previously, when that care was enacted, Medicare beneficiaries were dentureless, at least 55 percent of them were, but now they have teeth and care about them through the attrition.

Mr. DEUTSCH. So I mean, I guess the question sort of is, you know, how much more would you need to provide it under the existing system? How much more money would you need on a monthly basis to get back to the point where you can provide coverage and say, hey, to every beneficiary, you are not going to have one out-of-pocket dollar for prescription drug coverage? Because the reality, that is what seniors want. I mean, when seniors joined HMO's, what they wanted was the acknowledgement that when they chose to join an HMO, the healthcare costs, for all intents and purposes, were over. Their decision was to join the HMO or not to join the HMO, and their filing issues were over, and it gave them, you know, extreme comfort. And I guess what I am really hearing is that extreme comfort is gone.

Ms. HARMON-WEISS. As we mentioned previously, the years leading up to BBA included updates to our fees annually. They were quite different in different parts of the country, but as we heard from our colleague in MedPAC, they were based upon the fee-for-service experience on a county by county basis. At that time, this would be in the early 1990's, we were able to provide prescription drug coverage, we were able to take the Medicare money that would have been spent in fee-for-service, receive 5 percent less, and still provide coverage for physical examinations, which basic Medicare doesn't cover. We were able to provide a rather rich benefit package of prescription medication, all the wellness, all the preventative care, plus hearing aids, which Medicare doesn't cover, and a number of other programs and ways in which our benefit package was richer than Federal Medicare.

Mr. DEUTSCH. Right. And I guess, you know, one of the questions, though, is on an average, you know, basis—this is one of the other issues. I mean, there is the issue that Philadelphia is getting more than Bucks County, but the other issue, really, is what is Medicare+Choice getting in relationship to fee-for-service. I mean, there has been a real debate, and again, the chairman and I sit on the committee that has jurisdiction over Medicare and Medicaid, so we go through these debates, and there has been a real debate, which all of you are aware of for fee-for-service physicians, in particular, who are not members of HMO's, who feel that, you know, there was too much—you know, the benefit, the incentive for people to join HMO's was too good, and they had a real effort to sort of, you know, try to cut that back, to increase fee-for-service. On a percentage basis, you said that 5 percent, which was the original concept of Medicare HMO's. What is the differential now between a Medicare beneficiary, in terms of payment that you get, versus your HMO patient?

Ms. HARMON-WEISS. I think the graphic here is demonstrating the gap that is developing. If I am incorrect, please let me know,

but I think that graphic is demonstrating the gap that is developing between Medicare fee-for-service spending and HMO's right there. It is growing extraordinarily wide, as we have testified, 9.5 percent in 2001. And actually, I think we included that in our testimony, but came at it from our company's perspective.

Mr. DEUTSCH. So what we are saying now is that we are spending 9 percent more on a fee-for-service patient on average?

Ms. HARMON-WEISS. That is what the data says.

Mr. DEUTSCH. Ms. Berek, do you want to try to respond to that?

Ms. BEREK. What the data there is showing is the rate of growth in 1 year. If you average it out over the last few years, I don't think the difference is that great, because when the fee-for-service spending was going down in 1998 and 1999, our payment to managed care plans was going up by the flow, which was 2 percent.

Mr. DEUTSCH. Can I ask you, just so I understand this chart, which is kind of hard to understand——

Ms. BEREK. You got just about my limit on the chart, but we can try it.

Mr. DEUTSCH. Well, I mean, is this just total amount or is this per person? I mean, what does this chart show? I still have no idea what this chart is trying to explain.

Ms. BEREK. This shows, if I am correct, the percentage annual increase of the total amount.

Mr. DEUTSCH. So total amount. That has nothing to do per person?

Ms. BEREK. It has nothing to do with per person, right. And it is the annual increase of growth, so you don't see the base percentage growth. It is not showing you the base, it is showing you percentage growth on the base.

Mr. DEUTSCH. Right. So I mean——

Ms. BEREK. Excuse me. It is divided on a per person.

Mr. DEUTSCH. So it is per person. So is what we are saying now that a fee-for-service person is now getting 9.6 percent more than a Medicare reimbursement? I mean, what is the bottom line?

Ms. BEREK. The growth in spending for a fee-for-service beneficiary in the year 2001 was 9.6 percent. The growth in spending on a managed care beneficiary, nationally, was 4.4 percent, and in Bucks County was 3 percent. But if you are going back, in 1998, we spent less money on Medicare beneficiaries in fee-for-service than we did in 1997.

Mr. DEUTSCH. I guess, you know, one of the questions that I am trying to understand is, you know, when Medicare initiated the pilot projects to do HMO's which my recollection, again, is before we were in Congress, but really started in south Florida when Claude Pepper was chairman of the Rules Committee in the Congress, and started, actually, in my community in south Florida. And in fact, you know, it didn't exist. I mean, it was a creation of HCFA and Members of Congress did it as a pilot project, and the concept really was that it was going to save Medicare money, and that was the 95 percent reimbursement that you are saying. Are we at the point now where it would still save money but we are reimbursing at a higher rate for fee-for-service?

In other words, some of the things that you are talking about, which I think are really significant, and I am glad that you brought

them up. I mean, the utilization rate of mammogram. I mean, everyone in this audience, if no one gets anything else out of this meeting today, you should be aware that through the good works of our committee, Mr. Greenwood and myself, that since we were both elected to Congress in 1992, we have consistently added preventative coverage for Medicare as a benefit. Medicare, originally, didn't have any preventative coverage at all, so it now provides mammogram coverage, colonoscopy screening. As of July 1 of this year, 35,000,000 Americans will be eligible under Medicare for colonoscopy screening, which they weren't previously until July 1. So you know, it is Congress at work. But you are absolutely correct. The utilization rates for these screenings is incredibly low. I mean, you know, just scary. I mean, unfortunately, low. And for everyone in this audience, they should be aware that their Medicare, whether fee-for-service or HMO, they have benefits that they can avail themselves of, which we know, statistically, a very high percentage of people just don't do that. But the whole theory is that if you avail yourself of these preventative things, you are going to be healthier, and ultimately, you are going to save money.

So what I am trying to get a sense of, do we know is it working? I mean, are we cutting—in other words, I guess the question I am really trying to get to, are we cutting back so severely—in other words, it is a balance. It really is a balance. I think there shouldn't be an incentive for people to join fee-for-service, there shouldn't be an incentive for people to join HMO's. It should be a real choice that individuals have, but it has to be sort of a level playing field choice. And one of the issues about not having prescription drug coverage, which I think physicians who were not part of traditional, you know, or an HMO, had legitimate concerns. Physicians would come to me in my community and say, hey, I am losing patients to an HMO because they are getting prescription drug coverage. What can I do? Well, openly, the only thing you can do is have prescription drug coverage under traditional Medicare so that people can make intelligent choices.

But I guess, can anyone—can you try to answer that? Are we paying more than we should? I mean, you are doing it from a research basis. Go ahead.

Ms. BEREK. I was trying to ask our policy statistical person behind me to say can we tell you whether we are saving or not. We can tell you on a locality by locality basis what we are saving. I don't think we can give you the broader answer, and I don't think I can say to you, honestly, that HCFA understands right now whether we have the right level of incentive. We see the growth in managed care going down, which we do not think is good, and we want to see the growth in managed care going up.

And so I can say to you that we are committed to working with you and Chairman Greenwood to figure out what are the things we need to do, both in terms of policy and finance, to change the direction so that we do what Medicare+Choice was philosophically intended to do, which was increase the participation in managed care, increase the availability of choices for our beneficiaries, and whether I can tell you in theory it is saving what it should or not doesn't matter. It is not working in terms of the need to increase the choices for beneficiaries and increase what they need. So we

are committed to working with you to both look at the numbers, because I know when you pass a budget, it is numbers that count—to look at the numbers and to look at the rules, and see what are the things we have to change, what are the things we have to fix, and help you make the decisions to make those changes. But I can't—I mean, I can have somebody sit down with you afterwards on the detail, but I think we should focus——

Mr. GREENWOOD. The time of the——

Mr. DEUTSCH. The Chairman mentioned we are out of time. Let me just ask one very quick question as a last question.

Mr. GREENWOOD. Well, I have got to—here is our problem. We promised to be out of here at 11:30 so that they can set up for lunch, and Mr. Hoeffel—we have given the gentleman 15 minutes. We need to give the gentleman, Mr. Hoeffel, some time.

Mr. DEUTSCH. Okay. All right.

Mr. GREENWOOD. The gentleman from Montgomery County is recognized for 10 minutes.

Mr. HOEFFEL. Thank you, Mr. Chairman, and I will take less than that.

We have talked about three sets of numbers, basically. We have talked about the medical cost inflation that the carriers face and you want to be reimbursed at a rate that reflects the increased cost of medical care so you guys can continue to make the profit you need to make and provide the services you need to make. We have talked about the county by county reimbursement rate you get from Medicare per beneficiary, the amount that we pay you to provide a service and to pay the doctors and the hospitals. And we have talked about the county by county premiums you charge to the beneficiaries, to the customers.

And what really bugs me is the notion that we pay you more where there is higher medical costs, such as Philadelphia, but the system is so askew that your response in the marketplace is to charge no premium to the people that happen to live there and higher premium to the people out in the suburbs that have no—at a lower cost. And I am not blaming the representatives of the companies here. I mean, I think, fundamentally, this is Congress' responsibility to figure out how to balance this out. But that is what we have got to focus on.

And I wanted to say to the representative, Dr. Harrison, from the Medical Payment Advisory Commission, that in your report you said that—in your testimony, you said that the Commission is not yet ready to use a metropolitan area for payment because it may be too large an area to represent a homogenous healthcare market. I don't see why that is a problem. Why can't we figure out the service area for Aetna, the service area for Blue Cross, and then make sure that they are charging one premium for everybody that lives in that service area? And one more comment before you respond. You said that we need—the best way to define local markets awaits further research, which I think is the same problem. Congress can't wait much longer. We need to have the necessary research, and I don't understand why it is so hard for us to determine what a fair and uniform premium would be for these carriers to charge in a service area where they provide the same coverage.

Mr. HARRISON. Okay. Two issues. It used to be that you had to charge the same premium in a service area, but what happened was that the plans would then choose their service area and they didn't always go along county lines. And so they would sort of customize a service area to go with that premium and package. As Mr. Haggett said, depending on how you arrange these areas, you could have competitors only playing in parts of them and that wouldn't be competitively fair, because if they were only in the areas where they would get high payments, then they would be able to charge a lower premium than someone who is covering the entire market.

Mr. HOEFFEL. Well, maybe then we have to reimburse on a regional basis and then have premiums on a regional basis.

Mr. HARRISON. That is one possibility, yes.

Mr. HOEFFEL. Rather than reimburse on counties and have premiums based on counties. It just isn't fair the way it works now.

Mr. HARRISON. I think you are right, but our commissioners were concerned about some of the competitive issues when you got into some of the larger metropolitan areas, you know. If you look at the Baltimore-Washington Metropolitan area, it goes all the way to West Virginia, and you know darn well that there are different costs involved in treating people in West Virginia than in D.C.

Mr. HOEFFEL. Well, I thank you. I know we are out of time. I want to yield back. Thanks to the panel for your testimony.

Mr. GREENWOOD. Well, I thank all of our witnesses for being here today. I want to thank my colleagues for traveling here and participating in this hearing. Thanks to the Bristol Senior Center for hosting us. And thank you to all of the public for coming.

I think, as anyone who has sat here for the last couple of hours plus can understand, this is at one time a very complex issue. You can hear all this jargon and gobbledygook about AAPCC, and demographic factors, and geographic variations, and blended rates, and utilization rates, and so forth, and I can see the eyes glazing over as we get into all of this very complex discussion. But what we have to remember at the same time is that—and we hearken back to our first panel—this is about real people, real men and women who have served their country, who have lived their lives, and who have a right to expect at this point in their life that we, their elected representatives, will figure out how to take care of their healthcare needs, to provide them with the kind of healthcare that they need, that they have to have, or they don't have any choices about the medications that they take, and they have a right to the sense of security that they are going to have that taken care of for them.

I am hell-bent to get this done this year. I have two priorities in the Congress, and I think my colleagues shared this: (1) We have to get a prescription drug benefit into Medicare, we have to do it this year; and (2) We have to fix Medicare+Choice so that for those seniors who choose that benefit and find it best to their advantage, they have a program that they can afford, that, hopefully, they don't have to pay a premium for it, and they can offer them a prescription drug benefit, as well as the eye care, the dental care, and the audio care, and all of the rest. That is our responsibility to do it. I think I owe it to my mother and father to make that the

case, I think I owe it to everyone that I represent, and that is what we are going to try to do and try to do this year.

Thank you very much for being here.

[Whereupon, at 11:33 a.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Chairman Greenwood, I would like to congratulate you for holding this field hearing today. This is an important issue that affects your constituents and millions of Medicare beneficiaries across the country.

In 1997, Congress passed the Balanced Budget Act (BBA) of 1997, which included the provisions that created the Medicare+Choice program. This legislation redesigned the system for setting Medicare payment rates for managed health care plans that contract with Medicare. The goals in creating Medicare+Choice were to expand health plans to markets where access to managed care plans was limited or nonexistent, and to offer new types of health plans in all areas. Unfortunately, some of these goals have not been realized.

Medicare managed care enrollment has remained nearly level since the implementation of the Medicare+Choice program, increasing from about 14% of the Medicare population in 1997 to about 16% of the Medicare population by September, 2000. At the same time, more than 100 plans have either terminated their contracts and fully withdrawn from the program or partially withdrawn by reducing the geographic areas they served.

In areas, such as Bucks County, the reimbursement level paid by Medicare to Medicare+Choice organizations has been limited to a rate of 2 percent annual growth since 1998. This has led to the recent local developments where health care plans have decreased benefits and instituted a monthly premium, for the first time. Most studies and analyses of health care costs tell us that in order to provide quality health care, we must increase spending on this program at an annual rate greater than 2 percent.

Last year, Congress passed the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) in response to the information that I have just cited. Contained within BIPA is a provision that increases payments in counties where Medicare+Choice organizations receive the minimum percentage increase from 2 percent to 3 percent, for this year only. Clearly, this is a temporary fix and Congress must act this year to address the reimbursement methodology so that payments to Medicare+Choice organizations adequately reflect the growth in health care costs in these areas.

Chairman Greenwood and the Subcommittee staff have spent numerous hours reviewing data and information on the structure and management of the Medicare+Choice program. I look forward to hearing his findings. I am also eager to hear the testimony of the stakeholders who have been invited to this hearing. It is of the utmost importance to listen to the people who rely on these programs. It is also crucial to have a dialogue with those who are tasked with the management and implementation of this program. They work with the program every day and see its strengths and weaknesses first-hand.

Chairman Greenwood, I look forward to hearing what your analysis has highlighted as the important issues regarding Medicare+Choice payment methodology. I believe that an important part of modernizing the Medicare program is laying the foundation for more competition and future innovation in the Medicare program. Medicare+Choice is a fundamental component in the effort for testing competitive models that can provide Medicare beneficiaries with better health care. I look forward to working with you, and other Members of the Committee, in an effort to fashion long term solutions to the problems that have inhibited the growth of the Medicare+Choice program.

PREPARED STATEMENT OF HON. JIM SAXTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr Chairman, I am pleased to have the opportunity to provide testimony on the issue of reimbursement for Medicare+Choice plans. With the thousands of seniors in my district who are enrolled in Medicare+Choice plans and are deeply affected by the annual increase in premiums that have taken place, I believe this issue

needs to be carefully examined and I commend the Chairman for holding this hearing.

Beginning in the late fall of 1999, the Medicare beneficiaries in my district who were enrolled in Medicare+Choice plans received notification that their premiums would be increased substantially for 2000. In some instances, the premiums were increased by 250 percent. At the same time, benefits vital to many seniors—such as coverage of prescription drugs—were dropped. Clearly, this troubled many of the seniors in my district.

Unfortunately, this was not a one-time event. Once again, last fall Medicare+Choice enrollees in my district were informed by their health insurance plans that their premiums would again increase for 2001.

Many of those affected by these premium increases contacted my office. Because so many of them were on fixed budgets, they expressed how difficult it was for Medicare+Choice beneficiaries to afford two consecutive premium increases, especially when they were at such an extreme level. In addition, they were concerned because seniors in Philadelphia and New York City were receiving better benefits without the substantial increase in premiums.

After hearing the latter point raised by many of my Medicare+Choice constituents, I began to look into this issue and discovered the major discrepancies that existed between the reimbursement rates for each county—not only when you compare counties in different states, but also counties within the same state.

To say the least, the difference between the reimbursement rates for those plans who serve the three counties in my district and the reimbursement rates in Philadelphia and New York is staggering. Medicare+Choice plans in Ocean County receive $550.07 per enrolled beneficiary; those in Burlington County receive $569.18; and plans in Camden County receive $611.27 per enrollee. In Philadelphia County, Medicare+Choice plans are reimbursed at $769.77, and those plans serving New York City receive $838.75 per enrolled beneficiary.

In Ocean County, plans receive 29 percent less per beneficiary than Medicare+Choice plans in Philadelphia and 34 percent less than plans in New York City. When you take into consideration that this is a county with over 100,000 Medicare beneficiaries—17 percent of which are enrolled in Medicare+Choice plans—plans who serve nearly 20,000 seniors are being paid 29 and 34 percent less to provide health benefits than in neighboring cities.

In Burlington County, the pattern continues. The difference in the per-enrollee reimbursement is 26 percent as compared to Philadelphia and 32 percent in New York.

Finally, in Camden County, plans are reimbursed at 21 percent less than those in Philadelphia and 27 percent less than those in New York City. Important to note, the reimbursement level in Camden County is the highest in New Jersey, and yet it is way behind the levels of reimbursements in Philadelphia and New York.

In examining the justification for and the reasoning behind the Medicare+Choice premium increase in the last two years, there are also many other components of the Medicare+Choice program that should be taken into consideration, including increasing medical costs, undue regulatory burden within the Medicare+Choice program, and additional oversight on how the Medicare+Choice plans are using the reimbursements they receive.

However, when reviewing the reimbursements for the plans who serve the Medicare+Choice enrollees in my district versus those in Pennsylvania and New York, there is a drastic difference in these rates. Clearly, this disparity has and will continue to adversely affect the seniors who live in counties where Medicare+Choice plans receive a substantial—and seemingly unjustified—lower rate of reimbursement.

When the health care of thousands of seniors is put at risk, it is vital that all aspects of this important program be examined. Seniors need to be protected from having to face yet another premium increase or a notice from their Medicare+Choice plan stating that they are no longer serving the area.

Clearly, the reimbursement methodology of the Medicare+Choice program needs to be thoroughly reviewed, in hopes of finding a way to bridge the gap between county reimbursement rates. I am pleased that Chairman Greenwood has begun to move forward on this issue and I commend him for holding this hearing.