FOURTH IN SERIES ON MEDICARE REFORM: MEDICARE+CHOICE: LESSONS FOR REFORM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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FOURTH IN SERIES ON MEDICARE REFORM: MEDICARE+CHOICE: LESSONS FOR REFORM

TUESDAY, MAY 1, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:10 p.m., in room 1100 Longworth House Office Building, Hon. Nancy Johnson [Chairwoman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 24, 2001
HL–6

CONTACT: (202) 225–3943

Johnson Announces Hearing on Medicare+Choice: Lessons for Reform

Congresswoman Nancy L. Johnson (R–CT), Chairwoman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on Medicare+Choice: Lessons for Reform **The hearing will take place on Tuesday, May 1, 2001, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 2:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include representatives from Medicare+Choice plans and program experts. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The Medicare+Choice program as we know it today was created through the Balanced Budget Act of 1997 (P.L. 105–33). The new program, Medicare's Part C, was intended to significantly expand the range of health care options available to Medicare beneficiaries. Medicare+Choice gives beneficiaries the option of choosing to enroll in private, integrated health plans that often offer coordinated benefits and additional benefits, such as prescription drugs. Today, 15 percent of Medicare beneficiaries are enrolled in Medicare+Choice.

Although Medicare+Choice has proven popular with many beneficiaries, the program has recently encountered problems, resulting in significant plan withdrawals, premium increases and benefit cuts over the past three years. Policy analysts have attributed these developments to payment and regulatory problems. In the past two years, Congress has acted to increase plan payment rates and to decrease the regional variations in rates and benefits afforded to participants, with the goal of stabilizing the program and expanding beneficiary access to a wider array of choices. However, fundamental payment and regulatory problems remain.

In announcing the hearing, Chairwoman Johnson stated: "Medicare+Choice has a great deal to offer Medicare beneficiaries, ranging from important innovations in prevention and disease management to reduced cost-sharing responsibilities and increased benefits offered through some of the plans. Our challenge is to learn from the experience of implementing Medicare+Choice so that we can strengthen the program as part of our efforts to improve and modernize Medicare this year."

FOCUS OF THE HEARING:

The hearing's first panel will include representatives of Medicare+Choice plans, who will address their experiences and discuss the innovations in care made possible through an integrated and coordinated health care delivery model. The second panel will include experts to discuss the complicated Medicare+Choice payment system, the regulatory environment created by the Health Care Financing Administra-

tion and its impact on program implementation. Panelists will also suggest solutions to the program's problems that will help make it more market-oriented.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should *submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label*, by the close of business, Tuesday, May 15, 2001, to Allison Giles, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, typed in single space and may not exceed a total of 10 pages including attachments. **Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.**

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press, and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at "http://www.house.gov/ways__means/".

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairwoman JOHNSON. The hearing will come to order.

Mr. Stark is on his way, and we do have Members from both sides of the aisle, so I'm going to start with my opening statement. I will read it to him afterwards, if he wants to hear it.

[Laughter.]

Today the Subcommittee continues its series of hearings on ways to strengthen and improve the Medicare Program. This is our fourth Subcommittee hearing on Medicare modernization. In other hearings this year, we have undertaken a general overview of reform ideas, explored the impact of Medicare's regulatory burden on providers, particularly on small providers, and discussed the issues we will confront as we add a much needed prescription drug benefit to the program.

In addition, the Ways and Means full Committee has examined the issue of program solvency with Secretary of the Treasury O'Neill, and talked about the administration's health care priorities with Secretary Thompson.

Today's hearing focuses on Medicare+Choice. This important program has significantly expanded the range of health care options available to some Medicare beneficiaries. In fact, 15 percent of the program's beneficiaries are now enrolled in Medicare+Choice, and many of these beneficiaries enjoy reduced cost-sharing obligations, richer benefits, and a more coordinated approach to preventive health care and to disease management.

However, we all know that the program has confronted real implementation problems. Plan pullouts over the past 3 years have been significant. Premiums have increased and benefits have been cut. Payment systems are complicated and result in inequities that affect both plan participation and the richness of the benefit package offered to enrollees. The regulatory environment has stifled rather than fostered plan development.

Over the past 2 years, Congress has acted to increase plan payment rates and to decrease the regional variation in rates and benefits afforded to participants, with the goal of stabilizing the program and expanding beneficiary access to a wider array of choices.

However, a real problem remains. This afternoon we will hear from two panels of witnesses who will help us focus on both the strengths of the Medicare+Choice program and the challenges it faces. Our first panel consists of representatives of three health plans participating in the program. These witnesses will talk about the valuable services Medicare+Choice plans offer beneficiaries. I am particularly interested in the innovations in disease management made possible through the coordinated care delivery model at the heart of the Medicare+Choice program.

Our second panel will focus on two of the most complicated challenges facing the Medicare+Choice program: its convoluted payment system and its stifling regulatory environment. Our final witness, Mike O'Grady, will suggest solutions to the program's problems to stabilize it and make it more responsive to the needs of America's seniors.

I look forward to our witnesses' testimony and to working with my colleagues as we develop legislation to ensure that Medicare beneficiaries across the country enjoy real choices in a healthy, competitive system.

I might add for the Committee Members, I find one of the most difficult responsibilities to bear, as a Member of Congress, is to stay in touch, be aware of and open to the strengths of the programs that also have very real problems and about which there are real concerns.

If we are to modernize Medicare, we have to modernize Medicare fee-for-service and modernize the Medicare+Choice program, because each of them hamstrings in different areas of the country, and each of them make significant contributions. If we are to provide the best quality health care for our seniors, we have to have both programs strong, growing, and developing, and through each, we will learn different things that then, through their interactions, will fulfill the promise of Medicare, which we currently are not fulfilling, and that is the promise of access to state-of-the-art health care at a price you can afford.

[The opening statement of Chairwoman Johnson follows:]

Opening Statement of the Hon. Nancy Johnson, M.C., Connecticut, and Chairwoman, Subcommittee on Health

Today the Subcommittee continues its series of hearings on ways to strengthen and improve the Medicare program. This is our fourth Subcommittee hearing on Medicare modernization. In other hearings this year, we have undertaken a general overview of reform ideas, we have explored the impact of Medicare's regulatory burden on providers, and we have discussed the issues we will confront as we add a much-needed prescription drug benefit to the program. In addition, the full Ways and Means Committee has examined program solvency with Treasury Secretary O'Neill and talked about the Administration's health care priorities with HHS Secretary Thompson.

Today's hearing focuses on Medicare+Choice. This important program has significantly expanded the range of health care options available to some Medicare beneficiaries. In fact, 15% of the program's beneficiaries are now enrolled in Medicare+Choice. Many of these beneficiaries enjoy reduced cost-sharing obligations, richer benefits, and a more coordinated approach to preventive health care and disease management.

However, we all know that the program has confronted real implementation problems. Plan pull-outs over the past three years have been significant. Premiums have increased and benefits have been cut. Payment systems are complicated and result in inequities that affect both plan participation and the richness of the benefits offered to enrollees. And the regulatory environment has stifled rather than fostered plan development.

Over the past two years, Congress has acted to increase plan payment rates and to decrease the regional variations in rates and benefits afforded to participants, with the goal of stabilizing the program and expanding beneficiary access to a wider array of choices. However, real problems remain.

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I look forward to our witnesses' testimony and to working with my colleagues as we develop legislation to ensure that Medicare beneficiaries across the country enjoy real choices within a healthy, competitive system.

So I welcome our panelists. I am pleased to start this hearing, and I'm delighted that Mr. Stark has been able to conclude his work that we all have, with our hospitals in town today, and I do——

Mr. STARK. How did you know?

Chairwoman JOHNSON. Because your staff told me. But I just finished with my hospital people, and some from other States, and that's very, very important because we'll never understand the problems if our own providers don't line them out for us in pretty clear terms. Mr. Stark.

Mr. STARK. Thank you, Madam Chair, and thank you for accepting my tardy slip. I thank you for holding this hearing.

I think a lesson we can learn from Medicare+Choice to date is that it's not a program that will solve Medicare's ills. In fact, it has created a number of new problems, including seeing Medicare beneficiaries dropped from their health plans on a yearly basis, something that we never experienced prior to the existence of Medicare+Choice.

I have no quarrel with making private plan options available to Medicare beneficiaries, but the choice to enroll should be a choice. We have for years been paying these plans beyond their costs, and the plans use the excess payments to seek and maintain enrollment by offering extra benefits.

The General Accounting Office (GAO) and the Office of the Inspector General (OIG) of Health and Human Services have confirmed that the actual payment rates for Medicare+Choice plans have risen faster than per capita health care spending since 1997. The experts believe we are now paying private plans at least 98 percent of the fee-for-service costs, without taking into effect any risk selection.

As the Chair will recall, these same HMOs told us they could provide savings to Medicare, which was why the rate was set at 95 percent in the first place. To those who argue that we should be paying these private plans the same amount as the fee-for-service costs, we're already paying more. There is just no sense to that argument.

The GAO estimated that the HMOs were paid 21 percent more in 1998 than would have been paid under traditional Medicare to provide the same covered benefits to the HMO enrollees. That resulted in excess payments, relative to what they would have paid under Medicare, of over $5 billion. That's a thousand bucks a year per beneficiary. That would probably pay for their "Medigap". Actually, I guess they said it was $1,200 per patient, and I guess that could be spent by these managed care plans on additional non-Medicare benefits, as could we, if we had those savings in the fee-for-service Medicare, which most of our beneficiaries are now in.

The administrative costs of the managed care plans ran up to 32 percent, and the OIG found numerous questionable administrative costs that plans had submitted for payment, including in one case $250,000 for meetings and $800,000 in lobbying costs. I'm sure, Madam Chair, you and I didn't eat $800,000 worth of dinners from those managed care plans. And fines, which we paid for, for some reason.

Last year we gave the managed care plans a boost of more than $12 billion over 10 years, and Chairman Thomas took the floor and said every dollar that is added must be converted to benefits for individuals. This is not always for providers. It's supposed to be for beneficiaries. But I don't know as we've seen the Chairman's assertion become a reality.

The Health Care Financing Administration (HCFA) found that just four organizations returned to the program, after we raised the payments to them, and more than 65 percent of the money was going to enhance provider networks. So I'm willing to bet that providers will be in here later this year asking for more money again, and we will also hear that the managed care plans are overregulated or inappropriately regulated by an organization that favors their so-called competitor, and I think that's not true. It says here that's pure hogwash, but I would just tell you that I don't think it's true.

Just as major employers run their various health plans—fee-for-service to PPOs, HMOs—under one umbrella, so should HCFA run the plans under one umbrella. To argue that the agency favors one part of the program over another I think is ludicrous on its face and it would be inappropriate and inefficient to try and separate out of the program this managed Medicare+Choice program to a different regulatory agency. If we think we have problems monitoring the quality now, just think of the problems we would have doing it with more than one agency.

So at the end of the day, this much is true. Despite an infusion of reform and resources, enrollment in managed Medicare+Choice is the same now as it was when we started this journey in 1997. Industry consolidation has led to fewer plans participating, and that trend is echoed in the private market and in Medicaid and the Federal Employees Health Benefits Plan as well. Plans admit that money is not always the problem; there are other issues that dictate plan participation.

I would say this experiment has failed, but for reasons other than those that will be given by my colleagues and by our witnesses today. I am also saying let's not repeat this mistake by just restructuring in the name of reform.

I look forward to today's testimony, Madam Chair. Thank you.

[The opening statement of Mr. Stark follows:]

Opening Statement of the Hon. Fortney Pete Stark, M.C., California

Madame Chairwoman, I thank you for holding this hearing on the Medicare+Choice program. I share your desire to expand our knowledge of what is going on with this program—though I think the reasons for our interest are quite different.

There are many lessons we can and should learn from Medicare+Choice. These lessons provide valuable insights about how to move forward with changes in the Medicare program. I think the most important lesson we can learn from the Medicare+Choice program to date is that it is not a program that will solve Medicare's ills. In fact, it has created a number of new problems, which include Medicare beneficiaries getting dropped out of their health plans on a yearly basis—something that was never experienced prior to the existence of Medicare+Choice.

I have no quarrel with making private plan options available to Medicare beneficiaries. In fact, for decades, Kaiser Permanente has provided health care for fully half of my constituents and most of them are happy with that care. When those people become Medicare-eligible, many of them—like my in-laws—insist on staying with Kaiser. I support making it possible for them to do so. However, the choice to enroll in a private plan should be just that—a voluntary choice. Medicare's policies should be neutral with respect to whether beneficiaries should enroll in such plans. The program's payment policy and other rules should neither discourage nor encourage enrollment in HMOs or other private plans. Yet, while neutrality is desirable, for years plans have been paid beyond their costs and used the excess payments to seek and maintain enrollment by offering extra benefits at no or low extra cost.

Both the General Accounting Office and HHS Office of the Inspector General have confirmed that actual payment rates for M+C plans have risen faster than per cap-

ita spending since 1997. Experts believe we are now paying the private plans at least 98 percent of fee-for-service costs, without taking into account risk selection. And remember, HMOs said they could provide savings to Medicare, which is why the rate was set at 95% of the fee-for-service rate in the first place. Those who argue that we should be paying the private plans the same amount that as the fee-for-service costs can rest assured, because in many instances we are already paying more. In fact, the only way most of these plans can survive is to bribe beneficiaries to give up freedom of choice by offering better benefits than the traditional program—usually in the form of prescription drug coverage, lower cost-sharing and coverage for preventive services.

The GAO estimated that HMOs were paid 21 percent more in 1998 than would have been paid under traditional Medicare to provide covered benefits to the HMO enrollees, resulting in excess payments—relative to traditional Medicare—of $5.2 billion. The GAO also found that plans which terminated their Medicare contracts in 2000 or 2001 spent 22 percent of their Medicare payments—equal to approximately $1,200 per patient—on *additional* non-Medicare benefits, including prescription drugs, preventive services and lower cost-sharing.

Another investigation by the HHS OIG found M+C plan administrative costs in 1999 of up to 32 percent. It found numerous questionable administrative costs that plans had submitted to Medicare for payment, including nearly $250,000 for one HMO's costs associated with meetings, more than $800,000 in lobbying costs for seven HMOs, and more than $48,000 in fines and penalties for late tax payments by two HMOs. Yet these same plans tell us they are underpaid. It simply doesn't add up—for the taxpayers or for the beneficiaries.

Last year, Congress gave the M+C plans a payment boost of more than $12 billion over 10 years, not counting more than $20 billion in indirect increases that result from increased fee-for-service spending. Chairman Thomas took to the floor on October 26, 2000 to promise that "Every dollar that is added must be converted to benefits for individuals." He went on to say, "Let us remember that this is supposed to be not always for providers, it is supposed to be for beneficiaries." But a recent study by HCFA found that just four organizations returned to the program and more than 65 percent of the money is going to enhance provider networks.

While it is clearly important to have strong provider networks, is it really Medicare's responsibility to pay private plans more to contract with providers who generally already serve Medicare beneficiaries in the traditional program? While Medicare margins are generally quite comfortable for many providers, there is no doubt that some providers have signed unacceptably low contracts with private plans. But that's not the taxpayer's fault, nor it is Medicare's fault, nor is it the beneficiaries' fault. Yet all are paying the price as a result. Even so, I am willing to bet that providers will be in here later this year asking for more money. Accordingly, I hope that HCFA and the plans can document the increased provider rates that are being paid by the plans as a result of our most recent investment in the M+C program.

Another cry that we will no doubt hear today is that the M+C plans are overregulated or inappropriately regulated by an organization that favors their so-called competitor, fee-for-service Medicare. That's pure hogwash.

Just an major employers run their various health plans—often ranging from fee-for-service to PPOs to HMOs—under one umbrella, so should HCFA. To argue that the agency favors one part of the program over another is ludicrous on its face. It would be inappropriate and inefficient to separate out the M+C program to a different regulatory agency. If you think we have trouble monitoring quality now, just try doing it across different agencies.

For years, plans have been asked to provide concrete examples of the regulatory burden. The most frequent complaint appears to be related to the requirement to collect encounter data. But surely many of the plans already monitor these data for commercial populations; if they are not, I believe it is not too much to ask that they do so now. After all, how do they deliver preventive benefits and run disease management programs? How do they coordinate care? How do they manage a business in the absence of this critical information? Shouldn't we instead be asking about the beneficiary burden of not properly risk-adjusted payments or adequately monitoring quality-of-care?

At the end of the day, this much is true: Despite an infusion of reform and resources, enrollment in M+C is about the same now as it was when this stage of the odyssey began in 1997. Industry consolidation has led to fewer plans participating in the program, but that trend is echoed in the private market, Medicaid and the Federal Employees Health Benefits plan, too. Plans freely admit that money is not always the problem. There are other issues that dictate plan participation.

I would say this experiment has failed, but for reasons other than those that will be given by some of today's witnesses. The creation of M+C was a solution looking

for a problem, and it's now created one. Let's not repeat this mistake by taking the entire program down the road of radical restructuring in the name of reform. I look forward to today's testimony, and I thank the Chair.

Chairwoman JOHNSON. Thank you, Mr. Stark.

I'm glad you didn't use "hogwash", because good people can differ on these issues, and we do. Now I would like to recognize Mr. Ramstad for purposes of an introduction.

Mr. RAMSTAD. Thank you, Madam Chair, and thank you for calling this hearing today to discuss the Medicare+Choice program.

Madam Chair and colleagues, it is my pleasure to introduce to the Subcommittee Vic Turvey, who is President of the Midwest Region of UnitedHealthcare. I think everyone on this Subcommittee knows that UnitedHealthcare and its parent company, UnitedHealth Group, are important corporate citizens in my district in Minnesota. I am glad to see United represented at the hearing today.

This is truly an outstanding company that provides a shining example of the high quality, cost-effective health care that the private sector, working with the Federal government, can bring to Medicare beneficiaries.

I have spent considerable time with United's Medicare+Choice staff, and I know that United's employees are very dedicated. They care about the beneficiaries. Time and time again, I am amazed at the many high quality, innovative programs that United has developed. Certainly UnitedHealthcare and UnitedHealth Group have truly been a national leader in the health care field for seniors, and certainly in the Medicare+Choice program, always looking for new solutions to improve care for beneficiaries in the Medicare+Choice program, and in Medicare in general.

UnitedHealthcare and UnitedHealth Group are certainly very, very important players in Medicare+Choice. They have done it right, simply stated. So I look forward to hearing Vic describe some of United's efforts to enhance Medicare beneficiaries' health care coverage that are above and beyond the traditional programs offerings, and I am pleased again, Vic, to welcome you to the Subcommittee. Thank you for being here today.

I yield back. Thank you, Madam Chair.

[The opening statement of Mr. Ramstad follows:]

Opening Statement of the Hon. Jim Ramstad, M.C., Minnesota

Madam Chairwoman, thank you for calling this hearing today to discuss the Medicare+Choice program.

As a representative from a state hurt by the unfair and unjust inequity in the Medicare managed care reimbursement formula, I know firsthand the difficulties faced by seniors when irrational decisions at the federal level deny them the choices they deserve. As I have said repeatedly before this Committee, because Minnesota has a history of efficient health care, we are penalized by low Medicare+Choice payments.

The Medicare+Choice program does improve the coordination of care and provide our seniors with increased benefits, if reimbursements are high enough.

Today, we will hear about the innovative, comprehensive and coordinated care offered by great companies like UnitedHealth Group. These benefits aren't easily quantified or put on a chart for a cost/benefit analysis. However, they are incredibly important, especially for managing chronic diseases and keeping people healthier longer.

But when HCFA continues to penalize states like Minnesota which have historically provided excellent care at a low price, Medicare+Choice beneficiaries suffer. Any system that rewards the least efficient and penalizes those who watch the bottom line simply isn't sustainable.

That's why I was pleased that last year we were able to increase the minimum floor payment for Medicare+Choice to $475 in rural counties and $525 in urban counties. This first step toward fairness has allowed the two Medicare+Choice plans in Minnesota, UCare Minnesota and HealthPartners, to both reduce their premiums and increase benefits. This is the kind of responsible health care Minnesota is known for, and I am proud of what they've done.

Madam Chairwoman, I know this is a controversial issue, I know that everyone here today doesn't see eye-to-eye on the Medicare+Choice program. However, I know that managed care has an important role in improving patient care in the Medicare system and provides needed choices for our seniors.

Thanks again for your leadership. I look forward to learning more from today's witnesses on how we can best address this issue.

Chairwoman JOHNSON. I would also like to recognize Congresswoman Dunn for purposes of introduction.

Ms. DUNN. Thank you very much, Madam Chairman. I want to welcome Cheryl Scott, who is the President and chief executive officer of Group Health Cooperative to the Subcommittee today. She has been with Group Health since 1979, and she assumed her presidency in 1997.

She has served on the boards of the American Association of Health Plans, the Greater Seattle Chamber of Commerce, and the Health Care Forum. Cheryl also teaches as an associate clinical professor in the graduate program in health administration at the University of Washington.

She is recognized as a leader in health care and has focused her community involvement on addressing the uninsured and on education. Cheryl and Group Health have been committed to serving the seniors in Washington State. I commend them for reducing their premiums in the Medicare+Choice program once Congress passed the Benefits Improvement and Protection Act last year.

Madam Chairman, I appreciate having this opportunity to introduce her, and I think we can all look forward to hearing her suggestions to improve the Medicare+Choice program. I yield back.

Chairwoman JOHNSON. I would like to recognize Mr. McDermott for purposes of welcoming.

Mr. MCDERMOTT. I second the remarks of Ms. Dunn, but I also want to say that Newsweek ranked Group Health as the best HMO in the Northwest. It is no surprise to any of us who live there. Congratulations.

I think her testimony is good to listen to, because they have been operating since 1947 with lots and lots of experience in this area. Thank you.

Chairwoman JOHNSON. Thank you, Mr. McDermott.

My welcome to the first panel, which consists of Cheryl Scott, President and Chief Executive Officer of Group Health Cooperative of Puget Sound, Seattle, WA; Victor Turvey, President of the Midwest Region, UnitedHealthcare, Maryland Heights, MO.; and Dr. Bruce Weiss, Vice President, Medical Operations, AvMed Health Plan, Gainsville, FL. We welcome all three of you and look forward to your comments. Ms. Scott.

Mr. RYAN. Madam Chair?

Chairwoman JOHNSON. Yes, please.

Mr. RYAN. I would just ask unanimous consent to insert an opening statement into the record.

Chairwoman JOHNSON. Certainly, you may. We're glad to have you with us, a new member of our Committee.

[The opening statement of Mr. Ryan follows:]

Opening Statement of the Hon. Paul Ryan, M.C., Wisconsin

Two years ago, in the district I represent, the First District of Wisconsin, we had many seniors who were about to lose their Medicare+Choice benefits because two providers had to stop providing services. The reimbursement rates in Racine, WI, were simply too low for these providers to be able to continue to provide quality care.

I held a town hall meeting on the withdrawal of these providers. Over 2000 seniors showed up at this meeting to express their support for continuing a Medicare+Choice program. Seniors in my district told me they did not want to lose the choices and benefits that this program provides them.

Thanks to the efforts of one senior in attendance at that meeting a petition drive was started to improve the reimbursement rates for Medicare+Choice providers in Wisconsin. With the help of Congressman Bill Thomas, Members of this committee and the efforts of health care providers in the first district of Wisconsin, we were able to persuade a Medicare+Choice provider to stay in my district.

That experience taught me two things: 1) Seniors want and deserve to have choices in Medicare beyond those that the traditional Medicare system are able to offer; and 2) the current Medicare system is woefully inadequate to meet the needs of this population.

Medicare is plagued by inadequate reimbursements for managed care organizations all over the country but Wisconsin is one of the states that is hardest hit. The Medicare+Choice system developed under the Clinton administration does not adequately reflect the cost of care to providers.

Medicare HMOs in some areas of the country are able to provide prescription drug coverage through the Medicare+Choice program. 17% of all Medicare beneficiaries receive prescription drug benefits through this program. Currently, due to inadequate reimbursement rates, Wisconsin seniors and seniors in other parts of the country are not able to take advantage of prescription drug benefits in their Medicare+Choice HMOs.

The inadequate reimbursement rates for providers and the inability of Medicare to keep up with the changing needs of seniors, especially in states like Wisconsin, show the need for comprehensive Medicare Reform. I believe we need to allow seniors to have more choices in health care. I think Medicare+Choice has shown us that seniors want and need these choices.

The Medicare system needs reform because many current provisions are proving to be unworkable. The current system is overly complex and too many providers are not receiving adequate reimbursements-this situation threatens the benefits that seniors are receiving. Medicare should be reformed to allow seniors to have the same number of choices that Members of Congress receive in their health plan. Seniors have a right to choose the coverage that provides for their specific needs.

Chairwoman JOHNSON. Excuse me, Miss Thurman. I didn't realize you wanted to be recognized. My mistake. Before we proceed, it is my pleasure to recognize Karen Thurman of Florida.

Mrs. THURMAN. Thank you, Madam Chairman.

I just want to say a few things about Dr. Weiss. He is the Chief Medical Officer and Group Vice President of Medical Operations at AvMed Health Plan. Just for our information, that is Florida's oldest and largest not-for-profit health maintenance organization and we believe they provide quality health care coverage for about 325,000 commercial Medicare and Medicaid Members Statewide.

However, interestingly, as we go through this hearing today, and as he will cite to you, the Medicare+Choice numbers have actually fallen over the last several years because of changes, actually going from about 75,000 to 30,000 since 1999. But he has done a very good job, I think, of pulling together disease management studies on patients in and around the area, and not only coordinating their health care needs on site, but also their health care needs in home health care with their nursing staff, and providing some expertise that we believe actually gives us an advantage in management of disease control to our constituents.

I might add that they are actually in my district, their operations are there, and just so this Committee will know, we have had good times and bad times together, so I don't want it to be said that we've always had the best relationship, but we have also had a very good working relationship. I think that's kind of what happens in these situations when constituents call.

Dr. Weiss, we're glad to have you here today.

Chairwoman JOHNSON. And I welcome the panelists. Ms. Scott.

STATEMENT OF CHERYL M. SCOTT, PRESIDENT AND CHIEF EXECUTIVE OFFICER, GROUP HEALTH COOPERATIVE, SEATTLE, WASHINGTON

Ms. SCOTT. Thank you very, very much, and I particularly thank you, Congresswoman Dunn and Congressman McDermott, for your kind words. I means quite a bit.

What I would like to do today is to talk a little bit about Group Health and our philosophy of care, and I want to talk about innovation in a particular way. I really do appreciate the Subcommittee's interest in innovation, the Committee's interest in the patient. Oftentimes, I believe, when we get into the Medicare+Choice debate, we get into technical issues. This is a great opportunity to step back and take a look at what can we do for the beneficiaries, for our consumers, and for our citizens.

A bit about the Cooperative. It is not-for-profit. We take care of about 600,000 citizens in the State of Washington, including 60,000 Medicare beneficiaries. We are the Nation's largest consumer-governed health care organization. Our board of trustees—and I think Mr. McDermott was alluding to it—is elected by the Membership. Therefore, we, and I personally, are accountable to the Membership for the care they receive. It's a unique model and a model that we believe in quite strongly.

In terms of Medicare, we have been an active participant in the Medicare program since 1976, so we do have many experiences to talk about.

What I would like to talk about is something that is fundamental to this discussion around innovation, and that is a prepared financing mechanism. Prepayment gives the health care organization an ability to take care of the patient without tying economics to whether a patient is hospitalized, whether there's a physician visit, or whether there's a procedure. Therefore, you can design a whole continuum of care on behalf of that consumer. That continuum of care, the ability to not only treat disease but also to prevent illness, is an incredible gift, an incredible opportunity, and a choice that

we believe, particularly at the Cooperative, obviously, is a choice that is worth making.

It also allows you to really focus on working with physicians and consumers, because they choose to align themselves with health care organizations such as Group Health. Our success in large part is because our physicians and our consumers choose us, and they choose this kind of philosophy of care.

Is this for everyone? No. But it is an option, and a very exciting one, for a lot of people who would like to see their services coordinated on their behalf by a group of physicians accountable to their consumers in terms of their overall health.

So let's talk a little bit about the innovations that we've achieved, and I will give you three examples.

One is called evidence-based care. I think the Subcommittee probably knows this, but on a monthly basis, there are over 30,000—let me repeat—30,000 different citations in the medical literature. How is a practicing physician, let alone a consumer, to know what is the right evidence? What we have been able to do is start an evidence-based program for every single one of our physicians, particularly our primary care physicians. We actually have a group of doctors, pharmacists, nurses, who go over that literature and then publish, through our intranet, guidelines based on that evidence.

An example of how this works involves a Project HOPE study which said that we should increase our ACE inhibitors—that's for cardiovascular disease—we should increase the dosage and double it. We were able to get that recommendation out to our physicians and actually start to change our practice patterns almost immediately. That is very difficult to do when you're not population-based. That is very difficult to do when you don't have a continuum of care of services or a system of care. It is not impossible, but it's much more difficult to do.

The other thing that we are able to do is every single one of our physicians has a registry, a listing of each of their patients and the chronic care diseases, that they're dealing with. For instance, if I'm a doc at Group Health, I can go to my computer and see in my panel of about 2,000 or 2,500 patients, who has cardiac artery disease, who has diabetes. In terms of diabetic care, physicians can see whether patients have gotten their eye exams or their foot care exams.

In the case of cardiac artery disease a physician could ask, "Should I bring some patients in now based on this new study? Can I prevent illness before it occurs?"

That notion of technology, by the way, the ability to use automated clinical information systems, is key in terms of both health promotion and also taking care of people who are ill.

But it really goes beyond disease. What we really try to do is manage populations, not diseases. We are really there for the consumer, not necessarily just for the visit, the day, or the hospitalization.

The other issue that I would like to talk about is this notion of the mental and psycho-social issues associated with our seniors. In my written remarks I talked a lot about exercise and fitness. This isn't around attracting healthy seniors and trying to change your

risk pool. This is quite the opposite. This is giving people's lives back who have chronic debilitating diseases, and we have numerous programs—you can see in the testimony what those programs are—to give those people their lives back, to give them a sense of pride, to give them a sense of what's right.

Again, that is not tied to a visit a day or a hospitalization or a procedure. That is tied by the basic financing mechanism of prepayment.

Finally, uniquely to Group Health, we do have opportunities because we are a consumer organization. We are very, very committed to being accountable to our consumers. Again in my testimony you will see many different allusions to the programs that we provide.

Undoubtedly, we need to look at Medicare with new, fresh eyes. The reform debate holds great opportunities for us. This notion of prepayment, the ability to take care of patients in a different kind of way because we are prepaid, because we can offer a continuum of care, I think that is where the innovation can really flower. Working in partnership with government and with our consumers, I think we can be very, very successful.

Thank you very much.

[The prepared statement of Ms. Scott follows:]

Statement of Cheryl M. Scott, President and Chief Executive Officer, Group Health Cooperative, Seattle, Washington

I. Introduction

Madam Chairwoman and members of the Subcommittee, thank you very much for the opportunity to testify on our experiences in serving Medicare beneficiaries. I am Cheryl Scott, President and Chief Executive Officer of Group Health Cooperative based in Seattle, Washington. Founded in 1947, Group Health is a not-for-profit and with nearly 600,000 members, is the nation's largest consumer-governed health care organization.

Group Health Cooperative has a long-standing commitment to serving Medicare beneficiaries. Shortly after Medicare's creation, we began working with the government to design a program that would allow Medicare to work with prepaid health care organizations like Group Health. In 1976, we were the first organization to partner with the government under what was then referred to as the Medicare risk program. At present, we serve nearly 60,000 Washington state beneficiaries under Medicare+Choice.

II. Value in the Pre-Paid Model of Care

Over the years, the program's name has changed, but the fundamental concept—serving Medicare beneficiaries through a pre-paid model of care—has remained the same. This model allows us to direct resources to areas of greatest need and to be creative and innovative in designing programs. Simply stated, when you are not paid on an encounter by encounter or procedure by procedure basis, you can shift your focus to include longer-term improvement in health outcomes.

Pre-payment has enabled Group Health to deliver care over a broad continuum by investing in prevention programs to help people stay healthy, while at the same time making sure that individuals receive comprehensive care they need when they are ill. It also has enabled Group Health and other plans to develop highly integrated and coordinated care delivery systems by creating opportunities for physicians, hospitals, and other health providers and facilities to associate with each other. These systems of care are particularly crucial for Medicare members, who often have multiple health issues and see more than one provider.

III. Innovations in Serving Medicare Beneficiaries

Group Health has developed programs related to chronic illnesses common in the elderly including depression, diabetes, and heart disease. We also have initiatives in prevention and acute care for conditions such as breast, cervical, and colorectal cancer. At present, work is underway on a "senior care roadmap" that will unify

these initiatives with other special needs of seniors, including fall prevention and medication management.

Although the programs span a wide spectrum of health care conditions and approaches, they all reflect the partnerships created between an organization, patients, clinicians, and other providers that are the heart of the pre-paid model of care. Group Health Cooperative, our members, and providers have worked hard to devise these programs. I am pleased to have the opportunity to share more information about some of them today and to talk about how we partner with our providers and members in developing them.

Partnering with Providers to Improve Care Delivery for Medicare Beneficiaries

Focus on Evidence-Based Medicine

Since Medicare's inception, the practice of medicine has changed dramatically. Technologies and therapies considered to be highly advanced just years ago are quickly becoming outdated. Helping our providers keep up with changes and the best approaches to care is one of the most important contributions of Group Health's care delivery model. Our focus on evidence-based medicine—a systematic approach to collecting and critically evaluating available scientific evidence on treatment options—seeks to offer practitioners and patients the information they need to make informed decisions about treatment options. It also helps ensure that health care dollars are being spent on treatments that have proven benefits.

Since 1990, clinicians working in collaboration with the Guideline Development Support Team have developed more than thirty guidelines. Several of these guidelines address the treatment or prevention of conditions prevalent among Medicare beneficiaries including cancer screenings, diabetes, cardiovascular disease, heart failure, depression, and osteoporosis. These guidelines are meant to be useful aids in determining appropriate practices for many patients with specific clinical problems or prevention issues. They are not intended to replace an individual practitioner's clinical judgment or establish a rigid standard of care.

Teaming Up On Heart Disease Through The Heart Care Road Map Team

The Heart Care Road Map Team is one specific example of how our evidence-based approach can improve health outcomes for our Medicare members. The Team includes cardiologists, family practitioners, nurses, pharmacists, a health educator and quality improvement specialists, among others. Together, the Team works to analyze and evaluate available scientific evidence about heart disease and best available treatment methods, and then shares its findings and recommendations with our practitioners.

Recently, the Team decided to recommend doubling the prescribed dosage level for an angiotensin-converting-enzyme (ACE) inhibitor given to patients with heart disease. The decision was based on a Project HOPE study of nearly 10,000 subjects from 270 hospitals that indicated that for every 27 patients treated with an ACE inhibitor for five years, one death from cardiovascular disease, myocardial infarction, or stroke was prevented. Our system for evaluating and implementing evidence-based medicine, as recommended in the recent Institute of Medicine report, allowed us to respond quickly to this breakthrough study.

In addition, Group Health has an electronic disease registry, which helps our practitioners monitor whether cardiac patients are getting the treatment they need and clearly shows whether a patient is due for a cholesterol check or has been offered the currently recommended therapies. We know that our work in this area is paying off. Our 1999 Health Plan Employer Data and Information Set (HEDIS) performance measure showed that 87 percent of our adult members who had a heart attack received beta-blockers, which have been shown to lower blood pressure and reduce risk for another heart attack.

Improving Beneficiaries' Health and Well-Being Through Exercise

In the early 1980's, Group Health partnered with the University of Washington to examine key determinants of seniors' health and found that regular exercise and social interaction were the two most important factors. Since then, other studies have validated their findings. There is no segment of the population for whom exercise is not important. Whether an individual is 65 or 95, whether they are already physically active or restricted to wheelchairs, whether they are healthy or have painful crippling conditions, we know that exercise can make a difference. We also know that people with functional deficits have been shown to benefit the most from exercise.

With this in mind, Group Health set out to bring the benefits of exercise to individuals who have disabilities or serious, chronic medical conditions such as heart

disease, chronic obstructive pulmonary disease (COPD), arthritis, diabetes, and depression. One outcome of this effort is the "Lifetime Fitness" program offered in 5-week sessions in community senior centers around the area. Aside from the fitness component, the program offers members opportunities to socialize and to develop a community support network. To give you an idea of this aspect of the program, I share with you the following quotation, which appeared in Group Health's Senior Outlook Newsletter:

> "We have a telephone committee that calls members who have been absent two times in a row, just to tell them we miss them," he says. "A greeters committee helps new members feel at home, and another committee organizes occasional lunches out after class."
>
> Group Health Medicare+Choice Member, Age 87;
> Lifetime Fitness Participant for 2 Years

In addition to Lifetime Fitness, the Care Center at Kelsey Creek, Group Health's long-term care and skilled nursing facility, is working on an exercise program for nursing home patients that will serve as a model for our most frail beneficiaries. Finally, I urge you all to read the article submitted as an attachment about "Dancing Ladies" a ballet-based exercise program for women, many of whom have serious mobility difficulties.

Group Health takes its work in this area very seriously, and we continually strive to improve our programs. As such, we are evaluating our fitness programs to assess their impact on key health indicators. These evaluations will help us identify the need for any modifications to ensure that our programs meet the goals of "healthy aging"—optimizing function, preventing avoidable decline in health status, and enhancing quality of life.

Providing Beneficiaries Opportunities To Have A Greater Voice In Their Care

We believe that pre-payment is the basis for our innovations in health care for Medicare beneficiaries and that it creates unique opportunities for patients and providers that are not necessarily available in an encounter-based system of care. Unlike a system that pays by the encounter, a pre-payment system lends itself to establishing longer-term relationships and partnerships between the organization and individual. Group Health's Senior Caucus, a board-recognized special interest group, is perhaps one the best examples of these partnership opportunities. Senior Caucus members participate in a variety of activities including the work on our senior care roadmap. Group Health provides support for its activities, but the Senior Caucus operates independently under its own rules and policies. Since its founding nearly twenty years ago, members of the Senior Caucus have helped to develop:

- **The Senior Peer Counseling Program**, which offers short-term problem solving and "talking support" by trained senior volunteers.
- **The Group Health Resource Line**, which is staffed mainly by senior volunteers. Originally the Senior Information Line, it was expanded in 1990 to include health information for Group Health patients of all ages and connects Medicare members to services available through group Health and the greater community.
- **Silver Glen**, the only senior housing cooperative in the Greater Seattle area.
- **The Senior Outlook Newsletter**, which educates all senior members with timely articles about health promotion and current events in and around the Cooperative.
- **Senior health promotion pamphlets**, available through Group Health medical centers and the Group Health Resource Line.

In addition to having a say in program development and the Cooperative's governance, Group Health seeks to provide our Medicare members with a greater voice and role in their own care through our health education and promotion projects. At present, we have classes, workshops, forums, and support groups on a wide range of topics including Alzheimer's disease, cancer, diabetes, grief and loss.

One more specific example is Group Health's "Living Well with Chronic Conditions Workshop," a six-session workshop to help people learn how to manage their conditions and improve their quality of life. Workshop participants learn how to set realistic goals, achieve successes and build confidence in managing their health, covering topics such as nutrition, exercise, stress management, medication management and planning for the future.

IV. Ensuring The Viability Of The Medicare+Choice Program

Group Health Cooperative, like other plans here today, offers Medicare beneficiaries lower out-of-pocket costs and additional benefits not available in fee-for-service Medicare. These aspects of Medicare+Choice are tremendously important to

our members, particularly those with lower incomes who might otherwise face financial difficulties in accessing needed care. As described here today, our model of care under the Medicare+Choice program—for which the keystone is pre-payment—enables us to provide beneficiaries much more.

Group Health appreciates Congress' efforts to address payment and regulatory issues that in recent years have challenged plans' abilities to continue their participation in the program. As a result of the Benefits Improvement and Protection Act (BIPA), Group Health was able to reduce our members' 2001 Medicare+Choice monthly premium by $13. We put some of the additional funds into the benefits stabilization fund to help minimize any future premium increases that we might have to make. We also increased payments to our physicians and hospitals. We believe, however, that more needs to be done, particularly with respect to the regulatory environment. With that in mind, we offer the following:

• **Honor the Intent of Congress When Implementing Risk Adjustment**: The Health Care Financing Administration's (HCFA) current approach to risk-adjustment reduces Medicare+Choice payments, which has contributed to the instability in the program. Group Health urges HCFA to implement the risk-adjuster in a budget neutral manner, as expressed by Congress in the conference agreement that accompanied the Balanced Budget Refinement Act of 2000. In addition, HCFA's approach to implementing the "all-site" model based on collection of 100 percent encounter data from inpatient and outpatient settings is placing enormous demands on organizations and their providers. We urge HCFA to consider less burdensome alternatives that meet the goals of risk-adjustment.

• **Improve the Partnerships between HCFA and Medicare+Choice Organizations by Establishing Single Administrative Unit for Medicare+Choice Program Oversight**: We recognize that HCFA has many competing demands and responsibilities. However, the current oversight infrastructure for Medicare+Choice—which involves three separate offices—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 and oversight 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.

• **Refocus HCFA's Quality Program**: Clearly, Medicare+Choice organizations must be held accountable for the quality of care they deliver to Medicare beneficiaries. We believe, however, that HCFA's current approach to implement the quality requirements of the Balanced Budget Act of 1997 (BBA) through the Quality Improvement System for Managed Care (QISMC) has presented some challenges.

Group Health has received accreditation from the National Committee for Quality Assurance (NCQA). One of our primary concerns is that QISMC continues to lack clear coordination with NCQA and reporting standards of other organizations. This lack of coordination undermines the ability to develop and implement a meaningful process for deeming plans in compliance with quality requirements, which was a goal of the BBA. In addition, when QISMC is fully implemented, the number of quality projects required to be undertaken at one time, as well as the follow-up work on completed projects, will challenge plans' abilities to devote sufficient attention to each one. For these reasons, we recommend that HCFA reassess its quality oversight requirements. Specifically, we urge HCFA to reconsider its deeming approach to avoid undue interference with private sector standards and to reduce the number of QISMC projects.

• **Reduce the Scope of Standardization of Beneficiary Materials**: Group Health supports the goals of the standardization project—to ensure that information conveyed to beneficiaries is easily understood and to enable easy comparisons among plans. The HCFA initiative to standardize beneficiary materials appropriately focuses on comparative information about Medicare+Choice benefits. However, it also includes beneficiary information that is not used for plan to plan comparisons and which contains plan-specific information. We recommend revising the standardization initiative to focus solely on continuing to improve the standardized Summary of Benefits, which even though it has been in use for two years, still includes language that is confusing.

V. Conclusion

The current debate on Medicare reform presents tremendous opportunities for the same type of innovation in care delivery that we and other plans achieved by working with Congress and the Administration more than twenty years ago. The Medicare+Choice program—the latest iteration of pre-paid Medicare—has much to offer both in the present and future. We urge the Subcommittee to consider the val-

uable contributions made by organizations like Group Health in serving our nation's beneficiaries and to preserve and strengthen a pre-paid option under Medicare.

"Dancing their way to better health"
from Group Health Cooperative's Senior Outlook, Fall 2000

Last year I noticed that a number of the senior patients in my family practice at Northgate Medical Center were in downward spirals.

Many of them were coming into my office, the emergency room, or the hospital because of chest or stomach pain, arrhythmias, fatigue, headaches, depression, and anxiety. Often their children would come with them and plead, "Mom/Dad is going downhill. Isn't there anything you can do?"

There wasn't. Not in my entire medical bag of tricks. Medications never solved their problems and, while I encouraged them to exercise and get out socially, they lacked the motivation and will.

When I thought about the patients as a group, their stories were very similar. A couple of them had lost spouses in the last few years and had become isolated from the world. Some were facing moves from their lifetime homes to retirement apartments and were suffering major depression. Most of them had chronic conditions that were limiting their independence and their ability to enjoy life.

In short, each of my patients was facing huge losses. They all believed they were burdens to their families and friends, and the most common way they described themselves was "useless."

One day I was talking to a ballerina friend of mine who was preparing a dance about the miracle of the aging female body. I suddenly knew what we could do for those patients I'd been worrying about so much. We could start an exercise group at Northgate Medical Center—led by ballet instructors—that focused on muscle strengthening and flexibility, beauty and grace.

I went back to each of the patients and invited them to a ballet-based exercise program that would meet three times a week for four-and-a-half months. I told them that they should join only if they could come regularly and would be willing to put on a performance in the community at the end of the program. I also invited everyone to have lunch together one day a week after class.

Out of the 21 people invited to participate, 16 of them—all women—joined and attended almost every session. The most physically challenged of them had to take ACCESS vans or cabs to get there, and all of them had to challenge themselves to "just do it." That's no small feat when you're depressed and anxious, as we all know, but they came and they did do it.

About a month into the program, the women started talking about how much the class was helping them physically. "I can turn my head to look out the back window of the car now instead of just depending on the mirror," one said. "I can stand up and even hold a cup of coffee," said another who had been suffering from major balance problems.

At the weekly lunches after class, we talked about our lives, our families, our challenges, and our accomplishments. The women bonded as a group in a powerful way and, as they did, they began talking about the class in terms of friendships, perseverance, renewal, support, and love. Their strength and social integration had already gone further than I had ever imagined—and the wonderful result was that they almost never had to visit my medical office.

The idea of putting on a performance at the end of the program was originally just a tool for getting the women to think about who they were, how remarkable they were, and what they would say to the world if they had a chance. What piece of wisdom, or glimpse into their lives and history, would they share?

The performance was held at On the Boards in downtown Seattle in May. That night, backstage, these once shy and withdrawn women were like beautiful 16-year-olds—giddy and nervous. Their spouses, children, grandchildren, and friends were in the audience, ranging in age from 96 years to 10 days.

One by one, each woman took her turn at the microphone at center stage. One got up from her chair by herself—something she'd been struggling to do for three months—and walked unassisted to the mike, where she recited a poem about blossoming. Another rolled her oxygen tank to the mike and read "When I Am Old, I Will Wear Purple." Still another told the audience of the amazing sense of accomplishment she felt in simply being able to get dressed every day.

They made us laugh and they made us cry. In between their personal presentations, they had us clapping, stomping, and hollering as they did stretching, muscle building, and dancing routines to glorious music.

In the end, they hugged each other and some cried. They were so proud—and their families were so proud of them—they just glowed. These women, who had felt

like worthless burdens for so long, had accomplished a major transition. I felt honored to know them.

—by Dr. Chris Himes

Chairwoman JOHNSON. Thank you. Mr. Turvey.

STATEMENT OF VICTOR E. TURVEY, PRESIDENT, MIDWEST REGION, UNITEDHEALTHCARE, MARYLAND HEIGHTS, MISSOURI

Mr. TURVEY. Thank you, Chairwoman Johnson, and distinguished Members of the Subcommittee, for the opportunity to testify today on our experience in the Medicare+Choice program.

I am Vic Turvey, Regional President of UnitedHealthcare, responsible for our Midwest health plan operations, including Medicare+Choice offering in Iowa, Nebraska, Missouri, Wisconsin and Illinois. I am pleased to speak today on behalf of our experience in the program.

UnitedHealthcare and its parent company, UnitedHealth Group, have a longstanding commitment to Medicare beneficiaries. We are the largest provider of health care services to seniors in America. For over 20 years, we have provided seniors and disabled individuals a comprehensive alternative to traditional Medicare benefits, now known as the Medicare+Choice program.

Today, close to 400,000 beneficiaries are enrolled in our Medicare health plans in 63 counties across the country. Through our Evercare program, we provide coordinated care services to an additional 20,000 frail elderly individuals in various care settings. Separately, we provide Medicare supplement or Medigap coverage and hospital indemnity insurance to roughly 3.5 million AARP members nationwide through AARP's Health Care Options programs.

I want to provide you with a snapshot of Medicare+Choice, focusing first on the value we bring to Medicare beneficiaries, and then on issues with the current program structure that are detrimental to our Members.

First, we bring value beyond the traditional Medicare Program by coordinating the fragmented, diverse elements of the health care system and organizing the delivery of care around the best interests of the patient. We offer innovative services that help our Members lead healthier lives by empowering them to make their own choices, working with their physician, supported by information, and the best clinical evidence available.

Since 1996, we have offered beneficiaries a health plan that requires no additional premium beyond the monthly part B premium. In most markets, Members also get coverage for prescription drugs.

Members also benefit from our value-added features such as individually assigned customer service representatives, access to a 24-hour nurse line, and internet-based health information resources and programs that track their special health conditions and remind them to get regularly scheduled diagnostic tests. They also become a part of our care coordination program, where dedicated nurses follow their hospitalizations and make sure that services are understood, accessible and coordinated before, during and after they are

in the hospital. These services are unavailable outside of the Medicare+Choice program.

Let me describe some of these services in more detail.

Under care coordination, this allows Members to work directly with their physician to determine the best way to coordinate their own health care needs. Care coordination is designed to make it easier to get care while identifying and addressing gaps in care. It encompasses hospital admission counseling, health education, prevention and reminder programs, inpatient care advocacy, phone calls to high-risk Members post-hospitalization, identification and support programs for Members with complex and chronic illnesses, and long-term assessment and education programs to support Members with asthma, cardiovascular disease, and diabetes. We have received many letters over the last 2 years from Members describing how this program has changed their perception of what a health care plan can do for them and what a health care plan ought to be. We have also seen a notably improved health outcome.

Our personal service specialists are individually assigned to each Member. They provide them with one name to call to answer any question they may have and to resolve problems. This program helps to provide a familiar face to the health plan. It helps beneficiaries navigate the complexities of the health care system, a service which is particularly important to seniors.

Our Care 24 Program provides Members 24 hour a day, 7 day a week access to registered nurses, masters-level counselors and lawyers, to get answers to questions about medical issues, personal and emotional health, legal and financial issues, eldercare and other concerns. It also offers recorded messages from a health information library on over 1,000 health topics.

Finally, UnitedHealth passport allows Members to obtain coverage for routine care when they travel to other UnitedHealthcare Medicare+Choice markets. This is invaluable for "snow birds" that spend part of their year in Florida and other parts of the country.

All of these offerings are underscored by our commitment to support the physician-patient relationship. Our close relationship with physicians, hospitals and other health care providers is critical to improved medical outcomes. Our medical directors, physicians themselves, work closely with network providers to share our data on best practices within their community and in other cities as well. This is comparative information that doctors have generally never had available to them, and they love it.

When physician groups are incented to apply this quality and cost data we provide to them, they can achieve better outcomes at lower cost. While UnitedHealthcare is an industry leader in its ability to develop and distribute outcomes data, several other companies are also developing similar capabilities, so it is not unique to us.

The fundamental point is that this data, combined with proper balanced incentives from health plans, and then aligned with incentives originating from hospital system, is absolutely essential to efforts to improve quality and moderate cost increases.

Now, there are difficulties facing the Medicare+Choice offering. Our experience with physicians, hospitals and other health care providers illustrates one of the most significant problem areas in

the current environment. As stated earlier, one of our hallmark offerings is——

Chairwoman JOHNSON. Mr. Turvey, the red light has gone on. I know you're just starting at your recommendations. But if you could just give a very brief overview, I will come back to them in the question period.

Mr. TURVEY. OK.

Chairwoman JOHNSON. I have read your testimony and I——

Mr. TURVEY. On the recommendations, in summary, here is what we would recommend.

There are four key areas for program improvement: reimbursement, administrative simplification, provider relations, and an allowance for evolutionary benefit design.

Fundamental reform of the reimbursement is necessary to ensure long-term stability and viability of the program. We need a fair and comprehensive payment approach that more closely aligns current medical cost trends and factors in cost variability in different markets.

We need current administrative requirements to be streamlined at HCFA. We believe Congress ought to explore the reasons behind the increased difficulties with hospital and physician plans participation in Medicare+Choice, particularly focusing on plans' limited payment leverage in markets with dominant hospital systems.

Finally, we think reform of the system must recognize the evolutionary nature of the health care system itself, developing a program that allows for change as the system warrants.

We encourage Congress and HCFA to study successful contracting arrangements in the employer sector, such as nonrisk-based alternatives, as the basis for its own contracts with private health plans, in rural areas especially. HCFA could then operate like an employer, who self-funds employer coverage and partnering with health plans to bring value to their offerings by administering and managing the health and operational aspects of the benefit.

We think Medicare+Choice has much to offer, but the problems today are very real, and yet there is a great opportunity for positive change.

Thank you.

[The prepared statement of Mr. Turvey follows:]

Statement of Victor E. Turvey, President, Midwest Region, UnitedHealthcare, Maryland Heights, Missouri

Thank you Chairwoman Johnson, Congressman Stark, and other distinguished members of the Subcommittee for the opportunity to testify on our experience in the Medicare+Choice program. I am Vic Turvey, regional president of UnitedHealthcare, responsible for our Midwest health plan operations, including Medicare+Choice offerings in Iowa, Nebraska, Missouri, Kansas, Wisconsin and Illinois. I am pleased to speak on behalf of our experience in the Medicare+Choice program.

UnitedHealthcare and its parent company, UnitedHealth Group, have a long-standing commitment to Medicare beneficiaries. Our participation in the Medicare program is fundamental to our core mission—to support individuals, families, and communities to improve their health and well being through all stages of life.

UnitedHealth Group is the largest provider of health care services to seniors in America. For over 20 years, we have provided seniors and disabled individuals a comprehensive alternative to traditional Medicare benefits, now known as the Medicare+Choice program. Today, close to 400,000 beneficiaries are enrolled in our Medicare health plans in 63 counties across the country. Through our Evercare program, we provide coordinated care services to an additional 20,000 frail elderly individuals in various care settings (under the auspices of the Medicare+Choice program

and a demonstration project). Separately, we provide Medicare Supplement ("Medigap") and Hospital Indemnity insurance to roughly 3.5 million AARP members nationwide through AARP's Health Care Options program.

I want to provide you with a snapshot of Medicare+Choice, focusing on the value we bring to Medicare beneficiaries and a number of issues we face in the current program structure that we believe are detrimental to our members.

We bring value beyond the traditional Medicare program by coordinating the fragmented, diverse elements of the health care system and organizing the delivery of care around the best interests of the patient. We offer innovative services that help our members lead healthier lives by empowering them to make their own choices, working with their physician, supported by information and clinical evidence. Since 1996, we have offered beneficiaries a health plan that requires no additional premium beyond the monthly Part B premium. Beneficiaries who enroll in our plans get comprehensive coverage, much like the commercial coverage that many had through their employers. In most markets, members also get coverage for prescription drugs (typically offered on a two-tiered basis, with lower copayments for generic equivalents and higher copayments for brand name drugs).

Members also benefit from our value-added features such as individually assigned customer service representatives, access to a 24 hour nurse line and internet-based health information resources, and programs that track their special health conditions and remind them to get regularly scheduled diagnostic tests. They also become a part of our Care Coordination program where dedicated nurses follow their hospitalizations and make sure that services are understood, accessible and coordinated before, during and after they are in the hospital. These services are unavailable outside of the Medicare+Choice program.

Let me describe some of these special features in more detail:

• *Care Coordination* ℠ allows members to work directly with their physician to determine the best way to coordinate their own health care needs. Care Coordination is designed to make it easier to get care while identifying and addressing gaps in care. It encompasses hospital admission counseling, health education, prevention and reminder programs, inpatient care advocacy, phone calls to high-risk members post-hospitalization, identification and support programs for members with complex and chronic illnesses and long-term assessment and education programs to support members with asthma, cardiovascular disease and diabetes. We have received many letters from members describing how this program has changed their perception of what a health plan can do for them and have notably improved health outcomes.

• *Personal Service Specialists* are individually assigned to each member, providing them one name to call to answer any questions they may have and resolve problems. This program helps to provide a familiar face to the health plan, helping beneficiaries navigate the complexities of the health care system—a service particularly important to seniors.

• *Care24* provides members 24 hour a day, 7 day a week access to registered nurses, masters-level counselors and lawyers to get answers to questions about medical issues, personal and emotional health, legal and financial issues, eldercare and other concerns. It also offers recorded messages from a health information library on over 1,000 health topics.

• *UnitedHealth Passport* allows members to obtain coverage for routine care when they travel to other UnitedHealthcare Medicare+Choice markets. This is invaluable for "snow birds" that spend part of the year in Florida and other parts of the country.

All of these offerings are underscored by our commitment to support the physician-patient relationship. Our relationship with physicians, hospitals and other health care providers is critical. Our medical directors, physicians themselves, work closely with network providers to share our data on best practices within their community and in other cities as well. We also have undertaken a number of initiatives to simplify a doctor's interaction with the health plan so that they can focus on their patients instead of paperwork. Our Medicare health plans have been most successful in markets—such as St. Louis— where we work with physician groups who are incented to apply the quality and cost data we can provide to them. UnitedHealthcare is an industry leader in its ability to track utilization patterns and outcomes data; several other companies have similar capabilities. The fundamental point is that proper, balanced incentives aligned with incentives originating from hospital systems are absolutely essential to efforts to improve quality and moderate cost increases.

Difficulties facing current Medicare+Choice offerings

Provider Contracts: Our experience with physicians, hospitals and other health care providers illustrates one of the most significant problem areas in the current

Medicare+Choice environment. As stated earlier, one of our hallmark offerings is providing members access to broad, diverse, fully qualified providers. However, in many markets this has been hindered, as hospital systems increasingly prefer to revert to the Medicare fee-for-service payment system because it offers higher payment and no third party (health plan) involvement. In some markets, hospital systems have terminated their relationship with us mid-year (inconveniencing our members who often have to find new primary physicians in the remaining network or disenroll from their health plan to maintain their physician relationship); in others they have demanded payments on par with traditional Medicare.

This occurs as the gap between payment for hospital services under the traditional Medicare program and Medicare+Choice plans grows and provider groups pick and choose between participation in the two programs. Last year's Medicare, Medicaid and SCHIP Benefits Improvement Protection Act of 2000 (BIPA) served to widen the gap considerably as hospital payment increases generally outpaced Medicare+Choice increases. Consequently, in most markets we were forced to dedicate all BIPA increases to hospital and physician reimbursement to meet contracting demands and maintain adequate networks.

Reimbursement: In our experience, beneficiaries have seen a deterioration of benefit offerings since enactment of the Balanced Budget Act (BBA) in 1997, as annual payment increases have not kept pace with inflation. We have been able to continue to provide quality coverage to beneficiaries in many markets by streamlining our administrative procedures. We also have had to adjust benefit coverage, increasing copayment amounts for outpatient visits and hospitalizations and reducing or eliminating our coverage for prescription drugs. In almost half of our Medicare+Choice markets we no longer offer coverage for outpatient prescription drugs. Where we do offer coverage, the annual maximum is in the $200 to $500 dollar range (with the exception of Dade County, Florida where it is $1,500) with coverage limited to generic equivalents or steep copayment differentials for generic and brand. While we would like to see additional funding for the program, we believe that fundamental reform of the reimbursement system is necessary to address the many moving parts of the payment system and ensure long-term stability and viability of the program.

Administrative Issues: We believe that regulation and accountability is important and necessary to ensure fair, quality coverage for Medicare beneficiaries. However, the way that current administrative rules and procedures are established and enforced is burdensome and strains health plan resources. The complexity of Medicare+Choice administrative requirements, coupled with the lack of coordination between states, HCFA regions and central HCFA, means that plans may face conflicting interpretation of rules and be subject to multiple audits. In addition, the number of new rules has grown exponentially since enactment of the BBA. The new HCFA monitoring guide used to evaluate health plans during their biennial site visits includes 279 items for review (not including the BIPA requirements); before BBA, there were 146 items.

Based on our experience, the more problematic administrative items are:

• *2002 Enrollee "Lock-In."* The new lock-in requirement, which will be phased—in beginning next year, will likely add to beneficiary confusion and anxiety about the product, placing additional strains on a Medicare+Choice plan's ability to attract and retain members. We have found that the ability to disenroll at any time provides added comfort for a beneficiary who is enrolling in Medicare+Choice for the first time. If he or she is unhappy with the plan, the beneficiary can revert back to original Medicare or try another Medicare+Choice plan at any time.

• *ACR process*. The new June filing deadline (formerly in the fall) makes it very difficult to make accurate financial projections, and thus appropriate benefit decisions, given that only first quarter (January through March) data is available at that time.

• *Encounter data collection*. The current requirement to submit encounter data is very time consuming and costly, given questionable returns. Foremost in our concerns is the process for submitting the data to HCFA, which is cumbersome and resource intensive under the current fee-for-service based claims system. Additionally, the scope of data required for submission seems excessive, given the more limited data that is required for risk adjustment.

• *Standardized beneficiary materials*. HCFA's new requirement to use a standardized Summary of Benefits (created automatically from the database used for ACR submissions) has been problematic for our members. While standardization is helpful in allowing comparisons between plan offerings, some information and materials do not lend themselves well to standardization. In some cases, standardization has resulted in inaccurate descriptions and has made it difficult for beneficiaries to gain

specific information about individual Medicare+Choice benefit offerings and health plan administrative requirements.

• *Marketing materials/HCFA review*. 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. 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 our those who hear about changes in media reports, but then fail to receive notice until much later. This is particularly troublesome when we are held to a 30-day notice period for changes to the network or mid-year benefit improvements. In a number of 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 on our unique attributes.

• *Regulatory implementation*. The frequency and content of new regulatory and policy changes has increased staff time and resources considerably. In 2000, HCFA issued 15 new Official Policy Letters (OPLs), two revisions of one OPL, and the final Medicare+Choice regulation (the "mega reg"). Inconsistencies between regional offices and central HCFA add to the strain of regulatory interpretation, particularly for national health care organizations, such as UnitedHealthcare.

How do we fix the program and ensure its future viability?

While there clearly are a number of obstacles facing the current Medicare+Choice program, we believe the program continues to have much to offer seniors and disabled individuals and believe there are a number of changes that could significantly enhance the future viability of the program. First and foremost, we believe that the program must undergo fundamental reform to provide beneficiaries broad choices of coverage that best meets their needs in a manner that they can count on for years to come.

There are four key areas for program improvement: reimbursement, administrative simplification, provider relations, and allowance for evolutionary benefit design:

• Fundamental reform of the reimbursement system is necessary to address the many moving parts of the payment system and ensure long-term stability and viability of the program. A fair, competitive payment approach that is more closely aligned with current medical cost trend and factors in cost variability in different geographical markets and care settings is desirable.

• A thorough review of current administrative requirements with an aim to streamline processes, improve coordination and eliminate items that have negligible benefits for members would be advantageous.

• Congress should explore the increasing difficulties with hospital and physician participation in Medicare+Choice, focusing particularly on Medicare+Choice plans' limited provider payment leverage in markets with dominant hospital systems. Also, payment to hospitals and physicians should include incentives for efficient and appropriate health care delivery and outcomes.

• Reform of the system must recognize the evolutionary nature of the health care system, developing a program that allows for change as the system warrants. We encourage Congress and HCFA to study successful contracting arrangements in the employer sector (such as non-risk-based alternatives) as the basis for its own contracts with private health plans. HCFA could operate like an employer who leverages its assets by self funding employee health coverage and partnering with health plans, like ours, to bring value to their offerings by administering and managing the health and operational aspects of the benefit. In addition, Medicare+Choice should recognize the value of specialized programs like Evercare and allow them to exclusively serve frail elderly beneficiaries.

Medicare+Choice has much to offer. We encourage Congress and HCFA to experiment with different types of product offerings within Medicare that are tailored to specific populations and geographic areas. To this end, we already have begun to explore options with HCFA that bring the many unique, value-based attributes of our product offerings to the more traditional Medicare benefits and may be more sustainable in certain markets than risk-based Medicare+Choice offerings. Working together to address many of the items raised today, we can help to develop a renewed Medicare program that meets the needs of today's and tomorrow's beneficiaries. The problems with the program are very real, but there is a great opportunity for positive change.

Thank you for the opportunity to share our thoughts. I would be happy to answer any questions you might have.

Chairwoman JOHNSON. Thank you very much, Mr. Turvey. Dr. Weiss.

STATEMENT OF BRUCE WEISS, M.D., M.P.H., CHIEF MEDICAL OFFICER, AVMED HEALTH PLAN, GAINESVILLE, FLORIDA

Dr. WEISS. Madam Chair and Members of the Subcommittee, my name is Dr. Bruce Weiss. I am the Chief Medical Officer for AvMed Health Plans, based in Gainesville, Florida, in the heart of Representative Karen Thurman's district.

AvMed is the oldest and largest not-for-profit HMO in Florida. We serve some 300,000 Members, including approximately 30,000 Medicare Members, and 10,000 Federal employees and their dependents. AvMed is Federally qualified and accredited by both the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

I appreciate the opportunity to participate in today's hearing to describe the nature and scope of disease management programs in managed care plans and specifically the programs my plan offers to all Members, especially our Medicare members.

Disease management programs are one of he major enhancements over traditional fee-for-service Medicare that beneficiaries receive by enrolling in Medicare+Choice options. This is from the newest Provider Sponsored Organization (PSO) to the largest HMO. These programs are important elements of every Medicare managed care option—providing coordination of care, promotion of best practices, and patient empowerment.

Numerous studies have demonstrated that well-designed disease management programs have significantly impacted participants' well-being and overall health status. Patients with moderate to severe congestive heart failure have improved their functional status through disease management programs. This means that a patient who is essentially home—or bed-bound can get out and go to church, shop, or visit family. This is a major improvement in their quality of life.

At AvMed, we have eight care or disease management programs, six focusing on the illnesses of our Medicare beneficiaries: congestive heart failure, diabetes, end-stage renal disease, chronic wound care, and chronic obstructive pulmonary disease. All of these programs require an investment in staff, materials, and information systems to be successful. Nurses regularly call Members to assess their progress. Patients who appear to be deteriorating are referred to their primary care physicians or specialists for assessment and modification of their treatment. Medical problems are identified and addressed earlier, avoiding risk for the patient, hospitalization, and medical costs.

Unfortunately, these programs are labor and resource intensive and, therefore, limited to just a small percentage of our Members, focusing predominantly on those at highest risk.

AvMed and others are looking at new technology that will allow us to more efficiently monitor larger numbers of patients with lower administrative costs. Today, we have a pilot program in

which each morning our Members step on an electronic scale, which weighs the Member, asks several key clinical questions, and then electronically transfers this information to AvMed. Those Members reporting worsening symptoms or weight gain above limits set by their physicians are contacted by one of our nurses. In addition, this daily information is available to the Members' treating physicians in a summary form for ongoing use in managing their care.

It is through ongoing investments such as this that disease management programs are going to reach their full potential and be expanded to include a larger patient base. However, these population-based programs are expensive, require staff and expertise that is generally not available in most physician offices, and is not reimbursable under most fee-for-service plans.

I would like to share with you the experience of one of our Members. Mrs. "B" is a delightful 80-year-old North Florida Medicare beneficiary who joined AvMed in February, 2000. She was enrolled in our congestive heart failure program due to heart damage caused by her diabetes.

Last July, her husband died from lung cancer. In January, she fell and developed cellulitis, a serious infection of her leg, for which she was prescribed oral antibiotics. Shortly thereafter, she called our 24-hour Healthy Heart Hotline because her heart symptoms worsened and she was having increased difficulty breathing.

Mrs. "B" had stopped taking her antibiotics because she felt it was making her swell up. Our nurse contacted her physician, who called her and instructed her to resume her antibiotics. A nurse was then sent to her home and found that she had gained over five pounds and that she was only taking half the dose of her prescribed diuretic/water pill. An intravenous dose of a diuretic was given, and during follow-up visits, it was noted that Mrs. "B's" blood sugar was over 350 and that she had not been taking her insulin since her husband's death, since he was the one who was giving her injections.

Arrangements were made for Mrs. "B" and her daughter, also a diabetic, to be seen by her physician in his office, and both were instructed on giving insulin, following a diet, and exercising. Since this visit, Mrs. "B" has moved in with her daughter and both have become more compliant with their diets, managing their diabetes, and exercising.

As the administration and Congress consider options for stabilizing the Medicare+Choice program and pursuing reforms in the Medicare Program, it is critically important to ensure that Medicare is administered efficiently and effectively. The regulatory framework should be designed to promote, rather than impede, the implementation of disease management programs that improve health care quality for Medicare beneficiaries.

Again, I thank you for the opportunity to share with you some information regarding the exciting opportunities with disease management.

[The prepared statement of Dr. Weiss follows:]

Statement of Bruce Weiss, M.D., M.P.H., Chief Medical Officer, AvMed Health Plan, Gainesville, Florida

Madam Chair and members of the subcommittee, my name is Dr. Bruce Weiss. I am Chief Medical Officer of AvMed Health Plan. Based in Gainesville, Florida, in the heart of Representative Karen Thurman's district, AvMed is Florida's oldest and largest not-for-profit HMO, serving some 300,000 members in 11 counties, including approximately 30,000 Medicare members and 10,000 federal employees and their dependents. Due to the instability in the Medicare+Choice program, the number of Medicare members we serve has declined from 75,000 to 30,000 since 1999. AvMed contracts with close to 7,000 physicians and 126 hospitals, is federally qualified and is accredited by both the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

I appreciate the opportunity to participate in today's hearing and to describe the nature and scope of disease management programs in managed care plans and specifically the disease management programs my plan offers to all our members, especially our Medicare members. Disease management programs are one of the major enhancements over traditional FFS Medicare that Medicare beneficiaries receive by enrolling in a Medicare+ Choice option—from the newest PSO to the largest HMO. These programs are important elements of every Medicare managed care option—providing coordination of care, promotion of best practices and patient empowerment through education.

Disease Management Programs

Let me explain the process we use to implement disease management programs. First, our goals are to:

- empower our members through education;
- provide our members and health care providers with tools to improve our members' quality of life and promote preventive lifestyle choices; and
- facilitate a comprehensive and integrated health care delivery team concept to assure the best clinical and economic outcomes.

To achieve these goals, we have developed a strategy that involves:

- identifying the high-risk population;
- implementing and promoting national guidelines;
- implementing critical pathways;
- promoting effective client self-directed interventions;
- designing and implementing comprehensive case management and home health interventions;
- promoting safe and effective physician intervention; and
- measuring outcomes.

We implement this strategy using an integrated approach among health care professionals. Care coordinators serve as the liaison between members and health care providers, coordinating care and services while also performing educational and patient advocacy roles. Health care providers deliver treatment plans according to accepted "best practice" guidelines, while assisting with the coordination of care and providing continuous feedback on results. Home health care is also an important component of many disease management programs.

We evaluate our disease management programs using measures that focus on patient satisfaction and clinical outcomes, as well as performance indicators developed by the NCQA. These programs have been particularly important to our senior population in Medicare+Choice.

Numerous studies have demonstrated that well-designed disease management programs can have a significant impact on participants' well-being and overall health status. Patients with moderate to severe Congestive Heart Failure have been documented to improve their functional status through a CHF disease management program. This means that patients who were essentially home—or bed-bound can get out and go to church, shop or visit friends—a major improvement in their quality of life.

At AvMed we have 8 care or disease management programs—6 focusing on the illnesses of our Medicare beneficiaries: Congestive Heart Failure (CHF); Diabetes; End Stage Renal Disease (ESRD); Chronic Wounds; and Chronic Obstructive Pulmonary Disease (COPD). All of these programs require an investment in staff, materials and information systems to be successful. Nurses regularly call members to assess their progress. Patients who appear not to be improving are referred to their primary care physicians or specialists for assessment and modification of their treatment.

With care management, medical problems are identified and addressed earlier, avoiding potential risk to the patients, hospitalizations and medical costs. AvMed

and others are looking at new technology that will allow us to more efficiently monitor larger numbers of patients, with lower administrative costs. Today we have a pilot program in which each morning our members step on an electronic scale, which weighs the member, asks several key clinical questions and then electronically transfers this information to AvMed. Those members reporting worsening symptoms or weight gain above limits set by their physicians are contacted by one of our nurses. In addition, this daily information is available to the members' treating physicians in a summary form for on-going use in managing their care.

It is through on-going investments such as these, that disease management programs are going to reach their full potential and be expanded to a larger patient base. However, these population-based programs are expensive, require staff and expertise that is generally not available in most physician offices and is not reimbursable under most FFS plans.

To illustrate, I want to share the experience of one of our members with you. Mrs. "B" is a delightful 80 year-old North Florida Medicare beneficiary who joined AvMed in February 2000 and was enrolled in our Congestive Heart Failure Program due to heart damage caused by her diabetes. Last July her husband died from lung cancer. In January, she fell and developed cellulitis, a serious infection of her leg, for which she was given oral antibiotics. Shortly thereafter, she called our Healthy Heart Hotline because her heart symptoms worsened and she had increased difficulty breathing. Mrs. B had stopped taking her antibiotic for her leg problem, because it was making her swell up. Our nurse contacted her physician who called her and instructed her to resume her antibiotic. A home health nurse was also sent to her home and found that she had gained over 5 pounds, and that she was only taking half the dose of her diuretic/water pill. An intravenous dose of a diuretic was given. During follow up visits, it was noted that Mrs. B's blood sugar was over 350 mg/dl and that she had not been taking her insulin since her husband's death—he was the one who gave her insulin injections.

Arrangements were made for Mrs. B and her daughter, also a diabetic, to be seen by her physician in his office and both were instructed on administering insulin, following a diet and exercising. Since this visit, Mrs. B has moved in with her daughter and both have become more compliant with their diets, managing their diabetes and exercising.

Issues Facing the Medicare+Choice Program

The future success of the Congestive Heart Failure Program—and other innovative disease management programs offered by AvMed and other Medicare+Choice plans—depends on the long-term stability of the Medicare+Choice program. As effective as Medicare+Choice plans are at using disease management strategies to improve health care quality for Medicare beneficiaries, we cannot succeed without adequate funding and a sensible regulatory environment.

This hearing's focus on administrative and regulatory issues is highly appropriate, given the reality that the costs of Medicare's many regulatory requirements are rarely measured in comparison to their benefits. This forces health plans to spend scarce resources on compliance activities of questionable value and, as a result, leaves plans with fewer resources to spend on disease management initiatives.

Payment and regulatory requirements dictate the environment in which Medicare+Choice plans operate. The current payment and regulatory environment has forced many plans to make difficult decisions regarding their participation in the Medicare+Choice program. We are deeply concerned that the administrative and regulatory actions taken by the Health Care Financing Administration (HCFA), together with the unintended results of the Medicare+Choice payment formula, have undermined the program's stability. Rather than enjoying expanded coverage choices as planned under the Balanced Budget Act of 1997 (BBA), many beneficiaries face fewer coverage choices today.

Regrettably, this loss of choices means that fewer Medicare beneficiaries have access to the high quality health care services that are delivered through the disease management programs that AvMed and other Medicare+Choice plans are implementing. Ideally, all Medicare beneficiaries should have access to these services. In recent years, however, hundreds of thousands of beneficiaries have been forced to give up their Medicare+Choice plans and enroll in the old-style fee-for-service Medicare program.

Restoring these choices and stabilizing the Medicare+Choice program should be Congress' top priority in the 2001 Medicare debate. Medicare+Choice has the potential to serve as a foundation for the Medicare program of the future.

As the Administration and Congress consider options for stabilizing the Medicare+Choice program and pursuing structural reforms in the Medicare program, it is critically important to ensure that Medicare is administered efficiently

and effectively. The regulatory framework should be designed to promote, rather than impede, the implementation of disease management programs that improve health care quality for Medicare beneficiaries.

Again, I thank you for the opportunity to briefly share with you some information regarding the exciting opportunities surrounding disease management.

Chairwoman JOHNSON. Thank you.

I would like to make a comment on the GAO study that my colleague, Mr. Stark, mentioned at the beginning that suggested that Medicare managed care plans were being overpaid.

In 1998, the Medicare+Choice plans were paid at 2 percent more than the fee-for-service sector. That spending was 2 percent above the fee-for-service sector, but that was at a time, remember, when everyone agreed that through the 1997 Balanced Budget Act we had grossly over reduced reimbursement rates. And, frankly, the whole Medicare fee-for-service system was in terrible shape, and if we hadn't moved promptly to increase reimbursements, we would not have thousands of providers that are still alive out there.

So the fact that Medicare+Choice plans were 2 percent above that is, I think, not a testament to overpayment. If you look, and you take the projections that are on the books out, you will see that in coming years, the Federal Employee Health Benefit Plan (FEHBP) will be way up there, California Public Employees Retirement System (CalPERS) will be next, Medicare fee-for-service will be next, and Medicare+Choice plans will be the lowest-cost plan in 2001 and 2002.

So I don't necessarily consider that a good thing, that the Choice plans will be below fee-for-service. I think what we are about here today is to look at the strengths that Choice plans have brought to the issue of health quality for our seniors and then to look at some of the problems that you were running into.

And in that vein of problems that you are running into, Ms. Scott, you didn't get a chance to talk about what the problems that you would like to see solved, having consumed your 5 minutes, a terribly piddling amount of time, however, admittedly, you did not get to talk about the problems that you think it is necessary to solve for you to survive in the Choice arena. Would you enlarge on that, please.

Ms. SCOTT. Thank you for that. I concentrated on prepayment because I think without prepayment and the philosophy of prepayment, the problems we are trying to solve take on technical——

Chairwoman JOHNSON. Actually, just put that prepayment issue—I am very glad you mentioned that. You know, the Federal government pays States to take children out of the home. That is the way we make foster care payments. We will not pay States to keep children in the home, and that issue of tying payments to place of care is extremely destructive.

And I hadn't really made the parallel until you made such a clear statement about this in your testimony that one of the benefits of the integrated approach is that you get the payment and then you can decide what is the best location, as well as the most costive location for care. That was very well-taken. Thank you.

Ms. SCOTT. Thank you, Congresswoman.

Group Health has four recommendations for the Committee to consider, in terms of issues to stabilize the Medicare+Choice program:

The one is to honor the intent of Congress, when implementing the risk adjuster, and we can get into more of the detail about that. I think there is an appropriate role to have a risk adjuster, particularly in our State. Our State Employees Benefits Board, they work with a risk adjuster with us. We accept that. So we do not question for a minute the need for one. What we question is the mechanisms, and the methods, and the approaches by which to do that. And so that would be one area that we would like to discuss.

Secondly, I think the notion of HCFA and how HCFA is organized. There are very good people in HCFA. Unfortunately, they are siloed, if you will, in different parts of that organization, and so we can't do the best job in terms of a partnership with HCFA. Because of the silos, you do get different regulations. Sometimes they are at cross-purposes with each other. Our recommendation would be can we take a fresh look at how that is organized within HCFA and think through, in a thoughtful way, how we can partner best with HCFA.

I remember the days where there used to be an office in HCFA that did strategy, and pilot projects and demonstration projects, and we are really very interested in testing out new ideas. That would be an affirmative recommendation for this Committee, in terms of its relationships with HCFA.

The third area is HCFA's quality program. Again, it is the theory of unintended consequences. There is absolutely everything right about accountability for quality at Group Health, and I am sure my sister plans here would agree about that accountability. Unfortunately, Murphy's jumps up again on this particular issue of asking a different set of metrics, a different set of process, a different set of approaches around quality management and not necessarily coordinating those with existing accrediting bodies. Our worst fear, obviously, is that will create more administrative hassle, more rework, with not necessarily any beneficiary advantage.

And, finally, I think we do need to think about, and this is very technical, and I apologize, but as you know, seniors get confused by all of the stuff that comes at them. My mom and dad call me up and say, "What does this mean?" They are 86 and 84, and they are pretty good 86—and 84-year-olds, but still it is very, very confusing. So the idea of standardizing language, again, a very good idea, very good intent. The unintended consequence, though, is that we are afraid that is going to become even more confusing for our consumers simply because the standards that HCFA may say, in terms of definitions, may be different than what an employer for people under 65 might be saying. And, again, we have been dealing with different standards.

Chairwoman JOHNSON. We do need to look at that issue.

Because my time is also limited, I want to ask Mr. Turvey, and I hope some of my colleagues will allow you time to go into more specifically your recommendations as to how to overcome the challenges. But you do make, that is, the barriers to your future as a Choice plan, but you made a very interesting statement at the end of your testimony. You say, "To this end, we already have begun

to explore options with HCFA that bring the many unique value-based attributes of our product offerings to the more traditional Medicare benefits."

That issue of how can we translate what you have learned and what you have brought to the quality of senior care into the fee-for-service plan interests I think all of us very much. Could you enlarge on that statement.

Mr. TURVEY. Sure. This is a concept that we are considering as a pilot project in Iowa. The scenario we have in Iowa is a rather disorganized or at least not organized group of physicians in rural areas, especially. We are looking to develop a program similar to Medicare+Choice in that area.

These physicians, because they are not organized in large groups, because they don't have a great deal of capital available to them, cannot necessarily take on a significant risk that you would normally transfer to them under a prepayment mechanism or a standard capitation approach. And so we are looking to do something that is more on the order of a gain-sharing approach, where there is very limited economic risk on the downside. What we are looking to do is to set some quality incentives for them. And if they are to hit those quality incentives, then they would qualify for financial incentives, should there be any. So quality is placed first and then the financial side economics second. But, basically, it would be a minimal-risk program for them in rural areas to get their feet wet in Medicare+Choice.

Chairwoman JOHNSON. Interesting. Mr. Stark.

Mr. STARK. Thank you, Madam Chair.

Just a couple of questions to see if—my guess is that all Medicare+Choice is not alike, but, Ms. Scott, in Group Health Cooperative, are you a staff model or are all of your physicians on salary?

Ms. SCOTT. That is a good question, Mr. Stark. Four hundred thousand of our six hundred thousand consumers are served by the staff model, and——

Mr. STARK. I beg your pardon?

Ms. SCOTT. We have 600,000 Members; 400,000 are served by staff model group practice physicians, much like Kaiser, and 200,000 are served by community physicians in different communities throughout the State.

Mr. STARK. And with those 200,000 physicians, do you capitate the primary care doctor?

Ms. SCOTT. We capitate primary care, and then we pay fee-for-service on specialty.

Mr. STARK. And do you downstream the risk to the primary care docs in that 200,000 who are not in a staff model?

Ms. SCOTT. I understand your question. We capitate, but there is no downside risk to the physicians.

Mr. STARK. So there is no disincentive for those physicians to refer out for surgery or something like that.

Ms. SCOTT. No, sir.

Mr. STARK. Do you, in your staff model, do you own your own hospital facilities, for the most part?

Ms. SCOTT. That is another good question. We used to own a lot more hospitals than we do now. We mostly contract with hospitals right now.

Mr. STARK. You are not-for-profit?

Ms. SCOTT. We are not-for-profit. We are a consumer cooperative.

Mr. STARK. Do you have a figure that you announce publicly that you would call an overhead figure or loss ratio or however you want to term it?

Ms. SCOTT. Sure. The term "medical loss ratio" is kind of a crazy term, isn't it?

Mr. STARK. What was the term?

Ms. SCOTT. The term "medical loss ratio" is kind of a nutty term in some ways. Our overhead is approximately 10 to 12 percent, and we shoot for margins, in terms of return back into our programs of 3 percent.

Mr. STARK. Mr. Turvey, does United operate as a staff model or do you——

Mr. TURVEY. No, we are generally referred to as an IPA model or an independent contract.

Mr. STARK. And your primary care docs, do you downstream the risk?

Mr. TURVEY. We do. We do, generally, capitate primary care and pay off of a fee schedule to specialists.

Mr. STARK. A little louder. I am sorry. These mikes are bad. You have got to darn near swallow the microphone. I am sorry.

Mr. TURVEY. We capitate primary care physicians and pay a fee schedule to specialists, although, depending upon the health plan and depending upon the arrangement, we do have some sharing in surpluses and deficits for specialists and hospitals as well.

Mr. STARK. But, basically, the primary care docs are at risk for some amount.

Mr. TURVEY. Yes, they are.

Mr. STARK. And you don't own your hospital or diagnostic facilities, you contract that out, generally?

Mr. TURVEY. We contract with hospitals. We own no hospitals or physician practices.

Mr. STARK. You are a for-profit/nonprofit?

Mr. TURVEY. We are a for-profit publicly held.

Mr. STARK. What would you classify as your overhead in the same—it is hard with a cooperative, but if you add in stockholder return and whatever else you add in, what would you classify your, if you make that public.

Mr. TURVEY. Sure. We just released our first-quarter financials the other day. I think what was released was a medical cost ratio or benefits ratio of 84 percent, 10 percent for administration and 6-percent pretax profit margin, all products combined.

Mr. STARK. Let me try that again.

Mr. TURVEY. An 84-percent medical cost ratio, 6-percent pretax profit, 10-percent administration.

Mr. STARK. Or 16 percent, if I were comparing what Ms. Scott just gave me and what you are giving me, she is saying 10 to 12, you are saying 16.

Mr. TURVEY. That is correct, pretax.

Chairwoman JOHNSON. I thought she said 12-percent overhead and 3-percent profit for 15 percent.

Ms. SCOTT. Excuse me. It is 10 percent, if you will, administrative overhead and 3-percent margin.

Chairwoman JOHNSON. OK. Thank you.

Ms. SCOTT. So 13-percent total.

Chairwoman JOHNSON. Appreciate it.

Mr. STARK. Dr. Weiss, AvMed Health Plan. How are you structured?

Dr. WEISS. We are not-for-profit. We are an IPA or a network model, where we contract with the community physicians. We do capitate our primary cares, but only capitate them for the services that they provide.

Mr. STARK. Are they at risk for other services?

Dr. WEISS. No, they are not, and the specialists are paid on a fee-for-service basis.

Mr. STARK. And how would you state your overhead in the same terms that——

Dr. WEISS. Our medical cost ratio is 85 percent, our administrative expense is about 11 percent, and we target a margin of between 2 and 4 percent.

Mr. STARK. Thank you very much. It has been, well, I might as well ask this same question. Dr. Weiss, are you currently being sued by any of the medical associations in these RICO cases?

Dr. WEISS. No, we are not.

Mr. STARK. Anybody else after you for any major——

Dr. WEISS. Not that I am aware of.

Mr. STARK. Wow. Mr. Turvey, are you a plaintiff in any of these State Medical Association cases?

Mr. TURVEY. I am not familiar with any. Certainly, not within the Midwest Region, the States I am responsible for.

Mr. STARK. It is my understanding the Medical Association of Georgia has named you as a defendant—you are in good company, along with Aetna, Coventry, and Cigna—but if that is not your division, you might not know. Could I ask, Ms. Scott, is the State of Washington Medical Association after your hide?

Ms. SCOTT. No. Well, they are not suing us. Let us put it that way.

[Laughter.]

Mr. STARK. All right. My time has——

Mr. MCDERMOTT. If the gentleman will yield.

Mr. STARK. I would be glad to. I know you are the only one that is in court in Washington.

Mr. MCDERMOTT. The physicians, the State Medical Association had to be sued by the Group Health Doctors to get into the medical association back in the fifties.

Mr. STARK. Thank you, Madam Chair.

Chairwoman JOHNSON. Mr. Johnson of Texas.

Mr. JOHNSON OF TEXAS. Thank you, Madam Chairman.

Thank you all for being here. I like your comments, "siloed." Maybe HCFA is stuck in the mud, too, what do you think?

[Laughter.]

Mr. JOHNSON OF TEXAS. Mr. Turvey, in your testimony, you point out a new June filing deadline, formerly in the fall, to make

accurate financial projections and, thus, appropriate benefit decisions. Given only the first quarter, January through March, data is available right now, at the time for plans to submit their adjusted community rate (ACR) to HCFA, this is the plan's estimate of its costs for covering any additional benefits or additional beneficiary costs.

Based on the adjusted average per capita cost (AAPCC) and the ACR, which will determine those things, you know, more data I think will allow you to submit a more accurate ACR. What do you think an appropriate date should be for ACR submission to HCFA?

Mr. TURVEY. I think October would be reasonable. The reason is, if you are looking at a June deadline, you have got really only that first quarter that is halfway complete. So, if you can bump it back to October, you at least double your amount of credible experience data for the benefits priced in that current year.

Mr. JOHNSON OF TEXAS. That makes sense to me, and that is what most people are saying. How will this impact the beneficiary enrollment period, in your view?

Mr. TURVEY. I think if we can get HCFA's administrative review streamlined, that should not be problematic at all. At one time, I believe the ACR was done back in the October timeframe, so I don't think that should be problematic.

Mr. JOHNSON OF TEXAS. So you think you will be OK if you are given until October to figure it out.

Mr. TURVEY. I think we would, and what is more, because of the more accurate, more complete data, we would be able to sharpen our pencil a little bit better and perhaps offer a little bit better benefit for the cost because we would have to build in less conservatism for the unknown.

Chairwoman JOHNSON. Would the gentleman yield?

Mr. JOHNSON OF TEXAS. Yes, Madam Chair.

Chairwoman JOHNSON. This is a point of real concern to us. The problem with the October 1st date is that you won't necessarily know exactly what Congress is going to do, and to what extent we have addressed some of the barriers that in your testimony you bring to our attention in quite some detail.

If allowed you to make the decision after you are likely to know, then we are talking about your having that data, having made your decision in November, because you aren't likely to know until the end of October, when we should conclude our budget work.

So do you need the November 1st date? And if you made your proposal by November 1st, is there a review process that would still allow us to develop some reasonable rhythm to the open enrollment period?

Mr. TURVEY. Actually, I think we would find it greatly improved if we could back it up to later September. I wouldn't want to go into November. I agree that is really pushing it.

Chairwoman JOHNSON. And you think you can make the decision, even though it might not be completely clear what we are doing?

Mr. TURVEY. Well, that is problematic. You are right.

Chairwoman JOHNSON. I am not going to take this out of Mr. Johnson's time because this is something the Committee really has to be, we have to be realistic about. Now how many plans are going

to be able to, briefly, how many of you are going to be able to make the decision about the next year and the year after, if you don't know exactly what we are going to do about reimbursement rates and regulatory barriers?

Mr. TURVEY. I think we are going to have to know as soon as possible. I think what is really at risk here is that there are many health plans in critical markets, where I am sure they don't want to pull out because, as I think you all know, once you pull out of a market, it is very, very difficult to get back in. Your reputation is sullied. You can't just say 6 months later, "Well, we decided to reenter this major market." So plans are very reluctant to leave, thinking when they do, they may be out for a long, long time.

But it is really critical that, as plans make this decision, especially if they are losing a lot of money, and we are, in UnitedHealth Care in a few markets, a few major markets, it is going to be very, very important for Congress to come back and say, "Here is what we can do to at least limit your losses, your potential loss, for calendar year 2002," and that could at least buy some time for the health plans to stay in the markets, while some of these other factors, administrative and revenuewise, are being worked on over the intervening months.

Chairwoman JOHNSON. Now, Ms. Scott, you are a cooperative. You are exactly the kind of entity with long experience. Would you agree with Mr. Turvey that it will be hard to make the decision about where to stay in and where to go out?

Ms. SCOTT. I couldn't agree more.

Chairwoman JOHNSON. Would you have to make the decision to leave markets if we don't address some of the barriers that you have identified?

Ms. SCOTT. Thankfully, because of the Beneficiary Improvement Protection Act (BIPA), we are no longer faced with that decision in the State of Washington. There are other States where that is not the case, but in the State of Washington, it did definitely help us. But having gone through market withdrawals in the past, I will tell you the current situation is untenable because you are making decisions with just not enough data.

Chairwoman JOHNSON. Sorry, Mr. Johnson. I will give you another minute or two on your own time.

Mr. JOHNSON OF TEXAS. Bless your heart.

Dr. Weiss, you know, you talk about regulatory problems with HCFA, and it seems that people are jumping out of Medicare+Choice back to fee-for-service because they don't understand it or because you all are reducing your benefits because of regulation or regulatory morass, I guess is what we would call it, and it appears that HCFA has maybe doubled the little tick marks they tick on you every time they check on you. Is this a real problem, and how can we fix that, in your opinion?

Dr. WEISS. Well, the amount of regulatory oversight has increased dramatically in the last several years. We have no problem with accountability, the problem is or, actually, it appears that we are being accountable to multiple entities at the same time, sometimes with conflicting direction.

As far as for us to send a letter to our Members, we have to submit the letter to HCFA, waiting sometimes the 45 days before we

can send it out. It has had some impacts on implementing programs that we have scheduled and had to adjust the date or hold off doing programs that we think would have had some major benefits.

Also, as far as the scheduling of reviews, we are being reviewed annually by HCFA, and then we are also having all of our accreditation visits coming in. So it seems like we are usually in the accreditation or survey mode, where we are always having staff spending a great deal of time preparing for the next review. In our case, we get three reviews—we will have three reviews in 1 year between JCAHO, NCQA, and also the Medicare reviews.

Mr. JOHNSON OF TEXAS. How many people do they send in on those reviews?

Dr. WEISS. Medicare sent in about six people last year for the review and the other accrediting bodies will send in a varying number.

Mr. JOHNSON OF TEXAS. OK. Thank you very much. Thank you, Madam Chairman. I appreciate the extra time.

Chairwoman JOHNSON. Mr. Kleczka.

Mr. KLECZKA. Thank you, Madam Chair. Mr. Turvey, let me direct some questions at you, since your UnitedHealth is in my Home State of Wisconsin and also covers constituents in Waukesha and Milwaukee. Now, over the past year, you went from 500,000 seniors covered under Medicare+Choice down to about 410,000. Is that somewhat accurate?

Mr. TURVEY. That is correct.

Mr. KLECZKA. Now, is the reason for that 90,000-decrease due to participants leaving the plan or you closing markets in various States?

Mr. TURVEY. It is primarily due to us leaving markets in various States.

Mr. KLECZKA. Evidently, you were losing money so you packed up and left.

Mr. TURVEY. That is correct.

Mr. KLECZKA. You also indicated a short time ago that you are still losing money in various segments of the market that you are in. Would one of those areas be the State of Wisconsin?

Mr. TURVEY. No, I don't believe so. Chicago is our larger concern.

Mr. KLECZKA. So it is your intention, at this point anyway, to continue to offer Medicare+Choice in the State of Wisconsin, and specifically Milwaukee-Waukesha.

Mr. TURVEY. That is our intention.

Mr. KLECZKA. I am sorry. I didn't get the answer. Your answer was? Your answer to that was? Mr. Stark said, yes, if we would stop eating bratwurst and cheese.

[Laughter.]

Mr. KLECZKA. And since that won't ever happen, I have to rely on you for the correct answer.

Mr. TURVEY. I am sorry. I did not hear the question.

Mr. KLECZKA. All things being equal, you do intend to stay in the Milwaukee market.

Mr. TURVEY. Yes, we do intend to stay, regardless of what you eat up there.

Mr. KLECZKA. The reason I ask is because at one point we had about five providers. We are down to two providers, which would be yourself and Medicare Blue. I am familiar with the Medicare Blue operation. They are losing money writing in this market. I don't know how long they are going to continue.

So the point I am trying to make is this grand experiment of Medicare+Choice is decreasing in popularity and/or is losing money in areas so companies like yourself are pulling out. I think that is an important point to note because if you look at some of the Medicare reforms that we will be looking at, specifically, the Breaux-Frist proposal, it would actually expand Medicare+Choice. And I am saying if, in fact, you are losing money today and pulling out of various markets, and less seniors are now covered, how can we go and save the Medicare Program by expanding this somewhat failed experiment?

Now, one of the points you also made was that you are, one of the reforms that you are advocating would be a higher reimbursement. But we were told during a briefing seminar early on in the session, and Mr. Stark made mention of this, that, in fact, the Medicare+Choice is proving to be somewhat more expensive than fee-for-service. Now, if we are going to use the Medicare+Choice to save Medicare and it is more expensive, then we are not going to reach our goal by doing that.

Expand somewhat on one of the reforms being more reimbursement, more capita rates or higher per capita rates.

Mr. TURVEY. Well, I think, first of all, the program is quite popular, and all we have to do for evidence of that is——

Mr. KLECZKA. If it is so popular, how come UnitedHealth went from 500,000 to 400,000? That is a 20-percent loss.

Mr. TURVEY. Yes, but it is popular among beneficiaries. And for evidence of that, all you have to do is look at the feedback we get when we leave a market. We don't do it without a great deal of pain and negative feedback from those members. They do love the program. The problem is, as we have seen all along, although we have taken some steps to rectify that in the reimbursement, the reimbursement is still very uneven from market-to-market, and that——

Mr. KLECZKA. And that is something we are trying to reimburse on a congressional level, although we are doing it in such a slow manner. In fact, just to highlight what you have said, Milwaukee-Waukesha, per capita or capitation rate is $553 a month, Dade County, Florida, $834.

While we are on that point, what do you offer your Wisconsin Medicare+Choice beneficiaries above and beyond the fee-for-service program? What services do you offer above and beyond the fee-for-service program?

Mr. TURVEY. We offer the services that I detailed in the testimony, but beyond that we have reduced co-pays.

Mr. KLECZKA. No, no. Give them again. The first thing I would ask is, is there a drug benefit for any of these Wisconsinites? And I would assume, based on the per capitation, that the answer is going to be no.

Mr. TURVEY. The answer is no in Wisconsin.

Mr. KLECZKA. So what, specifically, do you offer a Wisconsinite above and beyond a fee-for-service program?

Mr. TURVEY. Fewer co-pays, and additional benefits, and better medical outcomes, and support services that I detailed in my testimony.

Mr. KLECZKA. What co-pays does the beneficiary save on, specifically?

Mr. TURVEY. Inpatient, outpatient.

Mr. KLECZKA. Which is, what, the $10?

Mr. TURVEY. Generally, $10. I am not real familiar with where Wisconsin is right now, but that is probably about right.

I think the thing to remember, with respect to comparisons to traditional Medicare, is that we offer better outcomes, we offer higher Member satisfaction, we offer increased benefits and really at no higher cost. Generally, it is somewhat lower cost. It is popular with the beneficiaries. What this program is not popular with is hospitals who now have had the reimbursement bar raised——

Mr. KLECZKA. Well, that is not totally accurate because it is not popular with constituents who want to stay with the same doctor they have been seeing for the last 40 years, and chances are that that doctor or physician, he or she might be part of your plan. So we are still getting, from our constituents, the fact that they want total choice of provider.

I know my time has expired. Maybe we will get another round. Thank you.

Chairwoman JOHNSON. Well, I certainly would just want to note that joining a Choice plan is an option. And so if your doctor is not in it, as I tell my seniors, don't join it. But often, because they are primarily in the densely populated areas, the chances are that your doctor and your hospital is going to be in it.

And I think Mr. Turvey's point was that when you look at how upset people were when they had to leave a market, it does tell you they liked participating in their plan. The purpose of this hearing is not to tear anybody down or build anybody up on either side of the Medicare Program, but merely——

Mr. KLECZKA. Madam Chair, I don't believe I was tearing anyone up or building anyone up. I was just asking some probing questions.

Chairwoman JOHNSON. I think the implication of your question of what are people getting for it. Yes, they are getting a premium cut, but the real thing they are getting for it is what he went into in great detail in his testimony that has helped implications: coordinated care, the access to a person in the plan so that you can always get your questions answered.

But this issue of coordinated care and disease management, this has to do with the future of Medicare. Seniors with chronic health needs need a different kind of governance and involvement. And I think I don't want to just gloss over that the only thing he is giving patients is a reduction in premium because that isn't the big issue here. The big issue from everyone testifying was disease management, was improved health outcomes.

Mr. KLECZKA. Madam Chair, if I may respond, evidently, you can't read my mind. The reason that I asked that question was because of the low capitation in Wisconsin, that is all these plans can

give my constituents and other Wisconsinites. If I would have had additional time, I would have went into the plan offerings in Florida, and I can bet you a dollar to a doughnut, in Dade County, Florida, there is probably some decent drug coverage, but naturally the reimbursement is almost $300 per month more. So——

Chairwoman JOHNSON. Well, one of his recommendations is that they need to have the same increases in reimbursement that we are providing to others and that we are providing bigger increases to hospitals than we are to the managed care plans that have to deal with them.

Mr. CAMP. No, Mr. Ramstad, I guess, is next.

Mr. RAMSTAD. Thank you, Madam Chair.

Mr. Turvey, I would like to ask you a question. When we passed the Balanced Budget Act (BBA), Congress was obviously focused on the fairness gap issue to address the unconscionable disparity in county-based health plan payment rates across the country.

I would like to ask you, based on your experience, was it prudent to set up a new payment method separate from fee-for-service payments or did we effectively create a whole new gap with fee-for-service and provider payments?

Mr. TURVEY. I think it was a well-intended move and well advised, but I think it had some unfortunate side-effects. Primarily, there are two things that happened that I noticed. It did not eliminate the disparity among reimbursement from county-to-county. And as Mr. Kleczka suggested with respect to where Milwaukee stands versus Dade Counties or others, I could give you similar stats for Cook County. There are huge variations. So that gap has not been narrowed anywhere near to the extent it should be.

Mr. RAMSTAD. Not to mention the Twin Cities of Minnesota vis-a-vis Dade County.

Mr. TURVEY. That is correct.

Second, the increases that went to hospitals, which I think were, to some degree, required, they were needed, they essentially raised the bar to where the hospital could come to us and say, "Now you have got a new target to match with respect to what you have to pay us." There was an arbitrage going on by the hospitals between traditional Medicare and Medicare+Choice. And so, essentially, we had to take our BIPA money and throw most of it to the hospitals, with most of the remainder of that to the physicians, and there was very little left over, contrary to our wishes, for improved benefits.

Mr. RAMSTAD. I would also, Mr. Turvey, like you to elaborate about your suggestions for improving and stabilizing the Medicare+Choice program by experimenting with nonrisk-based alternatives, particularly in low-payment places like Minnesota, where I have watched the program all but disappear in the last several years.

Mr. TURVEY. I think, in order to get utilization to more reasonable levels in areas where utilization is very high, in areas where physicians are not practicing under the best clinical information, that you need to make an investment in these physicians, especially in rural counties, where they are not familiar with much of this, and this information does come at a bit of a cost.

I think, if a program, such as that we are looking at in rural Iowa, could be established, where there was minimal downside risk

to a physician for participating, in essence, HCFA would be contracting, let us say, with the UnitedHealth Care on what we refer to in the industry as an ASO or Administrative Services Only contract, where there is very little upside, but there is minimal downside as well, we would have the opportunity to engage rural physicians in a contract with very limited risk.

And I think then, over a period of a couple of years, as you take the clinical information that Group Health spoke of and I spoke of earlier, with our physician data sharing, and you get that out to physicians, and you give them some primarily quality based, but then, secondarily, economically based incentives to improve their outcomes, then we will find that, as a byproduct, care becomes more cost effective and cost savings result.

I think that is the model we need for the rural areas, otherwise they are going to say, "We want no part of it. We can't afford to take significant risk. We will just play, but we will play under traditional Medicare."

Mr. RAMSTAD. That is the message we all need to hear, those of us working on this situation here in the Congress.

Let me, finally, ask you about difficulties in contracting with providers, particularly hospital systems, and how UnitedHealth dedicated the majority of your new, so-called new, BIPA payments to increase provider reimbursement. Maybe you could share some examples of the types of contract negotiations you have been engaged in with provider groups and why you found it necessary to devote BIPA dollars almost exclusively to providers.

Mr. TURVEY. Really, from the hospital's perspective, they see two things: Number one, with the increased reimbursement, there is a new standard for reimbursement, and they are saying match it or we depart—departicipate. For them, it is an improved bottom line to go to traditional Medicare.

Second, by going to traditional and getting out of Medicare+Choice, there are a lot of things they don't have to do. They don't have to be accountable to health plans or HCFA or others for measures of outcomes, especially quality. And I can't tell you how many times I have heard hospitals say, "Quality measures are a little squishy. They are a little elusive, so we if we can't perfectly measure them, let us not," and I think that is wrong. That is what we have seen, and we have seen it in St. Louis, where I have been very specifically familiar with it and involved in those negotiations.

Mr. RAMSTAD. Thank you, again, Mr. Turvey, for your testimony and for being so responsive to these questions. Madam Chair, my time has expired.

Chairwoman JOHNSON. I am sorry.

Mr. Lewis.

Mr. LEWIS. Madam Chair, since I arrived late, I think I should defer to the gentlelady from Florida.

Chairwoman JOHNSON. Congresswoman Thurman.

Mrs. THURMAN. I want to talk about the reimbursement issue a little bit because I find this a fascinating issue because I don't know that it is reimbursement totally. I mean, I think that we have done some things. Last year we did some incentives. Actually, Mr. Turvey, you, in UnitedHealth Care, came into Hernando Coun-

ty after we lost all of our Medicare+Choice programs. I don't know what your experience, and maybe you can't answer because that is not your part of the country, but we gave an incentive program. We tried to encourage people to come in there, and you and one other have, at this point, and I don't know what is going to happen. I mean, we are hearing a lot of rumors in the district that you all may be pulling out.

And I know Dade County gets talked about an awful lot up here. That is not the experience for most of Florida. Quite frankly, as Dr. Weiss can tell you, that is not. But there is a problem in my, I mean, I have the same problem with all of this moving around, but then I find situations where companies have gone into these areas getting less reimbursement than another county, and yet they stay in those counties, but pull out in a county that is getting a higher reimbursement. So I don't know what that mixture means, and I would love to hear your comment on that.

And the second thing, and this is, quite frankly, one of the things that I hear most, is the reason we are taking Medicare+Choice programs, I mean, I think, quite frankly, you all do a great job in the private sector. I think the Medicare+Choice program has some real issues on it.

But I think one of the reasons people come into that is because of the prescription drug. It has been mentioned, and I have got a spreadsheet that I have done on all of mine, based on what the prescription drug benefit is and what it isn't, and what are your feelings based on the HMO Medicare+Choice programs that you are seeing?

Do you think people are staying in these programs because of prescription drugs as much as anything, Dr. Weiss?

Dr. WEISS. I think absolutely on the prescription drug benefits. Some of the other benefits, especially as you go to the counties with the higher reimbursement, is the lower premiums or no premiums. When you look at the cost of a Medicare+Choice product in Broward County, which may have a premium and a pharmacy benefit, it is substantially below what a supplement would cost without a drug benefit. As you get into some of the other counties further north and more in your district, the pharmacy benefit is still there, but the premiums go up, and the pharmacy benefit goes down, I think the main draw for most people, is the pharmacy benefit.

Mrs. THURMAN. And, you know, let me ask that, because this is a question that always kind of never gets answered, but I ask it on occasion. I mean, you all are in different parts of the country, but you are also in—well, in your situation, you are mostly in Florida. Mr. Turvey, you are across the country, but you have different associations within your States, different States. You use the same pharmaceutical delivery system as we do in Dade County, as you would in Hernando County. I mean you have got Eckerd's, you have got Walgreen's, you have got K–Mart, you have got whomever is going to offer these things. Why is it that we cannot have the same thing in some other parts if you are doing—I mean, kind of like we have been looking at this whole issue with prescription drugs and best management, and third-party persons. I mean, why can't you all, in fact, contract with these people for the whole State

for the cost, giving us the same opportunity to participate in a prescription drug as you do in individual areas? The same companies.

Dr. WEISS. Well, in fact do have the same contracts throughout the State at the same reimbursement rate. What is interesting is the prescribing patterns and habits vary greatly in certain areas of the State. The most expensive area for us historically had been Palm Beach, which is not the highest reimbursement area in the State, but it had substantially higher costs than Dade or Broward Counties. So it appears that the physicians have a much greater ability to impact the cost than the contracts would, because again, we pay the same rate, whether it is in Gainesville, or Lake City, or down in Hollywood or Miami.

Mrs. THURMAN. So it is utilization?

Dr. WEISS. It is predominantly utilization. It is not the reimbursement cost of the pharmaceutical.

Mrs. THURMAN. Mr. Turvey, any one of my three questions.

Mr. TURVEY. Yes. I would say if you are looking for differences of why a pharmacy program can't be as rich in one county as another, why can't it be Statewide, sometimes the difference in hospital rates in a particular county will eat up what would have been available for the pharmacy benefit. So you have got to look to other components as well, or there may be an organized physician group that is a little better at negotiating their capitation. So those other elements can squeeze out the pharmacy piece.

You ask another question too, saying, are people initially attracted by the pharmacy benefits? I think the answer is yes. In my experience, which has been heavily in the St. Louis area, where we have 72,000 Members, they sure are. But then they stay for other reasons. They stay for the reasons I went through in my testimony, because they love the program. And recently we had one of our health care providers, an entire system, SSM Healthcare, drop from the system because to them, reimbursement was better under traditional Medicare, and they didn't have to organize their physicians to change their practice patterns for better outcomes, which is work, and is politically intrusive for them. So it is easy just to say, "We will go back to traditional Medicare and we will just run hospitals", and that is what we all were trained to do 10 and 20 years ago. So that is what they are doing.

But what was interesting is there were 12,000 Members affected. The vast majority of them are staying with us, even though 60 physicians are no longer available. The other thing that is interesting is some of those physicians, employed physicians, are now rethinking their employment contracts because they want to continue to serve those Members.

So it has been a great experiment to see how this plays out, but the fact of the matter is, people love the program, they stay in it, and they will change physicians, and their physicians will give it a second thought too. So we have seen that happen.

Mrs. THURMAN. So part of—so what I guess, the bottom line was—Madam Chairman, I am sorry—then is the fact that it is not just reimbursement, that there are private issues that are out there as well. I mean, I think that has to be on the record because that is all we ever hear about, and quite frankly, that is what we get in those letters that Dr. Weiss referred to, is "Call your Con-

gress person, increase those reimbursement rates." And in fact, I don't know how to respond to that except the fact of the matter is, I think there are other outside issues, and I think we need to let people know that.

Mr. TURVEY. They signed an agreement they were willing to negotiate and live with. That is the bottom line on it.

There is a point I would like to leave everyone with because I think it is fundamentally important to the future of the program and the future of Medicare as well. I guess I would equate the evolution of Medicare+Choice as maybe the auto industry in 1920. You know, clearly, this looked like the way to go with cars, but they were far from perfect. Now looking back 80 years later, you say, "My God, what if we decide to go back to horses?" I mean, it would now look absolutely ridiculous. And here is the parallel. The physician data sharing that sophisticated managed-care companies like Group Health and United and AvMed and others, what they are doing is building on the foundation for significantly better medicine in years to come. The information we give a physician when we say—your pediatrician—"Here is how you are prescribing. Would you like to know how other pediatricians in St. Louis are prescribing within your group, within the city? Would you like to see how they are prescribing in Denver for a particular diagnosis?" This program—a pediatrician is not a good example. Let us say an internist from Medicare. But the same thing applies.

This technology comes from this program and doctors are greatly educated by it, and they become better, more cost-effective practitioners. If the program dies out, this technology dies out with it, or at least is restricted to some segments of the commercial world. This is the promise of better medicine and more cost-effective medicine. And that is why it is incredibly important not to abandon this concept at its infancy. Fix the problems, and let us keep it going, and let us do what we can to keep plans from withdrawing from these critical cities, and time is short.

Chairwoman JOHNSON. Thank you, Karen. Congresswoman Dunn, Jennifer?

Ms. DUNN. Thank you, Madam Chairman.

Ms. Scott, I want to get your take on a couple of topics. I think I will push a bit more on the reimbursement issue. As you know, health plans in Washington State are reimbursed on a lower rate than health care plans in other States. This is a big problem for us. The goal of the Balanced Budget Act 1997 was to create greater parity in these reimbursements between health plans, and yet we continue to see great differences in payments. What changes do you think we need to make to the reimbursement formula to insure greater equity and payments between health plans?

Ms. SCOTT. Just building on my colleagues' remarks here, we do see these great disparities, county by county. A couple of reflections for the Committee. Number one, those are historical baseline data that is now five to 6 years old. They have not been updated. And that is where you see, you are building the Medicare program on a broken chassis, if you will, in terms of reimbursement.

Second, one of the things that Congress can obviously do is to get rid of budget neutrality when it comes to the blend. The blend was enacted with goodwill and good purpose to try to deal with those

disparities, but as long as budget neutrality is in place, it is a zero sum game, and so that is obviously another way that we can deal with that.

So I think we need to update the data. We need to look at budget neutrality, and to take a look at the blend. I think congresses have been clear that you want the blend. It is really a question of how you implement it.

Chairwoman JOHNSON. Ms. Scott and Congresswoman Dunn, would you yield a minute? Now, on this blend issue, because I don't think that even most Members of Congress——

Ms. SCOTT. I am sorry. I cannot hear you.

Chairwoman JOHNSON. On the blend issue, I don't think most Members of Congress realize what actually happened, but the blend was supposed to blend your local rate with a national rate. The goal was to bring the people below the national rate up, and to bring the people who were way outliers above the rate, down. But because there were more people below than there were above, the budget neutrality provision meant that you didn't get the blend portion.

Ms. SCOTT. That is correct.

Chairwoman JOHNSON. So you really didn't get the reimbursement increase out there in the real world that we put in the law, because at the end of the chapter, we added budget neutrality.

Ms. SCOTT. And Ms. Dunn is right, that that has been for the State of Washington, sounds like for Chicago and for parts of in Florida, in certain counties, that is why we have this, if you will, arcane disparity, and there are steps that Congress can take to, again, as you say, take the very high counties down a bit and bring the other counties back up to some normalized amount.

Chairwoman JOHNSON. So even in those instances where we offered you 2 percent as a minimum, many didn't get the 2 percent?

Ms. SCOTT. That is correct.

Chairwoman JOHNSON. Yes.

Ms. DUNN. Let me ask you too, Ms. Scott, on a different topic. We have a situation in Washington State that has continued to grow out of hand. HCFA doesn't account for health services that are provided to Medicare beneficiaries who seek care in military facilities, and so the calculation of the reimbursements doesn't go into the reimbursements that we receive.

Two years ago Congress required HCFA to submit a report accounting for the health services furnished by the Department of Defense and by Veterans Affairs to Medicare beneficiaries in both the Medicare+Choice program and the fee-for-service program. We haven't seen that report yet, but I am wondering if you would care to comment on how this exclusion has affected your plan and any thoughts you might have to work out this problem?

Ms. SCOTT. Thank you. What happens, just for those Members who don't know what happens, the population of the people in the armed services, and we have many defense bases in the State of Washington, are calculated as Medicare enrollees, but the cost of their care isn't calculated in our average area per capita amount. So you have a numerator and denominator problem, so you have a artificially depressed reimbursement rate for the State of Washington. That is what Congresswoman Dunn is talking about.

Chairwoman JOHNSON. Excuse me. Is that on the assumption that they are being cared for by the military system?

Ms. SCOTT. And we would be fine if then they would be taken out of the numerator, but they are in the numerator and not in the denominator. That is the inequity. And it is significant. And it is particularly, county by county, in Kitsap County and in Thurston County and in Pierce County, it is very, very significant. Obviously, we have not been able to get the traction within HCFA that we would want, Ms. Dunn. And so I think the answer may be help from Congress in being more explicit about your expectations of that inequity being addressed.

Ms. DUNN. I do have one more question if the gentlelady would yield to me for one question. Thank you very much.

I wanted to go to Mr. Turvey before we are finished here. Mr. Turvey, you point out in your testimony, some of the innovative health benefits that UnitedHealthcare provides. Specifically, your testimony talks about care coordination, long-term assessment, and education programs for diabetes, asthma and cardiovascular disease. You go on to relay your company's effort to personalize services for your Member through dedicated customer service representatives, round-the-clock access to nurses, legal experts and counselors. What kind of feedback are you getting on these services? Do they value them? And what sorts of quality indicators do you have regarding how these benefits have either improved the quality or reduced the cost of care?

Mr. TURVEY. It obviously depends upon the benefit you are talking about. The members love them. And they develop an astounding relationship between the personal service specialist and the Member. You can measure them through surveys. You can measure them through short-term and long-term disenrollment rates, which for us, our short-term disenrollment rate is about 5–1/2 percent, which is extraordinarily low, and in the areas where we don't have the personal service specialists and plans, we didn't put them in first, we see it significantly higher. So this is a key thing.

Members need someone, a name, a person, not just someone on the other end of the phone, but someone to talk to that they can confide in and say, "Here is my problem." Maybe it is not purely health, but if it is health-related or it is depression-related or it is family related. And through working through these issues, that is how the bond is there, that is why people stay. And you uncover health issues that you might not otherwise uncover.

Now, you couple that with all the other more clinical activities, such as post-discharge. The PSS or nurse-care coordinator will call someone's home and say, "Now, are you going to the follow-up visit with the doctor? Did you get a prescription filled? Do you have a way to get it filled? We have a van that will take you or get your prescription filled."

That sort of follow up to prevent readmissions and increased costs, we have example after example, but those are the kind of things that, while they are not cheap, Members love them, and they do pay off. They pay off in the longer term too. You can't get a 6-month payback on them.

Chairwoman JOHNSON. Thank you. Mr. Lewis.

Mr. LEWIS. Thank you very much, Madam Chair.

Mr. Turvey, your company, UnitedHealth, has a very visible and large presence in Atlanta and Fulton County, Georgia, my district. And I know that you are head of the Midwest, but do you have any idea what is the status of UnitedHealth and Medicare+Choice in Atlanta and Fulton County?

Mr. TURVEY. No, I don't. I know Teri Klein, our chief executive officer there, and I would be happy to call her tomorrow and get an answer for you tomorrow on that, but I don't know offhand.

Mr. LEWIS. I tried to read your testimony, and what do you think is the biggest challenge facing the Medicare+Choice program in the nation?

Mr. TURVEY. I think—well, of course, there are several of them, but I think the biggest one is, in certain counties, huge payment differentials from one county to another. I will give you a brief example of it. In St. Louis we have two rural counties, in Illinois, right around metro St. Louis. One had a 33 percent lower reimbursement until this past year. It was Monroe County, the only county my health plan in St. Louis ever wanted to withdraw from and had to, and then the reimbursement through BIPA came back and bumped it up 29 percent, made it viable. Now, there was no rational reason for it ever being that much lower.

Mr. LEWIS. Would it be different say in St. Louis, and then in Jefferson County, in the city and——

Mr. TURVEY. Oh, yes, it would. Yes.

Mr. LEWIS. I was in St. Louis yesterday.

Mr. TURVEY. But there are huge differences. Just an example, I have got some rates comparing Cook County to others. Now, everybody likes to point to Dade County, so that is a little unfair. But Miami is 34 percent higher. New York City is 28 percent higher.

Mr. LEWIS. Miami is 34 percent, Dade County is 34 percent higher?

Mr. TURVEY. Then Cook County. But it is not just Dade County. New York, 28; Philadelphia, 26; Houston, 20; Detroit, 15; Boston, 14; LA, 11. That 11 percent or even substantially less, on an enrollment of 30 or 40,000 Members, means millions and millions of dollars. It is the difference between a program being viable or being shut down, because you can only transfer so many millions of losses to the commercial segment in your town, and stay viable in those product lines as well. And by the way, up to now, that is exactly what we have done.

Mr. LEWIS. What should we be doing? What should the Congress be doing to bring some stability and uniformity I guess? Is that what we want, Madam Chair?

Chairwoman JOHNSON. Yes, stability.

Mr. LEWIS. Stability. What should we be doing? What is your recommendation?

Mr. TURVEY. I think, as she suggested a little earlier, do a good detailed review of the risk assessment methodology. It needs to be improved. And just look at these county-by-county differentials, and it is a real problem. It really is.

I remember when I ran a not-for-profit health plan for 10 years in Michigan. There was no way we could ever have a viable program in Grand Rapids, but in Ann Arbor, because of the university's influence there, I had friends who were starting a Medicare

Program there. They couldn't spend the money. They couldn't come up with enough benefits to file an ACR that would have gotten through HCFA. I mean it was ludicrous.

Now, the gap has been closed, but it is still significant. Now, there are other areas that we have covered, but that is the biggest problem.

Mr. LEWIS. I want to sort of follow up on a question that my colleague and friend from the State of Washington asked, Ms. Dunn, about do you get involved in the whole question of preventive—do you sponsor, I guess, health care fairs and festivals, to help educate? You know, it is very confusing for, not just senior citizens, but when you have several medications. How do people keep up? Do you get involved with the company and outreach?

Mr. TURVEY. We do. We get involved with community outreach. One of the things we have done for people who are homebound, is to have a van service to take them to their physician's office if they have a doctor appointment, because we want them to go there and spend some money and be taken care of, rather than sit at home because they don't have transportation. We get involved in all sorts of clinics, as I think all of my peer plans do here, where you get into the community and you go out and do education, or you pull your medical directors out to do education, where people congregate, in churches——

Mr. LEWIS. Shopping malls.

Mr. TURVEY. In shopping malls, and you do hypertension screenings, for example——

Mr. LEWIS. Churches, synagogues.

Mr. TURVEY. Blacks are prone to hypertension, and in the inner city, we do hypertension screenings, in the malls, in churches, wherever you can get to people and educate them. Education is cheap but vitally important. All of those kind of things we do.

Dr. WEISS. All of the Medicare+Choice plans are required to an assessment on a new enrollee. And so when someone signs up with our plan, in that initial 30 to 60-day period, they do get an assessment, frequently right after they enroll, right after that, just before, or right after they come on the plan. Also most of us do have community-based programs. We have one where we are doing health fairs for our diabetics, and inviting all of our diabetics to come and get all of their screening done on site, having providers come to community locations to do their foot exams, their eye exams, to draw their bloods, to do all of the things to try to minimize the consequences of diabetes, rather than having them go to four or five providers to get this all done.

And that is the whole concept behind trying to do the preventive care and the disease management. You can't just sit back and wait for them to come to you to provide the service. You have to find innovative ways to be able to get these services delivered to them, where they are.

Ms. SCOTT. You know, in the most simple way, if you are prepaid $300 versus if you are prepaid $700, guess what you are going to do with $300 versus what you are going to do with $700. And the investments you have to make to be a good health care organization under the M+C program, and if you are only getting $300, you are not going to be able to do these wonderful things that my col-

leagues and I have been suggesting. That is where the gap, that is where the issue around the blend, I think, I would agree is probably the most significant questions that is before this Committee.

Chairwoman JOHNSON. Thank you. Mr. English.

Mr. ENGLISH. Thank you, Madam Chair.

Mr. Turvey, in your testimony, you gave a detailed, and for some of us, a familiar criticism of the system of reimbursement in Medicare+Choice. We have elaborated on that a little bit in the course of this discussion. Can I ask you directly, should the current Medicare+Choice contribution be based on the underlying, and for some of us, rather perverse, county spending pattern of the traditional Medicare fee-for-service program, or should we go back to the drawing board and try to find a different way of providing that contribution?

Mr. TURVEY. I guess my most professional answer is to say I would leave that to the actuaries, but I think probably some hybrid would be appropriate, because the example I gave with Ann Arbor, theirs was ridiculously high because you had a huge university center, University of Michigan there. Now, that was wrong. It was inappropriate, but other cities, for example, Grand Rapids, traditionally conservative medicine, much lower expenditure rates, but then it wasn't viable. So some mix between those two cities would have probably made it practical for both cities.

Mr. ENGLISH. Also, Mr. Turvey, in your testimony, you offer some complaints with regard to the new HCFA requirement with regard to standardized beneficiary materials, and in some cases you say "standardization has resulted in inaccurate descriptions and made it difficult for beneficiaries to gain specific information about individual Medicare+Choice benefit offerings." Can I ask you to elaborate on that a little bit?

Mr. TURVEY. When HCFA tries to become too standardized or a direct apples-to-apples comparison, it lacks flexibility to describe some program elements that may be unique such as personal service specialists, Care 24, UnitedHealthcare Passport, these sorts of things. And so it really does the potential Member a disservice by not fully describing to them what a program might offer.

Mr. ENGLISH. Ms. Scott, you also, in your testimony, offered a similar criticism of the standardized beneficiary materials. Can you elaborate, do you agree with Mr. Turvey's comments, and do you have any further points to make on this?

Ms. SCOTT. No, I really don't. I think he pretty well described it. It is intent versus impact. The intent is the right intent. The impact is not what we want.

And coming back to how HCFA is organized, if we had one organizational unit within HCFA to problem-solve these issues, I don't think they would be coming to Congress. I think we would be able to deal with these on an administrative basis and not worry you around issues of this level of detail. And I would only offer that, sir, as well as an idea that a lot of this doesn't need to be coming to you, if we had an interface that was effective.

Mr. ENGLISH. Mr. Turvey, you also offer the criticism that the scope of data collected in the encounter data collection seems excessive given the more limited data required for risk adjustment. Would you care to elaborate on that, please?

Mr. TURVEY. Again, that is probably a better question for consulting actuaries, and I would be happy to even field a paper on that to you, but I think it is just administrative overkill and there is a cost to it. The encounter data collected now is well beyond what is required or the risk adjustment formula.

Mr. ENGLISH. Finally, for all three of you, many of us who represent areas on the margins, rural areas, areas with historically lower Medicare fee-for-service reimbursements, have worried about the stability of the Medicare+Choice program, and I know some of your comments have touched on this. But I guess my direct question to all three of you briefly, how far do you believe we should go? How far would you be willing to see us legislate to protect beneficiaries from the disruption of plan withdrawal? What specific safeguards and regulations and protections do you think are appropriate to write into the law to insure against this sort of disruption? Dr. Weiss?

Dr. WEISS. When you are addressing the withdrawal of the plans and the protection, obviously, the Members still will be able to continue to see their physicians if Medicare+Choice plan withdraws. So I think some of the protections are already there. It is not the case that their doctor is leaving. It is just that the benefit plan that they may have gotten through one of the Medicare+Choice plans are no longer there. And I believe the physicians will continue to follow their patients, regardless of whether they are in a M+C program or whether they are on the fee-for-service program.

Mr. ENGLISH. Mr. Turvey.

Mr. TURVEY. The best example I could think was where the hospital system I referenced earlier dropped out from our M+C program in St. Louis, and while this was more of an urban setting, the situation was this: they said to us, "You can't enforce our participation through the end of the year, beyond June 30th of this year, through December 31st, and you can't show damages." And in fact, we couldn't show damages because our sharing, our risk-sharing formula was we covered 20 percent of the deficits in their hospital fund. And so actually we were better off saying, "Go away, that's fine." But we didn't want to do it because we didn't think it was the right thing to do and we had a commitment to those Members. But We couldn't legally enforce the hospital system to perform.

I think if the government, HCFA, could have some penalty for them, that would have changed their decision, and those Members would have had that program intact in St. Louis through 12–31. They wouldn't be changing physicians right now.

Mr. ENGLISH. We had a rural hospital in my district in precisely the same situation. Ms. Scott.

Ms. SCOTT. I think the stability of the program and how we protect our beneficiaries from year to year, decisions that health plans may make, give us as health plans, some predictability about policy. We don't go in and out willy nilly and out commitment therefore is that we want to be stable as well. It is very hard to read the tea leaves right now, and because it is hard to read the tea leaves, as businessmen and women, and also as health care vision—you know, people who have a mission vis-a-vis health care,

when there is instability and you can't read the tea leaves, you tend to be more conservative.

So the one thing that you can help us with the most is give us a road map. We want to work with you. We are very much engaged in coming up with ideas to see if they work for you, so that there is that stability, because as you run your organization, and as you are mission driven, then with that, you can understand the trade-offs that you are making, and you can stay in longer, because it has a longer horizon than what we currently have.

Mr. ENGLISH. Thank you, Madam Chair.

Chairwoman JOHNSON. I thank the panel. Your comments have been very helpful, both in terms of the capacity of coordinated care plans, to improve the quality of health care for our seniors and better insight into the regulatory problems and the reimbursement problems that you face, that frankly, do compromise your future. Thank you very much.

Let me call the next panel forward. I am sorry this has been so long, but I do appreciate the Members' thoughtful question and the good answers of the panelists.

Madeleine Smith, from the Congressional Research Service; Bill Roper, Dean of the School of Public Health at University of North Carolina; Mike O'Grady, Senior Research Director for the Center of Health Affairs of Project Hope; Marilyn Moon, a Senior Fellow from the Urban Institute.

Welcome, and if we can just start right ahead, Madeleine, we will hear all four Members and then go to questions.

Dr. SMITH. You will have to speak right into the microphone and be sure to turn it on. Thank you. I am sorry. It is not on yet. And you do have to get very close.

STATEMENT OF MADELEINE SMITH, PH.D., SPECIALIST IN SOCIAL LEGISLATION, DOMESTIC SOCIAL POLICY DIVISION, CONGRESSIONAL RESEARCH SERVICE, LIBRARY OF CONGRESS

Dr. SMITH. Thank you, Madam Chairwoman and Members of the Subcommittee for inviting me to testify about payments under the Medicare+Choice program. My name is Madeleine Smith. I am a specialist with the Congressional Research Service.

There are two points that I would like to emphasize about the effects of payment reform under Medicare+Choice:

First, although the number of health maintenance organizations or HMOs in the program has declined, the proportion of Medicare beneficiaries enrolled in managed care has not changed much. In 1997, 14 percent were enrolled, today it is 15 percent. However, enrollment reached almost 17 percent of beneficiaries in 1998. Fewer beneficiaries have access to HMOs, but with the entry of a private fee-for-service plan, a type of Medicare+Choice plan, into the program, access for rural beneficiaries has risen.

Second, variation in payment rates has decreased. In 1997, the highest rate was three-and-one-half times the lowest rate. Today, the highest rate is one-and-three-quarters times the lowest rate. Nevertheless, benefits offered by Medicare+Choice plans still vary widely across the country.

There were at least two main reasons behind reform of the older AAPCC payment method under the Balanced Budget Act 1997: lack of access to a Medicare HMO in many areas and wide variation in the payments and benefits offered by HMOs. The Medicare+Choice payment rate in a county was set at the highest of three amounts: a floor or minimum amount; a blend or average of local and national rates; and a minimum update.

The floor increased rates in low-payment counties more quickly than would occur through blending. The minimum update cushioned the effects of blending on high-payment counties. After payment reform, the Medicare+Choice program has experienced three waves of plan withdrawals and service area reductions effective at the onset of the Medicare+Choice program in 1999 and annually since then. Interspersed between announced withdrawals have come two legislative responses.

Why did plans withdraw? Industry representatives believe that inadequate payments are a principal cause. HCFA, the Health Care Financing Administration, contends that withdrawals reflect strategic business decisions that transcend payment rate issues.

A recent report from Interstudy, which studies the HMO industry, indicates HMO failures and withdrawals in the general HMO market in 1999. The industry experienced its first annual decline in enrollment in nearly 30 years as the boom cycle experienced by HMOs in the mid-nineties came to a close.

In response to plan withdrawals, Congress acted twice to increase Medicare+Choice payments. The Balanced Budget Refinement Act 1999, the BBRA, made a few modest changes to raise future plan payments. The Benefits Improvement and Protection Act of 2000, BIPA, made more substantial changes, most notably raising the floor and increasing the minimum update for one year.

After a little over 2 years, have problems identified with the old payment rate method been fixed? Lack of access was seen as a consequence of low payment rates. The payment floor raised rates in many counties. Today, more beneficiaries in rural areas have access to a Medicare+Choice plan through Sterling Life Insurance Co., which operates a new private fee-for-service plan. As illustrated in the map to my right, Sterling offers coverage in 25 States and over half of the counties in the country. More than half of beneficiaries living outside metropolitan areas reside in Sterling's service area.

Sterling offers private fee-for-service coverage in the areas colored dark blue and light blue on the map. Sterling competes for Medicare enrollees with HMOs and other coordinated care plans in the light-blue areas. The gold-colored counties are served only by HMOs. No Medicare+Choice plans are available in the white counties.

To summarize, despite large payment increases in some counties and the entry of a private fee-for-service plan, the number of Medicare+Choice plans has decreased significantly overall and fewer beneficiaries have the option of choosing an HMO. Although the proportion of beneficiaries enrolled is slightly higher than it was in 1997, it is lower than in 1998.

Variation in payments has declined from a difference in rates of 3.5 times to 1.75 times. As the payment gap has narrowed, benefits

generally have declined. Fewer beneficiaries have access to a plan with a zero premium, especially one that includes drug coverage. Differences in benefits persist today. Some plans still offer full drug coverage for no additional premium, while others do not.

Thank you. This concludes my testimony.

[The prepared statement of Dr. Smith follows:]

Statement of Madeleine Smith, Ph.D., Specialist in Social Legislation, Domestic Social Policy Division, Congressional Research Service, Library of Congress

Thank you, Madam Chairwoman and members of the Subcommittee, for inviting me to testify about payments under the Medicare+Choice (M+C) program. My name is Madeleine Smith. I am a Specialist with the Congressional Research Service.

There are two points that I would like to emphasize about the effects of payment reform under Medicare+Choice:

First, although the number of health maintenance organizations (HMOs) in the M+C program has declined, the proportion of Medicare beneficiaries enrolled in managed care has not changed much. In 1997, 14% were enrolled; today, 15% are enrolled. This fairly constant percentage of beneficiaries enrolled in HMOs followed a period of rapid growth in enrollment that has not continued. Fewer beneficiaries have access to HMOs nationwide, but with the entry of a private fee-for-service plan into the program, access to an M+C plan for rural beneficiaries has risen.

Second, variation in payment rates has decreased. In 1997, the highest rate was 3½ times the lowest rate. Today, the highest rate is 1¾ times the lowest rate. However, benefits offered by M+C plans still vary widely across the country.

In the remainder of my testimony, I will review how rates were determined before the M+C program, and major reasons for reform of the payment system. Then I will turn to a brief discussion of how rates are currently calculated. Finally, I will summarize one effect of rate reform—plan withdrawals—and changes to the M+C payment rate calculations enacted since 1997.

Pre-BBA

Medicare has included a managed care alternative to traditional fee-for-service for almost 30 years, since the 1970s. Under the risk contract program created in 1982 (Section 1876 of the Social Security Act), an HMO received a single monthly capitation payment for each of its enrollees. This payment was known as the adjusted average per capita cost, or AAPCC. In return for the monthly payment, the HMO agreed to provide or arrange for the full range of Medicare services through an organized system of affiliated physicians, hospitals, and other providers.

The Health Care Financing Administration (HCFA) calculated the AAPCC for each of the over 3,000 counties in the US. A county's AAPCC was based on the costs of providing care under traditional fee-for-service (FFS) Medicare to a beneficiary in the county. Basically, HCFA determined the average per capita costs by adding together all of the Medicare FFS expenditures for beneficiaries living in the county, and dividing this by the number of FFS beneficiaries in the county. This county-level average per capita cost was adjusted for demographic differences between the county's Medicare beneficiaries and average beneficiaries nationwide. The county rate was set equal to 95% of the AAPCC to account for savings delivered by managed care organizations through coordination of care. Actual payments to HMOs for individual enrollees were adjusted for risk, using demographic characteristics of the enrollees, such as age, gender, and residence in an institution.

Each HMO was required to submit an estimate of its costs of covering Medicare services for its Medicare enrollees. This estimate is known as the adjusted community rate (ACR), and is still submitted today. If the AAPCC was greater than the ACR, the HMO was required to reduce beneficiary cost-sharing, enhance benefits, contribute the excess to a stabilization fund, or return the funds to HCFA. Many HMOs were able to provide additional benefits, such as prescription drug coverage, without charge to an enrollee because the AAPCC exceeded their ACR.

Reasons for Payment Reform

There were at least three main reasons behind reform of the AAPCC payment method under the Balanced Budget Act of 1997 (BBA, P.L. 105–33): lack of access to a Medicare HMO in many areas; wide variation in the payments and benefits offered by HMOs; and volatility of payment rates over time.

Lack of access to an alternative to FFS Medicare was the first perceived problem. The risk contract program expanded dramatically between 1993 and 1998, when the number of plans tripled from 110 to 346. In 1998, almost three-fourths of Medicare beneficiaries had access to at least one risk plan, and almost two-thirds had a choice of plans. Still, over one-quarter of Medicare beneficiaries nationwide lacked access to a risk plan, and most of these beneficiaries were in rural areas. Over 90% of Medicare beneficiaries in rural areas lacked access to a risk plan, while all beneficiaries in central urban areas had such access. Many of the counties without plans had low AAPCCs.

A second perceived problem was wide variation in payments and benefits offered by HMOs in different areas. In 1997, the highest payment rate was 3½ times the lowest rate: $767 versus $221 monthly for an aged beneficiary. An analysis of ACRs in 1995 showed that HMOs in Miami were required to offer benefits worth over $100 per month without charging enrollees anything: the payment rate was $100 per month higher than the HMO's costs of covering Medicare's benefits. In contrast, HMOs in Minneapolis were not required to offer any additional benefits: the payment rate was equal to the HMO's costs of covering Medicare's benefits. Beneficiaries in the federal Medicare program were receiving benefits that differed across localities.

A third perceived problem was volatility of the AAPCC over time, especially in rural counties. This problem occurred because of the relatively small number of Medicare beneficiaries in some counties: today, one county has 18 Medicare beneficiaries. If one beneficiary in a sparsely populated county incurred large Medicare expenditures in one year, the average per capita costs would skyrocket. If that beneficiary recovered or died, the next year the average per capita costs could plummet. Wide variation in payment rates over time was considered one obstacle to risk plan entry into some counties.

Other problems were more technical. The AAPCC was calculated based on average FFS Medicare costs. The costs of care provided to Medicare beneficiaries by Veterans Affairs (VA) or Department of Defense (DOD) facilities were excluded from the calculation. This could depress a county's AAPCC. AAPCCs also included payments for disproportionate-share hospitals (DSH) and graduate medical education (GME) even though some questioned whether HMOs were passing these funds through to hospitals.

Payments under M+C

In order to address some of these problems, BBA 97 included a new payment rate formula. The M+C rate in a county was set at the highest of 3 amounts:

- a floor, or minimum amount, set at $367 in 1998;
- a blend, or average, of local and national rates;
- a minimum update representing a 2% increase over the prior year's rate.

The blend calculation used the 1997 AAPCCs as the base local rate. National rates were an average of local rates, adjusted to reflect differences in input prices in each county. A portion of GME payments was excluded from the local rates used to compute the blend, beginning with 20% in 1998 and rising to 100% by 2002. The blend was phased-in. In 1998, 90% was based on local rates and 10% on the national rate; in 2003 and thereafter, 50% will be based on local rates and 50% on the national rate.

The formula included a floor and minimum update to alter the immediate effects of blending local and national rates. The floor increased rates in low payment counties more quickly than would occur through blending of local and national rates. The minimum update was included to cushion the effects of blending on high payment counties. At the time of enactment, analysis projected that over 80% of counties would be receiving blend payment rates by 2003. Among remaining counties, 16% would receive floor rates and 2% would receive minimum updates.

Payment rates were affected by other provisions in BBA 97, including statutory reductions in the national per capita growth percentage used to compute the local rate and the floor, and the budget neutrality provision which requires that aggregate M+C payments equal total payments that would have been made without changes to the formula. Both of these components were meant to guarantee budgetary savings. The M+C payment formula removed funding of GME from the calculation, but left DSH payments in the formula. No adjustments were made to account for care received through VA or DOD facilities. Finally, HCFA was required to implement a new risk adjustment system, based on the health status of beneficiaries, beginning in 2000.

Plan Withdrawals and Legislative Responses

The M+C program has now experienced three waves of plan withdrawals and service area reductions, effective at the onset of the M+C program in 1999, and annually since then. Interspersed between announced withdrawals have come two legislative responses, the Balanced Budget Refinement Act of 1999 (BBRA, P.L 106–113) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106–554).

Not all HMOs that had operated under the predecessor program chose to convert to the M+C program in 1999. According to HCFA, the 66 organizations that withdrew or reduced service areas affected slightly more than 400,000 beneficiaries in risk plans in 1998, about 6% of all risk enrollees. Slightly more than 50,000, less than 1% of risk plan enrollees, did not have access to another managed care plan and were forced to return to traditional FFS Medicare.

Plans announced further withdrawals and service area reductions in 1999 and 2000. Of the approximately 300 plans serving Medicare beneficiaries at the end of 1999, 99 plans withdrew or reduced service areas for the 2000 contract year, and 118 withdrew or reduced service areas for the 2001 contract year (GAO, 2000). These changes affected about 5% of M+C enrollees in 2000, and about 15% in 2001. About one-fourth of affected beneficiaries in 2000, and 15% in 2001, had no other managed care option available.

Why did plans withdraw completely or reduce service areas? Industry representatives believe that inadequate M+C payment rates are a principal cause of plan withdrawals. HCFA contends that withdrawals reflect strategic business decisions by M+C organizations that transcend payment rate issues. Studies of withdrawals by CRS, GAO and others have found that in 2000 M+C plans tended to withdraw from rural counties, where they may have had difficulty maintaining provider networks, and large urban areas, which they had recently entered or where they lacked sufficient enrollment. Similar results were found for 2001, with the added withdrawal of some plans with more extensive program participation. GAO notes that the pattern of M+C withdrawals resembles the experience of the Federal Employees Health Benefits program (FEHBP), with rapid expansion of plan participation between 1994 and 1997, followed by withdrawals of more recent entrants with few enrollees. A recent report from InterStudy indicates similar events in the general HMO market. In 1999, 83 HMOs (12%) ceased operations, many through merger, but 29 HMOs failed. The industry experienced its first annual decline in enrollment in nearly 30 years. Rural areas accounted for the greatest loss in enrollment, and 91% of HMO enrollees now live in urban areas. The boom cycle experienced by HMOs in the mid-1990s came to a close.

Congress acted to increase M+C payment rates. The BBRA in 1999 made a few modest changes to raise future plan payments by decreasing the scheduled reduction in the national per capita M+C growth percentage, and by reducing assessments for beneficiary education. It established bonus payments for plans that enter areas where no other plan is in operation, to encourage participation in rural areas, and it slowed down the Secretary's scheduled phase-in of risk adjustment. The BIPA in 2000 made more substantial changes to increase payments. For 2001, the floor rate was raised to $475 per month in lower populated areas, and $525 in areas with population of more than 250,000. The minimum increase in rates was raised from 2% to 3% for 2001. BIPA also extended the current risk adjustment method until 2003 (when a new risk adjustment method will be phased-in), and expanded the new entry bonus payments to encourage participation. Many other provisions with less general impact on payment rates were included. One notable BIPA provision allows M+C plans to offer reductions in the Medicare Part B premium as an additional benefit to enrollees, beginning in 2003.

Effects of Payment Reform

After a little over 2 years, have problems identified with the AAPCC been fixed? Lack of access was seen as a consequence of low payment rates. The BBA raised the floor to $367 per month, and the BIPA raised it again to $475/$525. Has access increased? In 1997, there were over 300 risk HMOs, and in 1998, there were 346. Today there are 179 M+C plans. The number of plans has dropped to about half.

Although the number of plans has decreased significantly, the proportion of beneficiaries enrolled has not changed much. In 1997, about 5.2 million Medicare beneficiaries (14%) were enrolled in risk plans. This increased to 6.2 million beneficiaries, or almost 17%, by 1998. In April 2001, there were 5.7 million Medicare+Choice enrollees, representing about 15% of the Medicare population.

Thirty-three percent (33%) of Medicare beneficiaries lacked access to a risk plan in 1997, including 91% of beneficiaries in rural areas. By 2001, 37% overall lacked

access to an HMO, including about 85% of beneficiaries in rural areas. With the entry of a private FFS plan, offered by Sterling Life Insurance Company, into the M+C program, access has increased. Sterling now offers coverage in over half of the states and counties in the country, where 38% of all beneficiaries reside, including 57% of beneficiaries living outside metropolitan areas. Sterling provides access to 18% of beneficiaries who would not otherwise have an M+C option.

Many counties not served by a managed care plan are served by Sterling, as shown in the map.[1] Sterling tends to operate in lower payment counties which previously did not have an M+C option. Sterling may serve these areas for several possible reasons. First, M+C payment rates may be higher than the average cost of fee-for-service care, especially in floor counties. Second, Sterling receives a 5% bonus for the first year, and 3% bonus for the second year, for serving counties that previously were not served by an M+C plan. Third, private fee-for-service does not require a network of providers, which is difficult to assemble and maintain in rural areas. Sterling pays providers the same rate as traditional Medicare, and does not permit providers to bill beneficiaries additional amounts (i.e., balance bill). Sterling provides very few additional benefits beyond the Medicare defined benefit package, but may reduce cost sharing for some beneficiaries, depending on the exact services used. Currently, Sterling charges enrollees a $65 monthly premium; enrollees must continue to pay the Medicare Part B premium of $50 per month.

Another goal of payment reform was to decrease the variation in payment rates and benefits. This has occurred. In 1997, the highest payment rate was three-and-one-half times the lowest rate. Today, the highest rate is one-and-three-quarters times the lowest rate ($834 versus $475), and the spread is even lower across metropolitan areas (about 1.6 times, $834 versus $525). This narrowing of differences in payment rates has been achieved by raising the minimum payment, or floor, while restraining growth in the highest paid counties to a 2% (3% in 2001 only) increase per year. (Managed care plans have argued that their costs have risen much more than 2% annually. HCFA projects an increase of 15.4% in nationwide per capita Medicare costs from 1997 to 2001. Plans receiving minimum updates over this period saw rates increase by 9.3%.) Additionally, as the payment gap has narrowed, benefits under M+C generally have declined. In 1999, 61% of beneficiaries had access to plans that charged no additional premium, and 54% had access to a plan that charged no additional premium while including drug coverage. By 2001, only 37% of beneficiaries had access to a $0 premium plan; only 26% had access to a $0 premium plan with drug coverage.

Recall the difference in benefits available in Miami and Minneapolis in 1997. Differences persist today. Several plans in Miami charge enrollees no additional premium and include full coverage of prescription drugs, both generic and brand name, for drugs on the plan's formulary. Contrast this to Minneapolis, where there are four M+C plans, three HMOs and Sterling FFS. Only one HMO offers any prescription drug coverage. For $81 per month, Minneapolis enrollees are covered for $100 in total drug expenditures every 3 months, for a total of $400 of coverage per year. In both cities, the HMO plans reduce cost-sharing and provide additional benefits, such as physical exams, eye care, and dental care.

Finally, payment reform was intended to reduce volatility in payments over time. Certainly payments have not decreased, as they did prior to M+C, but very large increases have occurred in some areas as a result of increases in the payment floor. Some counties saw rates rise over 100% between 1997 and 2001. The most recent rise in floors produced an increase of 14% in rates in non-metropolitan areas (from $415 in 2000 to $475 in 2001) and 26% in metropolitan areas (from $415 to $525). Moreover, some plans are receiving an additional 5% bonus increase in rates because they entered previously unserved areas.

This concludes my testimony. I thank the Committee for this opportunity to discuss M+C payment rates and will be happy to answer your questions.

Chairwoman JOHNSON. Dr. Roper, welcome.

[1] The map illustrates service areas of coordinated care plans and Sterling Life Insurance's private fee-for-service plan. Coordinated care plans include health maintenance organizations, preferred provider organizations, and provider sponsored organizations. Some coordinated care plans were not accepting new enrollees in February 2001. These plans are not included in the analysis summarized by the map.

STATEMENT OF THE HON. WILLIAM L. ROPER, M.D., DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL (FORMER ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION)

Dr. ROPER. Good morning or good afternoon, excuse me. Madam Chair, it is an honor to appear before you and the Committee and to discuss this important program. I salute your efforts to illuminate this issue and to try to make progress on it.

I am Bill Roper, dean of the School of Public Health, the University of North Carolina, Chapel Hill. I was HCFA administrator in the mid-eighties. And in the mid-nineties, I was senior vice president of Prudential Health Care and had medical management responsibility for our plans nationwide, including those in what is now the Medicare+Choice program. So I come at this from having run the program and then dealt with Medicare+Choice and HCFA later as a health plan.

The items that I would like to talk with you about are in prepared written testimony that I put forward, but I would like to speak more informally to ask you all to consider why the program undertook this notion of a better way to deliver Medicare services to seniors. It begins with the notion that the Medicare program, as originally envisioned in the mid-sixties, is woefully out of date, and the private sector has generated innovative new systems for the delivery of health care that the Medicare Program has not generally been able to take advantage of. These are organized health care delivery systems with incentives for quality in the services they deliver and efficient delivery of those services, incentives to foster innovation, and so forth.

When I was HCFA administrator in the mid-eighties, we were trying to launch this program, and I had the opportunity to write an op-ed piece for the Wall Street Journal, entitled, "Medicare's Private Option," and described the notion of allowing beneficiaries choice, not forcing them out of traditional Medicare, but allowing them choice of a variety of private options that took advantage of the innovations in the private health care market, and that began to happen in the late eighties and early nineties.

But through that time, again, when I was at HCFA, I was repeatedly asked the question by those representing private health plans, whom I was trying to interest in doing business in this area, I was asked, "Is the government a reliable business partner? Can we count on HCFA, can we count on HHS to deal with us in a fair and evenhanded way over time so that we can make long-term business decisions in this area?"

And I said, in the mid-eighties, "I think so, but you will have to wait and see." I think any fair judgment of the last 10 years would tell you that the Government is not a reliable business partner for private-sector plans like the ones that you just had testify so eloquently a moment ago.

In my written testimony, I have some recommendations which I commend to you, but they, I can summarize, are:

HCFA should create a single office within it to provide the oversight, and regulation, and guidance for this program. Dispersement across HCFA of responsibility for this program has been a very unfortunate misstep along the way of overseeing the program.

Secondly, the regulatory oversight needs to be streamlined. It does not need to be so cumbersome and so frustratingly burdensome for the plans that are trying to do the right thing for Medicare's beneficiaries.

And, thirdly, HHS and HCFA need to improve their decision-making processes and standardize them and especially make them consistent between the regional offices and HCFA's central offices so that people around the country, when they ask a single question will get the same answer so that people, again, can have a dependable business partner with which they can do business.

I think if those things are done, there is the opportunity for this program to grow and flourish. But I would urge you, as I said at the outset, to consider why you started down this path some years ago. It is not simply to create more laws, and more regulations and so on, but to offer a much better way for Medicare beneficiaries, and I believe that it is still very possible.

Thank you.

[The prepared statement of Dr. Roper follows:]

Statement of the Hon. William L. Roper, M.D., Dean, School of Public Health, University of North Carolina at Chapel Hill (Former Administrator, Health Care Financing Administration)

I. INTRODUCTION

Good afternoon Mr. Chairman and members of the Committee, I am William L. Roper, Dean of the School of Public Health, The University of North Carolina at Chapel Hill. Today, I hope to contribute to the Committee's dialogue from the perspective of one who has served as HCFA administrator as well as an individual who has interacted with the agency as a chief medical officer for an organization regulated by the agency.

Prior to my current post at UNC Chapel Hill, I was the senior vice president for Prudential HealthCare where I was responsible for medical management and other services supporting Prudential's health plans nationwide, including their Medicare+Choice plans. In this role I observed first-hand the intricate web of HCFA's regulatory processes and the inefficiencies and burdens they can create.

Before my tenure at Prudential, I served as the Administrator of the Health Care Financing Agency (HCFA) under President Reagan. During this time, I was responsible for managing Medicare and Medicaid through a period of significant change in these programs.

My thoughts about giving Medicare beneficiaries choices are long-standing. In 1987, I wrote an article for the *Wall Street Journal* editorial page on this subject entitled, "Medicare's Private Option." My message was simple: keep traditional Medicare intact, but increase choices available to Medicare beneficiaries by expanding the role of private sector health plans. At that time I wrote—and still believe today—that private plans, including managed care and indemnity plans, should compete with the traditional program on the basis of quality and cost. I oppose forcing older Americans to leave traditional Medicare in favor of private health plans. What I support is giving them choice. Do not take away the current Medicare system—just give beneficiaries more choices.

When I served at HCFA, we believed that well-managed private health plans offered an attractive alternative to traditional Medicare coverage. We were committed to giving private health plans a fair opportunity to compete and letting beneficiaries decide what option works best for them. Under this vision for Medicare reform, we at HCFA advocated a Private Health Plan Option, or PHPO, based on five goals:

(1) Ensuring appropriate access to quality care;

(2) Increasing incentives for efficiency;

(3) Reducing government's role in deciding how much to pay for individual health care services;

(4) Reducing government's role in micromanaging medical practice; and

(5) Expanding the range of choices available to both Medicare beneficiaries and health care providers.

These five goals—quality, efficiency, less government involvement in unit pricing and practice decisions, and more choice—might be useful to the Committee as guiding principles as you consider how to modernize Medicare.

II. MEDICARE+CHOICE NEEDS THE RIGHT REGULATION, NOT MICRO–REGULATION

As the Administration and Congress consider options for modernizing the Medicare program, it is critically important for decision-makers to ensure that the program has a strong administrative infrastructure that puts beneficiary interests first. To achieve this important goal, HCFA should adopt a new vision—a vision that places a strong emphasis on building cooperative partnerships with health plans, health providers and other private sector partners.

The goal of policy makers should be to create a more effective and efficient administration of the Medicare+Choice program. This includes a balanced approach to regulation that:

• **Stimulates growth and innovation in Medicare+Choice, and provides the maximum benefit and choice to the population it was designed to serve.** The healthcare system is evolving rapidly and the framework that regulates Medicare+Choice needs to be flexible enough to allow health plans to respond to these changes with new and advanced techniques in order to optimize beneficiary services and choices and improve quality.

• **Sets 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 plans 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.

• **Embraces flexible regulatory strategies for achieving program goals**. Health care is a dynamic industry where technologies to manage information, improve the delivery of services, and control costs are constantly evolving. A regulatory framework should promote, rather than impede these efforts. For example, the implementation of HCFA's risk adjustment approach is making excessive demands on Medicare+Choice organization resources and their provider partners that are not necessary to achieve the initiative's purpose. The approach is based on collection of 100% encounter data from inpatient and outpatient settings and requires Medicare+Choice organizations to develop all of the systems and staffing necessary to process claims in the same way as the fee-for-service Medicare program. The current system is extremely burdensome, costly and error-prone and needs complete re-evaluation.

• **Builds upon and utilizes existing, successful public and private sector initiatives**. An efficient regulatory framework will build upon existing and successful private sector oversight models and encourage the development of private sector best practices that can dovetail easily and effectively with program regulations. All too often we have seen a "not invented here" mentality in public programs that can impede the fulfillment of program goals.

III. RECOMMENDED COURSE OF ACTION

Based on these four principles of effective and efficient program administration, I recommend a four-point course of action:

1) Create a single office for oversight of the Medicare+Choice program. Medicare+Choice currently is governed separately by three HCFA Centers—the Center for Health Plans and Providers, the Center for Beneficiary Services, and the Office of Clinical Standards and Quality. The result has been a complex and needlessly confusing policy making process. All Medicare+Choice oversight responsibilities should be consolidated into one single center.

2) Streamline oversight responsibilities. The Medicare+Choice program is hindered in its efforts to serve beneficiaries because, since its inception, there has been a fragmented administrative structure that has been unable to set priorities or develop a clear, effective administrative strategy. The result has been a micromanaged and constantly changing regulatory environment that places equal—but arbitrary—emphasis on every requirement. Medicare+Choice needs right regulation, not micro-regulation.

Priorities should be established for the Medicare+Choice program for the balance of 2001, and each year thereafter, to reduce the number of regulations and

focus HCFA and Medicare+Choice organizations on ensuring beneficiary rights and plan accountability. For example, there should be an immediate reexamination of the numerous and duplicative plan audits and the site visit schedule should be converted to a two-year schedule. A new oversight approach should be implemented that reduces reviews of organizations that are performing well, and concentrates on those organizations that merit closer review.

3) Improve decision-making. HCFA's decision-making process involves many different parties at varying levels of seniority and in different Centers. Despite creation of cross-Center task forces, the complexity of this process and the lack of clear decision-making authority below the level of the Administrator's office results in delays that are frequently costly to M+C organizations and disadvantageous to beneficiaries. HCFA should consolidate and simplify its decision processes to respond quickly and correctly to the rapidly changing health care environment.

4) Create consistency between HCFA Central and Regional offices. M+C organizations across the country frequently receive different instructions and policy interpretations from the ten HCFA Regional Offices and the HCFA Central Office. 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 ensure that the Agency and its regional offices speak with one voice.

There are, no doubt, many specific recommendations that would improve the administration of the Medicare+Choice program. I have mentioned only a few.

It is important to note that these administrative changes, which can be implemented quickly to improve the regulatory environment in Medicare+Choice, do not speak to payment issues or other legislative matters health plans must face as they determine the future of their participation in the Medicare+Choice program. Administrative reform is only one element of a comprehensive reform package that places the Medicare+Choice program on a pathway of sustainable growth.

However, I would be remiss if in addition to the administrative issues I have described, I didn't address the issue of payment. Adequate payment is critical in order to attract health plans. Any payment methodology that departs significantly, either up or down, from local fee-for-service spending will cause market distortions. If Medicare+Choice rates are held below fee-for-service levels—essentially impeding the ability of Medicare+Choice from competing in local markets with traditional Medicare—ultimately the market response will result in fewer options for beneficiaries—options that could provide them with additional benefits.

IV. CONCLUSION

The Medicare+Choice program has the potential to serve as a foundation for the Medicare program of the future. With its focus on beneficiary choice and private sector participation, the Medicare+Choice program is designed to offer Medicare beneficiaries similar health care options that are available to Americans who obtain their health coverage through the private sector. Unfortunately, the Medicare+Choice program has suffered because of payment issues and administrative burdens.

An 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.

Chairwoman JOHNSON. Thank you, Dr. Roper. Dr. O'Grady?

STATEMENT OF MICHAEL J. O'GRADY, PH.D., SENIOR RESEARCH DIRECTOR, PROJECT HOPE, BETHESDA, MARYLAND

Dr. O'GRADY. Madam Chairwoman and Members of the Subcommittee. My name is Michael O'Grady. I am senior research director at Project HOPE. I appreciate the opportunity to comment today on the Medicare+Choice program.

As you heard today, certainly, there are still a series of problems that plague the Medicare+Choice program. The program still has

too few incentives for plans to compete for beneficiaries, providing the best care at the most competitive prices. The program still overpays in some counties and underpays in others. The program still relies heavily on fee-for-service experience to determine payments for plans. In many of our most urban and our most rural counties, fee-for-service experience is not a very good indicator of what an appropriate plan should be.

There are a number of essential points to consider in thinking about how this might be improved, but they all have one central theme, which is getting the incentives right. Compelling incentives are necessary so that plans really do try to offer the best-quality care at the best price.

There is also a need for incentives for beneficiaries to become prudent consumers of their own health care, to shop around between these different plans, to have the information that they need and to see some difference in terms of premiums so they can judge which plan is best for them.

One of the real advantages, as the beneficiaries tend to shop around and tend to be more prudent consumers, is it tends to buildup the incentive on the plans to be careful about what they offer and how much it costs. That has an additional advantage to the taxpayers in terms of slowing the growth rate of the program overall.

It is not particularly constructive to blame the plans for responding rationally to the incentives that they are presented with. Some counties they are offered very generous payments, others not very generous at all. They clearly have moved into those counties where the payments are high. They avoided the counties where the payments are low. If the incentives change, plan behavior should change as well.

Now how to improve the incentives to get the highest quality health care at the most competitive price. How to improve plan incentives? By improving the accuracy of the payment formula. Clearly, you have heard in other testimony today about how the payment formula is this sort of overpayment and underpayment.

Now there are two basic approaches that have been discussed in the debate so far. One is the one that we are currently using. Go with fee-for-service, but also adjust it. The floors that we saw first in the BBA and now the two double floors that we have seen coming from BIPA, the idea of you have got this distribution of very low-cost, low-payment counties, very high-payment counties. You truncate that distribution, basically, bringing it up using floors. There is not the same in terms of a ceiling, in terms of truncating the high, but they were limited to a 2-percent growth rate in BBA.

So the one method of doing it is staying with fee-for-service and, in effect, scrunching in the two ends from the high and the low end.

The other proposal that is out there is part of many of the premium support proposals that you have seen out there, which tends to be more likely to use a weighted average approach, where you basically look at the plan premiums, plan cost that operate in whether it is a county or a market, but all, both public and private plans, so you get this average of what is going on. If you have very high-cost endings, where the private plans are able to offer much

more inexpensively than fee-for-service, that will have a tendency to bring that payment rate down. If you are in very low cost, where fee-for-service is the lowest, by averaging in all of the plans, you will tend to bring that up again.

Now, right now what we've had, at least pre-BIPA, was we had a situation where plans competed for extra benefits and lower cost-sharing, as you heard from the first panel. BIPA took a first step to allow plans to start to offer actually premium differences. We hear of zero premium plans in Medicare+Choice.

It's a little bit misleading, because they are still paying their full $600 Part B premium. BIPA would allow plans to begin to rebate part of that $600, so that in terms of this idea of a prudent consumer on the beneficiaries part, they can start to shop around. There can be plan competition, not only for additional benefits but also for actually lower premiums.

Now, how to improve the incentives for the government to be more effective, to be a more prudent consumer. A number of the various reform proposals, not only the premium support, the Breaux-Frists and the Breaux-Thomases, but also President Clinton's competitive defined contribution, suggested moving significantly toward a system of more negotiation and bidding rather than the current, somewhat passive, where plans kind of complete an ACR, they send it in, those ACRs are audited after the fact. But there is not much real give-and-take at that point about what benefits are being offered and what premiums are being charged.

BIPA again took a small step in this direction, and there is a provision that brings in the Office of the Actuaries. So that at a minimum you will have the HCFA actuary sitting down with the actuaries from the plans and going over what assumptions did they use, what data did they use, and kind of what went into these benefit offerings and these calculations of premiums.

I have run out of time. Thank you very much.

[The prepared statement of Dr. O'Grady follows:]

Statement of Michael J. O'Grady, Ph.D., Senior Research Director, Project HOPE, Bethesda, Maryland

Madame Chairwoman and members of the Subcommittee, my name is Michael J. O'Grady and I am a Senior Research Director at Project HOPE. Previously I have served on the professional staff of the Senate Finance Committee, The Bipartisan Commission for the Future of Medicare, The Medicare Payment Advisory Commission and The Congressional Research Service. In those various roles I have had a chance to extensively study the Medicare program and a number of different health insurance programs, including the Federal Employees Health Benefits Program (FEHBP), The California Public Employees Retirement System (CalPERS) and private sector employer-provided health insurance programs. I appreciate the opportunity to comment today on the Medicare+Choice program and how it might be improved.

Problems That Still Plague the Medicare+Choice Program:

- The program still has too few incentives for plans to compete for beneficiaries by providing the best care at the most competitive price.
- The program still overpays in some counties and underpays in others.
- The program still relies heavily on fee-for-service experience to determine payments to plans. In many of our most urban and most rural counties, fee-for-service experience is not a very good indicator of appropriate plan payments.

How We Got Here:

The Medicare+Choice (M+C) program was created as part of the Balanced Budget Act of 1997 (BBA) to correct problems that existed in Medicare's Risk HMO pro-

gram. The risk plans had moved into some urban counties, but few rural counties. Some of the risk plans enrolled healthier, less expensive beneficiaries, but their payments were not reduced enough to adjust for their healthier mix of beneficiaries.

Under the BBA, payments to low payment counties were increased by the creation of a guaranteed minimum amount for every county. Payments to high payment counties were not cut, but their growth rates were limited to no more than two percent per year. In addition, the Administration was to develop a "risk adjustment" formula that would more accurately adjust plan payments to account for the mix of healthier and sicker people. The BBA also included a number of across the board cuts to plans that had nothing to do with improving the payment formula, but were necessary to meet the budget reduction targets of the bill.

By 1999 it became clear that the BBA cut Medicare spending much more than the Congressional Budget Office had originally estimated. Providers of all sorts, hospitals, physicians, nursing homes and Medicare+Choice plans, were arguing strenuously to restore some of the BBA cuts.

The congressional response was the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, and the Medicare, Medicaid, and SCHIP Beneficiary Improvement and Protection Act (BIPA) of 2000. The BBRA and BIPA went a long way to offset some of the "deeper than expected" BBA cuts. However, there is still a need to improve the way Medicare+Choice plans are paid.

Essential Points in Considering Changes to the Medicare+Choice Program—Getting the Incentives Right:

There are several essential points that need to be taken into consideration in thinking about how to improve the Medicare+Choice program. Most of these points center on a common theme: getting the incentives right. A well-designed Medicare+Choice program will have compelling incentives for plans to provide the highest quality benefits in the most cost-efficient way. It will also have incentives for beneficiaries to be prudent consumers of their own health care, so beneficiaries will "shop" among plans for the best care at the most competitive price. As beneficiaries act in their own interest, they exert pressure on the plans to keep premiums as low as possible. This competitive pressure slows spending growth, which results in savings for taxpayers.

These sorts of incentives are found in the vast majority of consumer decisions Americans make every day. The vast majority of prices are set, not by government formula, but by market competition. In the Medicare+Choice program the overall price is not set by government formula, but the government contribution is set by formula. A formula that does not always do a very good job of providing strong incentives for plans to offer quality coverage at competitive prices.

The current formula bases the government contribution on the county level spending by the traditional government operated fee-for-service (FFS) plan. FFS spending does not provide a good barometer of private plan costs in certain types of counties. Using FFS spending results in paying too much in some counties and too little in others.

In many rural counties there are serious problems with a shortage of medical providers. This shortage affects the Medicare and non-Medicare populations alike. It creates severe difficulties in gaining access to needed medical care. The result is that many rural counties have low FFS spending, lower than it would be if the people in those counties were receiving the medical care they needed. Using FFS spending as the measure of "appropriate" spending and setting the government contribution based on that level significantly reduces the likelihood that a private plan will find the government contribution adequate to offer care in these counties. Compounding this problem is the fact that the Medicare+Choice program and its predecessor the Medicare risk program have traditionally been exclusively health maintenance organizations (HMO). HMO plans have seldom had much success in rural areas, especially those with provider supply and patient access problems.

In some urban counties using FFS spending as the measure of "appropriate" spending results in Medicare+Choice plans receiving overly generous government contributions. There are a number of different reasons FFS spending would be significantly higher than Medicare+Choice plan spending in these counties. For example, some counties have an oversupply of providers. Hospitals have empty beds and physicians, especially specialists, have excess capacity. The FFS plan pays providers on a piecework basis. The more procedures they perform, the more they are paid. Managed care plans tend to negotiate with providers for discounts. Beneficiaries in managed care plans pay much less if they go to "in-network" providers. As a result, in-network providers see a higher volume of patients. Providers who wish to be part of the network often have to offer the managed care plan a significant discount. The result is that the exact same set of circumstances—oversupply and excess capacity—

tends to increase FFS spending and decrease managed care spending. The FFS incentives are to do more procedures to be paid more. The managed care incentives are to offer greater discounts to fill more beds and waiting rooms.

The Medicare+Choice plans respond rationally to the incentives they find themselves confronted with. Plans move into counties were the payment is adequate or more than adequate, for example Dade and Los Angeles counties, and stay out of counties where the payment is less than adequate, for example most rural counties.

The current Medicare+Choice incentive structure result in the following:

- In under payment counties—plans cannot afford to operate.
- In over payment counties—plans offer significant additional benefits, reduced cost sharing, but have few incentives to be cost efficient.
- In counties where the payment is about right—plans offer some additional benefits and reduced cost sharing, if they are more efficient than FFS.

It is not particularly constructive to blame the plans for responding rationally to the incentives built into the Medicare+Choice program. If the incentives change, plan behavior will change.

In all fairness to the designers of the current formula, it is extremely difficult to design an efficient, effective formula for hundreds of plans in thousands of counties. And, the government does have to have some way of determining what is an appropriate contribution. However, in Medicare+Choice the problem is that the current program relies too heavily on an inefficient formula-driven approach without the assistance of strong consumer incentives for the beneficiaries and effective negotiating authority for the government.

Why worry about getting the incentives right?

While there are obvious reasons to try to improve Medicare+Choice's incentive structure, there are also a few less obvious reasons. Two of the more obvious reasons are:

- To be careful with the taxpayers' money and
- The current system results in geographic inequities in benefits.

Over paying in some counties results in additional benefits and lower cost sharing for beneficiaries. On the one hand, if beneficiaries are willing to give up some choice of providers by entering a managed care plan; they should enjoy the rewards of additional benefits and reduced cost sharing. This can be particularly attractive to lower-income beneficiaries who cannot afford Medigap coverage and are not eligible for employer-provided retiree coverage. Still, this means that lower-income beneficiaries have this alternative in some counties and not in others. This is particularly problematic in rural areas where the traditional industries, such as agriculture, have an almost nonexistent track record at offering employer-provided retiree coverage.

Less obvious reasons to try to improve Medicare+Choice's incentive structure would include:

- The baby boom is still coming. Making Medicare as efficient as possible reduces future pressure to either reduce benefits or increase taxes.
- Protect the work-related nature of the Medicare entitlement. The greater the financing from general tax revenues the less Medicare becomes a benefit people earn and the more it becomes subsidized assistance.

Without a doubt it is better to have a budget surplus, than a budget deficit. However whatever the budget situation, the demographics of the American population have not changed. The baby boom is still approaching retirement and with it will come severe financial pressure on the Medicare program. Future Congresses will face difficult choices. Raise the taxes of the subpopulation still working, cut the benefits of future Medicare beneficiaries, or both? These will be very difficult decisions to face. But before confronting such difficult choices it seems incumbent on those responsible for the Medicare program to make Medicare as efficient a program as possible.

Most seniors view their Medicare benefits as something they have earned during decades of hard work and paying taxes. It is not clear if they are aware that in reality, payroll taxes and premiums only pay for 70 percent of Medicare. The rest is subsidized through general tax revenues. As the baby boom retires, the percentage of Medicare paid by the beneficiaries is projected to shrink from 70 percent to about 40 percent. The idea that Medicare is something beneficiaries have earned and paid for will be diluted considerably over the next few decades. A more efficient Medicare program with a slower growth rate helps maintain the work-related aspect of the Medicare entitlement.

How to improve the incentives to provide the highest quality health care at the most competitive price?

• Have plans compete based on offering competitive premiums, not just more benefits and lower cost sharing.

• Improve the accuracy of the payments formula to minimize under and over payments to plans.

• Move toward a process that involves negotiation and bidding, rather than relying solely on administrative procedures.

Before BIPA, plans were required to pass on all savings to the beneficiaries in the form of additional benefits or reduced beneficiary cost sharing. Their profits were limited to no more than the percentage they made on their commercial business. Unlike much of their commercial business, these incentives put plans in competition with one another to provide more benefits, rather than lower premiums.

BIPA allows plans to compete based on premium price, as well as benefits. Beginning in 2003, plans can offer beneficiaries a rebate on part, or the entire, Part B premium. Some Medicare+Choice plans are currently called zero-premium plans, but this only means the beneficiary pays nothing beyond their current $600 Part B premium. Under BIPA, if plans provide all the Medicare benefits and still have savings, they can rebate the entire $600 premium to the beneficiary.

Table 1 illustrates how premium competition can work in practice. The column labeled "Before Enrollees Switched" shows what the annual premium increase would have been if Federal workers and retirees had stayed in the same plan they had been enrolled in during the previous year, i.e., if no one switched plans. The column labeled "After Enrollees Switched" shows what the annual premium increase actually was, after workers and retirees chose their new plan for the upcoming year. In each of the years the Bipartisan Commission found data available, the effect on premium growth was the same—workers and retirees acted as prudent consumers and the result was to slow the growth rate of the program.

Table 1:
Average Premium Increases, Before And After Enrollees Switch Plans Under The Federal Employees Health Benefits Program, 1990–1998 (In Percent).

Year	Before Enrollees Switched	After Enrollees Switched	Result of Switching
1990	13.3%	8.0%	-5.3%
1991	5.7%	4.1%	-1.6%
1992	8.0%	7.3%	-0.7%
1993	9.0%	8.5%	-0.5%
1994	3.0%	2.7%	-0.3%
1995	-3.4%	-3.8%	-0.4%
1996	0.4%	-0.1%	-0.5%
1997	2.4%	1.6%	-0.8%
1998	8.5%	7.2%	-1.3%
Mean	**5.2%**	**3.9%**	**-1.3%**

Source: Bipartisan Commission staff analysis of OPM data.

The FEHBP and Medicare populations are not identical and the effect might be different for Medicare. FEHBP is only about 40 percent retirees and younger workers are probably more likely to switch plans than older workers or retirees. However, even if this consumer behavior yielded only half the savings found in FEHBP the effect on Medicare's financial well being would be substantial.

As mentioned above, BIPA has already taken the first step in this direction by allowing plans to rebate the beneficiaries' Part B premium. Premium price competition is a core component of most recent Medicare reform proposals including the Bipartisan Commission Chairmen's proposal and President Clinton's Competitive Defined Benefit proposal.

The introduction of premium price competition is a good first step, but plan payments are still based on an inefficient formula that overpays some counties and under pays others.

What options are available for increasing the accuracy of plan payments?

• Premium support strategies—base payments on the average premiums of all plans, public and private, like FEHBP.

• BBA-style strategies—set payment minimums to bring up the low payment counties and set payment maximums to slow the growth of high payment counties.

One of the key design components of premium support strategies involves using an average of all plans, both public (FFS) and private (M+C), to determine the level of government contribution. The most common example of this type of contribution formula is the one used in FEHBP where the contribution is set at 72 percent of the average premium[1]. The average premium calculation is adjusted to take into account the relative size of the different plans' enrollments.

During the deliberations of the Bipartisan Commission this design caused concern among some Commissioners who feared the traditional FFS plan would not be able to compete effectively and the result would be higher premiums for beneficiaries remaining in the FFS plan. Using this type of formula does mean that all plans, including the government-run FFS plan, would have to operate efficiently to keep their premiums competitive.

In President Clinton's response to the Bipartisan Commission, this design feature was modified. Rather than using average premiums, the Clinton plan stayed with using FFS spending to determine private plan contributions. This modification has the effect of protecting the FFS premium. This protection means beneficiaries who remain in FFS will not see upward pressure on premiums, but it also means that the incentives to operate efficiently will be significantly weakened. The FFS plan, which currently comprises about 85 percent of the program, will not face the same competitive pressure as the Medicare+Choice plans.

Another strategy was employed in the BBA and modified in BIPA. Rather than trying to replace the underlying formula with a more accurate one, the high and low ends of the payment distribution were truncated. The BBA used a two percent growth cap for counties with the highest payment levels. This did not cut payments to this counties, it attempted to limit the growth rate until lower payment counties could catch up. The BBA also truncated the low end of the distribution as well. It set a minimum amount that Medicare would pay plans regardless of the level of FFS spending in the county.

Under BIPA the idea of a floor payment was expanded significantly. A single floor payment amount was replaced with urban and rural floors. Floor payments were increased from $415 per month to $475 per month for rural counties and $525 per month for urban counties.

For rural counties this is a significant increase, but payment floors are a short-term strategy for a problem that goes well beyond Medicare. An under supply of providers and the resulting lack of access for both Medicare and non-Medicare people, will not be solved by additional money to private Medicare plans.

While the use of payment floors and ceilings may provide some short-term relief, they do not really attempt to determine what the appropriate contribution should be. It seems quite unlikely that all the low payment counties should be brought up to these higher levels or that all the high payment counties should be constrained to no more than two percent growth per year.

Rather than choosing arbitrary minimum and maximum payments, or tying payments to only one plan, using data from all the plans, public and private, has the advantage of capturing the experience of all plans. If private plans are operating at significantly lower costs, then the contribution will come down. If private plans are operating at significantly higher costs then the contribution will increase. In addition, it ensures that all plans, public and private, face the same set of competitive incentives.

Enhance the government's ability to act as a prudent consumer through negotiation and bidding.

BIPA again made a first step in this direction. Pre-BIPA, plans filed their benefit and premium offerings with HCFA through the Adjusted Community Rate (ACR) process. HCFA determined the completeness of the application, but made no judgement on the appropriateness of the estimates and calculations involved. After the fact, the ACR's were audited by HCFA, but by that time benefits were already received and premiums paid by the beneficiaries. BIPA did not replace the ACR process, but enhanced its effectiveness by adding a review of all applications by the HCFA actuaries. Before accepting a plan's application, the government actuaries will review the data and assumptions used by the plan to set premiums and benefits. This additional review is similar to the review the OPM actuaries make of FEHBP plans premium and benefit applications.

Most reform proposals, including the Bipartisan Commission, President Clinton's Competitive Defined Contribution and the Breaux-Frist proposals, would go further

[1] FEHBP also has a provision that the government contribution will not exceed 75 percent of the total premium.

than an actuarial review of data and assumptions. They all move toward approaches that rely on some combination negotiation and bidding.

The core element of all these proposals is to attempt to construct a set of incentives where plans do well if they provide high quality benefits and a competitive price. The government itself can become a more prudent consumer of health care and in doing so provide more benefits to beneficiaries at a lower cost to tax payers. Still that process is greatly strengthened if the incentives are such that the beneficiaries also become prudent consumers of their own health care. Beneficiaries' shopping to find the best value at the most reasonable price creates substantial competitive pressure on plans to offer the best benefits at the lowest price.

These two changes, basing payment on the experience of all plans, not just the fee-for-service plan and moving toward negotiation and bidding will go a long way toward getting the incentives right. These changes move the Medicare+Choice program away from a system that rewards plans for gaming a payment formula to system that rewards plans who best meet the beneficiaries' needs for the best benefits at the most reasonable price.

Chairwoman JOHNSON. Thank you very much, Dr. O'Grady. Dr. Moon, welcome.

STATEMENT OF MARILYN MOON, PH.D., SENIOR FELLOW, URBAN INSTITUTE

Dr. MOON. Thank you. I also appreciate the opportunity to testify today about this important issue.

I want to take a different perspective and look at Medicare+Choice from the standpoint of beneficiaries. This comes from my experience of having written a column for a number of years for the Washington Post and answering questions about confusion that people have, and from talking to a number of groups that do counseling for seniors and disabled persons in the Medicare Program, in particular from the Medicare Rights Center in New York, which runs a national hotline on HMOs.

Using private plans as an optional alternative to traditional Medicare fee-for-service does hold considerable promise for offering services to beneficiaries. Today I think you heard from three very good plans and the ideals from Bill Roper and Michael O'Grady about how to make those plans work better.

My basic concern is that, in practice, we have not seen those kinds of ideal situations in many instances. We have seen a much less than ideal reality. Both good quality plans and beneficiaries can be put at risk when that is the situation.

The organizations that contract with Medicare to provide counseling and information, or who run specific hotlines for beneficiaries, often find a disturbing pattern of denials of care in the Medicare+Choice program for some of the operators. Plans are supposed to cover all Medicare covered services, but hotline clients have included people denied, for example, cancer treatment that has been specifically approved in a national Medicare coverage determination.

Another example shared by the counselors was a patient effectively denied care because for a brain tumor. He did all of the kinds of research that you would want to do to make sure you know who should give you that care, but was denied being able to go out of network to one of the specialists in that particular kind of brain cancer because they had someone in the network who had

performed that operation twice. I think a lot of us would not consider that good quality care.

Another example is of an individual who needed chemo-therapy, whose wife was paraplegic, and the chemotherapy center was too far away for that person to get to. He offered to stay with his son and get care out of network. The plan denied him. He had to disenroll. In that case, he only had to wait a month to get chemotherapy. Eventually, when there's a lock-in, he would have to wait longer than that potentially.

These are examples of ways in which it is important, as we think about changes in the Medicare+Choice program, to remember that some of the issues, such as control over plans, such as oversight and quality monitoring, are extremely important. Unfortunately, not all the plans are as forward thinking as the people that we heard from here today.

If beneficiaries are going to be asked to take greater responsibility for their care, it is important to have in place the appropriate protections and controls for those who are cognitively impaired, frail, non-English speaking, or face other barriers to getting their care. This is likely to be half or more of the Medicare population.

The main attractiveness of plans to beneficiaries, at least initially, is that plans have been able to offer extra services. They have been able to do so, in part, because they can save costs on Medicare covered services, but also in part because they have received cross-subsidies in the form of higher Federal payments. It is the desire of plans to continue to get those subsidies and of beneficiaries to continue to have extra benefits, but this raises a number of equity questions.

In thinking about how to improve Medicare+Choice, I have a few suggestions to offer. First, I will address the two areas that were raised and talked about most today, that is, payments to plans and regulatory changes, and then I will discuss two other issues that beneficiaries need to have raised on their behalf.

The payments to plans, as Mike O'Grady very carefully spelled out here, can be done in different ways. But I think we also heard in the testimony today that there are two strains of thought. Plans say "give us more money to do good things," but the other argument is, "let's have competitive bidding to save costs to the Medicare Program." We haven't found a good way to bring those two conflicting goals together.

Certainly beneficiaries in Medicare+Choice would be happy to have you overpay because that would mean they would continue to get higher benefits in the Medicare+Choice plans, but that would be unfair to those who are in traditional Medicare and not able to get those benefits.

I believe, therefore, a first step is to provide a prescription drug benefit that could help to equalize the benefits that people get in all settings, and aid in some of the payment issues.

Second, complexity in regulations is certainly a problem. Everyone has a horror story, and they're all right, I'm sure. But they exist everywhere, not just in HCFA but in the plans themselves. A careful overview of regulations with both plans and beneficiaries' perspective in mind is appropriate.

Finally, we need to spend additional resources on helping beneficiaries understand these programs, understand their advantages and disadvantages, and work on increasing the stability of plan offerings. I don't think the answer is to pay plans more to bribe them to stay in areas. We need to work on finding ways to make the plans more appropriately recognize beneficiaries' the need for stability.

Thank you.

[The prepared statement of Dr. Moon follows:]

Statement of Marilyn Moon[1], Ph.D., Senior Fellow, Urban Institute

Thank you for the opportunity to be here today to testify about the lessons learned from the Medicare+Choice plans and their implications for relying on private plans to serve the Medicare population. My testimony today emphasizes beneficiary issues, and attempts to contrast them with interests of the federal government and private plans when appropriate. My concern about beneficiaries is a long standing one and has been influenced over the years by writing a column on coverage issues in the 1990s, maintaining contact with groups that counsel Medicare beneficiaries, and conducting research on Medicare. The opinions expressed here are my own and I am not representing any other group.

The Promise of Private Plans

Using private plans as an optional alternative to traditional Medicare fee for service holds considerable promise for offering services to beneficiaries. And expanding the role of private plans is often touted as the solution to Medicare's financing challenges. In theory, plans can play a pivotal role by:

- Providing coordinated care to beneficiaries with multiple health care needs;
- Experimenting with new and innovative ways of delivering care;
- Having the flexibility to offer additional services—like transportation services and home modifications—that may facilitate traditional care; and
- Competing for enrollment by offering lower prices, more services, or higher quality care.

Health care analysts have long sought to encourage coordination and flexibility of care in a capitated setting, giving plans incentives to find the least expensive ways to deliver care within a budget. This should avoid the overuse of services associated with fee-for-service medicine and offers opportunities to try out new approaches. And, if there is price competition, economic theory would suggest that this will keep the pressure on plans to be attractive to potential enrollees, increasing their market share and delivering care efficiently.

Medicare+Choice in Practice

Experience with private plans in Medicare suggests a less-than-ideal reality, however. Good quality plans seeking to serve patients well certainly exist, but a number of problems abound. Medicare has, since the 1980s, formally allowed beneficiaries to choose to be served by private plans (paid on a capitated basis) instead of remaining in the traditional fee-for-service part of the program. In 1997, this option was modified to allow plans other than health maintenance organizations (HMOs) to participate and to reform the payment system which, studies have shown, costs Medicare more for each enrollee than if they remained in the traditional program. Even with those changes, however, the Medicare program has not saved money for the federal government.

Although payments for most plans should be high enough to cover costs of required benefits, private plans have pulled out of markets or reduced the extra benefits offered. Further, there is little evidence to suggest that most private managed care plans do much to coordinate care either in Medicare or for the younger managed care population. Thus far, savings have mainly come from obtaining deep discounts from doctors, hospitals and other suppliers. And since Medicare had made inroads into discounting before most managed care plans came into the program, this avenue of savings has not reaped the same differentials in costs as were sometimes seen in the employer-based insurance market. Thus, the promise of substantially lower costs may be difficult to achieve.

[1] The views expressed herein are those of the author and do not necessarily reflect those of the Urban Institute, its trustees, or its sponsors.

In addition, beneficiaries have not been treated well by some of the private plans. Private plans have sometimes sought to save costs by limiting access to new technology, to exclude from their plans sub-specialists with considerable experience in treating certain types of illnesses, and to put in place other barriers to getting care. If done carefully and with appropriate medical practice in mind, these methods may be a successful way of holding down costs. But, many researchers have concluded that these are sometimes arbitrary or problematic barriers. A recent study by Berk and Monheit, for example, concluded that HMOs work best for the 90 percent of the population which is healthy. The problem is that the remaining 10 percent of health care users account for 70 to 75 percent of all health care costs (regardless of age).

The organizations that contract with Medicare to provide counseling and information or who run specific hotlines for Medicare beneficiaries often find a disturbing pattern of denials of care. Those on the frontline at the Medicare Rights Center, for instance, cite numerous examples of inappropriate denials. Plans are supposed to cover all Medicare-covered services, but their clients have included people denied a type of cancer treatment specifically approved via a national Medicare coverage determination. Patients are often denied access to care from specialists outside the network who have particular expertise in a given procedure. In one case, the HMO argued that since they had an in-network physician who had performed a particular type of brain surgery twice, they had no obligation to approve care outside the network by a more experienced physician. In another case, a patient needing chemotherapy had a transportation problem that prevented him from going to the in-network site. His only recourse was to disenroll from the HMO and get the chemotherapy in another location. In that situation, the delay was only for one month, but when the lock in goes into place (in which beneficiaries will have fewer opportunities to disenroll), such a patient could be severely disadvantaged. Although these are examples and it is not known how many people have such difficulties, it suggests that the "flexibility" available to plans can be problematic and that at least in some cases, patients do not have access to all Medicare-covered services. Ironically, these examples illustrate denial of "choice" in a form that is likely to be of more importance to beneficiaries than what is often touted as an advantage of private plans offering "choice."

A number of marketing abuses have also been found by those who work with Medicare beneficiaries. The family of a beneficiary with Alzheimers disease sought help when the beneficiary was suddenly denied coverage for various services; they discovered that the beneficiary had been enrolled in a managed care plan without the family's knowledge. One of the more egregious examples occurred when a group of Spanish-speaking elderly beneficiaries were taken to Atlantic City and on the bus were asked to sign a piece of paper (in English) that they were told was to get information about the health plan. In fact, they had "enrolled."

While complaints about excessive regulation are often made by the industry, there are a substantial number of examples of problems that require careful protections for beneficiaries. The denials and confusion cited above can be cleared up by case workers but regulations are needed to protect patients' rights. If beneficiaries are going to be asked to take greater responsibility for care, it is important to have in place appropriate protections and controls for those who are cognitively impaired, frail, non-English speaking, or face other barriers to their getting care. This is a substantially larger group than found in other populations served by managed care. In that way, Medicare is different and regulatory needs are also different.

The main attractiveness of plans to beneficiaries is that plans have been able to offer additional services. In fact, the ads that many plans run suggest the importance of vision, dental and drug coverage and mention only in small type that care must be received in network. Since plans have received payments higher than necessary for Medicare-covered services and because they may be providing those services at lower costs, they have been able to subsidize their offerings of additional benefits. But, over the last three years, these extra benefits have been substantially reduced in many plans. For example drug coverage has declined from 84.3 percent in 1999 to 70 percent having such coverage in 2001. Withdrawals have left a number of beneficiaries scrambling to enroll elsewhere or to get Medigap coverage if they return to traditional Medicare. And when drug coverage has been retained, stringent caps have been applied or substantial premiums levied on the beneficiary. The cross-subsidy for these extra services has been reduced.

Ways to Improve Medicare+Choice

Many ideas have been suggested about ways to improve the Medicare+Choice option. Two areas for reform have been emphasized both by plans and policy makers who wish to have Medicare rely more on the private market for managing care. These are reforms in federal premium payments to plans and reductions in the bu-

reaucratic complexity that restricts what plans can do. A beneficiary's perspective raises caveats about these first two issues and suggests additional issues including help in understanding the complexities of private plans and offering stability to those enrolled.

Payments to Plans. Although there is substantial criticism regarding the way in which the federal government pays plans, there is not a solid common ground between the goals of private plans and policy makers. Policy advocates of changing the way in which plans are paid usually focus on moving away from administered prices and toward a system of price competition in which plans bid against each other to attract patients. But plans are less enthusiastic about price competition. Under the current system, plans use extra benefits to attract patients. For beneficiaries, one of the main attractions to managed care—that is, extra benefits—would be eliminated. And because plans use extra benefits both as a drawing card and for offering better coordinated care by providing a full range of services rather than just those available from Medicare, they are also less interested in competitive bidding. The goal of most plans in the last few years has been to assure that payments are as high as possible, not to engage in competitive bidding.

Thus, it is not clear where payment reforms are likely to go. If the goal is to provide savings to the federal government, then lower prices will be necessary. The experience with the competitive bidding demonstrations suggests that this will be difficult to achieve because of opposition both from plans and beneficiaries who value the extra benefits that high payments allow. Further, two key problems need to be resolved before any change in payment policy will work well.

First, without good adjustments for health status, plans face no incentives to enroll sicker Medicare beneficiaries. In fact, the lack of a risk adjustment mechanism means that the easiest way for plans to be "successful" in the Medicare program is by attracting and keeping healthier beneficiaries and by encouraging those with health problems to disenroll. To the healthy beneficiary enrolled in such a plan, everything appears to be working well. They get extra benefits and are treated well by the plan. The problem is that other plans, traditional Medicare and sicker beneficiaries are made worse off by such a situation. Until this incentive is changed and plans embrace all types of beneficiaries, they will continue to seek a healthier population and will have little reason to make inroads in the treatment of the very sick. They are simply doing what is best for their business.

Second, the elephant at the table that no one can figure out how to deal with effectively is the geographic variation that exists across the United States in use and costs of health care. This is not just a problem of administered prices, it will arise under any system as long as people are sensitive about differing levels of costs by area. In areas where costs traditionally have been high, Medicare+Choice payments are also high. If a plan comes into that area and is successful at bringing costs of care down closer to the national average, they can offer extra benefits and do well in the market. This is not because they are more efficient or effective than plans in other parts of the country, but because they are working in an environment where there is likely excess use of services which make it easier to hold down costs.

The major adjustments tried to help with this problem have been unsuccessful. Raising the floor for rural counties does not work well since most private plans find it difficult to operate in such areas. Moreover, it potentially puts in place a system in which private fee-for-service plans may come in and provide the same types of services to beneficiaries at a rate that is much higher for the federal government than care under traditional Medicare. That essentially trades one problem for another. Further, the blended rate has not done much as yet to ease the situation for areas where costs have traditionally been low, largely because low costs in traditional Medicare have slowed that implementation. The new urban floors put in place this year are likely to have an effect, but again raise costs for the federal government. If enough money is thrown at the problem, then it is possible to bring all areas up to the level of inefficiency and high cost as now exist in only a few areas. That does not seem to be a prudent tact to take.

A better approach to improving levels of payment would be to add crucial benefits such as prescription drugs to the basic Medicare package. This would achieve several goals that would help both the viability of private plans and those in traditional Medicare who also have trouble getting prescription drugs. Adding drugs to the package would raise the contributions made to plans naturally, and although geographic variation would still be an issue, there would be less variation in benefit packages offered by plans. Further, if all plans offered a standard drug package, risk selection would be less of an issue and competition would work better. And, plans would be better able to coordinate care when the benefit package is more comprehensive. Finally, this change could reduce inequities in which traditional fee-for-

service beneficiaries receive no subsidies for extra benefits while those in HMOs do. Expanding this effort to other benefits such as preventive services could also help.

When the benefit package is comprehensive, it becomes more feasible to require plans to compete on price, either through competitive bidding or by offering a price discount for the Part B premium. Certainly the goal should be to find ways to move to a better pricing system, but a number of other changes in Medicare+Choice are needed as well, including adopting better risk adjusters, doing more work on geographic differences, and conducting demonstrations on alternative price setting approaches.

Complexity and Regulations. It is very difficult to determine how much plans are disadvantaged by the bureaucratic nature of the Medicare+Choice program. How many regulations are enough? What areas require the most oversight? While it is tempting to throw the current system out and start over again, many regulations continue to be needed. Two types of regulation and oversight are essential: assurances that quality care is being delivered and that beneficiaries have adequate protections from the types of problems chronicled above. The federal government as a prudent payer should not simply pay a capitated amount to private plans without safeguards and reporting requirements.

One of the major areas of complaint mentioned by plans are requirements to produce data on services provided. But without such information, it is difficult to track quality and to determine whether payments are appropriate. Is the problem that the federal government is requiring any information or does it have to do with formatting and other technical issues? It is hard to imagine that a well run business does not itself want to know what services are being used by what types of clients, so there should be grounds for agreement on providing data.

Most plans have a large commercial operation in addition to serving Medicare clients. Do they want to use the same screens for Medicare as they use for the working age populations? That would simplify requirements that they face, for example, but may not serve Medicare patients well who have different needs than working age families? The high rates of morbidity and special needs among the Medicare population are likely to require some special adjustments if they are to be served well by Medicare+Choice.

A reasonable goal of reforms in Medicare+Choice should be a careful review of existing regulations and requirements. But such a review should also closely examine whether there are *enough* protections for beneficiaries. For example, should plans be required to notify patients when they are hospitalized that all normal inpatient costs are covered by the plan and thus to ignore bills they receive directly from in-network providers? This common problem can be resolved, but how many beneficiaries just pay the bill and don't follow up? Should plans be required to get a card to an enrollee within a particular period of time so that the patient can access health care services, or be subject to a penalty? Again, this is an issue that seems to arise frequently. These should be easily resolvable issues, but need to be backed up with strong requirements from the federal government. The problems with plan oversight do not flow only in one direction, and the needs of Medicare beneficiaries should be included in discussions regarding regulation.

Finally, it is important to note that few private insurance companies escape problems of complexity and bureaucracy. Many patients, both young and old, find the requirements of their plans to obtain approval before getting some services, to determine which doctors and hospitals are in network and which are not, understanding the bills when they come due months later, and the need to appeal denials of care to be cumbersome, complex and overly bureaucratic. Thus, problems with the complexity of our current health care system are by no means inherent only to government. The goal should be to reduce these burdens throughout health care, but to lay the issue at the doorstep of only Medicare is misleading.

Better Information and Support for Beneficiaries. One of the key lessons of Medicare+Choice is that beneficiaries do not have a good understanding of what it means to join a managed care plan, what their rights are, or how to choose wisely. Many problems have arisen because people do not understand even the basic requirements of being in a managed care plan. After an initial start at federal funding for such information, today, less, not more, is being proposed for this crucial task. The small amount available per beneficiary is insufficient to provide the information needed for beneficiaries to be knowledgeable health care consumers. When private insurers spend 10 percent or more of their per capita allocation on marketing (which translates into $600 per Medicare beneficiary), they are implicitly acknowledging how expensive it is to reach this audience.

Medicare also needs to offer its beneficiaries more than just information. It needs to provide resources to help beneficiaries follow up with problems and to fund inde-

pendent sources of information that will help consumers make good choices. Independent rankings of plans and centralized enrollment for private plans through Social Security offices or elsewhere are two examples of ways in which the federal government could help empower consumers. Independent analysis comparing effectiveness of prescription drugs should be an essential piece of any prescription drug coverage. Special provisions to allow beneficiaries to disenroll to prevent abuses when the lock-in provision goes into effect may be needed as well.

Stability. Another issue that has come to the forefront is the disruption caused by plan withdrawals. In a market system, withdrawals should be expected; indeed, they are a natural part of the process by which uncompetitive plans that cannot attract enough enrollees leave particular markets. If HMOs have a hard time working with doctors, hospitals and other providers in an area, they may decide that this is not a good market. And if they cannot attract enough enrollees to justify their overhead and administrative expenses, they will also leave an area. The whole idea of competition is that some plans will do well—and in the process drive others out of those areas. In fact, if no plans ever left, that would likely be a sign that competition was not working well and/or that payments were too high. But this also means that beneficiaries have legitimate concerns about disruptions that will occur under any private plan option. Reforms in Medicare+Choice need to take into account the need for special protections and procedures for beneficiaries caught in these disruptive situations.

Is Medicare Ready for Greater Private Plan Participation?

In many ways, the Medicare+Choice benefit has been one of the less successful changes that have occurred in Medicare. Despite payments that should be sufficient to compensate plans for the costs of Medicare-covered services, the number of withdrawals of plans and cutbacks in services for those who remain reached a peak at the end of 2000. The resulting disruptions for beneficiaries have been problematic. At present, the program is neither saving money for the federal government nor achieving good, stable care for many of its enrollees. Private plans certainly have a role to play in Medicare, but many of the issues described above need to be resolved and the current program working well for beneficiaries before greater reliance is put on private plans under Medicare.

Chairwoman JOHNSON. I thank the panelists very much.

I'm going to raise a slightly different issue, and it may not be one on which you would care to comment, but it is central to our discussion of more appropriate payment rates for managed-care plans. It goes to this issue of the disparity between geographic areas.

In a preceding hearing, we had quite an interesting discussion about this, and the opinion of most of the experts there was that the disparities are not driven as much by difference in price for service as in patterns of utilization. One expert pointed out that he thought it was, indeed, unfair for the government to force a change in patterns of utilization on an area, that that should be a matter of medical practice and so on and so forth.

Now, there are some really scary issues about having your reimbursement rate determine what you're going to utilize when in that region the utilization pattern is very much higher. It is particularly disturbing when you look at the fact that the highest rates are where the densest medical capability lies. So, in Boston, where you have a lot of technology, in Miami, where you have a lot of technology, in the centers where you have incredible capability, you also are attracting patients from outside the district. You need that capability. So you don't necessarily want to bring the low areas up to that level. They would be terribly overpaid. And if you force the high areas down to some kind of—which is what the blend is doing, it's an arbitrary policy. But this is one of the problems with it. It

arbitrarily brings the top down without looking at the services bought.

I think from the beneficiaries' point of view, this is extremely concerning. The arbitrariness, the mechanicalness, of our efforts to change payment policy to somehow meet our political understanding, and the simplistic understanding of what ought to be an equitable payment rate is very flawed from the point of view of health practice.

I would like you to comment on that in the context of how do we honestly get to some payment structure, some formula, that will enable us to reimburse plans for the genuine costs that they experience in providing care to seniors. Dr. Roper, I will let you go first, since you were the former Administrator of HCFA.

Dr. ROPER. Thank you, ma'am.

You raise the central question in all of this. As the testimony has played out, you can see the vagaries of an administered price system and the challenges that flow from trying to come up with the perfect calculation, when really what the program should be trying to do is say: what does it cost for the efficient delivery of quality health care to the average Medicare beneficiary in a particular local area, when practicing according to national norms of practice style and so on.

That cannot be arrived at, I would assert, by some fancy administrative system with lots of computers. That has to be determined by local doctors in their local area, asking them through a bidding process what the price ought to be for that efficient provision of care in their local area.

Now, you can't do that overnight, but you ought, though, begin heading the program in that direction because, otherwise, the already arcane system is only going to get more encumbered and encrusted with all of the fixes that you are, with good intentions, trying to put in place.

But to answer the other part of your question that you began with, is it appropriate for a national program like Medicare to dictate to doctors how they should practice in a local area, should you force them to follow Jack Winberg's good evidence that practice across the country is quite different and it does not result in better outcomes for greater intensity of care.

I don't think we ought to dictate to doctors how they should practice medicine, but I don't think the Medicare Program ought to be foolish, either, and simply to overpay based on historical practices that bear not connection to reality is not a wise thing for the Medicare Program to do. Therefore, again, what seems best to me is encouraging us to move toward a system that rewards efficient delivery of care in each local market, and you can only determine that by a bid process.

Chairwoman JOHNSON. Thank you. Would anyone else wish to comment?

Dr. O'GRADY. Yes, I would like to make one slight comment in terms of having looked at the various reform proposals over the last few years.

There is one part of it that was fairly interesting in President Clinton's proposal, actually, having to do with how they would adjust geographically and how they would take this into account.

Given the politics of it, it was a little interesting also because the Clinton approach was more market based than the Breaux-Thomas and some of the others, where they really did take a look at this notion of what were both the public and the private plans doing in a particular area.

In a discussion with the people who worked on that proposal, what they said is—They were driven by certain things, the same kind of concerns you're talking about, where if you look at something like poor Dade County, who keeps getting beaten up in most of these discussions, they are saying that in discussions with various providers in Dade County, it's a situation where many people do not have their extended family. Their children do not live there, they have retired, they have come down. So whether you're working in fee-for-service or for one of the plans, you are somewhat more likely, if you're a physician, to keep that person in the hospital perhaps an extra day, day and a half, than you would if you were in Minneapolis or some other city, where you knew that their son or daughter was going to come and pick them up and take care of them.

So there may be some actual reasons why these sort of bump ups that we see have very reasonable ways to go on. I wouldn't say the full amount in Dade County, but something there. By taking that into account, you would see that sort of extra day in the hospital in both the behavior of the public and the private plans.

Again, there is that attempt to try and capture what you think is really going on in this area, what is the practice pattern, and how do different plans deal with it.

Chairwoman JOHNSON. Dr. Moon.

Dr. MOON. I would like to add just two things, because I think my colleagues have talked very well about some of the challenges of moving in this direction. I agree that you have to do it slowly.

I believe there should also be attention given to a large market comparability. The disparity of plan payments in counties that are next to each other is where a lot of people get upset, because they see those disparities across plans operating in a metropolitan area. Benefits and even coverage are excluded for some because of payment levels. A blending of those rates as well could be useful.

Secondly, I would add that the idea of moving to a benefit package that's more standardized over time makes enormous sense, but only if we invest in the kinds of information that are necessary to lead to good norms and standards of care. I think we're woefully ignorant of that in many cases. I certainly don't think the national average of spending is the right amount. The question is how on Earth do we standardize without good information?

I believe the Federal government has a role in understanding and pursuing, for example, best practices information and disseminating that to people.

Chairwoman JOHNSON. Thank you. Congresswoman Thurman.

Mrs. THURMAN. Thank you, Madam Chairman.

Dr. Roper, let me first ask you this question, to reiterate I think something you have already said. You recommended that all Medicare+Choice oversight responsibilities should be consolidated into a single office and——

Dr. ROPER. Yes, ma'am.

Mrs. THURMAN. Similarly, I guess, to what had happened when you were there?

Dr. ROPER. I created such an office, yes, ma'am, in 1986.

Mrs. THURMAN. Who do you think they should report to?

Dr. ROPER. I recognize where your question is headed. My bias is to have that office report to the HCFA Administrator. That's what you have that person there for. I believe that the Secretary and HCFA Administrator are charged with running the Medicare Program and they ought to be doing it in a way that is appropriate. If they're not, you get rid of them and get somebody else. But I think separating it out creates another series of problems that may not be for the best.

Mrs. THURMAN. Let me ask all of you this question. Dr. Moon, I think you made an excellent statement just a few minutes ago, because I happen to be in one of those areas in Florida where we have such situations, because I have kind of centered around large urban areas and, quite frankly, in many of those areas their reimbursement is less than what is in the counties next to them. So if you go to St. Pete and Tampa and those areas, I get about right about $450 a patient, and you go to the county next to them, Pasco or Hernando, and they're getting about 500-and-something dollars, about $530 per patient. Yet they get less benefits and they have problems out there.

I was just talking to the Chairwoman and kind of similarly to what I said to the folks before you. Medicare is based on risk, that the 39 million keeps the cost down, has the ability to do that.

Why is it—I know kind of why, because we have set up these territories. But if I live in the State of Florida, quite frankly, I think you deliver health care services in Dade County at a cheaper cost than you do in Hernando County. I just think that's a fact. But yet their reimbursement is higher.

Why could you not do an integrated system throughout the entire State, so that if you had $800 in Dade County but $500 in Pasco, but the same insurance company or the same plan is, in fact, covering them, why couldn't they collapse all of their patients together, give the money that they get, and then be able to provide the services with the same benefit plan than all of this "well, I live in Dade—" You know, Dr. Moon, I've got to tell you, I have a lot of people that move from Miami into my district, and let me tell you how mad they are when they get to the district. You know, "I don't have this plan, this is the same company, I stay signed up with them, I now pay a premium, I don't get a prescription drug"—they don't like it. Tell me what you think.

Dr. ROPER. Were you directing it to anybody in particular?

Mrs. THURMAN. I would like all four of you to answer that. You can start.

Dr. ROPER. That is a very appealing and elegant solution. The problem is, though, to accomplish that means bringing down the amounts that you're paying into Dade County, just to pick on them as an example. To do that requires telling doctors—I'm a doctor—telling doctors that you're going to pay them less than they have been used to getting from time immemorial, and changing the way they practice so that they practice in a more efficient, I would say, modern, up-to-date, data-driven fashion. To do that runs counter to

the perceived wisdom the American public has bought into over the last five or six years; that is, how dare anybody try to tell a doctor how to practice medicine.

Mrs. THURMAN. I'm suggesting that you take this kind of blend, so if you keep the $800 in Dade, you keep the $500 in Pasco—because those are kind of your numbers—and you add those all together and have this risk pool because they don't spend all of the money every month for every patient, and you kind of set it up like you do with Medicare.

Dr. Smith.

Dr. SMITH. I have two comments about this.

As I know you are aware, under the current law, a Governor can, with the consent of the governed, make a single payment area out of the State. In order to do that, the Governor would have to convince representatives of Dade County to take a lower payment rate than they do under the current situation.

I think one fact of the Medicare+Choice program that makes it impractical to do this is the competitive nature between plans. If plans can choose the areas in which they want to provide services, they can enter Dade County and not enter your countries. A plan that goes forward and says I will cover the whole State, and I will use some of the payment that I receive in Dade County to subsidize services that I deliver in lower payment counties, will be at a competitive disadvantage to a plan that does not take that position.

Mrs. THURMAN. Unless you said that everybody had to do it.

Dr. SMITH. Unless everybody were forced, unless the playingfield were leveled to force everybody to take that position, yes.

Dr. O'GRADY. I would agree with my colleagues here. I would say there is even a greater danger than what Dr. Roper laid out. You would also be alienating the beneficiaries, because you would be telling the beneficiaries in Dade County they were going to see their benefits come down to raise the benefits in the other counties.

Mrs. THURMAN. Not my district.

Dr. O'GRADY. Now you would have this sort of new, standardized benefit package.

Now, the private fee-for-service plan that Madeleine talked about, that, in effect, says for the State we're going to offer this fee-for-service benefit package, so it is—I mean, you're seeing that sort of a dynamic. They will take the payment rates from all the different counties. They certainly have to keep their fingers crossed, that they'll get enough people enrolling from the higher payment counties to balance off the people in the lower payment counties to make the numbers work right.

As far as I know, unless you know differently, they have one benefit package that they're offering across 22, 25 States.

Dr. SMITH. Right. It's a nationwide benefit package with a nationwide premium, so they have pooled half the States.

Chairwoman JOHNSON. This is a very interesting case. One of the things that I have stumbled across in talking to plans is that one of the things they don't like is that they are mandated to treat everybody actually the same. So unless the State of Florida developed a special deal with HCFA, they could not allow a plan to serve all of Florida and pay providers slightly less where, in fact, the costs were less, and pay providers slightly more. I believe they are

obliged by law to pay everybody the same, aren't they? Can they vary payments within their payment area?

Dr. O'GRADY. They negotiate rates, certainly, with different hospitals and different groups of providers.

Chairwoman JOHNSON. Right.

Dr. O'GRADY. I didn't think it was uniform.

Chairwoman JOHNSON. That way, they could actually, if there was a negotiating process, they could actually sustain the rates in Miami if they were appropriate, because some of those rates will be appropriate because Miami has big teaching and research centers that simply are more costly than other facilities.

That is one of the reasons we have to look at how could we blend the concept of negotiation into merging over these different designated payment areas, because they are so arbitrary and are based on data that is so old. We have to find some way to bridge that. I don't think you can merge. I think you have to go over.

Dr. MOON. What you want to do also is start with very defined catchment areas, where people in that area are getting their care. That avoids some of the problems, that people are actually getting very different kinds of care. So it may mean that you do less blending than you would otherwise, and instead of incorporating ten counties, you incorporate only three that are more similar.

If you did that, I think you also have to worry about some requirements on plans participation in those areas, if you give them a blended rate. You might be able to do an experiment in which you essentially say we'll give you a blended rate but you have to agree to participate in all three counties, for example.

Mrs. THURMAN. Madam Chairman, the reason I bring that up is because—you know, whether you take Florida or take it by region or wherever, the fact of the matter is—This is the whole problem I see with the Medicare+Choice program today. It's because of the fact that it is still the taxpayers' dollars, who are, in fact, paying for these Medicare+Choice programs, and they are different, which is what bothers me when we start talking about privatizing any of this. I have no control. I have less control now, today, with the people that I'm representing—and that's why I said, in my county, that doesn't work. It may sound good, but I don't have an answer for them when we talk about reimbursement. So I think we have a legitimate issue here.

Dr. Roper, while I don't disagree, to cut this out in its infancy, I also think that we have learned to walk now. Let's make it so that it's something that has parity for all Medicare+Choice patients and not just a few that happen to live in those areas where it's great, because I'm paying the same tax that they paid and I'm going to get a different benefit than they do.

Dr. ROPER. Quickly, two responses.

Yes, the issues of payment variation are mind-numbingly complex. But you run the whole Medicare Program and you face those same issues with part A payments to hospitals under the reflective payment system, and part B payments to doctors under the RBRVS system, and direct medical education payments to hospitals under that part of the program. So these disparate things that have arisen because of the way people did something back in the sixties,

that no longer make sense today, are not unique to this particular program, is my first point.

Second point. The alternative, Congresswoman, is greater and greater attempts by you, as very well-meaning, elected Representatives, and the good people over in the Humphrey Building, to micromanage the Medicare Program instead of saying we will entrust—And that's what you're doing. You said you couldn't control them, and you're right. But entrust the program to people in the private sector that you then audit and look over their shoulders, and if they don't do the right thing, kick them out of the program.

I think the alternative to that is ever more intense micromanagement of the fee-for-service program.

Mrs. THURMAN. But don't you think if we sent it out there and didn't get the results, that we wouldn't jump right back in and start micromanaging?

Dr. ROPER. You know, I accept your point.

Chairwoman JOHNSON. Mr. Lewis.

Mr. LEWIS. Thank you very much, Madam Chair.

Dr. Moon, in your written testimony you describe a situation regarding Spanish-speaking seniors. Can you share that situation with the Committee, and do you have any ideas on how we can correct these abuses?

Dr. MOON. The particular problem was that a group of Spanish-speaking Medicare beneficiaries were offered a trip to Atlantic City, with the purpose that on the way down they would get some information about joining an HMO. They were asked to sign what they thought was a sheet saying they were going to be sent additional information.

The presentation was in English. They signed an English document and it turns out they all had enrolled in that HMO. Most of them did not know that and continued to go to their old doctors, but got denied payment for the care. The people the counselors found out about, were retroactively disenrolled, but they don't know what happened to everyone.

This is an issues where some of the enrollment practices need better oversight. It is entirely possible that we could have better places where people got information and could enroll, for example in Social Security offices or over the phone to a government official rather than through the plan.

That might also help with the problem when there were a lot of withdrawals last November. Many of the plans fell way behind in getting the information out, so people didn't know if their enrollment "took." They enrolled in several plans when they hadn't gotten a card for 3 months, for example.

A number of problems need to be addressed to help beneficiaries wend their way through this system. I don't think by any means that we have all the actors in line who have just the beneficiary issues at heart, and I think, in fact, to protect the "good guy" managed care plans, you need to have some of these kinds of controls.

Mr. LEWIS. Earlier, Dr. Moon, in your testimony you stated that we need to spend additional resources, additional money, to explain and to educate people what is in a plan.

If you had all of the unlimited resources, and you had to come up with a plan, what type of blueprint or road map would you provide for the Congress to accomplish——

Dr. MOON. I think this is a tough problem, because a lot of these plans are complicated, and when people are making comparisons, it is difficult to know whether one plan is offering you, for example, a nurse that's going to answer all your questions which is a service you're going to love, as we heard earlier, or someone who is going to tell you that you cannot go to the doctor or you cannot get a particular service provided, which is another role that you can have a telephone person play. It is very difficult to sort out.

We need to fund some independent analyses of private plans. The Federal Government should help establish some entities that will go out and do consumer reports, and get them started and get them going. The work itself can't be from the government. They can't say that "x" plan is good and "y" plan is bad. Boards of actual consumers, who look and rate these plans could help.

I think a lot of the support for beneficiaries needs to be done on a one-on-one basis in person, rather than through some of the written materials. The idea of health fairs providing roundtable discussions by independent counselors is not a bad idea. You can train the trainers; that is, you can have some of the people that do counseling now go out and train other folks to then deal directly with people.

I know the Medicare Rights Center, for example, has some private money to train people in libraries to provide information, but also train them to understand and be able to deal with the questions. They also go out and train people in senior centers. These are all different ways in which you can get information out to the public.

But most of the activities of that particular organization go on because they get private grants and cobble together money, not because the Federal government is helping to provide this information.

Mr. LEWIS. I thank you very much, Dr. Moon.

Dr. Roper, given that you support maintaining private options as an option for senior citizens, will you be concerned if a competitive model indirectly forces people into private plans? Would that be a concern of yours?

Dr. ROPER. Pardon me, sir. I didn't understand. Would I be concerned if who forced who?

Mr. LEWIS. If some competitor entity or agency forced people into a private plan.

Dr. ROPER. I would surely be opposed to that. People ought to be making free choices based on what is best for them and their health care needs. And they ought to have the residual option of staying in traditional Medicare.

Mr. LEWIS. Thank you.

Chairwoman JOHNSON. As we conclude, I would just like to have Dr. Roper and Dr. O'Grady discuss this issue of how one should govern Medicare+Choice plans. I think that Dr. O'Grady is on record thinking that the governance should be outside HCFA. This is not an easy issue. If you each would enlarge a little bit on your opinions, I think it would be helpful to the Committee.

Dr. O'GRADY. It is a very tough question, to know exactly how to do this. There's a number of different things. And whether it can be done within the current corporate culture of HCFA, yes, I tend to see that as a very tough row to hoe.

We know that those sorts of decisions, some of the changes, some of the negotiations that Dr. Roper talked about, are currently done under the Federal Employee Health Benefits Plan (FEHBP). You know, a GS–15 at OPM, are they somehow a very different person than a GS–15 at HCFA? Well, they operate in two different agencies with two different corporate cultures. There is no real reason that a GS–15 in Baltimore couldn't do it, but they don't.

HCFA is an organization that, when I've gone and talked to them, there is a lot of ability to be homegrown. Many of the people have not had extensive outside experience. They have been with HCFA for the vast majority of their career. So what it would take to get HCFA to the point that they could sort of break out of their current way of looking at things, I guess I am concerned that it would take more than a reorganization, that it would take an infusion of people who had some private sector experience, not just government experience, who had worked for either large HMOs or large insurance companies, or from outside.

HCFA has done some very good work at bringing in people from outside, in terms of medical innovation, and some of their work on consumer information, they have done very good. But to think about their relationship with plans, so they could have more than just HMOs, which they have traditionally had for a long time, but we really haven't seen any PPOs, and we've seen only one fee-for-service, that idea of really having this wide variety, this wide choice for beneficiaries, and to move out of a formula-based approach into a more open negotiation, maybe it could be done. It just looks like a very tough haul to do within the current environment.

Now, one could argue from the other side. If you suddenly opened up tomorrow the new Medicare competitive agency or board or whatever, who would be the most likely people to sign up? Well, there's a fair number of people in Baltimore who might be interested in those jobs. So, to a certain degree, do you try and reform HCFA, do you try and start over again? You know, either way there's pluses and minuses to both.

Dr. ROPER. Michael has done a nice job of "on the one hand and on the other hand." I tend to believe that, of course, as he was saying, the new organization, wherever it's located, needs to be populated by people who know about how the private sector works. They need to be led by political appointees who know how the private sector works and can take advantage of all of those things.

My answer to Miss Thurman a moment ago was, having done all of that, and facing the option of having that person report to somebody other than the HCFA Administrator or reporting to the HCFA Administrator, I would opt to the latter.

If I can take one further moment, though, there is another alternative that has been raised, of moving all of this even outside of the Department of Health and Human Services and have it report to a free-standing board, supposedly to take politics out of the process. My urgent caution to you is that that would not take any politics out of it. It would just change the politics of the process. The

notion that the Social Security Administration (SSA) is now depoliticized I think is evidence of that.

Chairwoman JOHNSON. Well, I hear the arguments that you're both making. I would have to say that I'm terribly discouraged with some of the experience that I've had with HCFA over the recent years and consider some of the people that were brought in last year to be very talented and capable people. I worked closely with Dr. Berenson on just trying to get the letters to the nursing homes simple and real. That man was smart and he was determined.

We could not get a letter written that said this patient does not qualify for Medicare. You look today and it's just reference to paragraph this, paragraph that, section so and so, section so and so. This is to my small nursing homes. We talked to him about this and he understood it. He tried and he worked hard, and he's able. To my rural nursing homes, who can only hire the kid who graduated from high school accounting, this won't do. This won't do.

The government in Washington does not get that. I don't care how many appointees you put in at the top, if you're not out there and you don't try to train this kid to do what she can do in terms of accounting, it doesn't work. She puts that letter aside. She knows it's a denial. But she's worried. She told me this herself. "Then I look at it next week. I know it's a denial. I know it's time to move. But I think to myself, I'll call just to be sure." Another week passes.

Remember, the way we're doing nursing home reimbursements at this moment, which is absolutely insane, is that we will not reimburse you for care you delivered in February if your January bills aren't completely signed off and paid.

Now, why the government thinks that that's possible, when they make it so hard to pay bills, I don't know. But that's the system. So if this kid loses courage, January's bills aren't complete, and the February bills can't be paid. Then it compounds and compounds.

That is the kind of bureaucratic problem—I could give you 20 examples of this. I have oncologists out in the sticks who haven't been paid for three months. This represents millions of dollars of oncology drugs. You know how expensive they are, at $10,000 a shot. It's because we have a small problem in Washington that we haven't been able to figure out.

It has nothing to do with oncology. It has nothing to do with reimbursement rates. It only has to do with this bureaucracy talking to that bureaucracy, talking to the bureaucracy out in Connecticut—and I won't use the language that immediately comes to mind. People trying to deliver care to senior citizens in America, who are eligible for that care, can't get it, or won't be able to get it, if we can't solve these problems.

So I appreciate, Dr. Roper, in the best of all possible worlds, I do think it should all be within HCFA. But whether that is possible in today's world, at this time, I really think there is not the evidence to think that it is. So you want coordination in HHS. After all, it's all within one agency. You want accountability, and you definitely want oversight. But you don't want the kind of oversight of the HCFA Audit Division.

You know, I had them in my office a couple of weeks ago, and they said to me—and I appreciate this, and I'm very, very grateful—they said they had decided that a consent decree is not a good mechanism. Well, if you are a sole practitioner out in the woods of Connecticut, and someone comes in and looks at some of your cases and then, instead of sitting down with you and talking with you about why they think you under-coded or over-coded, instead they send you a consent decree, and at the bottom of the paper it says "you ought to get a lawyer", you know, we have lost our cotton-picking minds here in Washington. We forget that we're dealing with very small providers. If we forget that, those seniors will not have access.

So I have spent literally the last 3 months, and most of last year, on this level of provider problem. That is why I had a hearing on the administrative burden. I am dead serious. I don't care what else we do on the macro issues, we're going to clean up this shop.

And it's not that we don't have good people in HCFA. We do have good people in HCFA. They have been very cooperative and very helpful. They have said to me over and over again, "we're so glad you called. We need to talk to real people out there." So it's not their fault.

The system, if you're setting 10,000 rates and adopting it in 3,000 counties, and we keep adding new technologies, new diagnostic techniques, and now prescription drugs, you can't do it. You can't do it in a way that allows you the time to call the provider. So this is a big issue.

Mrs. THURMAN. Madam Chairman, I concur with your passion. I think you can tell us up here because we are the ones that face those questions and answers all the time, and probably because we sit on this Committee which means we get a lot more of those kinds of requests than others might.

I, quite frankly, think that Dr. Roper was kind of agreeing with what you are saying in a different way, that if you can consolidate them, one person is responsible instead of this bureaucracy or that bureaucracy or another, that one person would have oversight over one particular program—I don't want to put words in your mouth——

Dr. ROPER. Thank you, ma'am, for the opportunity.

If you begin with the assumption that leaving it in HCFA means you continue the morass that has been there, of course, that's a stupid decision. It may well be, Madam Chair, that there is no way to right the wrong without moving it out. If that's the case, then I would be the first to say move it out of HCFA.

Chairwoman JOHNSON. My concern is the level of reality that is a practical reality, in the regulations and in every area, that latent understanding of how people have to do this in the real world, in many areas, has been lacking. One of the reasons is, if you read the detailed testimony of the groups that testified here before us—and they were model plans—they can't stay in if we don't start doing some things.

How did we get there? We got there because, actually, the government's experience in the private sector is so limited that it's very hard to make practical regulatory decisions and provide good oversight.

Just the whole thing that one of them talked about, which he didn't go into detail here, but you read back in the testimony what JCAHO does and we approve of, and then we put a whole different system in place and we don't talk about how they can meld, and we get you caught in between the two quality improvement programs, and the second one we did, we spent time doing, why don't we spend time thinking about JCAHO that's out there and that quality process?

I don't want to damn the people in HCFA. I think they have been absolutely overwhelmed. They don't have state-of-the-art technology. We haven't supported them in the way we needed to, and we have given them so many new responsibilities. Nobody in America really understands what to do to manage the health care sector right now, none of the actors and none of the government agencies.

But, given that, and recognizing that, we can ill-afford to move ahead with such an insensitivity to the practical reality of delivering care to seniors, because if we continue to be so insensitive, there won't be care delivered and we wouldn't be arguing about Medicare+Choice because there will only be fee-for-service and it will be just like Medicaid. It will be so lousy that it will really provide very limited access.

That's my fear. If we don't shape up, we will have a plan just like Medicaid. I can tell you, no woman in New Britain, CN has access to an obstetrician outside of the community health center and the hospital clinic under Medicaid, because reimbursements have dropped so far below cost. So I am concerned about how we do that and we will think this through together.

Thank you very much for your testimony.

[Whereupon, at 5:00 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of Robert J. Gaffney, County Executive, Suffolk County, New York

Chairwoman Johnson and members of the Ways & Means Health Subcommittee, thank you for the opportunity to present testimony on how the Medicare HMO terminations have affected the senior citizens of Suffolk County, New York.

To put this issue into perspective, let me offer the following salient facts. Suffolk County has the largest population in the state outside of the five boroughs of New York City. The county is suburban and rural in nature—situated on 100 square miles of the eastern portion of Long Island. Of our population of 1.4 million residents, 163,000 are 65 years and older. According to our most recent estimates, our senior population has grown by more than 15% since 1990 and the increase over the next ten years is expected to be even more significant with the aging of the "baby boomer" population.

Over the past three years, our seniors have been adversely impacted by the withdrawal of health maintenance organizations (HMOs) from Suffolk County's Medicare market. In 1998, ten HMOs operated in Suffolk County's Medicare market. That same year, two companies notified 14,000 senior clients that their insurance coverage would end January 1, 1999. By the end of 2000, six more HMOs had pulled out of Suffolk County, leaving over 35,000 seniors scrambling to find health coverage; now only two HMOs remain in the Suffolk Medicare market. Over half of the New York State seniors affected by the HMO terminations live in Suffolk County. Last year, 35,552 of the county's 47,489 Medicare+Choice enrollees learned that they would be disenrolled from their HMO effective January 1, 2001. Those affected represent an incredible 75% of the plan's local enrollees. Clearly, the Medicare+Choice program is not working in Suffolk County.

Many of the affected seniors have been forced to switch insurance companies three times in as many years, often with less coverage and more out-of-pocket costs than when they first joined an HMO. The reason seniors often choose HMOs over traditional fee-for-service Medicare is that traditional Medicare generally has higher

out-of-pocket costs and does not offer prescription drug coverage. To receive coverage comparable to that offered by an HMO, they would have to purchase a Medigap policy. Medigap policies can only be offered in ten standardized plans, identified as plans "A" through "J." Plan "A" is the least costly covering only basic benefits such as coverage for hospital co-payments, additional hospital days, and part B Medicare co-payment coverage. Costs for a Plan "A" policy range from $72.00 to $115.00 per person, per month. Plan "J" is the most expensive plan at $296.00 per person, per month and includes co-payments, deductibles, prescription coverage, and other benefits. Unfortunately, Medigap policies are financially out of reach for many older people who enrolled in HMOs for the very reason that they cannot afford additional health costs such as premiums, co-payments, and prescription costs.

I would like to share with you the experiences that two seniors from Suffolk County had as a result of the HMO terminations. In the fall of 2000, Mrs. K. was notified that her HMO would no longer operate in Suffolk County in 2001, and she would have to join another HMO or return to traditional fee-for-service Medicare. After reviewing her options, Mrs. K. chose to join one of the two HMOs remaining in Suffolk County. The new HMO would cost her $300.00 more per year and offer fewer prescription benefits. In December 2000, her current HMO notified her that they would remain in the market but her premiums would cost an additional $840.00 per year and she would have to absorb higher out-of-pocket costs. Due to her familiarity with the doctors in the network, Mrs. K. decided to re-enroll in her original HMO despite the higher costs. She notified both plans of her wishes and received confirmation from both companies that she now had coverage with her original HMO. However, due to an error resulting from the large number of seniors enrolling and disenrolling in the plans, Mrs. K. learned that she was not enrolled in any plan. Despite her best efforts she was unable to resolve the issue on her own, which caused her undue anxiety and stress and left her without coverage. During this time, Mrs. K. felt she could not afford to go to a medical specialist for a needed treatment because the HMO did not have her in their system as an enrolled beneficiary and the services of her doctor would not be covered. It was not until the Suffolk County Office for the Aging intervened that Mrs. K. got the coverage she wanted and the medical treatment she needed.

In another case, Mrs. D., an 80-year-old Suffolk County senior, has been enrolled in three different HMOs since 1997. Initially, she was with an HMO that offered medical services at a center near her home. After that HMO withdrew from the market, Mrs. D. joined another HMO. Two years later, the second company withdrew from the market and Mrs. D. had to find a new carrier yet again. She is now enrolled in one of the two HMOs left in Suffolk County. Unfortunately, the changes in insurance coverage forced Mrs. D. to change primary care physicians three times in four years. For any patient, such a change is unsettling; for seniors, who frequently suffer from chronic ailments, the lack of continuity in care can pose a real danger to their health. In addition to these difficulties, Mrs. D. now must pay $900.00 a year in premiums for her insurance with higher out-of-pocket expenses than she had in 1997. At her advanced age, Mrs. D. should not have to worry about who her doctor is and if she can afford to pay for her coverage. Sadly, these stories are familiar to many Suffolk County seniors.

It is my understanding that the Medicare+Choice program was created in the Balanced Budget Act of 1997 to help alleviate some of the inequities experienced by Medicare beneficiaries living in rural areas and to improve Medicare's financial situation by controlling spending. The formula developed by the Health Care Financing Administration (HCFA) to accomplish these goals considered several factors including mortality rates, service costs and utilization of services. As a result of these changes, HMOs operating in the downstate area of New York now receive the least reimbursement for Suffolk County enrollees. Finding that it was simply not profitable for them to do business in Suffolk County, the HMO companies made a business decision to withdraw from our market.

The two remaining Medicare HMO providers in Suffolk County have increased their premiums and co-payments for 2001. In addition to higher costs, our seniors have been forced to change health care providers and in some cases have lost access to a number of local hospitals. Of equal concern is the limited prescription drug coverage offered by both plans—one has a $450.00 per year maximum allowance; the other covers only generic drugs. As was made clear in the 2000 presidential campaign, this aspect of health care is of grave importance to our senior population. Any plan that does not provide adequate coverage for prescription medications does not truly protect the health of seniors.

The Suffolk County Office for the Aging has been doing what it can to assist seniors affected by the HMO terminations by informing them about their health insurance options. However, the plan withdrawals have left our seniors confused and

frightened about their health coverage. We are fearful that seniors who can't afford the increased costs will no longer seek necessary medical assistance and forgo their prescribed medication.

The complexity of the formula used by HCFA to reimburse HMOs has made it difficult for local governments alone to determine what changes need to be made. Nevertheless, steps must be taken to make Suffolk County's Medicare market more competitive. I strongly urge congress to amend the 1997 Balanced Budget Act to restore adequate reimbursements for HMOs doing business in the Suffolk County Medicare market. You must revisit the methodology used by HCFA to establish individual county reimbursement rates. If the Medicare+Choice program cannot be adequately amended to provide relief to Suffolk's seniors, you must consider enhancements to traditional fee-for-service Medicare. Specifically, prescription drug coverage, premiums and co-payments must be included in order to provide the comprehensive coverage our seniors deserve.

As an elected official, I have always believed that it is our duty and responsibility to provide for those who cannot otherwise provide for themselves. Just as our children are our future, our seniors are our heritage and we owe it to them to do all that we can to provide for their health and welfare.

Statement of Samuel B. Wallace, Medical Researcher, Washington, DC

PREVIOUS TESTIMONY

SUBCOMMITTEE OF HEALTH, HOUSE WAYS AND MEANS COMMITTEE, BEFORE CONGRESSMAN ROSTENSKOWSKI, DEC. 4, 1975, HEARINGS ON NATIONAL HEALTH INSURANCE. TESTIFIED ABOUT USING A NASAL DECONGESTANT NOSE DROPS COMBINED WITH PENICILLIN PRODUCING CURES OF VIRAL, BACTERIAL AND PROTOZOYA ILLNESSES IN SHORTER PERIODS OF TIME USING SMALLER QUANTITIES OF MEDICINE.

WRITTEN TESTIMONY BEFORE SELECT COMMITTEE ON AGING CHAIRED BY CHAIRMAN CLAUDE PEPPER SUGGESTING MORE EXTENSIVE USE OF THE ANTIBIOTICS IN CURING CANCER AND LEUKEMIA

WRITTEN TESTIMONY SUBCOMMITTEE ON HEALTH SUGGESTING THE USE OF ANTIBIOTICS APPLIED SYSTEMICALLY AND LOCALLY IN THE TREATMENT OF CANCER AND LEUKEMIA. 1979.

ORAL AND WRITTEN TESTIMONY BEFORE THE SUBCOMMITTEE ON HEALTH OF THE HOUSE AND SENATE APPROPRIATIONS COMMITTEES, MAY 1984 SUGGESTING THAT MORE INTELLIGENT APPLICATION OF THE ANTIBIOTICS IN TREATING CANCER AND OTHER ILLNESSES WOULD RESULT IN THE CURE OF MORE ILLNESSES AND WOULD REDUCE HEALTH CARE COSTS.

ORAL AND WRITTEN TESTIMONY BEFORE THE SUBCOMMITTEES ON HEALTH OF THE HEALTH AND SENATE APPROPRIATIONS COMMITTEE CHAIRED BY CONGRESSMAN NATCHER AND SENATOR LOWELL WEICKER, MAY 1985 MAY HAVE BEEN PUBLISHED IN 1985 AND 1986. SUGGESTED THAT WHEN ANY FORM OF CANCER OR LEUKEMIA WAS TREATED SYSTEMICALLY AND LOCALLY THAT HIGHER CURE RATES WOULD RESULT AND THE PROBABILITY OF REOCCURRENCE WOULD BE SUBSTANTIALLY REDUCED.

SHORT ORAL AND WRITTEN TESTIMONY ON THE BEFORE A HOUSE SUBCOMMITTEE ON HEALTH SUGGESTING THAT PHARMACISTS AND NURSE PRACTICONER'S SHOULD BE ALLOWED TO PRESCRIBE THE LOWE COST SAFE AND EFFECTIVE ANTIBIOTICS IN SMALL QUANTITY IN 1985 OR 1986.

IN THE 1990'S LECTURED A CONFERENCE OF DOCTORS EXPLAINING THAT THE ANTIBIOTICS HAD LONG BEEN KNOWN TO CURE VIRAL ORDINARY VIRAL ILLNESSES CITING GOODMAN' PHARMACOLGY CO–AUTHORED AND CO–EDITED BY THE NIH SECOND EDITION 1955–1958 P.1388- "THE ANTIBIOTICS PENICILLIN AND TETRACYCLINE CURE VIRAL ILLNESSES. SEE ALSO SPANISH PHARMACOPIAE 1993 EDITION: NASAL DECONGESTANT COMBINED WITH PENICILLIN CURES ALL RESPIRATORY ILLNESSES."

IN THE 1990'S WHEN DAVID KESSLER WAS COMMISSIONER OF THE FDA LECTURED ANOTHER CONFERENCE OF DOCTORS INDICATING THAT SYSTEMIC AND LOCAL ANTIBIOTIC THERAPY STRENGTHENED THE PATIENT'S

IMMUNE SYSTEM AND WAS THE LEAST INVASIVE WAY TO TREAT MANY FORMS OF CANCER AND LEUKEMIA.

DISCUSSED MY IDEAS ON ECONOMICAL SAFE AND EFFECTIVE HEALTH REFORM MAKING BETTER USE OF THE ANTIBIOTICS WHEN I RAN FOR CITY COUNSEL IN THE DISTRICT OF COLUMBIA AND RECEIVED 50 VOTES ON VARIOUS LOCAL TELEVISION STATION.

BRIEF LECTURE BEFORE A CNN TELEVISION AUDIENCE INDICATING THAT THERE WAS AMPLE SOUND MEDICAL EVIDENCE THAT THE ANTIBIOTICS CURE RESPIRATORY VIRAL INFECTIONS.

TESIFIED BEFORE THE D.C. CITY COUNSEL ON SEVERAL OCCASIONS INDICATING THAT THE THE PROPER USE OF ANTIBIOTICS IN THE TREATMENT OF A WIDE RANGE OF ILLNESSES WOULD SAVE LIVES, REDUCE INFANT MORTALITY AND WOULD BE COST EFFICIENT.

LECTURED BRIEFLY AT AN INFORMAL CONFERENCE ON HIV AIDS CO–CHAIRED BY DR. FAUCI OF THE NAID URGING SYSTEMIC AND LOCAL NATIBIOTIC TREATMENT FOR AIDS PATIENTS SINCE THAT FORM OF THERAPY HAD PROVED EFFECTIVE IN TREATING BREAST CANCER AND BONE CANCER ACCORDING TO DR. BONADONNA AN NIH GRANTEE OF 20 YEARS AND THE JAPANESE PHARMACEUTICAL INDUSTRY INDICATING IN CHEM. ABSTRACTS APRIL 15, 1995: "PD–3. PENICILLIUM DIVERSUM 98% EFFECTIVE IN VITRO OR TEST TUBE AGAINST YOSHIDA SARCOMA (BONE CANCER)-THE HIGHEST RATING GIVEN ANY ANTICANCER AGENT. PENICILLIUM DIVERSUM IS PENICILLIN COMBINED WITH NAPHAZOLINE HCL. RIMIDOL MADE BY SQUIBB IN BRAZIL IS NAPHAZOLINE HCL IN 1% SOLUTION WHEN COMBINED WITH PENICILLIN IS SIMILAR TO PENICILLIN DIVERSUM. (THIS SAME FORMULA WAS DESCRIBED IN GOODMAN AND GILMAN'S PHARMACOLOGY AS A CURE FOR ASTHMA ON PAGES 1346—1347. IN MY TESTIMONY BEFORE THE SUBCOMMITTEE ON HEALTH OF THE HOUSE WAYS AND MEANS COMMITTEE I INDICATED THAT WHEN THIS FORMULA WAS TESTED IN BRAZIL THAT IT CURED ASTHMA IN ONE DAYS TIME. (THE NIH TODAY SAYS THAT THE ANTIBIOTICS CAN NOT CURE VIRUSES AND THAT THERE IS NO CURE FOR ASTHMA. THEREFORE "ANTIVIRAL THERAPY" FOR ASTHMA CONTINUES AT $5,000 DOLLARS PER YEAR UNTIL THE PATIENT SUCCUMBS TO ASTHMA. DR. FAUCI IGNORED MY COMMENTS AND REINSTATED NIH TESTS FOR INTERFERON EVEN AS A TRIAL FOR AIDS THERAPY THOUGH INTERFERON HAD A CURE RATE OF 05% AGAINST ASTHMA.

LOW COST SAFE & EFFECTIVE CURES FOR VARIOUS ILLNESSES INCLUDING HIV I AND III AIDS—Written Testimony before Subcommittee Health House Ways and Means Com. Samuel B. Wallace 1221 M St. 417, Washington D.C. 20005

The Importance of the Antibiotic Medicines in Health Care Reform can not be better illustrated than by the example of HIV I and III AIDS Therapy. Where alternatives to Antibiotics not only fail to cure that Disease but in the process increase the costs of unsuccessful Health Care ten thousandfold!

I. THE ANTIBIOTICS CURE HIV I AND III LEUKEMIA AIDS:

HIV I AIDS which was discovered in Japan in 1977 and is common to many parts of the world including South Africa where it is the dominant form. HIV AIDS I has been cured in Japan,the United States, Italy and elsewhere with the common Antibiotics such as Penicillin and the Antineoplasm Antibiotics. One case of the Antibiotics curing HIV I AIDS was reported in the *British Journal of Hematology* 1984, V. 58, 723–7: "Successful Chemotherapy with (the Antibiotic) Deoxycoformycin (which is similar in structure to Adriamycin or Doxorubicin) in Adult T Cell Lymphoma-Leukemia." (A Retrovirus similar to the HIV I and III AIDS VIRUS.)

The Cure of HIV I AIDS with Antibiotics such as Penicillin, Tetracycline, Bestatiin etc. has also been reported for thousands of Clinical Trials in Japan and it is often cured with the common Antibiotics even in the United States and Europe particularly among Medical Students and Nursing Students where it is called "Cat Fever" which is acquired by catabolizing or dissecting cats. It is also known as Cat Leukemia and is cured with Antibiotics by Veterinarians.

II. MEDICAL SCIENCE ALSO INDICATES HIV I AND ALSO HIV III AIDS HAS BEEN CURED WITH ANTIBIOTICS!

Although, it is not commonly known to the medical science there is important evidence from the scientific literature and from the science that suggests that HIV III AIDS has also been cured with the Common Antibiotics such as Penicillin, Tetracycline, Streptomycin, Bestatin as well as the Antineo-plasmic Agent Adriamycin

also called Doxorubicin.[1] *AZT and the weak Protease Inhibitors (Antibiotic derivatives) on the other-hand have been admitted by their manufacturers as not being a Cure for HIV AIDS*. It seems rather obvious, then, that Public Policy should be directed toward the application of the Antibiotics which *CURE HIV I AND III AIDS* rather than promulgating the use of the *Non-Curative AZT and the relatively ineffective Protease Inhibitors which its makers admit do not Cure HIV I or III because failure to Cure AIDS can harm many.*

SAFE AND EFFECTIVE LOW COST CURES FOR HIV I AND III

Even though thousands of Clinical Studies have been reported in Japan indicating that the ordinary Antibiotics: Penicillin and Tetracycline cure HIV I Leukemia better known as HIV I AIDS. It is better to use more systemic Antibiotic therapies because HIV III is more of a systemic Disease which is initiated in the Macrophage which also acts as a reservoir for the infection and because HIV III destroys both the Immune and Metabolic Systems, Cures 2,3,4 described below follow a more "systemic and local" approach directed to the Innate Immune System: i. e.-Macrophage–Direct Activation of the Enzyme Complement C–3 Pathway. (Complement and Macrophage both have Epinephrine Receptors.)

It was in Reported by the United Nations and the WHO and in an Article in the New York Times dated: April 6, 2000 that when the simple Antibiotic Bacitran was applied to Patients infected with AIDS in sub-Saharan Africa that the mortality rate for those AIDS Patients was reduced by 50%. It is said that this Antibiotic Curative Therapy in Africa cost $8.dollars per patient. *The following Cures are more effective in actually curing HIV I and III AIDS and are Safe Antibiotic AIDS Therapies that rely heavily on the AIDS Patients" Natural Innate Nonspecific Immune System. Universally acknowledged to be the First Line of Defense against all illness. Those Therapies should produce a Cure Rate of better than 80% rather than merely slowing its culmination as is the case with AZT and the weak Protease (Enzyme Inhibitors) Normal times of Cure should be two weeks at a cost of pennies per patient!*

1. An ordinary course of Penicillin or Tetracycline in 500mg units three times per day over a two week period Cures HIV I and sometimes HIV III AIDS.
2. Penicillin K or Tetracycline combined with the Nasal Decongestant containing synthetic epinephrine such as Neosynephrine made in the USA and Rimidol made by Squibb in Brazil.
3. Injection of Penicillin or Tetracycline or those Antibiotics combined with synthetic epinephrine into the surface of the bones of the four limbs and into surface of the cranium.
4. Capsules of Penicillin or Tetracycline that also contain small quantities of Synthetic Epinephrine at 1% Solution.

All the last three of the four Antibiotic AIDS Therapies cure HIV I and III AIDS in five to 14 days. And all of these Curative Therapies cost less than $8.00 dollars per patient and produce a Cure Rate approaching 90% because those therapies avail themselves of the Patients' Innate nonspecific Immune System universally recognized as the Patient's First Line of Defense against Infection.

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[1] Clinical Studies of the common Antibiotics such as Tetracycline and its special form Dioxicillin have produced Cures of HIV Leukemia. See for example Biomed. Pharmacological Therapy 1990; 44(2): 93–101. Randomized controlled study of Chemoimmuntherapy with Bestatin in acute Leukemia; Ota K, Ogawa, N. Nagoya Memorial Hospital, Japan. *Rinsho Ketseuki*, 1998 July;39(7);487–92:, "Effective Pentostatin-based Treatment of Adult T Cell Leukemia and severe artheritis." "Patients given Pentostatin and achieved complete remission." *Molecular Cell Biochem*. 1993 Feb 17;119(1–2):35–41: "Mechanistic Effect of Kijimicin on Inhibition of Human Immunodeficiency Virus Replication." By Yamauchi, t. Nakamura, M, Honama, H. Kawashima, K. Ohno, T. *Biomed Pharmacological Therapy*, 1991;45(2–3): 55–60:Review of Ubenimex (Bestatin) Immunomodulating Agent with low toxicity brings about significant improvements in the Immune Response. (Bestatin is composed of an Antibiotic combined with Napohazolene Hcl in weak solution as is Doxorubicin also called Adriamycin.) For other Scientific Evidence of the Curative Properties of Penicillin See *Med Trop* —1998,58(3),297–306: Article in French by Saissy, J.M., Ducouran, J.P., Tchoua, R, Diatta, B., . . . l'Hospital d'Instruction des Armees Bel . . . Mande, France: (paraphrased with direct quote: (For a) a Staphalocus Infection combined with AIDS: "Treatment is Antibiotic Therapy with Penicillin M. . . . PROGNOSIS IS GENERALLY FAVORABLE EVEN IN HIV INFECTED PATIENTS." A somewhat delphic statement which may indicate that the HIV AIDS and streptococus, treated with Penicillin survived both Infections. Far more relevant is the number of studies indicating that a patient with AIDS and Karpi sarcoma (Cancer) treated with a Common antibiotic or a an AntiCancer Drug was cured of the Karposi Sarcoma Cancer. And even when death did ensue ultimately from AIDS, there is the strong possibility that had the Antibiotic Therapy continued in the AIDS Patients treated for a short period of time with the Curative Antibiotic might well have survived AIDS if treated with the Antibiotic "Systemically and Locally" for a far longer period time. See Dr. Bonadonna's 80% Cure Rate for Breast Cancer Treated "Systemically and Locally".

BEST INNATE "SYSTEMIC" CURATIVE THERAPY: ANTIIBIOTIC DECONGESTANT NOSE DROPS

While ordinarily Injection of Antibiotics into the veins is considered sound "Systemic" Therapy,that form of Therapy treats the Immune System through Venular Blood System largely neglecting the glandular system. *It is significant, that Penicillin and Tetracycline Nasal Decongest-ant Nose Drops That I Rediscovered in Brazil in 1969 or 1970 whose effectiveness against Bacteria, Viruses etc. I reported in Testimony before the Subcommittee on Health of the House Ways and Means Committee Dec. 4, 1975 is the best Curative Therapy for HIV I and III because a very wide range of illnesses were cured in a far shorter period of time with ten percent of the PDR's recommended Curative Dosage*. This Antibiotic Therapy was described in Goodman and Gilman's: *The Pharmacological Basis of Therapeutics* 1955–1958 Edition, P. 1346–47: "*A Cure for Asthma: Penicillin and a Nasal Decongestant*" as well as the Spanish Pharmacopiae 1993 edition: "*Nasal Decongestant Cures Respiratory Illnesses*" which shows that such Therapy is the most effective "systemic" therapy for a wide range of Viral and Bacterial Illnesses. And should always be used in "Systemic" Therapy for all forms of Cancer and Leukemia. That application of Antibiotic Nose Drops is the best form of "Systemic" Therapy is also shown because:

(1) *Application of the Antibiotic Nose Drops treats the entire glandular system to which the Lungs are attached as well as the entire Blood system through which Blood passes through the Lungs to the heart*. Therefore, that form of treatment is truly "Systemic" in that it enters all the Immune Systems.

(2) This is also proven by empirical evidence because as is indicated in the Spanish Pharmacopiae 1993: "A Nasal Decongestant Nose Drops combined with Penicillin Cures Respiratory Infections."

(3) My Empirical tests in Brazil indicate that it cures a wide range of Bacterial and Viral Illnesses. And that it reduces severe bacterial and viral fevers as soon as it is applied as Nose Drops. And it uses only ten percent of the normal initial curative dosage as recommended by the PDR which is 500 mg Penicillin for the treatment of Pneumonia, for example. The Nose Drops produce the same curative effect with only 50 mg. of Penicillin. It is proved that that the curative process is begun immediately. because only the Activation of Blood Serum Complement can so swiftly reduce fevers.

(4) Adriamycin has been designated by the American Cancer Society as the most effective Anticancer and Leukemia Agent, the Japanese Pharmaceutical Industry on the other hand showed in *Chemical Abstracts* April 15, 1985 that PD–3; Penicillin Diversum combining Synthetic Epinephrine or Napha-zoline Hcl in weak solution with Penicillin was 98% effective against Bone Cancer in vitro, the highest rating ever given an Anticancer Antibiotic in vitro!

(5) Other forms of Cancer stemming from HIV III AIDS, such as Karposi Sarcoma have been cured with the common Antibiotics such as Penicillin, Adriamycin and Bleomycin (a Penicillin complex compound) (It should be noted that these are forms of Cancer stemming from HIV AIDS, itself.)

(6) The Antibiotic Nasal Decongestant Nose Drops also act as an Amazing Immunological growth factor that can cause the Immature Stem Cells that proliferate in Leukemia Patients to begin growing once more which reverses the Leukemia proliferation process.

No other form of Systemic Therapy uses smaller quantities of Antibiotic to produce Cures in much shorter periods of time. See Testimony Samuel B. Wallace, Subcommittee of Health of the House Ways and Means Committee, Dec. 4th, 1975. Therefore, the best systemic therapy particularly for HIV III AIDS Leukemia is the application of the Antibiotic Nasal Decongestant Nose Drops which treats the Lung Immune System, the most powerful Immune System in the human body because it is directly linked to both the Blood and Glandular Systems. This is confirmed by a prestigious Cancer Research Institute in Japan as well as by Dr. Bonadonna's five year Clinical Studies for Breast Cancer.[2]

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[2] In May 1988, Dr. Bonadonna, a Surgeon at Instituto Tumari, Milan, Italy and also an NIH Grantee indicated in Cancer Research May 1988 Treating Breast Cancer "Systemically" and "Locally", produced over a five year period higher Cure Rates than with Surgery or Radiation. That modality of Breast Cancer Antibiotic Therapy has produced Cure Rates as high as 80% but has not been applied to other forms of Cancer and Leukemia by the NIH. Dr. Bonadonna, an NCI Grantee, proved that when Breast Cancer is treated systemically and locally, a higher cure rate resulted than could be achieved when Surgery or Radiation is applied. It would seem cogent to also apply Systemic and Local Therapy to HIV AIDS Patients to prevent relapses and "latent metastasis" leaving a possible reservoir of AIDS infection in the supposedly cured AIDS Patient, see Umtae Kim, the Routes of Invasion and Routes of Reoccurrence and Metastasis are similar. They are Blood, Glandular, (and Bone Marrow.) Therefore common sense and sound Smedical

INJECTION OF ANTIBIOTICS INTO THE BONES IS THE BEST "LOCAL" ANTIBIOTIC THERAPY

The NIH influenced Practitioners have long treated the Bone Marrow Immune System which requires suppressing completely the AIDS Patient's Immune System and in particular the T Cell system including the much needed T4 Cells particularly in AIDS Patients which HIV III severely diminishes or destroys. But some studies have shown that such transplants because of such adverse factors as MHC rejection that Bone Marrow Transplants are themselves often fatal, sometimes at the rate of almost 50% which approaches the unlawful DeVorkian Type Medicine!

In 1985, this author proposed an alternative to treating the Bone Marrow with medicines that were both safe and effective-namely, by Injecting Antibiotics into the Bone in my Testimony given before the Subcommittees on Health of the House and Senate Appropriations Committee May 1985. In that Testimony indicated that all forms of Cancer should be treated "Systemically" and Locally" with the Curative Antibiotics and that the Antibiotics should be Injected into the bones of Cancer Patients in order to thoroughly treat such Patients and in order to prevent future reoccurrence and metastasis, citing the ten year work of Dr. Umtae Kim of the Rosewell Institute, Buffalo, N.Y. Injection of Antibiotics into the bone is the safest way to Administer Antibiotics and can even be given to new-borns before their veins are fully matured. *My own research indicates that Injection of Antibiotics into the Bones, thus treating the bone Marrow Immune System is second only to the Nasal Decongestant Nose Drops in terms of effectiveness. Thus, such treatment reduces a fever within approximately an hours time, while the Antibiotic Nasal Decongestant Nose Drops reduces the fever shortly after it is applied*. Clinical Studies by Japanese Oncologists have proven that Injection of Antibiotics into the Bone is a very powerful and effective form of Cancer and Leukemia Therapy. Apparently, there were in 1999 in Japan 50 Clinical Trials where Injection of Antibiotics were given in the Treatment of Cancer and Leukemia. Therefore it would seem logical that this safe and effective Cancer and Leukemia Therapy would also prove effective against HIV III AIDS Leukemia which resides in the Bone Marrow as well of course in the Lymph Nodes, Blood and Glands. Therefore, the Best Form of Antibiotic "Local" Curative therapy for HIV III Patients is Injection into the four limbs and the surface of the cranium, as well as injection into the AIDS Patient's Lymph Nodes because:

(1) It is in the Bone Marrow that Immune Cells normally grow and where obviously HIV Leukemia suppresses the growth of normal immune cells including the B, T and Macrophages and particularly the T4 Immune Cells which play an important role in the Regulation of the Immune Cells in the Immediate Immune Response as well as influencing the role of the circulatory Lymphocytes.(Susumi Tonegawa the Noble Laureate emphasized that without the T Cells even in the case B Cell and macrophage complement activity that those responses without the T Cell participation would fail. (See Scientific American, October 1985, Tonegawa on the Molecular activity of the Immune Cells, Page 128. Therefore Injection of Antibiotics into the Bone treats the HIV AIDS Infection in its locus.

(2) The Bone Marrow Immune System is the second only to the Lung Immune System in its power to begin the Immune Response and then effecting a Positive result, which is a Cure. For example, applying a Nasal Decongestant Antibiotic as Nose Drops to the Lung Immune System initiates the Curative Process immediately as is shown by its ability to reduce Bacterial and Viral Fevers which is accomplished almost immediately. Reduction of Fevers by Injection into the Bones is accomplished within one or two hours far shorter times than is normal which generally takes four to six hours. See the Medical Physiologist, Arthur Guyton.

(3) Injection of Antibiotics into the Bone thus Treating the Bone Marrow Immune System has proven to be one of the most effective ways to Treat and Cure various forms of Cancer and Leukemia. See Japanese Internet 1999 showing 50 Clinical Trials where Antibiotics cured various forms of Cancer and Leukemia.

CONTEMPORARY SCIENCE PROVES THE ANTIBIOTICS CURE HIV I AND III, BUT ONLY VAGUELY

The author and Medical Research Scientist has given some indication that HIV I and III Leukemia can be cured by Antibiotics and that Japanese Physicians have been treating and curing HIV I and III Leukemia or "AIDS" for many years. And their Ministry of Health Report indicating 600 cases of infection out of a 126 Million, the lowest rate of incidence for any modern nation in the world where inter-

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practice would suggest that in order to prevent "latent" reoccurrence or continued development of the HIV III AIDS Virus that "Systemic" and "Local" Antibiotic Curative Therapy is required.

national commerce is carried out, also proves that AIDS is cured in Japan where the doctors rely more heavily on Antibiotic Medicines than any other country on earth.

I pointed out above that "Systemic and Local" Antibiotic Therapy achieved by Dr. Bonadonna, Instituto Tumari that produced an 80% Cure Rate for Breast Cancer. See his Clinical Trials reported in Cancer Research, May 1988. And that a similar Antibiotic combined with an Immune Hormone cured HIV I and III reported in 1984 in The British Journal of Hematology V. 58, P. 272–279. I also pointed out that the Antibiotics had been used in some cases to treat and cure HIV Leukemia or AIDS in Europe and in the United States that doctors in Hospital or Clinics had encountered AID Strains resistant to Antibiotics a phenomenon that usually occurs where the same Antibiotic and the same disease have been recycled hundreds of times according to a biological study at Queens Hospital Sydney Australia.

It was obvious that as I had suggested in 1979 and 1985 that these two approaches to the treatment of HIV Leukemia had not only proved effective in the case of Dr. Bonadonna's Treatment for Breast Cancer. But had later been reported as being effective for Bone Cancer Therapy. See "PD–3. Penicillium Diversum: 98% Effective" in vitro the highest rating given any Antibiotic including the American Cancer Society's favorite Antibiotic, Adriamycin.

I emphasized in my Testimony of 1985 that the "Rediscoveries" that I had made in Brazil in 1970 and reported to the Subcommittee of Health of the House Ways and Means Committee, Dec. 4th, 1975 could be used to cure a very wide range of Viral, Bacterial and Protozoa Fevers and illnesses. See the Spanish Pharmacopiae 1993: "The Antibiotic Penicillin combined with a Nasal Decongestant (immune Hormone is A CURE FOR ALL RESPIRATORY ILLNESSES." My Report to Congress in December 4th, 1975 had shown that using Penicillin combined with the Immune Hormone Naphazolene Hcl (now known as Penicillium Diversum) cured Bacterial, Viral and Protozoa Illnesses in one third time less and required ten percent of the normal curative dosage as indicated by the Physician's Desk I Reference for Diseases that it indicated were curable by means of the Antibiotics. (Fifty milligrams of Penicillin rather than 500 Mg. As indicated by the Physican Desk Reference, for example.) And my "Rediscovery" of what is now called by Japanese Physicians: Naphazoline Hcl in 1% solution combined with Penicillin and administered as Nose Drops Is so effective that it could be tested in one days time against the rhino Virus illness, Asthma which it cures in one days time. *Or tested in one days time against ALL VIRAL, BACTERIAL AND PROTOZOA ILLNESS FEVERS because it reduces a fever to normal levels as soon as it is applied as Nose Drops*. A fact that I pointed out to NAIDS and to Dr. Fauci at an informal conference which was ignored when my Petition requesting one day tests was denied. That request was undoubtedly one of the least expensive requests ever made at the NIH and could have been conducted for less than one hundred dollars one hundred Patients at the NIH. Generally, similar Research Grants award the participating scientists millions and some times tens of millions of Dollars. That same formula Cures HIV I also called "Cat Leukemia" because Medical Students are infected dissecting or "catobolizing" Diseased Cats. Which in America is usually cured by a fifteen day course of Penicillin or Dioxicillin. And is cure by a Phenyephrine Hcl Nasal Decongestant similar to Naphazoline Hcl combined with Dioxcillin or Tetracycline or Penicillin IN FIVE DAYS.

Therefore, this Researcher had indicated a safe and effective low cost Cure for HIV I Leukemia or HIV I AIDS which could be readily duplicated by one day pilot tests or by full tests in five days. While the NIH, Buroughs Welcome now Welcome Galaxy and Hoffman LaRouche had offered expensive and ineffective nostrums which they admitted prolonged life but did not Cure HIV I or II Leukemia, Herpes, or even the relatively mild Asthma. In effect, they touted an ineffective treatment which they admitted did not cure mild viral illnesses including Asthma. HIV treatment costs the AIDS Patient or the U.S. Government TWENTY THOUSAND DOLLARS PER YEAR! Which was in sharp contrast to my proven Rediscovery which is Safe and Effective and costs mere pennies per patient: Penicillin or Tetracycline combined with a Nasal Decongestant containing Synthetic Epinephrine: Naphazoline Hcl 1% Sol or Phenylephrine Hcl in 1% sol.

AS A GENERAL RULE CONTEMPORARY SCIENCE PROVES THE ANTIBIOTICS CURE AIDS ONLY VAGUELY

The worldwide Medical Community, generally with the exception of Japan, has followed lockstep the NIH unsubstantiated hypothesis "the Antibiotics do not cure Viral Illnesses" and this despite the NIH's own Medical Text: Goodman's Pharmacology 1955–1958: Page 1388: "The Antibiotics Tetracycline and Penicillin cure Viral Illnesses." Even the prestigious World Health Organizstion or WHO has followed

the NIH Guidelines with the exception of its actions within the U.N. of April 6, 2000 where is recommended the use of Ordinary Antibiotics to treat AIDS in Subhararian Africa after some studies indicated that mortality due to HIV had been reduced by 50% by use of Antibiotics to treat and cure AIDS at a cost of $8.00 a year per patient. However, contemporary Medical Science has within the past several years produced new evidence that proves the Antibiotics Cure Viral Illnesses including further evidence that they cure HIV I and III. And this by means of the Innate Immune System Research where normally the Macrophage upon contact with the Virus or other antigen activates Blood serum complement through the C–3 alternative pathway. *I had proved in 1970 that this process can cause an instantaneous reduction of a Viral, Leukemia or AIDS Fever by the application Nasal Decongestant Penicillin Nose Drops sure evidence that the Macrophage, the principal immune cells that line the Lungs immediately and directly activate Blood Serum Complement before any circulating Immune Cells have time to act in a similar manner. Contemporary Science now indicates by vague indirect proofs of its own that the Antibiotics treating Patient's Innate Immune System can activate complement and begin the curative process for various viruses including HIV I and III.* That proof lies in the Discovery of Defensins which are natural Antibiotics which the human body, animals and plants produce. And by the recent Discovery of Alveolar Macrophages which are V iricidal and Antiturmor.

THE DISCOVERY OF DEFENSINS, ALVEOLAR MACROPHAGE AND MACROPHAGE CANCER RESEARCH ARE EVIDENCE THE ANTIBIOTICS CURE HIV I AND III LEUKEMIA

As I just indicated above Contemporary Science indicates to vague indirect proofs of its own that the Antibiotics treating Patient's Innate Immune System can activate complement and begin the curative process for various viruses including HIV I and III … That proof is the Discovery of Defensins which are the Antibiotics which human body, animals and plants produce. And the Discovery of Alveolar Macrophages which are tumidical as well as general Macrophage-Cancer-Leukemia Research.

THE DEFENSINS—NATURAL ANTIBIOTICS PRODUCED BY MAN AND ANIMALS ARE CAPABLE OF CURING VIRAL AND BACTERIAL ILLNESSES INCLUDING HIV I AND III. (THE FAILURE TO INCLUDE ANTIBIOTICS IN THE IN LIVESTOCK FEED IN ENGLAND ETC. MAY HAVE CONTRIBUTED TO THE SPREAD OF MAD COW AND HOOF AND MOUTH DISEASE IN ANIMALS. AND FAILURE TO TREAT HUMANS WITH AIDS WITH ANTIBIOTICS MAY HAVE CONTRIBUTED TO THE SPREAD OF HIV I AND III IN HUMAN BEINGS WORLD WIDE

****THE EXISTENCE OF DEFENSINS NATURAL ANTIBIOTICS MANUFACTURED IN THE HUMAN BODY IN THE BONE MARROW IS SIGNIFICANT BECAUSE THEY DESTROY VIRUSES*** ***

The existence of Natural Human Antibiotics which are produced by myeloid precursor cells residing in the bone marrow and stored in the cytoplasm granules of mature cells that are capable of destroying bacteria and viruses is significant for several reasons:

First it destroys a fundamental fallacy of the NIH which contradicted its own Text Goodman & Gilman's Pharmacology 2nd Ed. 1955–1958,Pharmaceutical Conferences in 1940 to 1950 and Armed Forces Records WWII and the American Cancer Society's and Japanese Doctors success in treating and curing Cancer and Leukemia Viruses with the Antibiotics. This contradictory conduct by the NIH is the basis for its reliance on ineffective and unsafe Antiviral Agents which have displaced low cost Safe and Effective Antibiotic Medicines that have long cured HIV I and sometimes HIV III Leukemia. This NIH fallacy has resulted in the World-wide AIDS Epidemic which has been characterized as Security Issue by the United Nations and may have resulted in the infection more than 100 Million human beings.

Second, the displacement of the low cost safe and effective Antibiotic Medicines by the NIH's Unsafe and ineffective nostrums has resulted in the rise in the cost of Medicines from 5,000 fold to 20,000 fold and has produced many new categories of formally curable illnesses being reclassified as incurable.

Third, the failure to make available synthetic Antibiotic Medicines has resulted in unnecessary loss of human life. And now animal life with the whole sale destruction of livestock caused by fear of infected animals that are now not given precautionary Antibiotics.

THE DISCOVERY OF TUMORCIDAL ALVEOLAR (LUNG) MACROPHAGE IS A STRONG INDICATION THE DEFENSINS NATURAL ANTIBIOTICS AND MANUFACTURED IN THE HUMAN BODY ARE CAPABLE OF CURING CANCER, LEUKEMIA AND HIV I AND III AIDS

Kazuyoshi Imaizumi, N. Hasegawa et al found that stimulation of the Alveolar Macrophage and Antigen Presenting Cells through the CD40 and CD40L complement receptors which expressed tumor cells could enhance the cytotoxic effect of macrophages and the Antitumor Immunity of the T Cells by investigating Antitumor activity against Lung Cancer cells. (The Lungs usually express low antigenicity and it is difficult to induce lung-cancer specific cellular immunity. They found that when murine Alveolar Macrophage were incubated with antiCD40 IgM antibody or 3LLSA–Cd40L cells alone, that no tumoricidal activity was shown. However, when alveolar macrophages were incubated with IFN-y (Interferon) that both the CD40 and IFN-y activated the tumoricidal activity of the alveolar macrophage, but that macrophage of CD40 complement receptor mice showed no such enhancement of tumoricidal activity . . . American Physiological Society; March 8, 1999.

Interferon is one of the weakest stimulants of Macrophage (perhaps a 5% cure rate against Asthma as opposed to a 90% cure rate with the Antibiotic Penicillin (k) combined with Naphazolene Hcl in 1% solution. See also PD–3: Penicillin Diversum=Naphazoline hcl combined Penicillin 98% effective in test tube against Yoshida Sarcoma or Bone Cancer Chem. Abstr. April 15, 1985 . . . See Congressional Testimony Samuel B. Wallace before,Congressman Rostenkowski of the House Ways and Means Committee, Dec. 4, 1975 where the author indicated that when a Nasal Decongestant containing the Immune Hormone synthetic Epinephrine combined with Penicillin and applied to the Lungs as Nose Drops that Bacterial, Viral and Protozoa Fevers were reduced to normal (which would include Cancer, Leukemia, HIV I and III AIDS Fevers which also demonstrates that Alveolar Macrophage tumoricidal activity is enhanced greatly by the application of the Nasal decongestant Antibiotic Nose Drops. See also the human body's ability to manufacture new Antibiotics called Defensins particularly after similar stimulation by antigen and the Nasal Decongestant Nose Drops . . . Which is also readily confirmed by Immuno Assays as indicated by the observed activity of Neutrophils which contain four Defensin human protein (HPN 1,2,3 and 4) 30% to % 0% See ASM Mews 5;56;315, 1990; R.I. Lehrer, Ganz and Selested. Who noted an increase in Cytokin NK-killer cells, an increase in Antibodies to viral antigen, and a decrease in the temperature of feverish mice and after Complement was activated and an increased pyrogens and Cytokins such as Interferon Gama (IFN-y.)

[Note: The Human Genome Project-the mapping of all known Human Gene sequences should be put in proper perspective. First, it should be recalled that a genetic predisposition to an illnesses does not mean the illnesses is incurable because genes by their nature are always changing. These changes in their structure caused by chemical or biological agents are commonly called mutat-ions in which the sequence of DNA coding is altered to produce a nucleotide sequence of mRNA which in turn codes an altered an altered polypeptide chain.)Thus, Genes are influenced by other components of the Immune Response. Therefore, a Genetic predisposition to a disease say caused by heredity is not a sentence to the inevitability to a disease or death because Genes are always changing and are subject to biochemical activity including that caused by medicines and Immunological responses to past illnesses. Second Genes do not act alone they act in conjunction with Immune Hormones, Enzymes, Immune Cells and Complement of which they are integral components, thirdly Antigen, B Cells, Antibodies, T Cells and Blood Serum Complement Protein and other Immune cells all act and are acted on by the genes. The latter fact being of great medical significance because though the genes cause the development of proteins such as the Antibiotics which act on the genes themselves. The Proteins are of greater importance in terms of the cure of the actual disease. Genes do not of themselves cure illnesses, they are instrumental along with Immune Hormones and Immune Cells in the process of synthesizing and augmenting the immune cells and Proteins that do in fact produce cures. Therefore to overemphasize the role of the genes is not good medicine because it distorts the curative process. Although *the Genes* do not of themselves produce cures, they are essential Components of the curative process and are markers for disease and by *acting on the amino acids the precursors of Proteins, they do play an important role in the curative process*. The Genes it must be emphasized do not directly Cure Illness or directly prevent Disease.]

The Amino acids are the building blocks of Protein that also help produce it at the site of ribosomes through the action of hormones, enzymes and low molecular weight RNA causing the release of ATP Energy in the Mitochondria Cells. This complex process is described at length in Albert Lehninger's BIOCHEMISTRY, 2nd Edi-

tion, 1978. Chapter 33: Translation: the Biosynthesis of Proteins P.929–954. This process is partially summarized in the same chapter on P. 952,Summary:

The synthesis of proteins from activated amino acids takes place on the surface of the ribosomes. Amino acids are first activated in cytoplasm by aminoacyl1-tRNA synthetases, which catalyze the formation of the amino esters of homologous tRNA; simultaneously, ATP is cleaved to AMP and pyrophosphate. The aminoacyl-RNA synthetasis are highly specific for both the amino acid and its corresponding tRNA . . .

THE ROLE OF THE GENES IN PROTEIN SYNTHESIS, CHAPTER 3: PROTEINS AND THEIR BIOLOGICAL FUNCTIONS, P.68, (PARAPHRASED)

The Genes by genetically coding the Amino Acid sequences in Proteins regulate the form and function of proteins that are reflections of those amino acid sequences. Genetic information is stored in the deoxyribonucleic acid (DNA), the informational macromolecule of the chromosomes.

". . . This information instructs each cell to produce a characteristic set of proteins in accordance with the central statement of molecular genetics: i.e., genetic information flows in the direction DNA—RNA—protein. It is the sequence of amino acids in the polypeptide chain of each type of protein that is ultimately specified or coded by the sequence of nucleotide residues in deoxyribonucleic acid (DNA)> The segment of a DNA molecule specifying one complete polypeptide chain is called a cistron or gene. . . . Gene normally remain in the chromosomes and do not directly serve as the coding templates during the biosynthesis of proteins, which takes place on the ribosomes. Instead the genetic message in the gene is first enzymatically transcribed to form a specific type of ribonucleic acid called messenger RNA [mRNA], whose nucleotide sequence is complementary to that of the DNA of the gene. . . .

IT IS THE PROTEINS AND NOT THE GENES THAT PLAY THE KEY ROLE IN THE CURATIVE PROCESS

As just described in my discussion of the Human Genome put in perspective above, I feel obliged to emphasize once more:

Genes are always changing and are subject to biochemical activity including that caused by Medicines and Immunological responses to past illnesses. Second Genes do not act alone they act in conjunction with Immune Hormones, Enzymes, Immune Cells and Complement of which they are integral components, thirdly Antigen, B Cells, Antibodies, T Cells and Blood Serum Complement Protein and other Immune cells all act and are acted on by the genes. The latter fact being of great medical significance because though the genes cause the development of Amino Acids which in turn synthesize Proteins such as the Antibiotics which act on the the Antigen and the Genes within the Antigen and within the Immune Cells themselves. *For example in 1979 Dr. Hamao Umezawa proved that the Antibiotic Adriamycin altered the Genetic structure of Cancer and Leukemia Cells and the Patients Immune Cells. In fact the Antibiotic Proteins by their nature always alter the Genetic Structure of the Antigen and the affected Immune Cells*.

Professor Lehninger in his text Biochemistry Chapter 3, Table 3–3, P. 64: Proteins and their Biological Function describes the Biological activity of Proteins including Hormones, Enzymes, Hemoglobins, including the protective proteins of Antibodies, Complement etc.

There are two basic forms of Immunity and Therapeutic Immune Response and the Acquired Response. The Innate Non-specific Immune Response which is basically Antigen Macrophage Activation of Blood Serum Complement through the its C–3 Complement Enzymatic Pathway. The Innate Immune Response is described universally as "the first defense against all disease."

However, all the very same Medical Textists go on to elaborate for the remainder of their text on the the Acquired Immune response which is Antigen Macrophage to B Cell–Antibody Activation of Blood Serum Complement or Antigen to T Cell to T4 & T8 Activation of Blo0od Serum Complement. My Research has emphasized the use of the Innate Immune Response which generally produces cures in shorter periods of time using smaller quantities of Curative Medicines which more often than not cost pennies per Patient. And therefore it is the Protein the Antibiotics properly applied Bacterial and Viral Illnesses. Therefore it is the Protein and not the Genes which actually cause the prevention and cure of the Disease.

Thus, it seems obvious that the Genetic Genome while admittedly important to medical research does not hold the key to discovering new Medicines capable of curing illnesses.

And obviously the Proteins which are the actual components of the Immune Cells and Antibiotics have historically proved capable of producing Cures and not unfulfilled promises.

DR HAMAO UMEZAWA DISCUSSED HIS DISCOVERIES OF IMMUNOMODULATORS (ANTIBIOTICS) FROM SECONDARY METABOLITES (NATURAL ANTIBIOTICS) DERIVED FROM PRIMARY NATURAL ANTIBITICS AND FROM ENZYME INHIBITORS (OFTEN ALSO ANTIBIOTICS) IN 1979. (HE USED THE SECOND AS EARLY AS 1953)

Dr. Hamao Umezawa, Ministry of Health Tokyo in 1980 indicated in a Research Paper titled: Screening of Small Molecular Products Modulating Immune Responses, P. 119:

P. 119: Very low concentrations (0.001–0.1 ug/ml) of Bestatin seem to modulate the differentiation of Bone Marrow Stem Cells.

P. 123: . . . Clinical studies in the past two years in Japan have shown that daily oral administration of 30mg Bestatin increased the percentage of T Cells.Blumgren, H., (1979) Studies in the immuno-stiumlatory effect of Bestatin in vitro and in vivo. Bestatin Conference, March 30th, 1979 in Tokyo, Japan.

P. 123: In (another) Clinical Study Bestatin administered orally in dosages of 30mg daily eliminated carcinomas without relapse after thirty days. . . . (And) . . . during those studies doctors noted that the frequency of other infections decreased.

P. 124: Conclusion: (Paraphrased)Studies of various Antibiotics and various Enzyme Inhibitors have shown that microorganisms are the treasures of organic compounds which have various structures and various bioactivities. The Genetic studies on the biosynthesis will elucidate the mechanism by which the microorganism has gained the ability to produce so many secondary metabolites . . . It is reasonable, therefore, to search for small molecular immunomodulators in microbial culture filtrates. I have established a method to find microbial products that can bind to immune cells. In fact, applying this screening method. I found small molecular immunomulators. Among them Bestatin which enhanced immune responses in mice, that have been shown to enhance the human defense system. Small molecular inhibitors do not seem to be antigenic, and are thought to be useful in analyzing the biochemical mechanisms of the immune response and to have potential activity in the treatment of Cancer."

Because of his discoveries in Cancer and Leukemia Medicine, his dedication, hard work and intelligent research which he was willing to share not only with his colleagues and students but to foreigners in conferences that he participated all over the world, I suggest that the United States Congress should use its influence to see that this great Doctor, Teacher and above all Medical researcher who in his research answered many of the questions that Researchers today are trying to discover is awarded the Nobel Prize for the first time in history, Posthumously, as the Medical Researcher of the past century.

It does seem logical from the standpoint of good medical science as Dr. Hamao Umezawa has shown that low cost Antibiotic Safe and Effective Innate Therapies which cure HIV I and III AIDS as well as a host of other Viral and Bacterial Diseases should be used as Curative Therapy before noncurative "antiviral agents" which cure nothing and cost fortunes are used for the treatment of the sick, here in America and throughout the world.

THE ECONOMIC IMPLICATIONS OF THE USE OF SAFE AND EFFECTIVE MEDICINES IN HEALTH CARE REFORM

Failure to emphasize the Requirements of the FDA Act as amended by Senator Kefauver and signed by JFK. Which demonstrates that not only great harm can come to Patients but also that great Economic damage can be done to the richest nation on earth due to failure to enforce the requirements of the FDA Act of Safety and effectiveness. No one can argue against the proposition that the current use of AZT etc with its notorious severe side effects and the use of extremely weak "cocktail" combination of extremely weak Antibiotic derivatives shows that both patients and our national economy are severely injured by such blatant and unnecessary violations of the FDA which ignore good medical science and practice. The result is that HIV I and III Patients, here, and throughout the world are not being healed but the lives are being slightly prolonged as also happens to patients with Asthma for similar reasons. The cost of such spurious unorthodox treatments for many many illnesses including AIDS is often astronomical. NonAntibiotic Antiviral AIDS Therapy generally costs approximately 20,000 dollars per year as contrasted to the five dollars total cost of Antibiotic Medicines and perhaps $50 to $100 dollars per year for the Antibiotic Medicines that can produce safe and effective cures for AIDS, for example.

THEREFORE, THE FIRST PRINCIPAL OF SOUND HEALTH CARE REFORM IS IDENTICAL TO THE REQUIREMENTS OF THE FDA WHICH IS TO USE SAFE AND EFFECTIVE MEDICINES WHICH ARE IN MANY INSTANCES THE SAFE AND EFFECTIVE ANTIBIOTICS

SECOND MAKING AVAILABLE CERTAIN SAFE AND EFFECTIVE MEDICINES FOR OVER THE COUNTER SALE BY LIFTING THE FDA IMPOSED REQUIREMENTS OF PRESCRIPTIONS CAN IMPROVE THE QUALITY OF HEALTH CARE AND REDUCE ITS COSTS.

Today as I pointed out in House Testimony of 1985, Doctors enjoy an undeserved monopoly in being permitted to solely prescribe medications for the sick when for example students of Pharmacy study medicines and their effects for a period of five years as opposed to the two years of the study the medical students who are really being prepared to be a surgeons rather than a Medical Doctors. Likewise experienced Nurse Practitioners and well educated Respiratory Therapist knowledgeable about Antibiotic Respiratory Therapy are also precluded from prescribing safe and effective cures for even Asthma 0which causes the cost of medicine to be raised 5,000 fold and again places the patient in a position where he must continue to go to the doctor until he finally succumbs to the a disease readily cured by Antibiotics. Again the doctor being the sole person authorized to prescribe medications is allows him to exercise an actual monopoly powers. And as such he may well be techniquely in violation of our Antitrust laws. Particularly when he uses noncurative medicines in place of low cost antibiotic medicines in order to enhance his own income by perineal treatment readily cured by the Antibiotics within a few days or less.

These problems have become so great in terms of their economic and medical impact that just recently it was reported in the New York Time May 11, 2001 that the Insurance Companies are proposing that Allergy Drugs be sold over the counter without a prescription because the heavily touted prescription drugs are placing a 4.7 Billion dollar burden on the Insurance Industry. I had proposed to David Mathews, the Secretary of HEW that the FDA should lift the prescription requirements of low cost safe and effective Antibiotics in small quantities for such medicines as Penicillin and Tetracycline which are known to be very safe and effective and nontoxic. My Petition was opposed at the Administrative Level and never resolved in the U.S. District Court for the District of Columbia. The Defendants had stated falsely "the Antibiotics due not cure Viral Illnesses" and my own testimony about empirical results that I had obtained in Brazil 1969–1974 against a wide range of viral and bacterial illnesses was not considered sufficient. I was not aware at the time that the NIH was in opposition to the very Medical Text it co-authored 1955–1958,Goodman and Gilman's Pharmacology 2nd Ed., 1958, P. 1388 or Pharmaceutical Conference Records and Armed Forces Medical Records which also indicated the Antibiotics cured Viral Illnesses. The NIH's position was also in direct opposition to the American Cancer Society's Text: "Oncology" which indicated that hundreds of Antibiotics were capable of Curing Cancer and Leukemia caused by various Viruses.

THE NEW YORK TIMES, MAY 11, 2001 ARTICLE, BY MELODY PETERSEN P.I:

"In an escalating battle between Insurance Companies and Drug Manufacturers over the rising cost of prescription medicines. One of the nation's largest health insurers, (Wellpoint Health Networks) will argue today at a federal (FDA) hearing that Claritin, the top-selling prescription allergy drug, and two of its competitors should be sold over the counter. (parenthesis added). . . . The insurer also says that the drugs, which are heavily promoted in television commercials . . . had a combined sale in the United States of $4.7 billion dollars last year, are putting a growing financial burden on the health care system."

"Prescription durg costs are increasing at a rate that is not sustainable," said Dr. Robert C. Seidman, Wellpoint's chief pharmacy officer. "We filed this petition to make health care more affordable."

As a Senior Citizen on Social Security, I recently faced a similar problem. I finally found a doctor who would prescribe an Antibiotic for Arthritis, my previous doctor having left this country to return to France several years ago. However, the cost for that Medicine was ten dollars per tablet of minocyclin antibiotic which has also been shown to be effective against artheritis. And then discovered that even the common Antibiotic Tetracylcine recommended by Dr. Brown of the Artheritis Clinic in Arlington now cost as much as ten dollars per capsule which I also could not afford. Tetracycline I have is manufactured and sold in countries like Brazil and Costa Rica and Mexico at a cost of pennies per capsule. I could for example journey to Mexico and the money it cost to travel from Washington to Mexico would be less

than the money that I would pay for ten capsules of Tetracycline. Those same Medicines would be manufactured by American Pharmaceutical Countries in those countries! Obviously, if a multibillion dollar Health Care Insurer can not afford the current price of Pharmaceuticals, then certainly a poor citizen on Social Security can not. It als o seems obvious that the Pharmaceutical Companies that do business in Central and South America meet their profit margins required to remain in business in those countries. And one wonders whether a Pharmaceutical Company that raise the costs of medicine from 25 cents a capsule to ten dollars a capsule an increase of 40,000 per cent is not making unconscionable profits according to Antitrust Standards? I suggested that it was in proceedings against the NIH from 1995 to 1999. And I estimated that the failure to use low cost safe and effective Antibiotics against a wide array of Viral Illnesses cost the U.SA. 300 Billion per year! Unfortunately, our court system however, did not consider that and the number of lives lost significant.

A saving of three hundred billion per year in high medical costs by the FDA lifting prescription requirements for the low cost Safe and Effective common Antibiotics would allow the present administration to cut taxes and would lift an economic burden imposed on the entire American Industry by ever soaring Health Care costs that they are often required to underwrite. Joseph Califano for example, who once reformed Chrysler Car Corporation's Health System Administratively, still found that Automobiles produced in Canada by that corporation's plants in Canada still cost ten percent more. The Canandian Health System relys more heavily on Antibiotics than does our own. And in Puerto Rico in a study for the Health Finance Administration, Miss Pagan indicated that the Puerto Rican Health Care System operated at ten percent per person of the American Public Health System. Thus, Puerto Ricans who are much poorer than Americans whose doctors attend American Medical Schools through the more extensive use of Antibiotic Medicines in their therapy-particularly for viral illnesses including Cancer and Leukemia. The Puerto Rican Health System is not only much more effective and efficient than the American Public Health Care System their Public Health System results in better qualifty health care and greater longevity. Interestingly enough it was reported in a recent RAND Corporation Study that the United States despite spending more person than any country in the world rank 37th in terms of the qualitity of care its citizens received in comparison to the quality of care and the resultant longevity of citizens of other countries. Obviously, then Americans are not getting what they pay for in terms of the quality of the the Health Care that they receive.

It has been argued by the Pharmaceutical Industry that lifting the prescription drug requirement for antiallergy drugs and by inference Antibiotic Medicines woulld disadvantage the Pharmaceutical Industry which has a right to charge as much for its medicines and nostrums as the market will bear. Unfortunately, this is an oversimplification because in the process of touting the more expensive and ineffective panaceas rather than the Curative Antibiotics, that Industry together with the Gene Tech Industry, particularly in touting the ineffective and sometimes dangerous antiviral agents such as AZT, Interleukin-2, Intereferon for the treatment of diseases that those products can not cure has in many instances violated many laws of this country including the laws prohibiting false advertising, fraudulent practices of selling ineffective products when there were low cost safe and effective Antibiotic alternatives about which they had full knowledge, which most legal experts believe would come under the category of a per se violation of our nation's antitrust laws. Those same corporations by continuing to tout AZT for eample, as a therapy for HIV I and III AIDS, AZT and even the weak Enzyme Inhibiting socalled "cocktail" when there are Safe and Effective Antibiotic alternatives not only violate the Safety and Effectiveness requirements of the FDA Act but even go so far as to violate the Dr. Divorkian Laws etc. So it is possible for the federal government to impose legal sanctions and to discourage such blatant examples of industry wide price fixing which enormously raises the price of even the Antibiotic Medicines. And if the Pharmaceutical Industry insists on continuing to sell Antibiotics at inordiantelyand unconscionably high prices to the consumer in its Medicare and Medicaid Programs, the government might well consider the establishment of a government run Antibiotic Productive Facility much like our national Post Office. Because the government should not be subisidizing blatant fraud and price gauging.

It is also noteworthy that the Antitrust laws apply to Pharmaceutical Companies in Europe and that many violations of Antitrust Laws here are also a violation of similar Antitrust Laws in Europe.

Recently one rather large Pharmaceutical conglamerate which manufactures Antibiotics that have cured HIV I AIDS offered 200 Million dollars to fight HIV I AIDS in South Africa with the noncurative Antiviral Agents such as AZT and the other combinations which do not cure AIDS where the HIV I strain of AIDS is dominant.

And the United States under the Bush Administration has pledged 200 Million dollars to fight AIDS in the developing countries. The sum of 200 hundred million dollars that that Pharmaceutical Company promised to contribute to the South African government to use Noncurative AIDS Medicines, if the Antibiotics particularly combined with the Nasal Decongestant Synthetic Epinephrine such as Naphazoline Hcl in 1% solution applied as Nose Drops three times per day for five days would if applied to the entire population cure AIDS in the entire country for a few million dollars. Since such Antibiotics HIV I treatment and cure costs pennies per patient. And in fact HIV I and III not AIDS could be virutually eliminated from all the countries of Africa if the entire population of Africa were treated with the same Antibiotic Nasal Decongestant Nose Drops for less than the 200 Million Dollars that a leading manufacturer of Antibiotics pledged in its "noncurative" "fight" against AIDS. This Congress might well ask that Manufacturer of Antibiotics why it was pledging so much for ineffective panaceas in South Africa but not making its curative Antibiotics available to the people it pretended to help. And that company might be asked was this offer made for purposes of evading taxes? Similarly, the United States Congress might require the American Pharmaceutical Industry to contribute to the costs of distribution of medicines to the poor in India where the Antibiotics are manufactured more cheaply but where the average Indian laborer can not afford even one tablet of Penicillin because it costs more than a days wages. Such an approach would actually save the American Pharmaceutical Companies much money in that it could be the basis of removing possible liability for what may well be a major Antitrust conspiracy to raise the price and fix the prices of Medicines worldwide. And because the false information that that industry has spread world wide that the Antibiotics do not cure Viral Illnesses despite their ability to cure the most virulent of the viruses Cancer and Leukemia and their fraudulent use of non-curative Viral Agents has contributed much to the spread of HIV AIDS all over the world.

The Congress might also consider the question of should our Patent Laws be revised so for example, exemptions to disclosure can be waived for major epidemics for which new medicines and new uses of old medicines are discoveed. True Health Care Reform common sense and good medical science and recent history has demonstrated requires the appropriate Curative Antibiotic Medicines today as it did in the time of Senator Kefauver.

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