STATUS OF THE MEDICARE+CHOICE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

DECEMBER 4, 2001

Serial No. 107–49

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

77–455 WASHINGTON : 2002

For sale by the Superintendent of Documents, U.S. Government Printing Office
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TUESDAY, DECEMBER 4, 2001

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

The Subcommittee met, pursuant to notice, at 10:10 a.m., in room 1100 Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
November 27, 2001
No. HL–11

CONTACT: (202) 225–3943

Johnson Announces Hearing on Status of the Medicare+Choice Program

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on recent changes in the Medicare+Choice program that have adversely affected seniors and people with disabilities. **The hearing will take place on Tuesday, December 4, 2001, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.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 The Honorable Thomas Scully, Administrator of the Centers for Medicare and Medicaid Services, an independent program expert, a beneficiary representative and representatives of health plans. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

The Medicare+Choice program was created through the Balanced Budget Act of 1997 (BBA 97) (P.L. 105–33). Medicare+Choice gives beneficiaries the option of choosing to enroll in private, integrated health plans that often offer coordinated and additional benefits, such as prescription drugs. Today, 15 percent of Medicare beneficiaries are enrolled in Medicare+Choice.

Although Medicare+Choice is popular with many beneficiaries, the program faces significant challenges. Enrollment in Medicare managed care had been increasing steadily until the changes mandated by BBA 97. Since that time, enrollment has declined by about 800,000 beneficiaries or about 12 percent. Prescription drug coverage has been eliminated or cut back dramatically in recent years, while program participants' cost sharing and premiums have increased, in some areas significantly. In 2002, only half of the Medicare population will have access to at least one Medicare+Choice plan with drug coverage, down from 65 percent in 1999. In addition, only one-third of the Medicare population will have access to a zero premium plan in 2002, down from 61 percent in 1999. Cost sharing for Medicare-covered services will jump 78 percent in 2002, from $14.88 per enrollee, per month, to $26.60 per enrollee, per month.

Next year more than 500,000 Medicare beneficiaries in 28 states will be forced to change their health coverage or move back to Medicare fee-for-service largely because reimbursement has not kept pace with health care inflation. Ninety-two thousand beneficiaries will no longer have a coordinated care option, 38,000 of whom will have to return to the Medicare fee-for-service program. These enrollees may supplement their lost benefits by purchasing a Medigap policy. The Medicare statute requires guaranteed issue for plans A, B, C, or F with any company within 63 days if the plan terminates coverage in a beneficiary's service area, but not if benefits are reduced or cost sharing is increased.

The Subcommittee is investigating recent reports that certain plans will significantly reduce benefits and increase premiums and cost sharing next year as a result of inadequate payments.

"Clearly, we are at a crossroads for Medicare+Choice. Recent benefit changes and cost sharing increases point to a fundamental flaw in the underlying payment formula that does not accurately reflect the cost of providing health services. Some fundamental changes are necessary this year to rationalize the payment and regulatory structure so seniors and the disabled who choose a Medicare+Choice plan enjoy the full range of supplemental benefits like prescription drugs and disease management not available in traditional Medicare," stated Chairman Johnson.

FOCUS OF THE HEARING:

Tuesday's hearing will focus on announced reductions in benefits and increases in cost sharing and premiums beneficiaries face next year as a result of plan decisions. The Subcommittee is interested in whether plans are meeting their requirement to provide all Medicare covered services and what needs to be done to improve benefits for seniors.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please note: Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to "*hearingclerks.waysandmeans@mail.house.gov*," along with a fax copy to 202/225–2610, by the close of business, Tuesday, December 18, 2001. Those filing written statements who wish to have their statements distributed to the press and interested public at the hearing should deliver their 200 copies to the Subcommittee on Health in room 1136 Longworth House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse messenger deliveries to all House Office Buildings.

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. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to *hearingclerks.waysandmeans@mail.house.gov* along with a fax copy to 202/225–2610, in WordPerfect of MS Word format and MUST 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://waysandmeans.house.gov/*.

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.

Chairman JOHNSON. Hearing will come to order. Welcome, Mr. Scully. Nice to have you back before the Committee.

We are here today because seniors are terribly upset by losing access to their Medicare+Choice health care plans and facing increasing premiums and changed benefits from those benefits offered by these plans in the past. In other words, I want to really put clearly on the record that we are here because seniors value their Medicare+Choice plans, and they are anguished, upset, frustrated and angry by the demise of those plans.

Enrollment in Medicare had been increasing steadily until changes mandated in the Balanced Budget Act (BBA) 1997. Since that time enrollment has declined by 800,000 beneficiaries, or about 12 percent. Prescription drug coverage has been eliminated or cut back dramatically, and even as benefits decline, program participants' cost-sharing in premiums have increased in some areas significantly.

Next year, 500,000 seniors in 28 States will be forced to change their health coverage or move back to Medicare fee-for-service largely because increases in reimbursements have not kept pace with health care inflation. In fact, in the counties where most Medicare+Choice beneficiaries live, fee-for-service reimbursements have risen at twice, that is two times, the rate that Medicare+Choice reimbursements have risen.

And I might also add that even those reimbursements that we have offered to Medicare+Choice have not been delivered. Of the 5.8 billion scored by the Congressional Budget Office (CBO) after the Balanced Budget Reconciliation Act (BBRA), only 2.2 billion was received by the plans because of the budget neutrality provisions elsewhere in that legislation.

Seniors are confused. They are angered by the unpredictability of Medicare+Choice plans because these plans have provided attractive and welcomed benefits, an alternative to traditional fee-for-service Medicare that beneficiaries value. Importantly, Medicare managed care plans provide health services that are unavailable to their counterparts.

Consider these statistics. All plans offer annual physicals, a benefit sorely lacking in fee-for-service Medicare. Virtually all plans have at least one disease management program, and the average plan has four disease management programs in place for seniors with chronic illness, and usually multiple chronic illnesses. This approach is extremely productive of good health and a higher quality of life. Ninety-five percent of plans have diabetes disease management programs. In 2001, 67 percent of Choice plan beneficiaries had access to some prescription drug coverage. Ninety-four percent of Plus Choice beneficiaries have vision care; 78.8 percent have hearing care. These are benefits that are not available in tradi-

tional Medicare. And seniors are making it abundantly clear that they prefer Medicare+Choice to fee-for-service Medicare.

At a minimum, we should reimburse these plans 100 percent of the fee-for-service cost or its full blended rate. This would provide the stability needed if, in addition, we create a more intelligent and less burdensome regulatory environment. Indeed, it is truly incredible that the General Accounting Office (GAO) could report that there is no one source plans can go to find the rules and regulations governing them.

The Medicare+Choice program is at a crossroads. Years of underfunding in many areas of the country and increasingly heavy regulations have resulted in reduced benefits, increased beneficiary costs and plans leaving the market. While last year very modest funding increases helped 2.9 million beneficiaries by lowering premiums and maintaining access to plans, next year costs will increase, and reimbursements will again rise a mere 2 percent or less. This is causing premium increases, additional restrictions on benefits and more plan withdrawals. This, in turn, is causing frustration, confusion and a sense of hopelessness for many seniors who have come to count on the many benefits of Medicare+Choice plans, and who find sufficient Medigap plan choices unavailable or too expensive and fee-for-service Medicare inadequate.

I would point out that I think one of the most burdensome aspects of the—of our failure to be able to support Medicare+Choice appropriately is that the people who are hurt the most are low-income seniors, the ones that are not so poor that they are helped by Medicaid, but not able to afford Medigap. And it is this group that the zero premium choice plans or the low-cost choice plans were a real Godsend to, because it meant they could go to the doctor and get health care without the 20 percent copayments.

In the past, underfunding Medicare+Choice, at least originally, was sort of seen as tolerable because, and I quote, as I have heard my colleagues say many times before, well, they can always go back to Medicare fee-for-service. What we see today is they don't like Medicare fee-for-service. One of the big complaints that we are going to hear later on is that seniors in Wisconsin are losing coverage for dialysis that is very dear to them. In fact, the coverage they are losing throws them back into the Medicare fee-for-service copayment structure. It is too expensive. They can't afford it.

But I think the big message here that we have often missed in talking about Medicare+Choice is that seniors need that option because it provides better benefits and the ability to manage chronic illness. Medicare—the Medicare statute requires plans to provide actuarial value of the Medicare-covered benefits. Mr. Kleczka and many seniors in my district have brought to my attention that the variations in some areas in benefits raise compliance questions.

A second issue is the eligibility of seniors for other plans. Under current law, seniors are guaranteed access to Medigap plans if their Medicare plan withdraws from the market. No such guarantee exists if the plan raises premiums or changes its benefit package dramatically. What would be the consequences of such a guarantee for seniors? What would be the consequences for seniors? What would be the consequences of the Medigap plans and, therefore, the availability of Medigap to all seniors?

It is clear that we must take on the challenge of fixing Medicare and stabilizing it for future years so that seniors have the choices that we promised them. It is also a pleasure to note that as we go to the floor this evening with the regulatory reform bill, we will pass a bill that will waive the lock-in by 1 year, and move the adjusted community filing date from July to mid-September, and also lengthen the enrollment period from 1 month to a month-and-a-half. These small changes will help, but they are merely a down payment on the regulatory reform efforts that have to be made to stabilize Medicare+Choice along with the funding issues which we are all now keenly aware of.

I look forward to working with you, Mr. Scully, and with the President and my colleagues on this Committee, and I congratulate you for the tremendous efforts that you have made administratively to simplify the governance of Medicare+Choice and encourage the plans to stay in. But it is this Congress's obligation to take this issue head on, because seniors clearly are being well served by the Medicare choice plans. They like them. They have a right to that choice. And it is abundantly clear now, as I think will come out over the course of today's hearing, that we have been negligent by even supporting them with the same level of reimbursement increases that we have supported fee-for-service Medicare.

[The opening statement of Chairman Johnson follows:]

Opening Statement of the Hon. Nancy L. Johnson, a Representative in Congress from the State of Connecticut, and Chairman, Subcommittee on Health

Today, the Ways and Means Committee continues its examination of the Medicare+Choice program. This is the ninth hearing by the Ways and Means Committee or Health Subcommittee on Medicare this year, and the second on Medicare+Choice.

I am pleased to welcome Tom Scully, the Administrator of the Centers for Medicare and Medicaid Services, back to the Subcommittee.

The Medicare+Choice program is at a crossroads. Since enactment of the Balanced Budget Act, the viability of this important option has faltered, with sagging enrollment, reduced benefits and increased beneficiary costs. Despite two Congressional attempts to breathe life back into the program, enrollment will once again decline next year. While last year's Beneficiary Improvement and Protection Act reduced premiums and allowed plans to continue serving 2.9 million beneficiaries, next year costs will increase, and additional restrictions on benefits will be imposed.

Enrollment in Medicare managed care had been increasing steadily until the changes mandated by BBA 97. Since that time, enrollment has declined by about 800,000 beneficiaries or about 12 percent. Prescription drug coverage has been eliminated or cut back dramatically in recent years, while program participants' cost sharing and premiums have increased, in some areas significantly. In 2002, only half of the Medicare population will have access to at least one Medicare+Choice plan with drug coverage, down from 65 percent in 1999. In addition, only one-third of the Medicare population will have access to a zero premium plan in 2002, down from 61 percent in 1999. Cost sharing for Medicare-covered services will jump 78 percent in 2002, from $14.88 per enrollee, per month, to $26.60 per enrollee, per month.

Next year more than 500,000 Medicare beneficiaries in 28 states will be forced to change their health coverage or move back to Medicare fee-for-service largely because reimbursement has not kept pace with health care inflation. Ninety-two thousand beneficiaries will no longer have a coordinated care option, 38,000 of whom will have to return to the Medicare fee-for-service program. These enrollees may supplement their lost benefits by purchasing a Medigap policy. The Medicare statute requires guaranteed issue for plans A, B, C, or F with any company within 63 days if the plan terminates coverage in a beneficiary's service area, but not if benefits are reduced or cost sharing is increased.

Despite these disappointing facts, Medicare+Choice has provided an attractive and welcome alternative to traditional fee-for-service for millions of Medicare beneficiaries. Importantly, Medicare managed care plans provide health services that are unavailable to their counterparts.

Consider these statistics:

- Virtually all plans have at least one disease management program.
- The average plan has four disease management programs in place.
- 95% of plans have a diabetes disease management program.
- In 2001, 67.2 percent of Plus Choice beneficiaries have access to prescription drug coverage.
- 94.1 percent of Plus Choice beneficiaries have vision care.
- 78.8 percent of Plus Choice beneficiaries have hearing care.
- 99.7 percent of Plus Choice beneficiaries are provided an annual physical.

These are benefits that are unavailable in traditional Medicare.

We have heard testimony in this Committee on a number of occasions that Medicare+Choice plans are overpaid. Pairing that testimony to the changes occurring in the Medicare managed care market defies logic. Plans don't leave profitable areas because they make too much money. Nor do they reduce benefits and increase premiums on a whim. In fact, the Medicare statute requires plans to provide the actuarial value of all Medicare covered benefits, and to offer additional benefits or rebates on Part B premiums if federal payments exceed anticipated plan costs.

Because of the continued plan exodus and the erosion of value of benefits received, it is clear to me we need to immediately stabilize the program through a short term infusion of additional dollars that will more accurately reflect the costs of providing health services. In the mid-term, Congress needs a whole-scale restructuring of the payment formulas to ensure the long-term viability of the Medicare+Choice program.

Recent ideas to peg funding to input prices or pay plans based on certain quality indicators, making government a value purchaser, are intriguing and merit further investigation.

In addition, Congress must take measured steps to improve the regulatory environment for plans. Today, the House will pass legislation to delay implementation of the so-called "lock-in" by one year, move the filing date for adjusted community rate filing from July to mid-September and lengthen the open enrollment period from one month to a month and a half.

While the challenge we face is daunting, it is not insurmountable. I look forward to working with you, Mr. Scully, with the President, and with my colleagues on the Committee, to get the job done.

Chairman JOHNSON. Mr. Stark.

Mr. STARK. Thank you, Madam Chair, for holding this hearing. We appreciate your willingness to use our Subcommittee's resources to investigate the questionable, if not illegal, benefit and cost-sharing changes being proposed by some of the Plus Choice plans for next year.

The impetus of this hearing really came from a proposal by UnitedHealthcare for beneficiaries in Milwaukee, Wisconsin, represented by Mr. Kleczka and our Committee, and this plan contains—or their plan for next year contains excessive cost-sharing increases that may well violate the statute's requirement that these Plus Choice plans cover at least all Medicare-covered services. And while United is the most extreme example I have seen, I am aware of other benefit packages offered in my district and other parts of the country that raise similar concerns.

Beneficiaries join these Plus Choice plans because the plans hold out the opportunity supposedly to get all of Medicare's benefits in addition to lowered cost-sharing and, depending on where you live, additional benefits like prescription drugs, vision care, hearing aids, as you pointed out. But at a minimum, the plans are required

to employ all Medicare-covered services. The plans are gaming this, and they are gaming it with benefit packages for next year, and it calls into serious question whether they are fulfilling their obligations under the law.

If you join a Medicare+Choice plan, you are prohibited by law from also owning a Medigap policy. Yet Medicare+Choice seniors in Milwaukee next year will face hospital charges that will far exceed the $812 deductible in Medicare fee-for-services. Beneficiaries in my district will pay $50 for each dialysis visit. Medicare-covered drugs that are self-injected or used for chemotherapy will cost some beneficiaries $250 a treatment; that is, out of their own pocket. Under these plans, the beneficiaries are paying more in Medicare+Choice than they would in fee-for-service Medicare. So if you are a low-income senior or person with disability, these Plus Choice plans with this kind of cost-sharing are a worse option than fee-for-service on its own.

These are Medicare coverage services that they are playing with, and the Plus Choice plans are upping the costs of these particular benefits for only one reason, and that is to avoid covering people that need those benefits. That is why I, along, I think, with my colleague from Milwaukee and a number of others have joined to introduce the Medicare+Choice Consumer Protection Act. This bill would do three things to help Medicare+Choice enrollees—not the plans, but the enrollees for a change. For beneficiaries who have seen their benefits eroded, it provides them with Medigap protections to leave Medicare+Choice and join a Medigap plan without medical underwriting. It eliminates the upcoming lock-in which would prohibit them from them being able to leave a Medicare+Choice plan and in general prohibits Medicare+Choice plans from charging higher cost-sharing for particular services than is charged in the Medicare fee-for-service program.

The Health Maintenance Organization (HMO) industry has won the battle to continually delay risk adjustment, which means we continue to overpay for the relatively low-risk population they serve. Now they are using benefit and cost-sharing techniques to further avoid risk and ensure minimal expenditures on this line of business. It is time we blew the whistle. Our bill would prohibit these practices and make the playingfield a little bit fairer for beneficiaries.

Now, unbelievably at the same time these plans are reducing coverage for Medicare-covered services, the HMOs are up here on the Hill trolling for increased payments. I hope everyone has an opportunity to review this new GAO report we released today entitled Medicare+Choice Recent Payment Increases Had Little Effect on Benefits or Plan Availability in 2001. As the title indicates, the report makes clear that the billion dollars in extra funds that went to Medicare HMOs this year did nothing to increase benefits or plan options for people. It is further evidence that what we need in Medicare+Choice are consumer protections, not additional money.

I am pleased that Mr. Scully and the representative from UnitedHealthcare are here to answer questions about their process for approving Medicare+Choice plans and the United proposal in particular. In addition, I would like to welcome Ms. Stephanie Sue

Stein and thank her in advance for representing the beneficiary perspective.

I would say, Madam Chair, that it is perhaps time we recognize that less than 15 percent of the seniors have signed up for these Plus Choice plans. They have caused more problems than all the rest of Medicare put together. The premium support plan that the Medicare Commission came up with is a blatant attempt to shove people into these Medicare+Choice plans. So when you don't have one in eight people who like them, why don't we just can them, use the money to support the Medicare system, provide perhaps a Federal Medigap policy that would cover all of our beneficiaries fairly, and one of these days we might even get around to a drug benefit if we stop giving big tax breaks to wealthy people.

[The opening statement of Mr. Stark follows:]

Opening Statement of the Hon. Fortney Pete Stark, a Representative in Congress from the State of California

Thank you, Madame Chair, for holding this hearing at the request of the Democrats. We appreciate your willingness to use the subcommittee's resources to investigate the questionable—if not illegal—benefit and cost-sharing changes being proposed by some Medicare+Choice plans for 2002.

As you know, the impetus for this hearing comes from concern regarding a proposed plan submitted by UnitedHealthCare for beneficiaries in Milwaukee, WI which is represented by the Honorable Jerry Kleczka on our committee. This plan contains excessive cost-sharing increases that may well violate the statute's requirement that M+C plans cover at least all Medicare-covered services. While United's plan is the most extreme example I have seen, I am also aware of other proposed benefit packages offered in my district and in other parts of the country that raise similar concerns.

Beneficiaries join Medicare+Choice plans because they hold out the opportunity to get all of Medicare's benefits in addition to lowered cost-sharing and, depending on where you live, additional benefits like prescription drugs, vision care, and hearing aids. At a minimum, the plans are required to provide all Medicare-covered services.

However, the gamesmanship being played with the benefit packages in many Medicare+Choice plans for next year calls into serious question whether these plans are fulfilling their obligation under the law.

If you join a Medicare+Choice plan, you are prohibited by law from also owning a Medigap policy. Yet, Medicare+Choice seniors in Milwaukee will next year face hospital charges that will far exceed the $812 hospital deductible in Medicare fee-for-service. Beneficiaries in my district will pay $50 for each dialysis visit. Medicare-covered drugs that are self-injected or used for chemotherapy will cost some members $250 a treatment. Under these plans beneficiaries will pay more in Medicare+Choice than they would in FFS Medicare. If you are a low-income senior citizen or a person with a disability, Medicare+Choice with this kind of cost-sharing is an even worse option than fee-for-service Medicare on its own.

These are Medicare-covered services that they are playing with and Medicare+Choice plans are upping the cost of these particular benefits for only one reason—to avoid covering people that need those benefits.

That's why Rep. Kleczka, myself, and a number of other colleagues in Congress joined together to introduce the Medicare+Choice Consumer Protection Act.

This bill does three simple things to help Medicare+Choice enrollees. For beneficiaries who have seen their benefits eroded, it provides them with Medigap protections to leave Medicare+Choice and join a Medigap plan without medical underwriting. It eliminates the upcoming "lock-in" which would prohibit beneficiaries from being able to leave a Medicare+Choice plan at their choosing. And, in general, it prohibits Medicare+Choice plans from charging higher cost-sharing for particular services than is charged in the Medicare fee-for-service program.

The HMO industry has won the battle to continually delay risk adjustment which means that we continue to overpay them for the relatively low-risk population they serve. Now, they are using benefit and cost-sharing techniques to further avoid risk and ensure minimal expenditures on this line of business.

We need to say no. Our bill would prohibit these practices and make the playing field a bit fairer for beneficiaries.

Unbelievably, at the same time that these plans are reducing coverage of Medicare-covered services, the HMOs are up on Capitol Hill trolling for increased payments. I hope everyone has an opportunity to review a new GAO report we've released today entitled, "Medicare+Choice: Recent Payment Increases Had Little Effect on Benefits or Plan Availability in 2001." As the title indicates, the report makes clear that the $1 billion in extra funds that went to Medicare HMOs this year did almost nothing to increase benefits or plan options for people. It is further evidence that what is needed in Medicare+Choice are additional consumer protections—not additional money.

I am pleased that CMS Administrator Scully and a representative from UnitedHealthCare are here today to answer questions about the agency process for approving Medicare+Choice plans and the United proposal in particular. In addition, I'd like to welcome Stephanie Sue Stein and thank her in advance for representing the beneficiary perspective.

Mr. JOHNSON OF TEXAS. Would the gentleman yield?

Mr. STARK. I will be glad to yield.

Mr. JOHNSON OF TEXAS. You know, there are people who don't like Medicare, too, and why don't we do away with it?

Mr. STARK. Well, Mr. Scully doesn't like Medicare. We will hear from him about that.

Mr. JOHNSON OF TEXAS. Well, that is great. I am glad we got somebody on our side. Thank you.

Chairman JOHNSON. There are differences of opinion—there are differences in opinion in regard to Medicare+Choice plans. There are differences that we need to air and evaluate as a Committee. I do regret that Mr. Stark today chose to give us a copy of a GAO report that he has had only as we sat down. Indeed, Pete, I think that violates the spirit in which we have been working, and if we are ever going to work out our differences of opinion about Medicare+Choice, we are going to have to give up such gamesmanship.

Mr. STARK. Madam Chair, you are quite right. At least I invited you to the meeting, which as a courtesy, you don't always extend to the Democrats. So at least we gave you the information as soon as we got it.

Chairman JOHNSON. At the time of the meeting, yes—at the hearing.

Mr. KLECZKA. Madam Chair, I would like to ask unanimous consent to enter my statement into the record.

Chairman JOHNSON. You certainly may.

[The opening statement of Mr. Kleczka follows:]

Opening Statement of the Hon. Gerald D. Kleczka, a Representative in Congress from the State of Wisconsin

I would like to thank Chairwoman Johnson for accepting my request for a hearing to investigate the reductions in benefits and dramatic increases in cost-sharing that beneficiaries face next year as a result of private decisions by Medicare+Choice plans.

I am particularly pleased that the Subcommittee has invited, at my request, Ms. Stephanie Sue Stein, Director of the Milwaukee County Department on Aging. Ms. Stein is a tireless advocate for senior citizens in Milwaukee and throughout the State of Wisconsin. I am confident that she will provide the Subcommittee a compelling, first-hand account of the devastating effects the benefit reductions are having on seniors and their families. Last month, UnitedHealthcare of WI notified 16,000 seniors in the Milwaukee area that their "PrimeCare Gold" Medicare+Choice plan would be changing to a new "Medicare Complete" plan beginning January 1, 2002. Although UnitedHealthcare decided to lower beneficiaries' premiums from $65 to

$55 per month, the insurer significantly increased rates and reduced benefits for numerous health services. For instance, last year, under the PrimeCare Gold plan, beneficiaries were not subject to a copayment for inpatient hospital services. Under the new Medicare Complete plan, beneficiaries will have to pay a copayment of $295 per day. Likewise, for the first time, beneficiaries in Medicare Complete will have to pay $150 per day for skilled nursing facility services, $30 per visit for outpatient rehabilitation, and 20 percent per outpatient visit for renal dialysis. In addition, Medicare Complete has a $4,800 out-of-pocket limit on inpatient and outpatient services. Unlike the new name, this coverage is by no means "complete."

The Medicare+Choice program was intended to provide more health insurance options and benefits for seniors at less cost. As so many Wisconsin seniors know, it has failed to deliver such promises. Since UnitedHealthcare is the last remaining Medicare+Choice plan in the Milwaukee area, senior citizens will be forced to pay significantly higher rates or return to the traditional fee-for-service Medicare program. But, if they do so, they are unable to purchase a Medigap supplemental policy without penalty.

To express my opposition to UnitedHealthcare's dramatic price increases, I wrote a letter to Mr. Tom Scully, Administrator of the Centers for Medicare and Medicaid Services (CMS), and requested his immediate intervention to reject these benefit changes and to ensure a viable Medicare+Choice option is available to Milwaukee residents. I have included a copy of this correspondence for the record. In addition, I have spoken personally with both Administrator Scully and U.S. Department of Health and Human Services Secretary Tommy Thompson to urge them to renegotiate this plan.

Both Mr. Scully and Secretary Thompson have been attentive to my plea on behalf of Wisconsin seniors enrolled in UnitedHealthcare's plan. Mr. Scully, in particular, has been responsive and has notified me during each step of the CMS approval process. I appreciate his personal attention to and concern regarding this critical matter.

Although some progress was made to lower the hospital inpatient copayment, I still believe that $295 per day for hospital inpatient services is outrageous and unacceptably high. A senior enrolled in Medicare Complete plan could be required to pay up to $4,800 for an inpatient hospital stay that would cost $812 under the traditional fee-for-service Medicare program. This is ludicrous, and I question its legality. Certainly, such a plan was not the intent of Congress.

Regrettably, CMS approved the plan, so I have taken other steps to help protect seniors who find themselves trapped in a plan in the future that no longer meets their financial or health needs. I have cosponsored legislation, entitled the Medicare+Choice Consumer Protection Act of 2001 (H.R. 3267), that would extend much-needed protections to seniors who would like to exit their Medicare+Choice plan due to the high rates and return to the traditional Medicare program with a supplemental Medigap plan.

Under current law, seniors whose Medicare+Choice plan drops their coverage have the option to buy Medigap insurance to supplement traditional Medicare without penalty. During this time, an insurance company that sells Medigap policies cannot: refuse to sell the policy to the beneficiary; impose a waiting period, exclude coverage for a pre-existing condition, or, charge a higher price for the policy because of health status.

Unfortunately, these protections are not provided to senior citizens who choose to disenroll in their Medicare HMO due to reduced benefits or increased cost-sharing. This critical legislation would ensure that seniors who leave their Medicare HMO for those reasons would be able to purchase Medigap supplemental insurance without penalty. H.R. 3267 would also prohibit Medicare+Choice plans from charging higher cost-sharing for a service than Medicare charges in the fee-for-service program, which has been of debate in UnitedHealthcare's Medicare Complete plan. It is imperative that the Subcommittee quickly considers this or other comparable legislation to ensure seniors have the time to carefully review their health care options and be assured the best possible care.

In the meantime, I am pleased that CMS seems to have heeded the concerns of senior citizens—at least for this year—by calling for a Special Enrollment Period (SEP), in which seniors can leave their Medicare HMO and have guarantee issue rights to purchase a Medigap policy. I look forward to hearing more details about this SEP from Administrator Scully during today's hearing. In particular, I hope to learn how CMS intends to notify seniors of this new special right to disenroll without penalty.

Again, I thank Chairwoman Johnson and Ranking Member Stark for their willingness to put a spotlight on the current situation in Milwaukee, Wisconsin and in-

vestigate the drastic reductions of benefits and increases in cost-sharing for beneficiaries in Medicare HMOs next year.

Chairman JOHNSON. Mr. Scully.

STATEMENT OF THE HON. THOMAS A. SCULLY, ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES

Mr. SCULLY. Good morning, Chairwoman Johnson and Representative Stark and members of the Subcommittee. Thanks for having me here today to talk about Medicare+Choice.

I would like to start off by saying I do, in fact, care a lot and do like the Medicare program. I have spent a lot of time in the last 20 years with Mr. Stark on things like RBRVS, resource based relative value scale, which we worked on 15 years ago or 20 years ago, and various other things trying to improve the Medicare program. And, in fact, contrary to, one of my more widely quoted but inaccurate statements, which I never said, I was attributed, as recently as this morning, in the paper to wanting to expand Medicare+Choice to 30 percent of the population. I, in fact, have never said that.

What I said months ago in a speech was that Congress and the CBO projected that Medicare+Choice, in 1997, would expand to 30 percent of the population, and that has not happened. In fact, the program has shrunk and is now at about 14 percent of the population. But it is not, in fact, a goal of the Bush administration or of mine to expand it to 30 percent.

I hope that I show balance in my interest in supporting the Medicare+Choice program and the fee-for-service program, which I have spent a lot of my time and my career working on. And I hope you find that in my 6 months at the Agency, that balance has been pretty fair.

Anyway, Medicare+Choice, I think, is, in fact, a very important option for many of our seniors. It has enabled them to take advantage of a lot of the benefits, extra benefits and services than Medicare beneficiaries in fee for service get. These can include in some areas, in some counties, prescription drugs, routine vision care and dental care.

Medicare+Choice can, in fact, make it unnecessary for seniors to purchase increasingly expensive Medigap plans. Those premiums are often higher than the Medicare premium itself. And I believe if you look at the demographics of the Medicare+Choice program, it is disproportionately low-income people that choose the Medicare+Choice program because it gives them the ability to frequently trade off slightly larger networks of coverage for drug coverage and lower co-payments. And I think it is a very viable and very important option, especially for low-income people, to have, and one that is unfortunately becoming more expensive and increasingly disappearing.

As you know, the Medicare+Choice program has changed a lot, not for the better, in recent years. I have given each member of the Committee—I think I have put up for the press—a recent set of charts that talk about Medicare+Choice changes in access, premiums, and benefits from 2001 to 2002, and I think it gives you

a very detailed picture of what is going on in the program and how the benefits are changing and how access to the benefits is changing. Obviously, hundreds of plans have left the program in recent years. They have had their service areas reduced, and as you can see in the chart in the back of my testimony, beneficiary access to the plans has dropped by about 15 percent over the last few years.

Medicare+Choice can't get access to extra services to these Medicare beneficiaries who want them if there is not a plan to sign up for. In 1999, there were about 1,200 adjusted cost rations (ACR) filed by managed care plans across the country. This year that number dropped to 474. So you can see that obviously this is a significant dropoff in plan offerings. Plan offerings are also far less generous in their drug benefits. Plans that have been offered with zero premiums or no significant beneficiary cost-sharing have largely disappeared.

It is very clear that annual increases in the Medicare+Choice program have failed to keep up with the rising health care costs and inflation. As a result the plans who stay in the program are left with two clear options, either reduce their benefits and increase beneficiary cost-sharing, or get out of the program. We have taken every administrative action we can possibly think of to try to stabilize the program and make it easier for plans to stay in, but it is clear that much more needs to be done to this program to protect what I think is still a viable option for many beneficiaries in many counties. I really believe, and the administration believes, that if Congress doesn't act to fix many of the problems in the program, the program will, in fact, blow away in the wind in the next few years.

Unfortunately, we are seeing a greater share of Medicare+Choice health care costs borne by beneficiaries, as we are going to talk about in a few minutes, I am sure, in Wisconsin. We are very concerned about that, and we have been tracking it closely. In our guidance to Medicare+Choice organizations this year, we advised them that their 2002 beneficiary cost-sharing proposals would be examined very closely. This year we identified a number of Medicare+Choice plan cost-sharing proposals that we thought were unreasonable, and we worked with the identified organizations to make the changes that we could in those programs. We are very interested in protecting beneficiaries and in being good business partners with the plans that are trying to provide those services, and we worked as closely as we could to make those plans better.

The staff, after the ACRs were filed this year, identified seven plans that they thought had beneficiary cost sharing that was not appropriate. We worked with each of those to make changes in the plans and did everything we could to make adjustments. For example, I worked extensively with Congressman Kleczka on some obviously very difficult issues with UnitedHealthcare of Wisconsin. And I appreciate all your help in working those out, Mr. Kleczka. We did make some changes in that plan. I really believe that in United's case—I am sure we will talk about this—their choice was to either get out of the program or change their benefit structure. We made some modest changes to their benefit structure. I also spent a lot of time looking at their finances and was convinced that

basically they were making virtually no money on this plan and had a combined loss ratio of virtually 100 percent.

Mr. Stark, I know you may not be aware of this, but, in fact, the plan in your district that had the $50 dialysis copayment has, in fact, lowered that dialysis copayment to $25 after we looked into that very specific issue.

Additionally, we are working to develop specific guidelines for plans that we hope will address the situation we faced this year when they submit plans for next year, as again I am sure we will discuss.

Our ability to either let plans in or deny them access to the Medicare+Choice program is somewhat limited. I am also happy to tell you—and this is something we recently discovered, and I think Mr. Kleczka knows because I told him on Friday—that we were not even aware legally because we declared a special election period for December, in fact, Medicare+Choice beneficiaries that want to drop out of their Medicare+Choice plan, even if it still exists in their county, such as United, do, in fact, have the ability during the month of December to drop out of the plan and will have guaranteed issue rights to Medigap plans up through March 4, 2002. So I believe it is relatively happy news.

So our concern, which I share with Mr. Kleczka, that people in certain districts where they have only one plan left with high copayments would be effectively trapped in that plan and not have the ability to drop out is, in fact, not the case. For this year, if they drop out in December, they can, in fact, get guaranteed issue to Medigap plans.

We are also trying to take important steps to make sure the beneficiaries know their health plan options and how to get answers to all of their Medicare questions. We, as you know, launched the $30 million advertising campaign to get seniors to call 1–800–MEDICARE and to use our Web site. We have, in fact, peaked at 65,000 calls a day. We are still getting about 30,000 calls a day. There is significant evidence that seniors are starved for information about those plans. We added 1,200 operators to our call centers. The call centers went from 5 days a week, 8 hours a day, to 24 hours a day, 7 days a week. They provide a whole new level of information that wasn't available last year. So if somebody calls up from Milwaukee and asks about their Medigap options, their plan options, their copayments or any plan offered in Milwaukee, for instance, hopefully, and I have tried this many times, an operator will be able to walk them through those options and walk them through our Web site.

So I believe that the information that is available for beneficiaries is a lot better than last year. It is still a big challenge to make sure the beneficiaries know what their options are, and we are obviously very anxious to work with you to make sure that everybody knows exactly what their options are before the end of the open season period.

Medicare+Choice is still an important option for millions of Medicare beneficiaries, and we are committed to working hard to make the program work and remain a viable option for the seniors that want it.

Let me just make a couple more points, and then I will wrap up. We have, in addition to the Medicare+Choice changes in benefits that I provided to the Committee and, I think, to the press, we also—and this is the first of a series—put out a health care market industry update and provided that for the Committee. We sent that out to a wide variety of people in Washington last week. I believe, having been involved in the managed care and hospital business for a long time, as the regulators of this business, it is our responsibility to make sure that we track what their profit margins are, how much money they are making on Federal programs, what the average return is. And this is the first of many market reports we are planning to put out.

This one is on managed care and shows the margins on managed care, but what it basically shows is the managed care business made a tremendous recovery in their commercial markets the last couple of years, but the direct correlation is the plans that have stayed in Medicare+Choice are doing terribly. They are the ones that are the worst investments, whether you are a bondholder or a shareholder. And their shareholders and bondholders are pushing them hard to get out of the Medicare+Choice program because their margins and their profits have recovered enormously in the commercial markets, and they are terrible in Medicare+Choice program. And anybody that is in the managed care business basically is getting a lot of pressure from their bondholders and their shareholders to get out of the business.

Another point I would make, which Mrs. Johnson made, is that when we passed the 1997 bill, the 1999 bill and the 2000 bill, one of the theories out there about new money—and I think what Mr. Stark alluded to—one of the points in the GAO study which I have looked at—they did give it to us for clearance—is that essentially a lot of the money that was put back in the program was put back in relatively rural areas on the theory that if you build it, they will come. If you put money in those areas, managed care plans will come.

Well, there aren't many managed care plans in those areas, and they, in fact, haven't shown up. So I think one of the points you can draw from the funding that has been put back in the program is that it has been put back in largely rural areas where the program is not popular. There aren't managed care plans in those areas, and they haven't shown up, and so the money has been largely unspent. And what has happened is that the urban areas and the suburban areas, where it is popular, have largely been starved.

So I believe if you go back to the 1999 and 2000 bills and look at what CBO projected would be spent in those areas, you could make a very strong argument that the number is about a billion dollars a year that was expected to be spent in the Medicare+Choice program that is not being spent. The money has been allocated to those counties, and there are no plans for beneficiaries to enroll in. So I think you can make a clear point.

And one final point, if you look at the years 1998 to 2002, commercial premiums in that timeframe have gone up 49 percent. In the Federal Employee Health Benefits Plan (FEHBP) that we are all in, premiums have gone up an average 46 percent. Medicare

fee-for-service has gone up 21 percent, and yet Medicare+Choice has gone up 11 percent. So it is pretty clear that when you look at the comparison in the health care business, what has happened is that costs have gone up, and the Medicare+Choice reimbursement has been relatively flat. So it is a very basic calculation for the plans. They have to raise their co-payments, raise their deductibles, raise their premiums or get out of the program. They are just not keeping up with their costs.

I'll just make one last point just to wrap up. I think fixing this funding is essential. I don't think there is any clear way to do it. Bob Berenson, who worked in the last administration, made a number of very constructive suggestions in a Health Affairs article that was just published last week. There are many ways to fix the program and fund it. The administration is very interested in working with all of you to do that. I really believe that structural changes to fix funding are essential, and we also believe that structural changes to make the program more consumer-friendly are essential. Basically virtually every plan in the Medicare+Choice program is a traditional closed-panel managed care plan, and in the under 65 population what people want and what seniors want are Preferred Provider Organizations (PPO) and point-of-service plans. Those are virtually nonexistent in the Medicare program.

And two things we need to do is fix the funding stream, one, and two, give seniors what they want, which is what all beneficiaries want, which is greater flexibility in having managed care plans that are not traditional closed-panel HMOs, but that have point-of-service options, PPO options, and give people the flexibility to choose benefits and plans they want. Thank you for having me today.

Chairman JOHNSON. Thank you very much, Mr. Scully.

[The prepared statement of Mr. Scully follows:]

Statement of the Hon. Thomas A. Scully, Administrator, Centers for Medicare & Medicaid Services

Chairman Johnson, Representative Stark, distinguished Subcommittee members, thank you for inviting me to discuss the Medicare+Choice program, and more specifically the level of beneficiary cost sharing some Medicare+Choice enrollees will be asked to pay next year to remain in the plans. Medicare+Choice is an important option for millions of our nation's elderly and disabled, and I appreciate the opportunity to discuss it with you today.

Medicare+Choice has enabled us to take advantage of private sector expertise to give Medicare beneficiaries more services for their premium, often with lower cost sharing and more benefits than are available under traditional Medicare. The private companies that provide Medicare+Choice benefits are required to cover all of the health care services that a beneficiary could receive in original, fee-for-service Medicare. Moreover, Medicare+Choice plans are valuable to beneficiaries because they traditionally improve on fee-for-service Medicare benefits by offering programs and covering services that are not covered under original Medicare. These can include prescription drugs, routine vision care, dental care, and lower copayments. They also make it unnecessary to purchase increasingly costly supplemental Medigap plans, with premiums that are often two or three times higher than the Medicare premium itself. By making these services and additional benefits available, Medicare+Choice provides more options to millions of people who are covered by Medicare in how they receive their health care; and millions are able to lower their health care expenses substantially. In addition, Medicare+Choice plans provide a valuable alternative to fee-for-service Medicare and Medigap, whose out-of-pocket costs are often much higher for beneficiaries.

As you know, the Medicare+Choice program has changed significantly in the last several years. Hundreds of plans have left the program or reduced their service

areas affecting hundreds of thousands of beneficiaries. Plans with both zero premiums and no significant beneficiary cost sharing have largely disappeared. In addition, plans are offering less generous drug benefits. This is because annual increases in Federal Medicare+Choice funding have failed to reflect rising health care costs. Unfortunately, as a result, plans that wish to stay in the program are left with two options: reducing benefits or increasing beneficiary cost sharing. We have taken many administrative actions to stabilize the Medicare+Choice program and reduce burden. Congress has acted to increase funding for Medicare+Choice in recent years, but much of the increase was targeted to areas with low enrollment. For example, between 1998–2002, Medicare+Choice rates increased 11.5 percent in counties that received the minimum payment update. This compares with a cumulative increase in fee-for-service spending of over 21 percent over the same time period. Thus, the rate of growth in fee-for-service rates is nearly twice that of Medicare+Choice in the counties where 65 percent of Medicare+Choice enrollees live. It is clear that much more needs to be done and we are committed to working with Congress and the plans to protect this valuable option for beneficiaries.

As mentioned above, following the trends in Medicare generally, we are seeing a greater share of Medicare+Choice health care costs borne by beneficiaries. This is similar to what is occurring commercially and in the fee-for-service Medigap market. I am concerned about this and have been tracking it closely. In our guidance to Medicare+Choice organizations earlier this year, we advised them that their 2002 beneficiary cost sharing proposals would be closely examined. This year we identified Medicare+Choice plan cost sharing proposals that we believed may have been unreasonable, and we worked with the identified organizations to make changes to their cost sharing proposals. We also required plans to promptly notify beneficiaries of any changes in their benefits or cost sharing. Because of our experience this year and our desire to protect beneficiaries, as well as to be good business partners to the plans, we are looking at reasonable ways that we can assist plans in setting cost sharing amounts for different benefits in the future. For example, I recently worked extensively with Congressman Kleczka on some tough issues in Wisconsin. I also am happy to announce that because the process for submitting ACRs was delayed this year, we declared a nationwide Special Election Period for all plans during the month of December this year. As a result, for this year only, all beneficiaries will have the option to request disenrollment from their Medicare+Choice plan and return to original Medicare during the month of December and to purchase a Medigap policy using their guaranteed issue rights, which will last until March 4, 2002. Of course, the premiums for these Medigap policies' premiums are also rising rapidly because of the gaps in benefits in the traditional fee-for-service Medicare program and increasing health costs generally. This is why we need to modernize benefits in the traditional fee-for-service program, as well as make Medicare+Choice payments fairer.

We also are continuing to take important steps in helping to ensure Medicare beneficiaries are informed of their health plan options and are able to get answers to all of their Medicare questions. We are conducting a $30 million beneficiary education advertising campaign, we expanded our toll free beneficiary telephone help line, and we mailed additional materials to advise beneficiaries of health plan changes. This sort of education is vital for beneficiaries to understand their health care options and make the decisions that are best for them, and the education campaign has generated substantial response from beneficiaries.

BACKGROUND

Medicare has a long history of offering alternatives to the traditional Medicare fee-for-service program to our beneficiaries. In the 1970's Congress authorized Medicare risk contracting with managed care organizations, and in the 1980's Congress modified the program to make it more attractive to managed care companies. In the Balanced Budget Act of 1997, Congress created the Medicare+Choice program to expand the types of private entities eligible to contract with Medicare to address some perceived flaws in the risk-contracting program and reduce variation in payment for plans across the country. Since passage of the BBA, Congress has refined the Medicare+Choice program through the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). These changes primarily address payments in the "floor" counties, not the "minimum update" counties that have the majority of Medicare+Choice enrollees and are facing the tightest pressures to control their costs even as health costs and costs in the Medicare fee-for-service program rise more rapidly.

This year about 5.6 million, or nearly 15 percent of all Medicare beneficiaries, were enrolled in a Medicare+Choice plan. For 2002, about 60 percent of all Medicare beneficiaries have access to a Medicare+Choice option, and about 536,000 bene-

ficiaries will be impacted by Medicare+Choice organizations either withdrawing from the program or reducing their service areas. Fortunately, most affected enrollees have at least one other plan available in their area for next year. Of course, these beneficiaries also can choose to enroll in traditional Medicare. The number of beneficiaries affected by the departing plans' decisions this year is smaller than many in the industry predicted and fewer than the number affected last year. However, despite our best efforts to slow the number of plan withdrawals through administrative actions, it is apparent that additional improvements need to be made to the Medicare+Choice program to encourage more plan participation and greater beneficiary access to Medicare options. Simply put, the Medicare+Choice payment system must be more responsive to the health care marketplace, so that the program can meet beneficiaries' needs. I look forward to working with Congress to achieve the important changes that beneficiaries deserve. We owe it to beneficiaries to make these changes soon to ensure that Medicare can continue to provide affordable options for beneficiaries.

STRENGTHENING MEDICARE+CHOICE OPTIONS

One of the most important ways that we can help beneficiaries is by working with Medicare+Choice organizations to ensure the program remains a valuable option. President Bush, Secretary Thompson, and I share the goal of improving the Medicare+Choice program and reversing the decline in plan participation. Yet some Medicare+Choice organizations are struggling with difficult business decisions. In fact, since my confirmation as CMS Administrator, I have personally contacted many of these plans and talked with them about how much the Medicare program and our beneficiaries need their continued participation. Fortunately, many of them have decided to continue to participate in the Medicare+Choice program.

To ensure that Medicare+Choice remains a valuable option for beneficiaries, we have taken a number of steps to reduce administrative burdens on the Medicare+Choice organizations. Earlier this year we announced a number of actions that will reduce administrative burdens on Medicare+Choice plans in a number of ways, including:

- **Permitting Medicare+Choice organizations to submit revised adjusted community rate (ACR) proposals in the fall.** Many Medicare+Choice organizations indicated that they would drop out of Medicare+Choice if forced to decide whether or not they would continue to participate in the program and provide final 2002 ACR information by the July 1 deadline. By giving plans until September 17th to make renewal decisions, and permitting them to file revised ACR proposals, which contain their benefit packages and cost sharing structures, as late as that date, we ensured that plans could better evaluate their participation in Medicare+Choice and their products for beneficiaries. We would like to work with Congress to make this change in law.
- **Emphasizing better results for beneficiaries.** We will replace calendar-driven audits of Medicare+Choice plans with results-based performance audits, so that we target audits at the plans whose level of performance requires review. This will allow the strong performing plans to spend less time with paper and more time with patients.
- **Providing consistency in quality improvement requirements.** We are developing quality measures that are sensible, reflect current industry practice, and build on the success of the private sector. To this end, we are working with industry representatives, such as the American Association of Health Plans, Blue Cross Blue Shield Association, Health Insurance Association of America, and American Medical Association, to plan and enhance the national Quality Assessment Performance Improvement projects. Additionally, we recently allowed quality improvement projects created for private plans and Medicaid to be used for Medicare.
- **Streamlining marketing review.** We are working to make the approval process for Medicare+Choice marketing material more sensible and less burdensome on the Medicare+Choice plans. We are taking steps to fast track our review of plan marketing materials, while at the same time ensuring that beneficiaries have timely and accurate information.
- **Expediting plan review.** We will expedite our review of potential Medicare+Choice plans that would serve markets left without a Medicare+Choice option or other alternatives to traditional fee-for-service Medicare.
- **Making policy changes quarterly.** It is critical that Medicare+Choice organizations have adequate time to adjust to new rules. Additionally, we strive to ensure that policy guidance is issued before Medicare+Choice plans' rate and benefit filings are due. To that end, and to ensure the Medicare Managed Care

Manual meets evolving needs, we will update the existing manual chapters quarterly. Any policy changes contained in the updates that create new burdens will not be effective until that policy change can be reflected in an organization's ACR proposals. We also have committed that no policy changes will become effective until the next contract year.

- **Re-evaluating the risk adjustment system.** We suspended our collection of physician and hospital outpatient department encounter data. Fair risk adjustment is an important priority, but risk adjustment must be done in a way that encourages innovation in health care delivery and not in a way that imposes outdated fee-for-service models. We are exploring a way of adjusting Medicare+Choice rates for risk that will balance the accuracy of data and administrative burden.
- **Consolidating private plan functions.** Medicare+Choice functions that previously resided within three different components of CMS now are all housed in one place at CMS: the Center for Beneficiary Choices, which will help ensure that we are responsive to the specific needs of Medicare+Choice plans. We are striving to improve coordination between Medicare+Choice and fee-for-service and to be more sensitive to the impact of systems changes on the plans. To this end, our Medicare+Choice staff now participates on the Medicare Change Control Board, which governs carrier and fiscal intermediary systems changes. Their participation helps ensure that the needs of Medicare+Choice plans are considered as the Agency determines future information systems changes.

Furthermore, we recently gave Medicare+Choice organizations new flexibility to work with employer-sponsored health plans so workers can seamlessly merge their pre-retirement benefits into Medicare coverage. This flexibility will give Medicare beneficiaries the kind of private plan choices currently available to many working Americans. Medicare+Choice organizations can tailor plans to the specific needs of employer group members while supplying all Medicare-covered health services, making it easier for them. And we plan to further reinvigorate the Medicare+Choice program by encouraging plans to modify their designs from "closed panel" HMOs to preferred provider organization and point-of-service models that have proved popular in the private sector.

PROTECTING BENEFICIARY COSTS

Each contract year, Medicare+Choice organizations submit to us their ACR proposals for the plans they intend to offer to Medicare beneficiaries in the following year. The ACR proposals describe the costs and benefits the plans intend to offer for their enrollees for the following year. We review the proposals to ensure that beneficiary premiums and copayments for basic Medicare+Choice benefits (Parts A and B and additional benefits) do not cost more than beneficiaries would pay on average for fee-for-service Medicare cost sharing. For 2002, the estimated average actuarial value of cost sharing amount is $105.31 per month per person. This $105.31 cap is an aggregate cap, not a per-benefit cap. Under this aggregate cap cost sharing for particular benefits can vary as long as the total average cost sharing (for Parts A and B and additional benefits) does not exceed the aggregate cap of $105.31. This actuarial figure excludes cost sharing for many other benefits that are part of modernized health insurance plans, but not Medicare including prescription drugs and disease management services. While there are not specific cost sharing limits for most Medicare benefits, Medicare+Choice plans cannot set cost sharing amounts for Medicare covered services at dollar amounts that would discourage people who have greater health care needs from enrolling in Medicare+Choice plans.

As a general rule, as long as the premium charged in addition to the actuarial value of cost-sharing under the plan is less than the actuarial value of fee-for-service Medicare deductibles and cost-sharing, the Medicare+Choice organization is free to structure its cost sharing how it sees fit. However, this year we found that some plans proposed charging beneficiaries what we believed were unreasonably high copays for particular services. The situation we witnessed this year is compounded by the fact that payment increases have not kept pace with plan costs nor have they kept pace with the costs of extra benefits that plans provide, particularly prescription drugs. Thus, we have a new challenge in balancing the need for plans to make decisions about their benefit packages and cost sharing amounts with the important requirement that plan designs do not discourage enrollment. The concern is always that high cost sharing could discourage beneficiaries, who have greater health care needs, from enrolling in or remaining a member of these particular plans.

To address this, we worked cooperatively with the plans to ensure that their cost sharing arrangements were made more reasonable, while at the same time helping to make certain that the plans would continue to participate in Medicare+Choice. While the final agreements we reached with the plans were not perfect, they were

much more reasonable than they were at the outset. Moreover, the continued participation of the plans in the Medicare+Choice program provides beneficiaries access to additional options and extra benefits. Even with the higher cost sharing, we expect that many beneficiaries will continue to find Medicare+Choice plans as a much more affordable option than the cost sharing and rising Medigap premiums under the traditional Medicare program.

We also are developing specific guidelines that we hope will help address the situation we faced this year regarding plans' ACR submissions. Our guidelines will make it clear that we will not approve cost sharing arrangements that could discourage beneficiaries with high health costs from enrolling or staying in a plan. In developing these guidelines, we will consider a number of factors such as the cost sharing in fee-for-service, the cost sharing of other plans in the service area, changes in the plan's cost sharing from previous years, as well as stop-loss protection and limits on cost sharing expenses. Our guidance also will explain how we plan to evaluate plans' benefit and cost sharing proposals.

EDUCATING BENEFICIARIES ABOUT THEIR OPTIONS

We know that our outreach efforts to educate beneficiaries about their health care options are vital. We also know from our consumer research with Medicare beneficiaries that far too many of them have a limited understanding of the Medicare program in general, as well as their Medicare+Choice, Medigap, and Medicare Select options. So for this year we added a vastly expanded advertising campaign to educate beneficiaries about the full range of options open to them. And we have enhanced our toll-free telephone help line, 1–800–MEDICARE (1–800–633–4227 or TTY/TDD 1–877–486–2048) with 24-hour service, seven days a week. We also have hired 1,200 customer service representatives at our call centers. These representatives are available to answer specific questions about an individual's health plan options as well as mail beneficiaries hard copies of the customized information immediately after each call.

Additionally, we are continuing to improve the resources we have available on the Internet for beneficiaries and their families to access comparative information and are providing a new decision making tool on our award winning website, *www.medicare.gov*. Our *Medicare Health Plan Compare* gives visitors the ability to compare benefits, costs, options, and provider quality information. This expanded information is similar to our other online comparative resources like the *Nursing Home Compare* and *Dialysis Compare* websites. With *Medicare Health Plan Compare*, beneficiaries are able to examine by zip code the Medicare+Choice plan options that are available in their area based on characteristics that are most important to them, such as out-of-pocket costs, whether beneficiaries can go out of network, and extra benefits. They also will be able to compare the direct out-of-pocket costs between all their health insurance options and get more detailed information on the plans that most appropriately fit their needs. In addition, we are working to provide similar State-based comparative information on Medigap options and costs. These outreach efforts are vital to ensuring that Medicare beneficiaries understand the options available to them, and that they can make the decisions that best fit their personal needs.

CONCLUSION

While Medicare+Choice is still an important option for millions of Medicare beneficiaries, the program has undergone some substantial changes since 1997. The days of plans offering zero premiums and no significant beneficiary cost sharing have for the most part passed. Health care costs continue to rise, and more and more of the financial burden is falling on Medicare beneficiaries. I have followed this transformation closely, and am working hard to educate beneficiaries about these changes as well as their options, monitoring beneficiary cost sharing, and working closely with the plans to ensure that beneficiary choices remain available. We have taken a number of administrative steps where we were able, but it is incumbent that we continue to work with you and Congress to strengthen the Medicare+Choice program for the future. Our beneficiaries depend on the choice that Medicare+Choice provides. Thank you for the opportunity to discuss this with you today, and I am happy to answer your questions.

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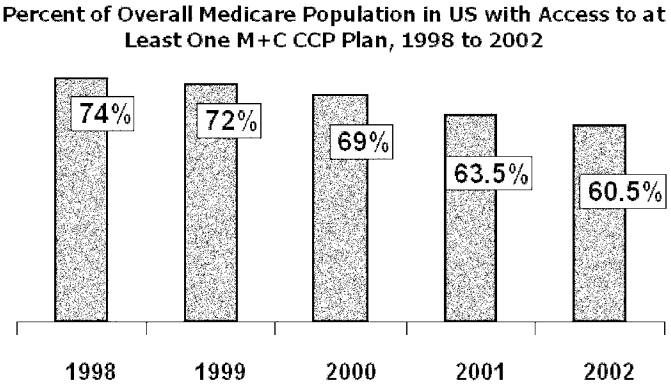
Access to M+C coordinated care plans (CCPs) declined as a result of 2001 non-renewal activity, but the decline in access was not as significant as in the preceding year.



In 2001, an additional 18% of the Medicare population had access to M+C through Sterling, the private fee-for-service plan. In 2002, an additional 16% have access to Sterling as the only available M+C plan.

Chairman JOHNSON. I agree with what you say. We certainly need to fix Medicare+Choice's problems, but we also need to open it up to the kinds of plans that Americans are choosing under the FEHBP and under all employer-provided plans.

Your facts that you just laid out are important, I think, for this Committee and for the public to be aware of. Fee-for-service Medicare increased 21 percent. Medicare+Choice over the same period of time, their reimbursements went up 11 percent. In the private sector employer plans went up 49 percent. And under the Federal Employee Health Benefit Plans, their costs went up 46 percent. So it is a dramatic difference. And it is no wonder that the Medicare+Choice plans are being forced to impose burdens on seniors that are extraordinary and make it very hard for them to stay in the Choice plans. On the other hand, it is also instructive that many of them cannot afford the Medigap alternatives and are dissatisfied and disappointed with the benefits under Medicare.

You say that we need to make structural changes in how we finance Medicare+Choice—changes in the payment formulas. Where are you in your thinking in regard to what those changes need to be?

Mr. SCULLY. Well, I know you have the ability to return to 100 percent of the AAPCC or adjusted average per capita cost, and there are other options. And I am not sure I am free, from the administration, to commit to a specific mechanism or funding level. We certainly would like to work with you.

I think there are a number of ways to do it. As I mentioned, Bob Berenson made some, I thought, constructive suggestions in an article he wrote that said that we really need to have a market basket. At some point we need to have a market basket to update Medicare+Choice costs just like we do hospital costs or physician costs or other costs, and that whatever the mechanism is, I think with all the best intentions in 1997 we basically detached the Medicare+Choice payments from the traditional Medicare Program. We made additional changes in 1999 to 2000, but effectively I think you can argue they backfired in a lot of cases. And in many cases you can find places where the Medicare+Choice rates are 85, 86 percent of the AAPCC, and there are other places where they are 120 percent.

So there are some counties where Medicare is doing extremely well in the funding, and there are some counties where it is clearly way below fee-for-service. I don't think reattaching it to fee-for-service is the right way to go, but I think structurally we kind of lost the balance between the incentives county by county, and in some places a great deal, and in some places a terrible deal.

Chairman JOHNSON. I think one of the things that the GAO study of this matter points out is that we don't have a good base as to what the costs are—I think Berenson's thoughts about improving the base. So I look forward to working with you on this. It isn't something that we can decide now, because the 100 percent fee-for-service is just a punt that varies tremendously. One of the problems in Wisconsin is this variation in the AAPCC in those areas and how much lower it is than Miami.

So we do need to look at what is that base from which we measure managed care costs. I think that is one of the ways to straddle some of the concerns that Mr. Stark has and some of the interests that I have. So we do need to do a very significant analysis of how we reimburse the Choice plans so that we have an honest and automatic factor that they can anticipate and count on and that will do more to stabilize this option for seniors than anything else we can do, in my estimation. Mr. Stark.

Mr. STARK. Thank you, Madam Chair.

Mr. Scully, thank you. We seem to spend an awful lot of effort, as I indicated before, on 15 percent of the Medicare population who are in these plans. I begin to suspect that maybe that is an indication of their relative popularity as opposed to fee-for-service plans or fee-for-service-plus on Medigap plan. And I suspect that there is—when you compare our Federal Employee Health Benefit Plan, for example, or private insurance, most of those plans pay for—I am going to guess—90 percent, maybe even more, of what we all spend on health care. And I would imagine that Medicare fee-for-service probably covers 50 percent of what people are out. And the managed care plans and Plus Choice plans are based on that 50 percent and not on first dollar coverage.

So there is a reason for those differences in cost increases, and if we truly wanted to have—people keep holding up our Federal Employee Health Benefit Plan—if we were going to make Medicare the equivalent of that, we would really have to have a Federal Medigap plan or increase the benefits quite a bit, wouldn't we? If we were to match Blue Cross low option fee-for-service under the

Federal Employee Health Benefit Plan with Medicare fee-for-service, there is a big gap, is there not, by private Medigap, or we would have to increase the benefits?

Mr. SCULLY. There are some Medicare+Choice plans——

Mr. STARK. If we are going to make the Medicare fee-for-service plan equivalent to the fee-for-service plans available to those of us who are Federal employees, we would have to up the benefits considerably by filling those gaps that are now often filled by a Medigap policy.

Mr. SCULLY. I think one of the points of President Bush's proposal this summer was to make it consistent. Certainly the FEHBP has much better benefits in some places than Medicare does.

Mr. STARK. We have a much more generous plan as Federal employees than the average——

Mr. SCULLY. Probably actuarially, I would say that is probably true, yes.

Mr. STARK. And the idea that we can fill this gap—and let us say it is 50 percent—by getting people to go into these Plus Choice plans or any other managed care plan just doesn't add up with numbers. Now, to the extent that—and I know that you don't like setting—that I do remember your testimony—you don't like setting rates, right? You don't like that part of your job.

Mr. SCULLY. I try to be as reasonable as I can in setting rates, but as a general matter, no.

Mr. STARK. I guess what I am saying, if you are going to go back to the risk contract plans, or if you are going to really control Plus Choice, you are going to have to offer some Federal standard, and that means you are going to have to set some rates for those gaps. I don't see that you are going to get any way to on—the plans are losing money. They are costing Medicare money, more money than we anticipated. The studies indicate that throwing more money in isn't going to get the plans to—isn't going to solve their problems the way they want them solved. And it may be we are going to have to have a Federal managed care plan where we negotiate the whole price against which the private plans can compete if they choose to, and then we might—that might be a solution to the problem.

I know you don't like that as well. I mean, I don't see any other way out is that—or have the Federal Government write a Medigap policy that says bare bones as we can make it, and, again, let the private insurers compete against it. It will be difficult because ours would be subsidized, but I don't see much other way around this if you want to continue to let the private managed care plans or encourage them, because they are going to move out quickly when they lose money, and that is going to leave a lot of our constituents and beneficiaries very unhappy, and that is the problem we face.

I hope that we could perhaps broaden the scope of what we do in how we provide managed care and let the government participate a little more, because on balance your agency does a good job on fee-for-service. I don't know why you couldn't do just as good a job in providing managed care. Are you willing to try?

Mr. SCULLY. A couple of things, just to comment on that. I think the President—you know, with all the things that have obviously happened this fall, some of our reform discussions have been set

back a little bit. We proposed significant Medigap reforms this summer, and obviously we are determined to get a drug benefit. As you remember, we worked on catastrophic many years ago, and we were on the same side.

Mr. STARK. Good benefit.

Mr. SCULLY. Not a popular position. It was a good policy. Not everyone shares that view, but I thought it was a good idea back then.

But we are determined. We think reforming Medigap on the private side is a good idea, and we would like to get a drug benefit. That is one of the major reasons I came back to the government.

Mr. STARK. I still got a copy of the old one.

Mr. SCULLY. I am not sure. You and I are the only ones that share that view. But I personally believe and I think there are many places around the country—there are still 5.1 million seniors in Medicare+Choice. There is no question that costs have gone up, premiums have gone up, but there are a lot of places where Medicare+Choice is still extremely popular.

I spent a lot of time last week with Mr. English, who is not here today, last week talking about some of the problems in his district. It is a tremendous deal.

I really believe that the funding formulas have created some inequities county by county around the country. Some places it is a better deal than others. Some places are a lot worse. I do not think the program is irreparably broken. I did read the GAO report. I think you can draw a lot of conclusions. My conclusion from it is the funding increases have gone to the wrong places. I have zero doubt in my opinion that putting more money back into some of the counties that I would argue have been financially starved a little bit would be a significant help in getting people back in.

I also think it is very difficult to make an apple—and I have had this discussion with GAO a number of times to compare—it is not an apples-to-apples comparison because the cost basis for hospitals, doctors, and everything else is totally different in the private plans versus the Medicare plans. And comparing them 4 or 5 years ago, the Medicare+Choice plans looked brilliant because we were arguably slightly over reimbursing Medicare. We reduced Medicare rates, and we control 45 percent of the rates, and we reduce those rates, and the costs could shift back to the private sector.

So it is very difficult to make an apples-to-apples comparison between the private plans and the fee-for-service plans. I think they both work well. I really do not believe I have shown any bias one way or the other toward either plan. I believe Medicare+Choice is a great option for people, and we would like to make sure it is still available, but I spend a lot more time on Medicare fee-for-service than I do on Medicare+Choice.

Chairman JOHNSON. Mr. Johnson.

Mr. JOHNSON OF TEXAS. Thank you, Madam Chairwoman. I appreciate the opportunity to talk with our friend Mr. Scully. I am glad you don't like Medicare either, according to Mr. Stark.

You talk about county by county. You guys over at Health Care Financing Administration (HCFA) have been moving the numbers around county by county, and I swear I don't understand how you can do that, and maybe you can explain that.

But you also talked about catastrophic, Mr. Stark, and it seems to me the medical savings account solved that problem.

But let me ask you this question, Mr. Scully: In a November 2000 report on Medicare State Medicaid Agencies (MSA), Medpack wrote that, "the Commission believes that the current demonstration has shown the private sector will not offer Medicare MSAs because of two basic market characteristics: one, little demand from the risk-averse Medicare beneficiary population; and, two, the expense and difficulty of marketing a complex product such as Medicare MSAs to a fragmented and scarce set of customers."

Do you agree with this statement? If not, what do you think we can do to fix the problem, you specifically, the Congress specifically, and tell us in detail what we as a Congress need to do, and what you as an agency need to do, in your opinion.

Mr. SCULLY. Well, my opinion, which may or may not be the administration position—I don't think we have one on this—I have the same concerns about MSAs and Medicare that I had about MSAs in the commercial market. MSAs in the commercial market under Medicare, in theory, should be just high-deductible plans where you give people essentially a cafeteria plan to spend their own money. I think that concept is a very solid one. I think the reason that the plans have not caught on in the commercial market and would have trouble in Medicare is that basically most people under 65 benefit from significantly lower negotiated rates in their Blue Cross plan or whatever, and people both 65 and Medicare do as well.

So most hospitals—and I just recently left the hospital business—most physicians charge—they have a charge rate and then what they actually get reimbursed. There are a lot of reasons why those are not the same, but nobody really pays full charges. Unfortunately it happens in those high-deductible plans. If you are not part of a network, you may pay double what everybody else is paying and burn through your own personal savings more quickly. I think basically the concept is the same as just having a high-deductible plan.

In the commercial sector, you are finding increased popularity to people having $1,000 or $2,000 deductible plans, but they work best when you can pay the negotiated rate from your Blue Cross plan up until that high-deductible level. When you pay full charges, which could be 40, 50 percent higher for a lot of providers—and really nobody pays those rates—you find that your pot of money you put aside is a lot less effective because you go through it more quickly.

I think that is a structural problem, and I think a lot of the rhetorical debate about this issue gets lost in the label. The reality is, in the commercial sector, you find a quick growing movement toward high-deductible plans where people spend their own money, but for the first $1,000 or $2,000, they are doing it at the Blue Cross or CIGNA, whatever their negotiated rate is. So they are getting the benefit of the lower negotiated rates for physicians, hospitals, clinical labs.

So I do think it can work. I think the biggest reason it hasn't worked in the past is the pot of money you put aside has generally not been spent at a negotiated discounted rate, which is what the

insurance companies do for you. So I think the concept is solid as long as it is part of the negotiated rate up until the threshold.

And I think it could work in Medicare as well. The issue there, which is a very complicated one that we spent a lot of time on, is when you set up different rate preferences, just like in Wisconsin, you draw different populations, and in a high-deductible plan you are generally going to draw certain populations. So you need to make sure you have a very risk-sensitive adjustment mechanism to make sure that you don't let all the people who aren't sick go into the high deductible.

Mr. JOHNSON OF TEXAS. Before we run out of time, tell me specifically in detail what you as an agency can do to fix it and what we as a Congress need to do to make that fix happen.

Mr. SCULLY. Well, my suggestion would be as a demonstration, we certainly could look at Medicare+Choice plans that have high deductibles, but that also trade-off on other benefits. I mean, high deductibles are obviously on the hospital side, but you can certainly give people the option, as long as you can risk-adjust it for the population you draw, to choose high deductibles and spend their own money with their physicians. That is certainly a viable option.

I think the issue is what is the rate they are going to be charged for whatever the pot of money is. If they go into the hospital—and, again, I am not trying to be critical—you will see a hospital will charge $3,000 for a service, and the local Blue Cross plan will pay $1,800 for that service. Well, if you are not benefiting from that discount, you lose the benefit of your own funding pretty quickly. It is just the way the hospitals, out-patient clinics, rehab clinics—virtually everybody does that. They have a charge rate that virtually nobody pays, and they have a rate that most of their customers pay, which is significantly reduced.

Mr. JOHNSON OF TEXAS. But you are still citing some facts and not telling me what we need to do specifically as a Congress and what you need to do as an agency to make it work.

Mr. SCULLY. I think as an agency we can work on some demonstration programs to use high-deductible Medigap plans and to make sure that we are trying to risk-adjust them appropriately so we are putting the right amount of money into them.

Mr. JOHNSON OF TEXAS. What does the Congress need to do, in your opinion?

Mr. SCULLY. Well, the issue there is at what point do you—there is an existing limit, which we are going talk about in a few minutes, which kicked in in Wisconsin that the beneficiary cost-sharing can't be more than $105.31 a month. When you get into high-deductible plans, obviously as an actual matter you probably get above that, depending on how you allocate your resources. But clearly, if people wanted to have catastrophic coverage, drug coverage, and trade that off for higher deductibles on hospitals or physicians, that is an option that doesn't exist right now.

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

Chairman JOHNSON. Mr. Kleczka.

Mr. KLECZKA. Thank you, Madam Chair.

Let me start off by thanking you for calling today's hearing. As the Administrator said, there are six other areas in the country

having a similar problem to Wisconsin and the UnitedHealthcare problem. So I think it is important that the Subcommittee examine what is going on in the Medicare+Choice marketplace and in future meetings try to respond to that.

I also want to acknowledge my colleague from Wisconsin Mr. Ryan, who is with us today, who, although his district has no Choice plans left, has interest in naturally the direction of the Medicare Program.

Mr. Scully, I also want to acknowledge you and thank you for being accessible over the last weeks. I think you showed true concern for the problem in Wisconsin and I am assuming the other parts of the country. As you know, we did talk numerous times. You did go back to the negotiating table to try to get the rate down, and you did to a small degree. I find the ending rate still outrageously high, but you tried. In my experience here in Congress, I have very few administrators such as yourself give me their home number. So if we don't get a better correction to this problem, you are going to be the recipient of many pizzas, but I do want to thank you.

You did, on Friday, announce that there will be a special enrollment period for those seniors in the UnitedHealth plan that chose to leave before the end of the year. Could you explain to the Committee if that is an existing authority in the Agency, and what is the criteria for you to grant a special enrollment period?

Mr. SCULLY. It is an existing authority in the Agency that, unfortunately, until Friday when I called you, we didn't realize we had. I think it was a difference of legal interpretations. I was not aware until Friday. I think it is good news. The issue is—hopefully we can get it out broadly—we declared a special election period for December so that seniors have an extended enrollment period in December to make their choices about changing health plans. By virtue of doing that, which I was unaware of until recently, we have the ability to give seniors the ability to drop out during the month of December and have the opportunity, for I think it is 63 days up until March 4, to enroll in a Medigap policy.

Mr. KLECZKA. Based on what rationale?

Mr. SCULLY. Apparently when we declare a special election period, we have the ability to waive the Medigap guaranteed issue restriction. It is not just in Wisconsin. So anybody in any plan, even if their plan stays in under prior law—just to clarify, because you have been more involved in this than others, previously if you were in Medicare+Choice plan, and you were an enrollee, and your plan stayed in that county, and you wanted to get out, there was no guaranteed issue for the Medigap plan. By virtue of us declaring an extended enrollment plan for December this year, the Secretary has the authority to basically give people guaranteed issue rights to get into a Medigap plan. So anybody that drops out of Medicare+Choice in December 2001, even if their plan remains in that county—United being an example this year—has the ability to get guaranteed issue into Medigap up through March 4, which is a significant benefit for people who have found that their copayments or premiums have gone up, and Medigap is a better deal for them. And one of the real concerns we both had in Wisconsin about people that wanted to get out of a plan with higher cost sharing

and switch over to Medigap, and when we first discussed this, I did not believe this option was available, and I was very happy, as I dug further, to find that it was.

Mr. KLECZKA. Like you, I join in your happiness that we do have this option so seniors not only in Wisconsin but in other States aren't trapped into a plan because of the legislative enactment of Medicare+Choice.

Now, what begs the question is, how are we going to notify, for my situation, the 16,000 seniors who are currently enrolled in United and try to get through all the mail that they are going to be getting during the holiday period to give them the news that should they decide and desire, they can dis-enroll with United, go back to fee-for-service, and then have a clear shot of getting a supplemental? How is your Agency going to inform at least this group of seniors?

Mr. SCULLY. It is a broader problem beyond your district, but certainly the word—we are trying to figure out the best way to do it now. Our concern is that it might be confusing to send out a mailing this month with all the other mail that comes through and all the information they have gotten from us already. So we are looking at a lot of other options as to what to do as far as working through our State health insurance programs with our partners in educating seniors, as well as working through the plans. We are making an aggressive effort to make sure that every senior that signed up for this plan knows that is an option.

We haven't quite decided what is the best way to go as of yet. We will be happy to work with you in the next week or so to figure that out. We have not decided whether an additional mailing is an appropriate route or whether we should go through the State health insurance department, State health insurance programs. We only discovered this on Friday, so we are still trying to figure out the best way.

Mr. KLECZKA. We better start acting on it immediately. And I will ask UnitedHealth some questions on this very same thing.

One last question, Madam Chair, if I might. Based on the other six plans that had similar problems in Wisconsin, were any as high in, let us say, the inpatient hospital deductible? Currently, as you know, for the United Choice plan, there is no deductible, no copayment. Their initial intention was to raise that to $350 a day. Through your efforts it was reduced to $295. Any other plans that fit that same criteria relative to such a dramatic change?

Mr. SCULLY. There were a few others around the country. There were seven that my staff came to me with right off the bat. We are calling them up and fixing them. And United is a little more complicated. I spent a lot of time with them. I think they did have some good arguments. They do have $4,800 stop loss, which is a catastrophic cap that a lot of plans don't have. You can debate the merits of that, but the fact is that most Medicare+Choice plans do not have the catastrophic stop loss.

The real compelling factor to me when I sat down with them is we can't force people. I spent a lot of time this summer, as I testified before, trying to call chief executive officers (CEO) around the country and say, please, on the margins, stay in. I hope, certainly, the Congress will fix the funding formula. And I spent a lot of time

talking to many plans, including a couple of Mrs. Johnson's plans in her State that did drop out, trying to encourage them on the margins, to stay in one more year, and hopefully the program will be fixed.

I talked to the CEO of United this summer, Dr. McGuire, and asked him to do that, and I think they made an effort in many districts to stay in. I told them $350 was not acceptable, and they lowered it to $295. I asked them to make a number of changes, and I said, "Look, if you can't make the changes, I would like to see your financial statements, and come in and show me that your medical loss ratios is how much you spend in Medicare, and your administrative loss ratio, your projections add up to pretty close to 100 percent." And theirs did; from what I can tell, close to around a little over 99 percent.

And my belief is we can't force somebody to lose money in this business. They aren't making money in this business. They stayed in Wisconsin in the hopes that the funding will be fixed. You can debate the merits of how they set up their plan. The plan was scored by our actuaries as being under the $105.31 monthly cost sharing out-of-pocket equivalent. And so I think I did the best I could to make the adjustments I could, but I couldn't force them to lose money, and I don't think they should be expected to do that. I think under the circumstances, United reacted responsibly to what my requests were, and I think had I seen that they had a total spending of 90 percent, I would have felt differently.

Mr. KLECZKA. Thank you for your help in this matter, Mr. Scully.

Chairman JOHNSON. I am now going to recognize Mr. Ryan, who is a member of the full Committee, not a member of this Subcommittee, but is keenly interested in this situation in Wisconsin. Mr. Ryan.

Mr. RYAN. Thank you, Madam Chairman. I was interested in what you said earlier, because as my colleague in Wisconsin just north of me noted, we lost all the Medicare+Choice in my area. Three years ago PrimeCare or UnitedCare pulled out of our area then, Racine, Kenosha and Walworth Counties. This year the last provider is pulling out. At that time 3 years ago when United pulled out of our area, we were able to in that give-back bill, the Medicare+Choice bill, increase the reimbursement rate for counties like southern Wisconsin counties.

Blue Cross came in and provided basically the same benefit, and they just pulled out this year reporting—and I was able to take a look at their books because I had the same questions you did—they reported $38 million in losses in that area, in Medicare+Choice, in our State.

So what we have seen in Wisconsin and what we saw already in southern Wisconsin, like what Mr. Kleczka is seeing in the Milwaukee region, is that this program isn't working. This formula isn't working. And when we take a look at this formula, you know, to put it quickly because it is such a complex issue, the formula is so flawed in its base premise that it basically rewards States that in the past had inefficient systems, had high, high costs, and it penalizes those States like Wisconsin that had efficient health care that kept its costs in check, and we were penalized with a lower

reimbursement rate. And since the inception of Medicare+Choice, we have never really fully addressed that issue.

In the past I have always been part of the legislative effort to fund the blend, to try and average the AAPCC system together to try and get the same kind of benefit in Wisconsin that seniors in Florida and other areas got, but we have really been unable to accomplish that.

I just got this GAO report and haven't had a chance to look at it, but I was interested in something you just said a minute ago, that the money that had been sent from Congress back into the Medicare+Choice program was sent to the wrong places.

Could you give me more comment on that and isn't this a case of literally having to redesign the entire formula so that it more appropriately and adequately addresses the true cost of providing the same benefits for Plus Choice across the country and were the last few Medicare+Choice bills written in more or less an inaccurate way, so that it actually benefited areas that shouldn't have gotten the benefit and left areas short that really needed the benefit because, as evidenced by the fact that we had this pullout in Milwaukee County, we saw the pullout in all the other areas in Wisconsin like other parts of the country, it just isn't working.

So the problem we have is everybody paid the same Medicare tax wherever they worked and lived in this country, but they are not getting the same benefit where they retire. That is especially true in Wisconsin.

So could you give me an idea of where we missed the boat, how our formula is flawed right now today and how we should fix it, and why and how we sent money to the wrong areas and how we can fix that, hopefully this year in this session?

Mr. SCULLY. I wish I could give you all those answers. I can give you some opinions. I mean, if you look county by county nationwide at the fee-for-service spending, there are massive variations, and I don't think the Medicare+Choice program can fix that. Everyone does pay the same taxes, but they most certainly don't get the same benefit in fee-for-service either. If you look at the county-by-county difference, the managed care plans are still loosely based on fee-for-service spending, and if you look at Miami or Los Angeles or New York City versus Milwaukee or rural Wisconsin, there are massive differences in what is spent, 2-to-1 in some cases in the Medicare Program, and those are due to practice patterns, hospital costs.

There are a lot more things going on in this program than meets the eye right off the bat. Believe it or not, Wisconsin's rates have actually gone up a little better than some other States in the last few years; they were lower to some degree, but the point about CBO is when you make actuarial judgments—like in the past few BBA bills, CBO makes a judgment about if we bring up the floor rates, which are based on the rural counties, by X number percent, how many people show up to provide those plans, and they assume that money will be spent and it is allocated in this way.

What has happened is nobody has shown up. So you have many rural counties across the country in Iowa, Minnesota, Wisconsin, and other places where Congress put money in assuming that if you put those plans together, they'd come, and nobody has come.

There are many reasons why they didn't come, including the fact there was an assumption 5 or 6 years ago when I came out of the hospital business when hospitals were reasonably weak, and basically, most managed care plans could negotiate significant discounts from them. Hospitals have got smarter, tougher, there has been a lot of hospital consolidation.

It used to be managed care plans could get significant discounts from Medicare fee-for-service amounts and Medicare+Choice, and now they are frequently paying 130 percent of what the Medicare Program pays because the hospitals have basically said, "we don't want to negotiate managed care," and they have gotten a lot tougher and stronger in the negotiating position. They have more leverage.

So in a lot of rural areas, we have one hospital chain, you show up with a managed care plan to offer Medicare+Choice and they say "we don't want you." So it is almost impossible to put together a network. So there are a lot more things going on here as to why Medicare+Choice just hasn't shown up, but my point was that Congress allocated money that is sitting there theoretically for somebody to show up and spend, and no plans have shown up.

So theoretically, the money was arguably misallocated, but the way the budget rules work, once it is put there, if nobody spends it, it is gone. So—and a lot of what Congress had done in past years was try to put money into the rural areas because theoretically, we are on cruise control in the urban areas, and what has happened in places like Atlanta, Milwaukee and other places where the—it was popular and there actually are managed care plans and people showing up, and there are multiple hospitals competing in the business and it still works reasonably well, is they have had 10, 11, 12 percent a year in, "inflation increases," and 2 percent cap increases in their Medicare rates and the math doesn't work.

Mr. RYAN. Well, I see my time has run out, but the risk adjustment you mentioned, I think, needs to be addressed by your agency because one of the base assumptions when Medicare+Choice was written in 1997 was that the healthy people would go. That is not the case. It is more sicker seniors and we need to work on that risk adjustment.

Chairman JOHNSON. Mr. Lewis.

Mr. LEWIS. Thank you, Madam Chair. Madam Chair, like my colleagues, I want to thank you for holding this hearing. I think it is very timely. Mr. Administrator, I thank you for being here. I have some question regarding your efforts on the 800 line. You mentioned in your prepared statement that you are spending more than $30 million in a massive advertising campaign to reach out to people. Are you tracking the questions, the concerns of the seniors that are using the 800 line?

Mr. SCULLY. Yes, sir. We have spent—it is not just the 800 line. We also spent quite a bit of money more than doubling the number of operators answering the 800 lines giving a lot more detailed information, and we do have—I think we have a million dollars-plus contract to evaluate it, and when the campaign is finished on December 16, we will have a report to Congress on how it went, and I know the appropriators, who were nice enough to allow me to reprogram the money for this year, because it is the first time I have

ever done it, will be as interested as I am in figuring out how it works, but we have gotten—we peaked at about 65,000 phone calls a day. I think we are still running about 30,000 calls per day. And I think it has been very popular with seniors, and one of the things that I found out when I came into the agency was that seniors love the Medicare program.

They think it is a great program. But they don't understand the difference between their Medicare premium of $50 that comes out of the Social Security check or Medigap, or where to find the nursing home or dialysis clinic. They love the program, but they are incredibly underinformed, and my view was that when we are spending around $7,000 a person on Medicare, spending 80 cents per person per year trying to give them better information about where to go is a good investment.

And fortunately the Appropriations Committee, at least for this year, agreed, and I hope they will agree to do it in the future, but so far I think it has been very successful. I hope we will find that out during the more objective evaluation. My personal evaluation—I still call the 1–800 number pretty regularly—they are probably tired of getting my mom and dad's information, but so far I have been pleasantly surprised. The operators have been great, the information has been great, and I would invite you to call yourself.

Mr. LEWIS. I will try. I will do it. Are you spending resources on both printed and electronic media?

Mr. SCULLY. Yes. We spent $30 million. You would probably be particularly interested, I hope. One of our concerns was that obviously minority and particularly the Hispanic—Spanish-speaking Hispanic population is more unaware of their Medicare benefits. I think we spent 20 percent of the finances on the Spanish media. We have spent a lot of advertising on Univision, Telemundo, and we in fact, have a whole separate ad campaign.

You may have seen the Leslie Nielson one on TV, but there is a separate one running on Spanish language TV. There is a large print campaign targeted at minority communities across the country, because obviously, they are the folks that tend to understand Medicare the least, but I would be happy to share our ad budget with you and show you——

Mr. LEWIS. I would be very interested in seeing it, Mr. Administrator. I think it is important to reach out to the minority community, the Hispanic, African American, and others that need to receive this information to get the necessary information in help and assistance.

Mr. SCULLY. I can assure you that I am very sensitive to that, but my deputy, Ruben King-Shaw who is, as you probably know, African American, if I ever forgot it, he reminds me about 40 times a day. And he spent a lot of time working on the ad campaign.

Mr. LEWIS. Thank you very much. I appreciate it. Thank you, Madam Chair.

Chairman JOHNSON. Mr. Camp.

Mr. CAMP. Thank you, Madam Chairman. Mr. Scully, thank you for being here and for your testimony. I know a couple of times at least through the discussion, you have mentioned that payment increases have not kept pace with costs, and as a result, there has been increased cost-sharing and reduced premiums have resulted

from that. And as you look at the reasons that Medicare+Choice plans have pulled out of the program, GAO cites in their report that it is for reasons other than payment, and I was just wondering what else needs to happen to make this program work, particularly what can Congress do to help make this program work?

Mr. SCULLY. I am actually surprised to hear that I really do believe that the biggest issue is really finances. I have tried—we have done a lot of things that, I think, make it easier. It was not uncontroversial that we moved the filing date back with a lot of encouragement from some in Congress to September 17. I believe, and some of you may know, I was on the board of Oxford Health Plan, for one of the big Medicare+Choice plans, for 8 years while I was in between my government stints, and I watched a lot of what they went through in Medicare+Choice.

It is very difficult in June or July to make a judgment on what your revenue's going to be for the next year, what your costs are going to be for next year and decide whether you are in or out and decide how you are going to accurately set the premiums. The longer you can wait, as an actuary, the easier it is to way make those judgments. Obviously, there is a tradeoff there about how long you can wait to tell the beneficiaries what their options are, and we have tried to reach that balance. I think that helped. I think we streamlined a lot of the options for managed care plans as far as their—you know, how quickly we look through their filings. I hope that has helped.

I think we have given them options to do more easily wrap-around seamless plans for employers. There are an awful lot of people that have managed care plans in their employer base when they hit 65 and they are retirees. They have to drop out and rejoin Medicare. We have made a number of changes this summer to make it more seamless so that employers could design wrap-around Medicare plans so that when employees hit 65, they could switch to Medicare without really knowing it.

So I think we have made a lot of changes to make the plans' lives a little bit easier. I am sure there is more that we can do. I think we have been pretty open to that. We have, as you may know, created 11 working groups. One of them is for managed care that includes all the beneficiary groups and the unions and patient advocates and the plans. We try to work with them all to sit down every couple of weeks and figure out what we can do to fix it. We are going to keep plugging away.

But I really do believe in many counties, this is still a great plan. In some counties, it is a terrible plan. I think a lot of it is funding and a lot of it is the distribution of the funding.

Mr. CAMP. We have put some funding in in the last two pieces of legislation that we have passed; yet there is still a lot of instability. You still think that is the primary——

Mr. SCULLY. I really believe—I may be wrong—most of that funding was put into what are called floor counties, which are mainly the rural counties to bring up the base, and if you look at it there are still shockingly few—I mean, Senator Grassley, who we all worked with a lot, was interested in—a lot of people in the Senate from rural States were interested in having Medicare+Choice, which had been popular in urban areas, to come into their States.

If you look at it, there is still very little Medicare+Choice, almost none in Iowa. Very little—I mean, we put in funding into the rural areas, and the fact is, managed care plans are not interested in offering the benefits there. So we created the magnet and no one came, I think.

Mr. CAMP. OK. Thank you very much.

Chairman JOHNSON. I would just like to clarify that the point is that the big money that went into Medicare+Choice went into creating the rural floor. Since there aren't plans, hasn't been any big growth of plans in the rural area, that money is actually not being spent. So it is not going into the Medicare+Choice system.

In the highly populated areas, because of the budget-neutral nature of the 2 percent or blend options, the money is not going in; so while $5.9 billion was supposed to go into that area according to CBO, only $2.2 billion went in. So where the recipients are, where the seniors who benefit from the programs are, they got no more than 2-percent increase and in the rest of the Nation they got huge increases, but there was no plan there to serve, and I think when you look at the number of years that the budget-neutrality provisions have limited the increase to 2 percent in an era when costs were rising much more rapidly and we were increasing reimbursements under Medicare fee-for-service at twice the rate, you can understand why these plans are doing poorly.

Now, no company puts a big investment in any new product, I don't care whether it is machine tools or whether it is health care, and not want to stay there, and the fact that plans are withdrawing isn't because they are lily livered, it is because they can't afford to stay. And if you look at what investors are saying about these plans, you can see the tremendous pressure from the private sector for them to pull out. That is all direct evidence that we are radically underfunding the choice options, and what the seniors are telling us is they like them and we have an obligation to tend to this issue. Ms. Thurman.

Mrs. THURMAN. Thank you, Madam Chairman, and thank you for having this hearing, and I would say to Mr. Scully that I agree with Mr. Kleczka that we have had an ability to get a hold of you, and we do appreciate the fact that you are very accessible to us when we have questions.

Mr. SCULLY. I love pizza, by the way.

Mrs. THURMAN. You love pizza? I don't have your home phone number that I know of. But I am a little concerned about what I am hearing today and I would say to Mr. Ryan, I have to tell you that I made your very same arguments 2 years ago when we had some of these hearings about Medicare and MedicareChoice that it was the same tax dollar, that this was, in fact, supposed to be a program that we all are supposed to enjoy and the benefits should be the same.

So I agree with you. I think there is a potential discrimination against this, but in saying that, one of the things that has concerned me, Mr. Scully, and maybe just because it wasn't asked for, but in your report that you gave us on the Medicare+Choice changes in access benefits and premiums, the one thing that we don't compare any of this to is fee-for-service. All we talk about is what is happening in the Medicare-for-Choice and not really look-

ing at what happens to the benefits under Medicare-for-Choice as versus what is happening under fee-for-service, and let me just give you an example.

In our Medicare and You 2002 Handbook, under the part where it talks about hospital stays, for example, it says for each benefit period, you pay a total of $792 for a hospital stay of 1 to 60 days. Under one of the current plans that we have discussed and we are hearing a little bit about, right now the copayment in inpatient hospital co-pay is $295 per day. It only takes 3 days to get almost to that $792. And then on top of that—so I did a little calculation and found out that under original fee-for-service, if I stayed in the hospital for 190 days, my out of pocket under fee-for-service would be about $6,554 but under the plan it would be $26,550. And if I am wrong, then that is fine. I just need to understand where I have made this miscalculation.

Mr. SCULLY. You are——

Mrs. THURMAN. But remembering this is under a plan in an area of—that we are looking at. The second would be then, I guess, under that same calculation under skilled nursing facilities, it says it went to $125 per day, but if I go into the skilled nursing I get the first 20 days basically free under Medicaid fee-for-service; is that correct? OK. But then under the plan that I am looking at, it would cost me about $12,500 under a particular Medicare+Choice plan, saving me then about $4,729. Now, if I am wrong——

Mr. MCCRERY. Ms. Thurman.

Mrs. THURMAN. I just want to be corrected.

Mr. MCCRERY. What plan are you looking at? Would you share that?

Mrs. THURMAN. I would prefer not to say, Mr. McCrery, because I don't want to take any shots at anybody at this particular time because I would rather have the opportunity to work out, but I can assure you this is a plan that is in the district that I represent, and we have looked at it very closely.

Mr. MCCRERY. OK. Thank you.

Mrs. THURMAN. I don't want to take shots at anybody.

Mr. SCULLY. I think I know the plan. I may be wrong but I hope—I believe that plan has a $1,400 catastrophic cap. Theoretically, you have to spend about 80 days in the hospital before you get to the break-even point, but——

Mrs. THURMAN. But even if I spend 3 days in the hospital under the $295, I am still almost to that cap; so if you stay to 4, I am still $200 less or paying more under my managed care than I would be under my fee-for-service so—-

Mr. SCULLY. I think the argument on those plans because I have had it with them the last 2 weeks is that for a senior—obviously, if you are a poor senior, you are in trouble in any case, but if you are relatively low-income senior who doesn't want to buy a Medigap plan and is worried about catastrophic coverage, you limit your catastrophic potential to $4,800 a year, which is something that Medicare does not cover and a lot of Medigap plans don't not cover.

Mrs. THURMAN. But does Medicare+Choice?

Mr. SCULLY. Well, hopefully you have an informed choice. That is the issue. And that you can drop out and if you want to join the

Medigap plan. But the Medigap plans are obviously very expensive and some of them don't have any catastrophic caps anyway.

Mrs. THURMAN. So I guess what I am trying to get at is that I would really like to see you all at some point do the comparison for those issues for fee-for-service because, quite frankly, the other issue is, and you make mention of it in your sheets again, that most of the drug coverage will decline in the overall population. Three States already are going to see significant declines in access to drug coverage. We already know that most of them are losing brand names, going to generic. The annual maximums are going down.

So I am trying to figure out if I have a senior come into my office and say, you know, Karen, I really need some help here, I am having a hard time understanding. If I have a real concern that I am sick or what—and I am looking at all these different things that I might have an option to, but the fact of the matter is under what currently fee-for-service is, which I pay my $50 with no premium other than that $50, I may be better off long term than I would if I went under a Medicare-for-Choice program, and if just you looked at—again, and I understand the 100 day part of it, but still $4,729, just under the skilled nursing, that is a drug benefit for me as a person. I mean, I might be able to——

Mr. SCULLY. I think that plan has a $4,800 catastrophic cap, but again, you have to get of a lot of service before you get there. I think the issue is the Medigap plans are also incredibly expensive. And when one of your seniors comes in and says, "am I better off under Medicare+Choice?" The real comparison is Medicare+Choice versus Medicare plus the Medigap and the premium, it is not always—it is not a simple calculation. I hope our 1–800 number has helped answer some of the questions.

I know the State health insurance programs which get grants from us, help that. But it is not an easy calculation. We do, in fact, have those comparisons, and you can get them on the Web site, but you have to compare—we do have those kind of breakouts on the Medicare+Choice plans, and you basically have to go back and compare it to the fee-for-service, and they are not—you know, you have to be kind of fast on the system to get there, but all of that information is on there.

But you are right, it is not always easy to figure out. It is one of the things we are hoping to help explain to seniors, but trying to figure out and sit down, because I have done it with my parents, and figuring out whether you are better off with Medigap plus fee-for-service or Medicare+Choice is a tough calculation in many cases.

Mrs. THURMAN. Then the follow-up question I would have to you because you made the statement with Mr. Kleczka that, and he was thankful that you went into negotiations with some of these plans, and in fact we did see the benefit or the premium reduced and/or the copayments reduced. When you talked to them, I mean, was that a part of the—I mean, I don't—is that a part of the conversation with them, I mean that here is what they could get under Medicare fee-for-services versus what you are giving them to under Medicare-For-Choice as to—as arguments? Can you give me some——

Mr. SCULLY. Yes. That is exactly the issues in the one case which we have talked about, $350 deductible seemed to me to be high and seemed to our actuaries. They brought it to me. The staff came to me and said we have 474 filings and we have seven that we think are the outliers that may, in fact, you know, not have the appropriate incentives for beneficiaries. And we talked to all seven of them to make changes, and the most difficult one was United, and the reason was they felt very strongly that the most attractive part of their plan was the $4,800 catastrophic cap.

We were concerned about the incentives provided if somebody was going to have a lot of hospitalization. You know, the reality is in a lot of cases, what happens is the hospitals eat the bad debt, but we were concerned about that. We knocked it down. But to be honest with you, the real issue for me was when I looked at their finances and found out that they basically—it wasn't like they had 90-percent loss ratios. They had 99-percent loss ratios, which is the combined administrative and medical costs, and I didn't think they had any more wiggle room; so I pushed them to change their benefits as much as I possibly could, and legally we have limited authority not to have them in there and to be honest with you, a lot of these plans stayed in there because I asked them to hang in there for one more year until Congress changed the benefits. So we were kind of between a rock and a hard place.

Mrs. THURMAN. So that analysis is available then?

Mr. SCULLY. Mainly with me, but I would be happy to go through it with you. It was largely me talking to them with a couple of my staff.

Chairman JOHNSON. Congresswoman Dunn.

Ms. DUNN. Thank you very much, Madam Chairman, and it is good to see you again, Mr. Scully. Thank you for being here to listen to our questions and our objections and our support and everything that goes into trying to beef up this program, so it becomes an efficient additional choice for people. I come from the State of Washington where health care has been provided in a very efficient way for the last 20, 25 years we have used HMOs, and people in Washington State, and especially in my district, appreciate this choice.

Obviously because our reimbursement rates are lower, we feel like we are being penalized for our effective delivery of efficient services and so the funding of the blend is very important to us, and budget neutrality has been a problem for us. But in the 1 year that we were able to increase our payments, we were very appreciative. One of our HMOs, I think it was Group Health actually passed the savings through to its—to its customers, and we appreciate that very much.

I want to ask you a question on a bit of a different topic today, though, that has to do with the Department of Veterans Affairs (VA) and the ability of veterans to be counted among Medicare beneficiaries when it comes to the reimbursement rate. Two years ago we required HCFA to submit a record, a report accounting for the health services furnished by the U.S. Department of Defense (DOD) and the VA to Medicare beneficiaries in both the Medicare+Choice program and also in fee-for-service, but since Medicare+Choice, that formula does not account for the services

that are provided currently in military facilities, the reimbursement rates in Washington State and other areas with high military presence are going to be lower than they really should be.

So I am curious, has the Centers for Medicare and Medicaid Services (CMS) completed this report and how can CMS address this issue so that we can find greater equity among the health care plans?

Mr. SCULLY. Well, I am not sure I have great news for you. When I knew you might ask this question from your staff, I looked into it. Apparently this report is done and should be sent to you shortly. It is in clearance, probably sitting in my inbox, but I will get it to you quickly, but I think what I learned last night was one of the conclusions was that we had limited ability to get good data from the VA and DOD and so there really was not—I think you are going to find one of the conclusions of this report is probably not going to be what you are looking for. Part of that is from not having good information. Now that I am more aware of this, Secretary Principi is an old friend of mine, I will try to work with the VA to get better information and with DOD and see if we can come up with more than I think is in the report that is coming to you. It goes through all the problems, but probably doesn't give you the results you want.

Ms. DUNN. We would very much appreciate that, and I think other folks who represent military areas, if they haven't noticed this inequity, it is important to a lot of us around the country. So we would appreciate your working with him to get the information, see if you can't get this one squared away. It is only fair and right now we are penalizing our recipients. Thank you. Thank you, Madam Chairman.

Chairman JOHNSON. I would like to recognize Mr. Cardin, who is also not a member of the Subcommittee, but has been very involved in our work.

Mr. CARDIN. Thank you, Madam Chair, and I very much appreciate the courtesy, and I appreciate your holding this hearing.

Mr. Scully, it is always nice to hear from you. I don't think there is much you could do or Congress could do on the reimbursement structure that would affect choice in the State of Maryland. Maybe you disagree with that, but from my conversations with the HMOs that have left the State of Maryland, any changes we make here in the reimbursement structure will have virtually no impact on their decision to stay out of the Maryland Medicare market. We could argue why, but I am not sure we are going to have any impact.

It seems to me that there are two approaches we could consider in regard to beneficiaries in Maryland. One is what Mr. Stark has talked about, and that is offering or expanding choice within the government-run insurance program by offering more choices than just straight fee-for-service Medicare. We do that, by the way, in Maryland, through the Municipal Health Services Program, which still exists in the State of Maryland. That program offers government-run HMO coverage to Medicare beneficiaries in my State. Second, if Congress does move forward in covering prescription medicines within the basic reimbursement structure—if it becomes a covered benefit within Medicare—a lot of the uncertainty and a

lot of the marketing changes will end. Reimbursing plans for the cost of prescription drugs will give us a better chance to attract private insurance companies into the Medicare market.

So I would appreciate your comments as to my observations. Is there anything we can do for the people of Maryland, and what is your view of the two suggestions that I have made—looking at a more innovative approach within Medicare itself, and of course, you are already on record on prescription medicines?

Mr. SCULLY. Well, among other things, I think you may know my dad was—I think he is close to one of your constituents and was in the Medicare+Choice in Maryland and lost that a couple of years ago. I can tell you from personal experience, his options that he had to fill in were significantly less fun and more expensive. I think one of the problems, and I watched this when Oxford dropped out county by county, when seniors lose the option, they get angry, and so once the plans drop out—one of the reasons I have tried to get a lot of plans to stay in by a thread this year is once they get out, seniors get angry, it is hard for them to get back in, and in some cases, they can't get back in under the law, but when they raise copayments, they raise premiums, they finally make the decision to get out, it is a big expense to get back in. It is a big expense to market.

Frequently they leave irritated seniors and they just aren't getting get back in for a while. So getting them back in, you have to make it a pretty good deal to get them back in once they drop out.

So I think you are probably right. I think one of the ways to get people back in is to change the benefit structure and then it is probably more expensive than we are talking about, but as I said, Medicare+Choice does not—there is only one PPO in the country basically, and that's Independence Blue Cross in Philadelphia. There are a couple other quasi point-of-service plans, but what most people under 65 want, and most of us are in, are hybrid plans that have some of the characteristics of managed care, and some of the characteristics of indemnity where you basically get to choose, and if you want higher co-payments or higher deductibles, you can go outside the network and go to any doctor you want.

So if you find out you have colon cancer and you want to go to a specialist, you can get any doctor you want. It doesn't have to be in the network. You are just going to pay a little more, and that is what is exploding in the under-65 market, and that is what sick people want, and it doesn't exist in Medicare outside of a couple of counties in suburban Philadelphia. I think that if we really want to make the private sector models an option in Medicare for seniors increasingly in the under-65 market, traditional HMOs are disappearing and these hybrid plans are what are exploding and that is not an option in Medicare. You either have traditional fee-for-service or you have basically a closed plan, managed care plan and there is nothing in between.

Mr. CARDIN. Of course, Congress had hoped that Medicare+Choice would encourage more private insurers to come up with these different models. We didn't want to just limit options to the traditional HMO and government fee-for-service. If I understood Mr. Stark's point, why not experiment with Medicare itself within the government-run program so that if the private sector is

not willing to offer coverage we should devise different benefit models within the Medicare system at the same level of public support. This way, we would not be putting the private sector at disadvantage.

Mr. SCULLY. Well, there are a lot of things that I think we can also experiment with that I am very interested in, like disease management capitation—like capitating some of these end-stage renal disease, ESRD, payments. There are a lot of places in the traditional Medicare Program where you can basically set up kind of many disease management programs to create the right incentives that are still in the traditional fee-for-service program, and we are looking at doing a lot of those things.

Mr. CARDIN. I will be talking to your dad to lobby you on behalf of new programs for Marylanders. Thank you, Madam Chair.

Chairman JOHNSON. Thank you very much, Administrator Scully. It is pleasure to have you before the Committee with your broad background in the history of Medicare and the problems it faces, and also the depth of your insight into the opportunities to strengthen it and offer to seniors some of the options that they clearly have demonstrated that they want. Thank you for being with us. We look forward to working with you to solve these problems. Thanks.

Mr. SCULLY. Thank you. The administration is very committed to helping you try to fix this, and we appreciate your invitation today.

Chairman JOHNSON. Thank you. May we now have Ms. Stephanie Sue Stein, the director of the Milwaukee County Department on Aging; Mr. Richard Jones, president, Government Relations, UnitedHealth Corp.; Mr. Peter Haytaian, vice president, Government Programs, Oxford Health Plans. Each of you will have 5 minutes. You may submit your statements in whole for the record and highlight them in your 5 minutes.

I will recognize Mr. Kleczka at this time for purposes of an introduction.

Mr. KLECZKA. Thank you, Madam Chairman. Madam Chair and members of the Committee, it is a great privilege for me to introduce a good friend of mine and a very good friend of the seniors, Stephanie Sue Stein, who is director of the Milwaukee County Department of Aging since 1993, and for the previous 19 years, was director of the Older Adult Services at Milwaukee's Social Development Commission. This outstanding agency that she currently is director of serves over 160,000 persons age 60 or older who live in Milwaukee County.

Ms. Stein has been a strong and effective voice for seniors in our community and throughout the Nation. She is an enormously well-respected and innovative leader and a tireless advocate for elder rights. I have had the privilege of working with Stephanie on a number of projects over the years and have always been impressed with her unfailing dedication to the seniors in our community and her impressive expertise on aging issues. It is a great pleasure for me to introduce Stephanie this morning and we look forward to hearing her comments.

Chairman JOHNSON. Thank you. I would also like to make just a very brief comment about Mr. Jones and the Oxford Plan. They have really been one of the creative actors in Connecticut and the

northeast in not only Medicare+Choice, but also in managed care in general. When they were the first ones to offer to the general public a managed care plan that covered acupuncture and some of the alternative medicine approaches. So they have been a very creative contributor in this era of dynamic health benefits. Sorry, not Mr. Jones. Mr. Haytaian. Sorry.

We will start in alphabetical order, Mr. Haytaian.

STATEMENT OF PETER HAYTAIAN, VICE PRESIDENT, GOVERNMENT PROGRAMS, OXFORD HEALTH PLANS, TRUMBULL, CONNECTICUT

Mr. HAYTAIAN. You want me to go first? Can you hear me? Madam Chair, Congressman Stark, Committee members, thank you very much for having me here today. My name is Pete Haytaian, and I am the vice president of Government Programs at Oxford Health Plans. We have—for those of you who aren't familiar with the plan, we are a Connecticut-based, New York regional plan that has 1.5 million members, 85,000 of which are currently Medicare+Choice members. When I joined the plan back in 1998 and took on the position of vice president of Government Programs, we, in fact, had 160,000 Medicare+Choice members and as I said today, we are down to 85,000 members, and as of January 2002, unfortunately down to 65,000 members. At the core of the problem—without repeating everything that has already been discussed, the core of the problem is in most of the counties that we were in predominately in places like Connecticut, all of Connecticut, all of New Jersey, Long Island, the northern counties of New York, the problem is the 2-percent increases that we received every year versus the 8 to 10 percent medical cost trends.

So it is precisely the issue you all have been talking about today, and we have unfortunately had to make a very, very difficult decision to exit those counties over the last couple of years. We are truly committed to the program and love the program and think that it offers a lot. I think there is a couple of points—a lot of points actually that weren't touched upon earlier that I think are fundamental to this program, but let me talk about where we are offering products and what we are offering, because I think we are offering products to all constituencies through the Medicare+Choice program that is fundamentally impacting their lives. Most importantly offering products to the financially vulnerable population, folks that have annual incomes of less than $18,000 a year.

We offer basically 3 products. Our lower tier product is called the Essential Plan, and in this plan we have an almost no-cost sharing. There is no premium. There is almost no cost sharing. There is a zero PCP, primary care physician, co-pay. There is a $10 specialist co-pay. We offer an unlimited generic benefit and the folks that we are targeting for this product are generally folks that are eligible for Medicaid and/or are eligible for State pharmacy assistance programs that I know you are all familiar with, in New York, for example, the EPIC or Electronic Privacy Information Center program, where folks generally can get probably the most comprehensive Medicare benefit package, I would argue, in the country today with all the aspects of everything we talked about today, including unlimited generic, and then being able to pick up brands through

programs like Medicaid and/or State Pharmacy Assistance Program.

We also have a mid tier product where most of our members reside and that—the fundamental distinction between that and the essential plan I just described is there is more cost sharing, but it also includes a $750 brand drug benefit, and then we offer another product to meet a different constituency, a point-of-servce product which Administrator Scully just talked about. But for folks that find premiums in the Medigap program to be exorbitant and want an added network option, we offer a point-of-service product for those folks. But again, our products focus in on the financially vulnerable population, folks that really don't have a choice. We talked about Medigap. The true numbers are that if people want to get comparable benefits that we are offering through Medigap, they are paying in excess of $3,000 a year in premiums in some instances, versus in our case, in the two products I described, zero premiums and unlimited cost sharing, or in the case of the Essential Plan, no cost sharing almost.

One other fundamental point that I want to make that no one has really talked about that I think fundamentally distinguishes the Medicare+Choice program from the fee-for-service program is within all our products, we offer not only disease management programs, but intensive health promotion programs. We built a program called the Falls Prevention Program, which is one of only—I think we are the only ones in the country that built a similar type program, where we built this with Yale.

We identify folks that are at risk for falls, we have OTs, or occupational therapists, and PTs, or physical therapists, that actually physically go into people's homes, meet with them on whether or not they have mats in their homes that are slipping or they have the appropriate durable medical equipment (DME) in their homes. We actually purchase these products for them so that they can prevent unwanted falls. You all hear about disease management programs all the time, but I don't know if you really understand how intensive they can be and how fundamentally they can impact people's lives.

We have a program for folks with COPD, which is chronic obstructive pulmonary disease, diabetes where folks for 7 weeks every week meet with professionals, both doctors and nurses and folks from our plan and learn about their disease in an intensive course. They get a book and they sit in the room for 2 hours and really understand how to live with their chronic condition. These are programs that fundamentally impact people's lives and are fundamentally different than the fee-for-service program when we ask what this program can offer.

So in conclusion, I think this serves a vital need, this program. I think that we can offer a very comprehensive set of benefits to folks that are in a financially vulnerable category. Folks love all the additional programs that we offer where we can offer it. I hope that you seriously consider the bills before you. I know there are a few bills in the House right now that talk about bringing reimbursements in at parody with fee-for-service, and I think that will create stability in the urban areas like we have talked about and it will also give us the opportunity to reenter some counties that

we unfortunately had to exit. So I thank you for your time and welcome any questions.

[The prepared statement of Mr. Haytaian follows:]

Statement of Peter Haytaian, Vice President, Government Programs, Oxford Health Plans, Trumbull, Connecticut

I. INTRODUCTION

Good morning. Madam Chairwoman, Congressman Stark, and other distinguished Committee members, my name is Peter Haytaian and I am the Vice President of Government Programs for Oxford Health Plans. I would like to begin by thanking you for the opportunity to come before this Sub-committee to discuss the status of the Medicare+Choice program.

As you may know, Oxford Health Plans provides services to about 1.5 million members in the tri-state region of lower New York, all of New Jersey, and Connecticut through traditional health maintenance organizations, point-of-service plans, third-party administration of employer-funded benefit plans and Medicare+Choice plans.

When I first joined Oxford back in 1997, Oxford had approximately 160,000 Medicare members in a service area that encompassed all of New Jersey, the greater New York City area, including Long Island, the northern counties surrounding and including Westchester County, and most of Connecticut.

Due to the payment inadequacies of the current system, Oxford has made the difficult decision to curtail our participation in the Medicare+Choice program in 1999, again in 2001 and most recently for 2002. At the core of the problem is the flawed M+C reimbursement methodology in the Balance Budget Act of 1997 that limits the growth of reimbursement in urban areas to two percent per year.

During the same period (1998–2002), most commercial and government health insurance programs experienced annual premium increases ranging from high single digits in the late 1990s to more recently mid to high double-digit increases. Meanwhile medical inflation has been approaching ten percent annually.

Consequently, as of January 2002, Oxford's Medicare Advantage program will serve approximately 65,000 members in a service area that has shrunk to include only the five boroughs of New York City and one county in both New Jersey and Connecticut. (See Attachment A)

We especially concerned with member displacement since a majority of our senior members are financially vulnerable, most with household annual incomes of less than $20,000. Without an M+C option many of these seniors are forced back to the Medicare fee-for-service program and are unable to afford supplemental policies (as high as $300/month) to receive a comparable level of benefits.

In fact, recent research shows that the rate of Medicare beneficiary health maintenance organization (HMO) enrollment is inversely proportional to income. Medicare beneficiaries had a HMO enrollment rate of 28% when their yearly income was less than $15,000. This rate decreased as annual income level increased.[1] In addition, in the urban Northeast, among beneficiaries who had Medicare supplemental coverage that was not subsidized, 41% were enrolled in Medicare HMOs.[2]

II. OXFORD HEALTH PLANS ROLE IN THE MEDICARE+CHOICE PROGRAM

In spite of the existing funding issues, the Medicare+Choice program has demonstrated that adequately funded plans can provide high-quality, comprehensive, affordable health coverage for a variety of populations that is not available in the Medicare fee-for-service program. This is readily evident in the New York metropolitan marketplace.

Through its many years of experience, Oxford has learned to craft its plan design to accommodate the needs of a diverse Medicare population by creating a portfolio of plan choices. Oxford's business decisions are governed in part by our understanding of our members' needs and preferences (e.g. zero premium products and prescription drug benefits), the local medical services market, etc. Oxford's philosophy firmly endorses the concept that one size does not fit all.

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[1] B. Virnig, et al., "Medicare HMOs: Who Joins and Who Leaves?" American Journal of Managed Care, April 1998.

[2] American Association of Health Plans, 2000.

Oxford Medicare Advantage Plan Offerings As Compared to Alternative Medicare Products

Oxford's portfolio includes three plans: The Oxford Medicare Advantage Essential Plan, The Oxford Medicare Advantage Plan, and The Oxford Medicare Advantage Plus Plan. These three options are specifically designed to cater to different populations.

The Advantage Essential Plan is designed to operate in tandem with New York's public assistance pharmacy program (EPIC) and to provide access to low-income beneficiaries. Through EPIC, low-income New Yorkers are able to get brand pharmacy benefits. Oxford also provides additional benefits not provided in fee-for-service program as well as relaxed cost-sharing requirements.

For example, in New York, the majority of members in the Medicare+Choice program are served through HMO products, with little or no monthly premiums. This population is predominated by low-income status beneficiaries that embrace gated delivery system products. For these populations, the Oxford Essential Plan's zero premium provides a rich benefits package that includes unlimited generic drugs, hearing and vision benefits, with no co-payments for in-patient hospital services, primary care physician visits or generic drugs, and minimal co-payments for specialty physician visits.

By contrast, less comparable Medicare supplemental policies are exorbitantly expensive. Last year, in New York, the average annual quote for a Medigap Plan A, which only covers only basic cost sharing was $890, while the average annual quote for Medigap Plan F, which covers 100% of Part B excess charges, was around $1,571.[3] In many instances, this means that beneficiaries would have to choose to pay premiums beyond their means for a Medigap policy to the detriment of other life necessities. Alternatively, Oxford's Medicare+Choice products provide an economical substitute that limits beneficiaries' out-of-pocket costs for catastrophic illnesses without saddling beneficiaries with undue financial burden.

The standard Advantage plan is an example of the traditional Medicare+Choice offering that is based on a zero premium product with a prescription drug benefit. This plan constitutes Oxford's core product. The plan covers physician visits, in-patient and out-patient hospital care, and $750 of outpatient prescription brand name drugs and unlimited generic drugs with minimal cost-sharing on the part of members-less than fee-for-service Medicare but more than our Essential Plan.

Finally, the Advantage Plus plan is meant to capture the beneficiary population that has traditionally shied away from Medicare+Choice in favor of "open access to care" products with additional benefits such as prescription drugs. We have identified this population as "Gap with concern" beneficiaries. The Advantage Plus plan is attractive to these beneficiaries because it combines a "point of service" product with extensive prescription drugs at a premium of $110 per month ($1,320 per year), whereas the national average for the richest Medigap policy (Plan J) is approximately $3,065 a year.[4]

III. THE MERITS OF THE MEDICARE+CHOICE PROGRAM

Oxford's Medicare+Choice Plans Offer Additional Benefits

One of the reasons for the popularity of Medicare+Choice plans is that they typically offer traditional benefits not covered by the Medicare fee-for-service program. All three of Oxford's New York M+C plans include pharmacy benefits, physical exams, vision and hearing services, preventive dental care, routine podiatry services, nutrition services, and a fitness benefit. Oxford also has an education and outreach program that works closely with local Departments of Aging, in order to access the best resources for our members throughout the communities we serve.

Moreover, our roster of participating physicians include more than 15,000 doctors, specialists, and complementary and alternative medicine providers ensures that our members have plenty of choices in choosing a physician. When our Medicare members need healthcare guidance when their physician's office is closed they may telephone Oxford On-Call (OOC) and immediately speak to a registered nurse. OOC is a 24-hour/seven-day-a-week healthcare guidance service operated under the direction of an Oxford Medical Director.

Oxford's Medicare+Choice Plans Offer Innovative Patient-Care Programs

Some of the most popular Medicare+Choice programs for our beneficiaries are the innovative disease management programs. Oxford's current M+C disease manage-

[3] Weiss Ratings, 2001
[4] Weiss Ratings, 2001

ment programs include stroke prevention, dialysis, asthma, congestive heart failure, and diabetes.

Oxford's Options for Living With Lung Conditions is a self-management program is designed to empower the lives of Oxford members living with chronic obstructive pulmonary disease (COPD) and asthma. A seven week workshop was created to educate members on lung conditions in general, and on topics of nutrition, exercise, coping skills, daily living skills, understanding medications/complications, and alternative wellness. An identical program exists for Oxford members living with diabetes.

In addition to the aforementioned program elements, the programs utilize health professionals to develop written materials and interactive presentations to teach members how to manage their conditions on their own. Comprehensive workbooks (150 pages long) have been developed to target various avenues of self-management.

The benefits of such programs have been validated through a number of scientific studies that have found that outcomes of care in HMOs were better than or equal to care in non-HMO settings.[5]

One of Oxford's most unique programs for members is our falls prevention program. The Oxford Activity & Safety Program For Fall Prevention is a primary prevention program, which uses in-home rehabilitation therapy services to reduce falls in a targeted Medicare population. To meet this objective, Oxford is the only managed care organization that offers the combined approach of occupational and physical therapy, and issues durable medical equipment for this program. (See Attachment B)

IV. THE CURRENT STATUS OF MEDICARE+CHOICE

Payment Relief Is Needed Now As A Bridge to Medicare Reform

A survey of the landscape of the Medicare+Choice program reveals that the program is at a critical juncture in its history. The lack of payment parity with traditional Medicare fee-for-service has led to significant losses that have forced plans to reduce benefits, raise premiums and other cost sharing, and in many cases like our own plan even withdraw from the program in certain areas. The current payment environment is untenable and threatens the viability of existing plans. A readjustment of the current payment methodology is essential to insure the continuing success of Medicare+Choice.

As I stated previously, the core of the problem is the flawed M+C reimbursement methodology in the Balanced Budget Act of 1997 that limits the growth of reimbursement in urban areas to two percent per year while medical inflation has been approaching ten percent. The Act and its successors (BBRA and BIPA) have elevated M+C reimbursement in areas of the country where fewer seniors reside and a select group of suburban areas. It is now time to significantly increase the reimbursement in the urban areas where most of the beneficiaries live.

As you know legislation has already been introduced to address this urban funding shortfall. HR2836/S1317 creates a fifth payment prong for urban counties by primarily reimbursing M+C plans at 100 percent of fee-for-service (FFS). One hundred percent of fee-for-service is a significant boost in most urban areas. However, in many urban counties graduate medical education (GME) accounts for a significant portion of fee-for-service costs, as much as 14% but generally about 6%. HR 2980 also creates a fifth payment prong for urban areas based on 100% of fee-for-service but including the GME costs without taking any funds from the current GME pool that is directly distributed to the hospitals.

I urge the Committee to act expeditiously on these proposals.

CONCLUSION

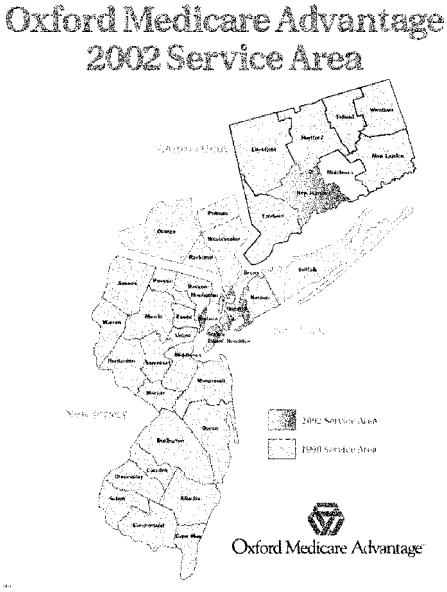
In the Medicare+Choice market, Oxford has tailored products to meet each segment of our market. We have launched new products and services, such as the "point of service" concept, alternative medicine initiatives through a contracted network of alternative medicine providers, a host of disease management programs and quality monitoring techniques. None of which are available to seniors in the traditional Medicare fee-for-service program.

A properly funded Medicare+Choice program is ripe for further benefit and health delivery innovation. Oxford's commitment to the Medicare+Choice program is evidenced by our long history of providing Medicare beneficiaries with access to high quality, affordable, patient-centered health coverage. We believe that Congress should enact a minimum payment two-year solution that addresses concerns about inadequate funding for the program. This will create a stable environment for our

[5] See J. Seidman, *Medical Care,* Vo. 36, 1998 (heart disease); and Preston and Retchin, *Journal of the American Geriatrics Society,* July 1991 (diabetes and hypertension).

company's participation in the Medicare+Choice program in anticipation of further Medicare reform. Madam Chairwoman and members of the Committee, I again thank you for the opportunity to discuss the Medicare+Choice program, and welcome any questions you may have.

ATTACHMENT A



ATTACHMENT B

Options For Living With Diabetes

Options for Living With Diabetes is a self-management program designed to empower the lives of our Oxford Medicare Advantage members living with diabetes.

The seven-week workshop has been created to educate members on diabetes as a disease, and on topics of nutrition, exercise, coping skills, daily living skills, understanding medications/complications, and alternative wellness. It is emphasized to the members that increasing knowledge of these areas can positively impact living with these conditions and subsequently improve the quality of their lives. Meetings are held for 3 hours, once per week for seven weeks. Members are encouraged to attend all of the seminars as the material presented builds on lectures from the previous weeks.

Health professionals have developed written materials and interactive presentations to teach members how to manage diabetes in their own lives. A 150-page, comprehensive workbook has been developed that targets various avenues of self-management. We encourage all members and their family members to take advantage of this exceptional opportunity for comprehensive learning.

Options For Living With Lung Conditions

Options for Living With Lung Conditions is a self-management program designed to empower the lives of our Oxford Medicare Advantage members living with lung conditions.

The seven-week workshop has been created to educate members on lung conditions as a disease, and on topics of nutrition, exercise, coping skills, daily living skills, understanding medications/complications, and alternative wellness. It is emphasized to the members that increasing knowledge of these areas can positively impact living with these conditions and subsequently improve the quality of their lives. Meetings are held for 3 hours, once per week for seven weeks. Members are encour-

aged to attend all of the seminars as the material presented builds on lectures from the previous weeks.

Health professionals have developed written materials and interactive presentations to teach members how to manage lung conditions in their own lives. A 150-page, comprehensive workbook has been developed that targets various avenues of self-management. We encourage all members and their family members to take advantage of this exceptional opportunity for comprehensive learning.

Activity & Safety Program For Fall Prevention

Description of Innovation

One of Oxford's most unique programs for members is our falls prevention program. The Oxford Activity & Safety Program For Fall Prevention is a primary prevention program, which uses in-home rehabilitation therapy services to reduce falls in a targeted Medicare population. To meet this objective, Oxford is the only managed care organization that offers the combined approach of occupational and physical therapy, and issues durable medical equipment for this program.

Description of Interventions

- Oxford Medicare Advantage members who have been identified as being at risk for a fall receive up to six physical therapy and six occupational therapy visits.
- Assessment and interventions include: balance, gait, medications, musculoskeletal strength, transfers, range of motion, environmental safety, and postural hypertension (blood pressure changes).
- Home visits by nurses are conducted if a member has postural hypotension or is taking medications associated with an increased risk of falling.
- Members are given a program of exercises to continue following the intervention.

Collaborative Arrangements

- Oxford Health Plans has collaborated with Department of Geriatric Medicine at Yale University to develop the Fall Prevention program.
- Community-based healthcare providers, including home care agencies and independent physical and occupational therapists.

Chairman JOHNSON. Thank you very much. I think your point that they are fundamentally different from fee-for-service is extremely important. Mr. Jones.

STATEMENT OF RICHARD JONES, PRESIDENT, GOVERNMENT PROGRAMS, UNITEDHEALTH GROUP, MINNETONKA, MINNESOTA

Mr. JONES. Thank you, Chairwoman Johnson, Representative Stark, and members of the Subcommittee, for the opportunity to testify on our experience in Medicare+Choice program. I am Richard Jones, president of Government Programs for UnitedHealth Group, responsible for our Medicare+Choice offerings across the country. As many of you know, UnitedHealth Group has a long-standing commitment to Medicare beneficiaries. Over the years, we have been proud of the services and benefits we have been able to offer to Medicare beneficiaries. We believe that the Nation's seniors and persons with disabilities who choose our plans have received a quality product that has produced positive medical outcomes, but like our health plans—like other health plans participating in the Medicare+Choice program, low reimbursement rates have forced us far too often to scale back the scope of benefits we offer enrollees.

Rather than abandon Medicare altogether as some of our health care plan colleagues have done and as many of our own investors have advocated, we decided to stay in as many Medicare markets as possible. It has been our hope that by staying in as many mar-

kets as possible for as long as possible, we can illustrate our commitment to the program and to the idea of providing competitive and innovative choices to our Nation's Medicare beneficiaries. Plans like ours 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 patient.

Our enrollees benefit from many of our value-based offerings such as individually assigned customer service representatives, access to 24-hour nurse line and Internet-based health information resources as well as programs that track their special health care conditions and remind them to get regularly scheduled diagnostic tests.

They also become part of our care coordination program where dedicated nurses follow hospitalizations and make sure that the services are understood, accessible, and coordinated before, during and after they are hospitalized. These services are unavailable to beneficiaries in fee-for-service Medicare. Over the past several years, some beneficiaries have experienced the deterioration of benefits in Medicare+Choice and in some markets, beneficiaries have lost their health care plan coverage altogether. We agree with the CMS that with—and many members of the Subcommittee that flaws in the current payment formula have caused this instability as annual payment increases have not kept pace with medical cost growth in many areas.

Our experience in Wisconsin is an example of the problems faced by Medicare+Choice plans nationwide. We offered a Medicare+Choice plan in Wisconsin since 1995. Medical cost inflation has exceeded 20 percent over the past couple of years and it has caused mounting financial losses. In fact, the other health plan in the Milwaukee area will leave the market at the end of this year and others have previously left. In order to stay in the market, we were forced to increase beneficiary cost sharing, including imposing co-pay on inpatient hospital and other services. This was a difficult decision for us.

As a result of our ongoing discussions with CMS, we recently altered the benefit package we originally filed to lower the inpatient co-pay to $295 per day. We are continuing to work with CMS on a demonstration in Wisconsin that would improve benefits and share financial risk between UnitedHealth Group and CMS. We believe we still provide Wisconsin seniors with a choice that many will value. For example, in fee-for-service Medicare, there is no limit on the out-of-pocket expenses a beneficiary may incur each year. Expenses like inpatient hospital visits, stays in skilled nursing facilities, diagnostic tests, durable medical equipment and supplies, outpatient services and emergency room care.

For seriously ill Medicare beneficiaries, these costs can quickly add up to tens of thousands of dollars. Under our Wisconsin Medicare+Choice plan, there is a $4,800 cap on the amount of out-of-pocket expenses that our members would pay in any 1 year. This is not simply a limit on hospital copayments. It is a total and complete limit on out-of-pocket costs for catastrophic protection for costs such as I outlined above. This limit, combined with the clinical and preventative services described, is especially attractive to

people with serious illnesses who have high service utilization during the year. Our plan is the only Medicare+Choice product in the Nation that offers such a benefit like that.

Madam Chairwoman, we know that even under the best of services, making a decision about health care is not easy for many seniors, given the complicated set of options around Medicare fee-for-service, Medicare+Choice and Medigap policies, and we believe there is particular confusion over these changes in Wisconsin. We want our enrollees to be knowledgeable and comfortable with the health plan choices they make and we are committed to take whatever actions to support these choices, and as part of that we are prepared and announce today and we share Representative Kleczka's concern that we are preparing and will be mailing to every enrollee a simple newsletter explaining the changes in the product as well as their Medigap rights.

We have been in contact with CMS to expedite that mailing. We are extending the hours of our customer service line from 8:00 a.m. to at least 7:00 p.m. each night. We will be using paid advertising, including an ad in the Milwaukee Journal Sentinel to publicize the extended customer service hours, and we are working with the Wisconsin Board of Aging and Long-Term Care to increase beneficiary awareness of their independent Medigap hotline.

In conclusion, we reiterate and appreciate the recent focus on these issues. We believe that Medicare+Choice has much to offer. We want to work to develop innovative solutions, work together to address the items that have been raised today and have been raised to date, and I will be happy to take any questions.

[The prepared statement of Mr. Jones follows:]

Statement of Richard Jones, President, Government Programs, UnitedHealthGroup, Minnetonka, Minnesota

Thank you Chairwoman Johnson, Representative Stark, and members of the Subcommittee for the opportunity to testify on our experience in the Medicare+Choice program. I am Richard Jones, President of Government Programs for UnitedHealth Group, responsible for our Medicare+Choice offerings across the country.

As many of you know, UnitedHealth Group has a longstanding 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 at all stages of life. We aim to facilitate broad and direct access to affordable, high quality health care through a variety of arrangements, including Medicare+Choice.

UnitedHealth Group is nowthe 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, over 300,00 Medicare+Choice beneficiaries are enrolled on our health plans across the country. And through our Evercare program, an innovative Medicare demonstration program, we provide coordinated care services to an additional 20,000 frail elderly individuals, the majority of whom live in nursing homes.

Over the years, we have been proud of the services and benefits we have been able to offer to Medicare beneficiaries. We believe that the nation's seniors and persons with disabilities who choose our plans have received a quality product that has produced positive medical outcomes. But like other health plans participating in the Medicare+Choice program, low reimbursement rates have forced us far too often to scale back the scope of benefits we offer enrollees. Rather than abandon Medicare altogether, as some of our health plan colleagues have done and as many of our own investors have advocated, we decided to stay in as many Medicare markets as possible. It has been our hope that by staying in as many markets as possible for as long as possible, we can illustrate our commitment to the program and to the idea

of providing competitive and innovative choices to our nation's Medicare beneficiaries.

Medicare+Choice Value

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 patient. Our enrollees benefit from many of our value-based offerings 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 to beneficiaries in fee-for-service Medicare.

Since 1996, we have offered a majority of our beneficiaries a health plan that requires no additional premium beyond the monthly Part B premium. Beneficiaries have access to a wide range of preventive benefits with no cost sharing requirements, including vision, hearing, and physical examinations. These are not covered in traditional Medicare at the same levels. In addition, we offer stop-loss coverage to beneficiaries with very high out-of-pocket costs.

The following are dexcriptions of some of the benefits that our Medicare+Choice enrollees enjoy that are not available to beneficiaries in traditional fee-for-service. For example:

- *Care Coordination* allows enrollees 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 enrollees post-hospitalization, identification and support programs with enrollees with complex and chronic illnesses and long-term assessment and education programs to support enrollees with asthma, cardiovascular disease, and diabetes.
- *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 enrollees 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. In addition, we offer a range of health and wellness education for individuals.
- *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 supporting 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 where we work closely with physician groups who apply the quality and cost data we can provide to them.

Challenging Decisions for 2002

Over the past several years, beneficiaries have experienced a deterioration of benefits Medicare+Choice plans are able to offer to supplement those covered in fee-for-service, as well as an increase in cost-sharing requirements. In addition, in some markets, beneficiaries have lost their health plan choices altogether**.** We agree with the Centers for Medicare and Medicaid Services (CMS) and with many members of this Subcommittee, that flaws in the current payment formula have caused this instability, as annual payment increases have not kept pace with medical cost growth in many areas.

In our view, this situation has been exacerbated by problems contracting with physicians, health care professionals, hospitals, and other providers. In many mar-

kets, hospital systems increasingly prefer to participate exclusively in Medicare fee-for-service because it offers higher payment and no third party involvement. In some markets, hospital systems have terminated their relationship with us mid-year, inconveniencing enrollees who often have to find new providers. While we have sought to remain in the Medicare+Choice program, this problem has been a major factor causing us to exit some areas. As we've made these difficult decisions, the quality of care that we can offer our customers has been our paramount concern.

Earlier this year, the Administration called upon health plans to remain in the market in 2002 and restated their commitment to work with Congress to enact comprehensive Medicare reform. We heeded this call to stay in the market, consistent with our long-term commitment to be a major partner with the Federal Government in providing quality health plan choices to beneficiaries. We stayed in as many markets as we could, despite the financial pressures. Ultimately, we reluctantly concluded that we had to discontinue service in 11 of 64 counties, affecting 57,000, or 16% of our enrollees. As of January 1, we will continue to provide coverage to over 300,000 enrollees in 53 counties nationwide.

In order to stay in the market, we had to reduce some benefits and increase beneficiary cost sharing in order to remain financially viable. In the absence of either short or long-term reforms, we are faced with a Hobson's choice—we can either stay in markets by reducing benefits, or exit and lose the chance to serve Medicare beneficiaries. No one wants to make this choice. We want the Medicare+Choice system to work. We believe that it is possible to reform the system to include adequate resources combined with quality and accountability measures that health plans must meet to reinvigorate and stabilize the program. And we hope this hearing will allow all of us to begin discussions aimed at injecting more innovation, more choice, and more stability into this important program for seniors and people with disabilities.

Our experience in Wisconsin is an example of the problems faced by Medicare+Choice plans nationwide. We have offered a Medicare+Choice plan in Wisconsin since 1995. Medical cost inflation has exceeded 20 percent per year over the last few years, and has caused mounting financial losses. In fact, the other health plan in the Milwaukee area will leave the market at the end of this year, and two others left previously. In order to stay in the market for one more year, we increased beneficiary cost sharing, including imposing a copayment on inpatient hospital and other services.

This was a difficult decision for us. These are not the levels of benefits we would ideally want to offer, such as the benefits we were able to offer in the late 1990's. As a result of our ongoing discussions with CMS, we recently altered the benefit package we originally filed to lower the inpatient hospital copayment to $295 per day. Although the difference between fee-for-service and this set of benefits is not as great as in years past, we believe a comparison of the overall benefits and costs of traditional Medicare, Medigap, and our Medicare+Choice plan shows that we still provide seniors in Wisconsin with a choice that many will value.

For example, in fee-for-service Medicare, there is no limit on the out-of-pocket expenses a beneficiary may incur each year—expenses like inpatient hospital visits, stays in a skilled nursing facility, diagnostic tests, durable medical equipment and supplies, outpatient services, and emergency room care. For seriously ill Medicare beneficiaries, these costs can quickly add up to tens of thousands of dollars.

Under our Wisconsin Medicare+Choice plan, there is $4,800 cap on the amount of out-of-pocket expenses that our members would pay in any one year. This is not simply a limit on hospital co-payments. It is a total and complete limit on out-of-pocket costs such as those I outlined above**:** hospital costs, inpatient hospital costs, costs of stays in a skilled nursing facility, diagnostic tests, durable medical equipment and supplies, outpatient services, emergency and urgent care, and more. This limit, combined with the clinical and preventive services described earlier, make this plan especially attractive to people with serious illnesses who have high service utilization during the year. Our plan is the only Medicare+Choice product that offers such a benefit, anywhere in the country.

We are well aware that even with this cap on out-of-pocket costs, our Wisconsin plan will be quite different next year than the one we currently offer or would like to offer. We are continuing to work with CMS on a demonstration in Wisconsin that would improve benefits and share financial risk between UnitedHealth Group and CMS. And we know that even under the best of circumstances, making decisions about healthcare is not easy for many seniors, given the complicated set of options around Medicare fee-for-service, Medicare+Choice, and Medigap policies.

There has been particular confusion over these changes in Wisconsin. We want our enrollees to be knowledgeable and comfortable with the health plan choices they make. And we are committed to take whatever actions we can to support these choices. For example, we run a toll-free number in Wisconsin that allows seniors

to ask questions about our Medicare+Choice plan. As required by the Centers for Medicare and Medicaid Services, we mailed a detailed explanation of our benefit changes to all of our enrollees. We will continue to review our benefit offerings during the year and want to work with CMS to explore ways to continue to improve our offerings in Wisconsin and across the country.

Conclusion

We appreciate the recent focus of this Subcommittee and the Administration on improving the Medicare+Choice program. We believe, as you do, that the program must undergo fundamental reform to provide beneficiaries broad choices of coverage that best meet their needs and the kind of coverage they will be able to enjoy and count on for years to come.

Three points deserve special consideration. As others have testified, 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 rural and urban markets is an important short-term goal.

Congress should also explore the increasing difficulties with hospital and physician participation in Medicare+Choice, focusing particularly on Medicare+Choice plans' limited provider payment leverage in some areas.

Reform must recognize the evolutionary nature of the health care system, developing a range of program options that allows for change as the system warrants. We encourage Congress and CMS to adopt successful contracting arrangements in the employer sector and non-risk-based alternatives as the basis for its own contracts with private health plans. Other options include disease management, care coordination, and specialized plans for frail elderly and dual eligible beneficiaries. We are encouraged by CMS's recent effort to encourage demonstrations in this area and want to continue to work together to develop innovative alternatives to traditional fee-for-service and HMO coverage.

Medicare+Choice has much to offer. As Congress and the Administration begin to discuss adding a prescription drug benefit to Medicare and other reforms, we urge you to consider changes to Medicare+Choice as part of the discussion. UnitedHealth Group is willing to go the extra mile to work with Congress and the Administration to help develop innovative solutions. Working together to address many of the items raised today, we can help to develop a renewed Medicare program that meets the needs of beneficiaries both today and in the future. 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.

Chairman JOHNSON. Thank you very much, Mr. Jones. Welcome Ms. Stein. It is a pleasure to have you.

STATEMENT OF STEPHANIE SUE STEIN, DIRECTOR, MILWAUKEE COUNTY DEPARTMENT ON AGING, AREA AGENCY ON AGING FOR MILWAUKEE COUNTY, WISCONSIN

Ms. STEIN. Thank you, Madam Chairwoman, Representative Stark, members of the Committee. It is my honor to appear here today to testify about the status of Medicare+Choice and to tell you about the urgent need for consumer protections in that program. I am the director of the Milwaukee County Department on Aging, and one of the things that we do is answer about 40,000 phone calls a year from seniors about all of their questions. We also receive money under the Senior Health Insurance Information Program. And we give that money to Legal Action of Wisconsin, which has a benefit hotline for people.

In January 1999, there were five Medicare+Choice plans offered in Milwaukee County and other parts of southeastern Wisconsin. Three of them had zero premium, they had very limited co-pays,

and so forth. By 2001, Blue Cross/Blue Shield of Wisconsin and Prime Care Gold, the UnitedHealthcare product, were the only products left available to seniors. They still had a very reasonable monthly payment and very low copayments when you saw a physician.

Earlier this year we learned that Blue Cross/Blue Shield would pull out of Milwaukee, leaving 10,000 people without that option in Medicare+Choice, but clearly those 10,000 people had other options and there was lots of time to inform them. We, Legal Action, our Medigap hotline, the State of Wisconsin, were able to mail to and talk to those 10,000 Blue Cross people to talk to them about what their options were. We had lost three other plans. We knew the drill. We knew what to do. We knew how to get to people.

In October, we were not prepared for what happened in Milwaukee when 16,000 beneficiaries of the UnitedHealthcare product received a letter that talked to them about what that product would look like in 2002. It began very nicely saying that their monthly premium would go down from $65 to $55 a month, and it said it would change its name to Medicare Complete, and then it said please read the following pages to see the list of benefit changes, and as has been pointed out today, those benefit changes included going from zero dollars a day to $350 a day deductible for inpatient hospital services, $150 up from zero for rehab in a nursing home, and a 20 percent copayment for every time you went to dialysis.

A friend of mine brought this letter to show to me one night after work, and his mother is on dialysis and he and she could not believe that a product like this had anything to do with Medicare. After the 16,000 people received this letter, our phones, the Medigap hotline, Senior Action of Wisconsin and the State of Wisconsin Health Insurance Program have done nothing else but talk to people about what their choices are in this product. The calls on all of those hotlines have exploded. We are not able to counsel people about any other benefits or to talk to them about any other programs because this has dominated what has gone on, and we are not just talking to people individually. We have held joint informational sessions with people.

On November 13, a very cold and rainy day in Milwaukee, and we have only had a few those this fall, 1,800 people showed up at two sessions because they knew that this plan no longer had benefit for them, and they wanted to know what to do. We have also petitioned our congressional delegation, my congressman, Jerry Kleczka, has been extraordinarily involved in trying to do something about this. We have written to UnitedHealthcare. We have asked Administrator Scully to do something about this plan and we found out on Friday that this plan now only has a $295 deductible still with the $4,800 cap, and that people do now have guaranteed issue and we are very glad that they are going to know about that, because once more they are going to be very confused, once more they are going to be getting very different information.

Some people have already made decisions and they made decisions based on the old information. This is not just happening in Wisconsin as has been pointed out here, this is happening in Connecticut. This is happening in California. People are being severely

affected by this. I really urge you to support the bill put forth before you that Representative Kleczka, Stark, and Thurman are supporting that would eliminate the lock-in for next year when there is so much confusion how can we lock people into these plans, that would extend the Medicare protections for guaranteed issue to people whose plans changed drastically, and would prohibit Medicare+Choice from charging larger premiums than traditional Medicare does.

There are thousands and thousands of stories from Milwaukee of people who don't know what to do, who are going to be severely limited from using the health care system because of what has happened in this plan and what has happened in Medicare+Choice after all.

My plea to you would be to offer Medicare recipients protections. My plea to you would be to return to what I think are the crowning values of Medicare, fairness and dependability, and this new principle of choice that has never been realized very well in Wisconsin is really not there for hundreds of thousands of people now. Thank you very much.

[The prepared statement of Ms. Stein follows:]

Statement of Stephanie Sue Stein, Director, Milwaukee County Department on Aging, Area Agency on Aging for Milwaukee County, Wisconsin

Thank you for the opportunity to appear today to testify about the necessity and urgency of Medicare+Choice consumer protections. I speak today as the Director of the Milwaukee County Department on Aging, the Area Agency on Aging for Milwaukee County, Wisconsin. Our agency has two functions which give us direct contact with Medicare+Choice participants in Milwaukee County. First, we operate an Information and Assistance line for older people, which handles approximately 40,000 phone calls per year. Second, we are the grantee of the Senior Health Insurance Information Program (SHIIP) funds for Milwaukee County. These funds are subcontracted to Legal Action of Wisconsin, which provides in-person and phone consultation for Medicare recipients in need of insurance counseling.

I will begin today by telling you about the fate of 16,000 Medicare+Choice consumers in Milwaukee County who are in dire need of protection. These seniors are not alone, however, and counselors from other parts of the country would like me to remind you of the gravity and universality of this situation. Finally, I will ask you to enact much-needed protections on behalf of seniors in Milwaukee County who are desperate for your help.

Milwaukee County

In January of 1999, there were five Medicare+Choice plans—three with zero premiums—being offered in Milwaukee County. Unlike plans in other parts of the country, none of these plans ever offered a prescription drug benefit, eyeglasses, or other added benefits. (I am sure that the insurance industry will, and has, told you how the disparity in the AAPCC rates leads to the difference in plans nationwide.) These plans had either $0 or $10 deductibles for physician office visits and $40 deductibles for emergency room visits. In 1999, then-Medicare recipients could shop for a +Choice plan that used their physicians and hospitals and was very affordable.

By 2001, Milwaukee County was left with only two Medicare+Choice plans—Medicare Blue, operated by Blue Cross/Blue Shield of Wisconsin, and PrimeCare Gold, sold by UnitedHealthcare of Wisconsin, located in Minnetonka, Minnesota. Although the monthly premiums and co-payments on these plans had risen ($65 to $70 per month and $20 co-payments), they were still affordable options for senior citizens.

In July of 2001, we learned that Blue Cross/Blue Shield of Wisconsin would withdraw its Medicare+Choice plan offering for 2002. The State of Wisconsin Board on Aging and Long Term Care, which runs our Medigap hotline, the Bureau on Aging and Long Term Care Resources, which oversees the State SHIIP program, and we, planned our educational and informational strategies to deal with this withdrawal. The 10,000 holders of this plan were informed, first by Blue Cross/Blue Shield, and then by us, that they had options. They could return to basic Medicare. They could

purchase a Medigap Supplemental plan with "guarantee issue," or they could join the remaining Medicare+Choice Plan, PrimeCare Gold.

As this was the fourth plan to withdraw, we knew the drill. Ten thousand people would be affected, but we would help them with their protected options. We were prepared. But we did not know what was coming.

During the week of October 15th, the 16,000 members of PrimeCare Gold received a letter from UnitedHealthcare. This letter was hand-delivered to me by a friend after work on Friday, October 19th. It begins well—"Dear Customer." Beginning January 1, 2002, your monthly premium will decrease from $65 to $55. In addition, the name of the plan will be changed to Medicare Complete. Also enclosed is a list of benefit—**BENEFIT**—changes. If you have questions, you can call customer service, which we later learned was located in Birmingham, Alabama. The letter was signed by Glenn J. Reinhardt, Chief Operating Officer of UnitedHealthcare of Wisconsin.

The benefit changes attached to the letter were, at first, unbelievable—and then horrifying. For instance:

(Service)	**PrimeCare Gold 2001**	**Medicare Complete 2002**
Inpatient Hospital Services	You pay $0 per day	You pay $350 per day.
Inpatient Psychiatric Services ..	You pay $0 per day	You pay $150 per day.
Skilled Nursing Facility	You pay $0 per day	You pay $150 per day.
Renal Dialysis	You pay zero	You pay 20% per outpatient visit.
Diabetes Self-Monitoring Training and Supplies .	You pay zero	You pay 20%. Syringes and alcohol swabs are not covered.

There is a $4,800 out-of-pocket limit on inpatient and most outpatient services.

Since my friend's mother receives dialysis three times a week, he and his family were stunned by this letter. They were sure there was a mistake. They were sure that "Medicare" would not allow this to happen. They were sure that, if this were the real plan being offered, that someone—I, the State, or the Congress—would be able to do something about it.

On Monday, October 22nd, our phones began ringing and they have not stopped. All of our local and State benefit systems learned of this situation and began to try and deal with it. The Medigap Hotline, our toll free insurance counseling number operated by the Board on Aging and Long Term Care, reports an average of 350 to 400 calls per day, up from the usual 150. George Potaracke, the Board's Director, reports that more callers are trying to get through, but that the system can only accommodate so many calls and that the Board's voice mail system completely backs up and shuts down every day. Callers are now waiting six to seven business days for a counseling session, up from a normal one to two day wait. The Board on Aging is mailing 1,200 to 1,500 pieces of printed material a week to recipients and their families, up from 400. Any callers, other than those facing Medicare+Choice issues, are being deferred.

Our Benefit Specialists at SeniorLaw of Wisconsin report 50 to 200 calls per day. They have had to set aside all non-emergency work and to pull all staff from every other project to deal with what they call the "Blue/Gold" issue.

In order to reach people in a more efficient manner, our Department, Legal Action, and the State of Wisconsin held joint information sessions on November 13th in Milwaukee and Waukesha Counties. On that rainy, cold, and nasty day, 1,800 seniors showed up—1,200 in the morning at Serb Hall on Milwaukee's South Side and 600 in the afternoon at Luther Manor on Milwaukee's Northwest Side. No one knows how many people tried to get into the sessions as people were parking a mile and more away. Three more sessions are planned.

But we have a dilemma. What are we to tell the holders of the UnitedHealthcare policy? What choice do they have? They have no guaranteed issue of a Medigap Policy. They have no other +Choice option. In many cases, traditional Medicare will leave them with unaffordable out-of-pocket expenses. What are we to counsel them to do? Where are their options and protections?

We, the Milwaukee County Department on Aging, legal services, the State of Wisconsin Bureau on Aging and Long Term Care Resources, and the Coalition of Wisconsin Aging Groups have agreed that this plan does not offer benefit to seniors and, if possible, they should get out.

But seniors expect more from us than individual counseling. They expect that we will advocate on their behalf to find solutions to their problems.

Senior advocacy groups in Wisconsin have petitioned our Congressional delegation to intervene with CMS, asking that they use their regulatory powers to assure that

this plan is drastically revised or rejected as any choice for Medicare beneficiaries. I am honored that my Representative, Congressman Jerry Kleczka, immediately understood the plight of his constituents and tried to halt the approval of this plan.

We, together with State officials, wrote directly to Secretary Thompson and to Administrator Scully to urge them to re-examine and re-negotiate this plan. We also asked them not to approve it.

We wrote to UnitedHealthcare of Wisconsin and its parent company, the United Health Group, and asked that they withdraw their plan so that our seniors would have guaranteed issue.

Both Richard Jones, President of Medicare services for United Health Group and William McGuire, Chairman and Chief Executive Officer of United Health Group, wrote to inform me that they were working with the Federal Government and the Congress to enact changes that will offer better benefits. In other words, they want more money. It is unfortunate that 16,000 older people find themselves in the middle of these negotiations.

We understand that the UnitedHealthcare plan is now approved by CMS with the only change being a $295 per day hospital co-payment rather than $350. Beneficiaries will still be expected to pay up to $4,800 out-of-pocket in addition to the $55 monthly premium for United's coverage and the $54 monthly premium for Medicare Part B. The excessive cost-sharing proposed by United raises questions about the value of this so-called insurance. It is now clear that many of the 16,000 seniors who have previously relied on UnitedHealthcare to provide access to affordable health care can no longer do so. It looks to us as though the benefit changes for 2002 are designed to discourage enrollment of beneficiaries who have health needs.

We, in Wisconsin and Milwaukee County, are furious at this outcome. We have spent thousands of dollars and thousands of hours trying to help people for whom there is today no consumer protection.

We have met with and asked Wisconsin's Commissioner of Insurance to intervene, using emergency powers to order guarantee issue, but we have been told she has no legal standing to do so.

My friend's mother has threatened to stop her dialysis. How many other people—alone and poor—will have no choice but to do so?

How will our hospitals collect the $295 daily deductibles, and will they then readmit people with outstanding bills?

There is no way for seniors to budget for this lack of benefit—any flare-up of a chronic illness, any sudden onset of disease, or need for rehabilitation will mean the need for large sums of cash. Isn't insurance supposed to protect people from exactly that? Isn't insurance supposed to provide peace of mind when dealing with illness? UnitedHealthcare and Medicare Complete have wreaked havoc in the lives of 16,000 people and their families.

Nationwide

We in Wisconsin are not alone. The Medicare+Choice promise—more health insurance options and benefits, better-controlled health care costs—has never been fulfilled in Wisconsin. But what about elsewhere? According to Weiss ratings, 536,000 seniors will be dropped from HMOs this year, on top of the 1.6 million who have been dropped since 1998. Those plans that drop coverage entirely leave seniors confused and betrayed, but those seniors are able to re-enter the Medigap market with the protection of guaranteed issue.

This is not the case with beneficiaries in plans that are drastically altered. In Connecticut, four companies terminated their coverage in 2000, dropping 52,000 beneficiaries. This year, two more plans, ConnectiCare and MedSpan, will terminate, affecting 39,000 beneficiaries. Only two managed care plans will remain, and they will cover only three counties.

Health Net, formerly known as Physician Health Services, will remain. Their plan will drop the use of the three main hospitals in the area. Inpatient hospital co-payments will rise from $0 to $500 per admission. Co-payments will be added for outpatient and inpatient surgery, radiology, diabetic, and dialysis benefits. And the co-payment for prescription drugs will increase $3 per prescription.

The California Health Advocates report that seven HMOs will drop their Medicare+Choice plans. In addition, there will be twelve service area reductions in parts of eleven counties. And, in the plans that will remain, premiums and co-payments are increasing and prescription drug coverage is decreasing.

One hundred thousand Medicare recipients in California will be affected by plans dropping coverage areas, raising premiums and co-payments and reducing drug benefits. The premium charged by Kaiser in Santa Clara County is going from $30 to $80 per month. PacifiCare's Secure Horizons is reducing the amount and type of

prescription drugs covered and will only cover generic drugs. In other PacifiCare plans, patients will be charged $400 for each hospital admission and a $50 co-payment for dialysis. Health Net will have a hospital deductible of $750 and has dropped all prescription drug coverage.

Claire Smith of California Health Advocates related to me many stories. One involves a Medicare cancer patient enrolled in Secure Horizons. She has been on chemotherapy since 1998. She is on her fifty-first treatment, but is alive, active, and a vital member of her community. Secure Horizons informed her that her chemo treatments, now free, will cost $250 per visit in 2002. In addition, they will charge $250 per radiation visit. She does not have the money to continue these treatments and cannot buy a Medigap policy. Another participant in Secure Horizons HMO of Pacific Health Care reports that his new 2002, $8,000 co-payment for dialysis, as opposed to a zero payment in 2001, is a "slow death sentence" for dialysis patients on fixed incomes.

A Plea for Consumer Protection

Medicare beneficiaries in Wisconsin, Connecticut, California, and many other states are asking the same questions. How can this new benefit package charge me more deductibles and co-payments than traditional Medicare? Why do I have such a short time to make a new choice, and why must I live with that choice for a year if it turns out to be wrong, or I didn't understand it? Why can't I be guaranteed the sale of a Medigap policy that I can afford and that will cover my health care needs when my plan changes so drastically?

These Medicare+Choice policies are not the same ones people bought when they took advantage of what they perceived to be the value-added benefits sold to them as Medicare+Choice. In fact, they are left with Medicare minus protection, Medicare minus the ability to buy a Medigap policy, Medicare minus the ability to choose different insurance.

I am pleased that Representatives Kleczka, Stark, Cardin, and Thurman on the Subcommittee and others have immediately recognized these real problems facing beneficiaries and introduced a simple, small bill—the Medicare+Choice Consumer Protection Act of 2001 (H.R. 3267)—that would cost the government nothing but provide real protections for Medicare beneficiaries stuck in positions like seniors in Milwaukee.

This legislation would: (1) Eliminate the Medicare "lock-in" provision that forbids seniors to enroll and disenroll from Medicare+Choice plans on their own timetable in 2002; (2) Extend the existing Medigap guarantee issue protections that apply to people whose Medicare+Choice plan withdraws from the program to anyone whose Medicare+Choice plan changes benefits, increases cost-sharing, or whose doctor or hospital leaves the plan; and, (3) Prohibit Medicare+Choice plans from charging higher cost-sharing for a service than Medicare charges in the fee-for-service program.

I hope that this Committee will seek to enact H.R. 3267—or something similar to it—quickly so beneficiaries would have some protections when caught in these traps.

These plans now call themselves new things—complete and secure and healthy—but they are not complete or secure or healthy. They are radically different, reminiscent of illegal bait and switch products offered in retail sales. The hundreds of thousands of Medicare recipients affected by these changes need guaranteed issue protections so that they can get out and buy an affordable Medigap plan. And, the new lock-in rules are a real recipe for disaster. We, in Wisconsin, cannot possibly counsel and find help for the 16,000 UnitedHealthcare enrollees and also warn other seniors of the lock-in provisions.

It is still not possible to get accurate and complete information on the CMS website about all of the plan choices. We have heard only through the press that UnitedHealthcare will change its hospital co-pay from $350 to $295, but beneficiaries have yet to be notified.

In a recent study conducted by the Medicare Rights Center (MRC), 80 percent of Medicare HMOs contacted (16 out of 20) gave incorrect information about the rights of people with Medicare to enroll and disenroll from a Medicare HMO in 2002. How will we in Wisconsin possibly provide counseling and help?

How can we expect older people to be wise consumers when the product they are buying can change dramatically every twelve months? How can we expect older people living on fixed incomes to meet the co-payments imposed by these plans? How can we lock them in with inaccurate and incomplete information?

Wisconsin Seniors

The people from Wisconsin would like answers to these questions, and remedy from you in the form of consumer protections. Our Medigap Hotline, benefit specialists, and Information and Assistance operators share stories daily about our seniors who need help.

- Stories of persons with severe health conditions such as cancer or end-stage renal disease who cannot afford Medicare Complete and cannot buy a supplemental policy.
- People who feel betrayed and taken advantage of for joining a policy on what they believe was false information.
- People who have been able to find a Medigap policy, but cannot afford it.
- People who will stay with Medicare Complete but who have resolved not to use it—not to seek health care.

My mother's friend, Dolly, thought she had an answer because she knew me. Of course, I would have a solution for her. Dolly is 75 but appears to be 55. A hairdresser all her life, she lives on a Social Security income of $700 per month. She lives in subsidized housing, gets energy assistance and some help with Medicare Part B. Of course, the wise health care decision for her was PrimeCare Gold—a $0 premium plus $10 deductibles for physicians' visits when she enrolled. Dolly has severe and crippling arthritis. She has had two strokes. She spends $150 per month on prescription drugs. With the new co-payments of UnitedHealthcare's Medicare Complete, she cannot afford to get sick—ever again. Without guaranteed issue it is doubtful we can find her an affordable Medigap policy.

What is she to do? I am supposed to have answers for people like Dolly. I am here today because there are no answers. I am here today to ask for your support for consumer protections for Medicare+Choice. It cannot be possible that the promise of Medicare will be reduced to the horror of health care uncertainty every year when the new plans are announced. It cannot be possible that we will abandon our seniors when they ask for help. It cannot be possible that we will leave our Medicare+Choice seniors without protection. They deserve better than that.

Thank you for the opportunity to speak on behalf of seniors of this nation.

Chairman JOHNSON. I thank the panel for their input and certainly, Ms. Stein, I do want to see fairness and dependability restored to the choice plans, dependability particularly. Seniors need to know, and the plans need to know what are going to be the terms this year, next year, and the year after, and that was our intent in establishing the Choice plans. For a lot of reasons a little vignette of all this is after the plans were established, the preceding administration about 6 months later put out 700 pages of regulations. This is hardly dependability and predictability, and that has been the history of this plan, regulatory change constant, reorganization of the Department so regulation was split up, the fact that there is today not one place a plan can go to find out what the integrated rules and regulations are that cover them, and we are changing a lot of that.

But unfortunately, the statutory treatment of the Choice plans has lead to this mess. Even the reimbursement that we would say we are going to give you 2 percent or the national blend, but not if it is over a certain amount of money. So I think you picked up today that we have treated Medicare fee-for-service far better in term of reimbursements than we have treated the Choice plans, and we have to deal with those problems. So my goal is dependability and reliability and choice and improvement of fee-for-service in its ability to deliver also some of the disease management options.

I read your testimony in detail. It was very eloquent. It is awful what is happening out there, but I would have to say—I was very

pleased with the administrator's comments that they can now get into Medigap. That is a problem that we have to deal with that seamless issue of choice, and we will, today on the floor, eliminate lock-in for 1 year, and then if we can get the Senate to agree, we will eliminate that. We will also give the plans better data before they say whether they are going to be in or out. They should allow more to stay. So if we address the regulatory issues and the funding issues and allow plans to make that decision at a rational time, we should be able to restore predictability and steadiness to this plan.

What is remarkable and I think we are not paying enough attention to, is that these plans are beloved because they are better than Medicare. They offer more services. And I think when we have not been able to offer annual physicals and we have tried for years, it took us 5 years to do mammograms, one of the advantages of these plans is that they are not limited by our benefit package, although they have to cover it all.

So I have really just two questions I wanted to mention, and I will just say what they both are as we go forward so that you can both comment on them, but I am very impressed with the various—and I appreciate the rundown, Mr. Haytaian. Am I saying that right?

Mr. HAYTAIAN. It is Haytaian.

Chairman JOHNSON. Haytaian. Armenian?

Mr. HAYTAIAN. Yeah.

Chairman JOHNSON. Your rundown of the history of your plans and that the Medigap comparable benefits would be $3,000. Now, when you look at that and you look at what United is trying to do, which is to say we will limit everything, not just hospital costs. Hospital costs, inpatient hospital costs—sorry—nursing stays, diagnostic tests, durable medical equipment and supplies, outpatient services, emergency and urgent care and more to $4,800 when a Medigap plan will cost somebody $600 plus they will have costs, when Medicare has no cap on costs. The heartbreaking example you give of the dialysis, the renal dialysis benefit, what they are being thrown back on is Medicare's benefit. Medicare's benefit is that same 20 percent.

So that shows you why people don't want to go back into Medicare anymore. They can't afford it. So at least United is saying yes, you will be back into the Medicare-type benefit for renal dialysis, but at least we will cap it. So I don't think we have a right to eliminate options that exchange a higher exposure for individual incidents for a cap because that is just one of the things, the options, that we are going to have to make sure is out there.

We want lots more options out there but given the funding irregularities, I do think that United has made a contribution by looking at how, even under the limited funding constraints they face, they have found a way to preserve a lot of their benefits and trade off the risk. After all, many won't be in the hospital at all. They won't end up being exposed to that, but they will have in the back of their minds this catastrophic limit, and I just wonder how you see that catastrophic limit as part of the structure of security that is of value to a senior.

Ms. STEIN. Madam Chairwoman, it is not so much how I see it, and I don't see it as a very good benefit, but it is really how older people see it. Older people see it as if I get sick, $4,800 is going to come out of my pocket, not over a year that I can budget for, not something that I can save for. I will need $4,800 to pay for my health care costs.

I don't see how that is a benefit. It is frightening to older people. And let us not forget that the plan that they have now in 2001 has a zero copayment for dialysis, a zero copayment for hospital stays, a zero copayment for rehab in a skilled nursing facility. To go from zero with all of those copayments to a $4,800 cap is a $4,800 increase in medical payments that those people will have to pay.

For lots of people returning to fee-for-service Medicare without a Medigap policy is not a good option because of the copayments under fee-for-service without Medigap. But now that we have the ability to do guaranteed issue, we can work with the 80 licensed insurance companies in Wisconsin who are going to be just as surprised that they are now going to have to offer guaranteed issue as we were to find some reasonable plans that will at least meet these deductibles and copayments. And we, too, will be working with the Medigap hotline in the State of Wisconsin and our benefit specialists to try and help people now make these choices.

Chairman JOHNSON. I think it will be helpful for all of us. And I think the education should be very evenhanded, because I don't think either you or I are in a position to judge. And it will vary tremendously from senior to senior as to whether a $4,800 cap is an advantage or disadvantage. I am coupled with very high health care costs because they both have so many chronic problems for whom that would be a tremendous benefit. So it depends a lot on the configuration of your health care needs as to whether the catastrophic benefit is more important than premiums that also carry with them a varied bundle of benefits.

If either of you would like to comment on this issue, the plan design and choices for seniors, I would be happy to have you do so.

Mr. JONES. We believe that we were faced with the choice of creating a benefit option or exiting the market.

Chairman JOHNSON. Or exiting the market?

Mr. JONES. In Wisconsin, as we talked specifically about Wisconsin. I would—we would never want to be a limiting factor to choice, and that would not be our intent. We would always want to be an added choice for senior beneficiaries. And we, too, are glad that the mandatory—no underwriting mandatory issue has been instituted. As we look at that, a number of the competitors across the country have a number of days co-pay, and they limit it for inpatient only. And we see that as we looked at that, there were too many situations that came up, therapy and other modalities of care, where there was no limit. Representative Thurman just pointed out that on the fee-for-service, the limit is over $6,000 if they were hospitalized for an extended stay. Under the pure calculation of the benefits that we issue, they would be very high, but it stops at $4,800. At that point there are no additional co-pays for any service at that point. So it is a change in benefits. It is a program that we hope is a choice for many seniors and adds to choice, not reduces choice.

Chairman JOHNSON. And what are the rest of your benefits, for instance, physician co-pay and—under this new plan, what is your physician co-pay?

Mr. JONES. The physician co-pay is $20 per visit.

Chairman JOHNSON. Are there any other benefits you should point out, as we have been focusing primarily on hospitalization and psychiatric, nursing home and dialysis?

Mr. JONES. I would indicate as in Medicare+Choice plans, that preventive care is covered. There is, as I outline—and I went through that very quickly—there are a number of programs, Care Coordination, the nurse line, that also help to organize the program for the seniors once they fragmented the health care delivery system.

Chairman JOHNSON. How about annual physicals?

Mr. JONES. It is covered.

Chairman JOHNSON. And do you have any information about the cost of cancer treatments under Medicare versus under your $4,800 threshold?

Mr. JONES. The chemotherapy would be subject to a 20 percent copayment or coinsurance, and under this that would be captured in that $4,800. And in many of those procedures, according to where they are delivered, there is either a $30 co-pay, and they are all captured in the $4,800 out-of-pocket cap—the catastrophic protection.

Chairman JOHNSON. Thank you. Mr. Stark.

Mr. STARK. Thank you, Madam Chair.

Ms. Stein, how nice to see you here. Tell me—I just want to compare some numbers in Milwaukee. What does a J Medigap policy roughly cost in Milwaukee County?

Ms. STEIN. If you are 65, you can probably get one for $70 a month.

Mr. STARK. That low? Let me give you some numbers here and tell me what I am missing. I am correct in assuming that United doesn't offer a drug benefit?

Ms. STEIN. That is correct. It never has.

Mr. STARK. I don't know why anybody would be dumb enough to sign up for it. Look at this. They are going to charge $660 next year, right?

Ms. STEIN. Right.

Mr. STARK. And you get the $4,800 out of pocket, and they will pick up everything over that. So you are really going to be, if you get really sick, $5,400 out of your pocket, and that doesn't include drugs, right?

Ms. STEIN. Right.

Mr. STARK. Stay in fee-for-service, regular Medicare, buy a J option, and I am going to say—I mean, you are telling me it is only less than $1,000. So for $1,000, then you have $2,400, because you have to pay 50 percent of the drug benefit, you are still not up to the $4,800 these guys are going to take out of your pocket, and you get a pharmaceutical benefit that is worth something on top of it, plus you could—if you didn't want to go to St. Luke's or if you didn't want to go to Frederick, you could go to Minnesota where Mr. Jones probably goes to—what is that fancy place—Mayo Clinic.

If you got the bus fare, he isn't going to let you go to Mayo Clinic under his insurance plan, but under Medicare you could.

So tell me why anybody who could qualify to get into Riverside High School could possibly, in a thousand years, want to sign up for a cockamamie plan that is going to gouge its folks $5,400 when you can go buy Medigap and have fee-for-service? Do they give you free beer on Fridays?

Ms. STEIN. They are just offering new counseling sessions. The last ones they held in hospitals and clinics and kicked our counselors out, by the way. They are now holding them in restaurants, and you have to have a—all in suburban Milwaukee County, and you have to have a reservation before you get there. But I don't know why anyone would sign up.

But, Representative Stark, I have to tell you I misspoke. There are no J plans being offered in Wisconsin. No Medigap plans, no Plus Choice offer any drug coverage to any people in Wisconsin at all.

Mr. STARK. So we should have a Federal drug benefit then?

Ms. STEIN. Without a doubt.

Mr. STARK. Let me ask, Mr. Jones, in your third quarter earnings statement, Mr. Jones, I can't quite figure this out. You talk about your strong financial performance and your Dr. Woods—is that the head guy—whoever—-

Mr. JONES. Are you referring to Dr. McGuire?

Mr. STARK. He wrote this. And he said he attributes part of this strong financial performance to an accelerated shift to our overall mix of business, to fee-based products and services and away from risk-based products. That is not just in Medicare, but in all your markets. Now, what do you mean by a fee-based product? Why are you switching to that? Don't you know how to manage medical care risks?

Mr. JONES. As a course and choice of the way that insurance has been delivered in the traditional managed care environment, approximately a year and a half ago, 2 years ago, United embraced a program called Care Coordination. In that program, the patient-physician relationship is honored. In that program, there is not a, if you will—a gatekeeper intervention. If a patient and a physician decide on a course of care, and it is—we do not use the medical appropriateness denials any longer——

Mr. STARK. That is a fee-based service?

Mr. JONES. Rather than operating in a risk base where you capitate and pass all risks to the physicians, the reimbursement now correlates to that care coordination, that physicians and patients make a choice and the reimbursement follows the care that is delivered, versus a risk-sharing, which is much more of the historical approach. I believe I am addressing your question.

Mr. STARK. That is right. So you are suggesting that by getting away from putting the physicians at risk and paying them on a fee base, you are able to make more profit?

Mr. JONES. We believe that—first off, that the members are better served by not having an interference with the patient.

Mr. STARK. Wait a minute. This is in your earnings statement. You are talking to the shareholders now. Let us leave the poor beneficiaries out of this. When you are talking to the shareholders,

you are telling them that you made more profit due to an accelerated shift toward fee-based product and services. From what I recall, that tends to fly in the face of what Oxford would tell you, that when you are trying to beat down the docs, you are much better capitating them than giving them unlimited fee-for-service. Wouldn't you agree, Mr. Haytaian?

Mr. HAYTAIAN. No. Actually we are not predominantly capitating doctors in our business. We pay them on a fee-for-service basis as well.

Mr. STARK. Do you save money that way?

Mr. HAYTAIAN. We don't believe in that way of administering care. We have always had a fee-for-service model, and we never had a capitating arrangement. With provider groups and Medicare, though, we do have some capitating models.

Mr. JONES. The acceleration, I believe, also has to deal with choice, that many more patients, beneficiaries, employers like—choose that delivery of care versus the capitated gatekeeper type of intervention that had been in the past.

Mr. STARK. I would think so. I am interested and somewhat surprised that you attribute that to being more efficient, if you understand, more profitable. And I always thought capitating or putting the physicians at risk would save you money in a managed care plan as opposed to paying basically unlimited fee-for-service, but you say no.

Mr. JONES. Representative Stark, the cost of putting all the administration around that type of program is not inexpensive. And also, it was not a favored way to give care to interact with the physician and the patient.

Mr. STARK. So you would advise us then, based on the private sector model, that in dealing with fee-for-service administration for that part of the Medicare plan, we should be more comfortable than worrying about spending a lot of money administering whether there is overutilization and just trust the normal relationship between the doctor and the patient?

Mr. JONES. I believe this has to go hand in hand with a great deal of information that is shared with physicians in terms of the quality outcomes and the feedback that goes with that.

Mr. STARK. I don't mean to intrude on the Chair's generosity with time, but I do, because I do question to Mrs. Stein why paying $5,400 with your $4,800 cap—so if there is no J, I guess the next best thing would be, what, H or one of those plans that would pay almost all the co-pays. Why aren't I better off—if you care to answer that, if not, the Chair can shut me up—why aren't I better off getting a Medigap policy and using Medicare fee-for-service than I would be under your plan where I have to eat up $4,800 and I would have high co-pays? How would you advise me if I were a salesman for your company?

Mr. JONES. Well, I don't presume to understand how all seniors make decisions, but I would say that there are any number of situations where a beneficiary—beneficiaries are not all alike. They find themselves in different stages of need for health care and different ways that they receive health care. I will just use two examples that may not be salient to the question, but we could find a Medicare beneficiary who is a 30-year-old with MS, or Multiple

Sclerosis, and is not in need of hospital care, but yet the coordination of their DME, the coordination of how they interact with the variety of cares that they need is very well managed in this program.

If you found that there was a beneficiary who expected to be hospitalized for an extended period of time during the year, and they looked at the total cost under Medigap and fee-for-service, and they were receiving care that was in other modalities as well, this would be a good plan for them.

There has to be enough education for them to evaluate their own circumstances and to make informed choices around that.

Mr. STARK. But try that if I can, and then I will shut up, Madam Chair, on just a common garden variety geezer like me, who doesn't anticipate any more than a flu shot and whatever else. Why would I, in my Medicare—suppose I don't have my Federal plan, which is much more generous—moving back to Milwaukee, why would I choose to pay the $55 to you and know I got to have $4,800 in the sock for extra co-pays and stuff, as opposed to laying out $100 and whatever for a thorough or the richest Medigap policy I can find, and I could probably still go to the same doctors that serve your beneficiaries? That is why—help me with that. That is what I don't understand.

Mr. JONES. The expectation is that either you are in a very intense course of care and you want to limit the total cost, and you would be able to peg that. You would know what that number is.

Mr. STARK. So that is when I would come to you.

Mr. JONES. That is one of the alternatives that would legitimately be considered in this, that if somebody is in a very intense course of care, this is a valid choice. And I would actually recommend that they pursue it because of all the other services that are rendered in the coordination of care with the nurse line, with the 24-hour access to advice.

Chairman JOHNSON. Thank you, Mr. Stark. Mr. McCrery.

Mr. MCCRERY. Mr. Jones, is United the only Medicare+Choice plan in the Milwaukee area?

Mr. JONES. Yes, sir, it is.

Mr. MCCRERY. And I believe we heard testimony earlier that there used to be several plans, but that they are all gone except for United; is that correct?

Mr. JONES. The Blue plan is exiting at the end of this year.

Mr. MCCRERY. So obviously, with the reimbursement level what it is in the Milwaukee area, it is difficult for Medicare+Choice plan to make it. Wouldn't that be a logical conclusion?

Mr. JONES. That certainly is our experience, yes.

Mr. MCCRERY. And I believe you testified that you all—that United wanted to stay in Milwaukee so that they would have a choice, and that is when you did your pencil work and changed your benefit structure and came out with this new plan?

Mr. JONES. Yes, sir. That is correct.

Mr. MCCRERY. And I think that is certainly logical and wouldn't quarrel with that; however, I do question how many people are going to choose this option. How many people do you have enrolled right now in your plan?

Mr. JONES. Sixteen thousand.

Mr. MCCRERY. And when must they make a decision to either stay in your plan or go to fee-for-service?

Mr. JONES. There are a couple of answers to that. Were it not for lock-in, each month they could make a choice to leave. If they want to have access to a guaranteed issue Medigap, they would leave on the exit of a plan. So if a plan leaves, they have 60 days—63 days to make a guaranteed issue choice. Without lock-in, they could make a choice every month. With lock-in, they would have to make that choice in the next month—or before March 4, excuse me.

Mr. MCCRERY. Before what?

Mr. JONES. March 4.

Mr. MCCRERY. Before March 4 they must make a decision whether to stay or exit under the fee-for-service. And you have 16,000 beneficiaries right now?

Mr. JONES. Yes, sir.

Mr. MCCRERY. Have you calculated how many of those 16,000 will remain in your plan?

Mr. JONES. We don't have a calculation of what—I am not sure there is a calculation of how many will stay in the plan. They will all make choices as they begin to enter the new year.

Mr. MCCRERY. How do you make a business plan if you don't make some assumption as to how many enrollees you are going to have? Don't you have some assumptions?

Mr. JONES. We don't make assumptions.

Mr. MCCRERY. What is your assumption?

Mr. JONES. I don't have that here, but we do expect that there would be fewer participants than there are today.

Mr. MCCRERY. Yeah. I mean, just at first blush, that would be my expectation, too. I gather you have the same plan in Florida—same structure, same benefit structure in your Medicare+Choice plan in Florida?

Mr. JONES. We have a number of the same benefits across our entire program, yes, but vary somewhat.

Mr. MCCRERY. Is this generally across the Nation, your new benefit structure for Medicare+Choice, or do you have different plans in different locations?

Mr. JONES. We have different plans in different locations.

Mr. MCCRERY. Dramatically different? Do you have plans that look like your old Milwaukee plan?

Mr. JONES. There are very few locations where we are able to sustain a program that looks like the old Milwaukee program. We did institute the out-of-pocket max, the catastrophic protection in all locations.

Mr. MCCRERY. Even with your low-deductible plans?

Mr. JONES. Right. We fundamentally believe it is a good safety net, a good benefit to provide for all beneficiaries that work with United.

Mr. MCCRERY. Mr. Haytaian, you talked about your essential plan, which is the plan you described would be great for low-income folks who are looking for zero deductible and so forth. Do you offer that plan everywhere that you offer Medicare+Choice?

Mr. HAYTAIAN. We offer it in the five boroughs in New York. We are only in one county in Connecticut, New Haven County. And 2002, we will only be in one county in New Jersey, Hudson County.

And we are not able to offer those products in Connecticut and New Jersey, but we do in all the boroughs in New York City.

Mr. MCCRERY. Why are you not able to offer that product in Connecticut?

Mr. HAYTAIAN. Because of the core issues we talked about today regarding reimbursement, and how fundamentally different reimbursements are in Connecticut and New Jersey versus New York, and how medical cost trends and actually unit costs are very similar to what we are experiencing in New York. We are not financially in a position to be able to do it.

Mr. MCCRERY. Thank you, Madam Chair. I may want to do some more questioning if we have a second round.

Chairman JOHNSON. Mr. Kleczka.

Mr. KLECZKA. Madam Chair, you indicated to Ms. Stein that part of the problem with the Medicare Program is the uncertainty. While I agree with you in part, I think the bigger problem is that we are dealing with sick people, and when you do that, you are going to find costs. And that begs the question whether or not the private insurance market, which didn't want these folks 40 years ago, are able to handle them and pay for their health care today. And when we get to the point where the Medicare Choice is going to be reimbursing at a much higher rate than fee-for-service, at that point I think the Congress should seriously look at increasing the fee-for-service program and expanding some of those benefits for annual physicals and some of the other things we talked about today, because we are going to be paying for it anyway.

Now, Mr. Jones—first of all, Ms. Stein, I heard reports in the market where some of your counselors and other agency counselors have been excluded from meetings.

Ms. STEIN. That is correct.

Mr. KLECZKA. What is the situation there?

Ms. STEIN. United Healthcare's first rounds of meetings that they announced in the market and to all of their beneficiaries were all in public places and hospitals and big, large community clinics. And we and Legal Action of Wisconsin sent counselors to all of those meetings because we had upset people—very upset people, and we wanted them to know that maybe they would be eligible for the SLMB, Special Low Income Medicare Beneficiary Program. We wanted to try to help them. We were asked to leave those meetings. Mr. Jones was gracious enough to write me a letter of apology, but unfortunately the next day we were asked to leave again.

Mr. KLECZKA. What is the current policy? Is there going to be an exclusion of people other than planholders from any future meetings, be it a restaurant or a public building?

Mr. JONES. No. Again, I will restate my apology that—-

Mr. KLECZKA. The policy has been changed, so I don't think we have to dwell on it, and these people will be permitted. Thank you for the change.

Quick question. You have been in the program since 1995. What has been your medical loss ratio from 1996 to 2001?

Mr. JONES. I cannot go back—I don't have the information to go back quite that far.

Mr. KLECZKA. Were you making money on the program in 1996, 1997, 1998?

Mr. JONES. I would potentially misquote that, but for the last 2 years, our medical loss ratio has been in excess of 90 percent.

Mr. KLECZKA. In excess of 90. That is 9 to 10 percent or—-

Mr. JONES. Pardon?

Mr. KLECZKA. There has been a profit in the program?

Mr. JONES. We have basically been break even.

Mr. KLECZKA. For how many years?

Mr. JONES. For the last 2.

Mr. KLECZKA. So at some point you were profitable? You made money writing these policies?

Mr. JONES. In Wisconsin—I would be happy to get you that information in a written format. I don't have that with me.

[The information follows:]

UNITEDHEALTH GROUP
Minnetonka, Minnesota 55343
December 21, 2001

Hon. Jerry Kleczka
2301 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Kleczka:

There has been considerable conversation about the changes in the benefits of the Medicare + Choice plans generally. Specifically, we have discussed the benefits in Wisconsin.

I have included an attachment per your request which summarizes United's Wisconsin operating results for Medicare for 1996 through 2000.

I am available and invite the opportunity to discuss these and other issues you may want to discuss.

Sincerely,

RICHARD H. JONES
President, Government Programs

The table below indicates the statutory operating results of UnitedHealthcare's Medicare + Choice product in Wisconsin named Prime Gold. These values are from the annual OCI filings. In 1996 and 1997, United was basically at breakeven or at a small profit in each of those years. However, in 1998, 1999 and 2000, it has incurred losses.

	1996	1997	1998	1999	2000
Revenue	$10,579,489	$36,262,944	$70,657,909	$85,508,419	$79,775,048
Medical	$8,904,572	$32,178,135	$66,135,084	$82,363,790	$75,601,419
Gross Margin	$1,674,917	$4,084,809	$4,522,825	$3,144,629	$4,173,629
BCR	84.2%	88.7%	93.6%	96.3%	94.8%
Administrative			$8,391,483	$8,431,872	$5,842,295
Pretax Loss			(3,868,658)	(5,287,243)	(1,668,666)

Mr. KLECZKA. In other States where you write Medicare Choice, do you have any that are comparable in the per day co-pay for hospitalization, inpatient hospital, of $295?

Mr. JONES. Yes, sir.

Mr. KLECZKA. Do you have any policies in the counties in Florida?

Mr. JONES. Where it is $295 per day? Yes, sir, we do.

Mr. KLECZKA. We are told that because of the fact we are not reimbursing you in States like Wisconsin, that you are in this predicament. However, on average in the State of Florida, we find that the per capita reimbursement is much, much higher than Wiscon-

sin's $554 per person, right? So to make the argument that Wisconsin is lax in the reimbursement doesn't prove the case when you are talking about the co-pays in a high reimbursement State like Florida.

Mr. JONES. The average that you had referred to for Florida is inclusive of Dade County and other high reimbursement counties. There are rural counties in Florida where the reimbursement is likewise not nearly as high as it is in some of those very urban areas.

Mr. KLECZKA. Based on the dramatic increases in the market area with your Choice plan, what is the anticipated medical loss ratio after these deducts and co-pays are put into place? What do you envision the medical loss ratio is for 2002?

Mr. JONES. Our anticipation is it will remain around 90 percent.

Mr. KLECZKA. And today you are at what?

Mr. JONES. Ninety-one.

Mr. KLECZKA. So Mr. Scully was in error indicating that your exposure for either 2000 or 2001 was 99.

Mr. JONES. When you add the administrative cost, it is higher than that. That is just the medical cost.

Mr. KLECZKA. Even with the high deductibles and co-pays, you are still going to remain the same as far as medical loss ratio?

Mr. JONES. Yes, sir. The medical inflation in that market has been over 20 percent for the last 2 years.

Mr. KLECZKA. OK. Quickly, Madam Chair, if I might. You indicated that you are going to notify all the current plan beneficiaries of the change, especially the Friday notice from CMS relative to the special enrollment period?

Mr. JONES. Yes, sir.

Mr. KLECZKA. You are going to tell your policyholders that they can get out?

Chairman JOHNSON. Isn't that the point we already made?

Mr. KLECZKA. Well, no, because my question is, you indicated that it is your hope that you hope CMS would expedite this mailing. I was under the impression you were going to do a mailing, and hopefully CMS was also.

Mr. JONES. Any communication that we are—that we send to a beneficiary has to be approved by CMS. We have been in contact with them, and they have been very cooperative to expedite that review so it can go out very quickly. What I referred to was their review of that communication.

Mr. KLECZKA. Is the list of 16,000 beneficiaries, is that covered under the Privacy Act? My further question will be, would it be possible for the company to either share that list with, say, the Marquette County Department on Aging to also get the word out, because none of us know specifically who these people are. And my fear is that even though CMS might do a mailing, you might have the ad in the Marquette Journal. In this holiday season with all the mail, with the mail scare, a lot of people aren't—even though we are trying our darnedest—aren't going to be aware of the fact that they have between now and the end of the year to go back to fee-for-service and would be eligible for a Medigap policy. And to make sure people don't fall between the cracks in trying to maximize the notification—you know, I could do one from my office.

Chairman JOHNSON. I appreciate the importance of your question. I think Mr. Jones is referring to the company's mailing, not CMS's mailing. And CMS is thinking about doing their own mailing. But it was clear from Mr. Scully that this issue of how do we make sure people get notified is not yet resolved. Mr. Jones is only referring to their own company's mailing. As to whether or not any company wants to share the list of their participants is a decision that companies will make.

Mr. KLECZKA. Would the company be willing to share that list, say, with the county aging department?

Mr. JONES. We would be happy to have participants communicate with us to our beneficiaries. We want them to be well informed about any decision. I would have to ask our legal counsel relative to the policy around that, and I would be happy to get back to you in writing on that very quickly.

[The information follows:]

UNITEDHEALTH GROUP
Minnetonka, Minnesota 55343
January 28, 2002

Mr. Bill Covey
1102 Longworth House Office Building
Washington, DC 20515

Dear Clerk Covey:

In response to the request for the release of the names and addresses of the 16,000 beneficiaries of our Wisconsin Medicare+Choice program, we must decline to release this information to the Milwaukee County Department of Aging in order to protect the privacy of our members.

It is the company's policy to protect the confidentiality of information that identifies individuals. We have provided the requested information concerning the profitability of the UnitedHealthcare Medicare + Choice product in Wisconsin from 1996 through 2000 to Representative Kleczka's office.

In summary, during 1996 and 1997, United was at breakeven or at a small profit in each of those years. However, in 1998, 1999 and 2000, it incurred losses. The product's benefit cost ratio ranged from 84.2% and 88.7% in 1998 and 1999, to 93.6%, 96.3% and 94.8% in 1998, 1999 and 2000 respectively."

Sincerely,

RICHARD H. JONES
President, Government Programs

Chairman JOHNSON. I do want to make the point because this is a big problem as we talk to each other about these issues. It is true that Florida in some counties offers a very much higher reimbursement rate than Wisconsin gets, but to conclude from that that, therefore, any company shouldn't be offering the same kind of incentives to constrain spending or to make their policies affordable is not a legitimate conclusion, because along with that higher rate -—in fact, the higher rate reflects a higher fee-for-service cost by Medicare, which in turn reflects a different pattern of practice or may reflect a different level of illness. We actually don't know that. So those higher levels that are allowed for managed care Plus Choice reflect the level of fee-for-service spending in that area, which does, now we do know, reflect very different patterns of practice.

So it is a complicated issue, and you just can't jump to the conclusion that because they are getting $800 someplace else, that means they are making a profit.

Mr. KLECZKA. I could beg to differ with you for a slight moment.

Chairman JOHNSON. Unfortunately, let us have everyone discuss, and then we can get back to that discussion. Mr. Ryan, would you like to comment?

Mr. RYAN. I appreciate you including me even though I am not a member of the Subcommittee, but on the full Committee. I feel like I am experiencing deja vu all over again.

And, Ms. Stein, you are probably familiar with the problems we have had in Racine County. We worked with your counterparts down there. Blue is leaving now. We had Primary Care leave 3 years ago. So this is the exact same thing we had happen. And what I find is interesting is the fact that you have in Milwaukee County five providers a number of years ago giving a fairly comprehensive benefit that seniors really enjoyed. In Racine, we had it 3 years ago. It was wonderful. People enjoyed it because they didn't have to go out and buy this Medigap plan, which was very costly. They are much more costly than $100 or $200 in Medigap in Wisconsin. So it at one time provided a very comprehensive benefit filling in the gaps that Medicare normally doesn't cover and giving especially low-income and sick seniors protection.

That protection is leaving. We now see that the costs—that the reimbursement rate relative to the cost is not keeping in pace, and so we see these huge withdrawals. So now you can understand, and I think, Ms. Stein, you put it very well in your testimony, how a senior feels. They don't see this as, oh, gosh, it is still a better benefit than Medigap. They see this as an incredible burden relative to their condition last year or a couple years before.

So now we see what the promise of Medicare+Choice could be but isn't today. And so we see our seniors having this incredible uncertainty in their lives which is extremely disrupting. So if there is anything that we learn from this hearing, this Committee has got to learn to make this work and put certainty back into their lives.

We know that Medicare is an outdated program, that it is giving basically people 1965 health care, and they have to go out and pay for the rest essentially, whether it is Medigap or a Plus Choice program where in some States it works and not in Wisconsin.

But I had a different line of questioning, but Mr. Kleczka was going down an issue I would like to follow up on, which is the letters you send to constituents. It was our experience in dealing with Blue in my neck of the woods that we could negotiate the language of your letters to our constituents so that they had all the information, meaning you would put the 800 number in for the County Aging Department, you would put our phone numbers, like Mr. Kleczka's phone number, in there.

In your letter that you negotiate the language with CMS, isn't it true you work with the County Department of Aging, the Congressmen from that area, to get all of the information that we all believe the citizens need so that they can make the most informed choice? And, Mr. Jones, would you be willing to work with these parties to get that language in your letter to these constituents so that we can make sure that everybody gets the information they need?

Mr. JONES. We would be happy to. Barring the meetings that we had in common, we have worked—that we had the difficulty with,

we have worked, I believe, fairly well with the agency and certainly would intend to—any information that would be helpful to the member to get more information, to get access to more information, to independent opinions on what the coverages should be, we would be very agreeable to having that included.

Mr. RYAN. You are planning another mailing, correct?

Mr. JONES. Yes.

Mr. RYAN. And you have to send that language to CMS before you send it out?

Mr. JONES. That is right.

Mr. RYAN. And you now would be willing to work with the Department of Aging and the Congressman to put the language together so that we all can be assured that 16,000 seniors who right now are very, you know, confused get that information and get multiple sources of people they can contact to get counseling? So you would be willing to work on that?

Mr. JONES. Yes.

Mr. RYAN. Because as has been mentioned here, everybody has a different situation. And if you are chronically ill and definitely on dialysis, maybe this is still a decent deal because of the cap. Maybe it isn't. But we at least need to get these people some information and access to multiple sources of counseling so they can make their own decision.

I will yield the rest of my time, and I won't go on the track that I was planning on going other than to say that we have been going back and forth on this issue for years. I am new to this Committee, but if it hasn't happened in your State, it is going to happen before too long. So we have to fix the basic premise—Plus Choice is a good one. You get comprehensive benefits that catch up with today's needs of health care.

So I thank you for agreeing to share that language and preapprove to negotiate with CMS. I yield.

Chairman JOHNSON. Mr. Lewis.

Mr. LEWIS. Thank you very much, Madam Chair. I would like to thank members of the panel for being here.

Ms. Stein, I would like to thank you for being here. You are really on the front line. You are out there trying to do what you can in providing health care for our seniors, making Medicare work. But as director of the Milwaukee County Department on Aging, you have a number of responsibilities. Could you tell members of the Committee how long you have been the director?

Ms. STEIN. I have been the director since March 1, 1993, so 9 years.

Mr. LEWIS. You not only get involved with efforts dealing with Medicare, Social Security, but you deal with all of the aging concerns and issues, retired senior volunteers, foster grandparents, senior companions.

Ms. STEIN. Elderly nutrition program. All of the long-term care programs in the State.

Mr. LEWIS. So you know a great deal about what seniors like and what seniors dislike.

Ms. STEIN. I hear a great deal and try to absorb it.

Mr. LEWIS. And you are very close to the needs and concerns of seniors?

Ms. STEIN. I certainly try to be. It is not just my job, but it is my mission and my passion, yes.

Mr. LEWIS. You spoke with passion. I read your testimony. I listened to everything you said. I don't want to put you on the spot, and you may not care to respond to this question, but do you think the United plan in Milwaukee is a good option for low-income citizens?

Ms. STEIN. For low-income citizens? I think it is absolutely not an option at all for low-income individuals. They will have to defer any health care—how can you as an older person plan for a flare-up of a chronic illness or a sudden accident? And if you are low income, and those things happen to you, and you have this health plan, you are going to have to come up with cash. And I think low-income means I don't have access to a lot of cash. I need to budget what I am doing. I need to get the best value for my money. So I think that this plan offers almost no value at all.

Mr. LEWIS. So, in essence, this plan, this proposal, would discriminate against people because of their level or income or their ability or capacity to pay? So that is not a sense of fairness, is it?

Ms. STEIN. I think it is not fair to low-income Medicare beneficiaries. I do not believe it is fair.

Mr. LEWIS. So you wouldn't recommend the Milwaukee plan to other urban centers like Atlanta, Chicago, New York or wherever?

Ms. STEIN. No. No, Representative Lewis. I don't believe that I would recommend this plan to any other urban areas or any other areas in the United States.

Mr. LEWIS. Thank you, Ms. Stein. Thank you for being here.

Chairman JOHNSON. Mrs. Thurman.

Mrs. THURMAN. Thank you, Madam Chairman, and thank our guests here for being here.

Mr. Jones, I just need to tell you, since this came up, but we went out on the Web site and whatever they are called these days, Mr. Scully's group, CMS, first of all, you need to know there is nothing in here that talks about the catastrophic part of this.

Mr. JONES. We are aware of that. We have asked CMS to address that. We believe—-

Mrs. THURMAN. You are saying that is a State-by-State benefit that does not change anyplace throughout the country?

Mr. JONES. Right. There is not a place to put that on the Web site.

Mrs. THURMAN. Second, you also need to know when you are asking them to make changes—I just called the 1–800 number to see if I could get information about the catastrophic part of it. It has been disconnected. So they need to change the phone number on here.

Mr. JONES. Eight hundred number for CMS?

Mrs. THURMAN. I don't know. I think it is a United number, and it is 1–800–973–6461. And I just called it, and they just said it has been disconnected. So that might be some good information to make sure that that is also available.

Mr. JONES. I will follow up on that immediately. Thank you.

Mrs. THURMAN. The other thing that I would like to ask, and particularly on the reimbursement issue, because it keeps being brought up here, and we have got several documents that show the

different reimbursements and different States and New Jersey versus Florida versus Connecticut. And one of them, I think, Madam Chairman, there was about a $23 difference between your State and one of my counties.

Chairman JOHNSON. In the AAPCC or in the Medicare reimbursement rate, Plus Choice rate?

Mrs. THURMAN. Right. And tell me how do you say your name again?

Mr. HAYTAIAN. Haytaian.

Mrs. THURMAN. Last year we gave some money back into reimbursement, or what we thought was some reimbursement. I want you to talk to me a little bit, though, because what I have found over the years, it is not just about reimbursement, and yet that seems to be the thing that everybody comes tells us because we are the cash cow up here. Aren't there other problems going on as well? I mean, for example, networks, doctors participating, hospitals participating who have just chosen not to do that because of—and quite frankly, because what we did under the BBA, they lost money or have suggested they lost money, although we did give some givebacks over the last couple of years as well. I think it is misleading to the public to just say that it is just about reimbursement. Would you agree or disagree?

Mr. HAYTAIAN. I think you are correct, but I will address the reimbursement issue first. I think there has to be some reasonable relationship between the reimbursement and actual medical costs in a specific region. If, for example, you are in a region where actual medical costs, fee-for-service costs, are 15, 20, 25 percent less than what you are receiving from CMS in the form of reimbursement, then it has to be a part of the discussion because it is almost a virtual impossibility to be able to offer any kind of reasonable product there. But there are other issues. I can't speak for the rest of the country.

Mrs. THURMAN. Can you give us some other ideas besides the networks that might be a problem?

Mr. HAYTAIAN. I do think there are network issues throughout the country. You read about it all the time when—I think Administrator Scully talked about it before. There are certain places in the country where potentially managed care will not work because there is just not enough volume there, and there is one hospital system, and the hospital system does not want to negotiate with a managed care organization like us. They basically tell us to take a hike, like the Administrator said. So that is a practical reality.

But at the end of the day, the large concentration of seniors are in urban areas, quite frankly, and this is a viable choice for seniors in urban areas and other places in the country, not just urban areas. But there are—to your point—there are areas where it may not be practical to administer a program like this.

Mrs. THURMAN. Ms. Stein, you were shaking your head, so let me let you have an opportunity to speak on that as well.

Ms. STEIN. Of course, we have seen—if you look at the information on all of the plans around the country, you have seen cutbacks in the use of physicians, in hospitals, in the drug payments, which we never had to begin with, but other places did. The cutbacks are very dramatic in Milwaukee, but they are taking place throughout

the entire Nation. And I can't remember which one of you said this, but if you haven't experienced it in your State yet, I bet you will.

So it is—we have a very serious problem, but I think other people are beginning to see the erosion of that Plus Choice promise in all of the plans.

Chairman JOHNSON. Will the gentlelady yield?

Mrs. THURMAN. Sure.

Chairman JOHNSON. Would you expound a little bit on the variations, just in a small State like Connecticut, of the reimbursement rates under Medicare and why you are only in one county? You used to be in more counties.

Mr. HAYTAIAN. We used to be throughout the entire State of Connecticut with the exception of one county.

Chairman JOHNSON. How many different reimbursement rates are there in the small State of Connecticut?

Mr. HAYTAIAN. For each county, there is a different reimbursement rate.

Chairman JOHNSON. So I think the problems we face are very serious. I really appreciate, Ms. Stein, about how passionate your testimony was, but the cause of this is years of under-reimbursement. They were doing fine before 1997, and then we limited them to 2 percent just as health care costs began to explode. So in negotiating down hard with their networks in order to stay within the 2 percent, they gradually lost network position.

And one of the reasons we are not getting a response in the rural counties is that the name of the Choice plans has been sullied because we have not given them the same increases as fee-for-service. Fee-for-service increases have been twice the increases in Choice plans. Now, that is irrational, and especially when the Choice plans have been able to use the money to provide better benefits.

Now, I think it is fair to say that anyone listening to how United has changed its benefit package would have to agree that it will now suit some and not others. It will be only a choice, and we will see whether anyone chooses it. Some of us sitting here think no one will choose it, but the company has reason to believe some will choose it.

I think some of us tend to underestimate the number of seniors there are that actually could be exposed to $5,000 in costs and trade off for that any higher exposure knowing that they are likely to be hospitalized so they are unlikely to have any costs. So that 5,000 rolls over from year to year.

These are the difficult things about making planned choices, but I think seniors need choice, and clearly we would not be here if Medicare fee-for-service was an adequate choice. It is not. That is why the Medicare Choice plans and Medigap plans have been popular. But Medicare—Medigap premiums have been skyrocketing as well.

So rising health care costs are impacting Medicare, and I believe it is our responsibility to see that everyone has access to a fair level of reimbursement so our seniors have the best choices they could possibly have, because our ability to modernize Medicare to keep up with the pace of medical developments, either diagnostic or treatment, is minimal, and the fact that it took us 5 years to provide mammogram coverage, and only last year did we cover Pap

smears is clear-cut evidence that you need out there some plans that have greater flexibility as to what benefits they cover and what benefits they don't. And going through his detailed answer, Mr. Jones didn't actually go over much of those benefits, those little benefits that they cover that Medicare doesn't.

So seniors will look at all of those things. We are faced with a very serious problem because we have failed to either keep up with honest reimbursement rates or create a reasonable regulatory environment, and so we are now seeing choices for seniors disintegrate. Seniors need those choices because Medicare is inadequate.

And we are going to have to come back to this subject in much greater detail later on. I thank the panel for their participation, and the meeting is adjourned.

[Whereupon, at 12:55 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of the Alliance to Improve Medicare

The Alliance to Improve Medicare (AIM) is the only organization focused solely on fundamental, non-partisan modernization of the Medicare program to ensure more health care coverage choices, better benefits (including prescription drug benefits), and access to the latest in innovative medical practices, treatments and technologies through the Medicare system. AIM coalition members include organizations representing seniors, hospitals, small and large employers, insurance plans and providers, doctors, medical researchers and innovators, and others.

AIM recently approved the attached recommendations on expanding health care coverage choices for senior citizens through improving the Medicare+Choice program. AIM's recommendations call for ensuring adequate payment levels for plans and providers, adopting different payment structures for different Medicare+Choice plan types, improving Medicare's regulatory framework, and increasing availability of Medicare beneficiary education materials.

AIM applauds Subcommittee Chairwoman Nancy Johnson and ranking member Pete Stark for their bipartisan efforts in the discussion of necessary regulatory reforms to the Medicare program. We hope the Subcommittee will consider AIM's recommendations as they continue their discussions on this issue.

Expanding Health Care Coverage Choices for Seniors through Improving Medicare+Choice

AIM is a coalition of organizations representing seniors, doctors, hospitals, small and large businesses, medical researchers and innovators, insurance plans and providers and others dedicated to improving and strengthening Medicare for all Americans. AIM seeks to ensure that all senior citizens have more health care coverage choices, better benefits (including prescription drug coverage), and access to the latest in innovative medical practices and treatments. These recommendations address problems specifically confronting Medicare's managed care program, Medicare+Choice.

In the Balanced Budget Act of 1997, Congress took the important step of creating the Medicare+Choice program as a health insurance benefits option to Medicare beneficiaries. This option was designed to offer more choices for beneficiaries, and to provide beneficiaries with the ability to obtain additional benefits not covered under traditional Medicare, such as prescription drug benefits. Many beneficiaries who have selected Medicare+Choice plans are pleased with their ability to select these plans, and believe they have benefitted significantly from the comprehensive integrated benefits. Indeed, most Americans under age 65, especially those utilizing employer-provided health care, have managed care coverage choices similar to those offered in the Medicare+Choice program, and as more baby boomers become Medicare eligible, they will expect those same plan choices under Medicare.

AIM believes the principles of beneficiary choice inherent in the Medicare+Choice program can serve as a foundation for strengthening and improving the Medicare program. Building and ensuring a strong Medicare+Choice program requires that beneficiaries have an expanded range of options similar to those available to Members of Congress, federal employees and retirees, and millions of working Americans under 65 years of age who are covered by private plans. The Medicare+Choice pro-

gram was envisioned to include a variety of health maintenance organizations, private fee-for-service plans, provider-sponsored organizations, and preferred provider networks but has been unable to attain that goal. Inadequate payments and excessive regulation of private sector plans and providers participating in Medicare+Choice have seriously constrained the ability to expand coverage areas and have caused numerous plans to withdraw from coverage areas where reimbursement was inadequate to cover even the costs of basic care. As a result, millions of beneficiaries are at risk of losing their access to these plans and the additional benefits they have offered.

(1) Ensure Adequate Payment Levels for Health Plans and Providers

Currently, Medicare pays one set fee per month for each beneficiary enrolled in a Medicare+Choice plan based on a payment formula in the Balanced Budget Act of 1997 and regardless of the number of services the beneficiary may require. This payment formula has resulted in inadequate payment levels for Medicare+Choice plans in many parts of the country. For example, payments to health plans in many counties have been capped at two percent (three percent in 2001) annual increases over the past several years, despite growth rates in local health care costs that are as much as 8 to 12 percent. This has resulted in significant disparities between Medicare+Choice payments and local fee-for-service costs in some areas and contributed to many plans withdrawing from the program and reducing service areas. AIM supports an immediate increase in funding levels in order to save the program.

(2) Adopt Different Payment Structures for Different Plan Types

The current one-size-fits-all Medicare+Choice program payment structure sets many plans up for failure, especially in rural areas, and is unworkable if the program is to succeed and provide a variety of coverage options for Medicare beneficiaries nationwide. For example, building rural health plan and provider networks is difficult given less conducive health care market economics. Plans in many rural areas have difficulties negotiating payments because of higher-than-average Medicare volumes and because the cost of bearing full risk for a potentially small population is relatively high when plans cannot spread costs over a larger pool of insured individuals.

The Federal Employee Health Benefit Program (FEHBP) provides an example of flexible plan design and benefit structures. The FEHBP allows qualifying participants to choose from among a minimum of 10 plans nationwide, varying in plan type, benefit structure, and cost. FEHB program offerings currently include PPOs, HMOs, and indemnity plans which do not participate in the Medicare+Choice program because of inadequate payment levels caused by the program's inflexible payment structure.

AIM supports Medicare+Choice program improvements that will ensure a competitive market-based system of health plan options similar to that available to private sector Americans and federal employees and retirees. Congress and CMS should ensure that beneficiaries have a choice of plan types similar to those available to FEHBP participants. Allowing flexibility in the Medicare+Choice program payment structure to accommodate different plan types would encourage creativity in the market and could encourage more participation by a wider variety of plans.

(3) Improve Medicare's Regulatory Framework

AIM members believe that excessive regulation present in the Medicare+Choice program reduces innovation and consumer choice. AIM believes Medicare administrators must reduce excessive program complexity and bureaucracy caused by the more than 110,000 pages of federal rules, regulations, guidelines and directives. AIM supports the elimination of real fraud and abuse in Medicare but our members believe this can be achieved without relying on unnecessarily complex and heavy-handed regulation. Providers and plans must not be forced to divert resources from patient care in order to respond to ever-changing regulation.

CMS has had a fragmented approach to Medicare+Choice program oversight in the past. AIM members are pleased that CMS Administrator Scully has recognized this problem and begun to address it with the announcement of the new Center for Beneficiary Choices to focus on Medicare beneficiaries in private plans. This will allow for greater efficiencies and streamline requirements that now may be developed within different offices. We recognize and applaud the efforts of the Bush administration and Congress to begin to streamline many burdensome procedures and we encourage the administration and CMS to consider these additional actions:

- Publish Guidelines for Beneficiary Materials: End efforts to standardize written materials for Medicare beneficiaries. The current requirement for CMS approval of all documents and CMS's long term objective for standardizing

many more communications is problematic. Health plans need to tailor their communications to their own programs. CMS should provide a checklist for plans of the information required to send to beneficiaries and develop marketing and communications guidelines.

• Create a Medicare Office of Technology and Innovation: Important new medical technologies and services must go through three sequential stages of Medicare decision-making—initial coverage, procurement code assignment, and payment level determination—before they are available to Medicare patients. This process has suffered from a lack of coordination and created long delays in patient access to new technologies.

(4) Increase Availability of Beneficiary Education Materials

In a survey of Congressional Medicare caseworkers, AIM found that many beneficiaries are unaware of existing opportunities for assistance from such organizations as State Health Insurance Assistance Programs and other medical hotlines or simply lack access to opportunities such as the Internet www.Medicare.gov and the 800 Medicare hotline. Additionally, some beneficiaries currently have difficulty comparing benefits available through Medicare fee-for-service with benefits available through Medicare+Choice plans.

Medicare beneficiaries should have easy access to good information and benefit comparisons on the types of plans available. Beneficiaries need adequate, easy to understand information and clearly identified customer service representatives and insurance agents who can provide assistance by explaining coverage and benefit information and options. CMS can assist beneficiaries by recognizing that, because some beneficiaries desire more information on available plans, there is a need for a range of resources varying in scope and detail. The www.medicare.gov web site currently offers differing layers of information not elsewhere available to beneficiaries. These materials should be available to all beneficiaries, not just those with web access. CMS has begun to address this problem by increasing its ability to mail comparative information to beneficiaries who contact the Medicare hotline but who do not have Internet access.

Beneficiaries also need additional assistance understanding Medicare claims and appeals procedures for denial of payment for services. CMS should expand efforts to clearly explain claims and appeals procedures should be provided to beneficiaries and providers.

Statement of Vicki Gottlich, Center for Medicare Advocacy, Inc.

The Center for Medicare Advocacy, Inc., (the Center) submits these written comments to be included in the record of the hearing set for December 4, 2001, on the "Status of the Medicare+Choice Program." The Center is a non-profit organization which provides education, legal advice and representation to elders and people with disabilities who are unfairly denied Medicare and other health care coverage. Center staff provide legal advice, self help materials, and representation for elders and people with disabilities. We also provide training, support, and technical assistance to Connecticut CHOICES, the state's health insurance counseling program, and to Medicare advocates across the nation. We thank the Subcommittee on Health of the Committee on Ways and Means and its Chairman, Nancy Johnson, for holding this important hearing on how recent changes in the Medicare+Choice (M+C) program have adversely affected older people and people with disabilities.

CONNECTICUT SPECIFIC ISSUES

This is the fourth year in a row that M+C plans have announced withdrawals from Connecticut.

ConnectiCare and MedSpan will withdraw from Medicare as of January 1, 2002. Only two Medicare HMOs will remain, PHS/HealthNet and Oxford. This will leave Medicare HMOs only in Fairfield, Hartford and New Haven counties. The Medicare managed care terminations affect approximately 39,000 Connecticut Medicare beneficiaries. In 2000, 52,000 Connecticut Medicare beneficiaries were affected when CIGNA, Aetna US Healthcare, and Antehm Blue Cross terminated their coverage. Health Net (then PHS) pulled out of two counties.

But plan withdrawals are only part of the problem. I would like to focus on one of the two remaining Connecticut plans, Health Net, formerly known as Physician Health Services, or PHS, to demonstrate the impact of changes made by existing HMOs on those beneficiaries who are enrolled in the plans or who would like to enroll.

A. Enrollment caps

In announcing that Health Net would remain in Connecticut, the plan also announced that the number of new members able to enroll in the plan would be limited. Oxford, the other remaining Connecticut plan, has already reached its enrollment cap and is not accepting new enrollment.

This year, open enrollment (the annual coordinated enrollment period) for M+C plans runs from November 1 through December 31. Older people and people with disabilities in Connecticut who did not act immediately upon learning that their plans were leaving may have been foreclosed from joining another Medicare+Choice plan. One older woman explained to a Center staff attorney in mid-November that she reviewed the written material describing her M+C choices in Connecticut that the Centers for Medicare & Medicaid Services (CMS) sent, but by the time she called the remaining plan in her area the plan was only able to put people on a waiting list.

B. Changes in provider networks

The Medicare Health Net plan for 2002 also announced that three hospitals previously in its network will NOT be participating in 2002. These are Hartford Hospital, Danbury Hospital, and Greenwich Hospital, three of the major hospitals in the area. Thus, unless the individual needs emergency or urgent care, services provided at any of these hospitals will not be covered in 2002. Further, physicians who have admitting practices only at these hospitals will not be able to participate in Health Net in 2002. Thus Health Net members who use these doctors, as a primary care physician or specialist, may have to seek new doctors, resulting in a disruption of care. Some enrollees who need hospital services will also have to travel longer distances to get those services.

C. Changes in benefit structure

Health Net's Premiums for 2002 will increase by $20 per month, from $79/month to $99/month; co-payments for doctor visits will increase by $5 per visit, from $15/visit to $20/visit.

Health Net also is adding co-payments for services for which the plan previously did not charge a co-payment. For example, the plan is going from a zero co-payment for dialysis services to a 20% co-payment. Inpatient hospital care and outpatient surgery were previously covered in full. In 2002, this will change dramatically. Enrollees will be responsible for a $500 co-payment per admission for inpatient hospital care and inpatient mental health care, and a $100 co-payment per surgery for outpatient surgery.

The co-payment for generic prescription drugs will increase $3 per prescription, from $7/prescription to $10/prescription. Insulin will no longer be covered.

D. Effect on Medicare beneficiaries

The following inquiry received by a Center staff member demonstrates the adverse impact of the new cost-sharing requirements on Medicare beneficiaries.

A woman who is enrolled in PHS/Health Net has been going to the hospital every month for a series of immune globulin shots. She has not had to pay anything towards the cost of this treatment. PHS has informed the woman that the treatments involve inpatient hospital care and that, starting January 1, the woman will need to pay the $500 co-payment each month. The woman was concerned about the accuracy of this information and her alternatives for obtaining treatment. She cannot afford this new and substantial cost for her health care.

Assuming for purposes of this statement that the plan's characterization of the immune globulin shots as an inpatient hospital service is correct,[1] the plan, under its new co-payment schedule, is indeed entitled to charge a $500 co-payment each month, as each month is a new hospital admission. The cost for the treatment through the M+C plan, therefore, clearly exceeds the cost to a beneficiary in traditional Medicare. If the woman disenrolled from the plan and returned to traditional Medicare, she would be responsible for a $812 hospital deductible in January at the start of her new benefit period. Because she would be within the same benefit period for each subsequent month's hospitalization, and because she would not exceed 60 days of hospital care within this benefit period, she would not have to pay another co-payment for the treatment.[2] Furthermore, if the woman were in traditional Medicare, she may have a Medicare supplemental (Medigap) policy that pays for the part A hospital deductible.[3] Thus, she would be able to receive the treatment she needs without any out-of-pocket costs, just as she received the treatment cost-free in 2001 from the M+C plan.

The simple answer seems to be that the woman should disenroll from her M+C plan, return to traditional Medicare, and purchase a Medigap policy. She is returning to traditional Medicare not because her M+C plan terminated its contract with Medicare, but because the change in her plan's benefit package makes the plan in appropriate for her health care needs.[4] This will be possible in Connecticut because any insurance company which sells Medigap plans A through G must sell them to any Medicare beneficiary over age 65 at any time, regardless of age, gender, medical condition or previous health insurance claims history. This means that insurance companies are not allowed to medically underwrite plans A through G for any Medicare beneficiary over the age of 65. This, however, in other states that do not have such protective legislation, this would not be possible.

OTHER PROBLEMS

Older people and people with disabilities who live in Connecticut are not the only Medicare beneficiaries to be adversely affected by changes in M+C plan benefit structures and plan networks. Similar problems are occurring around the country.

In Boston, a major provider, the Leahy Clinic, pulled out of the Tufts Secure Horizons plan, effective November 1, 2001. Affected beneficiaries who wanted to remain with their providers associated with the Leahy Clinic were able to change plans effective November 1. However, they will not have the same opportunity to change plans to continue care with their provider next year after the "lock-in" takes effect. Also in Massachusetts, Blue Cross& Blue Shield of Massachusetts will impose a $25 per day co-pay for days 1–20 of a skilled nursing facility stay starting January 1. No co-payment for those days is charged in traditional Medicare.5

The Kaiser M+C plan serving Central Maryland, including counties in the Washington, D.C.—Baltimore corridor, has also increased its premiums by $20-$30, depending on the plan, and increased per-provider co-payments. Like the Connecticut Health Net plans, Kaiser will be imposing a per hospital stay co-payment—in this case $300 per stay. Again, a beneficiary who requires several hospital stays in what would be one spell of illness under traditional Medicare will end up paying more out-of-pocket than if she were in traditional Medicare.

The California Council of the Alzheimer's Association reports that many M+C plans in that state have sent letters to enrollees saying the plans no longer have to provide beneficiaries with brand name prescriptions and will only make generic drugs available to them. Although some of the plans imply that the change in policy comes from CMS, CMS staff have assured the Alzheimer's Association that they have no such policy. The decision to limit prescription drug coverage to generic drugs is a decision made independently by each plan.

The shift to coverage of generic drugs only has a pernicious effect for people with Alzheimer's disease, certain cardiac conditions, and to people who rely on insulin. There are no generic equivalents for the name brand medicines they take. As a result, these beneficiaries are losing prescription drug coverage, often while paying increased premiums to the same plan.

PROPOSED SOLUTIONS

The Center for Medicare Advocacy, Inc. supports enactment of HR 3267, the Medicare+Choice Consumer Protection Act. The bill addresses problems being encountered by beneficiaries by:

(1) eliminating the M+C lock-in scheduled to phase in starting in January 2002;

(2) extending the existing Medigap protections that apply to people whose M+C plan withdraws from the program to anyone whose M+C plan changes benefits or whose doctor or hospital leaves the plan; and

(3) prohibiting M+C plans from charging higher cost-sharing for a service than Medicare charges in the fee-for-service program.

A. Lock-in

When the lock-in provisions were enacted as part of the Balanced Budget Act of 1997, Congress assumed that the M+C market would be more stable than it is today. Congress wanted to insure that beneficiaries would be able to continue the care they were receiving in a plan, and to protect them if a plan wanted to discharge them because the care they needed was too much or too costly.

Instead, plans are choosing to enter and leave M+C markets more frequently than anticipated. Doctors and other providers, both individually and in networks, also are choosing to join and leave M+C plans with unexpected frequency. Medicare beneficiaries therefore need to retain the choice they currently have to leave one M+C plan and join another, or to leave and return to traditional Medicare, in order to

continue care under a provider or to seek other care if their current plan no longer meets their needs.

B. Extending Medigap protections

One of the major purposes of the M+C program is to provide a beneficiary with the *choice* of how she wants to receive her Medicare. When a provider leaves a network, or a plan changes its benefit structure dramatically, the plan no longer meets the needs of the beneficiary in the same way as a plan that leaves the Medicare market no longer meets the beneficiary's needs. In theory, the beneficiary has the choice of returning to traditional Medicare and purchasing a Medigap policy. In practice, however, the beneficiary may not be able to exercise this choice because she may not be able to find a Medigap insurer that will issue her a policy. By extending the Medigap protections to beneficiaries who lose their M+C plans in the above situation, Congress will make the choice a reality.

C. Prohibiting higher cost-sharing than in traditional Medicare

Many plans have imposed higher cost-sharing than traditional Medicare for services needed by the sickest and neediest beneficiaries—inpatient hospital stays, skilled nursing facility stays, home health care, and durable medical equipment. The effect of these co-payments is to make the plans less desirable for these beneficiaries, and to discourage their enrollment in the plans. As a result, plans can keep costs down by either not having to provide services to people with acute and chronic conditions, or by shifting a larger portion of the cost of these services onto the beneficiaries. Though M+C plans are prohibited from discriminating against beneficiaries on the basis of medical condition, claims experience, receipt of health care, or medical history,[6] the plans in effect have achieved the same result as if they refused up front to enrollment beneficiaries who need these expensive services.

Furthermore, unlike the woman in Connecticut who contacted the Center for Medicare Advocacy, most beneficiaries do not know in advance that they will need extensive hospital care, skilled nursing care, or home health services. They may not review plan benefit packages for hospital co-payments, focusing instead on doctor co-payments and prescription drug coverage. Thus, if a need for such extensive care arises suddenly, they may be unprepared to make the co-payments. Further, unlike in traditional Medicare, there is no supplemental insurance to cover the large out-of-pocket expenses. Beneficiaries who are not wealthy enough to self-insure will be stuck with large bills, at a time when they are already in a crisis dealing with an unexpected health care problem. And, unfortunately, most beneficiaries do not have access to attorneys or other proficient Medicare advocates.

D. Universal prescription drug coverage

The California example of the shift from inclusive prescription drug coverage to generic coverage only underscores the need for a universal prescription drug benefit that is part of the Medicare program.

The decision by the private M+C plans to further restrict their drug benefit is based on their needs and not on the needs of their enrollees. As pointed out, the change has the effect of discriminating against people with chronic conditions for which there are no generic equivalents. These people are paying for a prescription drug benefit that is not available to them.

Medicare beneficiaries need a uniform, affordable, accessible benefit that is part of the Medicare program to assure that their health care needs are met.

Statement of the Hon. Steve Israel, a Representative in Congress from the State of New York

Good morning, Madam Chairwoman, Congressman Stark, and my distinguished colleagues. I would like to thank you for allowing me to speak to you this morning regarding the Medicare+Choice program and the bipartisan bill that I have introduced with Congressman Grucci of New York to help stabilize the Medicare+Choice program.

This fall, hundreds of thousands of seniors and other Medicare+Choice beneficiaries have been informed that their managed care health plans have left their communities because of inadequate payments, and that they will have to find new coverage and possibly spend more out of their limited incomes for the health care services that they need. I would like to bring to light the plight of millions of America's seniors and other Medicare+Choice beneficiaries who have been forced back

into fee-for-service Medicare because of the exit of their health plan including thousands in my own district. In large part, the problems generated by this underfunding can be seen as unintended consequences of the Balanced Budget Act of 1997 (BBA).

The BBA created a new program called Medicare+Choice. At the time, the BBA placed a strong emphasis on controlling future Medicare spending, in private health plans as well as in fee-for-service Medicare, as part of a broader effort to balance the Federal Government's budget. One of the key goals of the BBA was to increase Medicare beneficiaries' access to private health plans through Medicare+Choice—the idea being that America's seniors deserved the choices and expanded benefits that only health plans would deliver. While the BBA clearly achieved its objective of limiting spending throughout the entire Medicare program, this accomplishment has had the unintended consequence of reducing beneficiaries' access to health plans because of underfunding. Thus the BBA has diminished health care choices for Medicare beneficiaries in certain areas of the country in recent years.

Over the past three years, there has been a building consensus in Congress that the unintended consequences of the Balanced Budget Act (BBA) of 1997 have put severe pressure on the Medicare market as a whole, and Medicare+Choice health plans in particular. Payment levels in some parts of the country are so inadequate that health plans cannot meet the cost of health care services in those markets, and, they are having to drastically alter their benefit packages or leave these markets altogether. As you may know, there is bipartisan support for stabilizing the Medicare+Choice program and, in each of the past three years, there have been numerous bills introduced in Congress to deal with the issue of underfunding. The recognition of this larger problem led Congress to enact the Balanced Budget Refinement Act of 1999 as well as the Benefits Improvement and Protection Act of 2000 in a much-needed effort to stabilize the Medicare+Choice Program.

However, the Medicare+Choice program continues to be significantly underfunded in those areas of the country with the highest concentration of health plan members—these are the markets where payments to health plans for next year will increase by only two percent. These are also the large urban and suburban areas where the cost of medical services and inflation have been rising at up to ten percent per year. Close to 70 percent of Medicare+Choice beneficiaries are enrolled in these "two percent" counties. These are the people who need our help immediately so that they may continue to have access to the comprehensive benefits packages offered by health plans.

The instability of the program is especially troubling for enrollees who will have to either change their health plan or return to the Medicare fee-for service program next year because inadequate funding has forced their health plans to withdraw from the program. In January 2002, more than 530,000 seniors and other beneficiaries will have to change their health coverage as a result of these inadequate payments. This is in addition to the more than 1.6 million beneficiaries that have been adversely affected since 1998. Many other beneficiaries will face higher premiums or less comprehensive benefits packages for next year. Although more than 60 percent of beneficiaries enrolled in managed care plans receive some level of drug benefit this year, that number could also continue to fall because of inadequate funding. As a point of comparison, one need only look at 1999, when 84 percent of Medicare+Choice beneficiaries had access to some type of drug benefit. Those beneficiaries who have prescription drug coverage, today, are seeing tighter caps on their benefits. The percentage of Medicare+Choice enrollees who have an annual cap of $500 or less on their prescription drug coverage has increased from 11 percent in 1999 to 27 percent in 2001. The erosion of this much-needed benefit is one of the most glaring results of the underfunding of Medicare+Choice.

Many of the beneficiaries affected by plan withdrawals have been able to enroll in another Medicare+Choice plan in their area. However, a significant number have been left with only one option—enrolling in the Medicare fee-for-service program, which offers less comprehensive coverage and requires higher out-of-pocket costs than the typical Medicare+Choice plan. Millions more have experienced a reduction in benefits or an increase in out-of-pocket costs, including premiums, even though they were able to keep their Medicare+Choice plans.

Further evidence of the underfunding of Medicare+Choice plans is not too hard to find. A simple comparison of the government's payments to other parts of Medicare is the clearest reminder of the inadequacy of payment—Medicare+Choice plans in counties with almost 70 percent of total enrollment received a three percent increase in funding this year, a figure that pales in comparison to the increase in the Medicare fee-for-service rate nationwide over the same time period. The Centers for Medicaid and Medicare Services (CMS) has projected that Medicare fee-for-service spending, when measured on a per capita basis, increased by 9.6 percent in 2001.

As a continuing comparison to other sectors within health care—a survey by the Kaiser Family Foundation, based on responses from more than 1,900 employers, indicates that premiums for employer-sponsored health coverage increased by an average of 11 percent from spring 2000 to spring 2001. Any serious effort to stabilize the Medicare+Choice program must directly address these concerns by committing a significant level of additional funds to support the health benefits of Medicare+Choice enrollees.

New York state has almost 400,000 beneficiaries enrolled in Medicare+Choice plans, a majority of whom live in counties where plans have been limited to a two percent annual update since the BBA of 1997. In September of 1999, 12 HMOs offered seniors health plans in Suffolk County. Now only two remain.

This year, CMS reports that 65 Medicare HMOs did not renew their contracts, leaving an additional 160,000 senior citizens in America with no Medicare HMO option. Since 1998, more than 46,500 seniors and other Medicare+Choice beneficiaries have been affected in Suffolk County alone.

This is intolerable. Most seniors enroll in HMOs for coverage not provided by Medicare, but HMOs across the country are unable to renew their contracts with the Federal Government, leaving seniors without access to a prescription drug plan. In January 2002, 16,000 more Medicare+Choice enrollees throughout the state of New York will be adversely affected because of these chronic problems of underfunding.

Moving forward, I urge this Committee and all Members of Congress to seriously consider the following remedy to the immediate funding inadequacies in Medicare+Choice——

As you may know, I have introduced a bill that will help to prevent further disruptions for Medicare beneficiaries in the coming year. The "Medicare+Choice Equity and Access Act" (H.R. 2836) is a bipartisan bill introduced with my co-sponsor, Felix Grucci, Republican of the First District of New York. You also may know that a bipartisan bill was also introduced in the Senate by Senators Schumer of New York and Santorum of Pennsylvania who are also committed to stabilizing the Medicare+Choice program. The Israel-Grucci bill will work to bolster payments to the Medicare+Choice program, particularly in those areas that have not been targeted for relief by the Balanced Budget Refinement Act of 1999 (BBRA) and Benefits Improvement and Protection Act of 2000 (BIPA).

- H.R. 2836 adds a new element to the Medicare+Choice payment formula to allow plans to receive payments equal to 100 percent of local fee-for-service rates. Medicare+Choice plans in many areas have received payment updates of only two or three percent every year since the Balanced Budget Act of 1997 (BBA) was enacted. Adding a new payment element—equal to 100 percent of local fee-for-service rates—would provide more equitable payments to plans that have received only the minimum annual payment update in recent years when their costs have been increasing at two or three times that rate.
- H.R. 2836 eliminates the BBA's budget neutrality requirement to allow the "blend" component of the Medicare+Choice payment formula to be implemented. The BBA established the "blend" in an effort to provide for a more equitable distribution of resources in response to concerns that Medicare managed care payments varied unfairly across geographic regions under the old payment system. However, the BBA's budget neutrality requirement has resulted in the Medicare+Choice payment "blend" being funded in only one year since the BBA was enacted. Eliminating this requirement would allow Medicare+Choice plans to receive the higher "blended" payments that Congress originally intended.

By targeting assistance to areas that have received little or no assistance under BBRA or BIPA, we have managed to develop a solution that has the potential to complete the job of stabilizing the Medicare+Choice program. An opportunity still exists, if we act promptly, to save the Medicare+Choice program and ensure that Medicare beneficiaries continue to have access to the wide range of high-quality, affordable health care choices they deserve. I would like to remind my colleagues again that the future of Medicare rests with this Congress, and the first step in that future would be to deliver on the promises made by this body to America's seniors and disabled beneficiaries—we have to maintain a viable Medicare+Choice program to ensure that we can build on it when considering future avenues in Medicare reform.

Thank you for your time and the opportunity to testify before this Committee.

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