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The Heritage Foundation

F.Y.I.

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A GUIDE TO MEDICARE REFORM PROPOSALS

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INTRODUCTION

When Congress returns from its August recess, it will begin to consider the future of one of America's most popular entitlement programs—Medicare. Much is at stake for Americans of all ages.

The Medicare program is in dire financial trouble. According to the 1995 report of the Medicare Trustees, a seven-member federal board that includes three Clinton Administration Cabinet members and two other senior Administration officials, the Hospital Insurance (HI) Trust Fund is projected to be insolvent by the year 2002. The need and urgency for change is succinctly stated: "The Trustees believe that prompt, effective, and decisive action is necessary."[1]

To avoid the collapse of the program, Congress has only two choices:

Choice #1: Do not change significantly the way Medicare is run by the government, and assure future benefits by raising new revenues through higher payroll taxes and other taxes or by diverting money from other programs. This means Medicare survives only by draining money from the rest of the budget or by sharply raising payroll taxes.

Choice #2: Fundamentally change the way Medicare is run so that benefits are delivered more efficiently, thereby avoiding future tax increases or a diversion of money from other programs. This approach would aim to slow the rate at which costs are anticipated to grow.

Several proposals have been put forward in recent months, from outside Congress, to address the problems of Medicare. During the August recess, Members and the public can be expected to evaluate such proposals as they consider what actions should be taken regarding Medicare when Congress meets to finalize action on the budget.

To assist this evaluation, this *F.Y.I.* summarizes several of the leading reform proposals. These include plans advanced by the Clinton Administration, by "think tanks" (the Brookings Institution, Heritage Foundation, and National Center for Policy Analysis), by organizations repre-

1 *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, April 3, 1995, p.28.

senting the elderly (the National Committee to Preserve Social Security and Medicare and United Seniors Association), and by major organizations representing health care providers (the American Hospital Association, American Medical Association, Federation of American Health Systems, Group Health Association of America, and Healthcare Leadership Council).

This *F.Y.I.* is intended only to summarize these proposals, not to evaluate them; as far as possible, documents are quoted verbatim or paraphrased. Documents used in the summaries may be obtained from the issuing organizations.

While the proposals vary widely in detail, many share common themes. Only two (the Clinton Administration and the National Committee to Preserve Social Security and Medicare) can be described as leaving the current structure virtually unchanged. The others tend to emphasize three broad reform themes:

1) An option to pick private plans. Virtually all the reform plans would allow recipients to pick private plans as an alternative to the traditional Medicare program. Generally this is seen as a way to improve the quality of care and, by introducing a much greater degree of consumer choice within a competitive market, a way to reduce the rate of increase in Medicare spending. Some proposals would permit beneficiaries to choose plans with benefits that differ from the current Medicare package (Heritage, American Medical Association), while others would require the private plans to contain at least the standard Medicare benefits (Brookings, NCPA). Virtually all would retain the traditional Medicare program as an option.

2) A defined contribution. Virtually all the reform plans would begin to shift Medicare away from an open-ended program which pays for a set of benefits (a defined benefit) and toward a program which makes a financial contribution towards the health costs of a Medicare beneficiary. This is accomplished in several ways, such as a budgeted voucher payable to the plan chosen by the beneficiary (American Medical Association, Heritage) or a payment linked to the growth in general health care costs (Brookings, NCPA). Like the general option to pick private insurance in place of traditional Medicare, moving to a defined contribution system is intended to change fundamentally the incentives in the program, encouraging beneficiaries to seek better value for money.

3) The FEHBP as a model for reform. While virtually all the reform plans propose some form of new or revised administrative structure to organize and monitor a Medicare market of competing private health plans, several proposals (American Medical Association, Federation of American Health Systems, Heritage) adopt as an administrative model the program currently serving federal workers, retirees, and dependents. The Federal Employees Health Benefits Program (FEHBP) organizes a market of almost 400 private plans competing for the business of over nine million Americans.[2]

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2 Robert E. Moffit, "Consumer Choice in Health: Learning from the Federal Employees Health Benefits Program," Heritage Foundation *Backgrounder* No. 878, February 6, 1992.

THE CLINTON ADMINISTRATION

The following is a summary of the Medicare proposals outlined by the Clinton Administration on June 13, 1995, when the Administration unveiled a second budget blueprint. Specific details on the proposal have not yet been made available.

The President's plan to restore the fiscal integrity of the Medicare trust fund aims to reduce the growth in spending in Medicare Part A by $79 billion over seven years to ensure the solvency of the Medicare HI Trust Fund to 2005. These savings are based on the Office of Management and Budget's projection of Medicare spending under current law. (The savings to be achieved would be higher if the Congressional Budget Office baseline is used).

The White House plan aims to achieve such savings by reducing the growth of payments to providers, not by raising beneficiary costs. In fact, the Administration's proposal reduces the same beneficiary costs by eliminating the copayment for mammograms. The White House notes that only 14 percent of eligible beneficiaries without supplemental insurance schedule mammograms. One factor, say officials, is the required 20 percent copayment. To remove financial barriers to women seeking preventive mammograms, the President's plan waives the Medicare copayment.

The President's plan would expand managed care options for retirees to include variants such as preferred provider organizations (PPOs) and point-of-service (POS) plans. The plan also seeks to improve Medicare reimbursement of managed care plans, including a competitive bidding demonstration proposal.

Finally, the Clinton proposal aims to combat fraud and abuse, in part through an "Operation Restore Trust," a five-state demonstration project targeting fraud and abuse in the home health care, nursing home, and durable medical equipment industries. The President's budget proposal increases funding for these fraud and abuse activities.

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RESEARCH ORGANIZATIONS

AARON AND REISCHAUER (OF THE BROOKINGS INSTITUTION)

The following summarizes a proposal put forward on July 20, 1995, by Henry J. Aaron and Robert D. Reischauer of the Brookings Institution.[3] *Reischauer until recently was Director of the Congressional Budget Office.*

Like other policymakers, Aaron and Reischauer have defined several goals and principles around which Medicare reform should revolve.

First, Medicare reform should encompass the full package of benefits most Medicare beneficiaries use.

Second, "a reformed Medicare program should not result in the provision of health care to the elderly and disabled of a quality materially different from that available to the general population; nor should the delivery system for the elderly and disabled be segregated from that of the rest of the population (other than for definable services where medical reasons justify separate delivery, as with geriatric care)."

Third, "Medicare should create incentives for beneficiaries to seek care from efficient plans and should encourage physicians and hospitals to provide care of given quality at lowest possible costs."

Fourth, "Medicare beneficiaries should have a degree of choice among health plans similar to that enjoyed by the rest of the population."

Aaron and Reischauer believe the current Medicare program should be converted from a defined benefits program (service reimbursement system) into a form of defined contribution program (premium support system). Instead of paying for all services on a predetermined list, Medicare would pay a defined and set sum toward the purchase of an insurance policy that provides a defined set of services. "As with private insurance for the working population, plans could reimburse any provider the patient chooses on a fee-for-service basis (the current method Medicare uses for most beneficiaries), contract with a preferred provider organization, or operate through a health maintenance organization." These plans could manage care in any of the ways they currently practice or adjust as necessary for changes that may occur in the future. In short, every "Medicare beneficiary would receive a pre-determined, geographically variable amount that would be applied toward the purchase of a health plan providing defined services."

Health plans participating in the new program would be required to offer a defined set of services. While the new Medicare plan would not use the current Medicare benefits package as a model, it would add prescription drug and catastrophic coverage. Aaron and Reischauer believe that a standard benefits package is necessary because it will enable enrollees to compare the cost and quality of the various plans while reducing the risk of instability in the insurance market from plans altering benefits in an effort to attract healthier enrollees.

Marketing. Health plans choosing to participate in the new plan (commercial insurance companies, Blue Cross/Blue Shield plans, HMOs, PPOs, non-managed care networks) would be invited to submit bids on the standard benefit package for the "average" Medicare enrollee within a particular marketing area. The federal Medicare contribution to help the enrollee defray the cost of a plan in

3 Henry J. Aaron and Robert D. Reischauer, "Summary, Medicare, Where to From Here," July 20, 1995.

each market area would be the same regardless of which plan the Medicare enrollee chose. To ensure that Medicare enrollees are well-informed of their various options, local marketing organizations would be established to handle the sale of insurance and act as consumer advocates. As in the FEHBP, enrollees would choose a health plan for the upcoming year on an annual enrollment basis.

Health plans would receive risk-adjusted payments from Medicare based on age, gender, disability status, and other health indicators.

Premium Contribution. The initial federal payment would be set at 95 percent of the cost of the current Medicare package in the enrollee's market area. The size of the payment would be adjusted to exclude direct medical education, indirect medical education, and disproportionate share payments. It is projected that during a phase-in period of five to ten years, the federal payment would grow more slowly than projected budget baseline costs. Later, the federal Medicare payment would grow at the same rate as per capita spending on health care for the non-elderly population. Aaron and Reischauer contend that while this formula is somewhat rigid and will require periodic adjustments, it is more than likely that such an approach will yield appreciable savings over the projected baselines. The authors believe that as the competitive marketplace develops and enrollees become more comfortable with choosing their own health plans, the difference between the federal payment and the cost of insurance could be rebated to participants as non-taxable income or shared between the government and participants.

The authors believe that even under the most optimistic scenario, it will take several years for the necessary institutional infrastructure to develop and become operational. The authors believe that the current Medicare system should be run concurrently with the new choice-oriented proposal. But the new system would be mandatory for everyone who turns 65 and becomes eligible for Medicare at a date to be determined. Current Medicare enrollees would have the option of staying in the traditional program or moving into the new system.

Echoing the sentiments of the public trustees of the Medicare program, and like the authors of most other plans, Aaron and Reischauer call for the consolidation of Parts A and B.

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THE HERITAGE FOUNDATION

The following summarizes Heritage Foundation Backgrounder *No. 1038, "What to Do About Medicare," by Stuart M. Butler, Robert E. Moffit, and John C. Liu, dated June 26, 1995.*

To control costs while improving value and choices for beneficiaries, The Heritage Foundation advocates a conversion of the Medicare program into a system in which the government provides beneficiaries with a defined contribution that may be used either to purchase a Medicare-approved private health plan or to remain within the traditional health care program. This system would be, in effect, a modified version of the Federal Employees Health Benefits Program (FEHBP), which currently makes 400 competing private plans available to nine million active and retired federal employees and their family members.

The Heritage Foundation envisions a new Medicare system structured much like the successful FEHBP, but with modifications that refine the government contribution to make the new program even less susceptible to adverse selection effects that the FEHBP is and provide beneficiaries with better information on which to make choices. The new program would have four basic elements:

First, elderly and disabled Americans would have an entitlement not to a defined set of benefits, but to a voucher worth an amount based on a number of factors. The total federal expenditure for the voucher system would be limited to a program budget, with the voucher amount adjusted each year according to the budget. To achieve the target for Medicare in the congressional budget resolution, the Heritage Plan proposes that expenditures for the voucher be permitted to grow 7 percent in the year of enactment and 5.6 percent each year thereafter.

Second, the base for the voucher amount would be budgeted Medicare expenditures (combined net expenditures for Parts A and B) divided by the eligible population. This base would be adjusted up or down according to three basic categories:

❶ Primary risk factors, including age, gender, reason for eligibility (age or disability), institutional status, and End-Stage Renal Dialysis (ESRD) status.

❷ An income adjustment applied to one-third of the voucher, to be the equivalent of means-testing today's Part B premium.

❸ A local market variance, to reflect the weighted average enrollee cost of a "basket" of typical plans in any area. This would permit adjustments to reflect the cost of approved plans available in the area. This basket would consist of "typical" plans, such as the Medicare Standard Plan (see below), a catastrophic /MSA plan, a Blue Cross standard plan, and a comprehensive HMO plan. This is a refinement of the "big six" formula used by the Office of Personnel Management to set the government contribution to the FEHBP. Since the plans would have to submit detailed information on their prices and benefits before the annual open season, this adjustment would reflect the actual future market the beneficiary would encounter in the following year.

Third, in order to be permitted to sell insurance to Medicare participants, health plans would have to meet certain threshold requirements. Beyond these, they could offer varieties of benefits and delivery systems. There would be no restriction on the number of plans. To be Medicare approved, a plan must:

✓ Have a license to issue health insurance in the state or obtain approval from the Department of Health and Human Services (HHS).

✓ Provide services in a service area acceptable to HHS.

✓ Meet minimum solvency requirements.

✓ Include a core set of basic coverage determined by legislation. The basic package would have to cover "medically necessary" acute medical services, including physician services; inpatient, outpatient, and emergency hospital services; and inpatient prescription drugs, with a catastrophic stop-loss amount for these services. A plan thus could offer a much leaner package than today's Medicare program (although it would have to provide catastrophic protection, unlike Medicare today), but it could offer a range of services beyond the base coverage. For example, some plans might offer dental benefits, or drug coverage, or an MSA. States would be preempted from mandating additional benefits for plans serving the Medicare population. The Medicare Standard Plan (see below) initially would provide the services available today under Medicare Parts A and B. This Standard Plan would not be required to add catastrophic protection unless its board chose to do so or Congress required such a change in benefits.

- ✓ File with HHS a standardized statement of benefits (exclusions, copayments); a table of rates for the same actuarial categories used to determine Medicare benefits (age, institutional status); and consumer information as determined by a consumer advisory board. This information might include the results of enrollee satisfaction questionnaires, turnover rates, average out-of-pocket costs paid in the previous year by enrollees for the treatment of certain illnesses, and perhaps ratings by certain organizations. This price, benefit, and consumer information also would be available to any Medicare beneficiary upon request.
- ✓ Accept and continue coverage for any Medicare beneficiary applying during an annual "open season," or for any newly eligible beneficiaries, unless the plan receives a waiver from HHS because of capacity concerns. This requirement would apply to plans marketed by affinity organizations, such as churches, unions, or elderly groups, not merely to plans marketed by insurers or provider organizations.

Fourth, the government's role in the new system would be kept to a minimum. Under the new program, HHS no longer would be allowed to regulate the prices charged by providers; instead it would take on "umpire" functions more like those being carried out by OPM in the FEHBP system. The government, however, would have three important roles:

1. The government would establish a federal corporation, governed by an appointed board, to run a Medicare Standard Plan similar to the current Medicare program. The Standard Plan would be available in all markets, and the board would set premium prices to meet long-term solvency requirements. Subject to congressional approval, the board could adjust benefits, out-of-pocket costs, and payment levels in the Standard Plan.
2. As an alternative, the Standard Plan could be the traditional Medicare program, without a set premium and funded directly rather than by vouchers. While this alternative might have political advantages, however, the lack of a premium would make it more difficult for beneficiaries to compare the Standard Plan with competing private plans.
3. HCFA would calculate the voucher amount for each beneficiary, setting that amount after the plans had filed their price and benefit information for the following year.
4. HHS would conduct a Medicare open season, much as OPM does for the FEHBP. Before open season, Medicare beneficiaries would receive an information kit from HHS, including the amount of their voucher and standardized information on prices, benefits, and consumer satisfaction for Medicare-approved plans in their area, including the Standard Plan. Beneficiaries also would receive a selection form on which to indicate their choice. Once the selection had been made, HCFA would send the beneficiary's voucher to the chosen plan. The beneficiary would be responsible for any difference between the voucher and the premium costs, but could elect to have the government pay that difference and reduce his or her Social Security check (similar to the Medicare Part B option today). If the voucher amount exceeded the plan's premium, the difference would be deposited by HCFA into a Medical Savings Account of the beneficiary's choice. Disbursements from MSA accounts could be used only for medical expenditures eligible for the Internal Revenue Service Schedule A tax deduction.

Under The Heritage Foundation proposal, Medicare would operate much as the FEHBP serves federal workers and retirees. Medicare beneficiaries would be able to pick a private plan which included the services they wanted (beyond the core package), delivered in the way they wanted and, if they wished, through an organization with which they were affiliated (as many FEHBP enrollees do). Or they could decide to apply their voucher to the premium of the Medicare Standard Plan. Because beneficiaries would receive a voucher for a specific amount (paid directly to the plan of their

choice), they would have a strong economic incentive to pick the plan that best met their objectives of price, quality, and services.

The organization of services, selection of benefits, and payments to providers would be in the hands of plan managers competing for enrollees. Unlike the federal officials managing Medicare today, these managers would have the freedom and the financial incentive to experiment with new ways to deliver care at a competitive price. The voucher approach would give all plans an incentive to strive for the best pricing and not consider the voucher as a floor price.

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NATIONAL CENTER FOR POLICY ANALYSIS

Unless otherwise noted, the following summarizes publications issued by the Dallas-based National Center for Policy Analysis.[4]

The National Center for Policy Analysis (NCPA) has developed a proposal to allow "the elderly to withdraw their share of funds from Medicare, including Parts A and B, and purchase their coverage from any alternative private source they may prefer."[5] These private plans from which seniors may choose include a Medical Savings Account (MSA), a health maintenance organization (HMO), or an employer's health plan. Since present and future retirees would have an option of staying in traditional Medicare or choosing a private plan, the NCPA proposal "creates new options without eliminating existing ones."

Under the NCPA proposal, the Medicare program would make a payment to the MSA or private plan of an enrollee's choice to help cover the costs of care or insurance premiums. The "premium payment" would be adjusted to reflect the enrollee's age, gender, geographic location, and health status. Older and sicker enrollees would receive more financial assistance from the program to purchase private insurance.

For a private health plan to be eligible to participate in the new program, it would have to offer a base package, which would be the existing level of benefits and services currently covered under traditional Medicare. These plans are not precluded from offering additional benefits or charging additional premiums to cover these costs. Private insurers covering Medicare would be subject to guaranteed issue requirements and would have to provide coverage to any applicant currently on Medicare, regardless of health status. A significant aspect of the NCPA proposal is that private health plans would not be required to accept patients from other private plans covering Medicare beneficiaries but would have to accept individuals transferring from the traditional Medicare program.

The NCPA proposal emphasizes the use of Medical Savings Accounts (MSAs). One of the private options envisioned would be to couple a catastrophic policy with a Medical Savings Account. Based on the requirement that all private plans would have to offer the current Medicare package as a minimum package, all catastrophic policies would have to offer the same services currently in

4 Peter Ferrara, "Solving the Medicare Crisis," National Center for Policy Analysis, *Brief Analysis*, May 5, 1995.
5 Peter Ferrara, "Gingrich Can Avert GOP Disaster over Medicare," *The Wall Street Journal*, May 9, 1995, p. A20.

Medicare. Contributions to an MSA would be applied against medical expenses under the particular catastrophic plan's deductible. In addition to the Medicare contributions being deposited into an MSA, retirees could direct further deposits to the MSA beyond the payment made on their behalf by Medicare. While additional funds that are contributed to the MSA would receive no tax relief, the interest build up and subsequent withdrawals for health expenses would be tax-free. The NCPA proposal requires that during a 12-month insurance period, MSA funds be used only for medical expenditures. However, funds remaining at the end of the year could be withdrawn tax-free for any other purpose as well.

The NCPA proposal is intended to slow Medicare's rate of growth. One option offered by NCPA is to cap the rate of growth as determined by congressional budgetary targets. Another option would be to set the growth rate "equal to the rate of growth of private sector spending on the theory that working taxpayers should not have to bear the burden of Medicare taxes growing at a faster rate than their own private health insurance." A possible mechanism to achieve this reduction in growth, besides the cost-reducing incentives created by the voucher mechanism, would be to raise the current deductible level for Medicare beneficiaries in addition to increases in copayment-payment fees for services. Low-income households would be exempted from these increases under the NCPA proposal.

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RETIREE GROUPS

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

The following summarizes testimony presented by the organization's President, Martha McSteen, on July 19, 1995, before the House Ways and Means Subcommittee on Health.

The National Committee believes that the Medicare program has been a "remarkable success story" and that the private market's record on coverage of individuals and cost containment is inferior when compared to Medicare's. The provision of vouchers to the nation's elderly and disabled to purchase private insurance is "a type of reform which may well undermine Medicare and threaten the health security of seniors and the disabled." The National Committee is opposed to allowing the nation's elderly the choice of opting out of the current Medicare program and choosing a health insurance plan on the private market. While increasing choice is acceptable to the National Committee, such choices must be within the current Medicare framework of a defined set of standardized benefits.

The National Committee supports the following principles/proposals which it believes would secure Medicare's long term stability. It is the Committee's belief that if all its proposals are enacted into law, savings of $150 billion in the Medicare Part A Trust Fund would occur and the rate of growth in Medicare Part B spending would slow. Specifically, the National Committee calls for Congress to:

1. **Adopt** certain elements of the Clinton Administration's budget proposal. President Clinton proposes to save $10 billion over five years by making permanent several temporary provisions in current law, including the setting of Part B premiums at 25 percent. Other provisions include extending Medicare secondary payer provisions and permanently lowering payments to home health agencies and nursing homes.
2. **Extend** Medicare coverage to state and local government employees. This is expected to raise $7 billion over five years.
3. **Increase** the tobacco tax. The National Committee supports an increase in the tobacco tax to $2 per package. This would raise $15 billion a year for Medicare Part A, in addition to $1.5 billion for medical research.
4. **Reevaluate** Medicare payments for hospital capital costs and graduate medical education. The National Committee believes that a reevaluation could save between $7 billion and $23 billion over five years.
5. **Reduce** payments to hospitals for outpatient surgery and radiology. According to a recent HHS study, payments to hospitals for outpatient surgery and radiology have been excessive because of the formula for determining such payments. Savings of $20 billion over five years can be realized, says the National Committee, if a change to the formula or payment structure is made. Such savings should be directed toward lowering beneficiaries' copayments for these services.
6. **Introduce** stricter utilization review and a streamlining of Medicare administrative costs. While the National Committee believes that Medicare has an excellent record on administrative costs, averaging two percent of program outlays, it believes that further reforms can improve on this success, including the combining of Part A and Part B.

- **Increase** the eligibility age. The National Committee supports increasing the eligibility age for Medicare by tying it to eligibility for Social Security benefits. While the rationale behind such a proposal is to procure savings in the federal budget, no figures or estimates were provided by the National Committee in its testimony.

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UNITED SENIORS ASSOCIATION, INC.

The following summarizes a publication issued by USA, Inc., entitled "A Proposal for Reform: Resolving the Medicare Crisis."[6]

The United Seniors Association is an organization voicing the sentiment of senior citizens from across the country who support the American free enterprise system. Unlike the other national organizations purporting to advance the interest of seniors, USA, Inc. does not receive federal funding to lobby Congress. USA, Inc. has put together the following principles it believes should guide Medicare reform.

First, there should be no tax increases. Therefore, the current HI payroll tax of 2.9 percent should not be raised. Increases are unnecessary, says USA, Inc., because revenues from this source would increase over time as the rate of growth for household incomes increases.

Second, Medicare premiums should not be allowed to increase at a rate faster than the rate of general economic growth. USA, Inc. believes this would protect the elderly from facing a potentially large increase in future premiums, which could happen under current law.

Third, USA, Inc. calls for synchronizing eligibility for Medicare benefits with the retirement age for Social Security. Under current law, the retirement age for Social Security benefits is to rise from 65 to 66 between 2000 to 2005, and from 66 to 67 between 2011 and 2022. Thus, under the USA, Inc. plan, future retirees would not be eligible to receive Medicare benefits until these later ages.

While future expenditures would be reduced, no estimate is provided of how much the federal government would save.

Fourth, USA, Inc. actually proposes to raise the retirement age sooner and push back the eligibility age even further. Under the proposal, the retirement age would be delayed three months for every year starting in 1996, until it reached 70. The rationale for this change is that longer life expectancies, coupled with the pending retirement of the baby boomer generation, will produce a heavy strain on the Medicare program under the current financing scheme. USA, Inc. Believes that keeping individuals privately insured until age 70, using a combination of employer-provided insurance and previous savings, would help alleviate the financial pressures facing the HI trust fund and the overall Medicare program.

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6 Peter J. Ferrara, "A Proposal for Reform: Resolving the Medicare Crisis," USA *Issue Analysis*, No. 4, April 1995.

Fifth, any reform of Medicare must include a restructuring of the benefit package. Specifically, the Medicare benefit package must conform to the resources available to finance the program. Under the USA, Inc. proposal, the Medicare benefit package would be adjusted annually so that the program does not spend above the revenues coming in from the HI payroll tax, Part B premiums, and general revenues (taxes).

Sixth, the USA, Inc. proposal calls for an expansion of Individual Retirement Accounts for retirement medical purposes. This proposal allows every individual to contribute up to $1,000 per year to an IRA. While these contributions would be subject to applicable taxes, the interest would accumulate tax-free and withdrawals after age 65 would be tax-free for medical and non-medical expenses. The impact the proposal would have on the federal deficit and the budget is not estimated.

Finally, health insurance vouchers would be provided to the elderly population below the poverty level.

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PROVIDER GROUPS

AMERICAN HOSPITAL ASSOCIATION

The following summarizes testimony before the House Ways and Means Committee on July 19, 1995, by Richard Davidson, President of the American Hospital Association..

The American Hospital Association includes in its membership some 5,000 hospitals, health care systems, networks, and other providers of care. While the AHA has not come forward with a concrete legislative proposal, it has testified before the various congressional committees with jurisdiction over Medicare. The AHA has outlined four principles that it believes Congress should adopt in reforming the Medicare program:

❶ "Change the delivery system to encourage more use of coordinated care—cooperating groups of hospitals, doctors, and others who knit the fragmented delivery system together for patients and have powerful incentives to control costs."

❷ "Change the process by which Medicare benefit and funding decisions are made."

❸ "Make sure all stakeholders absorb spending reductions."

❹ "Ensure access to high-quality health care for the nation's most vulnerable populations—the elderly, poor and disabled."

Changing the Delivery System. According to the AHA's testimony, "The key is to restructure Medicare to encourage more use of coordinated care. Coordinated care is working in the private sector, and it can work in Medicare as well." The AHA believes that higher utilization of coordinated care will result in improved quality because an entire network of providers will be held accountable for a patient's care. Furthermore, coordinated care networks emphasize preventive care, and this leads to reduced costs.

Some examples of changes in the delivery system endorsed by the AHA:

✓ **Expanding the types of plans that Medicare beneficiaries can choose.** Among other options, according to the AHA, Medicare should contract with the growing number of non-managed care networks that also meet high standards for quality and public accountability and are able to offer a full range of services for a pre-determined premium. Under the AHA approach, these non-managed care networks would share the risk with the Medicare program.

✓ **Providing seniors with more information on health care plans.** Sending the elderly an annual report that compares coordinated care (managed care and non-managed care) plans and fee-for-service plans on the basis of quality, cost sharing, premiums, deductibles, and benefits will enable them to make sound and informed decisions.

✓ **Allowing for open enrollment on an annual basis.** The FEHBP allows all federal employees to choose their own health insurance plans each year. The AHA wants Medicare-eligible patients to be given the same opportunity. The federal government makes a fixed maximum contribution toward the health plan of an employee's choice, and the AHA believes Medicare should do the same for its beneficiaries.

✓ **Eliminating barriers that discourage creation of coordinated care networks** by inhibiting provider cooperation—the heart of coordinated care. For example, the AHA wants Congress to:

❶ Modify the physician self-referral law. While the original goal of deterring physicians from referring patients for unneeded services based on financial arrangements remains valid, it is overreaching in today's environment. The physician self-referral law, says the AHA, is as an impediment to hospitals, physicians, and other health care providers that are trying to work together by eliminating duplication of services. Since coordinated systems require varying levels of referrals and financial arrangements, this law should be reviewed and reformed.

❷ Reject "any willing provider" and mandatory "point of service" requirements. All health care providers qualified to be in a network should receive fair and reasonable consideration, according to the AHA. At the same time, networks must continue to have high standards for the number, type, and location of providers made available to enrollees. The AHA believes that forcing a plan to include any health provider regardless of practice patterns or history would not be in the patients' best interest. Instead, the AHA holds firm in its belief that for networks to provide efficient and effective coordinated care, they must be able to retain their autonomy in choosing providers that will work best within their particular goals and objectives.

Independent Citizens' Commission on Medicare. The AHA believes that creation of an independent citizens' commission on Medicare will serve in several important ways to retain the integrity of the Medicare program. "While Congress ultimately must be held accountable," the AHA believes that an independent bipartisan commission should assess each year how much money is needed to maintain the current program. Congress would review the commission's recommendations and set its own target through the regular budget process. The commission also would be charged with holding public hearings, translating the congressional budget targets into recommendations for a benefit package and provider payment rates that would be presented to Congress for an up-or-down vote (much like the base closing commission's report).

Shared Responsibility. The AHA believes that reducing the budget deficit and ensuring the financial solvency of the Medicare Hospital Insurance (HI) Trust Fund requires shared responsibility. To accomplish this, the AHA endorses a plan which will require everyone with a stake in Medicare —hospitals, health systems, physicians and other providers, and beneficiaries—to share the financial task of restoring the solvency of the HI fund. This means that changes in benefits, beneficiary cost sharing, eligibility, program revenues, and provider payments all must be included. Further reductions directed solely at providers are not viewed by the AHA as reliable and effective solutions. To bolster this point, the AHA notes that despite spending reductions of approximately $48 billion in Medicare hospital payments since 1988, Medicare continues to grow by approximately 11 percent each year. The AHA adds that for Medicare inpatient and outpatient care combined, 1993 Prospective Payment Assessment Commission data show hospitals losing 11 cents on each dollar it cost them to provide care.

If Congress adopted proposals which procured savings only by cutting provider reimbursements, the AHA estimates that by the year 2000, Medicare inpatient operating margins for hospitals could fall to *negative* 20.6 percent. Every type of hospital (rural, urban, large, small, teaching, and nonteaching) would be hurt, according to the AHA. To balance the reductions in Medicare payments, says the AHA, hospitals would have to continue to pass this loss in revenue on to other payers (non-Medicare patients and their employers).

Ensuring Access for the Nation's Most Vulnerable. In its testimony before Congress, the AHA reiterated a strong commitment to ensuring access for the elderly and disabled. The AHA believes that health plans should not be able to exclude individuals based on where they reside; nor should they be excluded systematically based on their previous health status or potential need for services.

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AMERICAN MEDICAL ASSOCIATION

The following summarizes a draft proposal by the American Medical Association entitled "Transforming Medicare and other Budget Proposals," dated June 22, 1995.

The American Medical Association argues for a voucher type approach in the Medicare program. As far back as 1986, the AMA endorsed a voucher for all Medicare-eligible Americans to use in purchasing health insurance. In its most recent proposal, the AMA proposes to transform Medicare into a system which emphasizes personal responsibility and choice. The AMA estimates that its proposal will save $162.2 billion over a seven-year period, based on an analysis conducted for the AMA by Price Waterhouse. The AMA believes that if its plan was enacted and continued through Fiscal Year 2002, it would keep the Medicare Hospital Insurance Trust Fund (Part A) solvent for at least the next 15 years.

Under the AMA proposal, all Medicare-eligible individuals will be allowed to choose to participate in the current Medicare program or in the optional "Medichoice" program. For those remaining in the "traditional Medicare" program, there will be changes in how the program is financed. These changes would:

1. **Abolish** current HI and SMI deductible and copayment requirements;
2. **Retain** one-half of this new amount as a Part A insurance premium for the reduced cost-sharing requirements;
3. **Establish** a Beneficiary Escrow Account (BEA) for each enrollee to accumulate the remainder of the supplemental amount as it is received from the enrollee each month;
4. **Charge** each BEA beneficiary with benefit payments made on his or her behalf during the year;
5. **Refund** to each enrollee any balance remaining in the BEA that exceeds benefit payments made on his or her behalf during the year;
6. **Exempt** Medicare beneficiaries eligible for Medicaid and other "qualified" beneficiaries from the requirement to contribute the extra amount; and
7. **Reduce** the contribution required of Medicare beneficiaries who have incomes less than 150 percent of the poverty level. The amount of the reduction will equal 100 percent minus the percent by which the beneficiary's income exceeds the poverty level. For example, a beneficiary with an income at 125 percent of the poverty level would have his all-inclusive deductible reduced by 50 percent. Physicians will be prohibited from charging beneficiaries with incomes less than 200 percent of poverty more than the amount reimbursed by the Health Care Financing Administration (HFCA). (A mechanism should be established for beneficiaries to establish their eligibility for this preferential treatment.)

Enrollees who choose to participate in the Medichoice program will receive for the following calendar year the appropriate actuarial value of their Medicare benefits, less the annual amount of any HI (Hospital Insurance, or Part A) and/or SMI (Supplemental Medical Insurance, or Part B) payments they otherwise would have to make. This is the "defined government contribution." A benefi-

ciary who chooses the Medichoice option will not be required to pay the HI/SMI premiums which he/she otherwise would be obligated to pay for traditional Medicare coverage during the period of Medichoice enrollment. The enrollee opting for Medichoice picks a private plan meeting certain conditions.

According to the AMA, the plans must include the following:

- ✓ **Health Benefit Plan Requirements.** Any plan may participate in the Medichoice program provided it meets certain minimum standards adapted to apply to the Medichoice program from the provisions governing chapter 89 of title 5, U.S.C., and 5 CFR 890.201 (FEHBP minimum standard requirements).[7]
- ✓ **Types of Benefits.** Plans participating in the Medichoice system must comply with similar guidelines governing the FEHBP (5 U.S.C. 8904). Benefits covered include payment for or direct provision of hospital care, surgical care and treatment, medical care and treatment, obstetrical benefits, health prevention services, prescribed drugs, medicines, and prosthetic devices, and other medical supplies and services.
- ✓ **Health Benefit Plans.** Health benefit plans participating in the Medichoice program may be of the following types:
  - ❶ **Traditional Health Benefit Plans.** Plans offering benefits under which payments for services are calculated according to the usual, customary, and reasonable fees or charges prevailing in the community in which a beneficiary obtains services from physicians, hospitals, or other providers of health services.
  - ❷ **Benefit Payment Schedule Plans.** Plans offering benefits under which certain sums of money, enumerated in a schedule of benefits provided under the plan, are paid to beneficiaries for services obtained from physicians, hospitals, or other providers of health services.
  - ❸ **Prepaid Comprehensive Medical Plans.** Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), or other plans which offer comprehensive health benefits on a prepaid basis.
  - ❹ **Medical Savings Account Plans.** Plans which offer catastrophic medical expense insurance in combination with establishing a Medical Savings Account (MSA):
    - ✦ Allowed annual deposits to an MSA are limited to the value of the annual government contribution amount. Part of the funds must be applied toward purchase of a high-deductible catastrophic insurance policy each year which must cover the types of services provided by the FEHBP program.
    - ✦ Contributions to an MSA equal to the value of the government contribution amount should be exempt from federal and state income taxation.
    - ✦ Distributions from a beneficiary's MSA should be exempt from federal and state income tax if used for medical expenses, health insurance premiums, and long-term care.

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7 The FEHBP is the Federal Employees Health Benefits Program. This serves over 9 million federal workers and retirees, and their dependents. Private plans compete to offer coverage to FEHBP enrollees. The plans offer a variety of benefits and must include a minimal standard set of services.

- ✦ Interest and dividend earnings on MSA balances should be exempt from federal and state income tax while they remain in the account.
- ✦ Other provisions relating to MSAs held by Medicare beneficiaries will be governed by rules applicable to IRAs, except that mandatory withdrawal at a certain age is not applicable to MSAs held by Medicare beneficiaries.

❺ **Enrollment in Medichoice.** Patients choosing the "Medichoice" option would have access to a wide range of plans similar to those offered by the FEHBP. Each person would receive:

- ✦ Advance notice of the government's contribution (to be determined actuarially) toward the cost of Medichoice plans;
- ✦ Information and rates on plans in the individual's area to assist "value comparison;" and
- ✦ A Medichoice election and enrollment form (available on attaining Medicare eligibility and on an annualized basis).

Patients would pay the difference when the plan costs exceed the government contribution or keep the savings when the government contribution exceeds the plan costs.

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FEDERATION OF AMERICAN HEALTH SYSTEMS

The following summarizes proposals for Medicare reform presented in testimony before the House Committee on Commerce, Subcommittee on Health and Environment, on July 18, 1995, by Tom Scully, President of the Federation of American Health Systems.

The Federation of American Health Systems is an association representing 1,700 for-profit hospitals.

The Federation argues that while Medicare is in dire need of reform, it must come in the form of substantive restructuring in addition to spending reductions. This restructuring means a new and privatized payment system. While the Federation is opposed to the level of Medicare budget targets proposed by Congress, it believes the best way to achieve those goals is to transform Medicare from a defined benefit program into one of a defined contribution.

According to the Federation, the best model for a privatized system is the Federal Employees Health Benefits Plan (FEHBP). By offering beneficiaries the flexibility to purchase health plans with the assistance of a voucher, and by providing financial incentives to use their medical coverage wisely, says the Federation, Congress can slow the rate at which the Medicare program is increasing. Instead of traditional cuts in Medicare, which take the form of price controls on providers of health care, competition in the health care market would drive down costs in a restructured program, just as it has in the private sector.

The benefits of moving Medicare toward a defined contribution system, says the Federation, are the significant savings the federal government can achieve and the higher quality of benefits that the nation's seniors would obtain. Implementing a privatized system would take several years. "The

Federation has advocated a smooth transition to this system. From 1996 to 2000, all seniors could opt to stay in the traditional Medicare program or voluntarily choose a private plan. After 2000, all seniors would choose plans in a system like FEHBP, where all plans, including traditional Medicare, received a defined contribution (from the government)."[8]

The Federation firmly believes that the free-market forces of consumer choice and competition, not price controls through federal regulation, are needed to reduce spending in health care efficiently. Competition would require health care providers to give value and better quality for the health care dollars the elderly would be spending. Furthermore, the Federation is adamant that "if funding is to be removed from the system, we'd prefer to adjust and streamline in response to a local market that creates rational incentives, not cuts in the current Medicare price setting system that already has created thousands of perverse incentives that produce only inefficiency."

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GROUP HEALTH ASSOCIATION OF AMERICA

Unless otherwise noted, the following summarizes testimony before the House Committee on Commerce, Subcommittee on Health and Environment, by Karen Ignani, President of the GHAA, on July 18, 1995.

The Group Health Association of America (GHAA) is the leading national association representing health maintenance organizations (HMOs). Their 385 member HMOs serve 80 percent of the 50 million Americans receiving health care through HMOs.

The GHAA supports a Medicare reform proposal that would allow enrollees to choose from various health plans currently "available to millions of working Americans both in the private sector and federal government: Medicare should be reoriented toward a model in which Medicare beneficiaries have the opportunity to choose from among a broad array of options that compete on the basics of quality, service, and cost, and are held to comparable accountability standards."[9]

In coming up with a set of principles and design for such a reform, the GHAA looked at the experiences of its member plans in both the private and public (federal government) sectors, including the approximately three million Medicare beneficiaries enrolled in managed care plans.

The crux of the GHAA's proposed reform is to facilitate the expansion of existing Medicare markets, encourage the creation of new Medicare markets, and ensure the viability and solvency of various health plans so they may absorb the increased capacity of future enrollees. In general, the GHAA recommends changes in the following five areas that would:

❶ **Improve** beneficiary information, awareness, and enrollment process.

❷ **Expand** the infrastructure of health plan choices available to beneficiaries.

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8 Tom Scully, testimony before House Committee on Commerce, Subcommittee on Health and Environment, July 18, 1995.

9 Karen Ignani, testimony before House Committee on Ways and Means Subcommittee on Health, July 19, 1995.

❸ **Maintain** strong standards for health plans participating in Medicare.

❹ **Begin** to transition HCFA from the current regulatory approach to the beneficiary choice model.

❺ **Transition** to improved Medicare payment methodologies.

Improving beneficiary information, awareness, and enrollment process: It is imperative, says the GHAA, in order to allow beneficiaries to make well-informed decisions about their health plans, that the information be made readily available and easy to understand. To do so, the Health Care Financing Administration (HCFA) should work with health plans participating in the Medicare program to develop educational information for beneficiaries. Basic characteristics of the various options, including services and benefits covered, premiums, deductibles, copayments-payments, should be made available. Such information should be sent to all prospective beneficiaries six months before they become eligible for Medicare. Another change endorsed by the GHAA is to allow newly eligible Medicare enrollees to elect HMO enrollment that is effective the first month they become eligible for Medicare, rather than require them to wait until the second month.

Expanding the infrastructure of options available to beneficiaries: The GHAA calls for a wider range of options to be made available to Medicare beneficiaries. Options ranging from catastrophic coverage plans, to fee-for-service, to the various types of managed care (HMOs, PPOs, IPAs), point of service, and non-managed care systems should be allowed to compete on a level playing field.

Maintaining strong standards for options participating in Medicare. All health plans should meet comparable standards designed to address access, quality of care, grievance procedures, and solvency. This is to protect beneficiaries who have been wrongfully denied access to coverage, or who are unsure about the quality of care they are receiving in comparison to other providers, and to provide the comfort and security that comes from knowing they are purchasing solid health coverage. Anti-managed care laws in existence throughout certain states should be pre-empted. The GHAA also calls on Congress to reform certain antitrust laws.

Transitioning HCFA to implement new model: The regulatory and bureaucratic infrastructure within HCFA needs to be changed to implement a consumer choice model. In the interim, HCFA should simplify administrative procedures for submission and processing of applications and claims. On a regional level, the GHAA says that HCFA should begin to narrow the variation in interpretation of policy by regional offices and encourage uniformity in the review and approval of contracts, products, and marketing materials.

Transitioning to improved Medicare payment methodologies. According to the GHAA, Medicare needs to conform to the changing environment surrounding health care and future payment policies. In practice, the GHAA proposes to turn the program from a defined benefits program into one of a defined contribution with incentives for beneficiaries to choose plans that deliver high-quality, cost-effective health care. Specifically, the payment mechanism envisioned by the GHAA "should permit these options to establish premiums for the benefits they offer, and should establish a defined government contribution based upon the per capita cost to the Medicare program of providing Medicare covered benefits to all eligible beneficiaries." ! 10

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10 *Ibid.*

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HEALTHCARE LEADERSHIP COUNCIL (HLC)

The following summarizes a "Draft Proposal" developed by the council's task force on Medicare.[11] *As such, it does not necessarily reflect an official or final position the HLC has taken with respect to Medicare reform.*

The Healthcare Leadership Council is comprised of managed care companies, pharmaceutical companies, hospitals (for-profit and not-for-profit), medical device manufacturers, and nurse practitioners.

The Healthcare Leadership Council's draft legislative policy initiative centers on five specific areas:

1. **Expand** Program Options and Establish Federal Standards for Qualification.
2. **Modify** Program Reimbursement.
3. **Restructure** Management and Oversight of Program.
4. **Preempt** State Anti-Competitive Health Plan Requirements.
5. **Ensure** Appropriate Support for Medicare Education, Research.

The HLC believes that the free-market principles of competition and consumer choice should enter the Medicare system. If Medicare beneficiaries are allowed a wide spectrum of health plan options, the efficiencies and success of the private marketplace will improve the Medicare program.

In the draft HLC approach, Medicare beneficiaries would be able to choose from the following list of options: traditional Medicare; Medical Savings Accounts; employer-sponsored plans; and all qualified managed care products (HMOs, PPOs, point of service, managed indemnity, and integrated provider systems). In order to facilitate the expansion of health plans in the marketplace, says the HLC, federal standards regarding health plan qualification must rely on the market, not a regulatory structure, to help shape effective plan designs that foster competition. With the exception of plan capacity and ability to serve new enrollees, all health plans, including Medicare supplemental plans, must provide coverage to eligible beneficiaries.

While the current Medicare benefit structure would act as a minimum benefits package in the HLC approach, the copayments-payment and deductible amounts would be allowed to vary by plan design and product. Health plans are allowed to offer additional benefits. The HLC explicitly prohibits the mandating of additional benefits. Much like the GHAA's proposal, the HLC supports a requirement which would inform prospective Medicare beneficiaries, at least 6 months prior to eligibility, of their various options and the nature of the Medicare program. Upon becoming Medicare-eligible, beneficiaries would have the option of enrolling in the private health plan of their choice or entering the traditional Medicare program. New beneficiaries would be enrolled automat-

11 Healthcare Leadership Council draft document, "Medicare in the 21st Century: Improvements in the Medicare Program," July 27, 1995.

ically in the traditional Medicare program if they fail to elect a private plan option. Beneficiaries currently insured in a private health plan option who fail to choose another plan during the enrollment period will remain in their present plan. Enrollees currently enrolled in the traditional Medicare program could opt out at any time during the year and enroll in a capitated plan option.

To allow the elderly to make informed decisions when choosing their type of health coverage, there would be an annual education period sponsored by the federal government. Educational briefing materials that are easily understood (much like the FEHBP pamphlets available to federal employees each year) would be made available. Health plans would be allowed to market their products provided they meet uniform and consistent guidelines as established by HCFA. To ensure that low-income beneficiaries did not face increased costs, subsidies would be maintained under current law (Medicaid continues to pay applicable Medicare premiums). Discretion would be given to the states in determining whether subsidized individuals stay in the current fee-for-service Medicare arrangement or are enrolled in a managed care option.

Federal payments for qualified health plan beneficiaries would be capitated. To ensure a fair playing field, traditional Medicare and qualified health plans would be required to accept the same average rates of increase in their capitated federal payments. All plans would receive the same federally defined contribution per beneficiary. Adjustments will be made according to current AAPCC methodologies (age, gender, and geography).[12] To help facilitate timely payments to health plans, reimbursements would be made directly from the government to the plan/provider. To meet annual expenditures as determined by Congress, increases in the initial capitated federal contribution would be limited to specified per capita growth targets.

The Health Care Financing Administration (HCFA) would be restructured and streamlined to reflect the changing environment in the health care market. Inconsistent rulings and determinations by regional offices would be reformed so that health plans have guidance and predictability in designing products.

State laws that are deemed to be anti-competitive and that have adversely affect Medicare choices and innovations in the marketplace would be preempted. For example, state requirements regarding "any willing provider, mandatory point of service, essential community provider, etc." would not be allowed.

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12 The AAPCC is the average area per capita cost, the payment made to HMOs in Medicare's risk contract program.