MEDICARE REIMBURSEMENT FOR ELDERLY PARTICIPATION IN HEALTH MAINTENANCE ORGANIZATIONS AND HEALTH BENEFIT PLANS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-SIXTH CONGRESS

FIRST SESSION

PHILADELPHIA, PA.

OCTOBER 29, 1979

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MEDICARE REIMBURSEMENT FOR ELDERLY PARTICIPATION IN HEALTH MAINTENANCE ORGANIZATIONS AND HEALTH BENEFIT PLANS

MONDAY, OCTOBER 29, 1979

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Philadelphia, Pa.

The committee met, pursuant to notice, at 9 a.m., in the Federal Reserve Bank Building auditorium, Sixth and Arch Streets, Philadelphia, Pa., Hon. John Heinz presiding.

Present: Senator Heinz.

Also present: David A. Rust, minority staff director; Kathleen M. Deignan, professional staff member; Faye Mench, minority professional staff member; Gwen King, legislative assistant to Senator Heinz; and Kathleen L. Makris, minority office manager.

OPENING STATEMENT BY SENATOR JOHN HEINZ, PRESIDING

Senator HEINZ. Good morning, ladies and gentlemen.

I would like to welcome you to this hearing of the Senate Special Committee on Aging to explore with me an area which I believe offers one of our toughest challenges in dealing with the health care needs of our Nation's older citizens. We have spent a great deal of time developing one of the finest health care systems in the world, but we have done so without any particular concern as to the cost involved or to those upon whom this cost will fall. Even worse, we have removed from the consumers of health care services the incentives to be prudent shoppers by taking them out of the direct line of payment for services rendered. Our system of reimbursement, instead of focusing on the quality of health care, focuses on the cost with no real concern as to whether a particular treatment or service is necessary or even if it is the best option. Employers, insurance companies, or the Government picking up the tab and cost is almost never questioned.

For the elderly, in particular, this reimbursement mechanism has worked a hardship. The medicare program, with all of its good intentions for meeting the health needs of older Americans, is falling farther and farther from its goal. Unable to keep pace with the soaring cost of health care services, medicare leaves older persons with ever-increasing out-of-pocket costs.

The rise in out-of-pocket payments for health care services is perhaps most evident when coinsurance charges under medicare go up. For instance, when the program first took effect in 1966, the inpatient hospital deductible under medicare was $40. By 1978, it

had increased to $144, in 1979 to $160, and the Department of Health, Education, and Welfare announced a few days ago that it is scheduled to increase by another $20 in January 1980 to $180.

I, as well as several of my colleagues in the Senate, believe the time has come to accomplish a major reform in our current system of delivering health care services. We must open the system to competitive market forces in our efforts to contain ever-escalating health care costs. Where market economies are successful in containing or reducing health care costs, we can begin to channel these savings into improving the quality of care or providing expanded health benefits. Although we experienced a 40-percent increase in medicare and medicaid costs between 1976 and 1978, there has been little increase in the population covered or the benefits received. As the percentage of the aging population continues to grow, the likelihood that any significant change in benefit offerings will occur is small unless we can alter the current health care delivery system to be more efficient and more cost effective.

Of even more importance is the faltering of the traditional doctor-patient relationship in the face of Government regulation. The Government response to controlling the high costs in the health arena has been greater and greater regulation. For the medicare program this has meant fewer and fewer physicians who are willing to accept assignment for medicare patients. This, in turn, reduces or restricts an older person's options in seeking health services.

I have joined in sponsoring two Senate bills, S. 1530 and S. 1485, which are designed to address some of the inherent flaws in our current reimbursement system for health care services and to open greater options in the delivery of health services for older Americans. S. 1530 would encourage greater participation by older persons in health maintenance organizations by offering incentives to HMO's to serve this population group. It establishes reimbursement on a prospective basis at a level equal to 95 percent of what the services are presently costing the medicare program if provided outside the HMO. S. 1485 incorporates this same provision and in addition extends it to include health benefit plans with reimbursement at the same 95-percent level.

While I support the concept embraced by these bills, I am bothered by charges which suggest that reimbursement at the 95-percent level would mean a windfall for HMO's or health benefit plans. I do not believe that Government should place itself in a position of providing excessive profits to any sector. This would merely be substituting one problem for another.

I am interested in providing sound competitive incentives which will begin addressing the need to control costs in the health care sector while at the same time opening wider freedom of choice to older Americans in selecting a health delivery system best suited to their needs. Because I do not feel that S. 1485 or S. 1530 entirely get at this goal, I have drafted a separate proposal which I hope might achieve that purpose. Essentially my proposal provides for prospective reimbursement for HMO's and health benefit plans who enroll older persons and provide those services required in medicare parts A and B, and in the case of HMO's, preventive health services described in title XIII of the Public Health Services

Act. Reimbursement would be at the 90-percent level rather than the 95-percent level specified in S. 1485 and S. 1530.

A further area where the three proposals differ needs to be mentioned because it addresses the issue of greater freedom to choose for older people. When an HMO is able to deliver services for less than is estimated in determining reimbursement levels, all three bills agree that the difference should be applied to increased benefits for the individuals enrolled. How this should be done, however, shows the three proposals at variance.

S. 1530 provides that the HMO would have to return the difference to its members entitled to medicare in a specified order of reduced payments and extra services which are determined by the Secretary. S. 1485 provides that the HMO must provide additional benefits that the Secretary finds to be equal in value to the difference between the estimated cost of providing service and the actual cost but does not provide for any specific ordering of benefits to be offered.

Under my proposal, maximum flexibility and choice is provided to the HMO as well as to the individual medicare beneficiaries enrolled. In my proposal, the HMO would prepare a list of alternatives from which a group of medicare recipients enrolled in the HMO would select the additional benefits they desire.

I am anxious to hear from the expert witnesses gathered here today. The issue of how best to deliver the health services needed by our older citizens is one we must deal with adroitly today before the problems are allowed to mushroom tomorrow. I sincerely believe that HMO's can play an important role in this health delivery system. It may require an educational effort on the part of HEW to make older people more aware of the HMO's potential in providing health services to them.

But will the elderly choose this option if it is more available to them? What special concerns do they have about the nature of HMO's which we should perhaps be addressing in expanding this option for them? Do the present proposals for revamping the reimbursement system for HMO's under the medicare program adequately produce the incentives necessary to attract more involvement of HMO's in the provision of health services to older persons? Will opening medicare reimbursement to health benefit plans produce the competitive edge we need to begin to effect cost control in the health sector?

We have proposals before us, we have questions galore, and we have experts to shed light and hopefully provide answers to some of these questions. We are also under a fairly tight time schedule which prevents us from hearing from all those who we know have something to contribute to this discussion. For those of you in attendance today, but not scheduled as witnesses, we have arranged for a town meeting form—available at the door—on which you may submit any comments you would like for inclusion in the hearing record. The record will be open for 2 weeks after today to receive your written comments.

With something of an eye on the clock, I would like to call our first witness, reminding all witnesses to please observe the 7- to 10-minute time limit for each oral presentation.

The first witness this morning will be Dr. Peter Fox, Director for the Office of Policy Analysis, Health Care Financing Administration. Dr. Fox is with us from the HEW national office in Washington, D.C., and he brings with him much valuable background and knowledge on both the experience with medicare reimbursement of HMO's and the administration's proposal for expanding and shaping that reimbursement mechanism.

Dr. Fox, we look forward to receiving your comments.

STATEMENT OF PETER D. FOX, WASHINGTON, D.C., DIRECTOR, OFFICE OF POLICY ANALYSIS, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY NANCY ANN NULL

Mr. Fox. Thank you.

My name is Peter Fox. I am Director of the Office of Policy Analysis in the Health Care Financing Administration. The major function of the agency is to administer the medicare and medicaid programs. I am accompanied by Nancy Ann Null, a colleague of mine in the Health Care Financing Administration.

I would like to thank you, Senator Heinz, for inviting me to discuss today the administration's proposal to reform the method of medicare reimbursement to health maintenance organizations. We are deeply grateful for your interest in this matter and for your being one of the original cosponsors of our bill. Your leadership is important in light of your assignments on two highly influential committees—the Senate Finance Committee, which has jurisdiction over medicare legislation, and the Special Committee on Aging.

The administration's proposal is designed to restrain rapidly escalating health care costs by introducing competition into the reimbursement system. It is also a vehicle for making additional benefits available to aged and disabled beneficiaries who join HMO's without a long-term increase in the Federal budget and, indeed, with a long-term savings.

The problem of rising health care costs are well known. In 1965, when medicare and medicaid were enacted, the share of the gross national product devoted to health was 6.2 percent. Today, it exceeds 9 percent. Spending for both hospital and physician services has almost doubled during the last 5 years.

The toll on the Federal budget has been enormous. Medicare and medicaid accounted for $41 billion in Federal expenditures in 1979, a $5 billion increase from the previous year.

Although time does not permit me to go into detail, there is ample evidence that most HMO's deliver high quality care at lower cost than the fee-for-service sector. Furthermore, through competition, both HMO's and fee-for-service providers can be induced to improve their performance.

However, despite the demonstrated effectiveness of HMO's, few medicare beneficiaries have enrolled. Today, medicare has contracts with only 55 of the 225 HMO's and other prepaid group plans now in operation. Some 500,000 medicare beneficiaries—2 percent of all beneficiaries—are covered by these contracts, most having enrolled prior to their retirement under an employee group plan. The medicare participation rate is roughly half that of the general population.

Federal policies are largely to blame for this situation. We have not rewarded HMO's for their efficiencies or beneficiaries for their choice of a more efficient delivery system.

Let me now discuss the reimbursement provisions in current law and the problems they create. HMO's that contract with medicare choose between being reimbursed on a cost basis or on a poorly structured risk basis. Under a cost contract, HMO's are paid their actual costs. As a result, any efficiencies or inefficiencies are directly reflected in decreases or increases in medicare reimbursement. There is no reward for efficiency, little reason for the HMO to seek actively to enroll medicare beneficiaries, and few financial incentives for beneficiaries to seek out economical delivery systems.

Current risk reimbursement provisions also have major problems. It is these provisions that the administration's bill seeks to change. HMO's base their operations on prepaid revenues of known amounts from which all costs must be met. Although the law offers HMO's risk reimbursement, it does not identify the revenue or cost targets that the HMO must achieve until after the contract period. If HMO costs are below fee-for-service expenditures, both measured after the contract period is over, the HMO keeps half of the savings as earnings or profits, up to a maximum of 10 percent of fee-for-service. The Government keeps the rest, and the beneficiaries get nothing unless the HMO chooses to share its earnings with them. If, on the other hand, the HMO does worse than fee-for-service, medicare pays only the fee-for-service amount. Although this formula can be very profitable for HMO's, it is so foreign to the way they are normally paid that only one HMO in the country has signed a medicare risk contract. In Pennsylvania, out of six federally qualified HMO's, only one has a cost contract and none has a risk contract.

As for our beneficiaries, they do not obtain better coverage by enrolling in an efficient HMO, except by paying an extra premium. They are nevertheless obligated to obtain all of their care from, or through, the HMO. This so-called lock-in provision of risk contracts restricts the beneficiaries' ability to seek health services outside of an HMO without prior authorization. This restriction is also placed upon private enrollees. The big difference is that private enrollees benefit through increased coverage or reduced out-of-pocket payments.

The administration's proposal is intended to begin to change this state of affairs. I do not present it as a panacea to the cost control and coverage problems that this country faces. We do, however, believe that it is a significant step in the right direction. It is meant to accomplish three objectives.

First, it would use medicare HMO payments to contain health care costs rather than fuel inflation. It would do so by stimulating competition in the medical care market. We want to give providers incentives to be efficient. Importantly, for the first time in the history of medicare, we want to reward beneficiaries for seeking out efficient delivery systems.

Second, it would expand benefits for beneficiaries who enroll in HMO's while generating long-term budgetary savings.

Third, it would make available to beneficiaries the same choice in health care delivery systems that the Federal Government man-

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dates employers offer their employees. Under legislation that you, Senator, helped draft while you were in the House of Representatives, the Federal Government mandates that all but very small employers offer their employees the option of joining an HMO if there is one in the service area. Employers must also make the same financial contribution to the HMO that they make toward coverage in the fee-for-service system. The Federal Government in effect discriminates against the aged and disabled by failing to make available this kind of choice to medicare beneficiaries.

We propose to pay an HMO 95 percent of what the Federal Government estimates in advance would be spent if a beneficiary were to receive care through the fee-for-service system. The HMO would be allowed the same rate of profit that it makes on its private enrollment, provided total reimbursement did not exceed the 95-percent ceiling. Most importantly, any savings above the HMO's normal costs and profit would be returned to enrolled beneficiaries in the form of reduced cost sharing—that is, coinsurance and deductibles—or coverage of additional services.

We would require that the HMO use these savings in a specified order. First, the HMO must provide preventive services, such as physical examinations and immunizations, without charge to the beneficiary. Next, the HMO must reduce or eliminate deductible and coinsurance obligations. Finally, the HMO could use any remaining savings to provide any additional benefits it chooses.

We believe that this ordering will improve the ability of beneficiaries to understand the benefits that each HMO offers. We estimate that about half of the HMO's that sign medicare contracts would be able to cover preventive services and fully eliminate the medicare deductible and coinsurance obligations at no cost to the beneficiary.

You asked me specifically to discuss your draft bill. It shares the objectives of the administration's bill, although it differs in some of the specifics. I would like to address two provisions that are of particular concern. First, you would reimburse at 90 percent of the fee-for-service system, compared with 95 percent in the administration's bill. Many HMO's have costs that are around 80 percent of fee-for-service, or a little higher. Thus the payment at 90 percent would significantly reduce the additional benefits that the typical HMO could offer. The basic reason for changing current risk reimbursement provisions is to reward beneficiaries for their choice of economical delivery systems. That principle implies market neutrality rather than a large discount from the fee-for-service payment level. Indeed, any attempt to save money in the short run will reduce the long-term competitive effect that both your and the administration's bills seek to achieve.

Another difference is that your draft bill authorizes contracts with State qualified HMO's and with health benefit plans that do not meet Federal standards. In fashioning our proposal, we have sought to achieve consistency in the definition of an HMO and in the requirements placed on these organizations by the medicare program and by the dual choice mandate on private employers in title XIII of the Public Health Service Act. State HMO laws are highly variable. For this reason, the provision in your draft bill would create problems of inconsistency among States and adminis-

trative difficulties for the Department. In addition, the title XIII qualification and compliance process, as well as the structural requirements it places on HMO's, provides a strong element of beneficiary and program protection that would be absent from your bill.

Let me make one final point. Our proposal does not entail special subsidies to HMO's. Special inducements for beneficiaries to join HMO's are provided only to the extent that the HMO is more efficient than the fee-for-service system. For too long, the complicated and inequitable formula now in the law has denied medicare beneficiaries access to HMO's on a basis comparable to employed groups. For too long, the Federal Government has missed an opportunity to use the medicare dollar to enhance competition and restrain rising health care costs rather than continuously fuel inflation.

Let me thank you again for the opportunity to appear today. I would be pleased to answer any questions, Senator.

Senator HEINZ. Thank you very much, Dr. Fox.

I have a few questions regarding your present program.

First let me ask if Joseph Healey, the director of the regional HMO office, is here today. Dr. Healey, are you here?

Would you mind coming forward and joining us, please.

I want Dr. Healey to join us, Dr. Fox, because he is the local Federal expert on the day-to-day operation of the HMO's and HEW's relationship with them.

I would like to ask first how would HEW divide up the administration of the new risk option between HCFA and the HMO office? What specific steps would you take to coordinate the administration of these programs in order to avoid duplicative regulatory burdens?

Mr. FOX. The design of the proposal itself is intended to reduce these burdens, particularly our use of the title XIII definition. It means that we can use the PHS qualification and compliance process as our process for certifying HMO's. We would want to coordinate that process to minimize the regulatory burden. One of the purposes of relying on the title XIII definition is to make it easier to administer the program in those areas where the common administration is appropriate.

Senator HEINZ. Going to the substance of the HEW proposal, essentially the administration's bill eliminates the cost option that exists under sections 1876 and 1833. How do you respond to charges that it is unrealistic to expect all qualified HMO's to enter into a risk contract and that by eliminating the cost option, your bill would only reduce HMO services?

Mr. FOX. Senator, in fairness that is not a central element of our provision although on public policy grounds we think it is the right way to go.

We do have a provision that any HMO without medicare experience can enter into a cost contract for up to 5 years. We have also taken the position that mature HMO's with medicare experience should deal with our beneficiaries on the same basis that they deal with the employed population. Indeed, some people who misunderstand the bill have argued incorrectly that efficient HMO's will go at risk and inefficient HMO's will go on a cost basis, which would

increase Federal expenditures. That is not possible under our approach.

We do incidentally allow, although it is not explicit in the bill, any organization to bill medicare on a fee-for-service basis, including an HMO. It is simply the special cost provisions for HMO's that we would eliminate once the HMO has some significant medicare experience.

Senator HEINZ. To make sure I also fully understand the administration proposal regarding the prospective calculation of rate payment, is the language of the administration bill in proposed section 1876(a)(1) intended to make the new procedure entirely prospective?

Mr. FOX. Yes, sir.

Senator HEINZ. A question seems to have arisen on that point, but it is your intention to make it entirely prospective.

Mr. FOX. Yes, sir.

Senator HEINZ. In many respects there seems to be broad agreement between us on what we want to do with medicare in terms of offering an option for more HMO participation while giving greater latitude to senior citizens to select their health care provider. Looking at some of the specific differences for a moment, I was curious about the comment on not allowing nonfederally qualified HMO's to participate particularly in view of the fact that there are not very many of them. It seems to me that as long as they must provide the benefits mandated in the benefit package and as long as they do all the other things that we tell them to do either in your approach or in our approach, they will do everything required of them, and I do not understand why that is inconsistent.

Mr. FOX. I am glad you raised that because this issue has probably caused more controversy than any other single issue. You are quite right. The proposals seek to achieve the same objectives though they differ in some respects. It is critical that we all work together and not get bogged down in some of the details.

With regard to the definitional issue, we are using the Federal qualification requirement for several reasons. First, we think it does offer important elements of beneficiary and program protection. For example, the Federal law mandates consumer participation in the governance of the HMO. It requires that each HMO have a quality assurance system that includes outside reviewers, and given the accusations that HMO's have at times incentives to underserve, we think this quality assurance system with the outside reviewer structure is important. It mandates a grievance system. There must be an internal grievance structure and if the beneficiary does not receive satisfaction, he or she can bring the grievance to the attention of the Department and we will look into the matter. None of these protections are foolproof but we think they are important.

The competitive aspect is a double-edged sword. Some people argue that we would promote competition by having a broader definition. However, there is also an anticompetitive aspect. Established HMO's particularly in States with dual choice laws need Federal qualification. The ones that do are the new HMO's that are trying to gain recognition, and they need it to qualify for Federal grants or loans, so you may in fact be penalizing some of

the smaller ones if established HMO's would not need Federal qualification.

In Pennsylvania there are six federally qualified HMO's, many of them rather small. Another six have requested qualification. There is only one HMO or organization that would be viewed as an HMO that we have identified that has not sought Federal qualification. So specifically, in Pennsylvania, while some of the HMO's may prefer not to have to obtain qualification, the requirement does not seem to pose major problems.

Senator HEINZ. At one time there was a considerable problem with the federally mandated HMO's. In the first instance HEW went out and started under their discretionary program, 50 to 100 of them without any standards whatsoever. Then the Congress in about 1973-74 passed the Health Maintenance Organization Act which set an unrealistically high level of benefits to be provided. That was subsequently amended, as I recall, in 1976.

My question is, did the 1976 amendments in fact make federally mandated or federally qualified HMO's viable and practical?

Mr. FOX. We think yes. We would like to keep the title XIII benefit package requirement, but from the perspective of medicare, it is the least important part of the title XIII qualification process and indeed——

Senator HEINZ. But it is the most expensive part.

Mr. FOX. We understand that it can be a problem in rural areas. In urban areas it is not that big a problem. If needed the concern is with the benefit package requirements of title XIII, our preference would be to retain the title XIII process except for the benefit package requirements rather than enact a much broader definition. In fact, we do suggest that, to the extent that you personally have problems with the title XIII definition, you use the title XIII as a starting base and suggest the elimination of specific requirements that strike you as unreasonable.

Senator HEINZ. Hopefully, our other witnesses who are here today will have particular expertise that will enable them to comment further on this point.

Let me ask, Dr. Healey, do you have any comment on that particular point?

STATEMENT OF JOSEPH P. HEALEY, PHILADELPHIA, PA., DIRECTOR, OFFICE OF REGIONAL HEALTH MAINTENANCE ORGANIZATIONS, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. HEALEY. I am not a physician.

Senator HEINZ. Mr. Healey, take a postgraduate degree any way you can get it.

Mr. HEALEY. I am associated with the Public Health Service and we run the grant program. We have not had that much involvement, to be perfectly candid, with any of our operational HMO's in region 3 in Pennsylvania thus far with medicare contracts.

Senator HEINZ. As I understand it, you have only one cost contract. Who is it with?

Mr. HEALEY. A cost contract with the Health Maintenance Organization of Pennsylvania. That is the only one thus far.

By and large I support what Peter has said here today. Particularly I support the proposal or his concern that there be a common definition on HMO's. It has caused some confusion not only in this State but in other States. In our region where States license HMO's there is no objection to that, obviously, but I certainly know that the public and employers in particular are confused. I think the medicare beneficiaries when they become more involved with HMO's will have a more common understanding of what an HMO is. A commonly used definition at both the State and Federal level will resolve some of the confusion.

Senator HEINZ. Let me ask you, Dr. Fox: How many title XIII HMO's are there?

Mr. Fox. There are 102.

Senator HEINZ. How many State-approved HMO's are there?

Mr. Fox. That I do not know.

Senator HEINZ. A rough estimate anybody?

Mr. Fox. The Public Health Service has identified under the broad rubric of prepayment plans, about 225. Many of these would not even remotely qualify as HMO's. For example, some of them are not at risk for hospital services, so that that number really does depend on your definition.

Senator HEINZ. As I understand your testimony, of the 102 title XIII's, how many beneficiaries are served?

Mr. Fox. Out of the 225?

Senator HEINZ. Out of the 225, 492,000?

Mr. Fox. That is correct.

Senator HEINZ. How many are served under the federally qualified HMO's?

Mr. Fox. 230,000.

Senator HEINZ. The 230,000 are not included in the 492,000, are they?

Mr. Fox. Yes, they are.

Senator HEINZ. They are?

Mr. Fox. Yes.

Senator HEINZ. And the 102 are included in the 225 or not?

Mr. Fox. Yes.

Senator HEINZ. All right. The one question I have regarding the grievance procedure, under title XIII: Does the Department presently have a consumer complaint handling system for the 102 federally recognized HMO's?

Mr. HEALEY. Well, in qualified plans, Senator, there is a mandated grievance procedure.

Senator HEINZ. I know that but I wanted to know if there is, in fact, such a procedure at work today and if someone who has a complaint can turn to a system in HEW for handling it?

Mr. Fox. Yes, there is. Right now to get qualification there must be, as I understand it, a grievance procedure.

Mr. HEALEY. Particularly to the Office of Qualification.

Mr. Fox. Then your question is, is there, in fact, a process where the beneficiary could bring a complaint to the Department?

Senator HEINZ. Yes.

Mr. HEALEY. The mechanism will vary, Senator. Usually a subscriber to an HMO if they don't reach satisfaction through the internal procedure with the HMO plan management, then a vari-

ety of mechanisms exist, including phone calls or written letters to HEW.

Senator HEINZ. Who do they go to? Do they go to you? Do they go to the Secretary's office?

Mr. HEALEY. In the case of a federally qualified HMO they will go directly to Rockville, Md., to the Office of the National Director and in particular to his Director of Qualification and Compliance.

Senator HEINZ. Very good. Would either of you care to make any comment on how difficult, in your judgment, it would be for any of the some 122 State-recognized HMO's to become federally qualified? Do you think half could do it, very few could do it, all of them could do it? How difficult would it be for most to become federally qualified?

Mr. HEALEY. I can only speak, Senator, to the ones I am familiar with particularly in Pennsylvania and other parts of this region. Most HMO's in region 3, which comprises six States, are located in Pennsylvania, and the State of Maryland, and the District of Columbia. I admit this would be a guess on my part but in my experience all of the federally qualified HMO's in Pennsylvania are licensed as State HMO's so there is no problem there and that is normally true for the few that are not federally qualified. I cannot speak for the Office of Qualification in Washington obviously but at best it is 50 percent for the named few that are not federally qualified.

Senator HEINZ. GAO had a 1978 report that was somewhat critical of HMO's for not specifically directing their services to medically underserved areas. How would HEW encourage HMO's to reach out to these areas so that in effect community grading was not somehow subverted?

Mr. Fox. The major reason for HMO's not reaching out to the underserved—I presume by that you mean the low-income population principally—is the reimbursement system.

Senator HEINZ. Or other high risk individuals. To give you an example, if the enrollment requirement for an HMO was that you had to walk up 12 floors in a building without an elevator, that might be a very effective way of screening out high-risk cardiac patients from participating in a medicare HMO option.

Mr. Fox. Well, the story about the HMO on the 12th floor without an elevator is apocryphal. We don't think that such an HMO would either survive our qualification process or survive in a competitive environment.

Senator HEINZ. It would only rent that office during a particular 30-day-enrollment period, the other 11 months of the year it would be on the ground floor.

How about Puget Sound, is that apocryphal?

Mr. Fox. In what sense?

Senator HEINZ. A health maintenance organization in Puget Sound.

Mr. Fox. Nobody has challenged the accessibility or quality services offered by Group Health Cooperative of Puget Sound. What has been challenged is the open enrollment process under the medicare risk contract. That open enrollment process was badly handled from both our and their perspective. They did not do an adequate job of advertising or making information available. We

think these problems have been rectified. However, beyond that, we also think that the Group Health Cooperative contract is an excellent example of why the existing law is very bad. Group Health Cooperative made $1.3 million in profits in the first year or 15 months under our program. They did turn some of the profits back to the beneficiaries; they were not obligated to. We would argue that the existing risk reimbursement allows for excessive profits.

Under the administration's bill, an HMO can make a market determined profit rate but they would not make more on medicare than on their private enrollment. We have also proposed open enrollment requirements so that the HMO must enroll without regard to the risk of the individual. As I say, I would certainly hope that any HMO that blatantly discriminated against people who are ill we would identify through our qualification and compliance process.

Senator HEINZ. The question of open enrollment and the question of serving medically underserved persons are, in fact, one and the same. There is a lot of evidence to suggest that people in nonrural medically underserved areas are high-risk patients; people in the inner city, for example, are medically high-risk patients. I am particularly concerned about your ability to insure that there is no skimming or creaming of the basic concept of open enrollment.

Mr. FOX. I don't want to oversell this bill. We are going at one segment of the underserved—the medicare elderly and disabled. We do not, for example, encompass medicaid within the scope of this bill. We do not have special provisions to locate in special areas without physicians or other providers. We think our bill does have adequate protections that would allow us to identify situations where the HMO is in fact discriminating against unhealthy medicare beneficiaries.

Senator HEINZ. One last question involving the difference in the bills on the percentage reimbursement to HMO's. You have 95 percent in the administration's proposal. That level of reimbursement has been accused of being too high, it has been accused of putting a drain on the trust fund, it has been accused of creating vast windfall profits—a very popular term these days, windfall profits. I am curious as to whether or not you can, for the record, answer those specific charges that others, as you are well aware, have made.

Mr. FOX. On the matter of profit, both our bill and yours preclude the HMO from making higher earnings or profits off our beneficiaries than they make off the general population. I would suggest that if even that profit level is too high, then let's put in an explicit limitation on profit. The important issue really is the additional benefits available to beneficiaries. We propose to reimburse at 95 percent. You have suggested 90 percent. Let's face it, the choice between the two numbers is judgmental.

From our perspective, we would like to approximate more closely what we consider to be market neutrality than 90 percent. The 5-percent difference really is an additional amount that goes into additional benefits for beneficiaries rather than additional profits for the HMO.

Senator HEINZ. Very well. Dr. Fox and Mr. Healey, thank you. We appreciate your being with us this morning.

Next is Dr. Morton Ward. I know he has a number of insights in caring for the elderly and new delivery modes such as HMO's. I want him to share with us his thoughts concerning the viability of what we are proposing to do with this legislation. First let me commend you for the fine work that you have done in this area.

STATEMENT OF MORTON WARD, M.D., PHILADELPHIA, PA., MEDICAL DIRECTOR, PHILADELPHIA GERIATRIC CENTER

Dr. WARD. Thank you, Senator, for the kind words.

I am Morton Ward and I am medical director of the Philadelphia Geriatric Center. This is an 1,100-bed facility which encompasses all level of care, including nursing home care and 56 acute hospital beds. Your concept of an alternate plan of care for meeting the health needs of the elderly is inviting. If that plan covers containment of costs or increased benefits or both, it is even more attractive. If such goals are attainable without further impairment of the quality of geriatric care, it would indeed be laudable.

Since HMO's operate on a prepaid insurance basis, the incentive to increase profit by curtailing services may be a deterrent to high quality care. Incidentally, I said my experience is with a geriatric facility. I have no HMO experience. If I were operating an HMO that caters to a substantial percentage of elderly patients, I would want some assurance of protection against financial loss because of possible cost overrides due to an uncontrolled demand for or need for health services.

In the absence of such assurance the elderly would be the last group I would choose to serve under such conditions and this is even truer with respect to the elderly above the age of 75 years.

My reasons follow: The older chronically ill patient is a problem in evaluation and management. His symptoms may be atypical and present difficulty in diagnosis. The incidence of malignancy increases with age and may require a good deal of study before the site is found. The elderly are accident prone. A statistical bulletin of the Metropolitan Insurance Co. in 1965 stated that the frequency of nonfatal accidents at age 65 and over was uncomfortably high. The annual rate per 1,000 was at that time 206 for women and 169 for men.

Each year 1 out of every 10 men and 1 out of every 8 women at ages 65 and over is injured in a home accident. In more than 1 out of 4 of these accidents the person was injured severely enough so that he had to be in bed for at least 1 day and 1 in 14 of the injured had to be hospitalized. With the large increase in persons over 65 since that time and especially since the over 75 is the most rapidly growing segment of our population, I feel sure that the ratios have increased.

The older patient not infrequently is depressed and lacks motivation to cooperate and get well. He frequently tends to accept his lot and delay seeking help or complains bitterly and constantly about the failure of treatment to cause significant improvement. There is a marked difference between the group from 65 to 74 and those above 75, the latter tending to be more frail and to require more services.

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Older persons tend to establish relationships with their physicians and do not react well to taking potluck or frequent changes in attending physicians. They, therefore, frequently try to continue with their family doctor even when they move out of his immediate area. When hospitalized they prefer the closest hospital since friends and relatives tend to be elderly and do not like to travel long distances to visit nor do they like to be out after dark particularly in the high-crime-rate areas.

Members of an HMO may have to accept a hospital bed that does not meet the above considerations. The older patient often suffers from multiple concurrent disease, enters the hospital more frequently and tends to stay longer. Frequent hospitalization and prolonged lengths of stay could be disastrous for an HMO.

In addition to basic hospital and office visit costs, the use of ancillary services such as the clinical laboratory, X-ray and electrocardiography could be considerable. These are costs which the HMO would have to bear and may not be able to control in this era of defensive medicine and increasing technology. The geriatric patient takes about one-third longer to see in the office than his younger counterpart. His sight and hearing may be impaired and it may take longer to be certain that he understands the physician's directions.

At a special conference I attended at the Veterans' Administration in Washington earlier this year a young woman presented her experience in a solo geriatric practice in Chicago. She worked long hours and found her practice financially unrewarding. She called in a management consultant who advised her that the restriction of her practice to the elderly was very costly. She had to move her office and include at least 50 percent of younger persons in her practice. The reasons for her difficulty included the large amount of time per patient for the elderly and third party reimbursement policies.

I feel that utilization review procedures in hospitals have had an adverse effect on the quality of care rendered the elderly. Many are discharged prematurely to conditions not supportive of continuity of good care. With HMO's the pressure for premature discharge may be increased and must be guarded against.

Many aged leave the hospital only partially diagnosed and partly treated. The danger to the elderly is not in overutilization but rather in underutilization and in some instances this is not even cost effective since some of these patients return to the hospital in a matter of days, if not hours.

Utilization of office visits may also present problems. A conscientious physician may accede to repeated requests for office visits for fear that this is the time that the patient is not crying wolf. When problems with reimbursement occur the frequency of telephone advice might tend to increase.

Regarding patients in nursing homes, our experience at this point under medicare part B reimbursement has been rather disastrous. In fact, if the HMO were to use the same flat fee and a patient entering the nursing home would not permit of an increased reimbursement, then the HMO would be ill-advised to continue taking care of that patient under these circumstances.

In conclusion, if an HMO were to ask my advice regarding service to the elderly under proposed legislation without safeguards at least initially against severe loss, my answer would be an unequivocal "No." If the alternative to financial loss is poor medical practice, the end result could be disastrous for both the patient and the physician.

Thank you.

Senator HEINZ. Dr. Ward, thank you.

You have outlined a number of problems in meeting the health care needs of senior citizens and you have set forth a warning that these may be of considerable significance to the health maintenance organizations. This indeed may be the case but I would like to know why these problems are significantly more difficult for a health maintenance organization to manage than for the present medicare system.

You cite, for example, that patients need more careful management either because they have a higher rate of accidents or because they have a higher incidence of disease. If the statistics that I am receiving are correct, there are fewer and fewer doctors who are willing to take the fee-for-service offered under medicare. I am concerned that there are going to be a large number of senior citizens who are without the kind of continuity of care that we all know is desirable. Why then is it not desirable to give those senior citizens more freedom of choice?

Dr. WARD. I am completely in favor of freedom of choice. That is not the problem. The problem is that even with current practice I am not sure that we are practicing with respect to the elderly the best quality of care of which we are capable. Part of this is because of the nature of the older patient per se. The other is that—my definition, for example, of healthy aged is you have not looked because if you would really look you would find that there are things wrong of which you are not aware and of which the patient does not complain. However, in the elderly this kind of preventive medicine could be very costly because the more you look, the more you find, the more you have got to investigate, the more you have to treat.

Senator HEINZ. Is that to say that preventive medicine is not cost effective for the elderly?

Dr. WARD. I have a feeling that good preventive medicine for the elderly would cost more than what we are doing now which is not very effective.

Senator HEINZ. What we are doing now is pretty costly. What you are saying about what we are doing now is that it is not very good, is that right?

Dr. WARD. I do not consider the quality of general geriatric care in this country anywhere near what is obtainable under present circumstances. Part of this has to do with our medical schools, it has to do with education and the physicians handling the elderly in understanding their problems and in being disease oriented rather than total patient oriented.

Senator HEINZ. I am an eternal optimist in matters like this, you understand, but it would seem to me that once a health maintenance organization enrolled a number of elderly that they would learn how to more effectively manage the health care problems of

older persons. Indeed my concern is that, if we don't gain more experience, we will never learn new approaches and we will be stuck with the present system. We all recognize that the present arrangement: (a) Is costly, (b) does not deliver for senior citizens very high quality health care, and (c) seems to lock us into a very inadequate concept when it comes to trying to improve the system.

Dr. WARD. I think that quality care is possible under any system and certainly including the HMO. I think it is more a problem of the motivations and the quality of care that is intended to be delivered by those who deliver that care and I think this is a basic source of the problem. What I am concerned about is that when the pinch is on—and the Federal Government has done this when the costs of certain programs such as the extended care facility became very expensive, then the Government curtailed the benefits that were permitted. What I am concerned about is that should the HMO find itself involved in approaching the limits of what they were allowed for a patient that the only answer for them might be to curtail the services in order to survive .

Senator HEINZ. The fundamental question that you are asking is whether or not it is possible to control the quality of the services provided by HMO's. Now federally qualified HMO's must have certain quality assurance, must meet certain standards and they must have certain procedures. Do you find fault with those procedures? Do you have any feeling as to whether they are effective or not?

Dr. WARD. I think the entire system of quality assurance is very ineffective. It has to do with drawing up and comparing patients, it has to do with comparing certain tests as to how often they are done in one group vis-a-vis another group. The quality of care lies at the bedside, it has to do with what is going on with that particular patient and nobody is assessing the total patient. For that reason I don't feel that any of the present systems, I don't care by whom contrived, really gives us a good idea of the quality of care delivered to a patient and I think that is the bottom line.

I care about whether the physician knows all of the problems that I have, whether he is addressing all of the problems that I have, and I am not interested if he is running an audit on cancer while I am suffering from some other disease. So I think present methods of trying to assure a quality delivery of care to an individual patient fall far short of the goal.

Senator HEINZ. What kind of a solution do you think makes sense? Is it a question of the particular orientation of health care professionals, doctors? Do we have to start training our health care professionals in a special way so that they are much more sensitive to the particular health needs of the elderly, or is it something else?

Dr. WARD. Our approach to the elderly and a switch from disease-oriented delivery of care to people-oriented care must change. I think there must be a concern for the individual patient rather than a concern for statistics. I think our orientation is wrong. I think we have to get down to the point of what we are doing with each and every patient and it requires people who are knowledgeable to go in and look at that, not to look at comparisons of statistics.

Senator HEINZ. Do you have any advice on how to do that?

Dr. WARD. The easy we do right away. I think it is difficult but I think it is possible. I think it is possible to spot check and go in and do it on individual patients and individual facilities or under individual circumstances and find out what is really happening.

Senator HEINZ. But if the imperative is having patient-oriented care, how do you motivate the health care delivery system which is composed of massive organizations such as Blue Cross, Blue Shield, and some 226 health maintenance organizations. It is composed of all kinds of hospitals, medical schools, extended care facilities, intermediate care facilities as well as various Federal, State, and local agencies. We are dealing with a really massive institutional framework. How do we get more focus on the patient? After all, that is the person that is supposed to be the beneficiary of all these institutions.

Dr. WARD. Hopefully, and we do see some beginnings that organized medicine will address its problems. We are seeing an increase in medical school interest in geriatric medicine. We hopefully will change the orientation of the physicians who deliver that care so that they will have insight as to what the real problems in delivering that care are. It will only be done by cooperation with all of the agencies, organized medicine, the Federal Government, the State government. One of our problems now has to do with the multiplicity of regulations and the compounding of regulations which really serve no useful purpose except to deter the physician in the delivery of that care. In fact, some of these things take the physician away from the bedside to all sorts of paperwork and decrease the time available for attention to the patient.

Senator HEINZ. If we can expand on that point. I think that is a good observation. I think there is a lot of truth to it, but isn't in fact that an argument for getting away from a cost-plus reimbursement system that we now have that says, fine, treat somebody and send us a bill and we will make sure that the service that you provided, after the fact, is the right service and make sure that you are billing us the right amount and not too much. If you bill us too little, that is your problem.

We will make sure that we pay you when we have the money and before you go broke and so on and so forth, but the present system which is fee-for-service lends itself and will always lend itself to that kind of problem. It seems to me what you are really making an argument for some kind of prepaid approach.

Dr. WARD. Any system of delivery of health care if properly performed, I think, can work. The problem gets to be not to destroy the incentive of the people who deliver the care to deliver the best possible care that they can. One of the most certain ways of curtailing costs is to put everything on a budget and everybody on a salary. We cannot exceed what you are giving. This is the English system. What I saw in England did not make me happy with the quality and the method of delivery of medical care.

What I am saying is that you must retain the best features of the present system and yet not deter the young physician, the most competent people, from entering the field—because they enter the field—and one of the main reasons they do is that the practice of medicine is a lucrative profession and the rewards eventually repay you for all the sacrifices made to reach that point. Let's not

deter the best people from going into the profession, let's also train them so that they are conscionable and that they will deliver the best possible care that they can without being wasteful but on the other hand not being neglectful either.

Senator HEINZ. Dr. Ward, we thank you very much. We appreciate your time. We have enjoyed having you with us and your comments are very helpful. Thank you.

Dr. WARD. Thank you, Senator.

Senator HEINZ. Our next witness is George Hauck, who is here representing the Pennsylvania secretary of the Department of Aging, Gorham Black. Secretary Black is the first secretary of the newly created Department of Aging in the Commonwealth of Pennsylvania. I am aware that the secretary is unable to appear personally this morning. I am very pleased that he was able to send you, Mr. Hauck. Please extend our best regards and best wishes to Gorham Black, your secretary, who is, I would note, a former Regional Director of HEW.

I look forward to hearing your comments and testimony. Please proceed.

STATEMENT OF GEORGE HAUCK, PHILADELPHIA, PA., SUPERVISOR, SOUTHEAST DISTRICT, DEPARTMENT OF AGING, STATE OF PENNSYLVANIA

Mr. HAUCK. Thank you, Senator Heinz, for your cordial invitation to participate in this hearing.

My name is George Hauck and I am the Philadelphia district supervisor, Pennsylvania State Department of Aging. I testify here today on behalf of the Pennsylvania Department of Aging, its secretary, Gorham L. Black, Jr., and Pennsylvania's 2 million citizens who are aged 60 and older.

The Department of Aging was created by Pennsylvania Act 70 of 1978 for the express purpose of helping our senior citizens remain active, viable members of their communities. The department is organized in such manner, through establishment of a Bureau of Advocacy, to explicitly recognize the role of the department in advocating for the needs of senior citizens.

It is quite obvious that a major need for the 60-plus population of our Commonwealth is for adequate health care services. Adequacy of health care services includes what may perhaps be an unattainable ideal, at least as I choose to define it—in terms of care that is accessible, comprehensive, of high quality, integrated with provisions of continuity and coordination, emphasizing prevention, yet delivered in a cost-effective manner with a bottom line of affordability.

Medicare provides a fee-for-service health insurance program for our senior citizen constituency. Medicare pays for some care—it does not insure that appropriate care is available and rendered. Medicare does not contain economic incentives for providers to deliver the most appropriate cost-effective care. The medicare system, while helpful and essential to the consumers it serves, has inherent problems. The structure of the benefit program, with parts A and B, deductibles and coinsurance is inherently complex and confusing to beneficiaries.

Government cost containment devices, such as the placement of ceilings on payment to physicians under the usual, customary, reasonable reimbursement system utilized in part B of medicare, may save the Government money, but results in failure of providers to accept assignment; that is, Government payment as payment in full. The beneficiary, on a limited and fixed income, becomes saddled with the burden of payment for the difference between what the Government pays as a reasonable amount to physicians and what physicians bill as their reasonable charge for services rendered.

Medicare does not pay for many of the most expensive, yet necessary, health care needs—prescription drugs, dental care, to name a few—of the elderly. The famous gaps in medicare, coupled with the increasing health care expenditures of medicare beneficiaries for noncovered, out-of-pocket, necessary health care services, and life on fixed incomes in an inflationary economy, create a real hardship of uncertainty and fear for senior citizens.

Integration of health maintenance organizations on a risk basis into the medicare system offers great hope for helping medicare beneficiaries who freely elect to enroll in this very attractive alternative. HMO's, representing prepaid health care delivery systems offering comprehensive service benefits to a voluntarily enrolled population, when opened to the medicare population in a meaningful and effective manner, show great promise for coming closer to the ideal of health care services to the elderly, which I spoke of earlier.

HMO's offer medicare beneficiaries much: HMO's don't just pay for care, they organize a delivery system and assume responsibility for the delivery of services to their subscribers. HMO's offer comprehensive benefit packages with an emphasis upon preventive health care services, ambulatory care, and cost-effective usage of inpatient hospitalization. HMO's emphasize quality health care services through formal quality assurance systems, organized grievance resolution systems, periodic choice of the consumer to transfer without penalty into alternative health insurance mechanisms, and freedom to choose a personal family physician from among those primary care physicians participating in the HMO. HMO's contain inherent incentives such as risk-sharing on the part of providers to deliver needed care in the most appropriate, efficient, and cost-effective manner. And finally, HMO's offer medicare beneficiaries, through prepayment, freedom from many of the burdens associated with deductibles, coinsurance, paperwork, finding physicians who will accept assignment under part B, and so forth.

Again, the bottom line is that HMO's are good for medicare beneficiaries. As an advocate for what is good for our senior citizens in Pennsylvania, therefore, I must advocate for the expansion of the availability of HMO options to our senior citizens who are eligible for medicare coverage. And, Senator Heinz, I must compliment you on the role you are playing here today in furthering the expansion of HMO's to our senior citizens here in Pennsylvania.

I must, most respectfully, offer one suggestion for incorporation into your bill. I suggest that the level of HMO reimbursement be targeted at a level high enough—perhaps 95 percent—to offer a

real inducement to HMO's in the Commonwealth to enter into medicare risk contracts.

I believe that this inducement is necessary. It is my understanding that most HMO's in Pennsylvania, while expanding and growing, will require additional time to significantly impact upon the health insurance marketplace. Most of the HMO's are not yet at the point of financial break-even. Thus, for the foreseeable future, it would appear that the State's HMO's—in terms of maturity, priorities, and financial well-being, would not seek out medicare contracts at reimbursement levels which are not high enough to offer an inducement. Any excess savings accruing to an HMO at say the 95 percent level can be required to be allocated specifically to serve the medicare population through increased preventive care, improved benefits, and so forth. Such an arrangement benefits everyone concerned—HMO's, the Federal Government, and medicare beneficiaries. An adequate reimbursement level will insure that Pennsylvania senior citizens do not have to unduly delay entry into the HMO system.

Once again, thank you for the opportunity to testify before you on behalf of Pennsylvania senior citizens.

Senator HEINZ. Mr. Hauck, thank you very much.

Let me ask you first, do you share any of the concerns of the previous witness, Dr. Ward, that health maintenance organizations, for their own sake, would be ill-advised to take on a large number of medicare beneficiary recipients?

Mr. HAUCK. I believe the testimony here indicates that we feel that there is a risk involved. I think that our responsibility should be to help reduce that risk, the risktaking on the part of the HMO's, coming into the system. I think that HMO's offer a viable option to a continuing treatment and medicaid treatment to the older person.

Senator HEINZ. Would you care to comment on the inclusion of health benefit plans in the medicare reimbursement proposal; that is to say, that other health care options beyond HMO's would be eligible to participate. If a "Blues" or other HBP could do a better job than medicare, that is, offer the same or a better benefit package, they would be permitted to get a contract to receive Federal reimbursement. Would you care to comment on that?

Mr. HAUCK. No, I feel I am somewhat handicapped in that I am not an HMO specialist. I think my testimony primarily reflects the position and the attitude of the secretary and I think in that instance I don't feel comfortable in commenting.

Senator HEINZ. Thank you very much, Mr. Hauck. We appreciate your joining us this morning.

Our next witness this morning will in fact be a panel of witnesses that includes Ralph Saul, chairman and chief executive officer, INA Corp., who is accompanied by James Walker, executive vice president, INA Corp., and Samuel H. Howard, vice president of planning, INA Health Care Group, Nashville, Tenn.

Gentlemen, we are pleased that you are here. I know that INA has had a considerable interest in this subject. Mr. Saul, I understand you have a statement that you wish to make. If so, please proceed.

STATEMENT OF RALPH S. SAUL, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, INA CORP., PHILADELPHIA, PA., ACCOMPANIED BY JAMES W. WALKER, JR., EXECUTIVE VICE PRESIDENT, INA CORP., PHILADELPHIA, PA., AND SAMUEL H. HOWARD, VICE PRESIDENT OF PLANNING, INA HEALTH CARE GROUP, NASHVILLE, TENN.

Mr. SAUL. I do, Mr. Chairman. I am accompanied today by James W. Walker, Jr., on my right, who is executive vice president of INA Corp., and at my far right is Samuel H. Howard, who is a vice president of planning of INA Health Care Group, a wholly owned subsidiary of INA Corp.

As you know, we are a large insurance-based financial services company headquartered here in Philadelphia. Our health care operations make us one of the largest hospital management companies in the world. We also operate two health maintenance organizations serving 170,000 members. It is the intention of the INA Health Care Group to continue our pace of expansion in the HMO field.

It is a special privilege to testify before you, Senator Heinz, in light of your long-standing interest in the health care of all Americans—and especially the health care of the elderly. Your previous experience in the House, as well as your work on the Senate Finance Committee and the Special Committee on Aging, underscore your commitment to seeking creative and comprehensive solutions to these problems. Indeed, my colleagues at this table were privileged to testify before the Finance Committee at the March 28 hearing on catastrophic health insurance. Your continuing interest in the application of market-oriented economics to our Nation's health care system and your penetrating questions at that time have stimulated our further study and analysis of health care financing problems facing Americans—especially older Americans.

This analysis has reaffirmed our commitment to four basic principles outlined in our March testimony. Federal health care programs should in our view:

One: Foster competition among alternative health care plans.

Two: Replace the Federal Government's retroactive cost reimbursement system with fixed premium financing, thereby creating incentives for insurers, providers, and consumers to control costs and utilize health care resources efficiently;

Three: Encourage consumer participation, cost-sharing and informed choice; and

Four: Improve access for all Americans to an acceptable level of health care benefits by rechanneling resources saved through these reforms into catastrophic insurance coverage, and possibly, if savings in the future permit, into expanded benefits for medicare and medicaid beneficiaries and the extension of federally financed health care coverage to the poor and near poor who are not presently covered.

We have reviewed your proposal for greater participation by health maintenance organizations—HMO's—and health benefit plans in the provision of health care services to the elderly. We fully support the thrust of your proposal. We believe it would contribute significantly to more effective Federal participation in

our health care system, consistent with these four principles of reform.

We have several comments on your proposal, Senator, and the more detailed statement of comments on the proposal are contained in a longer statement which we have submitted for the record.[1] I would particularly call your attention to pages 19 through 22 of our longer statement where we outline the principles of the proposal which we think are a great step forward and a number of modifications which I would like to comment on in my brief oral statement.

First, your proposal would enable older Americans to benefit from the lower costs, expanded service and consumer responsive conveniences that accrue from constructive competition among health care plans. Not only would State-licensed and federally qualified HMO's be encouraged but new, innovative types of health service benefit plans would become eligible to compete for the Federal medicare dollar. Moreover, Federal financing among the alternative plans would be equitable; no particular insurer, association, or HMO would be given unfair leverage or a competitive edge.

Your proposal also would begin the much-needed process of replacing the Federal Government's cost-plus reimbursement system with fixed premium financing and we think this change is a very major step. This approach would encourage cost-conscious behavior by insurers, providers, and beneficiaries in the utilization of health care services. We would like to see this concept refined and expanded in your proposal. If HMO's and private insurers are paid on a fixed-rate basis, they would have every incentive to control costs internally and to seek the most cost-efficient providers.

Perhaps the best example of a successful plan predicated on this principle is the Federal employees health benefit program—FEHBP—which has been in effect since 1960 and is now providing health care services to over 10 million individuals. Federal employees are offered a wide range of choices among competing health delivery systems. Whichever plan the employee chooses, the Government, as employer, contributes a fixed amount, calculated as a percentage of the average of the premiums of several of the largest plans. The employee pays the rest.

We believe that the method by which the Government's contribution to the premium is established in the Federal employee program is superior to the adjusted average per capita cost—AAPCC—formula now contained in your proposal. The so-called AAPCC mechanism is determined on the basis of actual inflated costs incurred under flawed Federal retroactive reimbursement policies—policies which might be based on the so-called cost pass-through reimbursement mechanism. It, therefore, does not reflect the efficiencies of truly competitive behavior. It does not reflect the competitive pricing of the marketplace in which insurers assume reasonable risks based on their actuarial experience. In contrast, the Federal employees' program establishes a Federal fixed-premium contribution by averaging premium charges established through competitive behavior.

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[1] See page 28.

Thus, we recommend inclusion in your proposal of a new formula similar to that used in the Federal employees health benefit program. A fixed-dollar Federal capitation payment toward the premium cost of each plan would be established as a percentage of the average of selected premium charges in the area served. The medicare beneficiary would pay the remainder of the premium cost of the plan of his choice. Such a payment would be in lieu of the contribution now made under medicare part B. Our preliminary studies indicate that the Federal Government should contribute 75 percent of the premium cost, but we believe that further study is required to determine what percentage of the average premium would maximize the benefits of this reform. It is important, however, that the percentage be set low enough to discourage profiteering, without asking medicare beneficiaries to pay more out-of-pocket than they do under present law. We would like to see the concept of fixed-premium financing expanded to all medicare coverage over a transitional period, replacing entirely the cost-plus reimbursement system.

Your proposal also would encourage informed consumer choice and participation—another important principle. Patients as well as doctors can and should participate in making critical choices about their health care. The claim that health care is too important to entrust to consumers is bureaucratic paternalism of the worst sort. Your proposal would insure consumer participation by providing real alternatives and by requiring that adequate information about them be made available.

We would recommend that the proposal also include flexible cost-sharing provisions for HMO's and health benefit plans that would replace the ceilings, deductibles, and copayment requirements under present medicare law. Such plans would have the flexibility to design their own combination of coinsurance, copayment, and deductible requirements and would be encouraged to include 25 percent across-the-board cost-sharing up to a cap of $2,500 per year. Holding a financial stake in their decisions would strengthen the incentive of medicare beneficiaries to choose wisely.

The fourth principle noted above would encourage improved access for all Americans to enhanced health care benefits. Your proposal would require that services now provided under medicare parts A and B be offered in any plan which qualifies for Federal fixed-premium financing. Presumably your proposal would allow various plans to offer additional benefits in response to consumer demand. The most efficient plans would be able—indeed would be required—to offer supplementary benefits without additional premium cost. We recommend that the savings to the Federal budget achieved from the efficiencies of competition, cost-sharing and fixed premium financing be rechanneled into expanded benefit coverage through the provision of catastrophic insurance, and possibly, if resources permit in the future, preventative health care and other benefits.

With these modifications, your proposal would realize more fully the underlying objective in the creation of the medicare program—that medicare beneficiaries not be treated as second-class citizens but that they receive the same health care service that is available to private paying patients, including the ability to choose among

alternative benefit plans and delivery systems. Thus, your proposal would be the first step toward a more rational, equitable and compassionate Federal health care policy for older Americans. It further represents the first step toward major reform of our Federal financing system. With such reforms, the Federal Government will become a leader in demonstrating how the marketplace promotes efficiency, how the consumer can make responsible choices, and how healthy competition will improve access to quality health care at a reasonable cost.

That completes my prepared statement, Senator. We are ready to answer any of your questions. I again want to express my deep appreciation to you for asking us and letting us testify this morning.

Senator HEINZ. Mr. Saul, thank you. We will have, I am sure, a considerable amount of discussion in just a few moments on your prepared statement and on other subjects. I am going to give the court reporter a break for about 5 minutes. We will adjourn for 5 minutes.

[Whereupon, the committee recessed.]

Senator HEINZ. Ladies and gentlemen, we will resume our hearing of the Special Committee on Aging.

A few minutes ago Ralph Saul from the INA Corp. completed his statement. He made several interesting observations and several very constructive suggestions. The first of those suggestions was that he would like to see the reimbursement principle better defined. In my draft bill we provide a formula based on 90 percent of what the medicare is essentially now paying and that such a fee be available to health benefit plans or to HMO's. You have indicated that the Federal employees health benefits program approach which is an averaging of what you have described as more efficient providers of health care should be used.

I would like to ask you what we should use in such an approach inasmuch as we may not have the same basis on which to make those comparisons. It seems to me that since most senior citizens are covered under medicare it is difficult for us to obtain comparable statistics to what the Federal health benefits plan uses. Can you help me with this difficulty?

Mr. SAUL. Let me try to be helpful, Senator, on that. I think what we are suggesting here is that the formula include and be based upon more than the pure fee-for-service system which, as I said in our testimony, I think has some of the disadvantages of the cost based reimbursement system.

What we would suggest is that the basis for determining the reimbursement or the per capita payment be an average of the premiums paid in a variety of plans.

Senator HEINZ. For the senior citizen population.

Mr. SAUL. For the senior citizen population, and that would include an indemnity plan and a service plan and perhaps some other comprehensive medical plans, all of which would provide the same benefits as provided under parts A and B of medicare. The whole point of this approach is to base the payment upon the premiums paid in a competitive or marketplace environment rather than basing the payment of one type of plan.

I don't know whether that fully explains the reasoning but I think that one of the great advantages, as we see it, of the Federal employees health benefit plans is that the payment formula is based upon an averaging of all types of plans provided to Federal employees, not only indemnity plans but prepaid plans, including HMO's.

Senator HEINZ. Regarding the particular percentage of reimbursement contained in the formula, the bills before us range from 95 to 90 percent—the administration recommends 95 percent, we have suggested 90 percent. You propose 75 percent. I assume that you feel that 90 to 95 percent is too high. If so, why?

Mr. SAUL. Well, I don't think we come before you with a massive study showing how we arrived at 75 percent. I think it gets back to the principle of the thing. As I understand it, under the present medicare system, the beneficiaries of medicare now pay about one-third of the total health care costs. Based not only upon that but also on our experience in running various kinds of health organizations, we believe there ought to be some principle of cost-sharing. The cost-sharing percentage ought to be somewhat less than the 33 percent now paid by the medicare beneficiaries, but 10 or 15 percent might be too low. There would not be sufficient cost-sharing built into the formula.

So I would say that we came out with 75 percent as somewhere between what we regarded as a 90 or 95 which was on the high side and 33 percent or one-third which is what the medicare beneficiary now pays for his medicare benefits as too low. I think the important point here is really to get back to the principle, Senator, and that is, based on our experience, it is important to maintain the principle of cost-sharing and that 75 percent would do it.

We also recommended that it be set at that level to eliminate possible profiteering, a concern which I think was alluded to earlier at this hearing. It is a fear that some people have if we set the percentage too high. It was our feeling that 75 percent would be the appropriate level.

Senator HEINZ. Let me ask you this. Under the present system, 100 percent of what medicare pays to the senior citizen in the way of benefits represents only approximately two-thirds of the senior citizen's medical costs. Why, if that is correct, would a 75-percent reimbursement of the 100-percent medicare payment result, as I think you claim, in senior citizens actually paying less than they do now?

Mr. SAUL. Mr. Howard.

Mr. HOWARD. Let me comment on the 75 percent. The 75 percent is 75 percent of the average premium for four plans as we described earlier. The existing medicare system is cost-based and currently medicare beneficiaries pay about 33 percent of the total health costs. The formula that is being proposed is 90 to 95 percent of that cost which represents or is intended to represent the full payment for medical services provided to the medicare beneficiary.

What we are talking about and what we are trying to articulate is a position of cost-sharing on the part of the medicare beneficiary at two points. The cost-sharing will occur at the time the premium is paid. The cost-sharing would also take place at the time services are rendered.

I believe if we have premium cost-sharing it would give the medicare beneficiary an incentive to select the plan that best meets their need. If you take the 90-percent approach and pay a fixed-dollar sum as the total-payment for a health plan, there is little incentive for the beneficiary to select among various alternative plans.

We further think that the 90 to 95 percent is really tied to a cost-based system, as Mr. Saul has indicated, which could be adversely affected by a shift of persons to HMO's from that system and this possibly has been alluded to not only today but at least in many of the writings that I have seen. What we are trying to do is to at least use as a model the system—Federal employees health benefit program—that is 20 years old, that we know has been offering HMO since 1960.

Senator HEINZ. Just so we get the terms of this discussion clearly referenced, you used the figure earlier that the medicare beneficiary pays about one-third his or her costs. The figure for the health care costs that I am given by staff indicates that medicare coverage pays in the neighborhood of 40 percent of total health care costs for older Americans. That includes, I assume, noncovered items—prescription drugs, dental care, deductibles, copayments, and any premiums such as the premiums under part B.

Are we both starting at the same point?

Mr. SAUL. I believe so, Senator, but let Mr. Howard go into that.

Mr. HOWARD. Our 33 percent comes from the 1977 data with the Department of HEW on aging which gives a per capita cost for persons 65 and over of $1,745. $463, or 27 percent of that, is direct payments by the persons over 65. Then you have the private health insurance coverage which they pay another $75 which is 4 percent and then they also have the medicare part B payment which is $8.20 which is another 4 percent. The rest are payments from private insurance, medicare, medicaid and that makes up the balance of it. My figure of 33 percent includes the premium payments that the elderly make to purchase medigap policies as well as the medicare part B premium payment and the direct out-of-pocket expense.

Senator HEINZ. As I understand the resolution of these numbers, if 43 percent in fact represents the $1,745 that medicare pays and 35 percent represents the direct out-of-pocket expenses of the senior citizen, the difference between 100 and 78 percent—in other words, 22 percent—is what would be paid by private insurers, is that correct?

Mr. HOWARD. And medicaid.

Senator HEINZ. And medicaid. All right.

Now I think there is a significant difference in what you are proposing and what we have written in this draft bill. As I understand it, you are saying that in addition to a 75-percent reimbursement, there should be more flexibility for deductibles and copayments. There would also be a premium paid directly by the senior citizens, is that right?

Mr. SAUL. Yes.

Senator HEINZ. What is the level of such a premium? Would it be the difference between 75 and 100 percent? In other words, would

it be 25 percent of what is now being paid per capita under medicare?

Mr. HOWARD. The difference between the average which is 75 percent and the cost of the plan selected would be the amount that the medicare beneficiary pays. For example, suppose that the average of the four plans is 100, 75 percent of that would be the subsidy and if they selected a plan that cost $85, they would pay $10.

Senator HEINZ. Fine. If a medicare beneficiary said, "I want a plan where I don't have to shell out any more than the fixed-dollar payment that is related to the Federal Government rate—75 percent of Y or 90 percent of Z or whatever it is. I want a plan where I don't have to put any more money up front than I already pay." Is it your feeling that a senior citizen could obtain just as much coverage at no higher cost from an alternative medicare as they do now from medicare?

Mr. HOWARD. I believe that they can, but it will require further study. I believe that you take the current medicare parts A and B benefits and compare that to the AAPCC for a given area, you will find that parts A and B represent about 75 percent of the AAPCC.

Senator HEINZ. At no higher cost in terms of deductibles, copayments, and additional payments.

Mr. HOWARD. Yes, none other than are currently in the medicare benefit package, plus the SMI premium.

Senator HEINZ. That is a very remarkable claim that I hope does not go unnoticed in the hearing record. What Mr. Howard was really saying is, "Hey, we can deliver at least as good health care as you are now getting at no greater risk to you for 75 percent of what is now being paid under the present fee-for-service system." If true, that is one of the most remarkable facts in the history of modern medicine and I hope it is true.

Let me ask you this because there is one more important caveat and that is quality. We have had a number of comments on how we can assure quality. Dr. Ward was here and he was rather skeptical as to what would happen to senior citizens once they were enrolled and prepaid. He was concerned that they would not get proper management and in particular he raised the specter, as I recollect, of premature discharge because it would be cheaper for the HMO. How do you respond to that question whether there is sufficient quality assurance guarantees here?

Mr. SAUL. I thought about that comment that Dr. Ward made and I think the answer to it, Senator, is that under the principles that are incorporated in your proposal and the principles that we are suggesting that there would be alternatives. In other words, if an elderly person found that he was not getting adequate care in an HMO that he was enrolled in, when the new enrollment period came up he could change. In other words, it gets back again to the principle that we have been talking about and that is that there should be alternative health care delivery systems for everyone, including the aged, and that if there was dissatisfaction with the quality of care in the HMO's that we run, the patients can go elsewhere.

Obviously it is in our interest, it is in the interest of anyone who runs an HMO, to make sure that their enrollees and their patients remain there, and the only way HMO's can remain in business

over the long run is the reputation they acquire in the marketplace for the delivery of quality health care.

Senator HEINZ. Well, fortunately the next panel represents three health payment organizations so I will have the opportunity to ask them that same question.

Are there any other comments, Mr. Saul, that you or your associates would like to make?

Mr. SAUL. Yes, Senator, I think the thrust of what you are proposing is absolutely on the right track. I think that just looking at the budgetary pressures the Federal Government is going to be facing over the next decade, particularly during the next 5 years with defense spending, that there will be, it seems to me, increased pressures on the various kinds of entitlement programs for greater efficiency in the delivery of benefits under those programs.

We will need innovative thinking in that area and I think it is the kind of innovative thinking that is incorporated in your proposals. I think it is very important that in order to make sure that the entitlement programs are most cost-effective without sacrificing the care and benefits to the elderly that we get at new types of mechanisms for doing it.

Senator HEINZ. Mr. Saul, Mr. Walker, Mr. Howard, thank you very much for taking the time to be with us this morning. The more detailed statement of Mr. Saul will be entered into the record at this point.

[The statement of Mr. Saul follows:]

PREPARED STATEMENT OF RALPH S. SAUL

Mr. Chairman, my name is Ralph S. Saul, I am chairman of the board and chief executive officer of the INA Corp., one of the Nation's largest diversified financial services companies and among the Nation's oldest commercial organizations. INA's history goes back to 1792 with the formation of its principal subsidiary and the Nation's first stock insurance company, Insurance Co. of North America. The total assets of the corporation are $11.9 billion and in 1978 INA's worldwide operations produced consolidated revenues of $4.2 billion and after-tax income for operations of $211.4 million.

I am accompanied today by James W. Walker, Jr., executive vice president of INA Corp., and Samuel H. Howard, vice president of planning, INA Health Care Group, a wholly owned subsidiary of INA Corp. INA's Health Care Group's operations include the world's largest hospital management corporation, Hospital Affiliates International, as well as INA Health Plan, Inc., which owns and manages two health maintenance organizations with a combined enrollment of 170,000 members. It is the intention of the INA Health Care Group to continue our pace of expansion in the HMO field.

Thank you for this opportunity to testify on an issue of great concern to the INA Corp. We are grateful, Senator, for your decision to hold these hearings in Philadelphia. It is a special privilege to testify before you because of your long-standing interest in the health care of all Americans and especially the health care problems of the elderly—an interest demonstrated by your experience in the House as well as your work on the Senate Finance Committee and the Special Committee on Aging. Indeed, my colleagues at this table appeared before the Finance Committee at its March 28 hearing on catastrophic health insurance. We greatly appreciated then your continuing interest in the application of market-oriented economics to our Nation's health care system and your thought-provoking questions. Those questions have stimulated our further study and analysis of health care financing problems facing Americans—especially older Americans.

PRINCIPLES OF REFORM

We remain committed to the four basic principles outlined in our March testimony. Under these principles Federal health care programs should:

One: Foster competition among alternative health care plans.

Two: Replace the Federal Government's retroactive cost reimbursement system with fixed-premium financing, thereby creating incentives for insurers, providers, and consumers to control costs and utilize health care resources efficiently;

Three: Encourage consumer participation, cost-sharing and informed choice; and

Four: Improve access for all Americans to an acceptable level of health care benefits by rechannelling resources saved through these reforms into catastrophic insurance coverage and ultimately into expanded benefits for medicare and medicaid beneficiaries and the extension of federally financed health care coverage to the poor and near poor who are not presently covered.

SENATOR HEINZ' PROPOSAL

We have reviewed your draft bill proposing greater participation by health maintenance organizations (HMO's) and health benefit plans in the provision of health care services to the elderly. We fully support the thrust of your proposal. We believe your proposal would contribute significantly to more effective Federal participation in our health care system, consistent with the four principles of reform noted above.

First, your proposal would enable older Americans to benefit from the lower costs, expanded service, and consumer-responsive conveniences that accrue from constructive competition among alternative health benefit plans.

Second, your proposal would begin the process of substantially reforming the medicare program, under which Federal retroactive cost-plus reimbursement eventually would be replaced entirely by prospective fixed-premium financing.

Third, your proposal would encourage consumer choice and participation in making critical and timely choices about his or her health care.

Fourth, under your proposal the Federal Government, instead of distorting the incentive system in the private health care industry, would become a catalyst for great efficiency, enhanced quality, and constructive entrepreneurship in the private sector. These efficiencies are translated, in turn, into expanded benefits for older Americans. Let me indicate more fully how your proposal will help achieve these four basic principles of health care reform.

COMPETITION

First, the proposal recognizes that competition in the provision of health care services works. In recent years, as the failure of Government regulations to control costs and promote efficiency has become increasingly apparent, there has been a resurgence of scholarly support for the effectiveness of competition in allocating resources in the health care sector.

Such academic support is reminiscent of the early stages of aviation deregulation where a few innovative scholars challenged the conventional wisdom that the aviation industry was like a public utility and therefore not susceptible to marketplace economics. Like the pioneers of aviation deregulation, health care scholars are setting a new course that could revolutionize Federal health policy.[1]

Competition promotes greater efficiency in the utilization of hospital facilities and medical services. And because such efficiencies are produced by impersonal market forces, they are not subject to the political and legal obstacles facing Government planners who attempt to curtail unneeded facilities or programs. Competition encourages diversity, innovation, and quality in the delivery of health care services. Innovators seeking to tailor their services to the needs of particular beneficiaries can introduce substantial efficiencies into a competitive marketplace. Health maintenance organizations can respond to consumer preferences for complete, one-stop and continuous health care service. Comprehensive insurers offer greater flexibility, enabling beneficiaries to shop around for the best specialists.

Your proposal would foster healthy and constructive competition in several ways. Not only would State-licensed as well as federally qualified health maintenance organizations be encouraged but new, innovative types of health service benefit plans would become eligible to compete for the Federal medicare dollar. Moreover, Federal financing among the alternative plans would be equitable; no particular insurer, association, or health maintenance organization would be given unfair leverage or a competitive edge. Finally, consumer information provisions would

[1] See, e.g., Robert B. Helms, "Contemporary Health Policy: Dealing With the Cost of Care," in Contemporary Economic Problems 327 (American Enterprise Institute 1978); Alain C. Enthoven, "Consumer-Choice Health Plan," 298 New England Journal of Medicine 709 (Mar. 30, 1979); Alain C. Enthoven, "Consumer-Centered versus Job-Centered Health Insurance," 57 Harvard Business Review 141 (January-February 1979); William Hsiao, "Public versus Private Administration of Health Insurance: A Study in Relative Economic Efficiency," XV Inquiry 379 (December 1978); Clark C. Havighurst, "Health Care Cost-Containment Regulation: Prospects and an Alternative," 3 American Journal of Law & Medicine 309 (1977); P. Ellwood & W. McClure, "Health Delivery Reform: Minneapolis," Interstudy (Nov. 17, 1976).

insure that beneficiaries are informed about alternative plans and able to make an intelligent choice among them.

FEDERAL FINANCING REFORM

A second fundamental principle reflected in your bill is the federal health care programs should encourage cost-conscious behavior by insurers, providers, and beneficiaries in the utilization of health care services. Intensive lobbying by the Carter administration on behalf of its ill-considered hospital cost containment legislation inevitably has focused public attention on the systemic causes of spiraling inflation in health care costs—causes that are largely attributable to perverse Federal financing laws and policies. By reimbursing providers retroactively on a cost-plus basis, medicare financing currently rewards increased spending, penalizes the cost-efficient, stimulates overinvestment in technology and excess capacity, and encourages overutilization of medical facilities and services.

Such incentives must be reversed. Instead of paying for health care services on a cost-reimbursement basis, the Federal Government should purchase health care coverage by paying prospectively fixed premiums to qualified plans. Such fixed payments should reflect competitive pricing in the marketplace. Under this principle, health maintenance organizations and private insurers would assume the risk. If their costs exceed revenues from premium payments by the Government and cost-sharing by the beneficiaries, they would have to absorb the losses. If revenues received exceed costs, they could reduce the beneficiaries' copayments, expand the services and benefits offered, provide rebates, or retain profits. To attain this flexibility, they would have every incentive to control costs internally and to select the most cost-efficient providers. Because the Government would treat all competing plans equitably—each plan in a particular community would receive the same Federal contribution—efficient plans which offered quality service would attract the greatest number of enrollees. They would set the competitive standard.

Perhaps the best example of a successful plan predicated on this principle is the Federal employees health benefits program (FEHBP), which has been in effect since 1960 and is now providing health care services to over 10 million individuals. More than 80 different health care plans participate in this program, offering Federal employees a wide range of choices among competing health delivery systems. Whichever plan the employee chooses, the Government, as employer, contributes a fixed amount, calculated as 60 percent of the average of the premiums of several of the largest plans. The employee pays the rest. Because the amount of the Government's contribution does not vary with the cost of the plan selected, employees are encouraged to select that plan which provides the greatest benefits at the lowest cost. Carriers offering the plans, in turn, are forced to compete for employee's premium dollars by reducing administrative costs and contracting with the most efficient providers of health care services.[2]

We find it ironic that, among the myriad new health insurance proposals now being debated in Congress, so little attention has been focused on one of the simplest but most successful programs ever.[3] And it's right in Congress own backyard.

Indeed, we believe that this committee will want to consider the method by which the Government's contribution to the premium is established in the Federal employee program. We believe that this method is superior to a formula based on a percentage of adjusted average per capita cost now contained in your proposal. Because the AAPCC mechanism is based on the flawed retroactive cost reimbursement system, the costs it generates are inflated. Thus, the formula does not reflect the efficiencies of truly competitive behavior. It does not penalize excessive spending or encourage insurers to assume the risk in responding to competitive pricing in the marketplace. Rather it builds the inflated costs of the present system into an actuarial base and creates an artificial incentive for providers to spend up to the allowable percentage that constitutes the Federal payment in order to maintain the

[2] Recently published findings of a study conducted over 1971-72 by Harvard Professor of Economics William Hsiao noted that the average unit cost of administering the FEHBP was 26 percent lower that the cost of administering medicare. William Hsiao, "Public Versus Private Administration of Health Insurance: A Study in Relative Economic Efficiency," XV Inquiry 379 (December 1978). See also A. E. Ruddock, "Federal Employees Health Benefits Program. I. History and Future of the Federal Program—1964," 56 American Journal of Public Health 50 (1966), cited in Alain C. Enthoven, "Consumer-Choice Health Plan," 298 New England Journal of Medicine 709 (Mar. 30, 1978).

[3] The statute establishing the FEHBP is 8 pages long, and the regulations implementing it are approximately 16 pages. See Pub. L. 86-382, now codified at 5 U.S.C. §§ 8901-8913; 5 C.F.R. § 890. In contrast, the medicare law (title XVIII of the Social Security Act) is 102 pages long and its regulations fill approximately 400 pages.

actuarial basis. Moreover, the auditing and reporting that would be required to establish the true costs would be cumbersome and would generate substantial overhead costs.

In contrast, the Federal employees' program establishes a fixed-premium contribution on the basis of subscription rates established through competitive behavior. Thus, we recommend that your proposal be revised to replace the existing adjusted per capita formula with a new formula similar to that used in the FEHBP. The Secretary of Health and Human Services, through the Health Care Financing Administration, would establish a monthly fixed-dollar Federal per capita payment toward the premium cost of each plan. The Federal payment would equal a fixed percentage of an average of certain subscription (premium) charges in effect or proposed at the beginning of each calendar year. Such a payment could not exceed 95 percent of the adjusted average per capita cost, which would insure that this alternative formula would be comparatively less costly for the Government. The average would be calculated by identifying those plans which offer, at a minimum, the benefits provided for in parts A and B of medicare and which serve the largest number of enrollees for each of the following categories: (a) An indemnity plan; (b) a service plan; and (c) two comprehensive medical plans.

The Government would pay a fixed percentage of the average premium, and the medicare beneficiary would pay the remainder of the premium cost of the plan of his choice in lieu of the contribution now made under medicare part B.

We believe that further study is required to determine what percentage of the premium cost constituting the Federal payment would maximize the benefits of this reform. It is important that the percentage be set low enough to discourage profiteering, without asking medicare beneficiaries to pay more out-of-pocket than they do under present law. Based on our preliminary analysis, we believe that 75 percent of the average premium costs would be the appropriate level. This level of Federal contribution should not increase the amount of out-of-pocket expenses incurred by medicare beneficiaries today. If the Federal contribution were established at 75 percent, then we believe that your proposal should be clarified to allow health benefit plans and HMO's the flexibility to increase their revenues through some combination of coinsurance (additional premium charges), copayments, and deductibles. The precise design of cost-sharing should be left to the HMO or benefit plan to determine, although the proposal could establish basic parameters (e.g., the proposal could provide both a ceiling and a floor on the amount of total cost-sharing allowed). While we believe 75 percent may be the correct level for the Federal contribution, we recommend further study of this issue because the way this payment contribution is calculated is essential to the establishment of an equitable basis for meaningful competition on price, quality of service, convenience, and cost-efficiency.

Long-term reforms in the medicare reimbursement mechanism, such as those you have proposed, represent a first step toward controlling costs and utilization far more effective than Band-Aid remedies like hospital cost containment legislation. For this reason, we would like to see the concepts introduced in your proposal expanded and broadened. Over a transitional period, all persons becoming eligible for medicare, except the disabled, would purchase medicare coverage from the private sector on a fixed-premium basis. Eventually the cost-reimbursement system would be replaced by fixed-dollar contributions by the Federal Government.[4]

We would also like to see your proposal clarified to insure that HMO's and health benefit plans have the incentive to price competitively, control costs, and deliver consumer-responsive services. Carriers whose costs are less than premium payments received should have additional flexibility to add additional benefits and services, invest in needed capital or human resource improvements, rebate to consumers a portion of their premium charges, or retain reasonable profits.

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[4]The Secretary of Health and Human Services would contract with qualified carriers for a uniform term of at least 1 year, automatically renewable in the absence of notice of termination by either party. Qualified carriers would include voluntary associations, partnerships, corporations, or other nongovernmental organizations, lawfully providing, paying for, or reimbursing the cost of health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements.

Eligible carriers, including HMO's, must be licensed by the States in which they serve. Carriers would agree contracturally with HHS to charge premiums that reasonably and equitably reflect the cost of benefits provided in the community, actuarially adjusted for medicare benefits and utilization. The Secretary would prescribe reasonable minimum standards for the health care plans and for carriers offering the plans, but the extent of the Secretary's authority should be expressly defined and limited by statute.

CONSUMER PARTICIPATION

The third fundamental principle is that of informed consumer choice and participation. Patients as well as doctors can and should participate in making critical choices about their health care. The claim that health care is too important to entrust to consumers is bureaucratic paternalism of the worst sort. Of all the choices that consumers must make, none is regarded as more important than those which preserve or restore the health of the individual. If consumers are capable of exercising intelligent choices in the marketplace, presumably they will exercise such choices responsibly on matters of personal health if they are presented with real choices, if they are adequately informed, and if they have a financial stake in the services performed.

Your proposal would encourage meaningul consumer participation by providing real alternatives to each medicare beneficiary. Consumers would be able to determine what price to pay for health care coverage, what additional benefits and services to include, whether to buy comprehensive, single-stop service, or retain the flexibility to select the best possible specialist, and what emphasis to place on convenience, ambience, efficiency, reputation, and quality of service. Each beneficiary's uniquely kaleidoscopic focus on these factors would determine his choice of a health care plan. And annual open enrollment provisions would insure that he has the right to change his mind. Beneficiaries dissatisfied with service or cost would be free to select a different plan during an open season established each year for this purpose. This annual open season approach has been very effective under the Federal employee health benefit program. It maximizes the opportunity for informed consumer choice based on comparative information while discouraging excessive marketing or destructive competition, an unfortunate byproduct of HMO development in certain sections of the country. It further insures continuity of health care service without creating substantial overhead costs.

Your proposal also includes some creative approaches to consumer participation. Under section 1876(i)(2) of the Social Security Act, as amended by your proposal, beneficiaries enrolled in an HMO would be permitted to select additional required benefits. Other provisions in the bill properly insure that beneficiaries have the right to a hearing before the Secretary and to judicial review in connection with certain disputes, and are adequately informed about their plan and alternative plans.

Fundamental to the application of market-oriented economics in the health care sector is meaningful financial participation by the consumer. For medicare beneficiaries, this means cost-sharing to the extent they are able to afford it and, more importantly, at a time when such cost-sharing will be a factor in making critical choices. Under the present law, medicare beneficiaries bear a heavy cost-sharing burden after substantial medical expenses have been incurred or hospital days accumulated. This approach turns the concept of cost-sharing on its head and destroys any incentive for consumers to choose wisely and providers to control costs. Rather, consumers should share the financial burden at a time when they are capable of exercising an intelligent choice and not after the critical decisions about insurers, plans, hospitals, or doctors have already been made and their financial resources are depleted. The purpose of cost-sharing is to foster efficiency and insure that adequate standards of care are provided at a reasonable and affordable cost, not to push those in extremis into financial and spiritual bankruptcy.

We would thus prefer to shift the cost-sharing burden under medicare forward, requiring beneficiaries to contribute to the cost of premiums (by paying the difference between the Federal capitation payment and the competitively priced plan) and authorizing certain deductibles and first dollar copayments for services provided, including a daily copayment for hospitalization in lieu of ceilings on the number of days or increasing cost-sharing as days are accumulated.

While the exact form of such cost-sharing could be left somewhat flexible, your proposal might be revised to encourage medicare beneficiaries to pay approximately 25 percent of the cost of their health care, including a portion of the charges for hospital and medical services, in lieu of deductibles, ceilings, and cost-sharing provisions under present law. Such a requirement must be combined with some kind of ceiling on total copayments or catastrophic coverage.

IMPROVED ACCESS AND BENEFIT

The fourth principle enumerated above would encourage improved access for all Americans to enhanced health care benefits. Your proposal would require that services now provided under medicare parts A and B be offered in any plan which qualifies for Federal fixed-premium financing. Thus, the proposal would establish a basic floor of acceptable benefits but presumably would not impose a ceiling on the

additional benefits that various plans may wish to offer in response to consumer demand. The most efficient plans may be able to offer supplementary benefits without additional premium cost. Indeed, under section 1876(i)(2) of the Social Security Act, as amended by your proposal, they would be required to offer additional benefits determined by the Secretary to be equal in value to the difference between the average per capita payment and adjusted community rate. Such benefits would be selected by the enrolled beneficiaries from among those offered by the HMO.

We believe that complete reform of the medicare program requires the enactment of some kind of catastrophic coverage. As noted above, the cost-sharing burden, to be effective economically, must be primarily on a first dollar basis. But the converse is equally true, older Americans should not have to choose between adequate health care and financial ruin, or to divest all the assets accumulated over a lifetime in order to spend their remaining days in dignity.

Thus, it is essential that catastrophic coverage for medicare beneficiaries accompany the reforms proposed in this bill, either as an addition to the bill or by the enactment of separate legislation. But it is also important that catastrophic coverage not be enacted without such reforms, for to add the budget-busting burden of a catastrophic program on top of the existing financing structure would exacerbate cost inflation.

We believe that the efficiencies achieved from the competitive reforms outlined above would permit rechanneling limited Federal resources, at no additional cost to the Federal health care budget, to enable provision of catastrophic insurance coverage for all medicare beneficiaries. In future years, additional cost savings possibly could be applied to broaden the basic benefit package to include preventive health care services, additional nursing home, home health, and mental health benefits and the expansion of medicare eligibility to certain older Americans not now covered.

ELEMENTS OF THE PROPOSAL

At this point, it may be helpful to summarize those aspects of your proposal which we enthusiastically support and those provisions which we believe could be strengthened or clarified in order to achieve the objectives noted above.

We fully endorse: (1) The creation of a new program under medicare which would enable qualified health benefit plans to compete for the Federal dollar; (2) the extension of the HMO option to State-licensed HMO's; (3) the emphasis on competition among alternative plans; (4) the establishment of fixed-rate premium financing; (5) the emphasis on consumer participation and decisionmaking; (6) the general principle of disclosure and adequate information for the consumer; and (7) the guarantee of basic benefits comparable to medicare parts A and B with provision for additional benefits.

We believe that the following modifications or clarifications would strengthen your proposal:

(1) A statement of policies or objectives should be incorporated in the proposal, which would provide that the HMO option and health benefit plan program be administered in a way that fosters competition, encourages cost-efficiency, insures informed consumer choice and enhances the quality of consumer-responsive health care services.

(2) The formula for determining the Government's per capita contribution should be revised to reflect competitive pricing in the marketplace, along the lines of the methodology used in the Federal employee health benefits program.

(3) The percentage used to determine the Government's contribution should be at a level which encourages responsible first dollar cost-sharing and discourages profiteering, without increasing the out-of-pocket costs paid by medicare beneficiaries.

(4) Open season provisions during which enrollees may change plans or terminate enrollment should be restricted to one 30-day period during the year to deter excessive marketing and destructive competition, to foster informed choice based on comparative information, and to insure continuity of care without excessive overhead costs.

(5) HMO's and health benefit plans should have the flexibility to apply the difference between premium revenues and costs to expanded benefits, additional services, investment in capital and human resource improvements, rebates on premiums, or retention of profits.

(6) Provision should be made for medicare beneficiaries to pay the difference between the Government's contribution and the premium cost for the HMO or benefit plan of their choice in lieu of payments under medicare part B.

(7) HMO's and health benefit plans should be exempted from present medicare ceilings, deductibles, and cost-sharing provisions and such plans should have the flexibility to design coinsurance, copayments, and deductible provisions that would

encourage across-the-board 25 percent cost-sharing by medicare beneficiaries with emphasis on first dollar cost-sharing.

(8) A cap of $2,500 should be established on total out-of-pocket medical expenses for any medicare beneficiary in any given year, which essentially would provide catastrophic insurance coverage under medicare.

(9) To work effectively, the HMO's and health benefit plans should not be encumbered with restrictive Government regulations and conditions. The proposal could prohibit the Secretary from promulgating regulations or establishing conditions that are not essential to the achievement of the policy objectives and could exempt HMO's and benefit plans from various certificate of need and other present regulatory requirements (including section 1122 of medicare).

We will append to this statement draft language that would accomplish these modifications.

OBJECTIVES OF MEDICARE

With these modifications, your proposal would realize more fully Congress underlying objective in the creation of the medicare program—an objective that has been lost sight of through the years. When Congress enacted medicare, it strongly intended that medicare beneficiaries not be treated as second-class citizens, but that they receive the same health care service that is available to private-paying patients. Your proposal would transform this ideal into a reality. Like private-paying patients, medicare beneficiaries could choose among alternative benefit plans and delivery systems. Like private-paying patients, medicare beneficiaries could change their mind and express their dissatisfaction with certain services or providers by choosing an alternative. Like private payers, beneficiaries would share in the costs at a time they are able to afford it. Under your proposal medicare beneficiaries would become first-class health care citizens.

LONG-TERM HEALTH CARE POLICY

Your proposal is an important first step toward a more rational, equitable, and compassionate Federal health care policy for older Americans. As a Nation, we have never had an effective long-term health care policy for our senior citizens. Instead of creating an environment in which they can live out their final years in dignity, we have too often demanded that older Americans—in need of increasingly costly and continuing care—divest themselves of all financial resources and assets to become eligible for subsistence care as wards of the state or charity.[5] We have simply put the elderly in bureaucratic boxes without really thinking about how to harness the creative competitive forces of our society to meet the needs of older Americans for long-term care and how to maximize the leverage of Federal dollars to stimulate innovative, consumer-responsive services.

I would urge this committee to give further consideration to how the sophisticated and somewhat revolutionary concepts embodied in your proposal could be expanded to provide for the long-term health care of older Americans. These principles could be adapted and applied to the medicaid programs in addition to medicare. Skilled nursing facilities, other institutional services, and home health care eligible for medicaid assistance could provide mandated service benefits in return for fixed-premium financing on a per capita basis. Medicaid beneficiaries would be encouraged to contribute to costs to the extent they can afford and would have the option to contribute and additional amount for added services, improved amenities, or better facilities without losing the Government's contribution on a dollar-for-dollar basis. Thus, for example, if the standard capitation rate were $25 a week, a beneficiary could pay $10 a week for a better room and receive $20 a week from the State including Federal matching.

A NATIONAL HEALTH INSURANCE ALTERNATIVE

While your proposal covers only a limited segment of the Nation's population, its underlying principles of competition, reimbursement reform, consumer participation, and guaranteed benefits have broader applicability for the Nation's health care system.

In your work in the health care area in both the House and Senate, Senator Heinz, you have not been afraid to question the conventional wisdom, to ask tough questions, to seek new and innovative solutions to intractable problems. We believe

[5] Such a perverse policy has provoked all kinds of loopholes, which, in turn, create inequities. The Commonwealth of Pennsylvania has dealt with the practice of giving away assets to qualify for medicaid by making ineligible any "person who disposes of real or personal property having a value of $500 or more without fair consideration within 2 years" prior to application for medicaid. 55 Pa. Code Ad. Reg. § 177.83(g).

that your proposal, if enacted, will demonstrate that market-oriented economics works in the health care field. Your commitment to these basic principles of reform is evidenced by your cosponsorship, with Senators Durenburger Boren, and Boschwitz of S. 1485, a bill "to encourage competition in the health care industry." That bill—the Health Incentives Reform Act—would apply these fundamental principles more broadly to our Nation's health care system. Indeed, we believe that some of the principles in S. 1485 could also be expressly incorporated in the proposal before this committee.

The first session of the 96th Congress thus far has been characterized by a clamorous debate on various national health insurance proposals—debate that undoubtedly will become enmeshed in the Presidential campaign during the coming election year. President Carter's national health plan, Senator Kennedy's Health Care for All Americans Act, and certain catastrophic insurance proposals have vied for the Congress attention, each flirting with the principles of consumer choice an competition. But the legislations you have sponsored, Senator Heinz, has pierced through the rhetoric and proposed fundamental reforms. In the coming months, the 96th Congress will need to choose from among the great diversity of viewpoints and wide range of proposals. This is a crucial time in the history of the national health insurance debate. Next year may well determine which course—ideologically, economically, and politically—will prevail.

We sincerely hope that the approach represented by your proposal is the approach that will prevail. Increasing regulatory intrusion into the country's health care system, enormous injections of deflated Federal dollars, and bureaucratic attempts to allocate resources simply will not work. We cannot build more programs and services onto the crumbling Federal financing foundation without exacerbating spiraling cost inflation and crushing Federal budgetary controls. We recognize that the Government has the legitimate responsibility to insure access for all Americans to acceptable standards of health care and to subsidize the care of those who cannot afford to pay for it themselves. But the Federal regulatory power that goes with this responsibility must be exercised in a way that will harness the forces of competition, not stifle them.

We strongly support your bill. It represents the first step toward major reform of our Federal financing system. With such reforms, the Federal Government will no longer distort the incentives system in the health care marketplace, encourage overutilization and inefficiency, or penalize innovation and cost-consciousness. Rather, the Federal Government will become a leader in demonstrating how marketplace economies promotes efficiency, how the consumer can make responsible choices, and how healthy competition will improve access to quality health care at a reasonable cost.

Senator HEINZ. Our next panel consists of John Nelson, president of the Greater Delaware Valley Health Care, Inc., from Radnor, Pa.; Robert Russell, executive director, Philadelphia Health Plan, Inc., Philadelphia, Pa.; and James Zimmerman, president, Penn Group Health Plan, Inc., Pittsburgh, Pa.

I understand that you gentlemen have developed a single statement which Mr. Nelson will present. I very much appreciate your interest in being here today. I want to listen very carefully to what you have to say because some wonderful claims have been made about how good HMI's and HBP's are and you have not had a chance to make them yourselves.

Mr. NELSON. I hope we show a fair degree of modesty.

Senator HEINZ. Mr. Nelson, we are glad you and your associates are here. Would you please begin.

STATEMENT OF JOHN NELSON, PRESIDENT, GREATER DELAWARE VALLEY HEALTH CARE, INC., RADNOR, PA., ACCOMPANIED BY ROBERT RUSSELL, EXECUTIVE DIRECTOR, PHILADELPHIA HEALTH PLAN, INC., PHILADELPHIA, PA., AND JAMES P. ZIMMERMAN, PRESIDENT, PENN GROUP HEALTH PLAN, INC., PITTSBURGH, PA.

Mr. NELSON. Mr. Chairman, I am John Nelson, past president of the Pennsylvania HMO Association and executive director of the

Greater Delaware Valley Health Plan, Inc., a federally qualified IPA serving 4,500 members in Delaware, Chester, Montgomery, and Philadelphia Counties of Pennsylvania. Accompanying me today are to my immediate left Robert Russell, executive director of the Philadelphia Health Plan, Inc., in Philadelphia, Pa., and on my far left James Zimmerman who is president of the Penn Group Health Plan, Inc., in Pittsburgh, Pa.

We do represent different types of HMO plans. Mr. Russell and Mr. Zimmerman represent federally qualified prepared group practice plans and I represent a federally qualified individual practice association.

I am going to skim through my statement rather than taking the time to read it. Just to comment briefly on the history of the development of HMO's in Pennsylvania, they really have been spawned over the past decade. Our older HMO's started to enroll members in about 1974. In terms of age, as you look at the older HMO's across the country, we are comparative youngsters.

Our growth really has been tied to a broad spectrum of support from Pennsylvania organizations such as employers, labor organizations, and other associations. Providers have played a key role in HMO's in Pennsylvania. I won't take the time to enumerate the organizations I have described in our presentation, but I do want to point out the fact that our association represents 13 member organizations which to date have enrolled 125,000 Pennsylvanians in HMO's. This does represent an increase of 25 percent since our last census, which was taken 9 months ago, and I think I am not overestimating in quoting that figure.

Our association, as I indicated, is a mixture of federally qualified HMO's and neophyte developing HMO's. I welcome this opportunity to express on behalf of our association our thoughts on the subject of HMO and medicare reimbursement to HMO's.

At the present time in Pennsylvania, as was indicated, only one of our member plans has a risk-based contract, that being the HMO of Pennsylvania. There are several drawbacks to that risk-based contract under section 1876. First, any retrospective cost-based system of reimbursement is at odds—and I emphasize that it is at odds—with the HMO's normal practice of providing health services for a fixed prospective payment.

We do not send the patient bills for health services rendered. A medicare beneficiary who is an HMO member has prepaid for his comprehensive health care and is truly relieved from the redtape of submitting claim forms and keeping track of deductibles. I think we will hear about that problem from representatives of medicare beneficiaries later. There is no question the redtape that is associated with the traditional filing of claims by medicare beneficiaries is almost insurmountable under the existing system, and HMO's do correct that problem.

Second, under section 1876 the HMO cannot recover the capital requirements created by its enrollment of medicare members because medicare allows reimbursement for only interest and depreciation expenses. In the integrated HMO structure this necessarily means that the premium charged to other members must carry the additional burden of meeting more than their fair share of capital requirements. Most importantly, under a cost-based system of reim-

bursement, the medicare beneficiary should receive the same equivalent potential value for his health care dollar that the HMO's other members enjoy. Under present law, the HMO offers a supplemental benefit package to the medicare enrollee. This package goes beyond parts A and B medicare services and involves a premium charge by the HMO. It buys out the medicare copayments and deductible, as well as including some of the other benefits in the HMO's basic package. The potential savings which result from HMO efficiency should result in lowering supplemental benefit premium costs or providing additional benefits to the older citizen.

In contrast to all of the medicare reimbursement mechanisms currently available, both the administration's proposal, S. 1530, and your own which we have reviewed, brings HMO medicare reimbursement squarely within the HMO's customary financial and benefit structure. Both bills use the prospectively calculated adjusted average per capita cost or AAPCC in conjunction with the HMO's adjusted community rate which is basic to arriving at a reimbursement method which will benefit medicare members and save money for the trust fund as well.

We were particularly pleased to note your cosponsorship of S. 1530 because we are convinced that it will open to medicare beneficiaries the full reward of HMO membership in a way which is equitable to the beneficiaries, to HMO's and to the Federal Government.

The concept of the AAPCC as an appropriate yardstick for HMO medicare reimbursement is not new. It appears in the current section 1876 risk-based reimbursement provision in a form substantially similar to that in your bill and in that of the administration. It is designed to reflect the cost in the non-HMO sector for the provision of medicare parts A and B services to a medicare population similar in composition to the medicare enrollees of the HMO. The major difference between the new proposal and the present law is that the new proposals would require that this calculation be made prospectively, in harmony with the HMO's method of premium calculation. This element of the proposal will be a strong incentive for more HMO's to serve medicare beneficiaries on a broad scale.

The second step in the new reimbursement mechanism is the determination of the HMO's adjusted community rate. The community rate is the per member per month charge which the HMO annually calculates will be necessary to provide covered services for all of its nonmedicare enrollees. This is the rate the employed group pays and it must be competitive with other area health insurance plans. It includes a capital margin factor so that the HMO can responsibly provide the facilities necessary for service delivery to its present and reasonably anticipated future members. The inclusion of this factor provides a financial incentive for HMO's to serve medicare enrollees, because through this means the medicare members bear their fair share of capital costs. This basic community rate is adjusted to reflect the additional time and care required by the older citizen and the benefit package allowable under medicare parts A and B. The resulting figure represents

the amount necessary for the provision of medicare-covered services to the HMO's medicare enrollees.

Because the AAPCC and the adjusted community rate are based upon a similar elderly population and identical benefit packages, they can be compared to determine the amount by which the cost of care in the non-HMO sector will exceed the HMO's premium for the provision of the same care. Parenthetically I would like to point out that data which shows adjusted community rates as a percentage of AAPCC's is limited. There is some evidence to support the conclusion that mature HMO's can deliver the medicare parts A and B package at less than the AAPCC. This means that relatively young HMO's, such as ours in Pennsylvania, which have little experience in serving medicare beneficiaries and whose membership is still small will have adjusted community rates in excess of an older, experienced HMO. I think that is an important fact to keep in mind.

There is certainly an age factor in terms of our experiences as we reach break-even points. It is, therefore, necessary to set the medicare reimbursement rate at a percentage which is sufficient to enable HMO's such as ours to reasonably accept the risk of enrolling medicare members while still being lower than the community costs to medicare in general.

This is one of the reasons for our strong support of reimbursement at 95 percent of the AAPCC as contained in the administration's bill. The other, and perhaps more important reason for our support of this rate grows from our conviction that the medicare enrollee should benefit from the choice of a system of health care which is more cost efficient than the predominant fee-for-service system.

HMO's offer their medicare members several advantages which they do not find elsewhere and I think this is an important point that I stress to you. The typical health insurance policy, as compared with an HMO membership, is sort of like having a hunting license to go find care. In contrast, the HMO guarantees the delivery of care. That is, if the doctors associated with HMO's like the Philadelphia Health Plan, the Penn Group Health Plan, and the health plan which I represent, actually guarantee that they will make services available.

If you look at today's typical health insurance policy, nobody is guaranteeing the delivery of those services. It is like a hunting license. Here is your permit, go look for care. And that is an important difference. Contrast that with our HMO's. We guarantee to the enrollee the availability of the doctors and hospitals who provide the comprehensive health care. The HMO medicare member does not have to worry about whether a physician will accept assignment or be surprised by a fee in excess of medicare coverage.

That older citizen is assured by the HMO that any health care needed will be available for the fixed monthly cost which the member has already budgeted for and anticipated, whether provided by a specialist to whom an HMO makes a referral or by one of the HMO's own physicians. In an HMO the older citizen soon becomes aware that his personal budget is not eroded by unexpected extra supplemental medical bills. The HMO provides access to

care which affords the medicare enrollee the benefits of preventive health services. These services are not preventive in the sense that the infirmities which come with age can be entirely avoided. However, they are preventive in the sense that the ready availability of routine care encourages the medicare enrollee to seek treatment early. Thus, the medicare beneficiary knows he can receive that care without any additional out-of-pocket cost and therefore seeking care early he can prevent that condition from becoming more acute and interrupt that process. This is one of the reasons that the hospital days per 1,000 for HMO members is substantially lower than for medicare beneficiaries treated in the fee-for-service sector.

It is for this reason, as well, that HMO's can provide medicare-covered services at a lower cost than the non-HMO sector. Here lies another sound reason for our support of HMO reimbursement at 95 percent of the average area per capita cost. We believe that any savings which are realized as a result of the medicare beneficiary's choice of a more efficient health care delivery system belong neither to the HMO, as could be the case under section 1876 risk-based reimbursement, nor to the Federal Government. The beneficiary should receive the savings which his choice generates in the form of additional benefits or elimination of cost sharing or both. It is like saying to the medicare beneficiary: Here is your chance to save some money, get more benefits. If you make this choice and agree to use the doctors and the providers within this system, you will reap certain rewards as time goes on.

While we firmly believe in the use of the savings to provide the medicare enrollee with an incentive or reward for joining an HMO, we differ from both your own bill and the administration's with respect to the precise mechanism for determining the additional benefits which should be offered.

We believe that the HMO is in the best position to tailor these added benefits to the needs of its medicare enrollees. The statutory ordering of benefits in the administration's bill is too rigid to accommodate the varying needs of enrollees in individual HMO's across the country. On the other hand, we do not feel that a special medicare enrollee group is required to insure that the medicare enrollee play an important part in the selection of the benefits offered. HMO members are already deeply involved in decisions regarding the benefit structure of the HMO as a whole.

For some of you who are present, you may not be aware that in all federally qualified HMO's one-third of the board of directors must be representative of the people enrolled in the HMO. Thus, they do have an opportunity to participate in determining policy. The resources of the HMO in terms of its finances, manpower, and facility capacity must be allocated to best serve all of its members.

One other section of your bill raises a similar issue. The bill requires the HMO to pay for services received out of plan "if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition." Basic to the HMO's system of providing health care is the requirement that in general all health services must be obtained through the HMO or through referral by an HMO physician. The HMO staffs for these services and incurs a cost to have them ready on a standby basis.

The purpose of the requirement is to insure that the HMO physicians, as part of a total health care system, have control over the services provided to enrollees. There is recognition of the fact that, even within the HMO's service area, an illness or injury might be so acute that it would be necessary for an enrollee to seek care at the closest available medical facility. In that event, the HMO will cover such services. An HMO enrollee is covered if he or she requires emergency or urgent medical services when outside the HMO's service area.

Now I am not going to dwell any more on that; that is outlined in our statement.

In summary, we are convinced that a new HMO medicare reimbursement mechanism which prospectively reimburses HMO's at 95 percent of the AAPCC and requires HMO's to use any savings in excess of their adjusted community rate to provide additional benefits to medicare beneficiaries is desirable. As a result it attracts more HMO's to serve and the older citizen to exercise an option for joining an HMO. The proposal has the added benefit of saving the Federal Government 5 percent of the cost of comparable care in the fee-for-service sector, which means that all parties affected—the beneficiary, the Government, and the HMO—derive a significant benefit from it.

We would support modification of the administration's bill in several respects, such as the replacement of the statutory structuring of benefits provided with the savings allowed HMO discretion in benefit selection. On balance, we believe that its essential elements are sound and equitable. We urge you to support its reimbursement mechanism, several major components of which are retained in your bill. We would welcome the opportunity to work with your staff as you continue to examine reimbursement of HMO's under medicare.

Thank you.

Senator HEINZ. Thank you, Mr. Nelson, Mr. Russell, and Mr. Zimmerman. That is a very comprehensive statement, it is very useful.

Let me ask you the $64 question. What would happen if we gave you a 75-percent rate of the adjusted average area rate? The Insurance Co. of North America, INA, has just said that for 75 percent, a senior citizen would be able to get from you, health care of equal or better quality at no increase in cost. Do you agree or disagree?

Mr. NELSON. Well, I disagree until I see the figures. I find it very difficult to find hard data which addresses this problem in terms of medicare. Now there is some data available in terms of the older established HMO's which have been enrolling medicare beneficiaries for a number of years. For example, the plan I was associated with, in Detroit, which was started by the United Auto Workers and Walter Reuther in 1960 provided continuing coverage for auto workers when they reached 65—when medicare was introduced in 1965, the opportunity was provided for auto workers to continue during retirement as members of the HMO. Today, the members have aged in the plan—about 7,000 older citizens, people over 65—who are medicare beneficiaries. They are using approximately 2,300 inpatient days of hospital care per 1,000 enrollees per year.

Now that rate is considerably less than the going rate nationally which I believe—and maybe your staff could correct me—is close to from 3,500 to 4,000 days per 1,000. Kaiser reports in a recent issue of Group Health News that their over-65 population is using something on the order of 1,950 days per 1,000 members, close to 2,000 days of hospital care per 1,000 members per year. The savings on inpatient days are used to provide more comprehensive benefits beyond the medicare benefits to their senior population which they have enrolled.

That is hard data. I have not seen other hard data that would support the fact that we could accept, as INA has proposed, 75 percent. Now 75 percent, you will recall, is in addition to what they asked the aged person to contribute. That is 25 percent more for medicare beneficiaries.

Mr. RUSSELL. I think the term "cost savings" is correct whereas you are talking about copayments. First of all, the senior citizens are in less of a position to pay those costs. HMO's have traditionally used these kinds of situations, copays and deductible for either one or the other, to reduce the premium cost or to discourage utilization. I think it is appropriate, within the HMO context, to discourage utilization.

The third factor is that HMO's have only one line of business providing medicare to individuals. We are not interested in creating a market situation, we are interested in providing health care.

Senator HEINZ. What do you say to the people who, like Dr. Ward, raise concerns about quality of care for senior citizens? He raised the specter of people being prematurely discharged. He raised the specter of not having adequate or appropriate referral to a particular doctor. How do you respond?

Mr. ZIMMERMAN. Senator, let me respond to that briefly, because I think that we have some of the concerns that Dr. Ward expressed. Let me point out the way an HMO is organized brings together management skills with the physicians' skills to provide a mechanism or framework to not only give comprehensive care, quality care, but do it in the most economical manner.

An HMO can work out a relationship for home care, for the use of hospices, for the use of skilled nursing facilities, for extended care. Every one of our members for whom hospitalization is recommended by a physician, has a discharge planning nurse who begins working with the patient and family to get the individual in and out of the hospital under the proper medical supervision as rapidly as possible. Our organization is set up to provide quality care and yet to be efficient. This permits us to have the hospitalization record with reduction in patient-days among many other cost savings factors.

Senator HEINZ. In the October 3 Washington Post there was an article that alleged that Group Health Association of Washington, D.C., used long delays in scheduling patients as a means of cost control. Isn't that a risk and how do we minimize or eliminate it?

Mr. RUSSELL. You are talking about quality of care. I think it should be divided into two parts, one clinical indicator in the sense I think an important part of care which is overlooked is patient satisfaction, consumer satisfaction. I think if you are going to talk about the quality of care you have to get into where the patients

responsibility to that. If in fact you have a survey of how many consumers you have, how many members or how the consumers feel, that of course will not prevail. All systems have a tendency not to serve those who have an inability to pay. That is a fact of life. It is the payment mechanism, not the capacity of the organization.

Senator HEINZ. That may be, but what if the article is correct——

Mr. RUSSELL. I don't know if the article is correct.

Senator HEINZ. Let's assume for the purpose of the argument it is true. What would be your response? What would be your response if you were in my shoes?

Mr. NELSON. I think, first of all, Group Health Association is a qualified HMO. That activity, if that is true, will come under the scrutiny of the compliance office of HMO's.

Senator HEINZ. But does that mean anything?

Mr. NELSON. Yes; it does mean something because if they are deliberately setting up a barrier for getting care, then they are flying in the face of the requirements to be a qualified HMO. I don't believe that they are. I think there has been a misinterpretation in the press, and I can talk about 17 years of association with prepaid group practice plans, such as the one in Detroit, which is now the Health Alliance Plan, which has the support of industry and labor and the one in Rochester, N.Y., that was started by Blue Cross/Blue Shield in conjunction with Kodak and Xerox. In both the pattern of arranging appointments is organized.

There is a system of prioritizing demands. As you think about health care, there are people who are worried about their health but are probably OK. They are going to be looking for appointments early. There are people who truly have a problem, and there is a way of sorting those problems out in terms of appointment time, so that the person who has an acute problem will get an immediate appointment, I am sure that is what happens in Group Health Association in Washington as it does in these other plans that are represented here today.

What we are talking about is the fact that there is more accurate data in an organized system of health care. We know what the leadtimes are for appointments. In Detroit, we had sampled the leadtimes constantly about once a week. For example, how long did it take to get an elective appointment for a 15-minute examination? How long did it take to get an appointment with specialists like the ophthalmologist? In the non-HMO system of health care how long does it take to get an appointment with an ophthalmologist? I have heard that sometimes people wait 6 to 8 months, but the recordkeeping is not there.

Senator HEINZ. Let me ask you this question. Do you think the present quality assurance mechanisms for federally qualified HMO's are adequate or should we in some way establish a special quality review for the elderly?

Mr. NELSON. I think the present system as it is structured for qualified HMO's and in certain States which license HMO's have systems of quality review which are more than adequate for reviewing the elderly as well as all other members.

Senator HEINZ. We have to move along but I want to get your comments on the record very briefly. My legislation allows State HMO's to participate as long as they meet all the requirements in the legislation. You represent a federally qualified agency. How do you feel about that?

Mr. NELSON. We support your legislation that nonfederally qualified HMO's if they are appropriately licensed or approved under State law should be permitted to enroll medicare beneficiaries into their program.

Senator HEINZ. Now regarding the ordering of benefits, I understand that Federal HMO's have a one-third representation of their client population on their governing boards. What is wrong with having a group of senior citizen enrollees decide how the benefits that you present in the various packages should be ordered? What is wrong with their making the selection of one from column A or two from column B?

Mr. RUSSELL. It is disruptive in the sense of legal responsibility for benefits design to rest with the board of directors of the corporation. To reflect its various constituency groups by differences in benefits packages it would have serious problems. Consider the ensuing struggle and discussion of a senior citizen's constituency versus a young working one with regard to benefits design of an HMO plan. It would appear to me that this would cause a proliferation of specifically designed packages which at some point would become unmanageable.

Senator HEINZ. The third point. I am of the understanding that you have taken exception to the payment for services out of the plan area that are exactly the same emergency medical services that you now provide.

Mr. ZIMMERMAN. That is not what we took exception to——

Senator HEINZ. I assume you are taking exception to——

Mr. ZIMMERMAN. The use of nonplan facilities or providers within its own service area for urgent care. For urgent and emergency care outside plans service area we do not take exception.

Senator HEINZ. You are saying it seems to provide it for within?

Mr. ZIMMERMAN. Yes.

Senator HEINZ. Suppose somebody is on the other side of town from your facility and they have a heart attack?

Mr. ZIMMERMAN. They go to nearest emergency facility. We do not take exception there.

Senator HEINZ. That is what that is directed at?

Mr. ZIMMERMAN. We think the language then should be clarified.

Mr. NELSON. Maybe it is a matter of semantics.

Senator HEINZ. It may be. In terms of substance I think we agree.

Mr. ZIMMERMAN. The instruction under the HMO is to obtain care of emergencies in the nearest hospital.

Senator HEINZ. Any other comments you three gentlemen care to make?

If not, thank you very much. You have been most helpful. Later we may have some additional questions for you. The prepared statement of Mr. Nelson will be entered into the record now.

[The prepared statement of Mr. Nelson follows:]

PREPARED STATEMENT OF JOHN NELSON

Mr. Chairman, I am John Nelson, past president of the Pennsylvania HMO Association and executive director of the Greater Delaware Valley Health Plan, Inc., a federally qualified IPA serving 4,500 members in Delaware, Chester, Montgomery, and Philadelphia Counties of Pennsylvania. I would like to acknowledge the presence of representatives of other members of the Association of Pennsylvania HMO's, a reflection of the strong statewide interest which we have in enactment of sound improvements in medicare reimbursement for HMO services. In addition, for the record, a list of the association's members, their locations, and their chief executive officers is attached.

The development of HMO's in Pennsylvania has spanned only the last decade. Our oldest HMO's began to enroll members in 1974 and since that time they have grown consistently in members and in size. Their growth is tied to the broad spectrum of employers, labor organizations, and providers in the State which have shown a strong interest in participatory health care. Specifically I would name employers, such as Sun Co., Scott Paper, and Westinghouse Electric; labor unions and associations including the United States Steelworkers, Ironworkers, International Brotherhood of Electrical Workers, Pittsburgh Firefighters, United Paperworkers International, the Oil, Chemical & Atomic Workers, Federation of Telephone Workers, United Auto Workers, Amalgamated Clothing Workers, and over 2,000 physicians providers as well as hospitals such as the Hahneman Medical College, Forbes Health System, Bryn Mawr Hospital, Crozer-Chester Medical Center, Mercy Catholic Medical Center, York Hospital, Rolling Hills Hospital, Hospital of University of Pennsylvania.

As a result, the Association of Pennsylvania HMO's now represents 13 member organizations which provide guaranteed delivery of comprehensive health care benefits to approximately 125,000 Pennsylvanians. This represents an increase in enrollment of about 25 percent since our last census 9 months ago (December 1978), and includes two federally qualified IPA-HMO's with a total enrollment of approximately 40,000 members and three federally qualified group practice plans serving about 55,000 members. Our enrollment is composed of workers and their dependents, State and Federal employees, as well as an increasing number of medicare and medicaid beneficiaries.

I welcome the opportunity to be here today to express the views of the Association of Pennsylvania HMO on the subject of HMO medicare reimbursement. It is our firm conviction that the direction taken by the administration's proposal, S. 1530 (H.R. 4444), will make the advantages of HMO membership more readily available to medicare beneficiaries—and we believe those advantages are substantial.

Today, in Pennsylvania, only one plan, HMO of Pennsylvania located in southeast Pennsylvania has a contract to provide services to medicare beneficiaries. Under section 1876 of the Social Security Act, this contract provides for a capitation payment to the HMO based upon its costs of providing medicare part B services to its medicare enrollees.

However, there are several major drawbacks to the section 1876 relating to method of reimbursement to HMO's. First, any retrospective cost-based system of reimbursement is at odds with the HMO's normal practice of providing health services for a fixed prospective payment. We do not send the patient bills for health services rendered. A medicare beneficiary who is an HMO member has prepaid for comprehensive health care and is truly relieved from the redtape of submitting claim forms and keeping track of deductibles.

Second, under section 1876, the HMO cannot recover the capital requirements created by its enrollment of medicare members, because medicare allows reimbursement for only interest and depreciation expenses. In the integrated HMO structure, this necessarily means that the premium charged to other members must carry the additional burden of meeting more than their fair share of capital requirements. Most importantly, under a cost-based system of reimbursement, the medicare beneficiary should receive the same equivalent potential value for his health care dollar that the HMO's other members enjoy. Under present law, the HMO offers a supplemental benefit package to the medicare enrollee. This package goes beyond parts A and B medicare services and envolves a premium charge by the HMO. It buys out the medicare copayments and deductibles, as well as including some of the other benefits in the HMO's basic package. The potential savings which result from HMO efficiency should result in lowering supplemental benefit premium costs or provide additional benefits to the older citizen.

In spite of these drawbacks, my own plan is in the process of negotiating a cost-based contract with HCFA under section 1876, because we do not want to exclude medicare beneficiaries and such a contract represents the only alternative for us.

Because of the weaknesses in present law, we cannot expect many medicare beneficiaries to join the HMO.

At the Health Service Plan of Pennsylvania, the Philadelphia Health Plan, and Penn Group Health, in order to be able to serve small numbers of members who reach age 65, these plans accept assignment and bill medicare on a fee-for-service basis. Again, even though they offer their medicare member additional benefits for a reasonable premium charge, neither the medicare enrollees nor the HMO's receive optimum benefits.

There are two other available methods of HMO reimbursement under present law, neither of which has been used by Pennsylvania HMO's. One, under section 1833 of the Social Security Act, constitutes a second method of retrospective cost-based reimbursement. Under this section the HMO contracts only for the provision of medicare part B services. The other method offers risk-based reimbursement under section 1876, however, calculation of the payment is still retrospective.

In contrast to all of the medicare reimbursement mechanisms currently available, both the administration's proposal, S. 1530, and your own, brings HMO medicare reimbursement squarely within the HMO's customary financial and benefit structure. Both bills use the prospectively calculated adjusted average per capita cost or AAPCC in conjunction with the HMO's adjusted community rate which is basic to arriving at a reimbursement method which will benefit medicare members and save money for the trust fund.

We were particularly pleased to note your cosponsorship of S. 1530, because we are convinced that it will open to medicare beneficiaries the full reward of HMO membership in a way which is equitable to the beneficiaries, to HMO's and to the Federal Government.

The concept of the AAPCC as an appropriate yardstick for HMO medicare reimbursement is not new. It appears in the current section 1876 risk-based reimbursement provision in a form substantially similar to that in your bill and in that of the administration. It is designed to reflect the cost in the non-HMO sector for the provision of medicare parts A and B services to a medicare population similar in composition to the medicare enrollees of the HMO. The major difference between the new proposal and present law is that the new proposals would require that this calculation be made prospectively, in harmony with the HMO's method of premium calculation. This element of the proposal will be a strong incentive for more HMO's to serve medicare beneficiaries on a broad scale.

The second step in the new reimbursement mechanism is the determination of the HMO's adjusted community rate. The community rate is the per member per month charge which the HMO annually calculates will be necessary to provide covered services for all of its nonmedicare enrollees. This is the rate the employed group pays, and it must be competitive with other area health insurance plans. It includes a capital margin factor, so that the HMO can responsibly provide the facilities necessary for service delivery to its present and reasonably anticipated future members. The inclusion of this factor provides a financial incentive for HMO's to serve medicare enrollees, because through this means the medicare members bear their fair share of capital costs. This basic community rate is adjusted to reflect the additional time and care required by the older citizen and the benefit package allowable under medicare parts A and B. The resulting figure represents the amount necessary for the provision of medicare-covered services to the HMO's medicare enrollees.

Because the AAPCC and the adjusted community rate are based upon the similar elderly population and identical benefit packages, they can be compared to determine the amount by which the cost of care in the non-HMO sector will exceed the HMO's premium for the provision of the same care. (Data which shows adjusted community rates as a percentage of AAPCC's is limited. There is some evidence to support the conclusion that mature HMO's can deliver the medicare parts A and B package at less than the AAPCC.) This means that relatively young HMO's, such as ours in Pennsylvania, which have little experience in serving medicare beneficiaries and whose membership is still small will have adjusted community rates in excess of an older, experienced HMO. It is, therefore, necessary to set the medicare reimbursement rate at a percentage which is sufficient to enable HMO's such as ours to reasonably accept the risk of enrolling medicare members, while still being lower than the community costs to medicare.

This is one of the reasons for our strong support of reimbursement at 95 percent of the AAPCC, as contained in the administration's bill. The other, and perhaps more important, reason for our support of this rate grows from our conviction that the medicare enrollee should benefit from the choice of a system of health care which is more cost efficient than the predominant fee-for-service system.

HMO's offer their medicare members several advantages which they do not find elsewhere. The most important is that the HMO guarantees to the enrollee the availability of comprehensive health care. The HMO medicare member does not have to worry about whether a physician will accept assignment or be surprised by a fee in excess of medicare coverage. That older citizen is assured by the HMO that any health care needed, whether provided by a specialist to whom the HMO makes a referral or by one of the HMO's own physicians, will be available for the fixed monthly cost which the member has already anticipated. In an HMO, the older citizen soon becomes aware that his personal budget is not eroded by extra medical bills. The HMO provides access to care which affords the medicare enrollee the benefits of preventive health services. These services are not preventive in the sense that the infirmities which come with age can be entirely avoided, but they are preventive in the sense that the ready availability of routine care encourages the medicare enrollee to seek treatment early, before a condition becomes acute. This is one of the reasons that the hospital days per 1,000 for HMO medicare members is substantially lower than for medicare beneficiaries treated in the fee-for service sector.

It is for this reason, as well, that HMO's can provide medicare-covered services at a lower cost than the non-HMO sector. Here lies another sound reason for our support of HMO reimbursement at 95 percent of the AAPCC. We believe that any savings which are realized as a result of the medicare beneficiary's choice of a more efficient health care delivery system belong neither to the HMO, as could be the case under section 1876 risk-based reimbursement, nor to the Federal Government. The beneficiary should receive the savings which his choice generates in the form of additional benefits or elimination of cost sharing or both.

While we firmly believe in the use of the savings to provide the medicare enrollee with an incentive or reward for joining an HMO, we differ from both your own bill and the administration's with respect to the precise mechanism for determining the additional benefits which should be offered.

We believe that the HMO is in the best position to tailor these added benefits to the needs of its medicare enrollees. The statutory ordering of benefits in the administration's bill is too rigid to accommodate the varying needs of enrollees in individual HMO's across the country. On the other hand, we do not feel that a special medicare enrollee group is required to insure that the medicare enrollee play an important part in the selection of the benefits offered. HMO members are already deeply involved in decisions regarding the benefit structure of the HMO as a whole, and it is important that all decisionmaking remain part of an integrated process. The resources of the HMO in terms of its finances, manpower, and facility capacity must be allocated to best serve all of its members. Fragmentation which would result from a special policymaking body for a portion of the enrollee population could be detrimental to all members.

One other section of your bill raises a similar issue. The bill requires the HMO to pay for services received out of plan "if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition." Basic to the HMO's system of providing health care is the requirement that in general all health services must be obtained through the HMO or through referral by an HMO physician. The HMO staffs for these services which incurs a cost to have them ready on a standby basis. The purpose of the requirement is to insure that the HMO physicians, as part of a total health care system, have control over the services provided to enrollees. There is recognition of the fact that, even within the HMO's service area, an illness or injury might be so acute that it would be necessary for an enrollee to seek care at the closest available medical facility. In that event, the HMO will cover such services. An HMO enrollee is covered if he or she requires emergency or urgent medical services when outside the HMO's service area.

The standard which is set forth in the bill describes the urgent services which HMO's now cover only if they are both out of plan and out of area. By permitting the HMO's medicare enrollees to obtain such services while "in area" the bill changes for a portion of its enrollees, a basic policy of HMO operations as an efficient health care system. In offering the option of seeking care outside of the HMO, it fails to recognize that such care is effectively provided within the HMO's service area. It potentially affects the economies which the HMO offers not only its medicare enrollees but its entire enrollee population. While we recognize that the goal of the provision, to insure urgent care for medicare enrollees, is a laudable one, there is an assurance that such services are currently readily available to all HMO members within their defined service area.

In summary, we are convinced that a new HMO medicare reimbursement mechanism which prospectively reimburses HMO's at 95 percent of the AAPCC and requires HMO's to use any savings in excess of their adjusted community rate to

provide additional benefits to medicare beneficiaries is desirable. As a result it attracts more HMO's to serve and the older citizen to exercise an option for joining an HMO. The proposal has the added benefit of saving the Federal Government 5 percent of the cost of comparable care in the fee-for-service sector, which means that all parties affected, the beneficiary, the Government, and the HMO, derive a significant benefit from it.

We would support modification of the administration's bill in several respects, such as the replacement of the statutory structuring of benefits provided with the savings allowing HMO discretion in benefit selection. On balance, we believe that its essential elements are sound and equitable. We urge you to support its reimbursement mechanism, several major components of which are retained in your bill. We would welcome the opportunity to work with your staff as you continue to examine reimbursement of HMO's under medicare.

ASSOCIATION OF PENNSYLVANIA HEALTH MAINTENANCE ORGANIZATIONS

Centerville Health Plan, Frederickstown, Pa., Richard Feise, administrator.
Central Medical Health Services, Pittsburgh, Pa., Christopher C. Stromee, administrator.
CommonHealth, Reading, Pa., Vernease Herron, president.
Eastern Pennsylvania HMO, Allentown Pa., Paul A. Blizniak, president.
Forbes Health Maintenance Plan, Inc., Monroeville, Pa., Joseph L. Voss, executive director.
Geisinger Health Plan, Geisinger Medical Center, Danville, Pa., C. Robert Fox, administrator.
Greater Delaware Valley Health Care, Inc., Radnor, Pa., John A. Nelson, executive director.
Health Maintenance Organization of Pennsylvania, Willow Grove, Pa., Leonard Abramson, president.
Health Service Plan of Pennsylvania, Philadelphia, Pa., R. Robert Herrick, president.
Laurel Health Maintenance Organization, Greensburg, Pa., Stanley Greenspan, executive director.
Penn Group Health Plan, Inc., Pittsburgh, Pa., James P. Zimmerman, president.
Philadelphia Health Plan, Philadelphia, Pa., Robert Russell, executive director.

Senator HEINZ. I would like to get a little bit out of order if I may because I know one of our witnesses has to leave.

Mr. Otis, would it be all right if we postponed hearing you for about 15 minutes?

Mr. OTIS. Certainly.

Senator HEINZ. I would like to ask our senior citizen panel to come forward—Lillian Holliday, William Zuckerman, Laura Nichols, and Dr. Harry Strieb, all of Philadelphia. We are delighted to have you. You are the people we have been talking about all morning and you are the people that we are trying to be of some help to.

I know that this happens to be a particularly involved and active panel of witnesses and in case they are too shy to introduce themselves as to their backgrounds, Mrs. Holliday has been past president of the Action Alliance of Senior Citizens for the past 2 years. Mr. Zuckerman is the president of the Senior Adult Council of Jewish Centers and involved in health planning here in southeastern Pennsylvania. Mrs. Nichols is a member of the board of the Center for Older Adults in the Northwest and Foster Grandparents in Philadelphia as well as lecturing in casework and counseling at the University of Pennsylvania for the Philadelphia Board of Education. Dr. Harry Strieb is a member of the board of the Philadelphia Corp. on Aging and a doctor with long service for the city health department.

We are delighted to have you. It is my understanding there has been a little collaboration among this group and that Mr. Zuckerman has a statement he is going to make on behalf of the panel.

Mr. ZUCKERMAN. Perhaps we should listen to Dr. Strieb. I was not sure what my testimony would be before I came, and after listening to all of these providers and professionals I am now more confused. I am sorry, but I do not have a prepared statement. I do have several questions I would like to raise to some of the previous speakers after Dr. Strieb reads his statement.

Senator HEINZ. Very good.

Dr. Strieb, why don't you proceed.

Mr. Zuckerman can just read his questions off so that they are part of the hearing record.

STATEMENT OF HARRY STRIEB, M.D., PHILADELPHIA, PA.

Dr. STRIEB. Not being an accountant or businessman I don't feel qualified to discuss properly the financial setups that have been proposed in the bill; nor for that matter am I concerned terribly with one defect I see in the HMO setup at the present time and that is that there is only a limited number of physicians and therefore there might be difficulty in getting a physician when needed. I think that defect would be corrected when the HMO's become more acceptable to the public and are accepted and more physicians will enroll in them. I don't worry too much about that.

The proposed bill would change the method of payment for medical service from a fee-for-service system to a per capita system. I heartily approve of the per capita or a fixed premium system of payment.

Also, much of the paperwork now involved in medicare would be eliminated. Coverage apparently would be much the same as at present, the medicare and plus-65 Blue Cross and Blue Shield with possibly a few differences favoring HMO. However, group subscribers with plus-65 Blue Cross and Blue Shield may also have major which I believe is at present not available with HMO. On the whole, however, I believe that the HMO system would be well accepted by elderly citizens who are not members of a group. But at best this is only a short step forward.

For the 30 years prior to my retirement I worked primarily in the field of preventive medicine, limited mostly to children. I believe it is essential to expand this to the entire population and especially to the older citizen who because of advancing years may be subject to many conditions which handicap or incapacitate him.

Hypertension, the "silent killer," can be detected easily in a routine examination and can be treated and controlled. But if not detected it may end up in a stroke or severe heart attack which may incapacitate the individual. Many older citizens submitting to regular physical examinations have written and receive the accompanying tests, but many more cannot afford this and do not know they have high blood pressure until disaster strikes.

Similarly, diabetes is easily detectable and treated but if not treated may lead to coma blindness due to retinitis, or to gangrene of the lower extremities. Glaucoma, the chief cause of blindness in those over 40, can also be easily detected in routine eye examination, but if untreated can lead to serious consequences.

Examples such as these can be listed without limit. Elderly citizens should be encouraged by a good health system to undergo routine examinations with the health systems paying for them. Now it could be that the health system, HMO, could pay from possible excess premiums. Not only would this help to preserve the health, well-being, and life of the elderly patient but would actually be less expensive than the present system of crisis medicine. This has been amply demonstrated by Kaiser on the west coast and by many other organizations that provide prepaid medical care.

Senator HEINZ. Dr. Strieb, does that complete your statement?

Dr. STRIEB. Yes.

Senator HEINZ. Thank you.

Mr. Zuckerman, would you like to proceed.

STATEMENT OF WILLIAM ZUCKERMAN, PHILADELPHIA, PA.

Mr. ZUCKERMAN. First, let me thank you, Senator Heinz, for inviting us to participate at this hearing. As volunteers, we are very much involved in trying to help senior citizens. After your office contacted me regarding this hearing, I spoke to several senior citizen groups. They think it may be a good program, but they do have some concerns. While I think your bill is a very excellent one, some of the figures I have seen here today are confusing to me.

At a recent HSA board meeting, a study made by a research organization showed the following breakdown of reimbursement for health care for senior citizens: Medicare pays 41 percent, insurers pay 21 percent, and senior citizens out-of-pocket pays 30 percent.

Senator HEINZ. Actually that was pretty much what we finally worked out.

Mr. ZUCKERMAN. Prior to it being corrected, I thought I heard medicare reimburses 75 percent. I was confused. Your bill states, I believe, 90 percent reimbursement by medicare and third-party payor. There are things that Dr. Ward had set forth in his testimony, and in a sense I guess he is right when he brought up the fact about care for the elderly and how much more care they needed.

The medical profession in Philadelphia are very proud that they have six medical schools. They should be proud. In Boston, there are only three schools. Dr. Ward alluded to this. The question I have raised many times of these medical professionals is, How many of these six medical schools include in their curriculum the study of gerontology? The answer was none. They say that the young medical student is not interested. We seniors have only a few years to live. A year or so ago, Cornell Medical School in New York City was the first medical school to include the study of gerontology in their curriculum. Dr. Ward referred to those over 75 as high-risk patients. I am one of them.

Senator HEINZ. Are you one of those irritable, accident-prone people he was referring to?

Mr. ZUCKERMAN. Yes; I reached that last August, a year ago August. I was 76 this past August and I don't feel any of those things. I do need some health care and I provide for it. The HMO's are good and have many pluses, but I think that the one minus that I see is for older people to change from their family physician to those at an HMO. It could be a traumatic experience. It was for

my wife and I when we moved from Boston to Philadelphia 8 years ago.

Who oversees or who monitors the caliber of health care delivered at the various HMO's? I know that we have a problem with the so-called PSRO's or the peer group. I don't know of any physicians that will speak about any other physicians as not being qualified. These are the questions I raise about the HMO's——

Senator HEINZ. We have that same problem in the Senate. [Laughter.]

Mr. ZUCKERMAN. Who does the monitoring? Is it the Federal Government? Is it the medical societies of the various regions?

I have many more questions, but I know that time is short and I have an appointment which I must keep.

Senator HEINZ. I don't want to hold you up. Let me try and clarify one thing because both you and Dr. Strieb indicated some concern that the senior citizens would in some way be forced into HMO's. All we are trying to do is simply provide an option. If some senior citizen wants to join an HMO, they can but if they don't want to they can continue to get exactly what they get now under medicare. No change at all. This is just an option—an election, if you will, by the senior citizen. Indeed if they want to join an HMO and 1 year later or at any time, I believe the way it is written in my bill, they could get out and go right back to medicare.

Your second concern depends a little bit on how the HMO is run. I believe that most HMO's guarantee you, as a part of your joining, that you will be assigned to a particular physician of your choice, thereby trying to deal with the problem that you and Dr. Ward and others have brought up which is the continuity of care.

As to the question you raised, who monitors the caliber of care for better or worse it is the same people that monitor the quality of physicians now. Whether or not that is as good as we would like it—it is going to be the same. Maybe we can find a way to make it better. We want good health care, the very best, for everybody. If we want to approve the peer group review system, we should do it, but our bill does not change the system either way.

I agree with you that there is not enough emphasis on gerontological medicine. This is wishful thinking perhaps but it is my hope that by focusing on permitting medicare recipients to enroll in HMO's we will build an incentive and expertise into the HMO-type of organization so that they will want to have a gerontologist on their staff. I want to see better quality health care develop and that would include the growth of geriatric medicine.

Finally, with the exception of two provisions of Federal law which are not working very well right now, section 1833 and section 1876, there is no way for a health maintenance organization to participate in serving senior citizens except through these two provisions of law and they are very cumbersome. Only a very small proportion, something like 2 percent of senior citizens, are presently participating in HMO's.

Does that help you with any of the questions that you were raising?

Dr. STRIEB. First of all, Senator Heinz, I did not mean to imply that any senior citizen would be forced into HMO—it would be a

deterrent to senior citizens joining it because they might not be able to get the physician they wanted.

Senator HEINZ. That is a decision I think that the senior citizens should be able to make.

Dr. STRIEB. As far as supervision is concerned, I think a physician in an organized setup would be under better supervision, closer supervision than he is now in solo practice.

Senator HEINZ. That is right. That is an additional benefit.

Mrs. Nichols or Mrs. Holliday, do you have any comment you would like to make?

STATEMENT OF LILLIAN HOLLIDAY, PHILADELPHIA, PA.

Mrs. HOLLIDAY. Yes, I have a couple comments because as it is now I am being brainwashed by all these insurance claims that are coming through.

Senator HEINZ. Do you mean the medigap?

Mrs. HOLLIDAY. The medigap, and I am talking about Kennedy, Long, Carter, and the AARP, all the local insurance plus HMO. I will say that most of the senior citizens are on 65 special. Now I am one of those kinds of women that the doctor was talking about. The average senior citizen after living a long lifespan does not like change. Plus that, after you get older you have a certain fear. I come from the system that always had a family physician that understood me mentally, emotionally, and physically.

Senator HEINZ. Can I interrupt.

Mr. Zuckerman, you have to leave. Why don't you go ahead.

Mr. ZUCKERMAN. Thank you again, Senator.

Senator HEINZ. I am sorry, Mrs. Holliday.

Mr. ZUCKERMAN. Forgive me.

Mrs. HOLLIDAY. Just be on time at the next meeting.

Senator HEINZ. Please proceed. I am sorry about that.

Mrs. HOLLIDAY. The physician understood the whole me and my family background and where I was coming from. I don't want to be turned down because when I get to be 75—of course I am up to 75—next year—if I have a cancer which I cannot control with all the other nuclear things that is going to give it to me anyhow, I don't want to be turned down because I am in that age bracket that would have cancer. I don't want to be turned down because I will have a heart attack. I pray not to have these things.

What we need is understanding people and concerned people who are going to talk to our needs and be able to understand our needs. The hospitals do not teach the young men how to adjust to senior citizens. They are taught about life and that is their main interest all right but there is another side of the coin and that is death whether we want to admit it or not.

I am also concerned about the short-term time into the hospitals which brings me up to long-time care. When you let that patient go home and they have no one there to take care of them, then they go into a nursing home or a bootleg boardinghouse—what I mean is not licensed—and then they are worse off at that than they were before they went into the hospital.

I am concerned about folks on the lower income because HMO means to me folks who have a good pension from the unions and do not depend on their social security. I am concerned about the

people who are dependent on their social security of about $300 or less and because they have a dollar over the cutoff period cannot get SSI. They are not concerned about the near poor who will not have that sort of money to buy this service.

Senator HEINZ. I think those concerns are very well stated, Mrs. Holliday. The reason that we focused part of our discussion on 75 percent of the average cost per capita instead of 90 or 95 percent was to determine at what level we could have the least out-of-pocket costs to senior citizens, while at the same time increasing benefits and providing more incentives for HMO's to enroll older people. We want to make sure that people who have certain diseases are not excluded. We also want to achieve a balance in terms of any copayments or deductibles—insuring that they are not, on the one hand, punitive to people in terms of being so expensive that individuals are forced to go without health care but at the same time trying to give people a moderate incentive to be rational in the use of health care. These are the competing influences that we are trying to balance out in the legislation. I think you stated it very well.

Mrs. HOLLIDAY. I took a lot of notes as the professional people were talking.

Last month at a meeting of 200 senior citizens I had a gentleman from the HMO come and speak to that group. I think the main thrust for all the HMO's that want to persuade or talk to the senior citizens, the thrust should be education. We have come a long way in that lifespan where I said we don't want to change but when they come out to talk they must be ready for questions and be able to explain it in everyday language that the average senior citizen can understand.

I have had them come to me and say, I will not change to go into health maintenance because I am satisfied where I am. I think if they come out with a better idea for the people that they are talking to—they are not all professionals. Some of us had only an eighth grade education, some just made high school. We have been 50 years out of school and have been busy making a living ourselves and raising a family. I think if they direct their speech or their thrust to the people who they are going to talk to, they may be able to sell their program easier.

Thank you.

Senator HEINZ. Thank you.

Mrs. Nichols, do you have any comments or any questions?

STATEMENT OF LAURA NICHOLS, PHILADELPHIA, PA.

Mrs. NICHOLS. I don't have as many statements as she has because my work has been quite different, but I have a few questions. One is: So many of our older people do have Blue Cross and Blue Shield, 65 special, and that costs quite a lot. Then comes HMO which will be equally as expensive or more expensive and I wonder what the advantage is.

Senator HEINZ. You are saying you think what we are proposing will be more expensive?

Mrs. NICHOLS. No, but I wonder what the advantage is.

Senator HEINZ. The principal advantage is that we give senior citizens a wider choice of health care coverage than they now have

under medicare. Hopefully, the scope of services available would be as good—if not better—than what is now covered under medicare and hopefully it could be provided at less out-of-pocket cost to you. The thrust of the legislation is, therefore, to provide more options to get better quality at less cost. It is not supplemental the way medigap insurance is to medicare. Hopefully the HMO's will do what Mrs. Holliday suggests which is to understand the needs of senior citizens and focus on education and preventive health care.

The basic problem, as I see it, with medicare is that it pays after the fact. You have to get sick, then you have to figure out whether or not you are sick enough to see a doctor. You go to the doctor, who says, oh, yes, you should have come to see me 2 years ago. Why didn't you tell me that you had diabetes? If you had told me that, we would not have to amputate your foot. That is cold comfort obviously whereas proper health care management could have solved that problem.

The idea then is to try not only to do better than medicare does but to really cut down on the need for the medigap insurance coverage.

Mrs. NICHOLS. I think that is very important. In talking with people who are older, so many questions were raised about HMO. Preventive care of sight, hearing, feet, and dental care are not covered, as I understand, by HMO or by medicare. All of these are important and might help prevent more catastrophic and expensive illness.

Senator HEINZ. That is absolutely right and that is what we are trying to do here.

Mrs. NICHOLS. I hope so. That is the question that so many people raise when I speak about this.

Mrs. HOLLIDAY. That is true.

Senator HEINZ. Obviously we are going to have to do a better job of making clear what we are trying to do.

Mrs. HOLLIDAY. Yes.

Mrs. NICHOLS. Yes.

Senator HEINZ. I think you pointed out we have a job to do in explaining to people, in plain English, what it is we are trying to accomplish.

Mrs. NICHOLS. The other question is the choice of physicians. I notice on the HMO you have physicians listed. What about your own physician?

Senator HEINZ. If we passed this legislation, you could still stay with your own physician.

Mrs. NICHOLS. Can you?

Senator HEINZ. Yes.

Mrs. NICHOLS. Because you see, as Dr. Strieb pointed out, many of these doctors have not been trained to deal with older people and their ills and the ills of older people and prevention of the ills of older people.

Senator HEINZ. Right. Thank you all very much. I appreciate your being here.

Mrs. HOLLIDAY. Thank you very much.

Senator HEINZ. Our next witness is Kenneth C. Otis.

Mr. Otis, thank you for setting aside your time so that our senior citizens could present their case.

Mr. Otis is the senior vice president of the Colonial Penn Group based here in Philadelphia. Colonial Penn is one of the largest health insurers of older Americans.

Mr. Otis, I think your comments would be more than welcome. I appreciate your willingness to be here and to help us. Please proceed.

STATEMENT OF KENNETH C. OTIS II, EXECUTIVE VICE PRESIDENT, COLONIAL PENN INSURANCE GROUP, PHILADELPHIA, PA.

Mr. OTIS. Thank you for the opportunity to contribute to these hearings. My name is Kenneth C. Otis and I am an executive vice president with the Colonial Penn Insurance Group. Colonial Penn is very interested in the problems facing the elderly today, as we have been for the last quarter century. We are, to the best of my knowledge, the only company which devotes virtually all of its resources to providing insurance and other services to persons aged 50 and over. In particular, we are specialists in the field of supplementary health insurance for the elderly, with three-quarters of our health insurance in force held by persons aged 65 and older.

We have been invited to comment on your proposed bill which would change the way medicare reimburses health maintenance organizations—HMO's—and which also would establish the concept of health benefit plans—HBP's—as another alternative delivery system for medicare beneficiaries. The bill has much to commend it, and we certainly agree with its stated purposes:

One: Specifically we agree freedom of choice is essential for the elderly.

Two: We agree the existence of valid consumer alternatives in health care delivery is a laudable goal, and we are intrigued with the approach taken by Senator Heinz.

Three: We agree health care cost escalation is a very serious problem for the whole population, and we must be open to all ideas on how to bring the increases under control.

While we support the goals of the bill, we would like to offer two caveats of a fundamental nature. Since 1966 we, as a Nation, have been astounded at the costs and ripple effects that medicare and medicaid have had on our entire health system. Before any changes are made in our current system, we urge that the full cost implications of what is being proposed, particularly the level of reimbursement to HMO's and health benefit plans, be given very careful study and be thoroughly debated.

My second word of caution is directed at the incentives which would be a part of the new HMO/HBP system. We note that in the fee-for-service system—that is, traditional medical practice—there are financial incentives for overtreatment. We must remember, however, that the HMO/health benefit plan will make more money the less service it provides; the incentive is, therefore, for undertreatment. While your proposal handles this potential problem by allowing the member to leave the plan with only 1 month's notice, this is an area which must receive constant scrutiny, particularly with elderly people involved.

If we can reach the point where a competitive balance is struck between the HMO/health benefit plan approach and the current

fee-for-service mode, it seems to me that the resulting tension is likely to bring out the best in both systems. The elderly consumer will know that there are alternatives if price is too high or if service is poor.

Because of the nature of our business, we do not consider ourselves expert in the field of HMO reimbursement and operations. However, we do have considerable experience with and knowledge of older people, including their health problems, spending habits and limitations, use of medical facilities, and needs for security and peace of mind. We apply certain criteria to the health insurance we design for older people, and I would like to share some of them with you today. I believe that they have broad connection to the matter before us today. I urge you to consider these criteria as you continue in your work of designing alternative health care delivery systems.

First of all, for any health benefit plan to be a real alternative, the elderly must be informed that the alternative exists, they must know how and when it is possible to apply for membership, and they must be guaranteed acceptance into the plan. We were talking about real versus phantom and I think Mrs. Holliday made a very eloquent statement. On the other hand, to maintain its financial integrity, the health plan must have some protection against those individuals who would, in order to save money, wait to enroll until they are about to check into a hospital. What is best for the medicare beneficiary and what controls are necessary to prevent people from taking unfair advantage of the system are two sometimes conflicting priorities which must be given careful attention.

Affordability is a very important criterion for the elderly. All too often we have seen the issue of cost shrugged off as a minor consideration, just as long as the plan is a good one and covers everything. But covering everything is a very expensive proposition for the elderly. I have some questions about the HMO/HBP approach on this issue.

I think our understanding has been enhanced in our discussions this morning and I will depart from the prepared statement slightly to say that there will be a question as to how the elderly will be able to obtain additional services that become part of the package that is in the bill. No HMO will be able to fill all the gaps in medicare through the additional benefits which will be provided to members at no extra cost. Will the medicare beneficiaries who belong to HMO's and HBP's have to pay for the noncovered expenses out-of-pocket? Will they be able to purchase excess additional coverage on a prospective basis? If they can't afford this excess additional coverage, must he or she leave the plan and search for a new set of medical providers? These are questions that clearly must be addressed.

Colonial Penn has always prided itself on the fact that we offer a range of supplementary health insurance products so that elderly consumers may choose the plan and price which best suits their needs and resources. It appears that the HMO/HBP alternative, as envisioned today, would have only one benefits package to offer. We do not feel that this approach is as desirable as a more flexible system since it confronts the medicare beneficiary with an all-or-none dilemma.

One of the greatest fears the elderly have is that a serious illness could lead to financial ruin. We assume that HMO's and HBP's would set comfortably high maximum benefits, thus providing not only good coverage but bringing peace of mind to its membership and assuring against catastrophic loss.

Simplicity is usually best, but a comprehensive health care plan offered by an HMO or an HBP would necessarily be fairly complex. At the very least, then, every effort must be made to communicate in simple terms with elderly consumers. All plan information must be in plain language, the type used must be large to aid those with vision problems and, of course, full disclosure of what is and what is not covered by the plan must be presented in an understandable format. Here again I think the issue of education was brought out very well by the preceding panel.

Finally, there would necessarily be regulation governing the alternatives being proposed in the Heinz bill, but we hope that it will be judicious in nature so as not to dampen the capacity of HMO's and HBP's to innovate.

As you continue to research and refine the ideas presented in this proposal, Colonial Penn would welcome the opportunity to serve as a resource.

I thank you for your attention and would be happy to answer any questions, Senator.

Senator HEINZ. Mr. Otis, thank you.

Having listened to your statement very carefully, let me make a few comments and ask you to respond to these comments with respect to the particular criteria you enumerated.

Your first criteria, you stress the need to find an appropriate balance between the guarantee of acceptance in a given plan and the need to protect the HMO or HBP from what you describe as people checking into the plan just before they check into the hospital. Now the way we have tried to accommodate that in this legislation is to provide for an annual enrollment period of 30 days. Obviously, as you note, we have tried to protect people by giving them 30 days to withdraw from the HBP or HMO. We have tried to achieve a kind of a fairly concentrated 30-day window, on an annual basis, for people who want to drop out of medicare and join an alternative health plan.

A second comment I would make is that if the per capita payment is set at 90 or 95 percent as opposed to 75 percent, essentially the marketing of the HMO is as follows to the senior citizen. We will provide you everything you now get under medicare plus *x*, *y*, and *z*. In other words, additional benefits would be the basis for convincing senior citizens that they should choose an HMO or HBP alternative to medicare. The benefit package to which you referred is simply saying we are mandating by law the minimum requirements for participation. We are saying for anybody who wants to offer this to a senior citizen and be reimbursed on a prepaid basis must offer no less than what medicare now offers.

Those are the two principal comments that I wanted to make and I am curious to hear your reaction. I think those are the more salient points of the discussion.

Mr. OTIS. I will attempt to take them in order.

I think 30-day limited enrollment periods are fine and I don't think that there is a problem there. Providing that the 30-day enrollment period is truly an open and well-publicized period and it is really available and if the communications are there, I don't think there is a problem. I think history has shown that that is not always uniformly the case.

With respect to the second comment, again I think our understanding of how the additional benefits work has been enhanced here today. I appreciated your comments to that point. Clearly if we are not facing the elderly with a plan that forces extra payment in order to participate in an HMO or HBP, then I think my problem at least goes away to that point.

Senator HEINZ. Mr. Otis, let me ask you this last question. From your perspective what do you believe the reaction of the insurance industry will be toward the development of health benefit plans in this kind of reimbursement program?

Mr. OTIS. I have to speculate a little bit on that. I cannot really predict how the industry might react. I think some insurers would be nervous and see this as a direct form of competition. I think most of us in the industry recognize the enormity of the health control, cost control problem that faces all of us today, and I think we recognize that health care delivery is something that both undoubtedly will and probably should change in this country, and I think our industry has, therefore, need to begin to understand how we can fit and contribute to that process. So for many of us I rather see it, long term perhaps, as an opportunity—certainly a reality—and that we need to accept it.

Senator HEINZ. Mr. Otis, thank you very much. We appreciate your being here.

That adjourns our hearing. Thank you all very much.

[Whereupon, at 12:30 p.m., the committee adjourned.]

APPENDIX

LETTERS RELATED TO HEARING

ITEM 1. LETTER FROM EARL W. DAVIS, SPRINGFIELD, PA., ASSISTANT STATE DIRECTOR FOR PENNSYLVANIA (EAST), AMERICAN ASSOCIATION OF RETIRED PERSONS, TO SENATOR JOHN HEINZ, DATED NOVEMBER 7, 1979

DEAR SENATOR: Thank you for informing me of your Senate Special Committee on Aging hearing held October 29th in Philadelphia. You advised me that if I had any comments, to submit them in writing, and that they would become a part of the hearing minutes.

I read the résumé of your proposal which was included with your letter. I must admit it was a little baffling but after listening to 3 hours of testimony, I was all the more confused. I felt there was a time during the hearing you were similarly perplexed.

My conclusions after thinking over what I heard at the hearing was that the program would be difficult to administer and would not reach everyone it was intended to serve. There were several questions that did not get answered during the hearing to my satisfaction.

I appreciate your interest in senior citizens and your willingness to give of your time to improve the welfare of those who have reached a point in life, where they can no longer defend themselves. Old age can be a lonely existence and any help such people like yourself can give to help them through this financial quagmire is greatly appreciated.

Sincerely,

EARL W. DAVIS.

ITEM 2. LETTER FROM HELEN L. COOKE, BENSALEM, PA., DIRECTOR, BENSALEM SENIOR CITIZENS ASSOCIATION, TO SENATOR JOHN HEINZ, DATED NOVEMBER 5, 1979

DEAR SENATOR HEINZ: I attended the Senate Special Committee on Aging hearing held in Philadelphia on October 29 and was pleased to hear about Senate bills S. 1530 and S. 1485 which you are sponsoring.

Although I have not read the actual bills, I support the concept of the bills. The elderly should have the choice of choosing a health delivery system just as employees have presently.

Personally, I have belonged to an HMO for 1½ years and have been thoroughly satisfied. However, as was noted in the hearing, the delivery system is only as good as the practitioners who serve in it.

We, at the Bensalem Senior Citizens Asociation, favor legislation that will offer older people a choice in selecting a health delivery system that will suit their needs and at the same time give them comprehensive health care at a reasonable cost.

Please send us a copy of S. 1530 and S. 1485 and keep us informed of their progress.

Thank you for your interest in the senior citizens.

Sincerely,

HELEN L. COOKE.

ITEM 3. LETTER FROM CAROLE A. LING, INDIANA, PA., EXECUTIVE DIRECTOR, INDIANA COUNTY AREA AGENCY ON AGING, TO SENATOR JOHN HEINZ, DATED OCTOBER 30, 1979

DEAR SENATOR HEINZ: The Indiana County Area Agency on Aging believes there is a definite need to bring about a change in the present health care system. Those

elderly on fixed incomes can no longer afford the exorbitant medical costs. We must direct our efforts to streamline hospital costs and doctor's fees.

It is sometimes difficult and indeed rare for an elderly person to find a doctor who will accept full assignment of the medical insurance payment. Furthermore, some medical insurances will only pay 80 percent of the reasonable charge following the required deductible payment. There almost appears to be a cooperation between the American Medical Association and health care providers to set fees well beyond a reasonable charge.

Specifically, medicare does not cover certain kinds of care such as: Private duty nursing, skilled nursing home costs beyond what is covered by medicare, custodial, and intermediate nursing home care costs, home health care above the number of visits covered by medicare, physician charges above medicare's reasonable charge, drugs, dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids.

The kinds of care mentioned above are the ones the elderly come to need the most. They have great difficulty paying for these kinds of services.

Hopefully, the health maintenance organizations and health benefit plans you are endorsing will ease some of the burden for the older person. We must provide more extensive coverage and improved benefits to enhance the quality of life for all older adults. The AAA supports the Senate Special Committee on Aging and its endeavor in the medicare reimbursement for the elderly enrollment in the health maintenance organizations.

It is imperative for us to provide the best health care that medicine and technology can offer to the elderly people of this country.

Sincerely,

CAROLE A. LING.

ITEM 4. LETTER FROM JOSEPH M. ZERILLA, BEAVER, PA., EXECUTIVE DIRECTOR, BEAVER COUNTY SENIOR CITIZENS, INC., TO SENATOR JOHN HEINZ, DATED OCTOBER 31, 1979

SENATOR HEINZ: I reviewed reimbursement amendments you are going to introduce to the Senate. I cannot add to your list, you have covered important areas of interest to senior citizens.

Beaver County Senior Citizens, Inc., membership consists of 8,437 members; incorporated in 1962 under separate cover copy of newsletter [1] published bimonthly.

On behalf of the Beaver County Senior Citizens, Inc., I wish to thank you for your interest. Our membership is grateful for your interest and consideration.

Hopefully, someday, I can speak with you personally. Heinz is a special name. I formerly coached at North Catholic High School, Troy Hill, Pittsburgh, Pa., which overlooks the Heinz plant.

Sincerely,

JOSEPH M. ZERILLA.

ITEM 5. LETTER FROM CAROL M. McCARTHY, PH. D., PHILADELPHIA, PA., PRESIDENT, DELAWARE VALLEY HOSPITAL COUNCIL, INC., TO SENATOR JOHN HEINZ, DATED OCTOBER 30, 1979

DEAR SENATOR HEINZ: The Delaware Valley Hospital Council is pleased to have this opportunity to present comments to the Special Committee on Aging on S. 1530, Health Maintenance Organizations Medicare Reimbursement Amendments of 1979.

First, we support this bill's intent to expand opportunities for the elderly to select among alternative health care delivery systems. Currently, elderly persons are extremely underrepresented in the service populations of most HMO's.

Second, we believe that the enrollment of increasing numbers of elderly in HMO's will offer an excellent and much-needed opportunity to examine how the cost structure and utilization characteristics of such organizations may change when they serve a more typical cross section of the population.

Third, we note that the prospective payment formula recommended in the bill is not related to the actual cost structure of an HMO. Not only does this represent a departure from the reimbursement principles of the medicare program, but it

[1] Retained in committee files.

makes it difficult to predict what actual incentives or disicentives will be created for HMO's to enroll medicare recipients.

We appreciate your consideration of these comments.

Sincerely,

CAROL M. MCCARTHY.

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